Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

4th September 2019

together we will

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Meeting of the Board of Directors
9am - Wednesday 4th September 2019
The Board Room, Education Centre
AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
1.	Apologies for Absence	Chair	Verbal	N/A
2.	Declaration of Interests	Chair	Verbal	N/A
3.	Chair's Business	Chair	Verbal	N/A
4.	Key Strategic Issues	Chair	Verbal	N/A
5.	Minutes of Previous Meeting – 7 August 2019	Board Secretary	Paper	4
6.	Board Action Log	Board Secretary	Paper	15
7.	Chief Executive's Report	Chief Executive	Paper	16
Quality and Safety				
8.	Patient Story	Head of Patient Experience	Verbal	N/A
9.	Infection Prevention & Control (IPC) Update (i) Outbreak status update (ii) *Clostridium difficile* Action Plan (iii) Proposals for Decant Facility (iv) IPC Annual Report 2018/19	Acting Chief Nurse / Director of Governance & Quality	Paper	19 20 22 35 40
10.	Learning from Deaths - Annual Summary Report	Medical Director	Paper	75
Performance & Improvement				
11.	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce, Director of Governance & Quality and Acting Chief Nurse	Paper	86
12.	Month 4 Finance Report	Acting Director of Finance	Paper	108
13.	Long Term Plan Update	Acting Director of Finance	Paper	124
Workforce				
14.	Consultant Revalidation and Appraisal Annual Report	Medical Director	Paper	126
15.	Communications and Engagement Strategy	Director of Workforce	Paper	139

Governance				
16.	Report of Programme Board Followed by presentation from Outpatients Transformation	Joe Gibson Alistair Leinster	Paper Presentation	169 N/A
17.	Report of Trust Management Board	Chief Executive	Paper	198
18.	Report of Safety Management Assurance Committee	Chair of Safety Management Assurance Committee	Verbal	N/A
19.	Report of Workforce Assurance Committee	Chair of Workforce Assurance Committee	Paper	201
20.	CQC Action Plan Progress Update	Director of Governance & Quality / Acting Chief Nurse	Paper	204
21.	Review of Board Assurance Framework	Board Secretary	Paper	221
Standing Items				
22.	Any Other Business	Chair	Verbal	N/A
23.	Date of Next Meeting – 2 October 2019	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

7th AUGUST 2019

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Chair
Janelle Holmes	Chief Executive
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director
Karen Edge	Acting Director of Finance
John Coakley	Non-Executive Director
Jayne Coulson	Non-Executive Director
Paul Moore	Acting Chief Nurse / Director of Quality and Governance

In attendance

Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
John Fry	Public Governor
Angela Tindall	Public Governor
Jane Kearley*	Member of the Public
Heather Richards	Member of the Public
Rory Deighton	Member of the Public
Rob Little	Member of the Public
John Mitchell	Member of the Public
Tom Cooper*	Member of the Public / Patient Story
Candice Jardine*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

Gaynor Westray	Chief Nurse
Chris Clarkson	Non-Executive Director
Paul Charnley	Director of IT and Information
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute

Reference	Minute	Action
BM 19-20/096	**Apologies for Absence** Noted as above.	
BM 19-20/097	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/098	**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	

Reference	Minute	Action
	updates regarding previous items would be provided within the Key Strategic Issues section of the meeting.	
BM 19-20/099	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Chief Operating Officer** – reported the news that the Trust had been named to receive funding of £18m for an Urgent Treatment Centre as part of 20 capital projects announced by the Prime Minister earlier in the week. This was as a consequence of a successful bid by Wirral CCG following recent public consultation regarding proposed changes for the Wirral health economy. Mr Middleton provided a brief outline of the next steps of the process in particular the detailed plans required to underpin the scheme. This is an opportunity to redesign the emergency care pathway, , providing a solution for the whole health economy and would be the single biggest project since the Trust was built. **Mrs Sue Lorimer – Non-Executive Director –** reported that following on from the previous item Finance, Business, Performance and Assurance Committee (FBPAC) would be considering the capital programme including underlying quality of the Trust estate as part of the overall Trust Financial Strategy. **Mrs Jayne Coulson – Non-Executive Director –** apprised the Board of Directors that following the recent meeting to discuss the Communications & Marketing Strategy it was agreed the focus would contain three elements: internal, external and branding. **Associate Medical Director, Women & Children's –** Mr Lund apprised the Board of the impact for the Division following the news that 'One to One' community maternity service have gone into administration. At present it is unknown how many of the possible 1600 women may require access to the Trust's services. **Director of Workforce** – advised that Board of Directors of the national concerns raised regarding the tax implications in relation to NHS pensions and the impact particularly for consultants and senior members of staff. Whilst this is being reviewed nationally the Trust has establishing a working group to consider the options available and was currently collating the data to understand the impact for the Trust. **Mr John Sullivan – Non-Executive Director –** advised of the significant work undertaken to address health and safety issues raised previously and this would be captured within the assurance report later in the meeting. **Medical Director** – provided feedback following the recent visit of Frank Field, MP to meet with staff in the Emergency Department (ED). Dr Stevenson reported ward changes as follows: • Ward 17 (Colorectal Unit) has moved to Ward 14 • Ward 14 (Surgical Assessment Unit) has moved to Ward 17 and SAU has been renamed Surgical Emergency Unit (SEU).	

Reference	Minute	Action
	These change mean the Colorectal Unit now has an increase in side rooms and therefore will enable better infection prevention control measures for this vulnerable group of patients. In addition, the larger SEU will enable flow of Surgical Patients from ED. **Chief Executive** – advised of the forthcoming interviews for the Director of Strategy and Partnership. The Board were also informed of regional discussions between organisations regarding the process for the reprovision of maternity services within Trusts already providing community services rather than undertaking a tender process following the collapse of the 'One to One' service as discussed earlier. A letter on behalf of all organisations has been submitted to Wirral CCG as commissioners of the service. The Wirral system financial position was discussed at a meeting with NHS England/Improvement with the key message being the expectation that the system will deliver the £1.1m surplus control total. Working together Wirral CCG along with Trust and other health economy partners are to review opportunities to redesign services to deliver efficiencies and a follow-up meeting is to be arranged for September 2019. The Trust has established an internal System Financial Recovery task and finish group to consider the opportunities to improve patient experience across the health economy. A set of slides outlining the areas identified are to be drafted and circulated to Board members for information. **Acting Director of Finance** – informed the Board that the Trust is required to submit a 5 year plan by the end of September which will subsequently be reflected in both the wider Wirral health economy and Sustainability and Transformation Partnership (STP) footprint plans. Due to the timelines a draft outline will be provided at the next Board of Directors meeting with final report to the FBPAC in September for approval. **Acting Chief Nurse /Director of Quality & Governance** – informed the Board that a key focus for the recent Chief Nurse meeting was sustainable staffing with prospect for the Trust to have an active role in the number of placements for trainees and exploit recruitment opportunities. ***The Board noted that although some members did not have detailed updates there were a number of topics already covered within agenda items.***	**AM/KE** **KE**
BM 19-20/100	**Board of Directors** **Minutes** The Minutes of the Board of Directors meeting held on 3rd July 2019 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 19-20/101	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including:	

Reference	Minute	Action
	• Serious Incidents • RIDDOR Update • A&E Board • CQC Inspection ***The Board noted the information provided in the June Chief Executive's Report.***	
BM 19-20/101	**Patient Story** The Board were joined by Tom Cooper and Candice Jardine, parents of twins Teddy and Sofia who apprised the Board of their story outlining the journey via Ronald MacDonald House, Alder Hey Hospital, Liverpool Women's Hospital and Wirral University Teaching Hospital (WUTH). The twins were born at 25 weeks, Teddy subsequently suffered extensive brain bleeds and Sofia a bowel infection leading to the removal of half of the bowel. Tom and Candice moved into Ronald McDonald House (WUTH) so they were able to spend 24 hours a day with the twins for the duration of their time in hospital, over 100 days. Following diagnosis of a bowel infection 'necrotizing enterocolitis' Sofia was transferred to the surgical team at Alder Hey whose prognosis was bleak, she underwent surgery the following day. Unfortunately Sophia's bowel was unable to be saved and she would need 'Total Parenteral Nutrition' (TPN) for the rest of her life and may eventually require a liver and bowel transplant. Following surgery it was expected that Sofia would be transferred back to WUTH but the family were informed that she would be moved to Liverpool Women's and they were concerned of the continued separation of the twins and the situation was further complicated as parents are not able to be accommodated on site. Sophia was finally transferred back to WUTH after four weeks to the care of the neonatal team which provided Tom and Candice much comfort at such a difficult time. Both Teddy and Sofia are doing well, but have a long journey ahead of them. On behalf of the Board, the Chair expressed his thanks and appreciation to Tom and Candice for sharing their experience and advised them that he would highlight the key issues that they had raised with the Chair's at the other Trusts. ***The Board noted the positive feedback received from Mr Cooper and Ms Jardine.***	

Reference	Minute	Action
BM 19-20/102	**Update – Outbreak of *Clostridium difficile*** The Board sought and received assurance concerning the outbreak of *Clostridium difficile (CDI)*. The weekly outbreak meetings continue. In the designated outbreak wards, and subsequently extended to cover all patient-facing clinical areas, specific interventions designed to enhance control have been, or are in the process of being, implemented. These include increased focus on hand hygiene compliance, staff training and awareness, simplification and implementation of standardised cleaning schedules, completion of vital maintenance work and replacement of unservicable bedside equipment which cannot be thoroughly decontaminated.	
	The Board acknowledged this was an outbreak involving a virulent strain of bacteria, which was difficult to control. The Acting Chief Nurse/Director of Quality & Governance stated compliance had improved in July. He was cautiously optimistic that the organisation was starting to get controls in place although it would likely be 3 – 6 months before he would be able to provide assurance that it was under prudent control due to the nature of the strain of infection. Jay Turner-Gardner, Associate Director of Nursing – Infection Prevention and Control explained that following analysis of cases within the outbreak wards a range of learning opportunities had been identified. She advised that these are being acted upon and extended beyond the outbreak areas. A summary of the key learning points and the controls that have been developed and strengthened were provided as detailed in the report. The Board acknowledged the seriousness of this matter and welcomed the support received from NHS England/Improvement and Public Health England in enhancing control. The Board understood that the aetiology of the bacterial strain meant that it could take some time to address, however, reviewed and sought confirmation that actions are being implemented with the necessary priority which reflects the Boards concern. The Board were satisfied that the Acting Chief Nurse had established the requisite command and control arrangements need to manage the situation and were encourage by the rapid improvements, most notably to: i. Hand hygiene compliance ii. Processes to replace unserviceable bedside equipment, and iii. Revision and development of standard operating procedures. The Board were satisfied with control over antibiotic usage. The Board remained concerned about environmental cleaning and the overall condition of parts of the clinical estate. The Acting Chief Nurse elaborated on and reiterated his advice to the Board to bring a decant facility into operational use as soon as reasonably practicable, this to accelerate vital maintenance and repairs needed to enhance infection prevention and control. The Board considered carefully the advice of the Acting Chief Nurse and his judgement on the need for a decant facility. It was acknowledge that there	

Reference	Minute	Action
	are a range of views concerning the effectiveness and need for decant facility. However, it was agreed that given the statistical significant of the Trust's exposure to *Clostridium difficile* infection prevention and control procedures was necessary. The Board commissioned the Chief Operating Officer and Acting Chief Nurse to prepare an all options appraisal for decant facility for consideration at the next Board. The Acting Chief Nurse furnished the Board with details of the *Clostridium difficile* action plan and progress update at each formal meeting of the Board until such time as the rate of infection is brought under better control. ***The Board noted the advice from the Acting Chief Nurse in their capacity as Acting Director of Infection Prevention Control (DIPC).***	**AM/PM** **PM**
BM 19-20/103	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Of the 52 indicators with established targets or thresholds 19 are currently off-target or not currently meeting performance thresholds. The Board recognised the significant improvement across a range of indicators such as and acknowledged the continuing work in relation to indicators underperforming. The lead Director for a range of indicators provided a brief synopsis of the issues and the actions being taken. Areas of focus for discussion were: • 4 hour A&E – although up to June the indicator was achieving trajectory, July has seen a dip in performance and it was noted this was also the national picture. Following a busy period combined with high levels of sickness performance was now back on track. Ambulance hand over time continues to improve. • RTT – although currently above trajectory, performance for July is in line with trajectory to achieve by March 2020. • 2 week and 62 day cancer waits – metrics to be reviewed due to quarterly performance only being finalised six weeks after quarter end, due to required confirmation of cancer status and shared pathways between providers. • MUST – overall performance has improved with deterioration due to a small number of cases. Introduction of combined harms panel to confirm and challenge and additional trigger added to Wirral Millennium. • Infection Prevention Control (IPC) indicators – these indicators are covered within agenda item BM 19-20/102, earlier in the minutes. • VTE – whilst disappointment at the recent dip in performance was expressed due to by-passing the alerts, introduction of reporting on by-passing from August 2019 and will generate a 'Live' dashboard. • SHMI – is in line with national average, review of data underway including Emergency Department (ED), the output to be reported through Patient Safety Quality Board (PSQB). • Appraisal – new contribution framework introduced as part of the values and behaviour work.	

Reference	Minute	Action
	• Attendance management– pilot of the attendance management system 'First Care' started in Estates and Facilities from 1st August 2019. The Board noted that staff side were not supportive of the process primarily due to service being delivered through a private provider and concerned about the effectiveness of the pilot due to other supporting measures being introduce in conjunction with this process. It was highlighted that the pilot was only in Estates and Facilities therefore the effectiveness of all new processes could be measured through other means. • Staff turnover – Workforce Assurance Committee to consider alternative initiatives across a range of staff groups. Training available to support managers to monitor and address issues. ***The Board noted the current performance against the indicators to the end of June 2019 and expressed congratulations to the Emergency Department team for the improved performance.***	
BM 19-20/104	**Month 3 Finance Report** The Acting Director of finance apprised the Board of the summary financial position and at the end of month 3, the Trust reported an actual deficit of £4.8m versus planned deficit of £4.9m. However, this includes c£1.3m of non-recurrent support from Wirral Clinical Commissioning Group (CCG) to achieve the Trust planned position and allow the PSF/FRF to flow to the Trust and the system. The key headlines for month 3 include: • The underlying position is £1.4m worse than plan cumulative and £0.4m worse in month. • The key drivers of the worse than plan position include depreciation and VAT c£0.6m, Aseptics unit closure £0.2m and pay pressures. Pay pressures primarily comprise temporary medical staffing costs and costs of ED capacity. Work on temporary medical staffing is underway with a deep dive to be presented to FBPAC. It was noted that the Trust is starting from a low base in terms of planning, governance and effective processes. • Income is broadly in line with plan with under performance in elective offset by maternity and diagnostics; noting non-elective activity/out patients being subject to block contract terms. • Cost Improvement Programme (CIP) delivered in month and year to date with £2.0m against a plan of £1.8m. The profile of the CIP increases in Quarter 2 and some slippage is expected. • Cash is £3.5m, being above plan. • Capital is slightly behind plan but the available £7.5m is fully committed. The programme has been reduced by £1.6m related to the car park scheme which has been deferred at national request. A detailed forecast has been completed for Quarter 2 which shows a £2.5m worse than plan position and applying run rate and expectations regarding recovery of CIP, the full year forecast outturn is £4.3m deficit. This assumes the planned closure of beds in October and there is no winter contingency. This includes non recurrent pressures relating to locum VAT and aseptics of (£0.5m), the depreciation issue of (£1.3m) and the balance of (£2.5m) being	

Reference	Minute	Action
	the net pay pressure. A further £0.8m of mitigations have been identified which would reduce the forecast deficit to (£3.5m). The Trust continues to pursue options for mitigation that do not impact on patient care, whilst ensuring controls are in place to manage current spend. The Board understood that following the recent medical staffing review Trust Management Board (TMB) are to monitor progress of the action plan to be developed based on the external review recommendations and Finance, Business, Performance and Assurance Committee are to undertake a 'deep dive' on medical pay due to lack of assurance as to when the Trust would see a reduction in the medical pay bill. It was noted that it was expected there would be some improvement in quarters 3 and 4 due to recent successful recruitment processes with start dates agreed later in the year. The forecast outturn does not reflect the risk regarding recent changes in pension contributions that may affect consultants and senior managers as the impact for the Trust is not yet fully understood. **The Board noted the M3 finance performance.**	
BM 19-20/105	**Six Facet Survey** The Associate Director of Estates and Facilities presented an overview of the elements of the Six Facet Survey. This included: • Facet 1 - Physical Condition Survey • Facet 2 – Statutory Compliance Audit • Facet 3 – Space Utilisation Audit • Facet 4 – Functional suitability Review • Facet 5 – Quality Audit • Facet 6 – Environmental Management. A brief summary including funding requirements for each of the elements was provided. In addition the risk summary profiles for both Arrowe Park and Clatterbridge sites informed discussion regarding the elements identified within the risk categories – low, moderate, significant and high. The Board understood that that it would require a significant period of time to address all conditions identified and the action plan should reflect new technology developments. The next steps are detailed below: • The data is to be verified during August with sign off of the survey at the end of the month. • The Board would be advised of any changes to the data. • Estates Strategy to be developed for the use of buildings/site going forward. Engagement with the Divisions will be undertaken to align the Estates Strategy with the Clinical Strategy. • Backlog maintenance element of the capital plan to be revised to reflect high risk items identified.	

Reference	Minute	Action
	The Board noted the Six Facet Survey update. The Chair on behalf of the Board thanked the Associate Director of Estates and Facilities and his team for the hard work and that this message is conveyed to colleagues in the team.	
BM 19-20/106	**Report of the Quality Committee** Mr Steve Igoe, Non-Executive Director, apprised the Board of the key aspects from the recent Quality & Safety Committee, held on 24th July 2019 which covered: • Infection Prevention and Control • Overall Quality Performance • Serious Incidents and Duty of Candour • Update on CNST Maternity Incentive Scheme • CQC Insight Tool and Action Plan • Board Assurance Framework The Board noted the Committee's items for escalation. ***The Board noted the Quality Committee report and approved the Trust's compliance with the CNST scheme.***	
BM 19-20/107	**Report of the Finance, Business, Performance Assurance Committee** Ms Sue Lorimer, Non-Executive Director apprised the Board of the key aspects from the recent Finance, Business, Performance Assurance Committee held on 24th July which covered: • Month 3 Finance Report • Board Assurance Framework • Quarter 2 and 2019-20 Full Year Forecast • Financial Strategy Update • Update on the Six Facet Survey • Quality Performance Dashboard • Cheshire & Merseyside Collaboration @ Scale • Reports from other committees ***The Board noted the Finance, Business, Performance Assurance Committee report and the risk of non-achievement of the financial control total and subsequent loss of central funding.***	
BM 19-20/108	**Report of the Charitable Funds Committee** Ms Sue Lorimer, Non-Executive Director apprised the Board of the key aspects from the recent Finance, Business, Performance Assurance Committee held on 30th July which covered: • Head of Fundraising Report • Tiny Starts Appeal • Community and Events Fundraiser • Finance Report • Charity Risk Register.	

Reference	Minute	Action
	The Board noted the Charitable Funds Committee report and the approval of an additional post to support the Charity's appeal targets.	
BM 19-20/109	**Change Programme Summary, Delivery & Assurance** Mr Anthony Middleton provided an outline of the Change Programme amendments during the past month and performance relating to the three large priority projects; Patient Flow, Outpatients and Theatres Productivity. It was agreed that 'on day cancellations' data should be reported as two separate categories – clinical / non clinical. Recruitment to the new Service Improvement Team is ongoing with the successful appointment to Head of Service Improvement post at the end of July. Interviews for other posts will take place 13th – 15th August. ***The Board noted the Change Programme summary, delivery and assurance report.***	
BM 19-20/110	**Report of Trust Management Board** The Medical Director provided a report of the Trust Management Board (TMB) meeting on 31st July 2019 which covered: • Quality & Performance Dashboard • Medical Staffing Review • Pension Group Update • Bed Capacity Model • Divisional updates • Wirral Integrated Musculoskeletal (MSK) Service • Integrated Pharmacy and Medicines Optimisation Service • Acuity and Dependency Solution • Month 3 Financial Position • Business case: Orthopaedic Consultant Programmed Activities • Chair reports from other meetings Following concerns raised regarding Palliative Care funding and System Working, the Medical Director was to prepare a letter on behalf of the Chair to escalate concerns to CCG and Wirral Community Trust. ***The Board noted the verbal report of the Trust Management Board.***	**NS**

BM 19-20/110	**Report of the Safety Management Assurance Committee**
	
	Mr Steve Igoe, Non-Executive Director, apprised the Board of the first meeting of Safety Management Assurance Committee, held on 1st August 2019 highlighting the key aspects which covered:
	
	• Health & Safety position status and update including
	  ○ Immediate response
	  ○ Work undertaken to date
	• Governance arrangements	

Reference	Minute	Action
	The Board acknowledged that there was much to do however there is at least now a pathway to resolution and a move past compliance and enhancement. ***The Board noted the Safety Management Assurance Committee report.***	
BM 19-20/111	**CQC Action Plan progress Update** The Acting Chief Nurse/Director of Quality & Governance apprised the Board of the continued progress pertaining to the CQC Action Plan and he was pleased to report there were no overdue actions. It is expected that the initial action plan based on the March and May 2018 inspections would be closed down by the end of August 2019. It was reported that there is some drift with the actions identified in the May 2019 inspection of Urgent Care. These are expected to be back on track within the next few weeks following the confirm and challenge meetings. ***The Board noted the progress to date of the CQC Action Plan.***	
BM 19-20/112	**Any Other Business** There were no items to report this month.	
BM 19-20/113	**Date of next Meeting** Wednesday 4th September 2019.	

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Chair

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Date

Board of Directors Action Log
Updated – 7th August 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 07.08.19						
1	BM 19-20/099	Prepare slides outlining opportunities to improve patient experience across the health economy	**AM/KE**	Complete	September '19	
2		Draft 5 year plan to be discussed at next Board meeting with final plan to be presented to the September FBPAC for approval.	**KE**	Complete – see agenda item 13	September '19	Final copy included for September FBPAC
3	BM 19-20/102	Options appraisal for decant facility to be prepared for discussion at next Board meeting.	**AM/PM**	Complete – see agenda item 9.3	September '19	
4		Clostridium difficile action plan and progress update as a standing item for Board until such time as the rate of infection is brought under better control	**PM**	Complete	September '19	Added to cycle of business for the Board of Directors until further notice.
5	BM 19-20/110	Letter to be prepared outlining concerns raised regarding Palliative Care funding and system working – escalation to CCG/Wirral Community Trust	**NS**	Complete	September '19	
Date of Meeting 01.05.19						
1	BM 19-20/027	Outcome of review of NHS Improvement Licence Undertakings to be reported to Board	**KE/AM/ AL**	Discussions ongoing, draft response prepared	October '19	Awaiting timeframe for process, yet to be determined by NHSI
2	BM 19-20/028	Patient Experience Strategy under development	**PM**	Draft for discussion at Patient Family Experience Group	October '19	Acting Chief Nurse requested to review and therefore timeframe revised

Board of Directors	
Agenda Item	7
Title of Report	Chief Executive's Report
Date of Meeting	4th September 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 August 2019.

National

Additional NHS Capital Funding

The Trust has received communication from Julian Kelly (NHSE/I CFO) to advise that our original capital limit has been reinstated following a £1.0bn increase in the DHSC capital limit by the Government. This means the £1.6m that was deferred for the car park scheme is now available for spend in 2019/20. Due to the time remaining in the financial year for the Trust to deploy capital, a review of the car park procurement timeframe, emerging risks and capital contingency is being undertaken and a proposal for sequencing and priorities will be reported to the FBPAC in September.

Cyber Security

The Trust has recently achieved the national Cyber Essentials Certification which is a good step forward. This was something that the GDE funding helped us to achieve but has involved a lot of work for the IT and Information Governance Teams. The next target is to achieve Cyber Essential Plus (CE+) which NHS England has set for 2021. Cyber security progress will be tracked by FBPAC.

Winter Planning

Communication leads from Merseyside, Cheshire, Lancashire and South Cumbria met with their NHS England / NHS Improvement counterparts in August to discuss winter communications.

Staff communication was the big topic for this meeting. A newly formed staff flu campaign is being created by the national team which can be altered locally. The upcoming flu season for the UK is often based on that of Australia. By all accounts our neighbours in the southern hemisphere have had a really bad flu season this year. This means there will be an even greater need for NHS staff to take precautions in the UK and a tailored communications campaign will help promote this importance.

The national communications team also highlighted a new length of stay campaign aimed at NHS staff. Patients who stay in hospital longer than is necessary may face associated risks. Called ‘Where best next?’, this national staff facing campaign has been designed to encourage senior leaders and healthcare professionals to foster a ‘Why not home? Why not today’ mindset.

Both campaigns will form part of the WUTH communications winter planning for 2019/20.

Regional & Local

Wirral A&E Delivery Board

The Board continued to focus on aspects of both Urgent and Unplanned care. Having received the Ambulance Conveyance Report from ECIST, a number of key actions were agreed to implement recommendations made. The overarching principle to refine and develop a sustainable process of Patient triage and handover, to ensure a patient is reviewed by the most appropriate pathway or specialisation. In preparation for Winter, the Board also agreed, as a collaborative health economy and wider system, that a review of overall patient length of stay was paramount. Having now identified a number of themes and reasons that contributed to extended hospital stays, community services should be prioritised to support this cohort of patients. This aspect will be supported further by ECIST recommendations to aid improved patient flow throughout the acute setting.

Internal

Serious Incidents

The Trust declared 3 Serious Incidents in July 2019. Two cases related to patient falls which resulted in injury and the third related to a delay in treatment. Full investigations are underway and will be monitored and reported via the Quality Committee.

RIDDOR Update

The Trust reviewed 4 RIDDOR reportable incidents at the SI panel in the month of July. 1 was a manual handling injury; 2 back injuries following moving and transferring incidents and the fourth was a patient fall (that met RIDDOR criteria) and has also been reported as an SI. All are being appropriately investigated and reported and monitored via the Quality Committee.

Executive Team Recruitment

Director of Strategy & Partnerships
Matthew Swanborough was recruited to the position of Director of Strategy & Partnerships on 9th August 2019. Matthew is due to join the Trust at the beginning of November.

Chief Finance Officer
The recruitment process for the Chief Finance Officer is currently underway, the process will conclude with interviews on Friday 20th September 2019.

Janelle Holmes
Chief Executive
September 2019

Board of Directors	
Agenda Item	9.0
Title of Reports	1.*Clostridium difficile* - outbreak update 2. Action plan to reduce the incidence of *Clostridium difficile* 3. Infection Control in the built environment 4. Infection Control annual report 2018/19
Date of Meeting	4.9.2019
Authors	1&2. Mrs Jay Turner Gardner – Associate Director of Nursing for Infection Prevention and Control 3. Mrs Jay Turner Gardner – Associate Director of Nursing for Infection Prevention and Control and Glen Adams – Associate Director of Estates and Facilities 4. Dr Julie Hughes, Interim Associate Director of Nursing (Apr – June '19) - Infection Prevention and Control/Deputy Director Infection Prevention and Control and Sarah Deveney Senior Infection Prevention and Control Nurse
Accountable Executive	Paul Moore – Acting Chief Nurse/Director of Infection Prevention and Control Anthony Middleton – Chief Operating Officer
Purpose of the Papers **1.2.3**	The following papers are to update and inform the Board of Directors of the current status regarding the Outbreak of *Clostridium difficile,* the associated improvement initiatives undertaken and those further proposed. **Health Building Note 00-09:** **Infection control in the built environment states:** *'Research and investigation have consistently confirmed that the healthcare environment can be a reservoir for organisms with the potential for infecting patients.* *The importance of a clean, safe environment for all aspects of healthcare should not be underestimated. It is important that healthcare buildings are designed with appropriate consultation, and the design facilitates good infection prevention and control practices and has the quality and design of finishes and fittings that enable thorough access, cleaning and maintenance to take place.* *Good standards of basic hygiene, cleaning and regular planned maintenance will assist in preventing healthcare-associated infection (HCAI); only if the built environment reflects these needs are schedules more likely to be successful not only in being undertaken on a proactive and reactive basis but also in reducing contamination and risks to patients.* *For HCAIs to be reduced, it is imperative that IPC measures are "designed-in" at the very outset of the planning and design stages of a healthcare facility and that input continues up to, into and beyond the final building stage. Designed-in IPC means that designers, architects, engineers, facilities managers and planners work in collaborative partnership with IPC teams, healthcare staff and the users to deliver facilities in which IPC needs have been anticipated, planned for and met'.*
4.	This is the 2018/19 annual report*. It is an account of the activities of the Infection Prevention and Control team and the performance of the trust in the management and control of infections during 2018/19. *Please note that there have been recommendations made in this Annual report- this is not the purpose of such report. Whilst these recommendations will be considered by the new substantive IP lead when reviewing the Infection Prevention service they may not form the basis of the 2019/20 IP strategy.

Clostridium difficile Outbreak update

In the 2019/20 year-to-date, there have been 47 reported *Clostridium difficile* infections (n=39 during Q1 against a Q1 trajectory of 22); the annual objective for WUTH is 88 in 2019/20. The Trust is therefore 17 cases above trajectory in Q1. The Trust is identified as an outlier with a statistically significant variance from other providers in the North West.

The Trust declared an outbreak of CDI in February 2019, it was initially declared on five wards at Arrowe Park Hospital where the *Clostridium difficile* cases were first identified. The outbreak was subsequently closed in April 2019. When cases continued to be identified following closure of the outbreak the outbreak was extended and re-declared in May 2019. Following reported incidences throughout the rest of the trust the Outbreak was declared closed on the five wards in July and extended to a Trust wide outbreak.

The cause of the hospital-wide outbreak is multi-factorial, namely around four key factors

- ***Environment*** the environment within Healthcare can have a significant impact on the prevention and control of infection and is an integral part of the design process for any building or developmental works to ensure that Infection Prevention is designed into all healthcare builds (NHS Estates 202).The environment at Arrowe Park is out dated with a much overdue lifecycle replacement, many fittings are beyond repair.
- ***Equipment*** Healthcare equipment can be a potential source of infection and up to one third of healthcare associated infections may be prevented by ensuring adequate cleaning of equipment (Schabrun and Chipase,2006). The state of repair of any piece of equipment will affect the ability to clean it adequately, it is therefore essential that the integrity of re-usable equipment is checked before being decontaminated appropriately between patients. Patient bedside tables, chairs and lockers are chipped, with bare wood exposed and cannot be cleaned effectively and will harbor harmful pathogens.
- ***Cleaning*** Good hospital hygiene is an integral and important component of a strategy for preventing healthcare associated infections in hospitals (Pratt *et al.,* 2006). Clinical evidence indicates that the hospital environment must be visibly clean, free from dust and dirt, and acceptable to patients, their visitors and staff (Pratt *et al*., 2006)
- ***Policies and procedures*** Legislation in the U.K regarding Infection Prevention is namely the Health Act 2006, which identifies a code of practice, which, by law, must be followed by all healthcare organisations. National guidelines and standards have been produced to improve quality of patient care and all hospitals must have written policies and procedures for reducing healthcare-associated infections (this is a requirement under the health act). Education and training of staff must be audited on a regular basis to ensure that policies and procedure are being followed i.e. hand hygiene policy.

Lack of facilities to isolate patients and insufficient priority being given to allow staff to follow essential Infection Prevention strategies to prevent the spread of Infection has also had an impact on how quickly the outbreak of CDI has become established.

Actions to address the key factors identified have been undertaken with a Trust wide increase in Audits, along with an increase in hand hygiene compliance monitoring. Wards have been decluttered to facilitate cleaning and cleaning standards reviewed and refined. In access of 1,000 pieces of patient furniture has been purchased in recognition that damaged and worn surfaces cannot be effectively cleaned including patient chairs, bedside tables, relative's chairs and lockers. New mattresses have been sourced following a Trust wide audit that revealed many needed to be replaced as they were contaminated with bodily fluids.

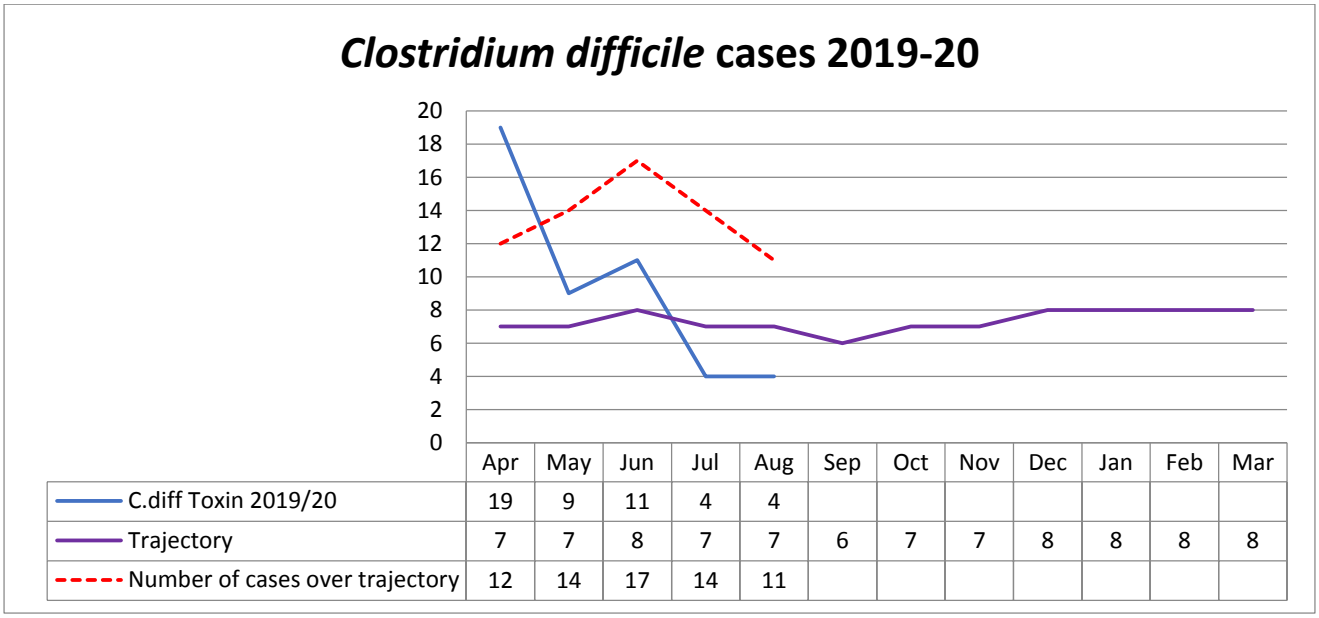
Key policies are under review and a more robust investigation process has been commenced following each diagnosis of *Clostridium difficile. A*n accountability framework has been introduced to ensure that any lapses in the quality of the care that we deliver are recognised in real time and learning outcomes documented and shared to avoid future failures.

Following intense scrutiny from Public health England and NHSI and NHSE a CDI action plan was submitted to the CQC in June and since this time there have been monthly updates to The Trust board and The Patient Safety and Quality Board. A *Clostridium difficile* improvement plan has been written along with a Patient Safety bulletin. An Infection prevention awareness campaign has been introduced and key messages are sent to all staff on a weekly basis along with a *Clostridium difficile* update message for staff when first accessing Cerner.

Weekly Outbreak meetings have continued since June.

Whilst there has been great improvements made following the interventions implemented at Arrowe park in recent weeks to reduce the risk of cross infection from *Clostridium difficile* one of the most important aspect has yet to be addressed, improvements to the fixtures and fittings of the patient environment in the Hospital. It has to be recognised that most of the wards are out dated, overdue lifecycle replacement and no longer meet legislative requirements as stipulated above.

On Monday 19th August 2019 the Associate Director of Nursing for Infection Prevention and Control and the Associate Director of Estates and Facilities met with Executive Management Team to review various option appraisals to upgrade our ward areas to ensure the estates was fit for purpose, this will promote effective cleaning to take place to minimize the risk to our patients of potentially harmful pathogens which are contaminating our present environment. These options are explored in another paper.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C.diff Toxin 2019/20	19	9	11	4	4							
Trajectory	7	7	8	7	7	6	7	7	8	8	8	8
Number of cases over trajectory	12	14	17	14	11							

Jay Turner-Gardner, Associate Director of Nursing – Infection Prevention and Control

Action plan to reduce the incidence of *Clostridium difficile* infection

Rationale: This action plan has been developed as a result of a recent outbreak of *Clostridium difficile* resulting in the Trust being above trajectory per month in year 2019/20 with an annual objective of 88.

Aim: Implement actions now to promote patient safety and remain under trajectory for future months

This is a working document

Outstanding
In progress
Complete

	Proposals	Rationale/Discussion	Responsibility	Target date for completion	Progress	
			EQUIPMENT			
	Replace damaged equipment that cannot be effectively cleaned	To ensure that all surfaces are intact and withstand effective cleaning	Corporate Nursing Team TF	Ordered in July 2019. Expected delivery August/Sept 2019	114 visitors chairs purchased 381 Patient chairs purchased 387 bed side lockers purchased 354 over bed tables purchased	In progress
	Mattress audit	To ensure that all mattresses are fit for purpose	AN	August 2019	100 new mattresses ordered prior to audit to ensure that there is enough stock to enable replacement.	In progress
	Remove Dyson fans. Ensure a cleaning SOP for bladed fans. Floor standing fans to be removed from clinical areas.	MHRA alert regarding decontamination issues with Dyson fans. Fans are a potential source of infection. Floor level fans circulate debris from the floor into the environment.	Ward managers. SOP to be written by risk and IPC.		Fan cleaning SOP written and circulated. Dyson fans asked to be removed. Awaiting assurance Floor standing fans asked to be removed. Awaiting assurance	In progress

	All key boards and mice are wipeable		Procurement (MP) & IPC Team (LY)	September 2019	Trial taking place on ward 38 of several different types of key boards during August 19 When appropriate key board identified monies to be sourced.	In progress
	Single use disposable tourniquets are used for patients with known Infection/Colonisation	Wipeable tourniquet's may be used between patients with no known infection/Colonisation	Procurement (MP) IPT (LY) Clinical staff	August 2019	Awaiting assurance	In progress
	Hand hygiene Gel dispensers are located at appropriate intervals	Trust wide standard set which needs to be rolled out across all wards/Theatres /Departments. Initial installation was like for like and the previous dispenser location needed to be reviewed.	IPT (LY) Procurement (CL) & Representatives from *DEB*	September 2019	Recent replacement of all Hand Hygiene products like for like. (Soap, Alcohol based Foam, Hand cream) Escalated to the company regarding concerns about the poor installation (JTG) 22/08/19	In progress
	All patients with known Infections/Colonisations have the appropriate single use B/P cuff which is cleaned between pt uses	Disposable Welch and Allyn FBF307/308/316 £96.00 box 20	Procurement (MP) IPT (LY) Clinical staff	August 2019	Awaiting assurance	In progress
	IPC approved wipeable B/P cuffs are used between patients with no known infection/Colonisation	Re-usable Welch and Allyn FBF317/318/320 £10.80 pair	Procurement (MP) IPT Clinical staff	August 2019	Awaiting assurance	In progress
	Single use items are never re-used		Health & safety (DH) IPT (LY) Ward staff	August 2019	Awaiting assurance	In progress

	Items of equipment are used for what they were originally procured for	Sharps bins are not used for any other purpose.	Ward manager	August 2019	Awaiting Assurance	In progress
	All waste bins are fit for purpose	Hands free lids- to avoid dirty bin lids being touched Foot operating- to avoid having to touch the lid Silent closing- so that it doesn't clash down Plastic feet _ to avoid rust marks on the floor Bumper at the back – to avoid damage to the wall when opened	Procurement (DL)			Outstanding
	All Blood Pressure machines have Clinnell disinfectant wipe dispensers fitted	To promote timely cleaning	Infection Prevention Team	August 2019	Representative visiting week beginning 6th August to visit all wards and commence installation. Re-visiting week beginning 2nd Sept	Complete
DE-CLUTTER						
	Remove bay buddies	These trollies kept outside of each bay store key items of equipment that due to their packaging cannot be cleaned. They are an obstacle which inhibits cleaning of corridors.	Ward managers	July 2019	Awaiting assurance from **all** wards	In progress
	A Patient bedside is kept clutter free	To ensure that all horizontal hard surfaces are clutter free so that they can be cleaned	Ward manager Ward Domestic	August	Patients advised not to bring anything in that cannot be stored in their lockers	In progress
	No perishable items are stored on the floor to promote effective floor cleaning	Plinths are not used to move items up from floor height. Plinths in use are removed	Ward manager & Estates team	Dec 2019	IPC advice needed to ensure appropriate storage of equipment	Outstanding

	Remove all hand hygiene posters from sink areas	The new dispensers have pictures of the correct hand hygiene technique	Ward manager	July 2019		In progress
	Remove all non-essential posters from clinical environment	Ensure any posters in use are laminated	Ward manager	July 2019		In progress
	Re-positioning of some of the floor graphics to remove trollies off corridors. Make good the area where the graphic was – Floor scrubbing may be required	Corridors are cluttered and some trollies can be moved a small distance to allow for the main thoroughfare of the ward to be clear and clutter free to assist with effective cleaning	Estates (GA)	Sept 2019	This will also allow for emergency escape if there was a fire.	Outstanding
	Clear the clutter campaign	Improve the collection an disposal of medical / offic equipment and waste items that do not fall into a specific waste collection.	Estates (DM)	July 209	Corridoors,Wards & Public Areas 2019.doc	Complete And ongoing
INFECTION PREVENTION PRACTICE						
	Remove trollies from outside of bays that contain gloves and aprons, this is not standard IPC practice.	IPC appropriate wall mounted glove and apron holders required to be installed outside every bay and single room	Procurement (MP) IPT	Sept 19	Dani centres identified by IPT as product of choice Monies need to be identified to purchase	Complete Outstanding
	Replace all glove and apron holders to IPC standard	IPC appropriate wall mounted glove and apron holders required to be installed inside bays and single rooms.	Procurement (MP) IPT		Dani centres identified as product of choice Monies need to be identified	Complete Outstanding

	Cease the practice of using communal toiletries	Remove communal hibiscrub and wall mounted dispenser form all shower rooms and bathrooms	Ward manager to remove product Estates to remove dispenser IPT	July 2019	Each pt to have individual toiletries Awaiting assurance	In progress
	All patients with known colonisation / Infection have bed sheets change daily	To promote a clean environment and avoid pts being nursed in a bed with potential harmful germs	Ward manager	July 2019	Awaiting assurance	In progress
	Patients with diarrhoea are isolated within 4 hours on first symptoms of diarrhoea	To avoid contaminating their local environment and risking cross infection to others	Ward managers		If patients not isolated immediately, incident form to be completed	In progress
	Patient shared equipment is cleaned between uses by the same patient, and uses between different patients	Clinell wipes used when no infection. Chlor-clean used with known or suspected infection.	Ward manager	July 2019	Audited monthly	Complete
	Clinical hand hygiene sinks are used for Hand Hygiene only	To avoid contaminating sinks during use	Ward Managers	July 2019	National guidance Awaiting assurance	In progress
	Plugs are removed from all designated Hand Hygiene Sinks	Hands must be washed under running water	Estates (GA)	July 2019	National guidance	Outstanding
	Perishable products are stored appropriately	Opened cereals and dried beverages are stored in pest proof containers	Ward managers IPT (LY)	July2019	Awaiting assurance	In progress
	Personal protective equipment is used appropriately	Support given to the wards by the IP Team	Ward mangers and all staff	July 2019		In progress

	All stores are stored in the appropriate manner to promote clean, safe care.	Avoid decanting consumables delivered to ward	Ward housekeepers and procurement Teams IPT (LY)	July 2019		In progress
	All Infection prevention signage is reviewed and standardised across the trust	Clear concise instruction	Infection Prevention Team (LY)	September 2019	Outbreak poster for ward entrance Single room signs Signs for bays	In progress
	Theatre staff wear appropriate clothing outside of the theatre environment	Theatre etiquette is reviewed and re-launched	Associate DON – Theatres (LB)	August 2019	SOP was ratified in May 2019' Reviewed by Associate director of Nursing for Infection Prevention 22/08/19 , awaiting comments	In progress
	Develop guidance around the use of toileting facility arrangements for patients nursed in single rooms without en-suite facilities.	Standardise practice throughout the Trust using a risk assessment approach for each area	Infection Prevention team and Ward managers	August 2019		In progress
	All patients visited the same working day who have *Clostridium difficile* toxin isolated from samples	To ensure that the patient is informed by a specialist nurse and that ward staff are supported in the patient management	Infection Prevention team	July 2019		Complete
POLICIES AND PROCEDURES						
	Review and revise *Clostridium difficile* policy	To incorporate more controls to be put in place .i.e. Sample on first episode of diarrhoea	Infection Prevention Doctor (KM) And Associate director of Nursing for Infection Prevention (JTG)	September 2019	To be ratified at the IPCC	In progress

	Review the admission criteria to the isolation ward (Ward 25) and its functionality	To facilitate the use of beds appropriately following a risk assessment approach.	Infection Prevention Doctor (KM) And Infection Prevention Team(JTG)	September 2019	To be ratified at the IPCC	In progress
	Develop standard operating procedure for the condemning of static mattresses		Chief Clinical Technologist (AN) And ADN IPC (JTG)	August 2019		Complete
	Develop standard operating procedure for the removal to storage area of static mattresses	Ensure all mattresses are cleaned appropriately, have a decontamination certificate completed and are removed by the porters in a timely manner to the designated storage area.	Chief Clinical Technologist (AN) And ADN IPC (JTG)	August 2019		Complete
	Improve hand hygiene compliance	Review H/H policy in line with new national guidance	IPT (LY) DDN's	August 2019	Weekly audits	on going
	Review PPE policy	Vinyl gloves are in use throughout the Trust, these do not provide good protection against BBV.	Infection Prevention Team Procurement	October 2019		
	Outbreak policy to be a standalone policy	At present it is a Norovirus outbreak policy	IPT (LY) IP Doctor (KM)	October 2019		
FACILITIES - CATERING/CLEANING						
	Cleaning methodology following patient discharge are reviewed and simplified	Introduce Three cleans. Basic. Terminal clean. Terminal clean with HPV	Facilities (MD)	August 2019	Liaise closely with Facilities	In progress

	A standard operating procedure is developed for the use and introduction of toilet brushes	No standard practice throughout the hospital	Hotel services manager (MO)and Associate director of Nursing for Infection Prevention(JTG)	July 2019	Completed August 2019	Complete
	Following evening food service there is a Standard operating procedure on where uneaten food stuffs are collected from the ward areas		Catering manager and (NC) Associate director of Nursing for Infection Prevention (JTG)	July 2019	Completed August 2019	Complete
	Domestic cleaning rooms have a hand hygiene sink / janitor unit.		Head of Estates & Facilities			
	Domestic cleaning rooms are organised, clean and tidy with appropriate storage of equipment		Hotel services manager (MD)	September 2019		
	Defective curtains and blinds are put right immediately		Hotel services manager (MD)	September 2019		In progress
	Televisions not in use are removed from the clinical areas	Patient line – We no longer have a contract	Estates (GA)	TBC		
	Waste holds are emptied and decontaminated at least daily		Hotel services manager (MD)	September 2019		

	Chlor-clean introduced as standard for environmental cleaning	Re-education of all staff. Introduce a revised Poster	IPT (LY) Health & safety (DH) Guest medical	August 2019	Company re-visited the trust in July to train the staff and ward walk again. Posters developed and delivered to the wards and placed in all sluices.	Complete Complete
	ESTATES- FIXTURES / FITTINGS					
	Vinyl floor coverings are intact	This allows for effective cleaning	Associate Director of Estates & Facilities	TBC		
	Skirting boards are attached to the wall with sealant intact	This avoids the ingress of harmful microbes, repels moisture and allows for effective cleaning	Associate Director of Estates and facilities	TBC		
	All designated hand hygiene sinks are of the correct hand hygiene sink standard	All wards have this requirement in varying numbers	Associate Director of Estates and facilities	TBC		Outstanding
	All windows in clinical areas are sealed with silicone	To allow for effective cleaning. At present the wood is perishing and there are gaps that need sealing to allow for cleaning	Associate Director of Estates and facilities	TBC	Window replacement required in the future.	In progress
	Historic un-utilised equipment wall mounts are removed	All wards have this requirement in varying numbers	Associate Director of Estates and facilities	TBC		Outstanding
	All bare wood is varnished to allow for effective cleaning		Associate Director of Estates and facilities	TBC		Complete
	Damaged and stained ceiling tiles are replaced	All wards have this requirement in varying numbers	Associate Director of Estates and facilities	TBC		Outstanding
	Ceiling tiles that have been removed are replaced.		Associate Director of Estates and facilities	TBC		Outstanding

	Effective segregation of dirty and clean areas on all wards	Dirty and clean clearly defined	Associate Director of Estates and facilities	TBC		Outstanding
	All areas require painting are completed	All wards have this requirement	Associate Director of Estates and facilities	TBC		Outstanding
	Holes in walls are made good	All wards have this requirement in varying numbers	Associate Director of Estates and facilities	TBC		Outstanding
	Environmental fixtures and fitting are of the required standard	All wards have this requirement in varying numbers	Associate Director of Estates and facilities	TBC		In progress
	Defective lighting is repaired/replaced	Some lights are hanging off and held together with sellotape, these cannot be cleaned and harbour dust.	Associate Director of Estates and facilities	TBC		Outstanding
	All hand wash basins have clean intact sealant with no visible signs of mould	Mouldy sealant is removed and re-placed with anti-mould sealant. Most wards require this at several sinks .	Associate Director of Estates and facilities	TBC		Outstanding
	All supply and extract grilles are cleaned	This should be part of pre-planned maintenance which needs to be re-instated.	Associate Director of Estates and facilities	TBC		In progress
	Removal and repositioning of IPC compliant signs, charts and notice boards.	These must not be cork or felt and should be glass fronted	Associate Director of Estates and facilities	TBC		Outstanding
	Removal of tissue dispensers	Toilet tissue dispensers have been installed in the bay on some wards?? why.	Associate Director of Estates and facilities	TBC		Outstanding
	Removal of old and worn floor graphics	These are unsightly and prevent the floor being effectively cleaned	Associate Director of Estates and facilities	TBC		Outstanding

	Replace IPS panels from behind toilets	Multiple locations throughout the Trust	Associate Director of Estates and facilities	TBC		Outstanding
	All wards are reviewed and assessed as to the placement of hand hygiene sinks being installed/located at the entrance		Associate Director of Nursing for Infection Prevention AND Associate Director of Estates and facilities	TBC	Review took place 15th august 2019	
GOVERNANCE						
	Clinical engagement at outbreak meetings required	This is essential to ensure that clinical Teams are updated in a timely manner and involved in initiatives to reduce infection.	Executive Medical Director	August 2019		Outstanding
	Identified clinical IP lead for each Directorate is required	This lead should chair divisional IP meetings, attend outbreak meetings and the Infection Prevention and Control committee	Executive Medical Director	August 2019		Outstanding
	The patients Clinician is required to attend all RCA/PIR meetings.	To ensure that patient management is discussed by the MDT caring for the pt.	Executive Medical Director And Chief Nurse (DIPC)	August 2019		Outstanding
	Review PIR process for *Clostridium difficile*	Changed wording to reflect national guidance (RCA). Executive summary to be written following review. Lessons learnt used to formulate an action plan with named persons responsible for completing.	Associate director of Nursing for Infection Prevention	August 2019	Flow chart produced to reflect new process developed AND AGREED AT ipcg ON Tuesday 20th August 2019	Complete

	Weekly Executive led CDI review meeting to adopt an accountability framework	To ensure that actions are documented and that they have completed by dates	Associate director of Nursing for Infection Prevention/ Executive lead Chief Nurse (DIPC)	July 2019		Complete
	Complete incident form for all diagnosed *Clostridium difficile*	To ensure there is an audit trail of incidence and embedded summary with actions documented.	Infection Prevention Team (LY)	July 2019		Complete
	Review hand hygiene audit recording process	To ensure that it is uniform across the trust	Les Porter Chris Hitchings	August 2019		In progress
	Review TOR for Infection Prevention & Control committee	To ensure that the correct people attend at timely intervals	ADN - Infection Prevention (JTG)	August 2019		In progress
	Introduce a G.P letter for all CDI Toxin and equivocal results	To raise awareness to G.P's and give information regarding caution with future antimicrobial prescribing	Associate director of Nursing for Infection Prevention (JTG)	August 2019		In progress
	Ensure all prescribers are aware of their responsibilities in relation to reducing the incidence of CDI	Present antimicrobial issues at grand round	Pharmacy (TY) and Microbiology (KM)	TBC		
		Raise awareness with clinical teams during induction		TBC		
		Education sessions regarding any lessons learnt from RCA investigations of CDI (.i.e. For Infection unknown Co-amoxiclav AND Gentamicin should be prescribed)		TBC		
		Roll out of ARK across Surgery		TBC		
		Roll out of ARK across Medicine		In progress		

EDUCATION /TRAINING						
	Review mandatory training to ensure all changes are reflected in the training package		Infection Prevention Team (LY)	Nov 2019		
	Communication campaign to raise awareness to all trust staff of the role they play in reducing all HCAI.	Key weekly Themes in the 'in touch' e-mail sent to all staff Little Gems	Mike Baker Les Porter	July 2019 July 2019	Review the feasibility of using the screen saver for each weekly initiative to ensure seen by all staff.	In progress Complete
	Launch of the 'Clean between' campaign	Week long campaign raising the awareness on all wards of the importance of cleaning patient shared equipment, removing contamination and interrupting the transmission of microorganisms.	Infection Prevention Team (LY) With support from Clinell	Sept 2019		In progress
	All patients receive a WUTH Infection Prevention guide for patients on admission	To inform our patients how they can help to comply with Infection Prevention recommendations	Divisional Directors of Nursing	Sept 2019	To be available in wall mounted dispensers next to alcohol based foam.	
	All patients diagnosed with CDI receive a WUTH *Clostridium difficile* guide	To inform the patient of the Infection and how it is going to be managed.	Infection Prevention Team	Sept 2019		Complete
	Use Cerner to raise awareness of the Trusts position on CDI		Infection Prevention Team Kate Osgood	August 2019		Complete

Compiled by J Turner-Gardner - Associate Director of Nursing for Infection Prevention and Control.

Wirral University Teaching Hospital
NHS Foundation Trust

Infection Control & Estates

Infection Control in the built environment

1. Executive Summary

The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

The Code of Practice (Part 2) sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained, it is essential that all providers of health and social care read and consider the whole document and its application in the appropriate sector and not just selective parts.

Under the Occupiers liability Act (1957), hospital authorities must provide safe premises, so that if patients are admitted to wards or hospitals where there is a known outbreak of infection, the hospital authorities might be made responsible for the death of a patient or injury suffered by a patient as a result of such infection.

2. Background

There has been a protracted outbreak of *Clostridium difficile* since Febuary 2019 at Arrowe Park. Investigations have recognised that the cause is multi-factorial, one of which is that essential Infection Prevention commodities do not meet recognised standards i.e. Glove and Apron dispensers and their location, Appropriate Hand hygiene sinks, sluice rooms, domestic rooms.

Repair and maintenance of the present out dated fixtures and fittings will not reduce the risk of potentially harmful pathogens which are contaminating our present environment as much as replacement of the fixtures and fittings to reflect updated design standards that allow more effective infection prevention and control.

In most incidences to replace fixtures and fittings in the quickest and safest manner having an empty ward to complete the works accelerates the completion and allows patients to return to a safe environment in a timelier manner.

To this end the Executive Team have debated and agreed in principle to bring a decant facility into operational use as soon as reasonably practicable; further discussions however would be necessary beforehand to understand precisely how any potential consequential risks could be mitigated as a prerequisite.

3. Benefits vs risk

The incidence of *C.diff* appears to be stabilizing by using a combination of controls, some of which draw on contingencies which may not be sustainable in the long term. In addition, isolation facilities remain limited, environmental cleaning has limitations due to the extent to which clinical areas can be thoroughly decontaminated given the maintenance and repairs outstanding (which vary between wards), therefore the residual risk of *C.diff* remains volatile and has been kept at a magnitude of 20.

4. Next steps - Estates Plan

On Monday 19th August 2019 the Associate Director of Nursing for Infection Prevention and Control and the Associate Director of Estates and Facilities met with Executive Management Team to review various option appraisals to upgrade our ward areas to ensure the estates was fit for purpose, this will promote effective cleaning to take place to minimise the risk to our patients from our present environment.

A series of audits had taken place to consider the most effective plan going forward which included the physical condition (6 facet survey), acuity and susceptibility of patients on wards, C4C Cleaning, Estates conditional reports and the *Clostridium difficile* reported incidences per ward.

These audits identified that there where elements of the physical environment on each ward that required urgent attention and must be done as they are fundamental to the healthcare environment. These included:

- Remove plugs from clinical hand hygiene sinks
- Remove and replace moldy sealant from all clinical hand wash basins
- Clean supply and extract grills
- Removal and repositioning of signs charts and noticeboards away from the clinical areas
- Removal of inappropriate dispensers i.e. Tissue / hibiscrub / gel
- Removal of wall mounted fittings that are no longer in use.
- Replace missing ceiling tiles
- Replace current apron and glove holders with Infection Prevention compliant version and review locations.
- Minor wall repairs

It is feasible for the refurbishment works identified above to be carried out working around patients with a timeframe of 10 days to complete each ward at a cost of £5k per ward to be funded by the Operations and Maintenance budget as the works would not be categorised as capital expenditure.

The programme of work will directly follow the *Clostridium difficile* Toxin rate by ward report:

- Ward 36
- Ward 22
- Ward 25
- Ward 32
- CCU
- Ward 33
- AMU
- M1 Rehab
- MSSW
- OPAU
- Ward 11
- SEU
- Childrens

The remainder of the wards will be addressed flexibly by utilising infection Prevention surveillance data to risk assess the sequence of the completion and will take a total of 60 weeks to complete.

In conjunction with the fundamental works being addressed there will be a rolling programme of light refurbishment carried out on the wards that have the highest recorded infection rates and patient risk:

- Sanitary ware, brassware & IPS Panels (capital)
- Flooring and skirting repairs – multiple locations
- Reseal Windows
- Linen cupboard – replace dividers with sliding doors & supply and fit shelving
- Removal of plinths – Multiple locations
- Replace IPS panels behind toilets – Multiple locations (capital)
- Upgrade Sluice rooms (capital)
- Upgrade Domestic rooms (capital)
- Review storage areas

These works will take 7-10 weeks per ward (depending on availability to move from area to area), working in a vacated bay (decant 4-6 beds at a time) and will take 7 years to complete.
This is to perform day to day reactive works and minor scheme work to enable the ward to achieve a minimum acceptable standard.

- Ward 21
- Ward 17
- Ward 38
- Ward 18
- Ward 27

This work will be tendered as a lot for procurement purposes with external providers invited to bid and will require a capital allocation of £60k per ward.

The refurbishment of Ward 30's ensuite shower and toilet rooms to allow for the placement of a hand wash basin has been allocated capital funding for 2019/20 and will continue as programmed, as access to some of the services is via ward 20 directly below this will also enable opportunity to plan works for Ward 20 at the same time.

The final programme will see a partial refurbishment and upgrade of wards and it is important to note that this element of work will require a degree of flexibility within divisions as it may be the case that the ward vacating the area may not return as the new environments will be assigned to the highest acuity and the most susceptible patients.

The criteria for cycle will be the assessed on the physical condition rating with data taken from the 6 facet Survey which has highlighted wards on the 2nd floor as the most in need of investment.

In order to maintain the programme of works, it is imperative that we utilise Ward 43 as decant facility (April onwards) / cover for winter pressures.

The proposed works will take 4 months working on an empty ward *(capital).* This will take 11 years to complete with a capital investment of circa £405k per ward and a rate of two wards per year. The procurement exercise will tender on an annual basis with bidders competing for two wards and will form part of the 2020/2021 capital bid from Estates.

All wards when completed will meet Estates and IPC standard and current legislation.

The upgrade involves the following.

- Upgrade Bathrooms, toilets, shower rooms
- Upgrade Sluice rooms to create a dirty to clean flow
- Upgrade Domestic room to create a
- Install new Sanitary ware, brassware & IPS Panels
- Remove wooden wheel stops under patient's beds and replace with Bed Head protection.
- Replace Flooring reflecting current guidelines
- Replace/ repair ceilings
- Replace Windows
- Re pipe DHW pipework
- Redecoration
- Repair/replace Doors
- Review and update Ward kitchen
- Ventilation deep clean (This cannot be done when patients are occupying the area)

Note: This phased programme will form part of the Estates Strategy for refurbishment.

Authors

Glen Adams - Associate Director of Estates and Facilities
Jay Turner-Gardner- Associate Director of Nursing, Infection Prevention and Control.

APPENDIX 1

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year11	Cost	Infection Prevention Impact
Option 1	35wards x £5k											£175K	Very minimal as basic
Cost	£175K												
Option 2	5 wards x £60K + 30 x £5K	5 wards x £60K	5 wards x £60K	5 wards x £60K	5 wards x £60K	5 wards x £60K	5 wards x £60K	This would involve moving 4/6 patients off the ward to allow for a rolling programme of repair throughout the ward. This would be very inconvenient for daily ward activities and would pose a risk to the remaining patients with reduced facilities, potential high levels of dust and noise pollution				£2250K + extra weeks incur a higher cost for tradespeople	Initial improvement however Minimal as Repair and maintenance based
Cost	£450	£300	£300	£300	£300	£300	£300						
Option 3	7 wards x £45K + 28 x £5K	7 wards x £45K	7 wards x £45K	7 wards x £45K	7 wards x £45K	This would involve moving all the patient off the ward, the works could be done quicker; there would be no health and safety issues to patients.						£1715K + Decant facility	Initial improvement however Minimal as Repair and maintenance based
Cost	£455	£315	£315	£315	£315								
Option 4	4 wards x £90K + 31 x £5k	4 wards x £90K	4 wards x £90K	4 wards x £90K	4 wards x £90K	4 wards x £90K	4 wards x £90K	4 wards x £90K	3 Wards x £90K			£3305K + Decant facility	High impact with lasting effects as a Partial upgrade
Cost	£515	£360	£360	£360	£360	£360	£360	£360	£270				
Option 5	3 wards x £405 + 32 x £5	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	3 wards x £405	£13525 + Decant facility	High impact. Long term effects, other wards deteriorating
Cost	£1375	£1215	£1215	£1215	£1215	£1215	£1215	£1215	£1215	£1215	£1215		
Option 6	2 wards + 33 x £5 (165)	2 wards	2 wards	2 wards	2 wards	2 wards	2 wards	2 wards	2 wards	2 wards	2 wards	35 wards in 17 years	High impact. Long term effects.
Cost	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£3.4 M	£59.5 M + Decant facility	Other wards deteriorate and increase risk

Wirral University Teaching Hospital
NHS Foundation Trust

Infection Prevention and Control Annual report 2018/2019

Authors

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1. Executive Summary

This is the 2018/19 Infection Prevention and Control (IPC) Annual Report. The purpose of this report is to provide an annual summary of the Trust's position and progress towards a zero tolerance approach to Healthcare Associated Infection (HCAI) and to alert the Board of Directors to any significant problematic infection prevention and control issues within the organisation. It also outlines the progress, activities and achievements in infection prevention and control made by Wirral University Teaching Hospital NHS Foundation Trust.

The report describes progress toward the objectives to have zero avoidable Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (table 1) and to achieve the *Clostridium difficile (C.difficile)* objective set by NHS England (graph 2).

The risk created by Carbapenemase Producing Enterobacteriaceae (CPE) has continued to threaten previous ways of working and as such, the report will demonstrate progress made with the planned CPE strategy.

In addition, the report will highlight the progress, activities and achievements made with infection prevention and control the previous year, identify areas that require further improvement and will highlight the key areas of focus for 2019/20.

2. Background

The implementation of robust, proactive IPC strategies have previously demonstrated a significant reduction in infection associated with MRSA bacteraemia and *C.difficile* and have supported the containment and management of the extremely difficult to control Norovirus. When WUTH reported the first case of CPE in May 2011, the Trust was compelled to introduce a CPE strategy to reduce the incidence of further spread and ensure patient safety. The IPC Team has continued to promote and direct a proactive strategy to manage and contain this extremely difficult to treat organism, with the focus on prevention to avoid colonisation in the first instance and ultimately clinical infection and mortality. However, this remains challenging in particular in relation to issues such as difficulty in isolation of patients due to high bed occupancy, patient flow, limited isolation and decanting facilities.

3. Report Summary

3.1 Infection Prevention and Control Team (IPCT)

- The IPCT continued to lead on the implementation of the IPC programme and provide expert advice regarding the prevention and control of infection
- The Infection Prevention Operational Review Team (IPORT) and Infection Prevention and Control Group (IPCG) have continued throughout 2018/2019.A further review is of the IPC governance structure is required.
- Terms of reference were updated for Divisional IPC meetings, IPORT and IPCG
-

3.2 Healthcare Associated Infection data

- There were 78 *C.difficile* infections apportioned to the Trust against a threshold of 28, with 44 of these deemed to be avoidable cases due to the identification of lapses in care. This showing an increase in 19% of avoidable cases from the previous year.

Hospital acquired *C.difficile* Infection was recorded on Part 1a of the death certificate of 2 of the 44 cases.

- There were 3 Trust apportioned MRSA bloodstream infection in 2018 / 19, compared with 2 the previous year
- There was 15 Trust apportioned Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections in 2018 /19, demonstrating a slight decrease from 19 in 2017 / 18.
- There were 47 hospital acquired E.coli Bloodstream Infections reported in 2018 / 19 demonstrating a 30% increase from 33 in 2017 / 18.
- Two categories of Surgical Site Infection (SSI) surveillance were included in the 2018 / 19 mandatory programme in 2019. A 5% surgical site infection rate was identified in reduction of long bone fracture
- The number of clinical sites positive for CPE doubled in 2018/19 compared to 2017/18. 2 CPE bacteraemia were reported and the number of new patients acquiring CPE colonisation increased.
- Targeted VRE screening continued in high risk areas; haematology, critical care and orthopaedics.
- Although Pseudomonas screening within the Neonatal Unit has continued to identify new cases of Pseudomonas aeruginosa and Pseudomonas putida, typing results have not indicated cross-transmission between babies.
- Throughout 2018/19 there were only 4 wards closed due to Norovirus with a total of 72 bed days a noted decrease from the previous year with 333 bed days lost.
- In the 2018 / 19 flu season was 2747 with 477 (17%) testing Influenza positive, 100 testing RSV positive (4%) and 2170 (79%) testing negative. There has been a significant increase in the number of negative swabs processed over the recent years.
- There were a number of incidents associated with chicken pox and mumps in 2018/19 and all resulted in both staff and patient contact tracing, immunity testing and information letters provided. This required significant resource from IPC, Occupational Health and the laboratory. There were also incidents associated with measles and pertussis.

3.3 Antimicrobial Stewardship

- Audit data from throughout the year demonstrates that the proportion of WUTH patients prescribed antibiotics at any one time (averaging 33%) and adherence to, or appropriate deviation from the trust wide antimicrobial formulary (averaging at 96%) has remained consistent from the previous year.
- Antibiotic continued to be reviewed within 72 hours of initiation (95%) but the outcome of 50% of these reviews is that the antibiotic continues unchanged. This is the 'focus' part of antibiotic prescribing. The Trust has been accepted onto a national multicentre trial, ARK, aimed to reduce antibiotic consumption by changing the culture around antibiotic use and empowering cessation of courses when infective causes ruled out.
- Antimicrobial stewardship ward rounds already in place have continued (gastroenterology, respiratory, acute medicine, OPAU, DME, critical care, orthopaedics) and additional ward rounds have commenced in colorectal surgery and an additional DME ward. Whilst there is need for microbiology ward rounds in other areas there is not

the capacity in the team to deliver these. Currently annual leave is also not covered due to lack of resource

- The electronic antimicrobial stewardship template on Cerner has gone live to provide clinicians with an easy way to 'focus' antimicrobials. It includes mandatory diagnosis of indication on initiation of antibiotics, 'face up' view of microbiological samples and results and a template for undertaking a thorough antimicrobial review.
- The 'Reducing the Impact of Serious Infections' CQUIN, parts 2c (antibiotic review) and part 2d (antibiotic consumption) ended March 2019. Part 2c was achieved. Part 2d is further split into 3 separate parts and of these only 1 (reduction in carbapenem use) was achieved. The targets not met were reduction in total antibiotic use and increase in use of antibiotics from the Access category of the WHO Aware list as a proportion of total antibiotic use.

3.4 Audit Activity

- Hand Hygiene Audits performed by the IPCT have identified a reduction in compliance during 2018/19, with an average compliance rate of 87%.
- During 2018 / 19, the IPCT performed 141 environmental audits. During 2018 / 19, the IPCT performed 141 IPC audits, an increase from the previous year. 16% (23) of these audits had a green rating, 61% (86) had an amber rating and 22% (31) had a red rating. The IPCT audits are now included in the WISE accreditation programme.
- A trust wide sharps audit was performed to identify compliance with sharps safety. 712 sharps containers were audited and results indicated issues with containers not being correctly labelled whilst in use, inappropriate items placed in the sharps bins and a large number of bins did not have the temporary closures in place.
- A Catheter Associated Urinary Tract Infection (CAUTI) audit was undertaken in June 2018 across the whole health economy. 2% (12) of patients were identified as having a CAUTI. 25% of urinary catheters had been inserted in hospital and 91% of all catheter insertions were documented.
- Adenosine Tri Phosphate (ATP) swabbing and Ultra Violet Light Tagging audits were performed weekly. Issues identified included domestic cleaning and ward equipment cleaning.
- A commode audit was performed in March with 85 commodes audited across the Trust. Only 42% (36) of the commodes were found to be clean and in a good state of repair.
- A food Hygiene inspection was completed in February 2019. One of the recommendations included the use of a commercial dish washer for reusable items such as jugs and beakers for patients.

3.5 The Environment

- The annual Patient Led Assessment of the Care Environment (PLACE) took place to assess wards, Outpatient areas, Accident and Emergency Department and internal/external common areas. For the cleanliness standard, WUTH scored 99.03% and 95.01% for condition, appearance and maintenance, scores that were above the national average
- Hotel Services continues to provide a comprehensive range of cleanliness services to support out Trusts IPC agenda.

- Additional Infection Control cleanliness services above team capacity are reported as a Hotel Services cost pressure.

4. Infection Prevention and Control Arrangements

4.1 Infection Prevention and Control Team (IPCT)

The IPCT have continued to lead on the implementation of the IPC Programme and to provide expert advice about the prevention and control of infection. The Associate Director of Nursing for Infection Prevention and Control post (vacant since April 2017) was recruited to in June 2018. However the post holder left the organisation in December 2018, leaving a gap in leadership for the team. The Infection Prevention and Control Matron continued to support the team in the interim and an Interim Associate Director of Nursing for Infection Prevention and Control/Deputy Director Infection Prevention and Control was appointed in January 2019 whilst the post was being advertised. A successful applicant was appointed in February 2019 who will commence in post in May 2019.

The IPCNs continued to provide continuous infection prevention and control cover, available out of hours to provide information, advice and support. Although there are three Consultant Microbiologists to provide continuous cover to support the IPCNs regarding clinical issues and associated advice this has been challenging due to their additional workload and staffing with Microbiology. The Infection Control Doctor is stepping down from April 2019 with no replacement appointed.

5. Infection Prevention and Control Reporting Arrangements

5.1 Departmental/Divisional Infection Prevention and Control Groups

The following groups meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG).

- Medicine and Acute Specialties
- Orthopaedics
- Special Surgery
- Surgery
- Theatres
- Women's and Children's
-

5.2 Infection Prevention & Control Group (IPCG)

The IPCG met six times during 2018-19, receiving assurance reports from the groups identified in the last section, escalating issues that could not be rectified at the IPORT. Reports were also received from Estates and Facilities, Water Safety Group, Decontamination Group and, Antimicrobial Pharmacist. IPCG meetings are held alternate

months. If attendance at monthly IPORT improves, it was agreed that quarterly IPCG meetings would be acceptable. However attendance remains poor.

5.3 Infection Prevention Operational Review Team (IPORT)

The Infection Prevention Operational Team, as the name suggests is an operational meeting to discuss the day to day aspects of IPC; the IPCG meetings are more strategic. IPORT only met four times during 2018/19 with Departmental and Divisional assurance reports submitted and discussed at each meeting. Outstanding actions from the reports, not able to be addressed by IPORT members, were escalated to IPCG.
IPCG and IPORT will be reviewed in relation to frequency for 2019/20.

5.4 Clinical Governance Group (CGG)

The IPCT continued to provide a monthly report to the Patient Quality and Safety Board (PQSB), attending the meeting alongside the DIPC to present the IPC report to members. The Group also received the minutes from IPCG.

5.5 Operational Management Team (OMT)

The Director of Infection Prevention and Control provided a regular verbal report to the OMT.

5.6 DIPC Reports to the Trust Board: Summary

- MRSA bacteraemia and hospital acquired *C. difficile* were reported via the Trust's Performance dashboard
- Infection prevention and control summary reports were included in the monthly CEO report to the Board of Directors

6. Healthcare Associated Infection Data

The Trust is required to participate in the mandatory surveillance and reporting of:

i. *Clostridium difficile*
ii. Staphylococcus aureus bacteraemia, including MSSA and MRSA
iii. Gram negative bloodstream infections including Escherichia coli (E.coli) bacteraemia
iv. Orthopaedic Surgical Site Infection

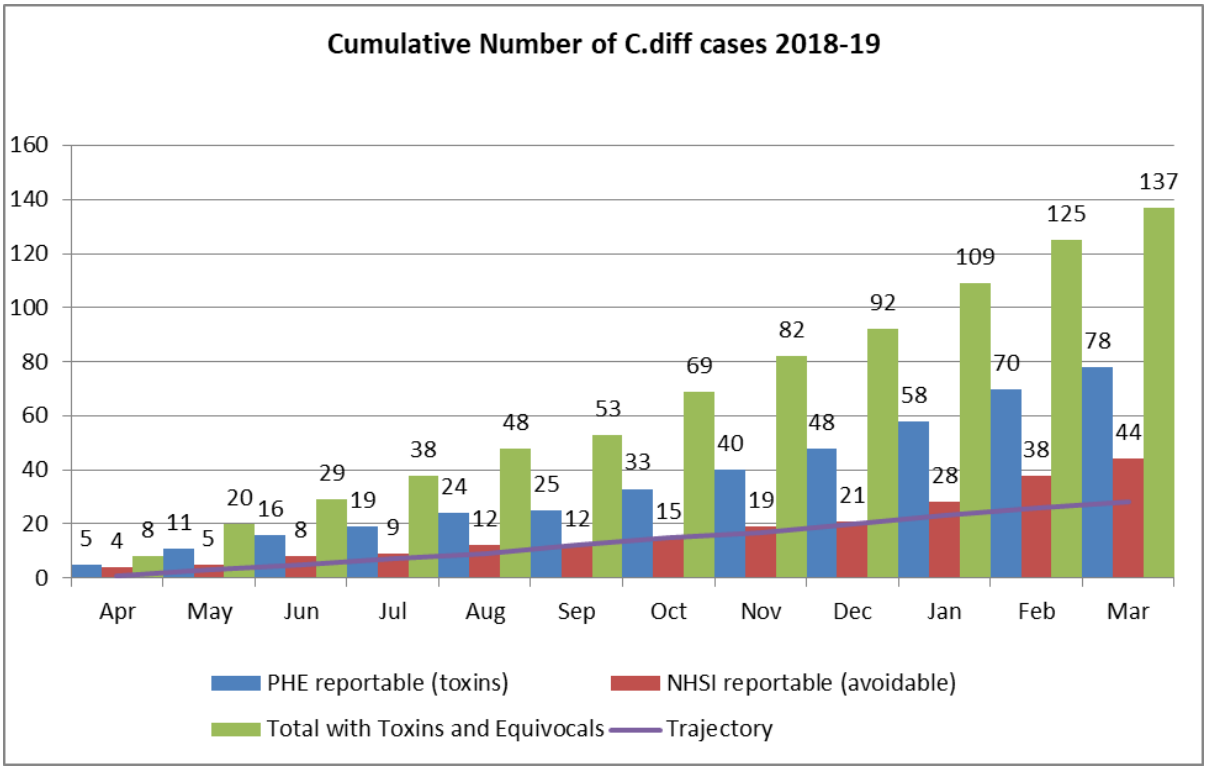
6.1 Clostridium difficile

Clostridium difficile infection (CDI) remains an unpleasant and potentially severe or fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. All healthcare organisations have been required to assess each *C.difficile* case in order to determine whether the case is linked to a lapse in the quality of care provided to our patients.
From April 2018 to end of March 2019, WUTH were working towards a *C.difficile* objective of no more than 29 avoidable toxin positive cases (the presence of toxins in a stool sample indicates *C.difficile* infection). WUTH did not achieve the objective of no more than 29 avoidable cases of *C.difficile and the number of patients* who have been *C.difficile* toxin

positive or equivocal during 2018-19 has resulted in an increased bio-burden of *C.difficile* within the environment. By the end of March 2019, WUTH had reported 78 toxin positive cases, all of which were subject to a full Post Infection Review (PIR). In August 2018 a new C.*difficile* PIR process has been implemented by the Director of Infection Prevention and Control (DIPC). This process requires for a multidisciplinary approach to determine how infection occurred, how future cases can be avoided and for lessons learnt to be shared throughout the divisions.

The PIR's identified 44 of the 78 cases were deemed to have lapses in care, this showing an increase in 19% from the previous year. Common 'themes' from the PIR's have identified that the management of diarrhoea flow chart had not been completed correctly to enable prompt detection, delay in isolation, inappropriate sample collection, lack of clinician engagement, lack of assurance in environmental and equipment cleaning and the estates issues on the of the wards.

Graph 1: Cumulative number of *C.difficile* cases against trajectory in 2018-19)



From April 2018 – March 2019 *C.difficile Periods of Increased Incidence* (PII's) have been declared by the IPCT in 8 wards within the medical division. This identified for the implementation of *C.difficile* improvement plans to be completed and monitored on a weekly basis.

During January 2019, *C.difficile* Infection was recorded on Part 1a of the death certificate of 2 of the 44 cases. The 2 Part 1a deaths linked to a ward with a PII and following ribotyping of the cases an outbreak of 027 *C.difficile* strain was declared. In January 2019 *C.difficile*

outbreak meetings were organised and action plans instated, with weekly meetings to review improvements.

Ward 25 beds 1 – 8 (*C.difficile* cohort beds) continues to be used for symptomatic *C.difficile* patients. In 2018/19 during increased operational and isolation demand *the C.difflicile* cohort was extended for a short period to support further side room capacity within the isolation unit for C.diff cases. During this time cohorting the C.diff and CPE patients separately proved difficult due staffing and layout of the unit.

A lesson learnt from the use of the isolation unit for C.diff was prompt step down from Ward 25 once a patient is asymptomatic of *C.difficile* to allow for further *C.difficile* positive patients to be transferred as soon as possible, releasing side rooms on base wards and reducing the risk of environmental contamination.
6.11 HPV programme

Due to increased bed occupancy and significant winter pressures there hasn't been opportunity to have access to a whole ward decant facility during 2018/19.
HPV was undertaken of bays and associated area when beds could be reduced to allow bay by bay decant. A 4 bedded bay on ward 26 was identified to assist the process.
A deep cleaning programme continued through the rest of the year when HPV of bays could not occur however where possible associated areas were HPV'd as part of the process.
Between April 2018 and March 2019 a total of 31 wards received a full ward deep clean. 5 of these included HPV bay by bay and 4 wards had a combination of deep clean and HPV.
Without an uninterrupted HPV programme, there is a risk that WUTH will not achieve the objective for 2019/20.

Recommendations for 2019/20:

- Review and maintain an uninterrupted HPV programme
- Relook at a programme for ultra violet light decontamination (UV-C) in areas where HPV is not possible
- Review the process for performing a Post Infection Review

6.2 Meticillin Resistant *Staphylococcus aureus* (MRSA)

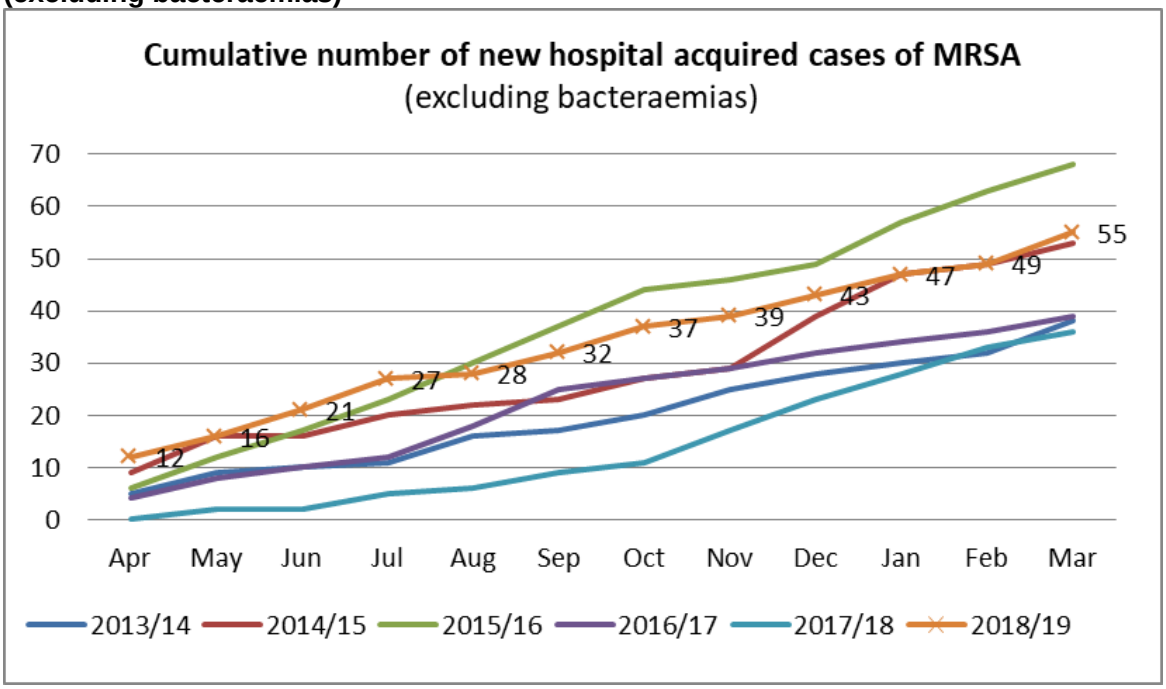
From April 2018 to end of March 2019 a Wirral wide total of 6 MRSA bacteraemia were reported which is a significant increase from 2017/18 were only 2 bacteraemias were reported. Post Infection Reviews (PIRs) that were undertaken as per the new NHS England guidance (on reporting and monitoring arrangements and post infection review process) for MRSA bloodstream infections resulted in local Commissioners assigning three of these cases to WUTH. Issues identified from the PIRs included the management of invasive devices and missed MRSA screening swabs.

Table 2: MRSA bacteraemia reported since 2007/08

MRSA Bacteraemia Reports	2007 - 2008	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	2018 - 2019
Pre 48 hours	9	11	8	9	3	1	2	0	2	3	1	3
Post 48 hours	12	10	8	5	1	2	2	3	2	1	1	3
Contaminants	5	5	1	0	0	0	0	0	1	0	0	0
Cumulative Total	26	26	17	14	4	3	4	3	5	4	2	6

The graph below demonstrates an increase in 44% of new hospital acquired cases of MRSA compared with the previous year. This is likely due to the inability to isolate all positive cases of MRSA because of competing pressures for side rooms. Investigations into HA MRSA colonisation have identified issues with effective vacation cleaning.There remains no information technology (IT) solution to provide assurance that all patients are screened at all appropriate sites on admission, as per Trust policy.

Graph 2: Yearly comparison of cumulative number of new hospital acquired cases of MRSA (excluding bacteraemias)



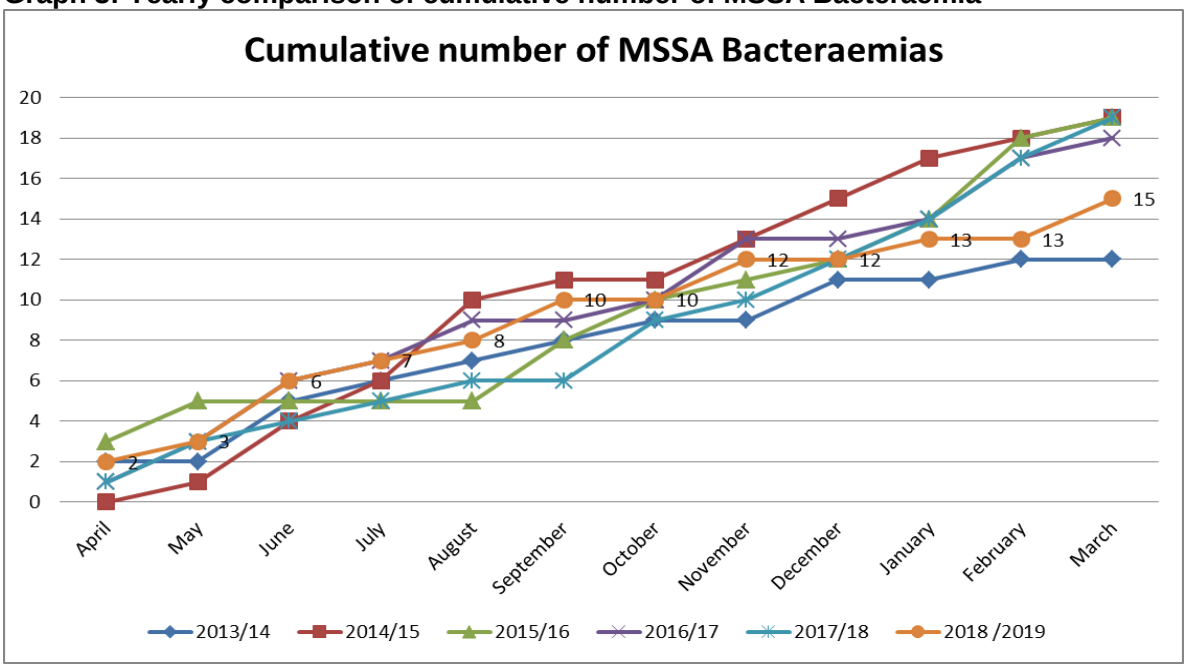
Recommendations for 2019/20

- Explore/develop IT solutions to enable the IPCT to capture screening compliance data across the trust
- Continue to increase side room capacity as part of the Estates strategy
- Bed Capacity management

6.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA)

MSSA is very similar to MRSA except that it is more sensitive to antibiotics including methicillin and it is more prevalent than MRSA. From January 2011, it became mandatory to report MSSA bacteraemia on a detailed basis. Objectives for the reduction of MSSA bacteraemia have not been set and it is not planned that these will be introduced in the near future.

Graph 3: Yearly comparison of cumulative number of MSSA Bacteraemia



During 2018/19 there were 15 cases of MSSA bacteraemia, this was a slight decrease from 19 recorded in 2017/18. SBARs (Situation, Background, Assessment, Recommendations) completed for these cases identified that the majority were related to invasive devices (i.e. peripheral intravenous cannula, peripherally inserted central lines and wounds. Despite investigations and recommendations provided, there is no assurance that these matters were discussed at Divisional Infection Control Meetings, or that actions were completed.

Recommendations for 2019 / 2020:

- Increase engagement; Divisions to perform SBARs so that learning can be identified and ownership / change in practice can be established and embedded
- Common themes to be communicated Trust wide

6.4 E.coli Bacteraemia

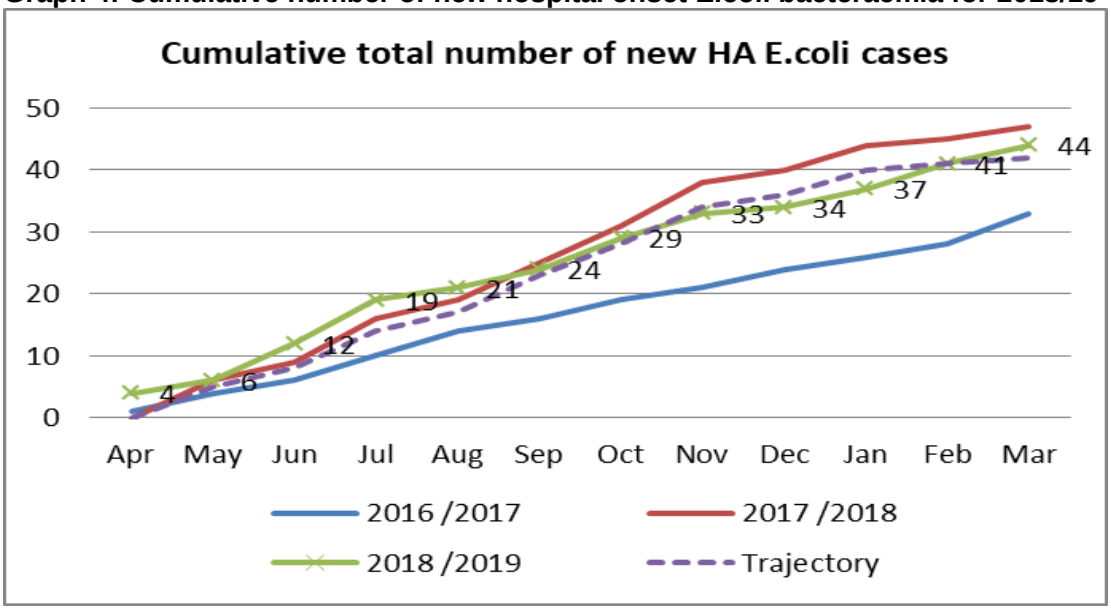
Mandatory reporting of all E.coli bacteraemia commenced in June 2011, however there have been historic issues with WUTH having technical and operational difficulties with submitting patient level data. All data from January 2016 has been locked down and signed off by the Assistant Director of Informatics, however there is a gap prior to this date.

E.coli infections represent 65% of gram-negative infections and resulted in 5,500 deaths in the NHS in 2015; they are set to cost the NHS £2.3bn by 2018. In November 2016, the

Secretary of State for Health announced a national ambition to reduce Gram-negative bacteraemia by 50% by 2021.

The majority of cases are community associated, in 2018/19 there were 215 community acquired cases compared with 44 hospital acquired cases a reduction from 2017/2018 with 47 cases identified. This standard poses a significant challenge and continues to require shared health economy colleagues to work collaboratively in order to achieve this ambition. The community IPCT does not have the resource to investigate the community associated cases. For all Hospital acquired cases of E.coli an SBAR investigation is circulated by the IPCT to support in identifying any key themes or trends and likely source of bacteraemia.
The IPCT document likely source of bacteraemia identifying that the likely source of bacteraemia is urinary tract in 19 (43%) of the HA cases.
The IPCT were also invited to NHS improvement to be a member of the UTI collaborative. The aim of the group was reduce UTIs with a focus on hydration. The IPCT presented their project nationally at the last UTI collaborative meeting and their project will be used as a national case study. A hydration leaflet was produced by the IPCT which all patients have access to on the wards and a member of the team attends the Nutrition and Hydration group

Graph 4: Cumulative number of new hospital onset E.coli bacteraemia for 2018/19



Recommendations for 2019/20

- The IPC Information Analyst will continue to submit data via the national HCAI data capture system
- Divisions to perform SBARs so that learning can be identified and ownership/change in practice can be established and embedded
- Continue to promote hydration
- UTI improvement team (Whole Health Economy Group) to continue to meet monthly.
- Continued focus on clinical practices particularly those associated with the insertion and ongoing management of urinary catheters

- A member of the IPCT team to attend the Sepsis group

6.5 Surgical Site Infection (SSI)

Mandatory orthopaedic surgical site infection (SSI) surveillance was undertaken between January– March 2019 for repair of neck of femur and reduction of long bone fracture. This was performed by a Registered Nurse within the Surgical Division with support from IPCT.
In Q1 of 2019 a 5% (7/132) infection rate was reported

	Number of patients in Study	Number of SSI	% Rate
Long bone	63	4	6%
Fractured Neck of Femur	69	2	3%
Total	**132**	**6**	

Recommendations for 2019/20:

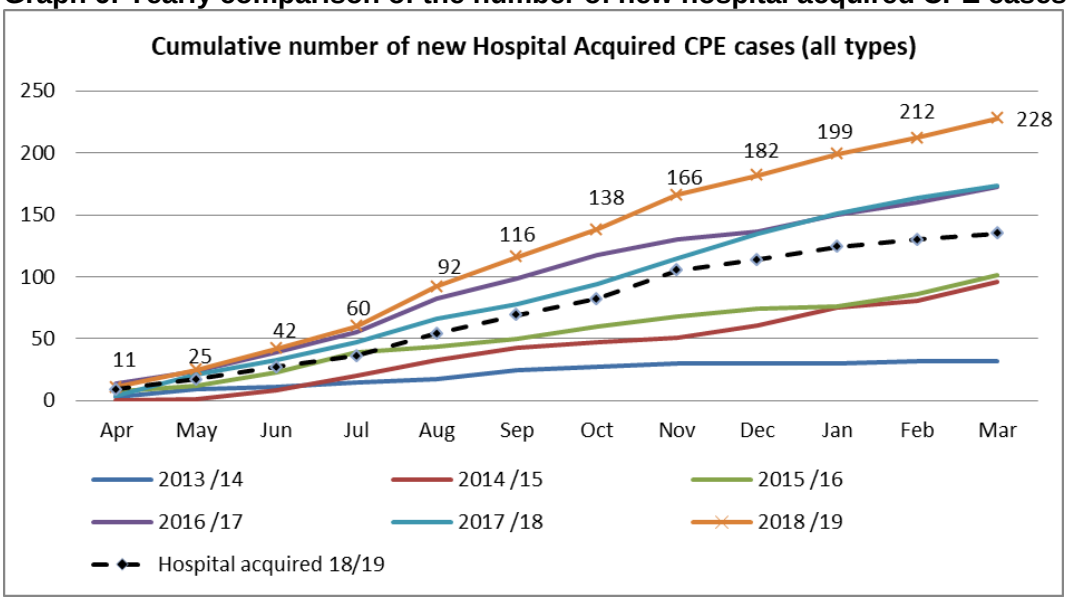
- The Surgical Division, supported by the IPCT, will explore the feasibility of extending the time period when performing mandatory surveillance and expanding the surveillance.

7. Non-reportable Organisms

7.1 Carbapenemase Producing Enterobacteriaceae (CPE)

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. Carbapenemase-producing Enterobacteriaceae (CPE) are Enterobacteriaceae that are resistant to carbapenem antibiotics (Meropenem, Ertapenem and Imipenem). CPE can cause wound infections, bacteraemia and infections of the urinary tract, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics.
The graph below demonstrates the predicted exponential increase in the number of patients becoming colonised with CPE, with 228 new hospital acquired CPE colonisation detected during 2018/19, an increase from the previous year (174 cases). It is essential to optimise existing IPC measures and identify more effective ways in which to manage these difficult to treat infections.

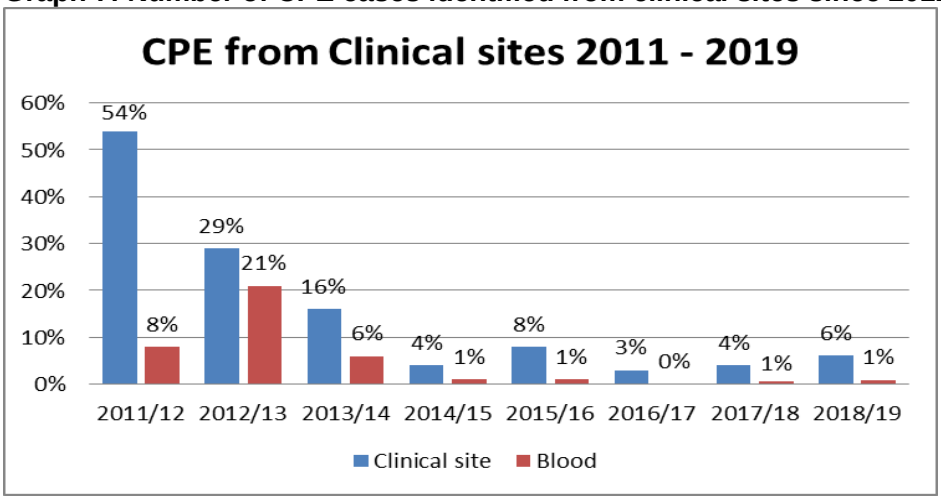
Graph 6: Yearly comparison of the number of new hospital acquired CPE cases (all types)



During 2018/19 there was 2 CPE bacteraemia reported. 1 patient was on Ward 24 and 1 patient was on HDU. A local review was undertaken for both cases. The patient on ward 24 had been on the ward during an outbreak of CPE. The patient had been highly exposed during his admission. The case on HDU had a previous history of CPE and the source of bacteraemia was likely to be pancreatitis. This bacteraemia was deemed to be unavoidable due to patient's underlying condition.

There have been 14 patients positive for CPE in a clinical site. This is an increase in CPE being detected in clinical sites, it is unknown if these patients were treated for a CPE clinical infection, however it is likely that if the patients were being treated for clinical infections the antibiotics would have been revised to cover for CPE, potentially leading to combined antibiotic therapy

Graph 7: Number of CPE cases identified from clinical sites since 2011/12



During 2018/19, when there was an increased incidence of CPE on a ward the IPCT would undertake regular checks on the ward using a specific checklist reviewing; isolation, screening, cleaning, use of personal protective equipment, hand hygiene, dedicated equipment and invasive devices / wound management. CPE specific improvement plans were developed for wards to manage a period of increased incidence to prevent this developing into an outbreak. There was a period of increased incidence of CPE reported on Wards 36 and Ward 20.
An outbreak of CPE was declared on ward 24 and an outbreak meeting was convened with PHE involvement.

Throughout 2018/2019 IPCT have continued to advise that bays are closed due to CPE exposure risk. Due to hospital capacity and the lack of isolation facilities keeping bays closed has remained a challenge.
Ward 25 (Beds 9-22) has continued to be utilized as a CPE isolation unit however due to the increases in the number of cases not all patients have been able to transfer to the unit due to capacity.

Recommendations for 2019/20

- Introduce readmission screening (within last 12 month) for CPE in line with PHE guidance. A business case is required.
- Explore and develop IT solutions to enable the IPCT to capture screening compliance data across the trust
- Development of IT solutions to support IPCT to manage CPE effectively
- Maintain optimum staffing levels of Ward 25
- CPE policy to be completed
- Review screening strategy with appropriate stakeholders
- Review IT solutions to ensure correct patient placement – solution available in Capacity Management; awaiting implementation.

7.2 Vancomycin Resistant Enterococci

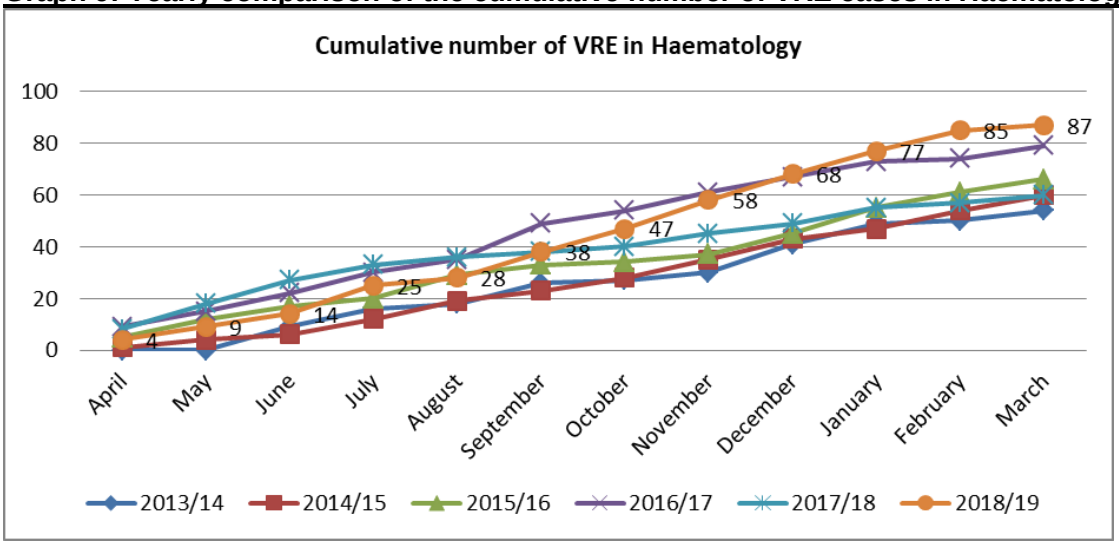
Enterococci are bacteria that are commonly found in the bowels of most humans. Vancomycin Resistant enterococci (VRE) are enterococci that are resistant to the glycopeptide group of antibiotics (Vancomycin and Teicoplanin). VRE commonly cause wound infections, bacteraemia and infections of the abdomen and pelvis, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics. Targeted screening continued in high risk areas to rapidly detect VRE in our most vulnerable patient groups i.e. haematology, critical care and orthopaedics.

Haematology

In 2018/2019 cases of VRE colonisation have risen with 87 colonisation identified.
The VRE cohort on haematology was discontinued in August 2018 due to the inability to cohort patients effectively on the ward due to beds not being left empty because of trust capacity. The general environment on the haematology ward is in need of modernisation in particular the ensuite facilities for patients in the single side rooms. Funding has been

agreed to update the ensuite facilities to include a wash basin and a date to commence the work is awaited.

Graph 9: Yearly comparison of the cumulative number of VRE cases in Haematology



Orthopaedics

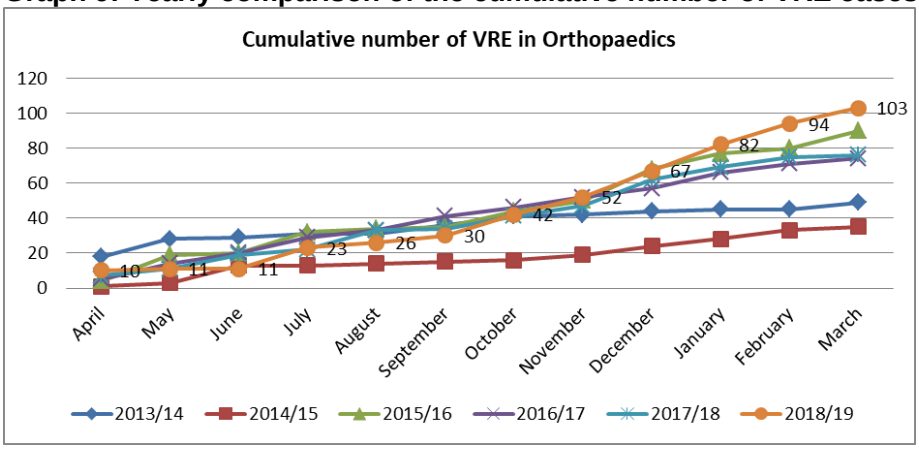
There has been an increase in the number of new colonization identified in Orthopedics compared with previous years.

All orthopaedic inpatients on ward 10, 11 and WAFFU continue to be screened for VRE on admission and weekly.

VRE positive patents identified through screening or patients with a previous history are transferred to Ward 11 (VRE cohort)

The cohort has not been maintained on ward 11 due to operational demand, staffing level and the reluctance to have empty beds on cohort for a long time. This has resulted in both positive and exposed patients nursed in one area and any empty beds were filled with non-orthopaedic patients. Due to lacks of beds in cohort areas of ward 11 VRE positive patients have been left on Ward 10 and WAFFU this has resulted in prolonged exposure, ongoing transmission and increased bioburden of the environment.

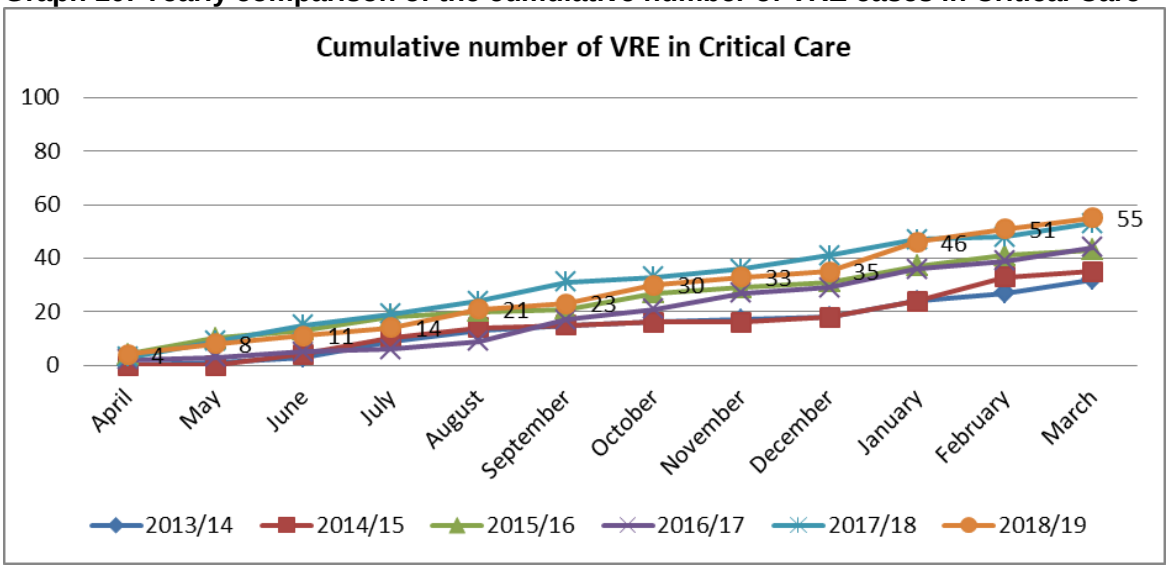
Graph 9: Yearly comparison of the cumulative number of VRE cases in Orthopaedics



Critical Care

The number of new VRE colonisations within Critical Care during 2018/19 has remained similar to 2017/2018. ITU have continued with their VRE screening strategy but have struggled to isolate all positive cases of VRE due to lack of side rooms. Funding was approved for more side rooms on Critical care and in March 2019 the work was completed to create 2 new side rooms.
The Planned Preventative Maintenance remains outstanding for Critical care.

Graph 10: Yearly comparison of the cumulative number of VRE cases in Critical Care



Recommendations for 2019/20

- Orthopaedic division to review screening strategy and consider rapid detection for VRE
- Launch the admission criteria for Ward 11
- Modernisation of the environment in Haematology (Ward 30).
- Haematology (Ward 30) admission criteria to be reviewed and recirculated

7.3 Pseudomonas aeruginosa

The IPCT have continued to provide representation at the Water Safety Group meetings and at extraordinary meetings held at the request of the IPCT during 2018/19. The IPCT have continued to promote the guidance on controlling / minimizing the risk of morbidity and mortality due to Pseudomonas Aeruginosa associated with water outlets (DOH 2013) in all augmented care areas. The team has continued to perform monthly pseudomonas inspections in these areas with the higher risk areas audited bi-monthly (neonatal unit and critical care unit).

Screening for Pseudomonas on admission, and weekly, has continued on the neonatal unit which identified 10 babies with Pseudomonas between April 2018 and March 2019. All 10 cases had been identified more than four days after admission to the neonatal unit and as

such, considered to be hospital acquired. All samples were sent for typing which did not identify any cross-transmission between babies.
The neonatal environment remains an issue and plans for refurbishment remain ongoing. Limited space to include lack of storage facilities has been identified as the major issue particularly as the unit is the level 2 NNU unit for the region. Due to the high demand of beds on NNU, parts of nursery are now modified as HDU 2. Mitigating actions are in place to prevent Pseudomonas Aeruginosa on the NNU to include filters on taps, sterile water for bathing and use of hand rub following hand washing. The neonatal infection control group led by the Advanced Neonatal Practitioner has developed a video demonstrating the correct removal of personal protective equipment and is used as part of the NNU induction training.

Recommendations for 2019/20

- Continue to monitor Pseudomonas cases within augmented care areas
- Continue with mitigating actions in augmented care areas
- Consider water sampling in Critical care
- Continue to undertake Pseudomonas checks in augmented care areas

7.4 Legionella

A review of water testing for Legionella bacteria was reviewed by the Water Safety Group (WSG) as there was concern that there was a lack of assurance that the mitigating actions to control Legionella bacteria in the water system was in place; maintaining hot water temperatures above 50°C (although updated guidance recommends maintaining hot water temperatures above 55°C) and ensuring all outlets of the water system are frequently in use. The WSG agreed to perform Legionella testing in clinical areas with susceptible patients and appliances that generate aerosols failed to achieve above 50°C on three consecutive occasions.

In 2018/19 the WSG agreed to perform sampling in line with the above criteria to the following areas as the temperature control regime could not be maintained on three consecutive occasions.

- Wards 20, 31, 32, 33, 52, Endoscopy, and Paediatric A&E.

Sampling results of June 2018 for Wards 31, 32, 33 and 52 were negative for legionella species, however Ward 20, Endoscopy and Paediatric A&E results were reported as positive.
It was agreed that no further sampling would be necessary for Wards 31, 32, 33 and 52 as the sample results were negative and appropriate reactive work had been carried out to maintain the temperature control regime of greater than 50^{o}C.

Ward 20, Endoscopy, and Paediatric A&E were subject to further pre and post sampling, in-depth surveys of the distribution system, remedial engineering works, local disinfections and hard flushing of outlets, to control / reduce the risk of legionella bacteria in the water distribution system. Bacteria filters were installed on clinical outlets and showers on ward 20.

Sample results for Endoscopy were reported as 2 out of 24 outlets positive and 3 out of 29 outlets positive for Paediatric A&E. Further sampling required for Ward 20, Endoscopy and Paediatric A&E.

Recommendations for 2019/20

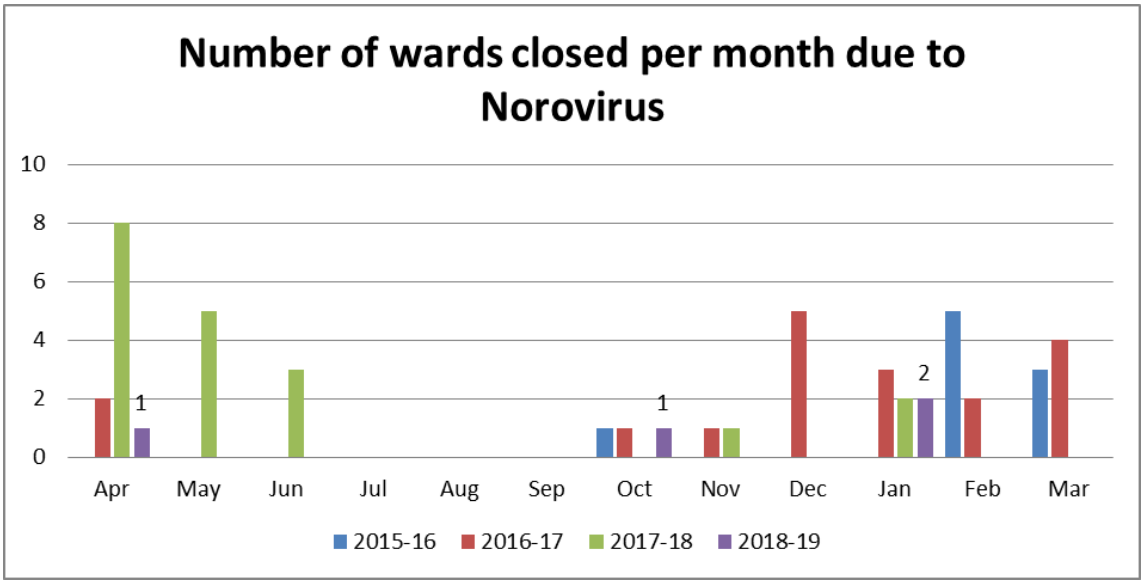
- Monitor hot water temperatures to identify outlets where temperatures are not maintained consistently
- Continue Legionella water testing in areas where there is lack of assurance that mitigating actions are in place
- Consider extending water testing for Legionella and Pseudomonas to include high risk areas
- Water Safety Group to monitor results of water testing and implement remedial actions
- Promote heightened awareness around the necessity for under used outlets to be flushed in line with guidance from an end user perspective
- Monitor compliance with L8 guard system.

7.5 Norovirus

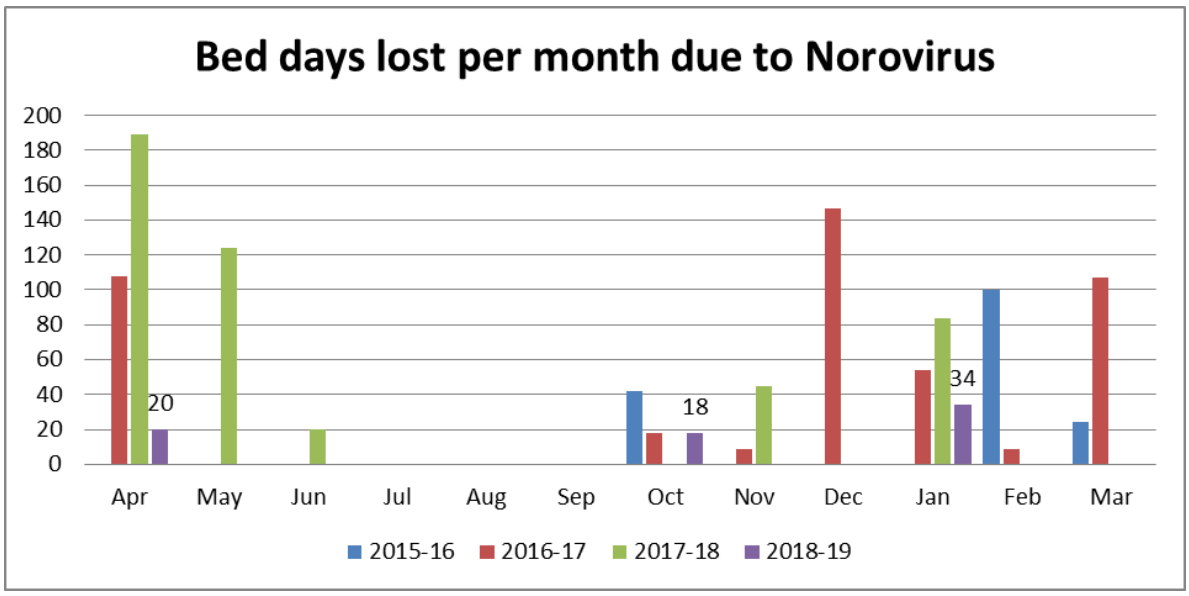
Norovirus, also known as winter vomiting disease, causes gastroenteritis and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another.

The graphs below compare the Norovirus season with the previous four seasons.

Graph 11: Comparison of number of wards closed per month due to Norovirus



Graph 12: Comparison of number of bed days lost per month due to Norovirus



Throughout 2018/19 there were only 4 wards closed due to Norovirus with a total of 72 bed days lost which a noted decrease from the previous year with 333 bed days lost.

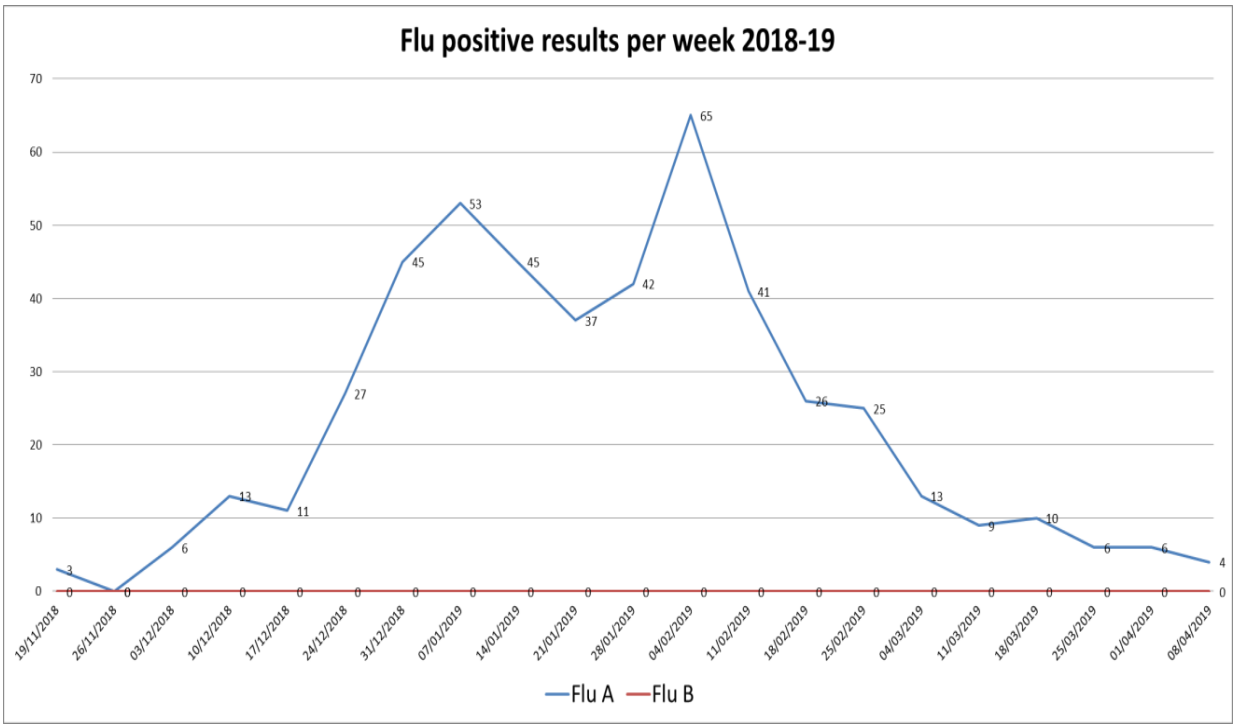
Most outbreaks originated from patients being admitted to hospital with symptoms; however it is suspected that some also originated from visitors. During Quarter 1 there was 1 ward closed with 20 patients symptomatic and 3 staff reported to be symptomatic. During Quarters 3 and 4, there were 3 wards closed due to Norovirus however there were 52 bed days lost. During this period there were 57 patients symptomatic and 14 staff reported to be symptomatic. Through 2018/19 wards were closed for a period ranging from 3 to 13 days, with an average of 6 days. The IPCNs reviewed the affected wards daily ensuring all practices were in place, providing an update at each bed meeting and reopened beds at the earliest opportunity to support bed flow, however this on occasion resulted in an extension of the outbreak.

The Launch of the M-page portal to include vomit chart allowed prompt action, detection and review of patients with norovirus or other viruses that included symptoms of diarrhea and vomiting.

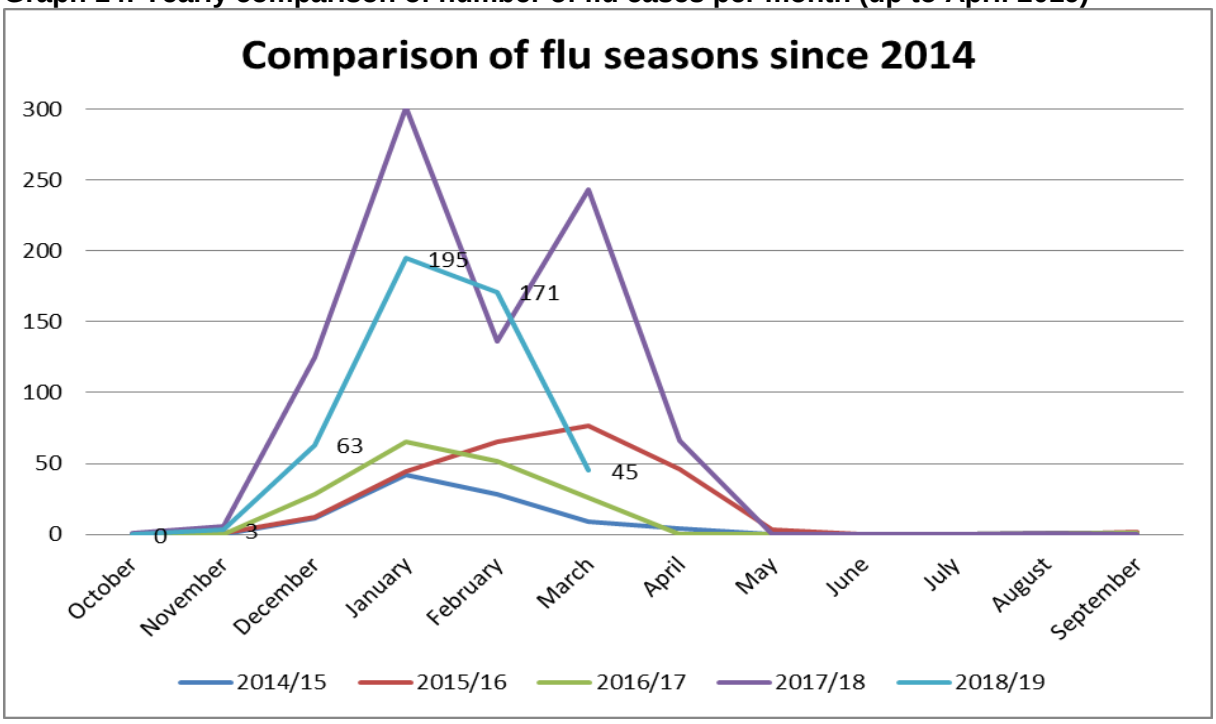
7.6 Seasonal Influenza

Between August 2018 and April 2019, 477 cases of influenza were diagnosed in the in-patient population. The only strain identified this season was influenza Type A. As demonstrated in the graph below, there were a number of peaks of activity regarding influenza cases within the Trust. The first peak of activity occurred during December 2018 followed by a second peak of activity in January and again in February.

Graph 13: Weekly flu season comparison of different flu strains (up to April 2019)



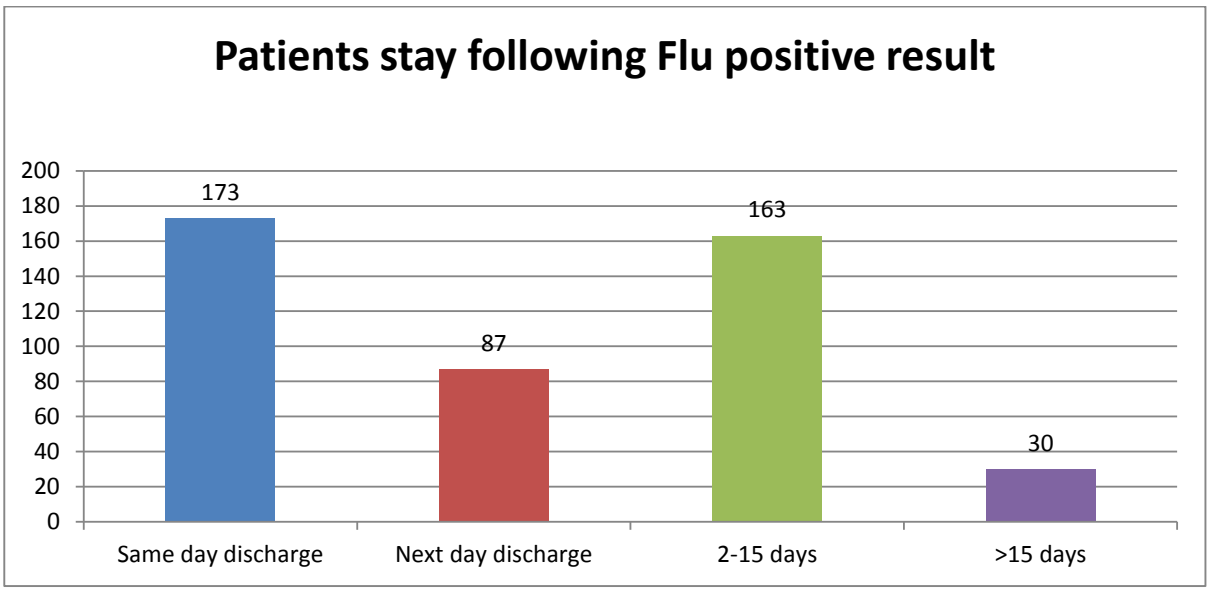
Graph 14: Yearly comparison of number of flu cases per month (up to April 2019)



The graph above demonstrates a decrease in positive flu cases seen within the Trust during 2018/19 flu season in comparison to 2017/18. Influenza type B cases were most prevalent

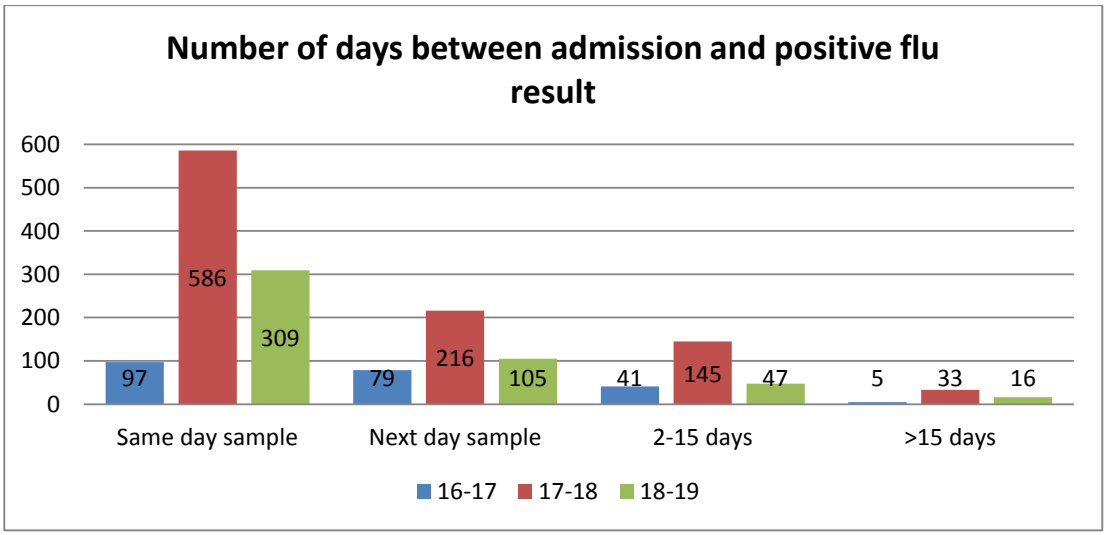
in the previous year whereas Influenza type A has been the only strain seen this year.

Graph 15: Length of Stay 2018/19 (up to April 2019)



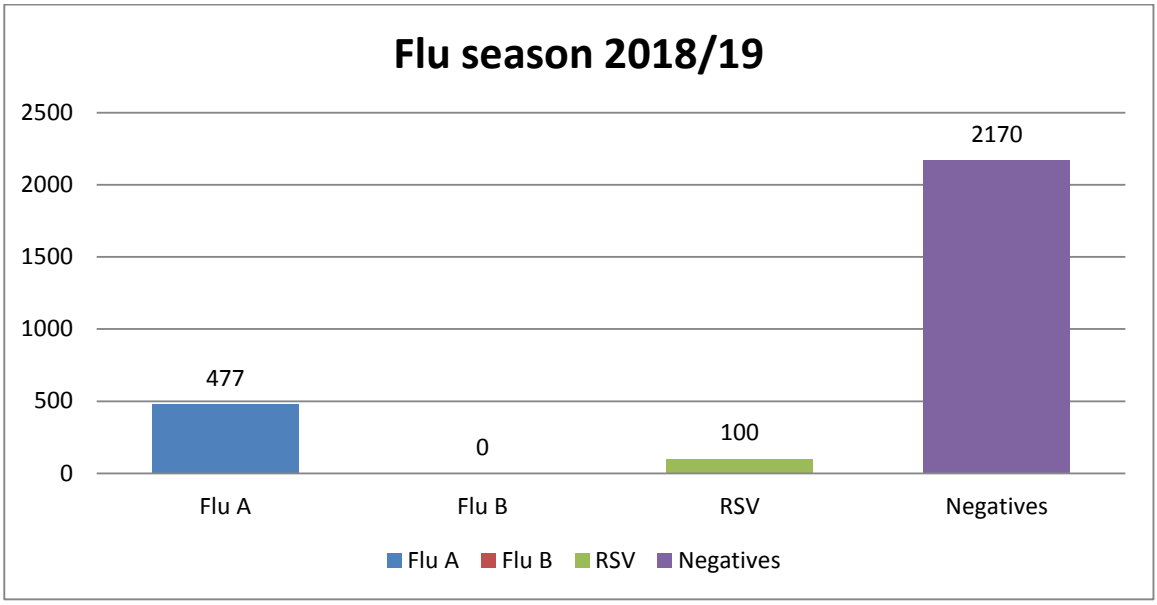
During 2018/19 flu season the largest percentage of patients were discharged same day (38%), followed by patients who were admitted for 2-15 days (36%). Data was not collected in relation to reason for admission to understand whether length of stay was appropriate in relation to underlying conditions. In comparison with the previous year's season there was an overall increase by 21% of patients being discharged same day following flu result therefore reducing exposure to others and length of stay within the Trust.

Graph 16: Yearly comparison of the number of days between admission and sample date.



65% of overall samples were taken on day of admission which was a 6% increase on the previous year's total resulting in inpatients being promptly treated, isolated and with appropriate precautions and therefore reducing the risk of transmission to others.

Graph 18: Total number of tests processed during Flu season 2018/2019 (up to April 2019)



The total number of flu swabs processed during August 2018 to April 2019 was 2747 with 477 (17%) testing Influenza positive, 100 testing RSV positive (4%) and 2170 (79%) testing negative. There has been a significant increase in negative swabs processed over the recent years. Increased focus on ensuring the Flu Criteria is appropriately followed is necessary to potentially see a reduction in negative swabs being processed.

The POCT cLiat Flu has been in use since October 2019 and is still operational. POCT has greatly improved the timing of results taking only twenty minutes for patients presenting to the admissions areas suspected of flu to have a result and therefore prompt isolation, treatment and precautions for these patients. This has been particularly beneficial out of hours and has assisted with operational flow within the Trust.

IPC supported the conversion of a small room on MSSW/MAU as a "POCT MiniLab" which provides an isolated safe area for all POCT devices.

There are plans for a POCT Flu kit to be set up for the AE Department in preparation for the next flu season. A dedicated co-ordinator and training in AE and training will be necessary for implementation.

If a patient with confirmed, or suspected, flu is requiring an aerosol generating procedure (AGP), staff performing these procedures must wear an FFP3 respirator to protect themselves from inhaling the aerosols generated. IPC organized 4 sessions from July to

October led by a representative from Full Support to train new fit testers and update existing fit testers to ensure staff within their departments were fully prepared for the flu season. Full assurance was not provided from all high risk areas regarding completion of fit testing often due to fit testers moving departments, sickness or due to gaps in staffing and being unable to have the time and appropriate venue to undertake.

With regards to Flu vaccination 84.5% of frontline healthcare workers vaccinated compared with 81.3% last year. WUTH was fourth highest in the northwest region compared to seventh place last year. There were a number of actions that worked well and contributed to the high level of vaccination.

Recommendations 2019/20

- Provide fit test training for key individuals within each Division to ensure staff in high risk areas are fit tested for appropriate FFP3 respirators
- Explore POCT within AE department ensuring a POCT lead for the department and staff training is in place.
- Education regarding criteria for flu screening to reduce number of inappropriate flu negative results.
- Plan to have Peer vaccinator in every clinical area e.g. ward, department
- Even earlier communication plan actions and launch prior to campaign for Healthcare vaccination.
- Use of all day flu vaccination clinic on both sites
- Communication and meeting with managers to support improved buy-in to ensuring their staff are fully informed and encouraged to have the vaccine or complete the opt out form.
- Identification of and focused action on the high risk clinical areas.
- Early meeting with all relevant stake holders to prepare for coming flu season.

7.7 Incidents of Communicable disease to include Chicken Pox, Measles and Pertussis

During the period from the 1st April to 31st March 2019 the IPCT and occupational have managed 5 cases of chicken pox to include a patient on the haematology ward, a visitor on the neonatal unit and a domestic in the maternity ward. There were 4 cases of mumps, a patient with measles on ITU and 1 cases of pertussis in a child who transferred to another hospital.

8. Antimicrobial Stewardship

Antimicrobial resistance is one of the biggest public health concerns that we currently face and is second on the nation risk register behind terrorism. Optimal antimicrobial stewardship practices are key to slowing the rate of resistance developing. These practices are described in the Department of Heath guidance document, ‘Start Smart then Focus’. This document describes steps to undertake when commencing an antibiotic and when and

how to deliver an antibiotic review that considers all clinical information to arrive at the most clinically appropriate outcome for the patient that reduces the risk of inappropriate prolonged use of broad spectrum antimicrobials.

Data from Trust wide audits 2018-19 demonstrates that on average 97% of inpatients are prescribed antibiotics at any one time.

8.1 Start Smart.

The key recommendations to ensure antibiotics are started appropriately are;

- Documentation of the indication for antibiotic use on the prescription and in the clinical notes.
- Compliance with the Trust wide antimicrobial stewardship formulary. When deviation from the formulary is clinically appropriate, e.g. in allergies or when recent sensitivities are available, this must be fully documented within the patient notes with the rationale for this decision.
- Submission of appropriate patient specific clinical samples for microscopy, culture and sensitivity (M,C&S) testing.
- Course length or date for review specified at commencement of antibiotics to prevent courses continuing in error.

Compliance with these recommendations are measured

- Monthly during the Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit, undertaken by the Pharmacy Stewardship Technician. Five patients on antibiotics are selected randomly for each ward and included in the audit.
- Annually during the Antibiotic De-escalation audit (Nov 2018). All patients initiated on parenteral antibiotics during a period of a week are followed up at 72 hours to ascertain if appropriate antibiotic review has been undertaken.

Work to support compliance with these recommendations through 2018-19 has included the inclusion of mandatory field to document antibiotic indication when prescribing antibiotics. This went live as an optional field February 2018 but was made mandatory October 2018 due to low uptake.

8.1.1 Documentation of indication for antibiotics

ASPIRE data demonstrated that the indication for antibiotic use is documented in the medical notes 99% (average 2018-19) and on the prescription 100% (average 2018-19.)
The annual de-escalation of antibiotics audit demonstrated that the indication documented in the medical notes differed from that on the prescription 31% of the time, therefore further work is required to ensure these fields are completed accurately.

8.1.2 Formulary compliance

ASPIRE data demonstrated that formulary compliance or appropriately documented deviation was 96% Trust wide 2018-19.

8.1.2 Sample collection

Data from the annual review of antibiotic de-escalation (Nov 2018) demonstrated that M,C&S samples are sent for 75% of patients.

8.1.3 Course length/review date documented.

A monthly Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit is undertaken by the Pharmacy Stewardship Technician. This demonstrated that formulary compliance or appropriately documented deviation was 96% Trust wide 2018-19.

8.2 'Focus' review

This step describes the clinical review of the antibiotic course that is expected to occur between 24 and 72 hours after initiation of an antibiotic course.

The aim of this review is for clinicians to assess the patients' clinical picture, alongside M,C&S results indicating organisms present and their sensitivities to enable the best outcome for the patient to be implemented. Start Smart then Focus guidance suggests five potential outcomes. These are;

- Stop antibiotics. This is the option when an infective cause has been ruled out or the patient has improved clinically to such an extent they no longer require antibiotic therapy.
- Change to an oral option. In haemodynamically stable patients, who are absorbing oral medicines, parenteral antibiotics are not required with few exceptions, (such as cystic fibrosis and endocarditis)
- Switch the antibiotic. This would be with the knowledge of M,C&S results enabling a more narrow spectrum antibiotic to be used or to a more broad spectrum antibiotic if the organism was resistant to current therapy.
- Continue antibiotics in patients who are improving but not clinically appropriate for one of the above steps.
- Discharge on Outpatient Parenteral Antimicrobial Therapy (OPAT) for medically fit patients requiring to remain on parenteral antibiotics.

The annual de-escalation audit demonstrated that 95% of patients received an antibiotic review within 72 hours of antibiotic initiation. Of these the outcomes were as below.

8.3 CQUIN Performance 18-19

The 'Reducing the Impact of Serious Infections' CQUIN, parts 2c (antibiotic review) and part 2d (antibiotic consumption) ended March 2019.

Part 2c was achieved for each of the 4 quarters through the year.

Part 2d is measured annually and further split into 3 separate parts and of these only 1 (reduction in carbapenem use) was achieved. The targets not met were reduction in total antibiotic use and increase in use of antibiotics from the Access category of the WHO Aware list as a proportion of total antibiotic use.

8.4 Next steps 2019-20

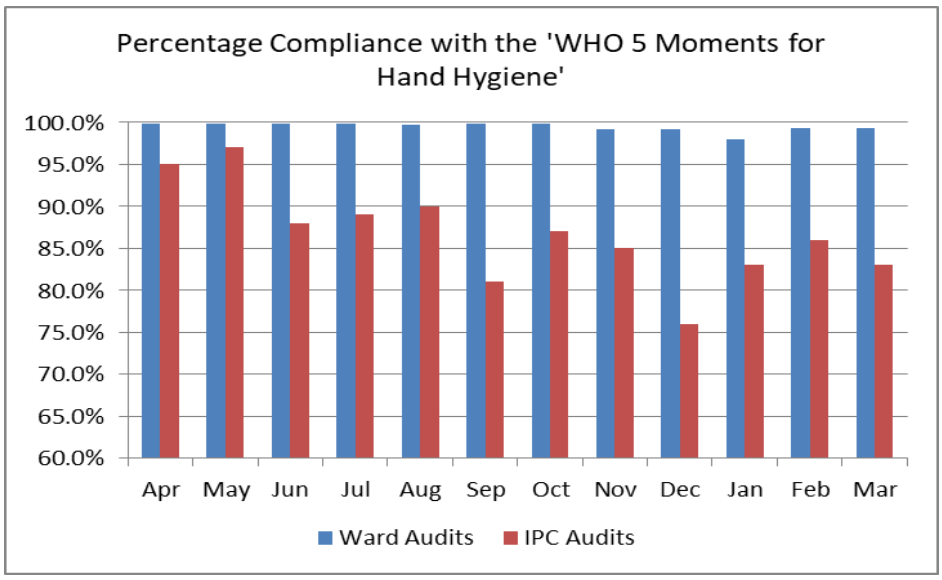
- Further develop the electronic antimicrobial stewardship mpage to make it more user friendly and thus promote update which is currently low.
- Roll out participation in national, multi centre trial ARK, aiming to promote effective antimicrobial review and change the culture around antibiotic prescribing to reduce total antibiotic consumption.
- Continue antimicrobial stewardship ward rounds in existence and produce business case for increased resource to enable further roll out Trust wide.

9. Audit Activity

9.1Hand Hygiene Audits

Adherence to hand hygiene is measured by direct observation of health care workers in clinical settings. The following graph demonstrates Trust compliance against the WHO 5 Moments for Hand Hygiene. Hand hygiene audits are performed weekly by ward staff within their own areas, whilst the IPCT perform ongoing random audits as they visit clinical areas. Ward level audits are collated weekly by the IPCT and sent out to a wide circulation at the month end. The IPCT audit results are circulated monthly in the monthly IPCT data report.

Graph 19: Comparison of the percentage compliance against the WHO 5 moments for hand hygiene between audits performed by IPCT and ward staff



Hand Hygiene compliance has reduced during 2018/19, with an average compliance rate of 87% when staff were audited by the IPCT. The common theme in non-compliance is staff failing to comply with the bare below the elbow policy.
The IPC Team have continued to promote hand hygiene and bare below the elbow, particularly during the awareness campaigns for World Hand Hygiene Day and Infection Prevention and Control week. Staff who do not comply with hand hygiene policy are escalated to the Triumvirates and Medical Director who will write to the individuals concerned to endorse the importance of complying with hand hygiene.

Recommendations for 2019/20

- Launch of National Hand Hygiene and Standard Precautions Policy as part of May 5th Clean Hands Save Lives WHO Campaign
- To participate as a pilot site for the Hygiene Automated Electronic Hand Hygiene Compliance Study
- To work with Comms to promote National Hand Hygiene and Standard Precautions Policy as part of May 5th Clean Hands Save Lives WHO Campaign and refresh/review hand hygiene compliance and BBE across the Trust
- Change company that provide Hand Hygiene Products

9.2 Adenosine Tri Phosphate (ATP) swabbing and Ultra Violet Light tagging audits

The IPCT and Hotel Services perform regular ATP swabbing and ultra violet tagging throughout all wards. Performing these audits allows the IPCT to identify if the equipment and environment has been cleaned. Common issues identified include Apron, Toilet dispensers grab rails and Blood pressure monitors not being cleaned. Results are regularly feedback to the relevant teams.

Recommendations:

- Continue to monitor with ATP and UV light audits
- IPCT to regularly review results and report common themes and trends to the divisions and hotel services

9.3 Sharps Safety Audit

A Trust wide sharps audit was performed by a representative from Daniels, Trust supplier of sharps bins. Overall 712 sharps containers were audited.

Key findings

- 42 of the sharps containers audited were not being correctly labelled whilst in use
- 15 of the sharps containers had inappropriate items placed in them
- 57 sharps containers did not have the temporary closures systems in place
- 6 sharps containers had protruding sharps evident

Recommendations

- Annual sharps audit and staff education from the Daniels representative.

9.4 Catheter Associated Urinary Tract Infections (CAUTIs)

A CAUTI prevalence audit was undertaken on the 12th June 2018 across the whole health economy. There were 594 persons with an indwelling urinary catheter who were audited across the community and acute Trust:

- 25% (150) of the urinary catheters audited had been inserted in hospital and 72% in the community setting. 91% of all urinary catheters had documentation of insertion.
- 58% of the catheters inserted had been inserted for acute urinary retention or obstruction
- Only 35% of the patients with a urinary catheter had a catheter passport
- 2% of patients were recorded to have a CAUTI (12/594) with 1 patient documented as having a hospital acquired CAUTI
- 40% of patients with a CAUTI had a urine sample collected prior to antibiotics

The results were reported to the CAUTI group and recommendations included: to undertake a repeat Whole Health Economy audit in 2019; The UTI improvement group previously the CAUTI group meet monthly and report to the Harm Free Care Group.

Recommendations

- Annual CAUTI audit
- UTI improvement group to support recommendations from the CAUTI audit

9.5 Commode Audit

A Trust wide commode audit was undertaken by the Clinell Company who supplies our commodes in March 2018.
Overall there were 85 commodes audited with only 42% (36) of the commodes found to be clean and in a good state of repair. 69% (59) commodes had been labelled as clean however 29% (17) of these commodes were found to be soiled. 34% (29) require replacement parts.

Recommendations

- Report to be discussed at divisional IPC meetings
- Commode handover document to be utilised across the divisions

9.6 Food Hygiene Inspection

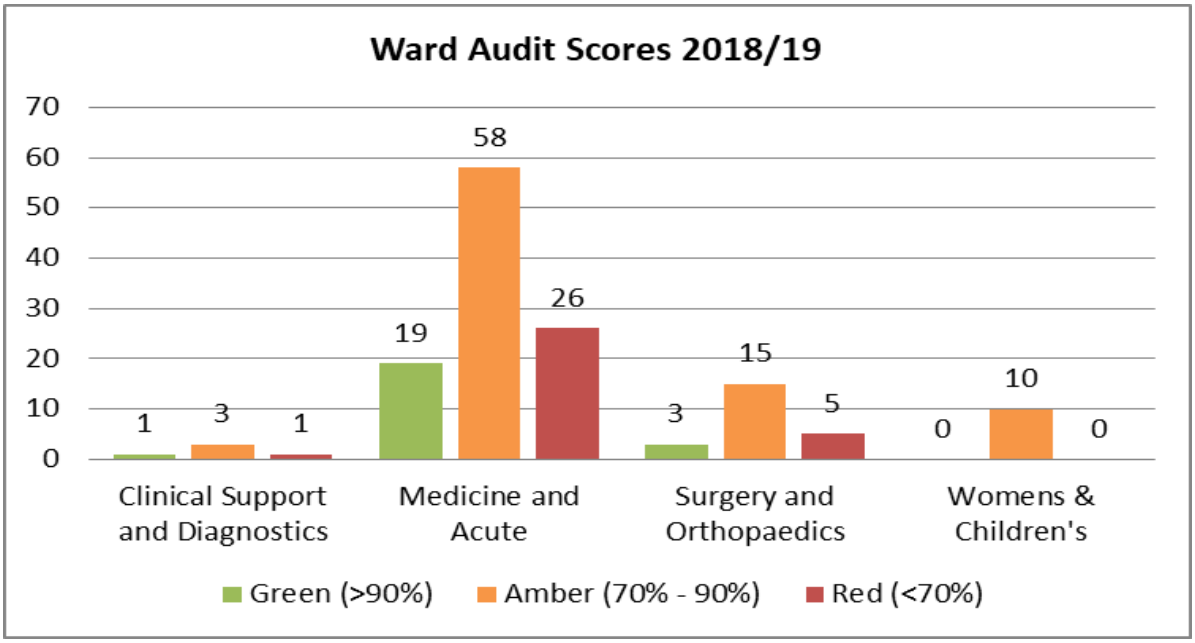
A Food Hygiene inspection was completed in February 2019. Issues identified include patient's food storage and correct labelling, incorrect disinfectant products available in the kitchen and incorrect fridges. It was also strongly advised that any reusable items such as jugs, beakers and cup holders etc. are washed in a commercial grade dishwasher.
Recommendations from the visit included ensuring that all fridges including snack fridges are of commercial grade, consider a separate hand wash basin in kitchens when they are

being upgraded or refurbished, staff training and correct storage. Catering are now collecting all jugs and beakers etc. for cleaning in the commercial grade dish washer.

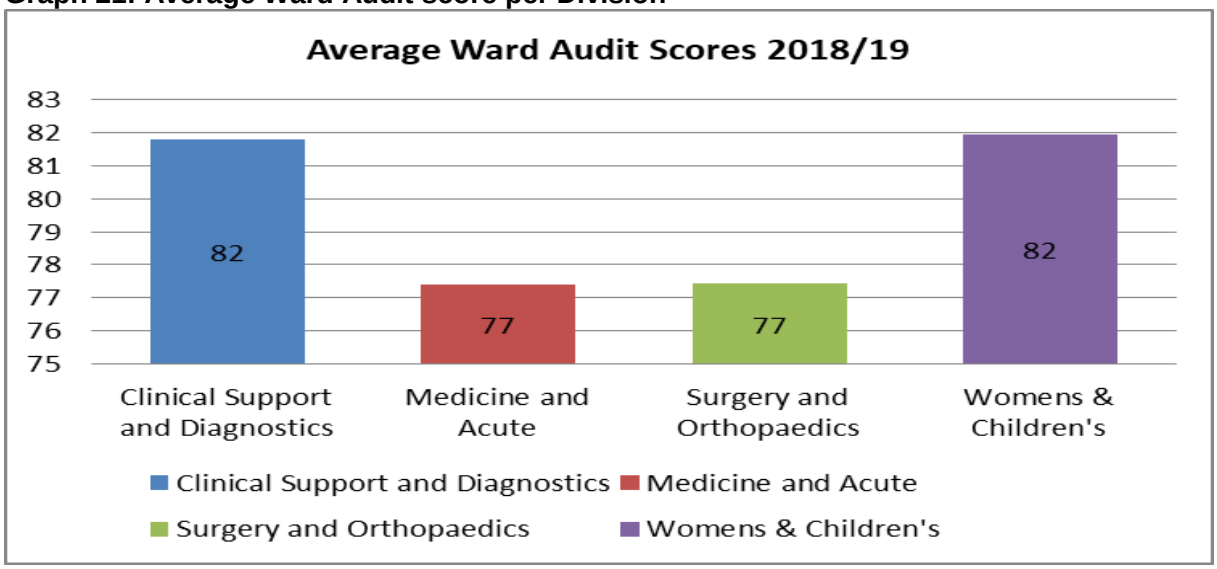
9.7 Environmental Audits (Perfect ward app and WISE accreditation)

Infection Prevention and Control Ward / Department audits are performed by the IPCNs using a locally adapted version of an audit tool promoted by the Infection Prevention Society (IPS). The tool covers elements of policy and practice including hand hygiene, use of personal protective equipment, ward environment, care and decontamination of equipment, disinfectant and antiseptic use, waste disposal, sharps handling and disposal and linen handling and disposal. Audit results are communicated to senior staff including ward sisters and infection control leads to enable staff to address shortcomings. The audit tool was adapted in 2019 and is now available on the perfect ward app and the audit is used to support the WISE accreditation. During 2018 / 19, the IPCT performed 141 IPC audits, an increase from the previous year. 16% (23) of these audits had a green rating, 61% (86) had an amber rating and 22% (31) had a red rating.

Graph 20: Number of wards achieving Green, Amber and Red status per Division



Graph 21: Average Ward Audit score per Division



Following the audit, ward sisters are responsible for resolving issues and escalating any issues that cannot be resolved at ward level to the divisional IPC meetings; progress with actions are monitored by the Matrons with any outstanding actions escalated to IPORT. This process requires further divisional ownership to ensure that the audit cycle is closed with assurance to IPORT that the actions have been addressed.

Recommendations 2019/20

- IPCT to continue to work with the WISE accreditation team through use of the IPC audit on perfect ward app

9.8 High Impact Interventions (HIIs)

The HII care bundles are designed as rapid improvement tools to ensure the right thing is done for all patients by all staff at all times. These include:

- Insertion and ongoing care of renal, central and peripheral lines
- Insertion and ongoing care of urinary catheters
- Ventilated patients
- Preventing surgical site infection
- *C.difficile*

There was no assurance during 2018/2019 that staff were robustly monitoring high impact interventions (HII). Compliance with these care bundles are discussed at Divisional IC meetings. There was no electronic system to collate and report compliance in 2018.
In 2019 the HII bundles have now been uploaded to the Perfect ward app

Recommendations 2019/20:

- IPCT to promote the use of the HII on the perfect ward and divisions to ensure appropriate staff have access to the system to enable increased compliance.

- Ensure compliance is discussed at monthly divisional IPC meeting

9.9 Infection Prevention and Control Review

In March 2019 NHSI performed a review following an outbreak of C.Diff. The visit identified that the Trust had completed a great deal of work on the integrity, decluttering and cleaning of the environment and development around hand hygiene and general Infection Prevention and Control principles was also praised. The report highlighted that the relatively new process for reviewing C.difficile cases through the executive panel has supporting shared learning across the whole health economy and engagement and ownership across the divisions.

Recommendations included:

- Utilising ARK for the use of antimicrobials.
- Develop strategies and practise to reduce the risk of pneumonia by focussing on oral hygiene, or reducing catheter associated UTI by having clear catheter management and removal.
- Using the opportunity of changing the hand hygiene products to promote and reinforce the bare below the elbows guidance and Hand hygiene policy throughout the Trust.
- A second toilet clean in addition to the check cleans on the wards.

10. Care of the Environment

10.1 Hotel Services

Hotel Services continues to provide a comprehensive range of cleanliness services to support out Trusts IPC agenda.

Infection Control cleanliness services include:

- Rapid Response Infection Control Cleans
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme
- HPV Decant Replacement Deep Clean Programme (when not possible to follow HPV programme due to a decant ward not being available)

Additional Infection Control cleanliness services above team capacity are reported as a Hotel Services cost pressure.

Facilities Management (Cleaning Standards) Review
Assignment Report 2018/19 Mersey Internal Audit Agency

A review of Facilities Management (Cleaning Standards) was undertaken as part of the 2018/19 Internal Audit Plan, as approved by the Audit Committee.

- The cleanliness of any healthcare environment is important to implement infection control, protecting patients and staff in the workplace.
- The Trust has a duty to comply with the National Cleaning Standards and to meet the requirements of the Care Quality Commission Regulation 15: Premises and Equipment.
- The overall objective of the review was to assess the effectiveness of the systems in place to ensure that the Trust meets its obligation to provide clean premises.

Executive Summary

There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. **Substantial Assurance**.

Recommendations 2018/19:

- To be included in the working group for the introduction of Capacity Manager.
- Continue to review with Infection Control the Capacity of the Cleaning Resource.
- Establish and continue to complete an assurance report for IPORT.
- Introduction of the MICAD C4C software version to ensure compliance and future assurance to the expected amendments to the National Cleanliness Standards (summer 2019).
-

10.2 Patient Led Assessments in Care Environments (PLACE)

A patient-led assessment of the care environment (PLACE) is a National system for assessing the quality of the hospital environment, which replaced the Patient Environment Action Team (PEAT) inspections from April 2013. PLACE assessments apply to all hospitals delivering NHS-funded care, including day treatment centres and hospices.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in 6 specific areas to include cleanliness and general building maintenance. From 2016 the assessment also looked at aspects of the environment in relation to those with disabilities. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours. Most importantly, patients and their representatives make up at least 50% of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally. The IPCT supported the inspection to assess wards, outpatients, A&E departments and internal/external common areas against two of the five standards, these being cleanliness and condition, appearance &

maintenance of the general environment. The other standards assessed include food and hydration; privacy, dignity and wellbeing, dementia and disability

Table 6: WUTH PLACE results compared with the national average for 2017/18. Results reported in September 2018.

Standard	WUTH Score	National Average
Cleanliness	99.03%	98.5%
Condition, Appearance & Maintenance	95.01%	93.4%

National Plans for 2019

The timetable for the PLACE collection this year (2019) was moved to accommodate the review of the PLACE programme. The review is still ongoing but we can confirm that work continues towards the collection opening in early September 2019 for a period of around 10 weeks. Nationally there will be a series of pilots to look at how the changes agreed by the National Steering Group will work in practice, once these and any subsequent changes are complete we will be preparing the paperwork for publication. In addition we are planning to hold some training sessions across the summer which all PLACE leads will be invited to attend.

10.3 Environmental Improvement Programme

A 2018/19 backlog maintenance budget of £3.9m had been awarded to enhance the safety and quality of our buildings and equipment with a positive impact on patient, visitor and staff experience.

With the focus on patient safety and experience, the Trust awarded capital expenditure on new ward nurse call systems, roofing, flooring & winter bed spaces as well as large sections of road resurfacing. The capital expenditure also allowed for upgrades to critical ventilation systems. Many of these repairs had been identified as possible risks to infection control with damaged flooring, doors, walls and ceilings requiring attention and repair.

Recommendations for 2019/20

- Refurbishment to Ward 30 en-suite facilities
- Flooring repairs
- Fire Safety upgrades

11. Education and Shared Learning

Training and educational programmes have been developed and delivered by the IPCT in accordance with national policies, service requirements and local need. In addition to ad hoc training sessions and promotional campaigns, the IPCT have continued to deliver corporate induction for all groups of staff and provide mandatory infection control updates. The IPCT have also provided educational and information sessions for doctors from F1 to Consultant level and sessions delivered to Medical Students at each year of their training.
The IPC promoted CLEAN week in 2018 focusing on doing the basics brilliantly i.e. environmental cleaning and hand hygiene with stands in the main Foyer and dining rooms and visiting the wards with quizzes and competitions. The CLEAN week was well evaluated and proved useful to all staff.
The IPCT promoted hand hygiene for National Hand Hygiene Day and Hydration through the use of the quality bus and stands in the main foyer.
The IPCT attended the Trust safety summit to present a C.diff post Infection review

Recommendations for 2019/20

- Promote Infection Prevention Control week and World Hand Hygiene day
- Support Infection Prevention Ambassadors to promote best IPC practice
- Explore the feasibility of holding an IPC study day

12. Conclusion

2018/19 has been a particularly challenging year for the IPC team with lack of consistent leadership; however the team have continued to deliver a quality service for the Trust including positive proactive messages, as demonstrated in the previous section.

The ongoing challenge with meeting the CDI objectives with periods of increased incidences in several areas and the outbreak on Ward 23 was exacerbated by being identified as an 027 strain known to cause increased morbidity and mortality and difficult to manage. In addition the ongoing bed pressures, patient flow and side room availability contributed to management and control.

It has been disappointing that Wirral CCG have not achieved the quality premium for the reduction in E.coli bloodstream infections; however this needs to be addressed as a whole health economy to achieve significant reductions in this area, although this will have resource implications.

Progress with the IPC Improvement Plan needs to be monitored closely to ensure these actions are delivered within the revised timeframes.

Despite the difficulties there have been positives with the Trust achieving 84% compliance for vaccination uptake, the IPCT also supported the implementation of ANTT and have been recognised nationally for the project to reduce UTIs and improve hydration.

A robust IPC surveillance system is essential to be able to monitor all healthcare associated infections and identify the potential for outbreaks before they occur. This will also support

the IPCT team in reducing the requirement of data entry. To this end, it is essential that an IT solution is sourced and introduced.

13. Recommendations

The following recommendations aim to promote prevention with early control, as MDROs present a significant risk to patient safety, make it difficult to sustain the infection reductions already achieved, and greatly impact the day to day operations of the hospital:

- Continue to improve/develop surveillance systems to support effective delivery of a preventative IPC service
- Provide permanent onsite rapid testing initially for CPE then consider extending to flu and norovirus
- Review the cleaning strategy and ward HPV programme and compliment this with UV-C
- Maintain the standard *C.difficile* strategy
- Maintain the standard MRSA strategy
- Maintain norovirus strategy
- Monitor VRE strategy
- Monitor Pseudomonas strategy

Authors

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Accountable Executive

Gaynor Westray
Chief Nurse / Director of Infection Prevention & Control

Board of Directors	
Agenda Item	10
Title of Report	Learning from deaths annual summary report
Date of Meeting	4th September 2019
Author	Dr Mike Ellard, Deputy Medical Director (interim)
Accountable Executive	Dr Nicola Stevenson, Executive Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 4 Catastrophic failure in standards of safety and care
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	Yes

1. Executive Summary

The Annual Summary Report seeks to bring together the progress to date and work undertaken through 2018/19, to highlight the key learning themes and outline the plans to further enhance the agenda through 2019/20.

2. Background

CQC published its report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS.

CQC's recommendations were translated into seven national workstreams and the Learning from Deaths framework was published in March 2015. The Learning from Deaths framework placed a number of new requirements on trusts:

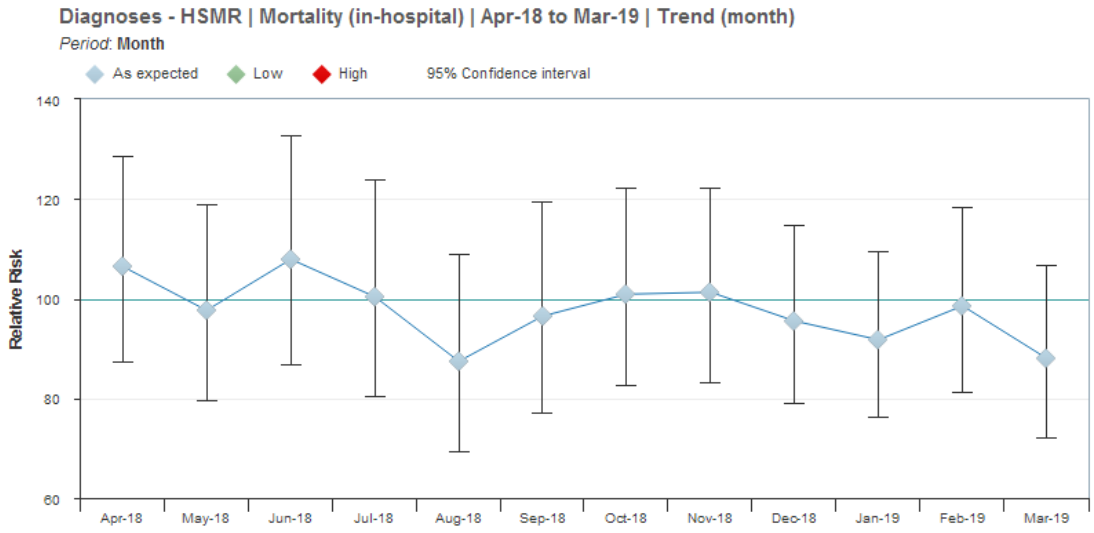
- From **April 2017** onwards, **collect** new quarterly information on deaths, reviews, investigations and resulting quality improvement (specified information required).
- By **September 2017**, publish an **updated policy** on how the trust responds to and learns from the deaths of patients in its care.
- From **Q3 2017** onwards, **publish** information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (specified information required).
- From **June 2018**, **publish** an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

3. Key Issues/Gaps in Assurance

3.1 Wirral university Teaching Hospitals (WUTH) Mortality

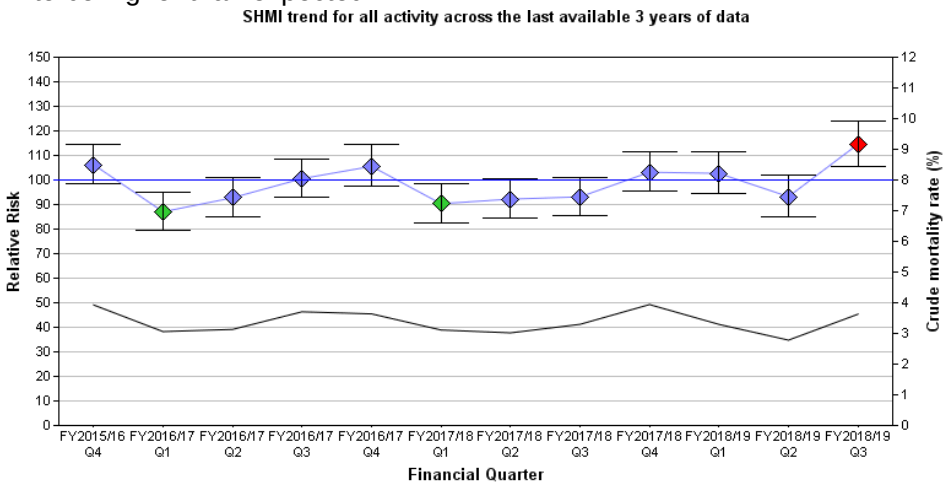
There are two national mortality indexes for the hospital: Firstly HSMR-hospital standardised mortality ratio - this measures 85% of in-patient deaths adjusted for palliative care, social deprivation and admission history. It is a more timely mortality index.

Graph 1 illustrates the monthly mortality trend between April 2018 and March 2019 for the whole Trust (HSMR) demonstrating positive performance throughout the year with relative risk being within the as expected range and a reduction from November 2018 which shows further improvement.

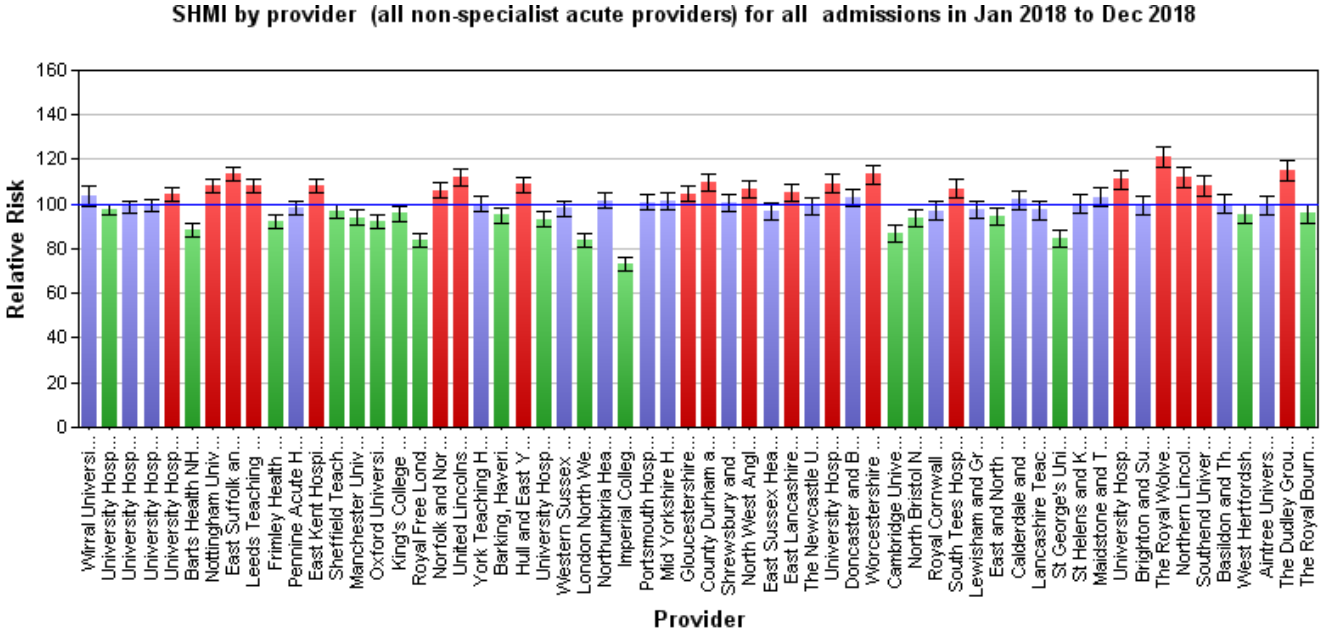


Secondly SHMI – Standardised Hospital Mortality Index – this measures all deaths in the hospital and those occurring within 30 days of discharge.

Graph 2 illustrates SHMI quarterly data from Q4 2015/16 to Qtr 3 2018/19. Until Q3 2018/19 the Trust was within the expected range, however a national change to the model has resulted in the data showing WUTH to be higher than expected.



Due to the changes in the model comparison can no longer be made with previous Trust data. However Graph 3 below shows how we compare with other Acute non-specialists within the region.



3.2 Dr Foster

3.2.1 Alerts

Regular training is being provided to the Clinical Effectiveness team from Dr Foster on how to report on any negative alerts. This will involve accessing Dr Foster every month once updated to look at any alerts indicated so that these can be investigated by Analysts and the relevant Clinical Lead.

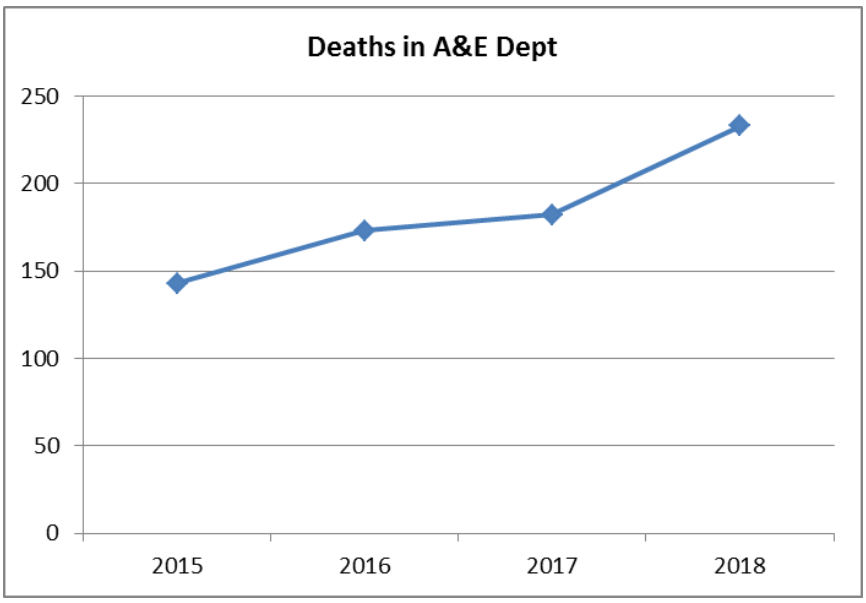
In February 2019 it was highlighted from Dr Foster that Cardiac Dysrhythmia was alerting. Dr Foster provided the Trust with a Trust mortality report which highlighted there is a high volume of activity with a primary diagnosis of residual codes and also the potential impact of some of the recent

septicaemia coding changes. The Trust are currently undertaking deeper analysis to identify any appropriate actions that may need be taken.

3.2.2 Detailed analysis (A&E)

Whilst the number of acute admissions increases year on year, the number of deaths within ED has risen significantly in 2018.

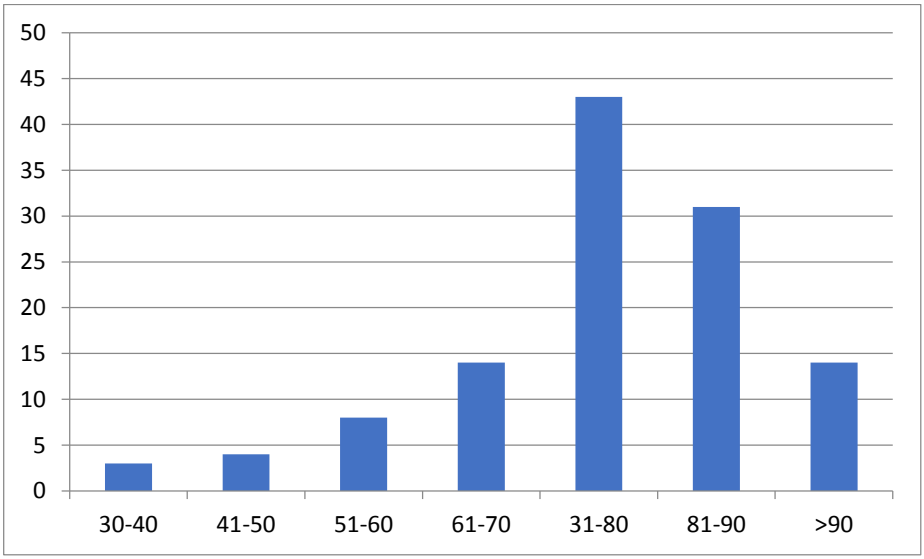
Graph 1 WUTH Deaths within ED



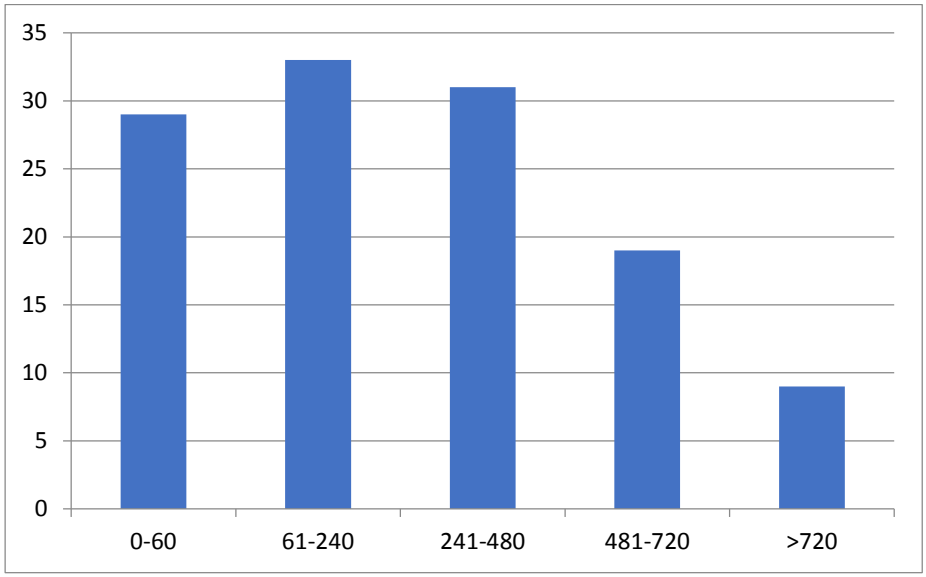
In 2018-19 there were 219 deaths within ED. As a result of the increased number of deaths, WUTH went from 10th place in NW region in 2016-7 to 3rd highest in 2018-19

Each case in 2018-19 data was reviewed through the CERNER system. Of the 219 cases, 129 (59%) were as the result of an out of hospital arrest. The remaining 90 cases were assessed further for age, presence of community DNACPR or palliative care and duration of time in ED prior to death.

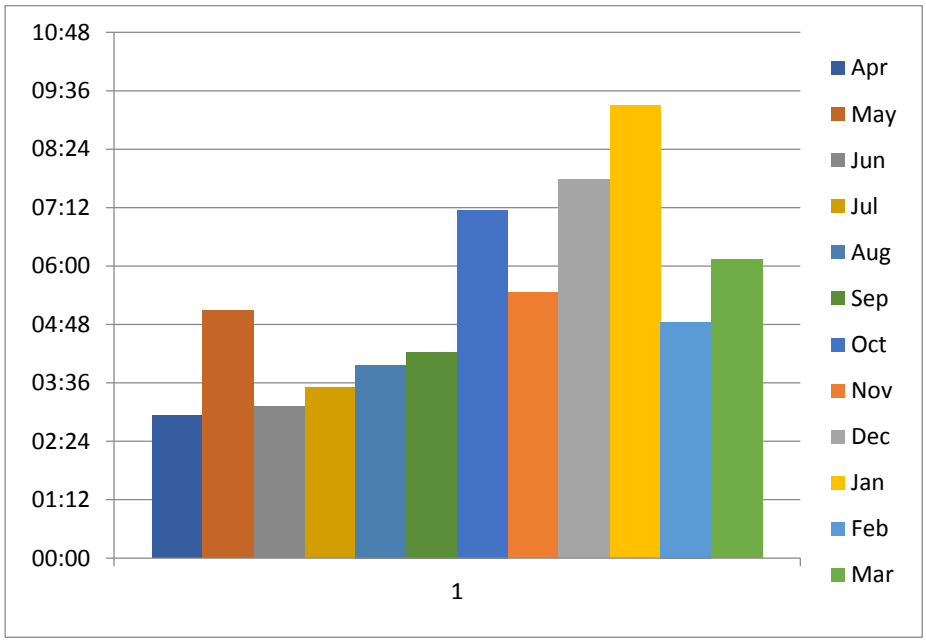
Graph 2 age of patients who die in ED



Graph 3 duration of time in ED prior to death (minutes)



Graph 4 Ave time in ED (hours:minutes) each month



Of the 90 non out of hospital arrest cases 11 were receiving palliative care (12.2%) and 12 had community DNACPR in place (13.3%). Within this latter group 1 had an advanced directive not to be admitted to hospital and 4 had expressed a wish to die at home. Of the remaining 67 cases, 11 had no clinical documentation on CERNER to enable further assessment of care.

Of the remaining 56 cases the documented working/definitive diagnosis was;

Ruptured aneurysm	3
Intracerebral haemorrhage	9
Sepsis	7
In hospital arrest (chest pain, difficulty breathing, unwell)	10
Resp failure	5
Pnemonia / LRTI	11
Anaphylaxis	1
Gastointestinal obstruction/perforation/bleeding	10

15 of the 56 cases had DNACPR decision in ED documented on CERNER. In 3 cases there may have been a delay in definitive treatment (unable to transfer to CCU, deterioration more than 2 hours in ED with minimal CERNER documentation). All other cases had documentation of DNACPR, dying phase or were too unstable for transfer to another clinical area)

3.3 Primary Mortality Reviews and Structured Judgement Review (SJR)

In October 2018 a decision was made to utilize Ulysses (WUTH's electronic governance system) to track primary mortality reviews and progress to SJR's. January 2019 we started to record all patient deaths through the Ulysses Safeguard system. Primary Mortality Review forms were replicated into the system, which meant that now all reviews could be completed electronically and automatic reminders were triggered.

Total Number of Deaths subject to review (01/04/18-31/03/19)	Primary Mortality Reviews	Higher level reviews undertaken	No. of deaths investigated under SI framework (and declared as serious incidents)	Total Deaths considered potentially avoidable
1423	522	33(16)	2	4
()* - In Progress				

Avoidable Death Assessment Score	Score 1 Definitely Avoidable	Score 2 Strong evidence avoidable	Score 3 Possibly Avoidable >50:50	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoid ability	Score 6 Definitely not avoidable
	0	0	4	0	3	17

3.4 Coroners Inquests

There were 8 Inquest cases involving Trust staff heard by the Coroners Court during 208/19. There was 1 case where natural cause of death was recorded but with Regulation 28 report for Prevention of Future Deaths Coroner issued.

3.5 Maternity, Neonatal and Paediatric Mortality Review

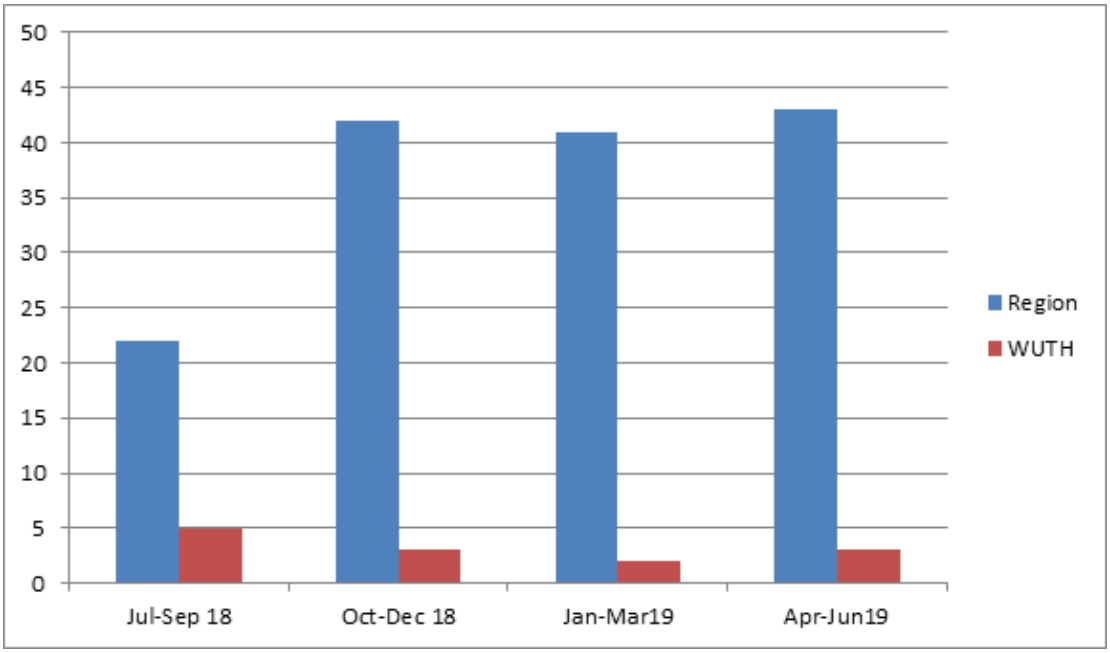
Deaths within these services, with the exception of gynaecology, are subject to robust external scrutiny and review processes.

The Perinatal Mortality Review Tool (PMRT) process was implemented in January 2019 and all deaths since December 2018 have been reviewed using the PMRT review process. All relevant cases have a multidisciplinary review which includes peers and reports are submitted to the national perinatal institute. In the last report (June 19) which covered January 18-June19 there were a total of 8 completed reviews. There were no cases of substandard care or care likely to have affected outcome. Lessons for learning within the speciality included documentation of carbon monoxide levels, extending smoking cessation support of family members when the mother is a non-smoker and to include an algorithm for concealed pregnancy in the Unborn policy

Between April 18 and March 19 there were no maternity deaths.

3.6 Learning Disability

The national 2018 paper was published in May 2019 by Bristol University. Regional data from local area contacts are published quarterly. Deaths within this group of patients at WUTH, compared to the Cheshire and Merseyside region are as follows



The national review listed a number of recommendations for national and regional bodies as well as local authorities and CCGs. Recommendations that are directly applicable to WUTH include;

1. It is never acceptable rationale for learning disabilities to place a Do not Attempt Cardiopulmonary Resuscitation (DNACPR) order. Nor is it acceptable to place it in Part 1 of the death certificate.
2. Local LeDeR steering groups should use demographic data to compare trends within the population of people with learning disabilities and evidence if ethnic minority groups are representative of the area.
3. Emerging themes on recognition of deteriorating health and minimising risks of pneumonia / aspiration pneumonia.
4. The CQC have been tasked to review DNACPR orders and treatment escalation person plans relating to patients with learning disabilities at inspection visits

Whilst at a regional level the number of trained reviewers has increased, at WUTH there is no trained reviewer. A member of staff with learning disabilities training has been nominated for regional training.

The percentage of reviews taking place within Cheshire and Merseyside has now increased from 25% in Q2 18-19 to77% in Q1 of 19-20. Of the 68 reviews substandard care which may have affected outcome was noted in 2 and in another 2 substandard care was noted in one or more significant areas though not felt to affected outcome. Good or excellent care in all areas was noted in 63%

3.7 Engagement with families and Carers

The Learning from Deaths Guidance set clear expectations for how NHS Trusts should engage meaningfully and compassionately with bereaved families and carers prior to and following a death.

In July 2018 additional guidance to support the work with bereaved families was published by the National Quality Board. The guidance was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in investigations, as well as with voluntary sector organisations.

There are eight principles that set out what bereaved families and carers can expect. These are:

- Being treated as equal partners.
- Receiving clear, honest, compassionate and sensitive response in a sympathetic environment
- Being informed of their rights to raise a concern
- Receiving help to inform decisions about whether a review or investigation is needed.
- Receiving timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison
- Being partners in an investigation as they offer a unique and equally valid source of information and evidence
- Being supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to

Bereaved families and carers are provided with a bereavement survey from the Bereavement office. These are reviewed and any issues are discussed with the families /carers by an identified member of the patient experience team. The palliative care service also support in investigating any concerns

3.8 Learning identified; actions taken in response, and an assessment of the impact of actions taken

Learning	Actions implemented	Impact
• Delay in discharging frail and elderly patients often results in their deterioration.	• Heightened awareness through communication • 2019/20 Quality improvement target • Transformation team project in progress	In progress
• The need to follow the naso-gastric tube policy	• Awareness raising/ training and competency assessments • Internal alert distributed • Discussed at Trust Safety Summit	Reduction in NG tube incidents
• The need to follow the MEWs policy.	• Routine monthly audits through perfect ward App. • Implementation of RCP NEWS2 e-learning package, national framework competencies, Clinical Champions and delivery of AIMS course	Updated Deteriorating Patient alert well received by the workforce. Further work on increased frequency of observations and appropriate escalation required

• The need to perform Mental Capacity Assessment.	• Perfect Ward audits / app to monitor compliance with MCA / DoLS • The MCA tool now has a list of specific decisions + free text option to support completion of MCAs.	DoLS applications continue to show a significant increase, with the quarter Q4 2018/19 increasing by 85% on 2017/18s Q4.
• Ensure the safe administration of oxygen to patients, particularly if they have a sensitivity to oxygen;	• Education and support regarding oxygen policy and safety provided. • Regular audits	• Education programme with league tables for px monitoring effect . Been noted as good piece of work • Improvements in O2 prescribing and management by 42%
• Falls prevention	• Revised and updated In-patient falls policy • Safety checklist to be added to Wirral Millennium • Initiative to reduce inappropriate out of hours moves.	• Initiative for 'out of hours' moves continued and now embedded • There is now a daily list sent to Bed Bureau to inform staff that a patient has a diagnosis of dementia and should not be moved inappropriate
• Documentation of Do Not Resuscitate for CardioPulmonary Resuscitation	• Ongoing audit case notes for completion of the purple DNACPR booklet	In progress
• the need to improve communication with patients and those important to them. • proactively managing care that ensures appropriate levels of intervention, with due regard to benefit and burden. • more proactive in communication within clinical teams particularly on agreeing ceilings of care	• Our new End of life Care Strategy 2019-22 focuses on the communication needs of patients and those important to them.	NACEL Audit March '19 demonstrate areas of good practice (as well as some requiring further improvement).

3.9 Sharing learning from deaths

Divisions and Clinical Services share learning from Deaths internally through their local Divisional arrangements e.g. good practice meetings/ specialty meetings etc. Mechanisms for sharing lessons learnt across the Trust include Safety Bites Bulletins; Monthly Safety Summits and through the Trust Governance arrangements. Sharing also occurs across the system through regional networks such as NWCoast.

At present however divisional / clinical services reviews are not included in quarterly or annual learning from deaths papers.

3.10 Publication of Learning from Deaths information 2018/19

In line with the requirements of NHS Improvement and the CQC the Trust has presented the Learning from Deaths Report to the Board of Directors for all four quarters of 2018/19,

The percentage of mortality reviews completed (along with SHMI; HSMR) are now recorded within the Trusts Quality Performance dashboard which is presented monthly to PSQB and the Board.

An annual overview of this information was presented within the Trusts Quality Accounts.

4. Next Steps

Medical Examiner

In June 2018 the Department of Health & Social Care published its response to the consultation on plans for the long overdue reform of the death certification system in England and Wales and the approach to introduce a medical examiner system nationally from April 2019.

The roll out began in primary care for deaths in the Community. Whilst it was not mandatory at that time the NHSI now states that Acute trusts in England and local health boards in Wales have been asked to begin setting up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation.

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establishing if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures.

Initially medical examiner offices are being asked to focus on the certification of deaths that occur within the acute trust where they are based. In time, they will be encouraged to work with local NHS partners and other stakeholders to plan how they can increase the service to cover the certification of all deaths within a specified geographical area. This will expand the service to cover deaths in other NHS and independent settings, as well as deaths in the community.

During the non-statutory phase of implementation NHSI/E, along with the Department of Health and Social Care, are collectively supporting acute trusts to manage the financial impact of establishing and running local medical examiner offices.

5. Conclusion

The number of primary mortality reviews has increased significantly in 2019 following the creation of a PMR support team and use of Ulysses Safeguard for submission and tracking. The mortality review process is evolving to include a proactive focus on Dr Foster data, local LeDeR reviews and targeted reviews following serious incidents.

6. Recommendations

1. Speciality reviews to report into trust mortality processes facilitating maximum learning opportunity
2. Staff education on use of CERNER End Of Life documentation
3. Identify locally key staff for LeDeR death reviews

4. Perform audit of LeDeR deaths in last 4 quarters to identify cause of death, DNACPR process, nutrition and use of NEWS2
5. Audit case notes where in hospital DNACPR is documented on CERNER to identify compliance with documentation
6. Improve coding of causes of death through clinical teams reviewing deaths in a timely manner with coding staff
7. Review palliative care / community DNACPR pathways with local partners
8. Examine GIRFT or other available resources for regional comparison of ED death categories to identify areas for service improvement.
9. Develop criteria for reviewing deaths for persons with Mental Health issues.

Board of Directors	
Agenda Item	11
Title of Report	Quality and Performance Dashboard
Date of Meeting	4th Sept 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 July 2019.

2. Background

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

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

3. Key Issues

Of the 56 indicators with established targets that are reported for July 2019:

- 15 are currently off-target or failing to meet performance thresholds
- 33 of the indicators are on-target
- 8 awaiting identification of threshold and therefore not rated

Any details of specific changes to metrics are listed at the foot of the dashboard.

The Trust does not yet have confirmation of a new target / threshold for this year for e-coli cases, so performance this year is shown against the 2018/19 monthly threshold.

Appendix 2 details the indicators that are not meeting the required standards within month in an exception report, excluding finance indicators which are covered in the separate finance report. The report includes a brief description of the **I**ssue, the remedial **A**ction and expected **I**mpact.

4. Next Steps

WUTH remains committed to attaining standards through 2019-20.

5. Conclusion

Performance against many of the indicators is not where the Trust needs to be. The quarterly report on exceptions will provide monitoring and assurance on progress.

6. Recommendation

The Board of Directors is asked to note the Trust's performance against the indicators to the end of July 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

July 2019

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	DoN	≤0.24 per 1000 Bed Days	WUTH	0.22	0.18	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.18	0.22	0.09	0.09	0.15	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (audit sample size 150)	Safe, high quality care	MD	≥95%	WUTH	84.8%	80.1%	82.9%	81.6%	78.4%	80.6%	89.9%	95.0%	98.7%	96.2%	86.0%	91.9%	94.6%	92.2%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	95.3%	95.0%	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	96.4%	96.3%	96.8%	96.0%	96.4%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.4%	96.5%	95.7%	95.5%	97.2%	96.2%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	3	2	1	3	2	4	2	4	2	1	1	4	3	2	
	Never Events	Safe, high quality care	DQ&G	0	SOF	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	1	0	0	0	0	0	1	0	0	0	0	0	0	0	
	Clostridium Difficile (healthcare associated)	Safe, high quality care	DoN	≤88 for WUTH FY19-20, as per mthly trajectory	SOF	1	3	0	3	4	2	7	10	5	19	9	11	4	43	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	7	2	3	5	4	2	3	4	2	5	2	0	2	9	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	18	18	15	13	23	9	10	6	5	12	9	8	5	9	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	0	1	0	0	0	2	0	0	0	0	0	
	Hand Hygiene Compliance	Safe, high quality care	DoN	≥95%	WUTH	89%	90%	81%	87.0%	85%	76%	83%	99%	99%	98%	91%	98%	99%	99%	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	DoN	≥90%	WUTH								98%	99%	99%	99%	98%	98%	98%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥90%	WUTH	87.4%	-	85.6%	90.4%	91.5%	91.4%	91.6%	92.8%	93.9%	93.6%	93.9%	93.7%	93.6%	93.6%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥90%	WUTH	82.7%	-	82.2%	86.0%	87.2%	87.1%	87.6%	88.7%	90.7%	90.9%	91.0%	90.7%	90.4%	90.4%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥90%	WUTH	85.6%	-	86.5%	87.2%	91.7%	91.4%	93.6%	92.6%	93.5%	91.4%	92.8%	91.5%	92.3%	92.3%	
	Attendance % (12-month rolling average) (*)	Safe, high quality care	DHR	≥95%	SOF	95.13%	95.13%	95.09%	95.06%	95.07%	95.06%	95.05%	94.98%	94.90%	94.81%	94.74%	94.63%	94.51%	94.51%	
	Staff turnover	Safe, high quality care	DHR	≤10%	WUTH	10.4%	9.9%	9.9%	10.0%	9.7%	9.6%	9.7%	9.7%	9.8%	10.0%	10.2%	10.5%	9.5%	9.5%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	Between 6 and 10	WUTH	7.6	7.5	7.1	6.9	7.1	7.0	7.3	7.2	7.2	7.2	7.3	7.4	7.3	7.30	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

July 2019

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	–	–	97.22	–	–	104	–	–	–	–	–	–	–	104	
	HSMR	Safe, high quality care	MD	≤100	SOF	95	95	92	92	97	97	98	99	99	–	–	–	–	99	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	–	–	86%	71%	56%	76%	73%	56%	43%	76%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	71%	78%	67%	74%	84%	87%	83%	81%	94%	92.0%	95.0%	90.0%	93.0%	92.5%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	16.4%	12.8%	15.7%	18.8%	15.9%	
	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	386	387	411	409	408	397	437	457	438	421	415	403	383	406	
	Long length of stay - number of patients in hospital for 21 or more days (*)	Safe, high quality care	MD / COO	Reduce to 107 by March 2020	WUTH	-	-	-	-	-	-	-	-	-	199	190	171	171	171	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.2	4.1	4.2	4.3	3.8	4.8	3.0	4.4	4.4	4.8	3.9	4.8	4.1	4.4	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.4	5.0	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.8	5.5	5.1	5.2	5.4	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	913	961	888	936	925	917	903	788	914	871	970	884	887	903	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	13	6	18	12	17	14	10	16	14	11	14	10	11	12	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	89.5%	86.3%	85.5%	88.5%	87.5%	

NOTE: Mortality data is collected from 90 days post month of death (i.e. January data is closed in April). As such cells will remain in white for 3 months, after which the performance level will be locked and rated.

Quality Performance Dashboard

July 2019

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	8	16	14	19	18	15	20	14	13	13	13	17	16	59	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	89%	89%	86%	87%	84%	92%	85%	87%	87%	87%	89%	91%	91%	90%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	11%	12%	11%	10%	11%	10%	11%	11%	13%	9%	11%	10%	12%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	98%	97%	98%	98%	98%	98%	97%	97%	98%	97%	96%	98%	97%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	25%	14%	22%	24%	18%	18%	19%	15%	13%	19%	22%	31%	38%	28%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	95%	94%	94%	94%	95%	94%	95%	94%	95%	94%	94%	95%	95%	95%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	96%	100%	100%	96%	100%	100%	99%	98%	96%	94%	97%	99%	93%	96%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	37%	17%	28%	11%	19%	37%	27%	36%	44%	25%	29%	44%	29%	32%	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

July 2019

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2019-20	SOF	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	73.6%	81.1%	83.5%	81.9%	81.9%	
	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	2	0	0	0	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	213	326	474	371	440	393	379	323	273	437	118	54	76	171	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% through 2019-20	SOF	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	79.04%	80.72%	80.12%	80.06%	80.06%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	26,836	27,308	26,556	26,862	27,367	26,157	27,506	28,367	27,309	26,223	27,317	25,733	24,733	24,733	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019-20	National	57	56	40	43	30	28	28	19	0	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	99.5%	99.3%	99.5%	99.2%	99.2%	
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	95.7%	92.3%	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	91.9%	94.0%	94.0%	94.0%	93.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	98.2%	96.3%	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	96.8%	96.5%	96.7%	97.1%	96.8%	96.8%	
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	85.4%	87.9%	85.7%	85.1%	85.3%	86.2%	85.4%	86.5%	85.8%	85.3%	87.9%	86.3%	85.5%	86.3%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	DoN	TBC	WUTH	140	123	155	119	165	118	178	153	157	162	195	180	178	178.75	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	DoN	TBC	WUTH	24	25	22	19	13	13	27	28	17	17	12	15	17	15	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	≥90%	National	72%	75%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	5	0	4	2	3	2	2	1	3	4	4	4	1	3	

Quality Performance Dashboard

July 2019

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	–	–	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	500 for FY19/20 (ave min 42 per month until year total achieved)	National	70	48	42	38	57	38	43	41	59	31	31	45	50	157	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.6%	85.7%	88.2%	77.6%	81.1%	82.1%	83.6%	83.6%	

	Indicator	Objective	Director	Threshold	Set by	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	2019/20	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-3.340	-1.458	-0.098	-0.825	-5.721	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-0.237	-0.630	0.914	-0.828	-0.781	
	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	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-6.0%	-6.8%	-5.2%	-4.1%	-4.1%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-19.5%	-26.8%	-15.6%	-46.4%	-46.4%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-14.0	-21.3	-15.9	-16.5	-15.9	
	Capital Programme		DoF	On Plan	WUTH	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	52.1%	31.0%	28.0%	14.7%	28.0%	

WUTH Quality Dashboard Exception Report Template August 2019

Wirral University Teaching Hospital NHS Foundation Trust

Safe Domain

Eligible patients having VTE risk assessment within 12 hours of decision to admit

Executive Lead:

Medical Director

Performance Issue:

A WUTH target has been set that at a minimum 95% of eligible patients will have a VTR+E risk assessment performed within 12 hours of the decision to admit. This was not achieved since April 2019 with the average for 2019/20 at 92.2%.

Action:

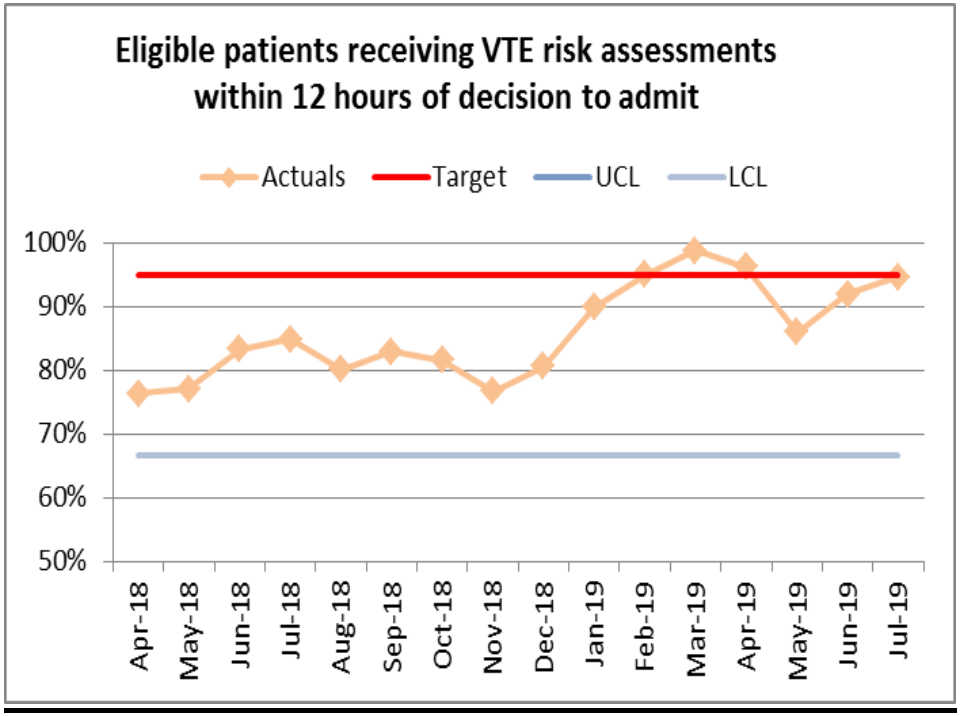
Baseline in 2018 was low, performance improved with VTE alert introduction in January 2019 but has declined as increased "by-passing" therefore reporting on alert "by-passing" to be introduced August 2019.

'Live' dashboard compliance tool being used to highlight problem locations/specialties. Feedback to AMD/CD/CL's.

Increased awareness of areas of failure by location/specialty and further targeted actions.

Expected Impact:

Gradual improvement to occur over 2019.



Clostridium difficile – healthcare associated

Executive Lead:

Acting Chief Nurse

Performance Issue:

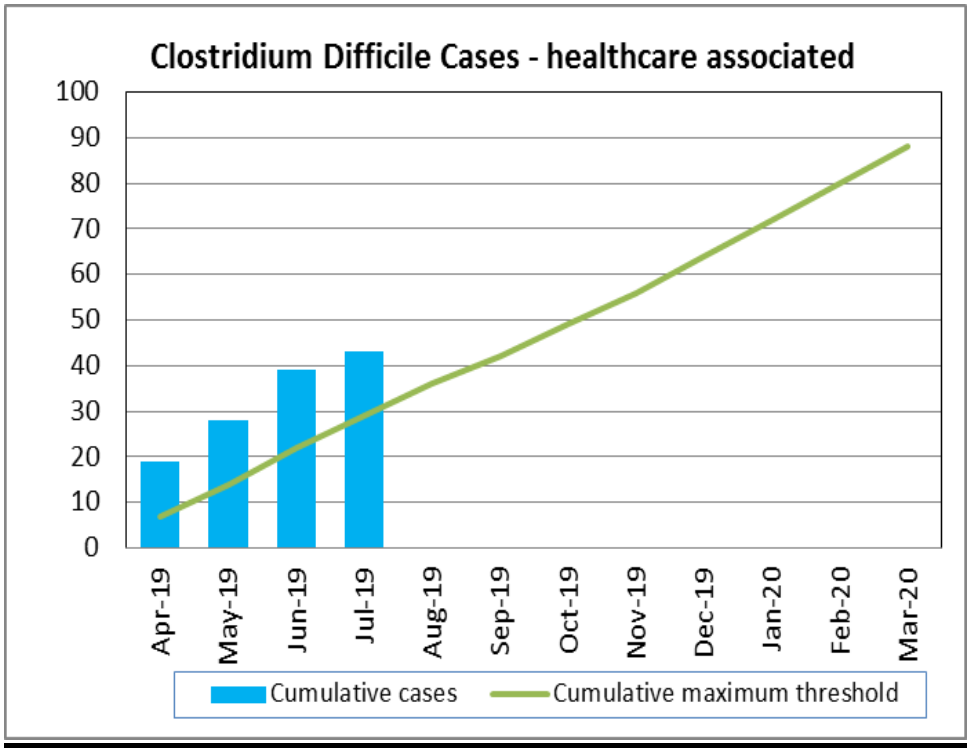
An annual objective has been set by NHSI for WUTH to have a maximum 88 *Clostridium difficile* cases (Hospital onset healthcare associated & Community onset healthcare associated) for 2019-20. A monthly trajectory was mapped out for the year. Up to July 2019 there have been 43 cases against the cumulative monthly trajectory of a maximum 29 cases.

Action:

- Outbreak declared and weekly meetings commenced
- Ward IP improvement plans developed
- Outstanding estates issues escalated
- Cleaning standards reviewed and improved
- Programme of de-cluttering initiated
- Broken and damaged equipment being replaced
- Investigation process reviewed and a more robust accountability framework process implemented
- Trust wide awareness campaign introduced

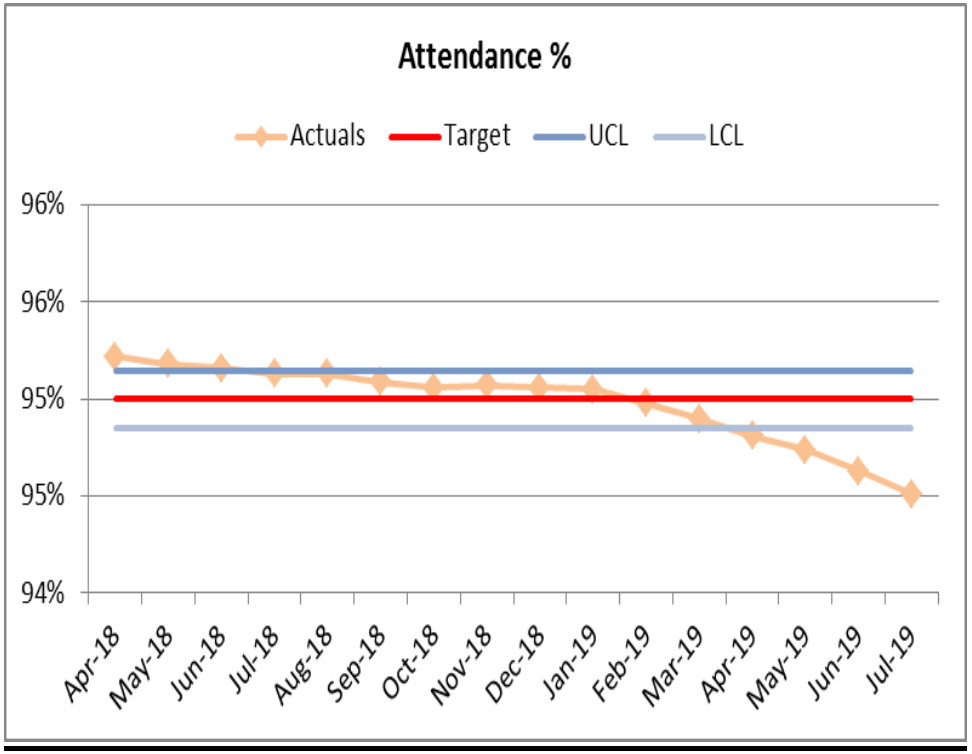
Expected Impact:

- All staff become empowered in how they can help to reduce infections
- Reduction in CDI anticipated, there has been a reduction in July (N=5), although the nature of this outbreak is such that the Board should be prepared for increases, especially during periods of very high demand and occupancy.



Staff attendance % (12 month rolling average)

Executive Lead: Director of HR / OD
Performance Issue: WUTH has a target set at a minimum 95% attendance of staff, calculated as a 12-month rolling average. This standard is scrutinised by NHSE&I under the Single Oversight Framework. The 95% standard has not been achieved since January 2019, with the monthly position deteriorating.
Action: Full Position outlined within Appendix 3.
Expected Impact: To improve attendance to the 95% target over the next 6 months.



Effective Domain

Nutrition and hydration – MUST completed at 7 days

Executive Lead: Chief Nurse

Performance Issue:

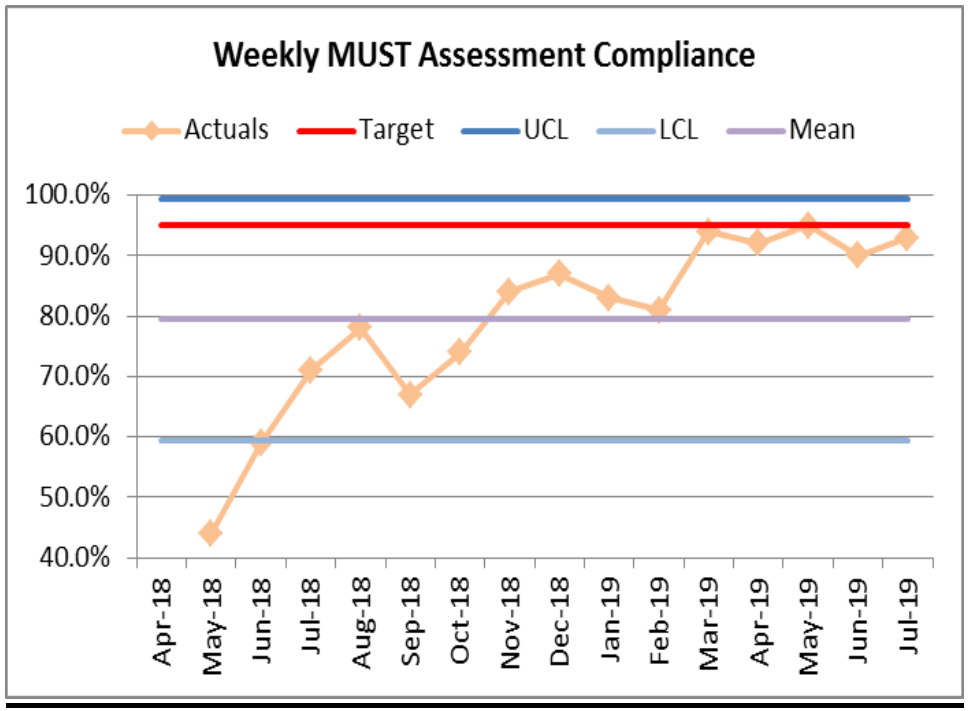
An internal WUTH target is set at a minimum 95% compliance with MUST recording every seven days. Although achieved in May 2019 for the first time, performance for June and July were back down to 90.0% and 93.0% respectively.

Action:

MUST compliance is currently being reported weekly. All non-compliance is being monitored and scrutinised via the patient harms panel. MUST assessments are now being monitored daily across all Divisions by Matrons and ADNs to ensure full compliance. This process will continue until significant assurance is achieved. Within the Division of Surgery, a new process has been implemented where the MUST assessment is completed in the SEAL unit pre-operatively. Divisional Directors of Nursing are monitoring compliance on a daily basis.
The Trust Lead for Nutrition & Hydration is in the process of standardising the MUST risk assessment process i.e. ensuring individualised care (weighing on day 7 or more frequently is the patient's condition changes rather than having a 'weigh day' for the ward). All patient safety huddles to be patient/risk focused rather than information giving, ensuring that the Trust M Page on Cerner is incorporated into the safety huddle thus identifying all risk assessments which require updating in line with Trust policy and agreed national standard. Additional safety huddle to be introduced at 3pm across all wards to ensure that compliance is met.

Expected Impact:

It is expected that 96% and above will be achieved on a continual basis following the revised process and closer monitoring by the senior nursing teams.



SAFER bundle: % of discharges taking place before noon

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

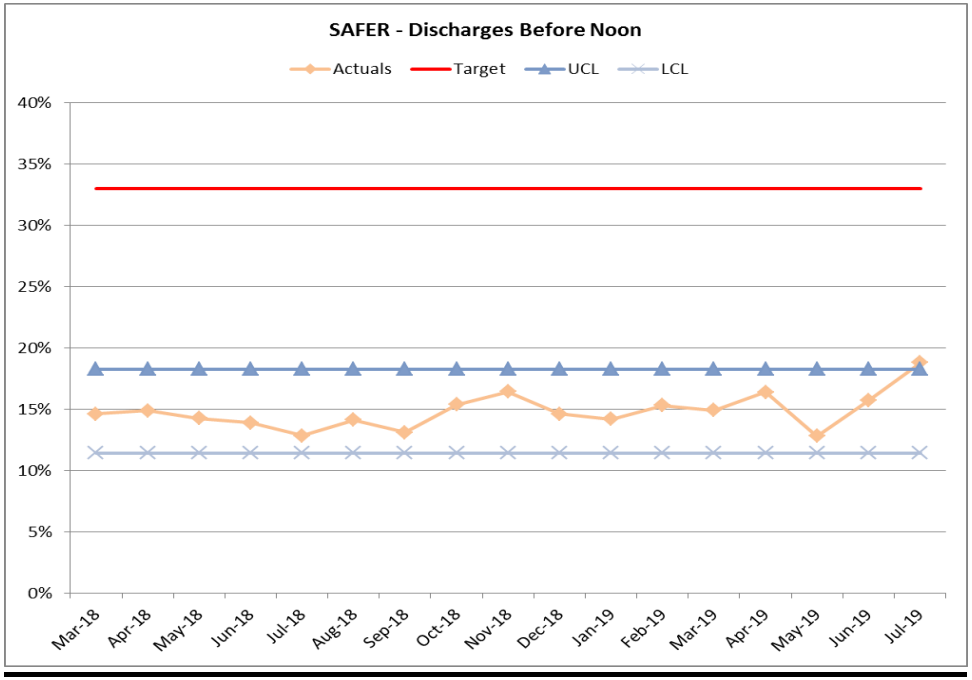
A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. This standard is consistently not achieved, with the average for 2019-20 at 15.9%.

Action:

Continued focus with ward MDTs to reinforce the importance of preparing for early morning discharge through action focused board rounds and afternoon huddles. Aiming for TTHs and discharge summaries to be done the afternoon/evening before discharge wherever possible.

Expected Impact:

To consistently deliver over 20% by the year end, as part of staged improvement to 33%



SAFER bundle: average number of patients in hospital for 7 days or more

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

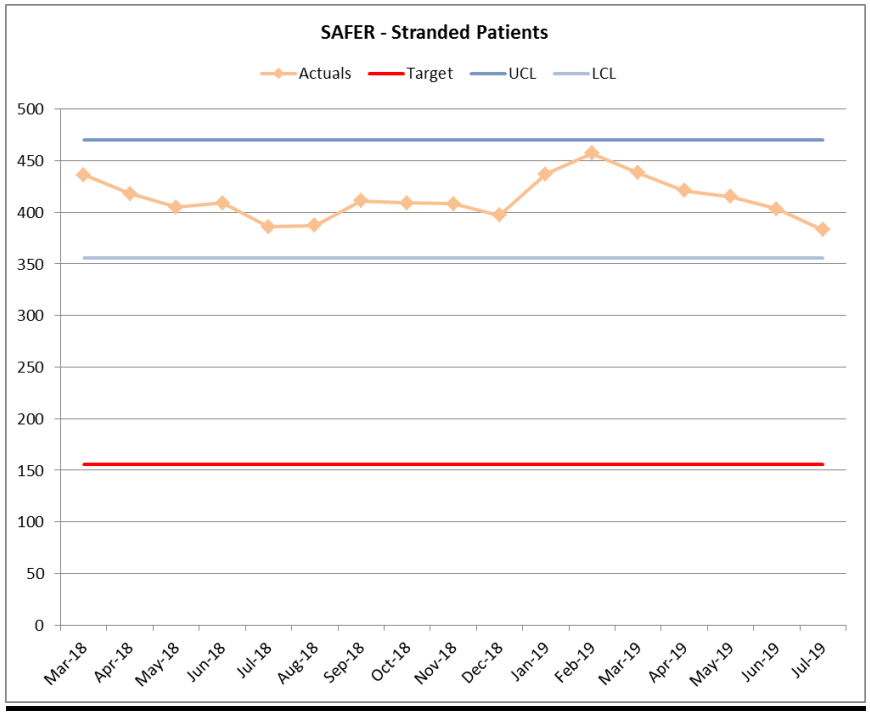
A WUTH target has been set to reduce the number of patients in hospital for seven days or more to a maximum 156. The numbers remain considerably above this target, with an average for 2019-20 of 406.

Action:

Maintenance of MDT board round to drive actions towards discharge and eliminate delays. Reviewing/adjusting electronic whiteboards to increase use during board rounds. ECIST input into and observation of ward board rounds to identify key areas for improvement. Weekly ward posters to show discharge and LOS progress from previous week.

Expected Impact:

Reduction in absolute numbers (77) linked to the 21 day primary target.



Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse
Performance Issue: A national standard is set that providers should not have mixed-sex accommodation, except where it is the overall best interests of the patient or reflects personal choice. Patients in critical care areas do not count as a breach of these guidelines on clinical grounds, until 24 hours after they are well enough to be transferred to a more general ward area. WUTH breaches of the guidelines are consistently in relation to patients waiting more than 24 hours for transfer from critical care areas to general wards. There are no adverse safety or quality implications identified as a consequence of these breaches in Intensive Care Unit (ICU)
Action: Monitored daily via bed management processes. Capacity and demand / bed modelling being identified (TMB August) to ensure Trust has capacity to meet the needs of level one patients in general bed base. Introduction of capacity manager Q4.
Expected Impact: The above actions will continue to contribute towards minimising the risk as far as possible given the prevailing operating conditions.

FFT recommend rate: ED

Executive Lead:

Chief Nurse

Performance Issue:

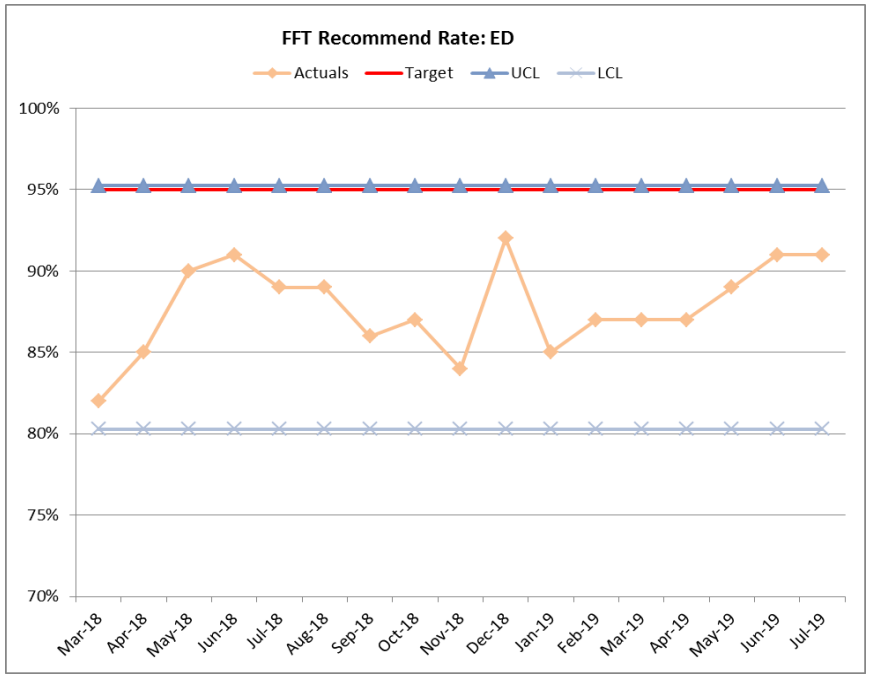
A WUTH target is set at a minimum 95% recommend rate. This standard is improving, with the average for 2019-20 at 90%.

Action:

Additional patient experience rounds have been introduced in times of pressure apologising for delays and offering refreshments. Emergency Department (ED) have recruited to all nursing vacancies in this area enabling improvements in the quality and experience of care received.

Expected Impact:

It is expected the Trust will continue with an upward trajectory achieving compliance by Q4.



FFT overall response rate: ED

Executive Lead:

Chief Nurse

Performance Issue:

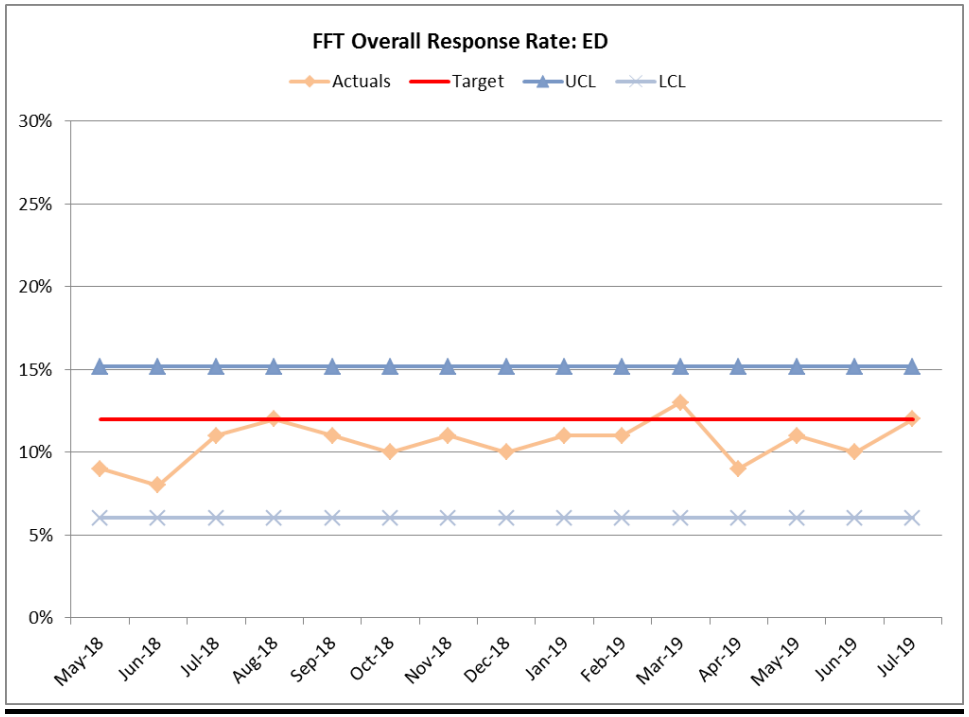
An internal WUTH target is set at a minimum 12% response rate. This has been achieved only three times in the last 12 months, including July. The current average for 2019/20 is 11%.

Action:

Children's ED introducing IPAD technology (Fabio Frog) and drawing cards to encourage children's feedback. Additional patient experience volunteers have been deployed to this area.

Expected Impact:

We anticipate the response rate to remain broadly in line with the England average.



Responsive Domain

4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)

Executive Lead:

Chief Operating Officer

Performance Issue:

The Trust has a recovery trajectory agreed with NHSI for 2019-20 for the 4-hour Accident and Emergency target. In May & June 2019 performance was above the trajectory, but July was 81.93% against a trajectory target of 85%.

Action:
The Trust is working with ECIST to implement changes to A&E specialty input times and process, which accounts for a significant number of breaches. During September and October the efforts of the Trust and the wider economy are focused on a reduction in 21 day+ patients.

Expected Impact:
A 40% reduction in over 21 day patients is the equivalent of 78 occupied beds (54 from current levels)

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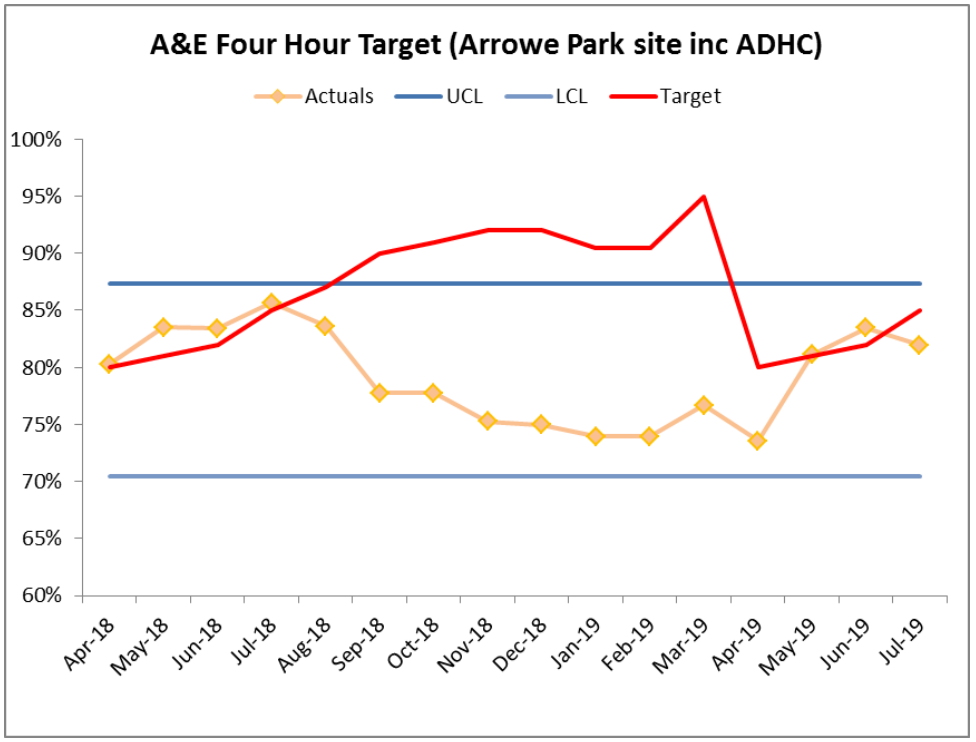


Well-led Domain

Number of patients recruited to National Institute for Health Research studies

Executive Lead:

Medical Director

Performance Issue:

A WUTH target has been set to recruit 500 patients to National Institute for Health Research (NIHR) studies in 2019-20. The trajectory has been set at a target 42 per month until the annual 500 is reached. This has been achieved in both June and July, but the average so far in 2019-20 is 39.25.

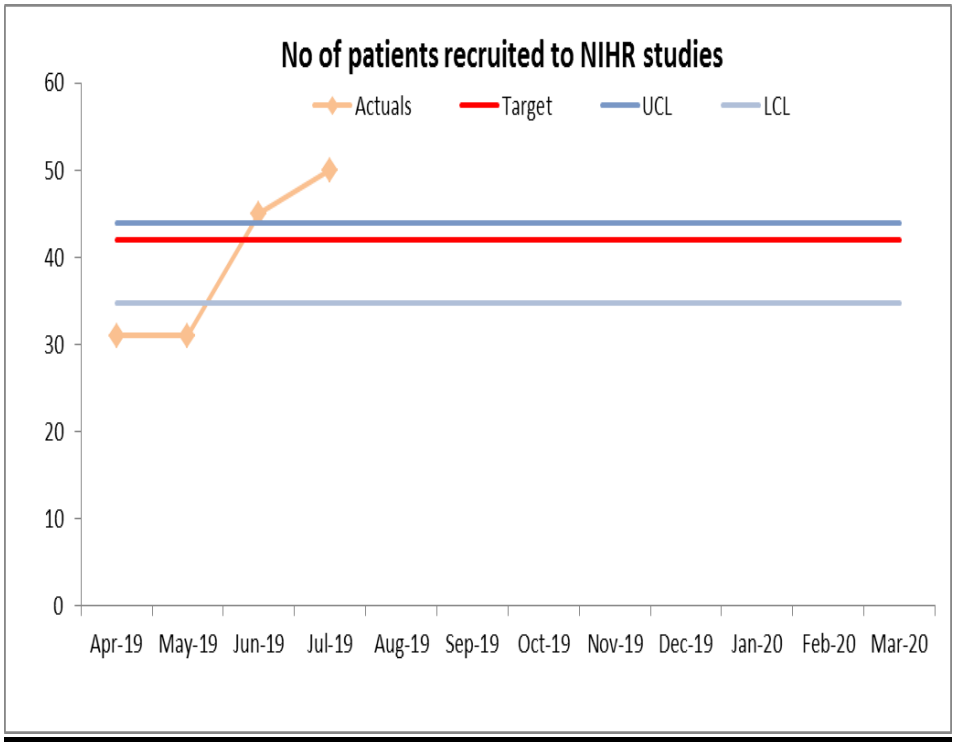
Action:

The Research Department will continue to ensure recruitment to open studies is maximised.

AMD's asked for named Clinical Research Leads, one for each Division, these are to be identified. The overall aim of these new posts will be to promote and increase research activity.

Expected Impact:

Increased opportunity for patients involved in high quality research.



Appraisal compliance %

Executive Lead:

Director of HR / OD

Performance Issue:

WUTH has a target set at a minimum 88% of staff to have had an appraisal within the expected timeframes. The 88% standard has not been achieved since March 2019, with the average for 2019-20 being 81.1%.

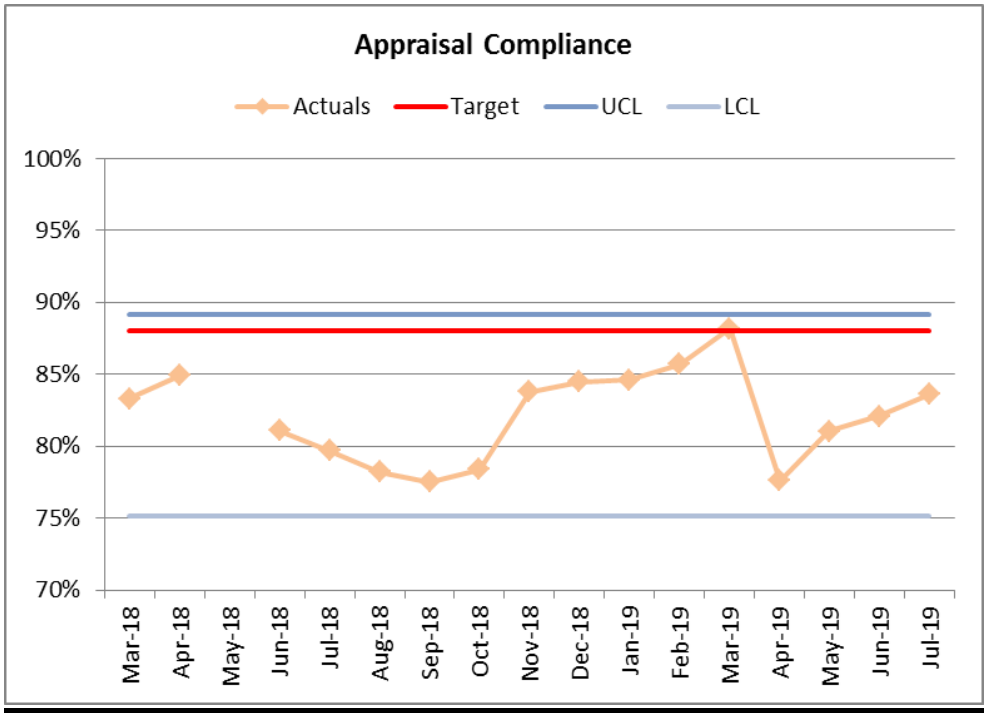
Action:

Performance metric revised to reflect 12 month period as previously advised. Appraisal compliance is monitored through the Divisional Performance Reviews.

Note: there is some time lag between appraisal taking place and recording this on ESR.

Expected Impact:

Improved appraisal rate within the next 6 months.



Wirral University Teaching Hospital NHS Foundation Trust

WUTH Quality Dashboard Exception Report Template August 2019

Staff attendance % (12 month rolling average)

Action

It is recognised that a dual approach to addressing attendance is required. The two critical elements are:

(a) Creating the conditions that facilitate 95% attendance
(b) Effective application and governance of the process and policy.

These are supported by effective monitoring and reporting.

The following actions have been undertaken:

Creating the conditions

(i) Introduced a new attendance policy from 1st July 2019 that includes the use of the Bradford Factor scoring system as well as the use of regular (four weekly) reviews. The policy focuses on offering employees a range of health and wellbeing measures designed to keep them at work or get them back at the earliest opportunity.

(ii) From 1st August 2019 the Trust has been piloting a sickness absence management company (First Care) in the Estates and Hotel Services Division. This 6-month pilot will run to January 2020 but the first data results will be available from mid-September 2019. Regular focus groups are taking place with managers, HR and First Care in that Division.

Live data from the First Care pilot is being used by managers in the Estates and Hotel services to track and intervene in cases to address reasons for absence and find return to work solutions.

(iii) Introduction of an Employee Assistance Programme from the 1st September 2019 to all WUTH staff operated by a company called "Health Assured." This will facilitate immediate referrals for mental health issues, counselling and other welfare support such as financial advice.

(iv) Identified areas within our absence management procedures, such as the occupational health department, which require additional support to ensure that employee cases are being dealt with in a timely manner. Options for additional resources to support occupational health are currently being explored.

(v) The 'effective people management' four day programme for ward managers commences on 3rd September 2019. The programme to be opened by Acting Chief Nurse/Director of Quality Governance.

(vi) Co-producing a training session based on our attendance policy to be delivered by our solicitors for managers to complement the attendance training in the effective people management programme. The objective of the training is to provide the employment law perspective of dealing with employees' attendance.

(vii) HR Business Partners are receiving regular coaching in their roles which includes absence management facilitation.

(viii) A 12 month health and wellbeing plan is in place and has been presented to the Workforce Assurance Committee. The health and wellbeing plan covers physical, mental and financial health and wellbeing. Work is underway to support 'fast tracking' of employees through various services.

Effective application and governance of the process and policy

(ix) Working with the Trust's Governance team to establish a "Confirm and Challenge" process (similar to that used for CQC PIR requests) to be used by all line managers, supported by HR Business Partners, to ensure that Trust policy is being consistently and promptly applied. This will generate statistical and other evidence (and reports to Board) about whether regular absence reviews are taking place, that all identified actions are being carried out and should identify any weak points, hot spots or emerging themes that would benefit from additional management scrutiny. We are anticipating that we will have this ready to introduce no later than end of September 2019.

(x) Re-iterated across the divisions the need for all absences and their causes to be reviewed by line managers as soon as they occur and put action plans in place to encourage return to work as soon as possible.

Monitoring and reporting

(xi) The HR Business Partners will meet with the Director of Workforce on a monthly basis to present data from the confirm and challenge process in order to provide assurance on progress, identify hot spots and advise on the necessary interventions that are being taken.

Reports from this process will be provided to the Workforce Assurance Committee.

(xii) Sickness absence is already being tracked in the Divisional Performance Reviews. However, going forward a deep dive on attendance will be on the agenda each month.

Board of Directors	
Agenda Item	12
Title of Report	**Month 4 Finance Report**
Date of Meeting	4th September 2019
Authors	Shahida Mohammed, Acting Deputy Director of Finance
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
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 4 Finance Report 2019/20

Contents

1. Executive summary

The Control Total issued by NHSI to the Trust for 2019/20 is a "breakeven" position. Delivery of this enables the Trust to access c£18.8m of sustainability/recovery support to reduce the underlying deficit.

After careful consideration and independent review, the Trust accepted the "control total", albeit with challenges which includes a CIP requirement of £13.2m.

The following summary details the Trust's financial performance during July (Month 4).

The plan to deliver a "breakeven" position has been profiled to reflect the expected variation in income recovery and the anticipated delivery of cost reductions, QUIP and transformational schemes during the year.

For Mth 4 the Trust had planned a break-even position, actual performance was a deficit of (c£0.8m), an adverse performance against plan of (c£0.8m).
This is reflected in the cumulative performance position, the YTD plan is a deficit of (c£4.8m), and the actual position is a deficit of (c£5.6m), a variance of (c£0.8m).

1.1 Key Headlines

- For Mth 4 the Trust had planned a breakeven position, actual performance is a deficit of (c£0.8m).

- The key components of the position are:

	Qtr1 £m	Mth 4 £m	YTD £m
Depreciation	(0.3)	(0.1)	(0.4)
VAT (medical locums)	(0.3)	(0.0)	(0.3)
Aseptic Unit - closure	(0.2)	(0.0)	(0.2)
Divisional Restructure	(0.1)	0	(0.1)
18/19 Costs	(0.1)	0	(0.1)
Pay Pressures	(0.4)	(0.3)	(0.7)
Income	1.4	(0.1)	1.3
Non Pay Pressures	0	(0.3)	(0.3)
TOTAL	**0**	**(0.8)**	**(0.8)**

- Pay costs exceeded plan by a further (£0.4m) in July, increasing the year to date overspend to (c£1.4m). The main driver is agency spend on Consultants to cover gaps and pressures in ED and includes the VAT pressure which has been abated from mid-July. Premium costs have also been incurred to cover gaps in the Junior Drs. rotas. In addition c£0.1m relates to costs of additional activity in Gasto., this is offset by additional income.
- Non pay pressures include costs associated with outsourcing MSK related activity to deliver operational standards and the "Prime Provider" contractual terms, and costs of theatre loan kits.

- During Mth 4 patient related income delivered plan, within this position income for elective gastro. activity exceeded plan. This was offset by reduced adult Critical Care activity, mainly due to reduced complexity. Welsh neonatal activity was also below plan.

- To ensure a "break-even" position was achieved in Q1 the Trust accessed "accelerated" support from WCCG of c1.4m. This guaranteed the Trust received FRF/PSF central monies of £1.9m.
- Excluding the additional support, the Trust's YTD underlying position is an actual deficit of (c£7.0m) against a planned deficit of (c£4.9m), an overspend of (c£2.1m)

- Cash balances at the end of July were £3.7m which was c£0.2m above plan. This is due to 19/20 opening cash above plan (£2.5m), EBITDA and donations above plan (£0.3m), capital cash below plan (£3.4m) and controlled variances in the working capital cycle (£5.4m).

- Cost improvements planned to be delivered YTD amount to £2.8m, this target has been exceeded by c£0.2m. Included within this position is the non-recurrent benefit of c£0.3m for energy credits, this is supporting the in-year position.

- Although the year to date capital spend is slightly behind plan (c£0.3m), the Trust is forecasting to deliver the revised capital plan submitted in July 2019.

- The Trust delivered a UoR rating of 3 as planned.

- The Board is asked to ratify the recommendation of the Finance Performance Group to vire capital budget of c£0.2m from existing GDE Digital schemes which will be deferred into 2020 and c£0.1m from contingency to a new scheme to replace c400 PC/laptops due to the requirement to roll out Windows 10; as Windows 7 will no longer be supported post January 2020. This ensures the trust can utilise new NHS Digital licenes as nil cost. The replacements are required as the oldest equipment is not compatible with the new technology. Failure to do so before March 2020 will result in the Trust being liable for licence costs of c£1.2m and increased cyber risks.

2. Financial performance

2.1 Income and expenditure

Month 4 Financial performance	Annual Budget £'000	Current Period Budget £'000	Current Period Actual £'000	Current Period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
NHS income from patient care activity	325,038	27,424	27,450	26	107,117	108,635	1,518
Non NHS income from patient care	4,532	398	374	(24)	1,513	1,331	(181)
Income - PSF/FRF/MRET	18,804	1,359	1,359	(1)	4,809	4,808	(1)
Other income	28,362	2,528	2,435	(92)	9,531	9,505	(26)
Total operating income before donated asset income	376,736	31,709	31,618	(90)	122,969	124,279	1,310
Employee expenses	(255,177)	(21,237)	(21,767)	(530)	(86,911)	(88,180)	(1,269)
Operating expenses	(108,356)	(9,348)	(9,490)	(142)	(36,609)	(37,189)	(580)
Total operating expenditure before depreciation and impairmer	(363,533)	(30,585)	(31,257)	(672)	(123,520)	(125,370)	(1,850)
EBITDA	**13,203**	**1,124**	**362**	**(762)**	**(551)**	**(1,090)**	**(539)**
Depreciation and net impairment	(9,219)	(763)	(837)	(73)	(2,993)	(3,250)	(257)
Capital donations / grants income	0	0	0	0	0	0	0
Operating surplus / (deficit)	**3,984**	**361**	**(475)**	**(836)**	**(3,544)**	**(4,340)**	**(796)**
Net finance costs	(4,233)	(358)	(350)	8	(1,396)	(1,381)	15
Gains/(losses) on disposal	0	0	0	0	0	0	0
Actual surplus / (deficit)	**(249)**	**3**	**(825)**	**(828)**	**(4,940)**	**(5,721)**	**(781)**
Reverse capital donations / grants I&E impact	249	21	14	(7)	84	76	(7)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	**0**	**24**	**(811)**	**(835)**	**(4,856)**	**(5,644)**	**(788)**

- Excluding the the additional support, the Trust's cumulative underlying position is an overspend of (c£2.1m).
- Pay pressures have continued, mainly agency spend on Consultants, cover for Junior Medical vacancies and bank costs for nursing staff covering sickness.
- Nurse vacancies rates have reduced from the previous year, in addition to improvements in bank fill rates. High levels of sickness in some areas has resulted in the further use of bank nurses to maintain safe staffing levels across the wards. Vacancies remain in non-clinical areas and have non-recurrently supported the delivery of CIP.
- The Aseptic Unit re-opened in July; however this is not manufacturing at full capacity until September, and is causing a cost pressure.
- Non pay pressures include the impact of MSK outsourcing and clinical supplies costs.
- Some of the pressures are non recurrent, and actions have been taken in relation to authorisation of non-core consultant costs, all non-stock orders are now approved by Divisional Directors or Executive Directors only.
- This is supported by the weekly "scrutiny panels" lead by the HR & Finance Executive Directors, which are now reviewing both clinical and non-clinical vacancies, non-core spend, discretionary non pay spend, medical agency staff 'hotlist' and tracking CIP deliverables. Medical rota pressures escalation are authorised by the Divisional Directors.

Items not included in the original Plan

- **Locum pay VAT**

During July the Trust successfully transitioned to an alternative HMRC approved "VAT compliant" model for the supply of medical locums. This has ensured the financial pressure included in the year to date position relating to quarter 1 of (c£0.3m), has been mitigated going forward.

- **Depreciation**

  There is a pressure of (c£0.4m) YTD in operating expenditure from additional depreciation charges which relate to changes in estimates of asset lives provided by the Trust's external valuer. These changes were mandated by amendments to valuation instructions issued by the Royal Institute of Chartered Surveyors (RICS) in February 2019.

  Although this is a national issue, NHSI has maintained the view that this is a matter for individual trusts to manage and mitigate locally.

  As discussed during the planning process, the additional costs (c£1.2m) are not included in the 2019/20 plan.

2.2 Operational adjustments to the 2019/20 Plan (net zero impact)

The table below details in-year operational adjustments to the initial plan submitted to NHSI in April 2019.

Month 4 Budget Reconciliation	**Breakdown by Budget**		
	Income £'000	Expenditure £'000	Deficit £'000
Base Budget 19/20	122,780	(127,720)	(4,940)
CIP - Increase Clinical Income Oral Surgery	50	(50)	0
Extra Day adjustment value	(51)	51	0
NNU Block adjustment	30	(30)	0
PbR excluded drugs, devices & bloods adjustment	(46)	46	0
Non Recurrent Income Targets	118	(118)	0
Realignments (inc CIP)	88	(88)	0
M4 Closing Budget	122,969	(127,909)	(4,940)
Net Trustwide (Increase)/Reduction	**189**	**(189)**	**0**

2.3 Income

	Activity						Income					
	Current month			Year to date			Current month			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income from patient care activity												
Elective & Daycase	4,257	4,615	358	16,680	16,735	55	4,686	4,876	190	18,457	18,275	(182)
Elective excess bed days	280	455	175	1,113	1,329	216	77	110	33	304	326	22
Non-elective	3,792	3,690	(101)	14,988	14,757	(230)	8,296	8,235	(61)	32,815	32,854	39
Non-elective Non Emergency	427	427	(0)	1,603	1,734	131	950	964	14	3,532	3,768	236
Non-elective excess bed days	1,051	1,023	(28)	4,136	4,567	431	285	276	(9)	1,121	1,231	110
A&E	7,510	7,785	275	29,247	30,641	1,394	1,293	1,346	54	5,034	5,099	65
Outpatients	25,624	27,678	2,054	101,640	100,163	(1,477)	3,053	3,070	18	12,086	12,019	(67)
Diagnostic imaging	2,434	2,712	278	9,669	10,142	473	183	186	2	725	726	1
Maternity	523	513	(10)	1,914	2,007	93	487	443	(44)	1,778	1,751	(27)
Non PbR							6,587	6,450	(137)	26,062	27,251	1,189
HCD							1,541	1,534	(7)	5,238	5,238	(0)
CQUINs							186	186	0	744	745	0
PSF/FRF/MRET							1,359	1,359	(1)	4,809	4,808	(1)
Total NHS Clincial Income	45,900	48,898	2,998	180,992	182,075	1,083	28,983	29,036	53	112,704	114,089	1,386
Other patient care income							59	61	2	237	283	46
Non-NHS: private patients & overseas							50	36	(14)	140	132	(8)
Injury cost recovery scheme							89	49	(40)	356	269	(87)
Total income from patient care activities							29,181	29,183	2	113,438	114,774	1,337
Other operating income							2,528	2,435	(92)	9,531	9,505	(26)
Total income							31,709	31,618	(91)	122,969	124,279	1,311

- Overall patient-related income is in-line with plan. In month PbR is over plan by £0.2m offset by an under performance against Non PbR, largely driven by reduced adult Critical Care bed days, and Welsh neonatal activity
- The YTD income position includes the accelerated transformation support from Wirral CCG of c£1.4m. Excluding this the position is broadly balanced.
- The elective performance is driven by an under performance in Colorectal, Urology, Upper GI and T&O. The Orthopaedic under performance has been mitigated by the MSK block benefit.
- Non-Electvie (NEL) activity slightly exceeded plan from an activity perspective, however the casemix was less complex. In-line with the contractual agreement for NEL cumulatively c£1.2m has been included reflecting the support from Wirral CCG.
- Neonatal activity is based on a “block” for 2019/20 this has benefitted the position by c£0.3m.
- “Other Operating Income” is under-recovered in month due to reduced training income (offset in costs) and SLA performance.

2.4 Pay

Pay costs exceed plan by (£0.5m) in month, increasing the cumulative overspend to (c£1.3m).

The table below details pay costs by staff group for July and cumulatively.

	MONTH 4 (£'000)			CUMULATIVE (£'000)		
STAFF GROUP	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
CONSULTANTS	(3,300)	(3,614)	(314)	(13,379)	(14,420)	(1,041)
OTHER MEDICAL	(2,363)	(2,481)	(119)	(9,579)	(10,171)	(592)
TOTAL MEDICAL	**(5,663)**	**(6,096)**	**(433)**	**(22,958)**	**(24,591)**	**(1,633)**
NURSING & MIDWIFERY	(6,045)	(5,949)	97	(24,708)	(24,005)	703
CLINICAL SUPPORT WORKERS	(3,955)	(4,094)	(139)	(16,123)	(16,727)	(604)
TOTAL NURSING	**(10,000)**	**(10,042)**	**(42)**	**(40,831)**	**(40,732)**	**99**
AHP'S, SCIENTIFIC & TECH	(2,636)	(2,651)	(15)	(10,637)	(10,777)	(140)
ADMIN & CLERICAL & OTHER	(2,938)	(2,978)	(40)	(12,485)	(12,080)	405
TOTAL	**(21,237)**	**(21,767)**	**(530)**	**(86,911)**	**(88,180)**	**(1,269)**

- The table above details pay (for all substantive and non-core spend) by staff category.
- The spend on Consultants reflect pressures in some specialties where agency is being used and premium costs are incurred to cover vacancies and sickness as well as the use of WLIs.
- Other medical pressures reflect shortages in the trainee grades on the February rotation. There is a medical staffing review underway to understand the issues/impact of the trainee grades and alternatives for managing the rotas. The junior doctor rotation for August 2019 looks to be more favourable, which will alleviate some of the additional costs.
- Although Nursing and midwifery staff costs are underspent in Mth 4, this has reduced from previous months reflecting increased “fill” rates, and an increase in staff sickness in certain areas. Following the nurse review last year the ward budgets now reflect the approved ward staffing models including the new nurse investment in the Acute Medicine Unit and the Bed Management Team, substantive recruitment initiatives are ongoing. Overall qualified nursing vacancies across the organisation have reduced, however actual staff commencement is phased across quarters 2 and 3. Costs in relation to clinical support workers and trainee nurse associates, are partially mitigated by the nurse vacancies.

- The position in relation to administrative and infrastructure posts reflect vacancies which have supported the non pay overspends in certain areas.

The table below details pay costs by category for July and cumulatively

Pay analysis	Annual Budget £'000	Current period Budget £'000	Current period Actual £'000	Current period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(243,447)	(20,286)	(19,203)	1,082	(82,781)	(78,418)	4,363
Bank	(241)	(20)	(979)	(959)	(84)	(3,651)	(3,567)
Medical bank	(3,074)	(236)	(605)	(369)	(1,145)	(2,528)	(1,383)
Agency	(7,415)	(612)	(896)	(284)	(2,567)	(3,255)	(688)
Apprenticeship Levy	(1,000)	(83)	(83)	0	(333)	(328)	5
Total	(255,177)	(21,236)	(21,767)	(530)	(86,911)	(88,180)	(1,269)

- The underspend in substantive costs increased further, offset by an increase in non-medical bank staff costs.
- Agency costs exceed the NHSI cap by (c£0.7m) as at the end of July. The NHSI agency cap was set before the VAT implications of the current medical locum provider contract where identified. Although the Trust now uses a VAT compliant model, within the year to date position this represents a pressure of (c£0.3m).
- A “deep dive” into the Medical pay costs has been requested by the FPBAC committee, a meeting is scheduled to take place in late August to review the findings, and actions being taken to mitigate this pressure.

2.5 Non pay

Non Pay Analysis	Annual Budget £'000	Current period Budget £'000	Current period Actual £'000	Current period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
Supplies and services - clinical	(33,958)	(2,823)	(2,824)	(1)	(11,379)	(11,563)	(184)
Supplies and services - general	(4,578)	(381)	(398)	(17)	(1,519)	(1,570)	(52)
Drugs	(23,773)	(2,207)	(2,235)	(27)	(7,920)	(7,918)	2
Purchase of HealthCare - Non NHS Bodies	(7,477)	(612)	(744)	(132)	(2,528)	(2,737)	(209)
CNST	(12,948)	(1,128)	(1,128)	0	(4,513)	(4,513)	0
Consultancy	(0)	(0)	(33)	(33)	(0)	(129)	(129)
Other	(25,622)	(2,196)	(2,128)	69	(8,750)	(8,759)	(9)
Total	(108,356)	(9,348)	(9,490)	(142)	(36,609)	(37,189)	(580)
Depreciation	(9,219)	(763)	(837)	(73)	(2,993)	(3,250)	(257)
Total	(117,575)	(10,111)	(10,327)	(215)	(39,602)	(40,439)	(837)

- Non pay expenditure excluding depreciation exceeds plan by (£0.6m) cumulatively, as detailed in the table above and was overspent by (c£0.1m) in July.
- Clinical supply costs cumulatively are showing a pressure and largely reflect increased activity and acuity, the year to date position also includes theatre loan kit costs some of which relate to 2018/19.
- Purchase of healthcare non-NHS is largely in Radiology and reflects capacity constraints and the use of outsourcing for radiology reporting (offsets pay underspends), and costs associated with MSK activity undertaken by a private provider.
- Consultancy costs continue in-month largely to support transformation and governance. This cost is offset by vacancies in these areas.
- Other costs include all areas of discretionary spend which are reviewed in detail at the monthly scrutiny panel. The June position reflects the energy rebate credit in Estates. This category also includes the impact in mth and year to date of the closure of the Aseptic Unit.

2.6 CIP Performance

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	Fully Developed £k	Variance £k	In Progress £k	Total £k	Variance £k
Transformation										
Patient Flow	Antony Middleton	481	398	(83)	1,500	1,417	(83)	0	1,417	(83)
Theatre Productivity	Antony Middleton	265	186	(79)	1,000	555	(445)	365	921	(79)
Outpatients	Antony Middleton	309	309	**0**	1,000	1,000	**0**	0	1,000	**0**
Demand Management	Antony Middleton	30	0	(30)	500	0	(500)	300	300	(200)
Digital	Paul Charnley	129	21	(109)	500	0	(500)	420	420	(80)
Sub total - transformation		**1,215**	**914**	**(301)**	**4,500**	**2,972**	**(1,528)**	**1,085**	**4,058**	**(442)**
Quipp & Cross cutting workstreams										
Workforce	Helen Marks / Tracy Fennell	167	16	(150)	1,500	0	(1,500)	1,342	1,342	(158)
CNST	Antony Middleton	0	0	**0**	653	590	(63)	0	590	(63)
GDE	Paul Charnley	8	8	**0**	500	500	**0**	0	500	**0**
Endoscopy	Antony Middleton	0	0	**0**	150	0	(150)	13	13	(138)
Meds Management	Pippa Roberts	135	151	**16**	568	539	(29)	80	619	**51**
Procurement	Karen Edge	94	122	**28**	526	395	(131)	136	531	**5**
Tactical and transactional										
Divisional and Departmental	Divisional Directors	1,186	1,802	**616**	4,784	4,298	(486)	692	4,990	**206**
Total		**2,805**	**3,014**	**208**	**13,181**	**9,294**	**(3,886)**	**3,348**	**12,642**	**(539)**

- The overall CIP delivered as at the end of Mth 4 is £0.2m above the NHSI plan.
- Transformational productivity schemes are all below plan with the exception of outpatients, but are mitigated financially in the divisional financial performance from the divisional allocation of the growth reserve.
- Workforce schemes – the nursing e-rostering scheme has been reviewed/agreed with further work ongoing to assess the non ward savings. Work is ongoing on the medical workforce scheme particularly in the Medicine division and will be shortly finalised. Any shortfall that materialises will be reallocated to the divisions for in- year mitigation.
- Priorities have been agreed for the Digital scheme and will deliver recurrently from 2020, slippage in year has been returned to the Divisions for additional BAU.
- Cross-cutting medicines management and procurement schemes continue to marginally over-deliver as at M4.
- The BAU schemes continue to over-perform but are heavily supported by non-recurrent vacancy mitigation particularly in the Corporate Division.
- The “in- progress” schemes are monitored on a weekly basis by the Exec. Directors, in addition to reducing the “unidentified gap”.

3. Use of Resources

3.1 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%	-17.4	4	-16.3	4	-30.4	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-0.4	4	-0.6	4	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-4.0%	4	-4.4%	4	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-0.4%	2	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	0.0%	1	27.0%	3	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has overspent against the agency cap. This reflects the VAT implication of the HMRC ruling (31 January 2019) in relation to the removal of VAT exemption for the supply of medical locums. The Trust has adopted an alternative model (which went live on 8 July) so that VAT will no longer be incurred.
- The *Distance from financial plan* metric is currently above plan as a result of the year to date EBITDA position.
- The month 4 UoR rating is 3 overall, which matches the 2019/20 plan UoR rating of 3.

4. Forecast

The forecast reported at the previous Board was a year end deficit of (£4.3m) based on a detailed review of Q2 and assuming a steady run rate. Further mitigations were identified that would reduce the deficit to (£3.5m).

However, the Month 4 position did not deliver in line with expectations with an (£0.8m) adverse variance to plan against a forecast (£0.4m) adverse position.

	Annual	Month 4			Mth 4 -Forecast	Forecast
	Budget £'000	Budget £'000	Actual £'000	Variance £'000	Variance £000	v Actual £000
NHS - Clinical Income	325,038	27,424	27,450	26	53	(27)
Non NHS income/ Private Patients/ICR	4,532	398	374	(24)	2	(26)
Income - PSF/FRF/MRET	18,804	1,359	1,359	(1)	0	(1)
Other Income	28,362	2,528	2,435	(92)	(10)	(82)
Total Income	376,736	31,709	31,618	(91)	45	(136)
Pay	(255,177)	(21,244)	(21,767)	(523)	(418)	(105)
Non Pay	(108,356)	(9,109)	(9,258)	(149)	85	(234)
Total Expenditure	(363,533)	(30,353)	(31,025)	(672)	(288)	(339)
Depreciation/Finance costs	(13,452)	(1,121)	(1,187)	(66)	(73)	7
Actual surplus / (deficit)	(250)	235	(593)	(828)	(361)	(467)
Reverse capital donations / grants	249	21	14	(7)	0	(7)
Adjusted financial performance surplus/(deficit)	0	256	(580)	(836)	(361)	(475)

The key variations to the forecast position were:

	£m
Additional pay costs in relation to Gastro. activity	(0.1)
Critical Care activity below forecast and Homecare impact	(0.1)
Gastro income not included in the forecast	0.1
MSK Outsourcing	(0.1)
Clinical Supplies	(0.1)
Other Income (ICR/SLA's)	(0.1)
TOTAL	**(0.4)**

It is of note that pay costs (excluding the increased costs associated with the additional Gastro. activity undertaken during July) are in line with expectations, as was planned clinical income. The income shortfall relates to areas over which the Trust has limited control and which are subject to activity variation. However, non-pay moved adversely and a deep dive into both MSK and clinical supplies costs in Surgery are underway.

The adverse position in Month 4 will affect the initial forecast position which was based on the Q2 run rate. It is now of the utmost importance that a full month by month forecast to the end of the year is completed and a recovery plan developed to minimise the financial risk. This work is currently underway and will be presented to FBPAC at its meeting on the 26th September and Board will be updated subsequently.

5. Risks & Mitigations

Risk 1 - Operational Management of the position

- Management of agency medical staff costs, work is ongoing to recruit substantively to key critical gaps and reduce dependence on non-core capacity.
- The activity performance position is monitored weekly by the Chief Operating Officer to ensure the elective program and the RTT 18 wk and 52 week quality standards are delivered.
- The weekly performance "scrutiny" panel review non-clinical vacancies, discretionary non pay spend, non-core spend and the agency 'hotlist'.
- Monthly review of Divisional performance is undertaken by the Executive Directors as well as a more detailed Director of Finance review.
- The alternative model to mitigate VAT exposure in relation to the supply of medical locums commenced from July 2019.

Risk 2 – CIP Performance

- Performance against milestones is monitored on a weekly basis by the Executive Directors with weekly CIP gateway monitoring of all programmes.
- Support from the Service Improvement team to ensure transformation schemes are delivered and the pace is maintained to deliver productivity improvements on flow and efficiency.
- The business as usual (BAU) schemes from the divisions are well under way. Any delivery gaps have been largely mitigated via non recurrent vacancies

Risk 3 – Cash

- If the plan is not delivered this would require loan funding which has not been planned for, as the Trust has signed-up to deliver a 'break-even' position.
- In order to maintain liquidity, the cash position is being proactively managed. Robust cash management processes are in place to forecast additional cash requirements with sufficient notice to engage effectively with DHSC/NHSI, should the need arise.

Risk 4 – Capital Expenditure

- Delays to the delivery of detailed capital schemes present risks of potential capital underspend at year end. The capital position is actively managed through monthly divisional performance meetings and via the Finance and Performance Group.
- NHSI asked trusts to adjust capital expenditure plans as the initial plans were too high, at a national level, for 2019/20. Initially, the Trust refused, on the basis that capital plans were based on necessity. Subsequently, a 20% reduction was nationally mandated. The Trust has therefore deferred £1.6m (17.5%) to 2020/21 in relation to the Car Park scheme. The adjusted capital plan for 2019/20 is £7.5m.
  The Trust was further advised on 16th August that the original Capital plans are to be reinstated following the additional Capital support provided nationally. The Trust is undertaking a reassessment of the Capital requirements for 19/20, and will update the Board at the next meeting.

6. Conclusion

Although the Trust delivered the financial plan for Qtr1 with the non recurrent accelerated support of c£1.4m received from Wirral CCG. During Mth 4 the position deteriorated by a further (£0.8m). The Trust continues to face operational challenges, mainly in relation to the recruitment of key medical posts and resourcing capacity to maintain flow, which has continued in Mth 4. It has to be noted the Trust nursing vacancies has reduced compared to 18/19, in addition to improved NHSP bank "fill" rates across wards and in ED. Both of which will ensure safe staffing models in clinical areas are achieved. However high sickness rates in certain key areas is impacting the position.

Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan. The weekly executive lead scrutiny panel is also reviewing both clinical and non-clinical vacancies.

Exceptional items such as the impact of VAT on medical locums and depreciation have impacted the position (c£0.6m) year to date. The VAT issue will abate from early July as an alternative VAT compliant model has been adopted.

The cost improvement plan for 19/20 is £13.2m, although this is challenging, the Trust has set up weekly internal monitoring to maintain focus and pace in delivery. The meetings are chaired by the Chief Executive.

The 19/20 plan was supported by positive contractual agreements reached with both Wirral CCG and NHS England – Specialised Commissioning. The agreements reflect overall "system support" to ensure the Trust is able to deliver the control total and access the central funding.

This was further evident in the "accelerated" support offered by Wirral CCG of c£1.4m to ensure the control total for Qtr 1 was achieved, thus enabling the Trust and the System to receive the PSF/FRF allocation of £1.9m.

Going forward the Trust is actively working with partners in the Wirral System to develop a system-wide financial recovery plan for 2019/20, to ensure the control total for both the Trust and the System are delivered, which will enable the full allocation of PSF and FRF monies to be accessed.

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

Karen Edge
Acting Director of Finance
September 2019

Board of Directors	
Agenda Item	13.0
Title of Report	Long Term Plan Update
Date of Meeting	4th September 2019
Author	Karen Edge
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 3 PR 5
Level of Assurance • **Positive** • **Gap(s)**	Gaps – key data not yet released nationally (PSF/FRF) & key Trust strategy papers not yet developed/approved
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

Following the release of the NHS Long Term Plan Framework, the Trust is required to submit a 5 year plan (19/20 outturn is Year 1).

The draft submission date is the 27th September but the Trust is required to submit its plan to the Cheshire & Mersey Health Care Partnership (HCP) to allow consolidation by the 13th September.

The HCP have confirmed that this initial submission does not need to be approved by individual Boards.

There will follow a review and workshop facilitated by the HCP.

The final submission is due by the 15th November and it is proposed that FBPAC reviews progress at its meeting on the 24th September with a recommendation to the Board on the 6th November.

2. Background

Guidance has been issued to support the implementation of the long term plan. There is a particular focus on targeted investment into primary care (via PCNs), community care, mental health and digital. These investments are expected to realise capacity benefits in hospital providers that will lead to cash-releasing efficiencies. Commissioners CCG's have been given fixed 5 year allocations and can also draw from the targeted investment.

NHSE/I will indicate the level of Financial Recovery Funding (FRF) at a system level and the target financial position. Organisation's in deficit will need to agree recovery plans where they are not in financial balance.

STP's are expected to co-ordinate and aggregate system plans. Systems need to produce a Strategy Delivery Plan (document) and each Organisation needs to complete a template including workforce, activity and financial (income, expenditure and capital) information. The template also requires efficiency and financial recovery plans.

3. Key Issues/Gaps in Assurance

Planning assumptions have been provided by NHSI/E in relation to inflationary uplifts for income, pay, non-pay, drugs and CNST. Efficiency expectations have been notified as 1.6% for Providers in deficit. The Trust will allocate the efficiency target against internal themes including Procurement, Medicines Management, Corporate and clinical Business as Usual.

There is an expectation that local systems will agree the level of activity growth. Within the Healthy Wirral plan there is an agreed approach of managing growth through the work of the Healthy Wirral programme, containing cost in providers and taking an element of the system growth funding to the system deficit.

The Trust is yet to receive confirmation of the level of allocated FRF/PSF and this will drive any additional system efficiencies that will be required over and above the Provider 1.6%.

The plan needs to include a 5 year capital programme and will initially contain an extrapolation of our 3 year plan and the additional Urgent Treatment Centre allocation of £18m. Any requirements as a result of the Estates Strategy and/or Clinical Strategy will be included within the final submission if available.

The HCP review workshop will cover:

- Review of the draft aggregate submissions
- An oversight of the Strategy, Financials, Activity and Workforce picture
- Present the plans for the top four or five programmes of work to transform I.e. acute sustainability collaboration at scale, cancer and mental health
- Agree assumptions to include in the final plan

4. Conclusion

The Trust and Wirral system are preparing the initial draft submission based on the agreed Healthy Wirral approach and known assumptions in regard to inflation and efficiency.

5. Recommendations

The Board is asked to note this update.

Board of Directors	
Agenda Item	14
Title of Report	Appraisal and Revalidation Annual Board Report and Statement of Compliance
Date of Meeting	4 September 2019
Author	Amanda Branson Dr Catherine Hayle Liam Reeve Dr Nicola Stevenson
Accountable Executive	Dr Nicola Stevenson
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Choose an item
Data Quality Rating	Choose an item
FOI status	Choose an item
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

Wirral University Teaching Hospital
NHS Foundation Trust

A Framework of Quality Assurance for Responsible Officers and Revalidation

Appraisal and Revalidation Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

Contents

Wirral University Teaching Hospital Annual Board Report Appraisal Round: April 2018 – March 2019

Section 1 – General:

The board of Wirral University Teaching Hospital can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   Date of AOA submission: 6.6.19

   Action from last year: New RO commenced in October 2019, has attended the RO training, and has received her first appraisal by NHSIE.

   Comments: Overall, results were positive, showing appraisal rates above the regional mean. However, a lower rate among SAS doctors was noted, and this requires additional scrutiny, alongside work to ensure we are doing all possible to support our SAS doctors.

   Action for next year: RO to meet with SAS doctor lead to discuss and agree mechanisms of support for SAS doctors. Interrogate data in more detail re. incomplete / missed appraisals in the SAS doctor group, and present this information to the RO.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: New RO now in post, and has undergone RO training.

   Comments: None

   Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Action from last year: None

   Comments: None

   Action for next year: None

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: None

   Comments: This is an area of ongoing focus. Specifically, we need to agree how recently the cohort of agile doctors should have worked within WUTH to maintain their prescribed connection to us. Currently our connections are reviewed every three months, and we need to consider whether this should occur more frequently.

   Action for next year: Agree with HR and update process for monitoring our connections every month.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Senior Medical Staff Appraisal Policy 215 (v2.2), was reviewed and agreed at JLNC in December 2018. Comments: The policy may need to be reviewed again to incorporate any changes in practice arising out of point 4. Action for next year: Consider if a policy revision is required once joint work with HR complete.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: While a peer review has not been carried out, we have carried out an internal review of our own processes based on the 'Framework for Quality Assurance for Responsible Officers & Revalidation' in respect of the appraisal section. Comments: The review identified two areas that needed to be developed as soon as possible: performance review of new appraisers, and the development of an Information Governance Policy. All new appraisers now receive a performance review by a senior appraiser after their first three appraisals. Action for next year: The Information Governance Policy will be completed by the end of 2019.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Agile doctors to be included formally in the appraisal process if they have worked in the organisation for more than one year. Those who have worked within WUTH for less than one year are incorporated into the Director of Medical Education's local ARCP system (as this is felt to be most appropriate to the needs of doctors in this group). There is an SAS doctor lead, who also monitors the welfare of agile doctors. Comments: It is positive to note that there was an improvement in this group engaging with the appraisal/ARCP process during 2018/19. There is a proposal to move nil hours contract workers who currently have a connection with the Trust onto 20% annualised contracts. This proposal includes access to Trust RO, two days study leave plus £140 budget, access to e-portfolio and access to Trust ARCP review process. Action for next year: Work will continue on ensuring this group engage going forward. Ongoing work led by HR to ensure the numbers of agile doctors on nil hours contracts are reduced, and that support and supervision structures are improved. The SAS Lead will undertake a pre-appraisal checklist with agile doctors to increase their understanding and engagement with the process.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

   Action from last year: Risk management reports have been re-established following a short period of time when this was not occurring. All appraisals continue to be quality assured, and close attention is paid to ensuring supporting information is provided from any work outside of WUTH.

   Comments: None

   Action for next year: None

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

   Action from last year: None

   Comments: Reasons for missed or incomplete appraisals are recorded, and appropriate action taken at the time, according to the needs and circumstances of the individual concerned. In these situations, the RO is involved when necessary, often during monthly RO meetings.

   Action for next year: None

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

   Action from last year: An updated policy was agreed at JLNC in December 2019.

   Comments: None

   Action for next year: We may need to review the appraisal policy again during 2019/20, in keeping with any improvement work carried out.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

   Action from last year: None.

   Comments: During the appraisal round 2018/19 there were 312 appraisals to be undertaken and approximately 68 appraisers who on average undertook 5 appraisals over the course of the year. Whilst there are currently sufficient trained appraisers within WUTH, the appraiser role is not a formal one, so appraisers are at liberty to stand down without notice. This can cause practical problems as their allocated doctors have to be given to other appraisers sometimes at short notice. This is sustainable at the moment. Doctors continue to put themselves forward as new appraisers, and the number and quality of appraisals will be kept under review.

   Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: None Comments: Appraisers receive annual feedback from the doctors they have appraised; have their summaries formally quality assured with the use of the excellence tool once a year; are encouraged to attend the Appraiser Support Group; and are observed once by the A&R Manager. New appraisers now undergo face-to-face performance review with a senior appraiser after their first three appraisals. Action for next year: Two appraiser refresher days are being held in the 2019/20 round, with both internal and external speakers covering a variety of 'hot topics'.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: The Medical Appraisal Lead/Senior Appraisers review appraisal documentation of all doctors each year. The Responsible Officer reviews the doctor's documentation within the revalidation year. Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: There were 49 revalidation recommendations and six recommendations for deferral in the period April 2018 – March 2019. WUTH's deferral rate is 11%, which performs well against the national deferral rate of 16.3% reported by the GMC. All revalidation recommendations were completed on time. Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: There is no uniform approach at present, although all doctors receive written confirmation if their revalidation recommendation is to be deferred.

Action for next year: Recommendation for deferrals or non-engagement will be discussed personally with each doctor (followed by email confirmation). All doctors will receive confirmation that they have been recommended for revalidation via email.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: The Trust was rated 'Inadequate' in the Well-Led domain during CQC inspection in 2018. A new governance structure, led the Director of Quality & Governance, has been embedded. The Trust has a high level of engagement as evidenced by high numbers of (low level) incident reports, good attendance at weekly Serious Incident meetings and monthly Safety Summits, and regular reviews of governance dashboards, including at Board level.

Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: The following information is uploaded to the doctor's appraisal document for reflection and discussion at appraisal: risk management report detailing incidents, complaints and litigation; Dr Foster report if applicable; 360 feedback; research information where applicable.

Action for next year: A template letter is in development, which will be sent in advance of the appraisal to any doctor who the RO wishes to reflect on a specific incident or concern

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: The Trust has appropriate and established policies in place to deal with fitness to practise concerns. Any doctor who is under investigation is expected to declare and reflect upon this on their appraisal documentation.

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: None.

Comments: When a concern about a doctor is raised, the 'Procedure for handling concerns about the conduct, performance & health of medical and dental staff' policy is followed. All serious concerns are reported immediately to the Responsible Officer.

A Medical Staff Remediation Policy is in place. This document includes advice on remediation and resources available locally and nationally which WUTH can access.

There were 2 cases which required intervention in the period 1st April 2018-31st March. On both occasions, the Trust made the decision that no further investigation was necessary. As the numbers are very small, it is difficult to assess whether these are representative of our whole medical workforce in terms of protected characteristics. However, a recent piece of work has been carried out to assess whether doctors who are awarded EBAs are representative of our eligible medical workforce as a whole.

Action for next year: Terms of reference for a ROAG (Responsible Officer Advisory Group) to be agreed and put in place. Data regarding protected characteristics of any doctors discussed by the ROAG will be collected and analysed prospectively.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year: None

Comments: There is a process by which the Responsible Officer communicates with other Responsible Officers as necessary

Action for next year: Formal procedure to be agreed and put in place

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None

Comments: Concerns raised regarding a doctor's practice are escalated to the Responsible officer as per the 'Procedure for handling concerns about the conduct, performance and health of medical and dental staff'. Any formal meetings will be attended by a senior HR representative. The Human Resources Department will encourage the adoption of a consistent approach in accordance with accepted standards of good personnel practice and employment legislation as well as the policy mentioned above. Risk management forms are produced for every doctor prior to their annual appraisal, and list any incidents, complaints and legal claims the doctor has been involved in. Doctors are expected to reflect on any incidents, complaints and legal claims (in any organisation within their scope of practice) at their annual appraisal. It is checked that this has happened during the quality assurance process. Dr Foster reports are provided for all consultants (which include data regarding mortality, complication rates and length of stay), and these are also discussed and reflected upon at annual appraisal together with any available outcomes data.

We monitor doctors' engagement in risk management processes (e.g. incident reporting, attendance at safety summit, leadership of local reviews or RCAs) at each annual appraisal and through the quality assurance process of each appraisal. All doctors are encouraged to engage proactively in risk management processes to support our learning culture.

Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: An electronic recruitment system called TRAC ensures all the compliance and pre-employment checks are completed prior to hiring any Trust employees.

Agency workers are sourced through agencies on the HTE framework which gives us assurance that these workers have met satisfactory checks. Compliance pack is checked by Medical Staffing team before booking a temporary external worker.

Action for next year: Work to be undertaken on accessing RO to RO forms and the consequent exchange of information.

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions:

Good progress has been made against the actions set out in last year's departmental action plan. Any outstanding items have been carried forward into this year's plan, and actions identified in this report have been incorporated. Progress against this will be reviewed in the monthly Appraisal & Revalidation Team meetings and Responsible Officer meetings.

Overall conclusion:

We have seen significant change within the Appraisal & Revalidation Department during the 2018/19 year, with the appointment of a new Responsible Officer and a new Medical Appraisal Lead. The ongoing support of an experienced Appraisal & Revalidation Manager & Administrative Secretary has provided much needed continuity during this time. Monthly RO meetings occur consistently, and the RO reviews all appraisal documentation in detail in the revalidation year. All revalidation recommendations have been made within the necessary timescale. A new senior appraiser role has been developed, and two senior appraisers are now in post. These new team members have embedded well into the team, and the role is evolving as we progress within our new structure. The senior appraiser role has allowed us to provide proactive face-to-face support to doctors at risk of deferral or non-engagement, as well as introducing a formal 'performance review' meeting for new appraisers.

We continue to perform well compared with benchmarking data in term of both appraisal compliance and revalidation rates. A key area of focus for the year ahead is reduced rates of appraisal compliance within the SAS doctor group. This is a small group, so periods of ill-health/maternity leave etc. for a few individuals can skew the data considerably. However, we are keen to ensure that our SAS doctors have all

possible support to facilitate engagement in the appraisal process, and are committed to the implementation of the SAS Charter. There are key actions agreed for the year ahead in relation to this, and these will be a focus for the named SAS Lead.

We continue to provide new appraiser and refresher training in-house, and are able to offer new appraiser training to external organisations. We have also developed strong links with Clatterbridge Cancer Centre, and invite their appraisers to our refresher training.

Following a challenging period within the organisation in terms of higher than average rates of concerns being raised about medical staff, the number of concerns has reduced significantly in the past year (from 11 cases requiring intervention in 2017/18 to 2 cases requiring intervention in 2018/19).

Section 7 – Statement of Compliance:

The Board of Wirral University Teaching Hospital has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Wirral University Teaching Hospital NHS Trust

Signed:

Name: Janelle Holmes

Role: Chief Executive

Date:

Board of Directors	
Agenda Item	15
Title of Report	DRAFT: Communications, Marketing and Engagement Plan
Date of Meeting	4th September 2018
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**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

As the organisation progresses on its journey of improvement, an updated Communications, Marketing and Engagement Plan has been created.

Currently in draft form, this plan spans a two year period and fully covers a proactive approach to communications, marketing and engagement following the recent launch of the new WUTH vision.

The WUTH Board of Directors are asked to note this plan and to delegate final approval via the Workforce Assurance Committee.

2. Background

Having a current and appropriate Communications, Marketing and Engagement Plan will give direction in the messages being delivered internally and externally.

This plan offers a fresh, considered approach to communications, marketing and engagement as it will play a proactive and crucial role in shaping positive perceptions of the organisation.

Working hand in hand with WUTH's newly developed vision to deliver the best patient care and to make the organisation a great place to work, effective communication will play a major part in achieving these ambitions. This plan describes the focus, interventions and the deployment of resources to support the delivery of the set objectives.

It will set out to do the following:

- Ensure employees are engaged and feel part of WUTH at every level
- Rebuild confidence in WUTH with stakeholders
- Be positive and celebrate what WUTH does well
- Engage support to address quality, performance and financial challenges
- To develop connectivity with patients, staff and stakeholders around service improvements

3. Next Steps

This draft communications, marketing and engagement plan has been presented to the following groups and committees for comment:

- Workforce Steering Group
- Workforce Assurance Committee

The plan has also been looked at externally by a communications consultant.

The plan is now presented to the WUTH Board of Directors for noting.

4. Recommendations

The WUTH Board is asked to note the contents of the plan and to delegate final approval via the Workforce Assurance Committee.

DRAFT V0.3

Wirral University Teaching Hospital NHS Foundation Trust

2019 - 2021

Communications, Marketing and Engagement Plan

together we will

wuth.nhs.uk

Contents

Executive Summary

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is one of the biggest and busiest acute hospital trusts in the north west of England. Following a challenging period of change and disruption WUTH is beginning to make strong progress on patient safety and quality. There is however still much to do to instil patient, public and staff confidence and engagement.

This two year plan proposes a fresh, considered approach to communications, marketing and engagement, as it will play a proactive and crucial role in shaping positive perceptions of the organisation internally and externally.

WUTH has an emerging vision to deliver the best patient care and to make the organisation a great place to work. Effective communication and engagement will play a major part in this achieving these ambitions. This plan describes our focus, interventions and the deployment of resources to support the delivery of the objectives. This plan will set out to do the following:

- Ensure employees are engaged and feel part of WUTH at every level
- Rebuild confidence in WUTH with stakeholders
- Be positive and celebrate what WUTH does well
- Engage support to address quality, performance and financial challenges
- To develop connectivity with patients, staff and stakeholders around service improvements

To fulfil the aims above, this plan will be based on a number of key objectives to help deliver them, all of which are supported by a series of deliverables. The objectives of this plan are:

- ***Narrative:*** Develop a single, compelling narrative for the organisation around changes in services
- ***Staff, patient and public communication:*** Improve existing internal and external communication channels, including an increase in two-way communication
- ***Engaging campaigns:*** Provide communications support for major organisational campaigns, initiatives and plans
- ***Stakeholder engagement:*** Drive, manage and oversee an engagement programme with local and national stakeholders
- ***Celebrate success:*** Celebrate successes internally, amongst staff, and in mainstream and social media for the public and wider stakeholders

This plan also sets out how the organisation will evaluate and measure its success.

Introduction

This two year communications, marketing and engagement plan describes how WUTH will design and prioritise efforts and resources in delivering robust communication, marketing and engagement with patients, staff, stakeholders and the local communities the organisation serves.

Background and context

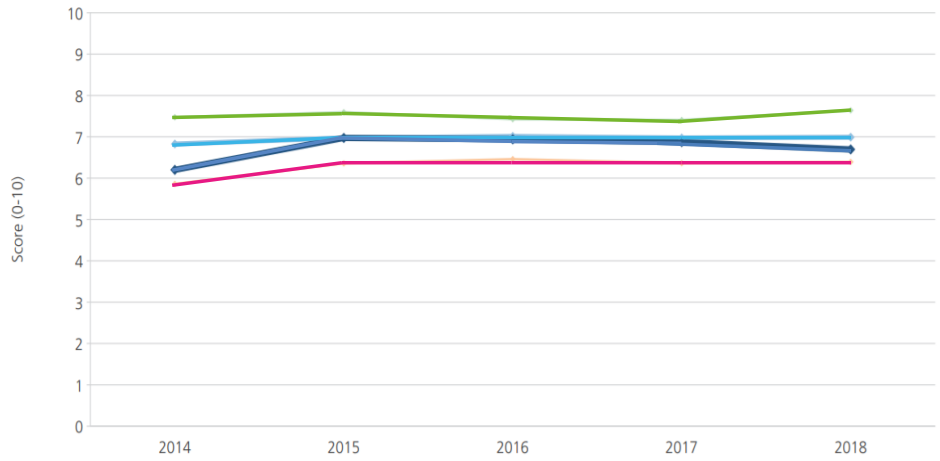
WUTH is committed to keep improving communication, marketing and engagement. Through effective channels it can manage, motivate, influence, explain and create conditions for change. The need to communicate, market and engage effectively with the dedicated workforce, the patients and public it serves as well as partners and stakeholders is central to the ongoing reputation management of WUTH during its current journey of improvement.

WUTH had been at the centre of a challenging period and had been subject to negative attention by regulators as well as national, regional and local media. The uncertainty caused in 2017-2018 by leadership changes and restructuring, the most recent Care Quality Commission (CQC) inspection report and their 'Requires Improvement' rating have all had a reactive impact on perceptions of WUTH.

The results from the 2018 NHS Staff Survey (**Figure 1**) would echo the challenges the organisation continues to face. 2014 was a very disappointing year for staff engagement in which the organisation scored 6.2 out of 10. This placed WUTH in the bottom 20% of acute organisations nationally.

Although the staff engagement score increased over subsequent years rising to 6.9 out of 10 in 2017, the challenges and uncertainty of the last 12 months has seen a lower staff engagement score of 6.7 out of 10.

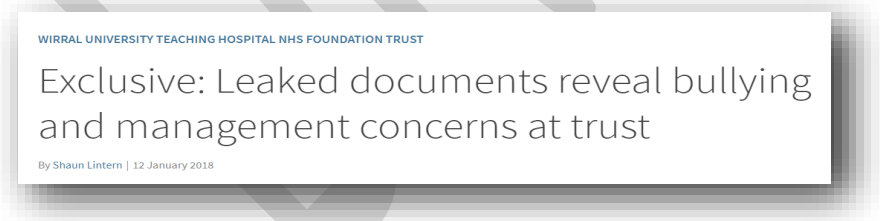
Figure 1



WUTH score	6.2	7.0	6.9	6.9	6.7
Best acute score	7.5	7.6	7.4	7.4	7.6
Average acute score	6.8	7.0	7.0	7.0	7.0
Worst acute score	5.9	6.4	6.5	6.4	6.4

In addition to the NHS Staff Survey, WUTH received disappointing feedback from a Medical Engagement survey (undertaken in 2017). The concerns raised in the survey highlighted a perception of 'disconnect' between medical staff and management.

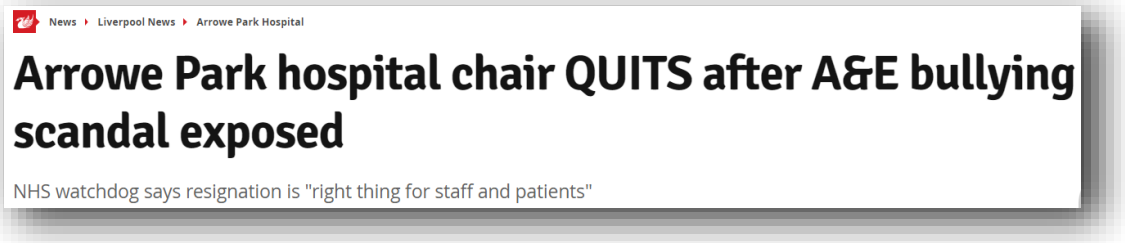
The challenges highlighted above created a number of reactive headlines in the media locally and nationally such as:


WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

Exclusive: Leaked documents reveal bullying and management concerns at trust

By Shaun Lintern | 12 January 2018

Health Service Journal (12th January 2018)


News › Liverpool News › Arrowe Park Hospital

Arrowe Park hospital chair QUITS after A&E bullying scandal exposed

NHS watchdog says resignation is "right thing for staff and patients"

Liverpool Echo (28th February 2018)


Leadership at Wirral NHS trust 'unstable'

13 July 2018 Share

Inspectors visited the trust's facilities between March and May

BBC News (13th July 2018)

Following changes to senior leadership throughout 2018, stability and confidence is once again beginning to show and settle. The challenge to bring confidence back into the organisation remains very real. A WUTH wide piece of work to reset and reshape the vision, values and behaviours of the organisation has now been finalised (July 2019). This includes the creation of a brand new strategic vision and how this will link into the wider NHS Long Term plan around workforce, patient information (digital) and stakeholder collaboration.

In order to ensure that communication, marketing and engagement is effective from a workforce point of view, WUTH needs to understand who its internal audience is and their preferred methods of communication.

Detailed in **Figure 2** is the outcome of research undertaken by Barclays in 2013, which identifies the audiences by age group and their preferred method of engagement along with the profile of the WUTH workforce:

Figure 2

	Maturists (born before 1945)	Baby Boomers (1945-1960)	Generation X (1961-1980)	Generation Y (1981-1995)	Generation Z (Born after 1995)
WUTH workforce count (as at 28/02/19)	* (number is lower than 5)	972	3153	2106	175
Communication media	Formal letter	Telephone	Email and text message	Text or social media	Hand held devices
Communication preference	Face to face	Face to face, but telephone or email if required	Text message or email	Online and mobile	Facetime

Approach

Effective leadership, line management and the employee voice are key enablers of engagement. Engagement is also an essential ingredient in meeting the challenges facing the organisation, in particular to productivity and efficiency and in order to achieve the quality outcomes for patients.

WUTH wants to educate and develop its senior leaders, managers and team leaders in the importance of engagement and giving those individuals the tools and the means to take responsibility for making sure effective systems are in place for communication and engagement. This is in addition to supporting them to raise the profile of the organisation through the promotion of positive achievements and successes wherever possible.

This plan also provides a framework for effective communications that are clear, honest, timely and relevant. It recognises that the best communication is always two way; bottom up as well as top-down.

Aims

The aims of a successful two year plan are to:

- **Ensure colleagues are engaged, and feel part of WUTH:**

  Engagement should not be viewed as just improving communication but using engagement opportunities with the workforce to shape decisions, address issues and support the strategic direction. Successful engagement will need commitment and visible support from the Board, Executives, and managers at every level of the organisation.

- **Rebuild confidence in WUTH:**

  One of the key focuses is to rebuild confidence in WUTH (internally and externally) and the services provided, WUTH needs to be positioned as a trusted partner, and as an organisation that consistently delivers what it says it will. WUTH also needs to ensure it has a strong voice locally, given the developing landscape of the health service and the NHS Long Term Plan. This two year proposal for communications, marketing and engagement is designed to cement and protect the status of WUTH as a provider of high quality care and a great employer.

- **Be positive, and celebrate what WUTH does:**

  WUTH has historically failed in having a systematic approach to publishing all the good work that takes place both within and outside the organisation. It is important that WUTH shares the excellent services that it delivers with stakeholders including the local and national media, MPs and regulators. WUTH needs to encourage its clinical workforce to enter into awards to showcase their work. This subsequently has an impact on how WUTH is viewed by patients and staff which in turn may improve ratings in relation to the NHS Friends and Family Test.

- **Engage support to address quality, performance and financial challenges:**

  Restoring confidence in the organisation means addressing quality, performance and financial challenges. An effective work programme will serve both as an enabler in this regard, but also as a way of demonstrating grip and traction, as well as celebrating progress.

- **To develop connectivity with patients, staff and stakeholders around service improvements:**

  To impart awareness, understanding and positive perception of benefits to patients, staff and the organisation in relation to WUTH service improvement programmes using a range of engagement tools and methods.

Objectives

In order to support the delivery of these aims, the following measurable objectives for the duration of this plan have been set:

A) *Narrative:* Develop a single, compelling narrative for the organisation

- Develop an over-arching narrative, supported by a clear statement of priorities and enabling work plans

- Develop a set of supporting key messages, which are in turn tailored for different audiences (both internally and externally) to enhance understanding and buy-in
- Produce a range of engaging digital and paper communications collateral to help support and embed narrative and key messages
- Develop a brand and visual identity to support narrative and organisational ambition
- Ensure greater visibility of the executive team and senior managers/clinicians as part of embedding the narrative, particularly internally amongst staff

B) *Staff, patient and public communication:* Improve existing internal and external communication channels, including increase in two-way communication

- Improve quality and read-rates for existing staff internal communications channels
- Increase face to face and two way communication opportunities with staff and patients
- Develop a short and long-term plan for the WUTH website (public and staff)
- Further develop the new monthly magazine for staff, *In Touch*, to complement our improved (and existing) communication channels
- Develop an action plan and toolkit to improve the way in which managers brief their teams and how WUTH communicates to its staff
- Scope the possibility of introducing a WUTH staff app for smartphones to further engage with colleagues

C) *Engaging campaigns:* Provide communications support for major organisational campaigns, initiatives and plans - e.g. Vision, Values and Behaviours work and/or Patient Flow, Outpatients and Planned Care

- Identify key organisational projects requiring communications support/input
- Develop bespoke internal and external communication plans, all of which link to the organisation's single, compelling narrative
- Use creative, innovative communications tools and techniques to reach different audiences, including traditionally hard to reach internal groups (such as medical workforce, facilities and estates) and external groups (such as the relatives and carers of elderly patients who are ready for discharge)
- Regularly measure and evaluate the success of campaigns, and adjust/amend approach as appropriate

D) *Stakeholder engagement:* Drive, manage and oversee an engagement programme with local and national stakeholders

- Undertake a stakeholder mapping exercise to ensure WUTH is targeting key influencers, and to identify gaps that may exist
- Nominate named individuals to establish links with key stakeholders as part of 'buddying arrangement'
- Hold quarterly engagement events for key stakeholders, plus more regular bespoke activity for local MPs (including tours of services and meetings with clinicians)
- Regular blogs/opinion pieces from members of the executive team/senior clinicians

E) *Celebrate success:* Celebrate WUTH successes internally, amongst staff, and in mainstream and social media

- Deliver a programme of positive local, regional, trade, national and international media coverage (print, online and broadcast). An updated Media and Public Relations Plan can be found as **Appendix A**.
- Ensure greater and more effective use of our social media channels (public and staff), particularly Facebook, Twitter, Instagram and LinkedIn, to celebrate successes and to convey our improvement journey
- Extend the use of video, graphic and interactive content via internal and external communications channels
- Fully engage with national media opportunities, especially documentary making, by capitalising and focusing on its longer term benefits rather than shorter term risks.

Implementation

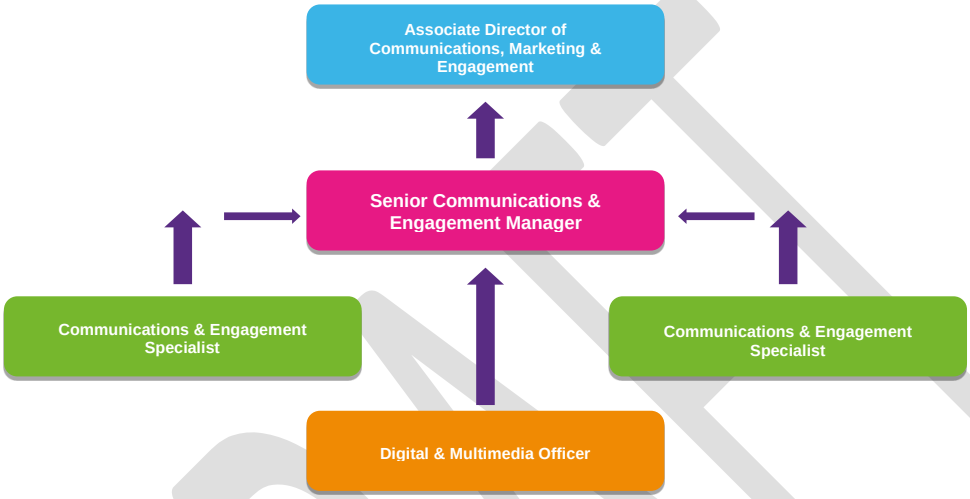
Appendix B outlines the implementation plan. Progress of the plan will be tracked through the existing workforce governance arrangements.

The resources delivering the plan

The responsibility of delivering this plan will be through a recently restructured corporate Communications and Marketing team function.

This restructure follows a decision in 2018 to align the Communications and Marketing Team with the Staff Engagement Team to make better use of available resource and to ensure a clearer vision and centralised direction is achieved.

The corporate Communications, Marketing and Engagement Team currently consist of the following:



In 2018, the line management responsibility for the organisations Medical Photography department transferred to the Communications department. There is great untapped talent available here from a photography, illustration, graphic design and reprographics point of view. Further scoping work is being undertaken to understand how this team can support the organisations objectives. The ambition is to create a fully functioning 'engagement hub' which will offer a proactive drive to communications, marketing and engagement, both internally and externally. This hub will be able to react to the requirements of a newly formed WUTH strategy, five year plan and NHS Long Term Plan.

The success however of the Communications, Marketing and Engagement department, and in many ways its perception, will need to shift from a reactive service into a motivated strategic communications function which fully enhances the vision and future direction of the organisation.

Evaluation

To ensure the objectives of this plan are being met, it will need to be monitored and evaluated.

Existing surveys can be used to monitor progress, and it is intended that the following three key metrics will help assess the effectiveness of internal communications activity:

- **National NHS Staff Survey**
- **Staff Friends and Family Test**
- **Monthly 'temperature' checks across the organisation**

In addition to the above, other key performance indicators (KPIs) will be introduced such as providing a regular update on reputation management through media exposure. Additional analytics such as public and staff website figures as well as analytics for our staff and public social media channels will be gathered on a regular basis.

A monthly report will be produced for the Executive team, called Insight. This will provide an overview of the previous month's communications (internal/external) activity.

Plans are also in place to increase face to face communication between the Communications, Marketing and Engagement team and colleagues throughout the organisation. Ad hoc communication and engagement surveys will be produced for these face to face encounters which will enable us to get qualitative feedback about how we are communicating, and where staff feel improvements can be made.

Measuring the effectiveness of external communications activity, particularly with patients and stakeholders, is more challenging. There are plans to carry out phone calls or face to face interviews with a small number of patient representation groups and stakeholders (including WUTH governors) on a six monthly basis, in order to understand how effectively WUTH is communicating, and/or what additional information channels they wish to have from the organisation.

APPENDIX A

Media and Public Relations Plan

2019

Introduction

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) recognises the significant role the media and journalists can play in the public's perception of our organisation. We aim to maintain strong, professional relationships with the media and with journalists. This Media and Public Relations Plan sets out how we will liaise with the media to maximise positive media coverage and public relations activities and how we will manage actual and potentially negative media coverage.

The plan also covers areas such as the use of facilities at WUTH and use of our grounds for filming and interviewing staff/patients. It also covers patient consent issues, photography and issues around reactive (unplanned) media interest.

Media Relations at WUTH

Media Relations at WUTH is the responsibility of the Communications, Marketing and Engagement team.

The team is responsible for:

- Producing news releases to promote the services, facilities, achievements and successes of the organisation and its staff.
- Producing statements in response to requests for information and/or allegations against the organisation.
- Identifying appropriate spokespeople for quotes and interviews and issuing responses to the media which meet deadlines.
- Ensuring that statements and quotes which are sent to the media in response to reactive (unplanned) and proactive (planned) enquiries are approved by any patients quoted, the member of staff concerned, his/her line manager and, where appropriate, the relevant Executive Director/Chief Executive/Chair. If a patient is unable to consent, approval should be sought from a parent, close family member or legal guardian.
- Protecting patient confidentiality at all times, ensuring compliance with the Caldicott Report (1997) and the Data Protection Act (1998).
- Accompanying reporters, photographers and camera crews when on hospital grounds.
- Providing advice and support to any staff or patients who are responding to a media enquiry or wish to initiate a story (a good news story) and may need help, for example, with a press release.

- Publicise actions taken by the organisation against people who commit offences against WUTH employees, property or premises, where viable in line with NHS England guidance.

Contacting the Communications, Marketing and Engagement Team

During normal working hours (which are normally Monday to Friday, 8.30am to 5.30pm), media and PR enquiries should be directed as follows:

- If the enquiry is deemed urgent and there is potential reputational damage to the organisation which needs immediate attention, this should be directed first and foremost to Mike Baker, Associate Director of Communications, Marketing and Engagement, on Ext 8376, or 0151 604 7003 or email mikebaker1@nhs.net.
- In his absence, other urgent and non-urgent enquiries should go to:
- Lyndsay Young, Senior Communications and Engagement Manger, on Ext 8375 or 0151 604 7640, or email lyndsay.young@nhs.net.
- Angela McLaughlin, Communications and Engagement Specialist, on Ext 7267 or 0151 604 7267, or email angela.mclaughlin@nhs.net.
- Kathryn Green, Communications and Engagement Specialist (Tuesday – Thursday), on Ext 8066 or 0151 604 7762, or email kathryngreen2@nhs.net.
- Charlotte Williams, Digital and Multimedia Officer on Ext 7360 or email charlotte.williams19@nhs.net.
- The general email address for the Communications, Marketing and Engagement team is wih-tr.communications@nhs.net.

The team is committed to providing prompt and accurate responses to queries received from the media.

All out of hours urgent media enquiries should be directed to the on-call executive through the main switchboard on 0151 678 5111.

Postal address: Communications, Marketing and Engagement, D Block, Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral, CH49 5PE.

Handling media enquiries

The Communications, Marketing and Engagement team is the first point of contact for all media enquiries on both proactive (planned) and reactive (unplanned) issues.

Should journalists approach WUTH staff directly on any issue that relates to the organisation, its staff or patients, or to ask for an opinion or comment from a WUTH expert on a medical issue, they should be channelled via the Communications, Marketing and Engagement team so that they may provide appropriate advice or support.

The use of WUTH clinicians, some of whom are nationally renowned in their field of expertise, is encouraged by the organisation as this helps to raise WUTH's profile on a regional and national level. Enquiries such as this should be referred to the Communications, Marketing and Engagement team.

As a part of standard incident reporting routines, staff should inform the Communications, Marketing and Engagement team if they know of an incident or event that has happened which may result in negative publicity and therefore affect the organisation's reputation. This allows the team to look into the facts and prepare a suitable response in case any media enquiries are received.

The team will endeavour to keep staff informed about key media coverage that affects the Trust and also ensure stakeholders are fully briefed about any media enquiries/activity that could have an impact on them (or their members) directly or affect the reputation of the organisation.

It is recognised that clinicians must prioritise their clinical commitments (patient care), but it is important that all staff respond as quickly as possible to media enquiries when asked. This will ensure media reports relating to WUTH are balanced by giving the organisation an opportunity to put across its side of the story and capitalise on any positive opportunities to promote WUTH.

The team will usually contact the Divisional Triumvirate or an appropriate senior manager with any controversial media enquiries. However, if they are not contactable and a quick response is needed, the team may contact any appropriate member of staff to get the information required and ensure deadlines are met. Any reactive statements issued to the media will usually have WUTH executive level sign off prior to it being issued (see below). Exceptions may apply in the case of positive, non-contentious news releases, issued proactively to promote a 'good news' story.

Signing off media statements

A media statement is an official response from WUTH, usually in response to a negative or controversial enquiries received (as opposed to a news release which is issued proactively). Media statements are written by the Communications, Marketing and Engagement team on behalf of the organisation. Media statements relating to a negative or controversial issue are always signed off by a member of the executive team prior to them being issued.

Patient condition checks

The media sometimes request patient condition checks. This usually happens if a patient comes into the hospital through the Emergency Department as these admittances (such as a violent attack, road traffic accident and house fire) create greater public interest for the media to cover and report on.

There may also be rare occasions when condition checks are requested in respect of a celebrity/VIP who has been admitted after an illness or accident.

The following condition checks protocol must **always** be followed:

During working hours (which are normally Monday to Friday, 8.30am to 5.30pm), all media condition check requests should be referred to the Communications, Marketing and Engagement team. A member of the team will contact the relevant unit/ward in order to get this information and discuss whether it is appropriate to release the information. Consent must be sought from the patient or from their next-of-kin/parent/legal guardian via the appropriate manager.

The Communications, Marketing and Engagement team will only provide a media condition check if the journalist has the name of the patient, address and/or date of birth. This is so the team can be sure they are giving out the condition check about the correct patient.

When a media condition check comes into the Communications, Marketing and Engagement team, and the journalist has provided the necessary information as mentioned above, the team will contact the relevant unit/ward and speak to the appropriate manager to request the check.

Only basic information should be provided, on the following scale:

- Patient has been discharged
- Fine
- Satisfactory
- Improving
- Comfortable
- Stable
- Serious
- Critical

If the patient has died, this information should only be given out if the relatives/next-of-kin have been informed of the death and have given consent for this information to be released.

Journalists have been known to contact units/wards directly for patient condition checks. If this does happen, staff must not give out any patient information. Instead staff must refer the journalist to the Communications, Marketing and Engagement team (or on-call executive if out of hours) through the switchboard.

All condition checks received by the Communications, Marketing and Engagement team are logged appropriately.

The same protocol applies for all patients, including a celebrity or VIP.

Outside of normal working hours condition checks should be approved by the executive on call.

Media enquiries about prisoners receiving medical care at WUTH

Although very rare, WUTH may receive media enquiries requesting details (either condition checks or other information) about a prisoner who is receiving medical care at WUTH.

If this does happen, and in the interests of security, it is important that no identification relating to a prisoner, or prison staff, is disclosed by anybody except the Prison Service or Police.

Colleagues from WUTH must not talk to the media about prisoners without permission from the Communications, Marketing and Engagement team or the Prison Service/Police.

Proactive (planned) media relations

One of the roles of the WUTH Communications, Marketing and Engagement team is to maximise publicity for good news stories, provide necessary information to the media and identify suitable members of staff and, where appropriate, patients for interviews.

The team relies on WUTH colleagues to let them know about any good news stories in their division/department/ward that would be suitable to promote via the media.

Stories have different media appeal factors. If you are in doubt about the appeal of a potential news story, please check with the Communications, Marketing and Engagement team. Subjects for positive stories may include:

- New services, procedures or ways of working.
- Awards and accreditations.
- Improvements to services.
- Research projects.
- Personal achievements.
- New medical equipment.
- Positive patient experiences or feedback.
- Anything unusual or out of the ordinary.

News Releases

The Communications, Marketing and Engagement team is responsible for the writing of news releases on behalf of WUTH and can advise when is the best time to send and issue these to the media. All stories will be individually considered and their 'newsworthiness' assessed. Some stories may be considered not appropriate for issuing to the media but may be promoted via other channels e.g. the organisation website, Twitter feed, Facebook page, internal communications, staff magazine, newsletters etc.

If an external organisation/agency wishes to issue a news release that mentions WUTH, this should be submitted to the Communications, Marketing and Engagement team for approval before it is signed off and issued.

VIP (very important person) and celebrity visits to WUTH

WUTH's Chairman and the Executive Team should be made aware of any proposed visits by VIPs or celebrities. The Communications, Marketing and Engagement team should also be advised so that they can provide appropriate advice and support for managing the visit and to manage media interest.

If colleagues are intending to arrange such a visit, they should contact the Communications, Marketing and Engagement team in the first instance so that appropriate guidance can be given.

Published articles and papers

It is recognised that colleagues contribute to medical, scientific or management (specialist) journals. If such information is published, the Communications, Marketing and Engagement team would appreciate details so that they may consider the potential for promoting the information to colleagues and stakeholders via WUTH's communications channels. The team also has strong links with local, regional and national media and may be able to pitch published articles and papers to them to create additional proactive publicity for the organisation.

It is also possible that the publication of articles in specialist journals could prompt media enquiries on both a local and national level. By informing the Communications, Marketing and Engagement team of the content of the article and when it is likely to be published in advance, the team can plan for any follow-up enquiries and be prepared for wider interest in the article.

Interview requests

Requests for interviews, filming and photographs will normally come into the organisation via the Communications, Marketing and Engagement team. If any such requests are made direct to WUTH colleagues, these requests must be redirected to the Communications, Marketing and Engagement team in the first instance.

WUTH colleagues should exercise caution if approached for an interview, comment or information when on organisation premises (or working out in the community) as it is not unknown for reporters to pose as others in order to obtain information (undercover reporting). All requests for comments or interviews should be referred to the Communications, Marketing and Engagement team who can offer the relevant advice.

Any media who come onto WUTH premises should be able to identify themselves, usually by the form of appropriate identification such as an ID badge. The team is able to supply media with a WUTH 'media pass' should this be required.

Members of the media should always be accompanied when on WUTH premises. If any media representatives or film crews are seen inside the boundaries of the organisation's site, and are unaccompanied, please inform the Communications, Marketing and Engagement team or contact security via the switchboard.

Media filming and photography requests

All requests from media for filming or photography on WUTH hospital grounds must be approved and led by the Communications, Marketing and Engagement team. Where possible, a member of the team will be present to oversee any filming/photography. If, for any reason, a member of the team is unavailable to oversee any media request such as filming/photography, a nominated member of staff will be fully briefed prior to any media engagement.

The team will ensure that written consent is obtained from any patients/guardians/visitors involved in media engagement such as interviews/filming/photography. A record of this consent will be kept in the Communications, Marketing and Engagement office in accordance with GDPR guidelines. The team will accept verbal consent from WUTH staff taking part in any media engagement, although consent may be asked for if the media engagement is high level.

Accidental recording of patients/guardians/visitors/staff in the background must be avoided. If

patients/guardians/visitors/staff do not wish to be included, the filming/photography or the location may need to be changed. Photography or film footage must not contain the name of a patient or their personal information without their consent. Media crews who do not adhere to these requests will be asked to stop filming/photographing and leave WUTH premises.

Requests from the media to interview patients

Any requests for interviews with patients and/or next of kin should be directed to the Communications, Marketing and Engagement team. Permission for any interview on hospital grounds will only go ahead if:

- Appropriate written consent is obtained from the patient or a legal guardian/parent for children under the age of 16 years.
- The Consultant/nurse-in-charge/ward manager agrees that the patient is medically fit enough to be interviewed and that it is appropriate to do the interview in hospital and is unlikely to cause disturbance to other patients or interfere with the work of other WUTH staff.

Urgent out-of-hour requests from the media should be referred to the on-call executive through the main switchboard (0151 678 5111). Non-urgent out of hour requests from the

media should be directed to the Communications, Marketing and Engagement team by emailing wih-tr.communications@nhs.net. These requests will be dealt with promptly.

Patients/next-of-kin requests for interviews on hospital grounds

Patients, parents or next-of-kin may contact the media directly about proactive and reactive matters involving the organisation.

All requests for interviews from patients, parents or next-of-kin should be referred to the Communications, Marketing and Engagement team before any media is allowed onto WUTH premises.

The team will assess any such requests on a case by case basis and advise on what involvement, if any, the organisation should have. Under no circumstances should media interviews/filming take place if requested by a patient/next of kin without having prior agreement from the Communications, Marketing and Engagement team, or if out of hours the on-call executive.

Request from media for comment from WUTH on national issues

Media (whether local or national) may contact WUTH and ask for a comment on local or national issues. The Communications, Marketing and Engagement team will advise on whether it is in the organisation's best interest to make a public comment, draft a suitable comment or approve a proposed comment. Such requests/comments will also require executive approval. The Communications, Marketing and Engagement team will also use its discretion on determining whether such a request needs to be escalated to the NHS national communications team.

Major Incidents

A major incident may attract immediate (and possibly large-scale) media interest depending on the nature of the incident or emergency the hospital is dealing with.

It is therefore critical that any media handling is dealt with effectively as the public will turn to the media during a time of major incident. Equal care should also be taken in any public statements issued through social media, which is where many people will turn to for information at such times.

Should a major incident be declared, it is essential that any information given out to the media is accurate, timely and delivered through easily accessible channels, such as the WUTH website and WUTH social media sites, to prevent the media from going elsewhere for information which may be from a less reliable source.

All media enquiries in relation to a major incident will be dealt with by Communications, Marketing and Engagement team, in line with the WUTH Major Incident Plan. In the event of a major incident taking place outside of normal working hours, members of the

Communications, Marketing and Engagement team will be contacted via the hospital switchboard.

Internal incidents

An internal incident is an incident which presents a significant danger to patients, staff and the public or which has the potential to significantly disrupt or harm the reputation of the organisation.

Internal incidents can take a variety of forms, for instance a power failure or explosion. These types of incidents may cause immediate disruption to hospital services, or a perception of disruption and as such may attract media attention similar to that of a major incident.

Should an internal incident occur, it is the role of the Communications, Marketing and Engagement team to manage both internal (staff) and external communications.

In the event of an internal incident taking place outside of normal working hours, the on-call executive will ascertain its severity and whether members of the Communications, Marketing and Engagement team should be contacted (via the hospital switchboard).

- Ends –

APPENDIX B

Implementation Plan

April 2019 – March 2021

Narrative: **Develop a single, compelling narrative for the organisation**			
Activity	**Channel**	**Frequency**	**Status**
Communications, Marketing and Engagement Plan	Document on staff website	Every two years	Completed
Media and Public Relations Plan	Document on staff website	Every two years	Completed
Updated brand guidelines and corporate messaging	Document and templates on staff website Reminders via internal staff channels	As required	Current brand guidelines to be updated once new vision and strategy is launched (Proposed July 2019)
IMPORTANT: Other ***Narrative*** activity will be developed, altered or stopped as this two year plan progresses. **This is a working document**.			

Staff, patient and public communication: **Improve existing internal and external communications channels, including increase in two-way communication**			
Activity	**Channel**	**Frequency**	**Status**
Staff - In Touch *(Focuses on staff stories, as well as their achievements, wellbeing and learning opportunities)*	Email, staff website. Some stories also make staff social media	Weekly. Issued every Tuesday.	To be launched June 2019
WUTH – In Touch *(Updates on key corporate information, and issues affecting the entire organisation)*	Email, staff website, staff social media	Weekly. Issued every Thursday.	To be launched June 2019
Leaders – In Touch *(Nominated managers/ leaders/ clinicians to hear about Executive updates to cascade to their staff)*	Face to Face forum, presentation slides/messages then placed on staff website	Monthly	To be launched June 2019
In Touch Magazine *(Monthly staff magazine covering key corporate stories and staff achievements)*	Digital – staff website and staff social media Print – Distributed across the organisation	Monthly	Completed
Messages from the Board *(A brief summary of the latest Board and its key messages)*	Email and staff website	Monthly	Completed

Staff website *(Relaunched in summer 2018)*	Staff website	On-going	Completed
Staff social media *(WUTH has a growing community using our dedicated staff social media channels)*	Facebook Twitter	On-going	Completed
Safety Bites *(Monthly update of incident learning)*	Email	Monthly	Completed
Screensavers *(Organisation wide messages displayed on as many computer screens as possible)*	Screensaver	On-going	Complete
Staff App *(Further opportunity to engage with colleagues remotely via their smartphone)*	Smartphone	On-going	Currently scoping options to create feasibility report by summer 2019
Senior Visibility *(Continuous opportunity to increase senior visibility where possible)*	Face to Face	On-going with protected time	June 2019
Staff Noticeboards *(Printed material displayed for staff)*	Noticeboards	On-going	Needs relooking at. Piece of work required regrading locations and effectiveness Would digital noticeboards work better? Autumn 2019
Communications and Engagement roadshows *(Greater opportunities for the Communications and Engagement team to get out and about)*	Face to Face	Fortnightly	Regular diary time for the team to go out and visit teams/department Summer 2019
Global emails *(Urgent communication to staff)*	Email	As required	Completed, but needs developing and reducing where possible
IMPORTANT: Other ***Staff, patient and public communication*** activity will be developed, altered or stopped as this two year plan progresses. For patient communication, please see 'Stakeholder engagement' below. **This is a working document.**			

Engaging campaigns: **Provide communications support for major organisational campaigns, initiatives and plans - e.g. Vision, Values and Behaviours work and/or Patient Flow, Outpatients and Planned Care**			
Activity	**Channel**	**Frequency**	**Status**
NHS Staff Survey	Face to face, social media, public and staff websites, email bulletin, presentation.	Annual	Completed this year and ongoing annually. Survey period is September – November.
Digital journey	Face to face on wards, presentations, stakeholder meetings, public events, email bulletin, WUTH websites, social media, posters.	On-going.	Completed and tasks ongoing.
Service Improvement	Marketing materials, email updates on stats, patient discharge booklet	On-going	Completed and tasks ongoing.
Flu	Social media, posters, email updates, website, face to face	Annual	Planning starts summer.
Vision, Values & Behaviours	Workshops, surveys (online and physical), face to face, presentations, email bulletins, websites, social media, physical branding.	Ongoing	Completed workshops and moving on to next stages of implementation.
Wirral winter	Video, social media, email bulletin, websites.	Annual	Planning starts summer.
Recruitment	Social media campaign, websites, marketing, recruitment events.	Ongoing	Completed and ongoing.
IMPORTANT: Other ***Engaging campaigns*** activity will be developed, altered or stopped as this two year plan progresses. **This is a working document.**			

Stakeholder engagement: **Drive, manage and oversee an engagement programme with local and national stakeholders**			
Activity	**Channel**	**Frequency**	**Status**
Media Relations *(Increase the number of positive stories being sourced and provided to the media)*	News Releases	On-going	Positive, credible news releases issued as appropriate – April 2019 Develop a wider and targeted media distribution list – July 2019 Provide greater media training opportunities to staff
GP and Primary Care	CCG newsletter	Issued on Wednesdays by the CCG	Regular update at least once a month on WUTH news. Completed.
MP	Newsletter and Face-to-face	Quarterly	Sent direct through email. Autumn/Winter 2019
Councillors	Newsletter	Quarterly	Sent direct to councillors via email addresses. Same as MP newsletter. Autumn/Winter 2019.
Local Authority	Internal Communications via Press Office.	Ongoing	Ad-hoc as and when council staff require information. Completed.
Local healthcare	Link in with internal communications / newsletters for Community Trust etc	Ongoing	Regular updates from WUTH. Completed.
3rd Sector	Newsletter	Quarterly	Email same newsletter as MPs and councillors. Autumn/Winter 2019.
Regulators	Dashboard / newsletter	Quarterly	Emailed to regulators Autumn/Winter 2019.
Governors, Members and wider Public	Social media / Press / Face to Face?	Ongoing	Regular social media and media articles. Also face-to-face interaction/patient stories etc As required.
IMPORTANT: Other ***Stakeholder engagement*** activity will be developed, altered or stopped as this two year plan progresses. **This is a working document.**			

***Celebrate our success:* Celebrate our successes internally, amongst staff, and in mainstream and social media**			
Activity	**Channel**	**Frequency**	**Status**
Staff Awards	Awards ceremony / marketing and PR / media relations / internal communications.	Annual	Planned for this year. Event to run Autumn.
Recognition cards	Physical cards	On-going	Delivered to wards. Completed.
Staff/patient stories	Staff magazine, staff and public websites, social media, press.	On-going	Completed and ongoing stories to be covered.
News Releases	Local and national newspapers, radio, TV.	On-going	Completed and ongoing with further news releases.
Employee of the Month	Staff magazine / social media / public and staff websites	On-going	Re-launch planned for this year Summer 2019.
Team of the Month	Staff magazine / social media / public and staff websites	On-going	Re-launch planned for this year Summer 2019.
Incentives eg discounts, gifts	Fruit baskets, competition prizes, websites updated with staff benefits.	On-going	Weekly fruit basket is being delivered. Competitions are monthly in the staff magazine.
External awards	Award ceremony / media relations / social media / email bulletin.	Ongoing	Completed but also ongoing for further awards.
Long service certificates	Awards ceremony	Annual	Completed for 25 and 40 years. Presented by the Chair.
Retirement certificates	Certificates	On-going	Completed for all who retire. Presented by the Chair.
IMPORTANT: Other ***Celebrate our success*** activity will be developed, altered or stopped as this two year plan progresses. **This is a working document.**			

Board of Directors	
Agenda Item	16
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	4th September 2019
Author	Joe Gibson, External Programme Assurance
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

SUMMARY

1. Overview

The scope (see slide **2**) of the Change Programme has changed during the past month. The Programme Board confirmed - at its meeting of 21 August 2019 – that the 'Quality, Safety and Governance' work stream would be managed outside the change programme and governed as 'business as usual' improvement work. Moreover, for the next iteration of the scope, the 'Hospital Upgrade' project and the 'World Class Administration of Patient Services' project would be introduced.

Otherwise, the Executive Team continues to direct enhanced focus on the three large **priority** projects within the Change Programme; Patient Flow, Outpatients and Perioperative care.

The overall ratings assessments (see slides **3 and 4**) have altered:

1.1. Governance Ratings

Two projects moved from amber to green rated while one project deteriorated to red rating, based upon the SharePoint evidence. SROs should act to secure an increase in green ratings underpinned by assurance evidence; all change, in a safety critical system, needs to be transacted within a transparent and safe framework.

1.2. Delivery Ratings

This month has seen an improvement, to the tune of two projects moving from amber to green and two projects moving from red to amber. For the sake of clarity, amber rating remains indicative of substantive issues albeit considered within the competency of the project team to resolve. The areas for attention are the definition and realisation of benefits and robust tracking of milestone plans.

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

DELIVERY

2. Programme Delivery – Priority Areas

Responding to the request from the Board of Directors in their meeting of May 2019, each month the metrics from the three priority project reports to Programme Board will feature in this report. This will allow Board members to see transparently the dials that are being used to monitor the impact of the project work. It will be an opportunity for the Senior Responsible Owners (SROs) of those projects to describe to the Board the progress being made, challenges encountered and solutions being implemented.

2.1 Flow. The metrics for the Flow project are shown at slide **6**.

2.2 Perioperative. The metrics for the Perioperative Medicine project are shown at slide **7**.

2.3 Outpatients. The metrics for the Outpatients project are shown at slide **8**.

3. Service Improvement Team

Recruitment into the new Service Improvement Team (formerly known as the Strategic Transformation Team) structure has been completed; the interviews were completed over the four days of the 29 July and 13-15 August. Appendix 1 refers to the new structure and all posts were successfully appointed to. The quality of candidates for all bands was extremely high and those selected offer excellent technical experience across programmes/projects as well as first rate personal characteristics. The quality and number of candidates applying speaks to the positive reputation of the Trust and the desire of a wide range of NHS staff to work here.

There will remain gaps in the team establishment for some 2-3 months as we await notice periods to be served and the new staff to arrive. However, the remaining team members and project teams are working hard to mitigate any impact and the maintenance of the assurance ratings is testament to their efforts over recent weeks which are to be commended.

ASSURANCE

4. Programme Assurance - Ratings

The attached assurance report has been undertaken by External Programme Assurance and provides a detailed oversight of assurance ratings per project. The report provides a summary of the assurance provided to the Trust's Programme Board as a gauge of the confidence in eventual delivery. The actions needed to improve those confidence levels are described in the assurance statements for each project and this independent monitoring will continue to assess the assurance evidence. The assurance evidence has been discussed at the Programme Board meeting (the membership of which includes a non-executive director) held on Wednesday 21st August 2019.

5. Assurance Focus

In aggregate, the assurance ratings for the top 3 priority projects - namely Flow, Perioperative Care and Outpatients - carry much greater weight than the other 6 projects. This weighting is true not only in terms of their significance to the Trust mission in the near term but also the size and degree of difficulty of the work involved.

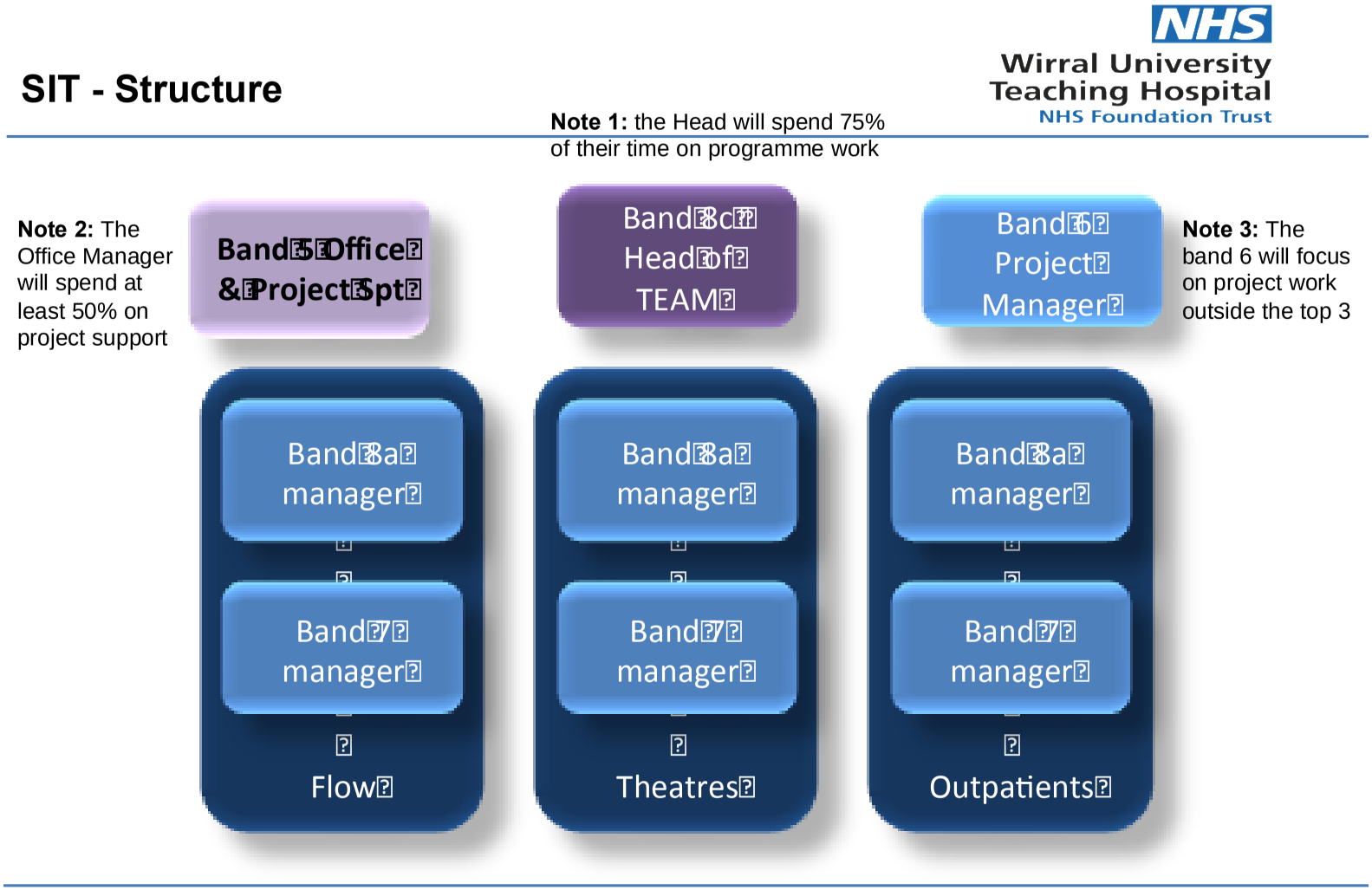
The first page (slide **10**) of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress.

6. Recommendations

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

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

Appendix One – Resource Structure of the Service Improvement Team



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Change Programme Summary

External Programme Assurance

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NHS Foundation Trust

P Priority Project

S Suspended Project

WUTH Trust Board of Directors

Programme Board – CEO Chair

Workforce Planning (WRAPT) SRO - Helen Marks

Improving Patient Flow
SRO - Nikki Stevenson

- P Ward Based Care for Earlier Discharges **Lead: Shaun Brown**
- P Transformation of Discharge Services **Lead: Shaun Brown**
- P Command Centre **Lead: Shaun Brown**
- P Assessment Review **Lead: Shaun Brown**

Operational Transformation
SRO - Anthony Middleton

- P Perioperative **Lead: Jo Keogh**
- P Outpatients **Lead: Alistair Leinster**
- Diagnostics Demand Management **Lead: Alistair Leinster**

Quality, Safety & Governance
SRO - Paul Moore

Pipeline 'Themes'

- A Positive Patient Experience
- Care is Progressively Safer
- Care is Clinically Effective and Highly Reliable
- We Stand Out

Digital
SRO - Nikki Stevenson

- GDE Meds Management **Lead: Pippa Roberts**
- GDE Device Integration **Lead: TBD**
- GDE Image Management **Lead: TBD**
- GDE Patient Portal **Lead: Mr David Rowlands**

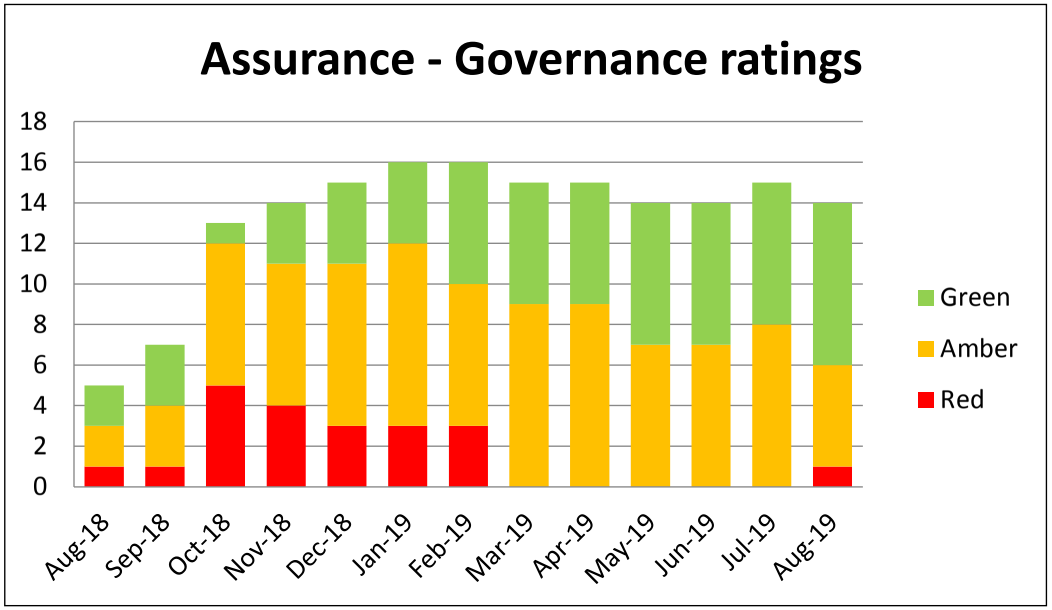
Partnerships (GDE Enabled)
SROs - per programme

- **Healthy Wirral** Medicines Optimisation **Lead: Pippa Roberts**
- S **Wirral West Cheshire Alliance** Pathology **Lead: Alistair Leinster**

Change Programme Assurance Report - Trust Board Report - August 2019

S Brimble – Project Support

Wirral University Teaching Hospital NHS Foundation Trust



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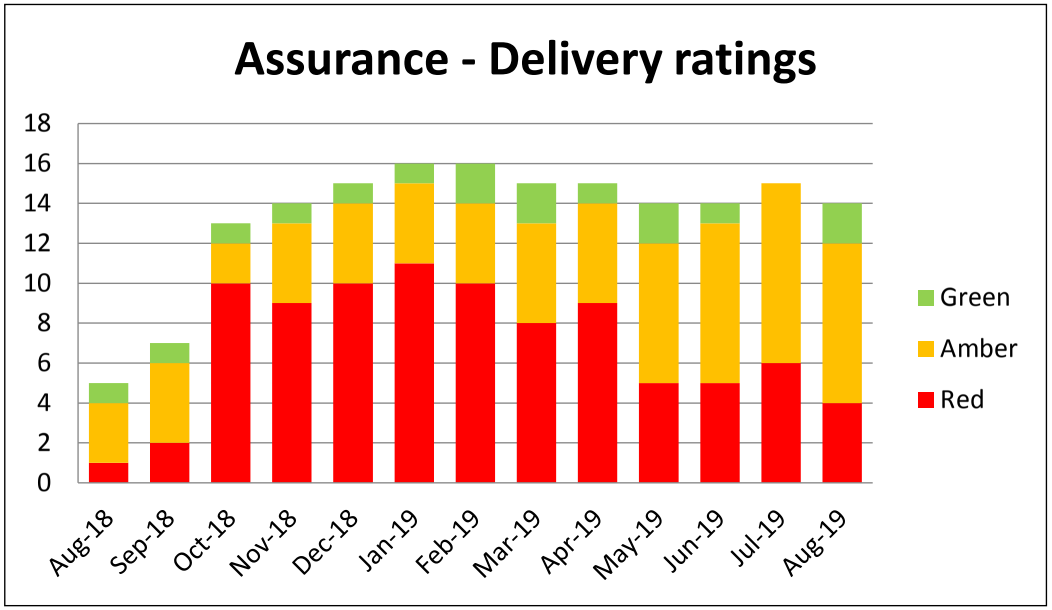
Change Programme Assurance Report - Trust Board Report - August 2019

S Brimble – Project Support

Wirral University Teaching Hospital NHS Foundation Trust



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Priority Projects Highlight Report - Metrics

Senior Responsible Owners

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Highlight Report – Patient Flow Improvement
Reporting Period – July 2019
Programme Lead – Nikki Stevenson

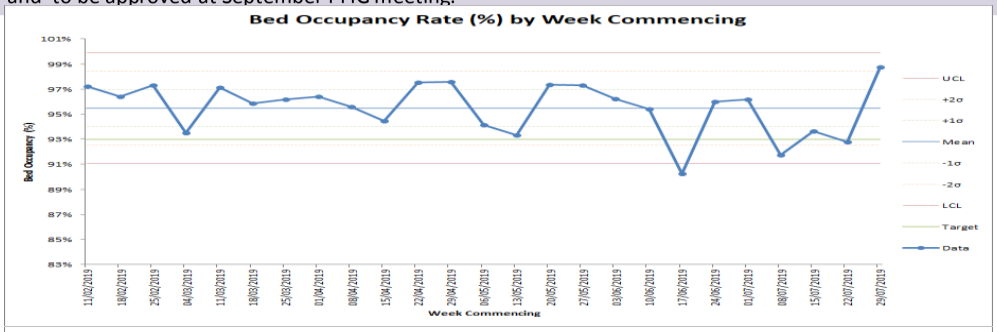
Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	Ward Based Care: PID, TOR & Milestone plan being revised to incorporate Transformation of Discharges and recommendations following ECIST support, to be signed off at Sept' PFIG. Assessment review: Milestone plan to be updated and KPIs to be developed.
Green	Red	Command Centre: expected benefits and metrics to be confirmed

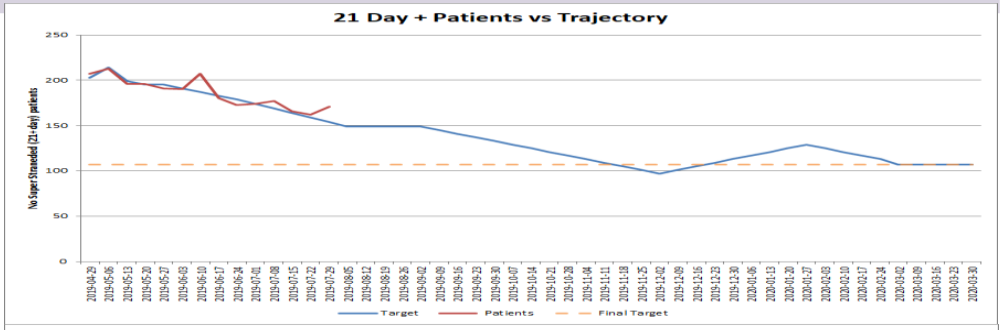
3 things you need to know

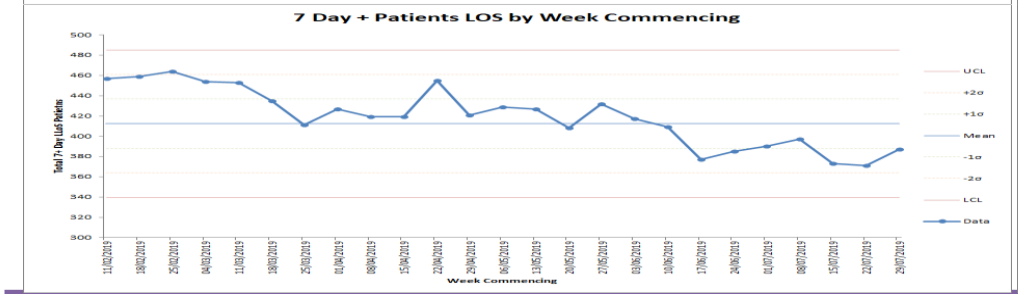
Continued focus on 21 day + LOS patients in line with ECIST reporting requirements, 12 week intensive support in place to address recent increase in 21 day + LOS above the trajectory. As per advice from ECIST the 7 day LOS metric will be replaced with ED LOS from next month.

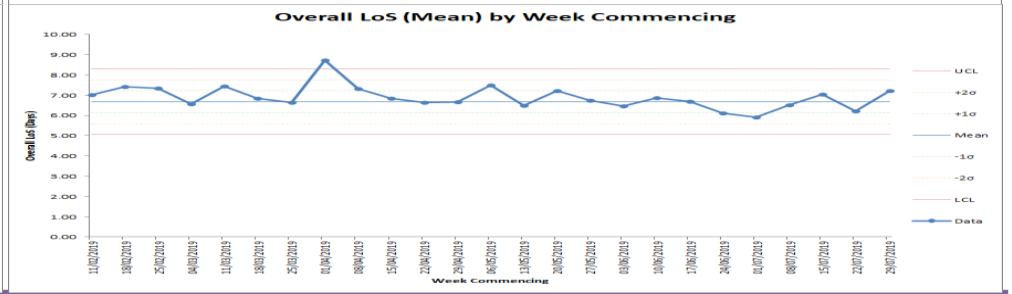
Go live date for Capacity Management (CM) and LanchPoint is now planned for 18th Nov 2019. Due to operational pressures with the ECIST intensive support programme within the Trust, ED staff cannot be released for training until w/c Monday 30th September. and therefore the project team recommend a Go Live for both systems at the same time so as not to delay CM.

UMAC (Urgent Medical Assessment Unit) 'go live' occurred on 22nd July '19. Ward 17 and SAU swapped locations on 1 August '19 which will facilitate the surgical assessment review. Scopes for SAU & GAU defined and to be approved at September PFIG meeting.









Escalation

None

Highlight Report – Perioperative Medicine
Reporting Period – August 2019
Programme Lead – Jo Keogh

Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	A review of current KPI's thresholds will be undertaken to ensure that they are fully reflective of programme progress and position.

Four things you need to know

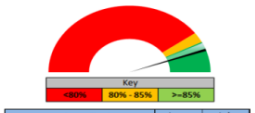
Main Focus: Three phase recovery scheme has been submitted as a capital priority to the Executive Team for consideration to fund

Theatre Scheduling System – tender process did not generate any viable interest. The Trust's IT Team have developed an in house solution that the Perioperative Medicine Steering Group have approved and asked the team to progress

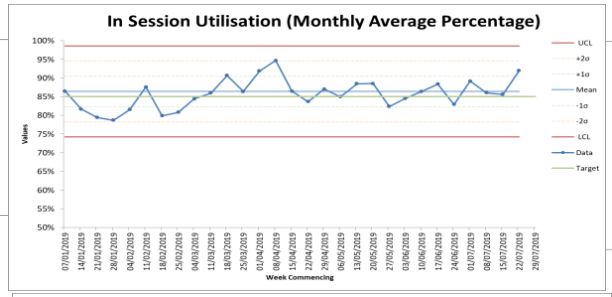
Pre-Op move to main outpatients is scheduled for 27 August

Meeting arranged with Joe Gibson to discuss potential revision of KPIs

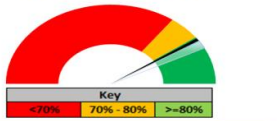
In-Session Utilisation



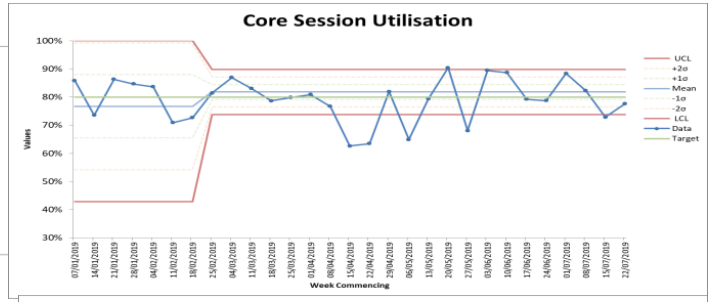
In Session utilisation (Monthly Average %)	June	July
	85.5%	88.5%



Core Session Utilisation

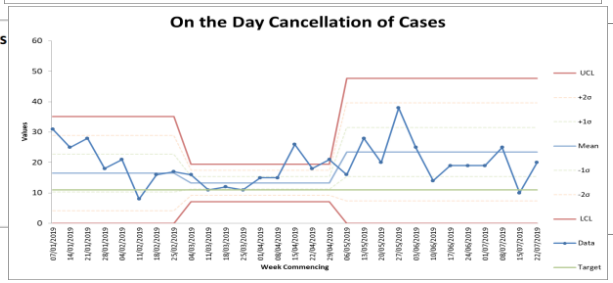


Core session utilisation Target 80% of 52 week capacity	June	July
	83.8%	80.5%



Avg On the Day Cancellation of Cases

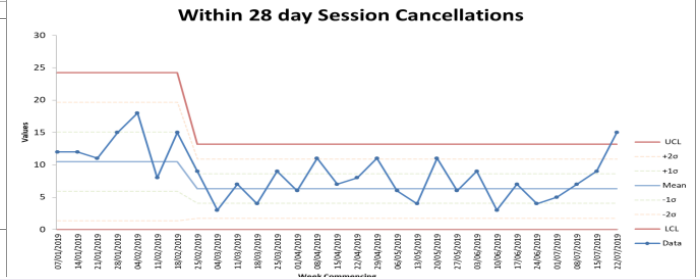
Case Cancellations on the Day – Reduce to a Daily Avg of 11	June	July
	19.8	18.5



Late Cancellation of Sessions

Minimise session cancellation within 28 days of session date (four week lockdown)	Target
	0

April	37
May	33
June	23
July	42



Escalation

Nil.

Highlight Report – Outpatients
Reporting Period – July 19
Programme Lead – Alistair Leinster

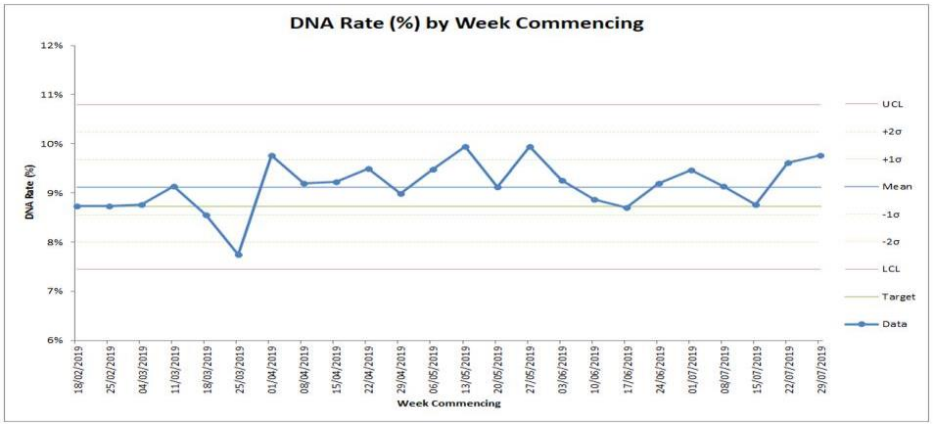
Overall Governance	Overall Delivery	Plan to turn green
Green	Green	N/A

Things you need to know

Current delivery of outpatient activity levels now meeting overall contract plan. Project plans per workstream developed and signed off to ensure clarity on actions and next steps. Achieved green ratings for both Governance and Assurance ratings this month.

Outpatients Engagement Workshop with DDs, DMs and Clinical Leads is being arranged for start of October to communicate the outpatients vision & objectives and to provide specialty specific clinic information to support the identification of opportunities for providing non face to face activity. Rapid improvement work to develop models for 'enablers'.

E-Triage options appraisal being developed following the feedback on costings around image capture software. A demo of e-Referral Service-Advice & Guidance functionality to the project team has provided input into the planning for the engagement workshop along with case studies from implementation at other Trusts.



- Activity vs plan in development
- New : Follow up ratio will be available once benefit start date has been identified

Escalation

Nil

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Programme Assurance Ratings

Joe Gibson
21 August 2019

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Change Programme Assurance Report -
Trust Board Report - August 2019 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance		Delivery	

- **'Ward Based Care for Earlier Discharges'** There is now a comprehensive communications plan TOD v3, 5 Mar 19, and this will need tracking to assure delivery. There is also evidence of stakeholder engagement uploaded to 7 Jun 19. There is a 'TDS Internal Plan' updated to Jul, now with significant delays (in excess of 2-3 months) and no revised milestone plan to deliver this element. The key KPI - Long Stay Patient Improvement Trajectory (Target) to reach 282 by Oct 19 shows information to June 2019; there is clear improvement but not yet achieving target trajectory.
- For he **'Command Centre'** there is now evidence of widespread stakeholder engagement with clinical groups across the Trust up to Aug 19**.**
- For **'Transformation of Discharge Services',** there is now a comprehensive communications plan TOD v3, 5 Mar 19, and this will need tracking to assure delivery. There is also evidence of stakeholder. engagement uploaded to 7 Jun 19.
- The '**Assessment Review (Medical)'** scope document comprises the PID v0.6 dated 24 Jun 19, for the 'Medicine & Acute Assessment Unit Review'; this has now been signed off by the Steering Group.

Perioperative Medicine Improvement	Governance		Delivery	

- The **'Perioperative Medicine Improvement**' Steering Group is governing with evidence of meetings to 6 Aug 19; an action log is now in place to assist governance.
- There is extensive evidence of wider stakeholder engagement uploaded to 8 Jul 19 and including the May-July Divisional Newsletter. A communications plan is now available, this will need to be tracked.
- The revised milestone plan, now updated to dated 1 Aug 19, is a detailed and well tracked document and has been re-baselined (to archive previous delays) by means of an Exception Report to the May Programme Board.
- The four metrics being tracked, monthly – Core Session Utilisation; In-session Utilisation; Avg On the Day Cancellation of Cases; and Late Cancellation of Sessions . These KPIs, developed in the PID, are tracked on the dials and supporting data uploaded on 8 Jul 19; they continue to show an overall 'amber' rating but with positive trends.

Outpatients Improvement	Governance		Delivery	

- The **'Outpatients Improvement'** project team is in place with ToR agreed at the meeting of 1 Nov 18 and documents to evidence the meetings up to 5 Aug 19.
- A detailed Gantt chart has now been produced, uploaded 15 Aug 19, to cover 2019/20 following approval of the revised PID; this is being tracked to show progress against milestones.
- The number 1 KPI for the programme, achievement of plan, is reported as being consistently delivered and the delivery status reflects that overall position (albeit other metrics may not all be precisely on track).

Workforce Planning - Programme Assurance Update – 21 August 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a revised PID v0.2 dated 16 Mar 19 has been drafted with benefits described; however, there are no benefits start dates or metrics identified (that could lead to estimated financial benefits). **2. & 3.** There is now evidence of regular meetings up to 12 Aug 19**. 4.** There is now evidence of some stakeholder engagement in the form of engagement events in Oct/Nov 18 but further evidence of engagement through 2019 is required. **5.** EA/QIA are now signed off. **6.** High level planning dates are in the PID (delays from original dates are not explicit) and there is now a trackable Gantt chart plan that exists as a stand alone document and has been updated to Aug 19 (with revised dates for at least one task to be entered). **7.** There is now evidence of a Workforce Dashboard (Trust Level) dated 22 May 19 but no explicit link to programme metrics or start dates attached; it is stated that these will be completed following the pilot stage. **8 & 9.** There is a risk register v1 and last review date of 7 Jun 19 - the RAID Log also records the 1 live issue. **Most recent assurance evidence submitted 15 Aug 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 – 21 August 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. The scope document comprises the 'Final Approved' PID, TDSS Issue v1.0 dated 7 May 19, for the 'Transformation of Discharge Services Sustainability Programme'. There is also now a 'Long Stay Review SOP' uploaded on 8 Jul 19. 2. Project Team names are now complete on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v7 dated April 2019) and there is also a comprehensive action log updated to 3 Jun 19. **4.** **5.** EA/QIA have been completed for an 'Independent Provider Led Discharge Unit'. **6.** There is a 'TDS Internal Plan' updated to Jul, now with significant delays (in excess of 2-3 months) and no revised milestone plan to deliver this element. **7.** The key KPI - Long Stay Patient Improvement Trajectory (Target) to reach 282 by Oct 19 shows information to June 2019; there is clear improvement but not yet achieving target trajectory**. 8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed up to 2 Jul 19. **Most recent assurance evidence submitted 8 Jul 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		●	●	●	●	●		●	●	●	●

Command Centre - Programme Assurance Update – 21 August 2019

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

Independent Assurance Statement

1. The PID, draft v0.5 dated 26 Jul 19, lacks metrics by which benefits will be measured and these are in the process of being developed. There are also business cases pending for: 'Domestic Service' dated 23 Jul 19 and 'Capacity Management Devices' dated 12 Aug 19 (approved at the interim PFIG 12/08/19). **2. & 3.** Evidence of documented project meetings is available up to the action log updates post the meeting of 12 Aug 19 and ToRs are also in evidence. **4.** There is now evidence of widespread stakeholder engagement with clinical groups across the Trust up to Aug 19. **5.** EA has been drafted and QIA signed-off. **6.** The new Command Centre Project Plan has been updated to 9 Aug. 19 shows a number of delays of 2 to 3 months. **7.** As described above, there are no metrics as yet for the benefits to be measured; these are still in development as the benefits are intrinsically linked to patient flow. **8 & 9** There is a RAID Log showing the date of risks last reviewed as 8 Aug 19. **Most recent assurance evidence submitted 14 Aug 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											

Transformation of Discharge Services - Programme Assurance Update – 21 August 2019

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

Independent Assurance Statement

1. The scope document comprises the 'Final Approved' PID, TDSS Issue v1.0 dated 7 May 19, for the 'Transformation of Discharge Services Sustainability Programme'. **2.** Project Team names are now complete on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v7 dated April 2019) and there is also a comprehensive action log updated to 3 Jun 19. **4.** There is now a comprehensive communications plan TOD v3, 5 Mar 19, and this will need tracking to assure delivery. There is also evidence of stakeholder engagement uploaded to 7 Jun 19. **5.** EA/QIA have been completed for an 'Independent Provider Led Discharge Unit'. **6.** There is a 'TDS Internal Plan' updated to Jul, now with significant delays (in excess of 2-3 months) and no revised milestone plan to deliver this element. **7.** The key KPI - Long Stay Patient Improvement Trajectory (Target) to reach 282 by Oct 19 shows information to June 2019; there is clear improvement but not yet achieving target trajectory. **8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed up to 2 Jul 19. **Most recent assurance evidence submitted 8 Jul 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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			●	●	●	●	●		●	●	●	●

Assessment Review - Programme Assurance Update – 21 August 2019

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

Independent Assurance Statement

1. The scope document comprises the PID v0.6 dated 24 Jun 19, for the 'Medicine & Acute Assessment Unit Review'; this has now been signed off by the Steering Group. **2.** Project Team names are now complete on this dashboard. **3.** Agenda and papers in evidence for the 'Acute Medicine Clinical Governance Team Meeting' of 17 May 19 with Action Log to 28 Jun 19. **4.** There is a communications plan dated 5 Jul 19 which will need tracking to assure delivery; there is extensive stakeholder evidence up to 24 Jul 19. **5.** EA drafted and QIA has now been signed-off (7 Aug 19). **6.** The milestone plan has been updated to 13 Aug 19 (needs some minor formatting issues addressing); there are some delays to key milestones. **7.** There is no evidence yet of measurement of KPIs. **8. and 9**. Risks and issues are featured in a RAID Log and were reviewed up to 28 Jun 19. **Most recent assurance evidence submitted 7 Aug 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														
2.4	**Assessment Review**	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		●	●	●	●	●		●	●	●	●

Perioperative Medicine Improvement – Programme Assurance Update – 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Jo Keogh	Gaynor Williams	Implementation	Green	Amber

Independent Assurance Statement

1. The PID v5 dated 8 Apr 19 has a comprehensive set of objectives and measurable benefits defined with metrics; it was signed off by the Project Board on 8 Apr 19. **2.** A Project Team is in place with a wide range of activity in evidence. **3.** The Perioperative Medicine Steering Group is governing with evidence of meetings to 6 Aug 19; an action log is now in place to assist governance. **4.** There is extensive evidence of wider stakeholder engagement uploaded to 8 Jul 19 and including the May-July Divisional Newsletter. A communications plan is now available, this will need to be tracked. **5.** The QIA has now been revalidated. **6.** The revised milestone plan, dated 1 Aug 19, is a detailed and well tracked document and has been re-baselined (to archive previous delays) by means of an Exception Report to the May Programme Board. **7.** KPIs are developed in the PID. The dials and supporting data, uploaded on 8 Jul 19, show an overall 'amber' rating but with positive trends. **8 and 9.** Evidence in place concerning risk and issue management and 'date of last review' information now added to 4 June 19. **Most recent assurance evidence submitted 6 Aug 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 - 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	TBC	Implementation	Green	Green

Independent Assurance Statement

1. Issue version of PID v1.0 dated 10 Jun 19 was approved at Operational Transformation Steering Group on 10 Jun 19. **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 meetings up to 5 Aug 19. **4.** There is now a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan 19 (this will need tracking) as well as action planning from stakeholder workshops; detailed engagement/information packs developed for all specialties, an example is on SharePoint. **5.** The signed QIA has been submitted. **6.** A detailed Gantt chart has now been produced, uploaded 15 Aug 19, to cover 2019/20 following approval of the revised PID; this is being tracked to show progress against milestones. **7.** The two KPIs now being tracked - 'Cancellations within 6 weeks' and 'DNA Rate' - are both consistently tracking above target. **8 and 9.** There is a comprehensive RAID Log in evidence with risks and issues last uploaded on 5 Aug 19. **Most recent assurance evidence submitted 15 Aug 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 - 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Clare Jefferson	Design	Green	Amber

Independent Assurance Statement

1. The project PID, ISSUE v1.0 was approved (as draft version 0.9) at the Operational Transformational Steering Group meeting on 13 May 19. It is supplemented by a BOSCARD, 'Initiation Pack' and the paper 'Unwarranted Variation & Demand Management: Pathology Tests', A Bamber. **2.** A project team is defined. **3.** There is a comprehensive meetings log with agendas and action notes to 5 Aug 19 and associated action log. 4. There is a stakeholder mapping assessment and the Comms Plan has been incorporated into the Project Milestone Plan where it is tracked. There is evidence of stakeholder engagement uploaded to May 19. **5.** A QIA/EA has been drafted and QIA has been signed off on 18 Mar 19. **6.** A comprehensive milestone Gantt chart plan has been developed, dated 8 Jul 19, on which tasks have been updated to Jul 19 and which shows delays to some 50% of milestones (albeit many delays are short lived). **7.** There is now a comprehensive document describing baselines, targets and trajectories together with a full financial profile; however, the first benefit start date planned for June 2019 has been delayed to July and so an advisory 'amber' rating has been applied. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as v2.2 of 5 Aug 19. **Most recent assurance evidence submitted 12 Aug 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);	Anthony Middleton		●	●	●	●	●		●	●	●	●

Digital: GDE Medicines Management – Programme Assurance Update – 21 August 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. All PID metrics cross-referred to SoPB: OPD PID v3 dated 24 Apr 19; AMS PID v6, 24 Apr 19; MAT NNU PID v4, 24 Apr 18; MED Eye PID v5, 24 Apr 19; Paper Charts PID v2, 24 Apr 19; EPMA in OPD PID added 4 Jan 19; metrics required for benefits. **2.** The 'Programme Core Team' now complete. **3.** ToR Issue 2 dated March 2019 'Pharmacy Medicines Optimisation and Informatics Group' in evidence. Notes of VTE meetings available to 28 Jun 19. PIDs now approved by the 'Project Board'. **4.** Some limited evidence available of wider stakeholder engagement. **5.** No EA/QIA in evidence**. 6.** AMS PP v3 1 Mar 19 appears to be complete, not clear if sustain & review phase is planned; Analytics PP 6 Sep 18 shows sustain & review gate required; Mat and NNU PP v4 dated 9 Sep 18, shows significant delays; MED Eye PP v2, 5 Apr 19, shows significant delays. Paper Charts PP v 25 Jan 19, now largely out of date and no sustain and review period planned. Pharma Outcomes PP v1 20190702 uploaded 13 Aug 19. **7.** Of the 20 benefits defined on the 'Meds Benefits Matrix' uploaded March 2019, none has an implementation date and there are only 3 with targets; however, all PIDs now refer to the SoPB. **8 & 9.** Risks & Issues: RAID Log v22, 24 May 19; risks reviewed 27 Mar 19. **Most recent assurance evidence received 10 Jul 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**	This meeting exists to monitor progress of the agreed and ratified GDE Medicine programme. To ensure that appropriate resources are available to meet the requirements of the programme and objectives and benefits are identified and realised. There is also an acknowledgement that it is essential that BAU work for the Pharmacy service is carried out in parallel. It is understood that BAU and GDE projects will impact on each other as essentially the same resources are required for both. This meeting will support prioritisation of work for both BAU and GDE projects.	Nikki Stevenson		●	●	●	●	●		●	●	●	●

Digital: GDE Device Integration – Programme Assurance Update – 21 August 2019

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

Independent Assurance Statement

1. Infusion Pumps GDE PID v0.4, 23 Feb 19; benefits to save nurses time, prevent inaccurate data into EPR (no metrics). PCECG GDE PID v0.3, 01102018; benefits 'tbc'. Vitalslink GDE PID v0.8, 23 Feb 19; benefits: a. save nurses time @ 30,665 hours by Apr 2020 b. ensure all basic observations are recorded accurately - details provided for Mar - May 18 has shown a decrease "in error" rate to 0.1119% (baseline 0.2161%). SECA PID v0.6 dated 23 Feb 19 has objectives and 1 of 3 benefits defined. **2.** 'Core Team' names on dashboard completed. **3.** Device Integration Project team minutes in evidence to 12 Feb 19. PIDs have now been approved (Feb 19) in a 'Project Board'. **4.** 'Vitalslink Communication Plan', 30102018, is a schedule for Proj. Board and not evidence of engagement. **5.** No EA/QIA in evidence. **6.** SECA Project Plan, 5 Jul 19, shows some delays. Infusion Pumps project plan, 25 Jan 19, needs to show completion/progress of tasks. Device Integration Plan v0.10 4 Dec 18 has many elements complete but overdue 'Go Live' in Paediatrics from Jun 18; plan now completes Feb 19. PCECG Roll Out Plan 4 Jul 19, largely on track. Vitalslink Roll-Out Plan of 27 Jun 19 is just commencing. **7.** No evidence of tracking of benefits. **8 & 9**. Evidence of review of risks on SharePoint to 12 Feb 19 (register needs date of last review). **Most recent assurance evidence received 5 Jul 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**	To connect and integrate Medical Devices with Wirral Millennium enabling the automation of results recording in the following areas: Observations, ECG's and Infusion Pumps	Nikki Stevenson		🟡	🟢	🟢	🔴	🔴		🟡	🔴	🟡	🟢

Digital: GDE Image Management - Programme Assurance Update - 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Nikki Stevenson	Michelle Murray	Implementation	Amber	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 have been completed. **3.** Evidence of project meetings: Medical Photography to 18 Apr 19 and Carestream to 25 Apr 19. **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.** Revised Project Plan, dated 4 Jul 19, received for Med Photo which appears largely on track. Bronchoscopy Plan previously updated to March 2019 and now significantly out of date. Theatre Plans updated to 3 Jul 19 and appear largely on track. Colposcopy PP 07112017 started and finished in Nov 17 has been submitted (but not clear why). **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** A consolidated 'Risk and Issue Log' is now in use, updated to 20 Jun 19, and needs a 'date of last review' column for risks. **Most recent assurance evidence received 8 Jul 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 - 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Mr David Rowlands	Katherine Hanlon	Implementation	Red	Amber

1. PID v1.5, 25 Oct 18, approved by project board on 28 Jun 17. 3 benefits reducing follow-up O/P appts for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit baseline cited for Urology with £36.5k target). Patient Story defines patient benefit. **2.** The 'Programme Core Team' names on this dashboard to be completed. **3.** Minutes of the Project Meeting available to 12 April 2019. **4.** There is a Comms Plan, v4 24 Oct 18, which has some activities recorded but lacks forward looking schedule; there is also a presentation to Project Board of 20 Mar 19. **5.** No EA/QIA in evidence. **6.** Milestone Plan, v1.6 of 5 Mar 19, is tracked but behind schedule in some areas. **7.** 2 graphs show, prospectively, the level of benefits expected from 2020. **8 & 9,** Risks and Issues: RAID Log, 1 Apr 19, captures risks and issues and these were - for the most part - last reviewed at the Project Board of 23 Mar 19. **Most recent assurance evidence received 8 May 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 Cerner Millennium electronic medical record (EMR). The patient portal is essential for remote surveillance and self - management of patients living beyond cancer. The portal, along with a robust tracking system will allow for patients to be managed remotely and therefore reduce the amount of follow ups required within a hospital setting.	Nikki Stevenson											

Partnerships: Women & Children's - Programme Assurance Update – 21 August 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Gary Price/Joe Downie	TBD	Implementation	Amber	Red

Independent Assurance Statement

1. Scope is in: 'Appendix 1, Wirral and Western Cheshire Women and Children's Alliance objectives and KPIs: Summary. Revised Nov 18 Overview'; a PID has been uploaded but appears to be at least 12 months out of date. A Women's & Children's Alliance slide pack, Mar 19, also available. **2.** 'Programme Core Team' in place. Minutes of a W&C Alliance Leadership Group of Wednesday 20th March 2019 are available. **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 some evidence of strategic engagement and a recent start on an incomplete process map for the Paediatric Hub. **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. **7.** There are 7 KPIs associated with the programme reported on SharePoint these are being rated: 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 4 Apr 18.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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
Collaboration - Women and Children															
6.2	**Women and Childrens**	The Cheshire and Mersey STP calls for local solutions for women and children's services to address workforce and quality challenges	TBD												

As agreed at the Programme Board on 19 June 2019: project removed from change programme scope, it will be re-initiated if the collaborative launch a project

Healthy Wirral: Medicines Optimisation - Programme Assurance Update - 21 August 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. PIDs have now been uploaded for the following projects: HW AMR (draft), HW MOCH (draft), HW Pan Mersey (draft), Mental Health, and HW Stoma; eTCP, were updated and uploaded 14 Aug 19. Some of these PIDs are only partially complete and benefits are either only partly defined or cross-referred to the GDE SoPB. **2.** Notes of Healthy Wirral Meetings and Highlight Reports are available up to Aug 19, including the 'Medicines Optimisation Programme Board' up to Jul 19. Highlight reports uploaded 5 Jul 19 include: Mental Health, Med Safety, AMR and TCAMs. **3.** Governance structure shows how the 'Medicines Optimisation' now fits as part of the revised 'Healthy Wirral' programme structures. The ToR were updated as of 9 Jul 19. **4.** There is continuing evidence of GPCP stakeholder engagement and comms. **5.** EA/QIA signed off 18 Mar 19**. 6.** There is now a detailed milestone plan, v3 uploaded 15 Aug 19, with some workstream dates remain to be decided**. 7.** Biosimilar financial savings are shown in 'Adalimumab Biosimilar Implementation: January 2019 Update' but there is no evidence of measurement of other benefits. **8 and 9.** There is a monthly risk and issues log in place and updated to Aug 19 (although it is in non-standard format) with 'date of last review' as Jul 19. **Most recent assurance evidence submitted 14 Aug 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
Collaboration - Healthy Wirral														
6.3	**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 - 21 August 2019

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

Independent Assurance Statement

1. The scope document comprises the 'Strategic Pathology Collaboration Wirral and West Cheshire: Current Positon and Next Steps' dated October 2018 and submitted to the Trust Board on 1 November 2018. This has now been supplemented by a summary document. **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 are available to 28 Feb 19. **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. **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 13 Mar 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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
Collaboration - Wirral West Cheshire Alliance															
6.4	**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.	Karen Edge												

As agreed at the Programme Board on 17 April 2019: assurance ratings suspended pending a decision on project initation

Subject:	Agenda Item 17 Proceedings of the Trust Management Board held 22.08.2019	**Date:** 4th September 2019	
Prepared By:	Andrea Leather – Board Secretary		
Approved By:	Janelle Holmes, Chief Executive		
Presented By:	Janelle Holmes, Chief Executive		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**Risk associated with non-delivery of financial control total based on M4 outturn.**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care – exposure to infection, VTE assessment and attendance management.**
Staff Impact	**Attendance management and appraisal compliance represent a risk to workforce effectiveness**
Services	**None identified**
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.**

Committees/groups where this item has been presented before

N/A

Executive Summary

1. Executive Summary

- The Trust Management Board (TMB) met on 22/8/2019. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors.

2. Divisional Updates

Updates from each of the clinical Divisions were provided for information with the following actions noted:

(i) Surgery – transfer of Preoperative Assessment Service to OPD with effect from 27th August 2019. Development of the electronic theatre scheduling anticipated to 'go live' at the end of September.

(ii) Women & Children's – continuing impact on service following community midwifery service provided by One to One going into administration. Letter to be sent to CCG with offer to provide assistance with support services eg serious incident management and confirm support of an independent review surrounding the collapse of this service.

(iii) Diagnostics and Clinical Support – meeting arranged with Cerner at the end of August to discuss resolutions to address the ongoing PACs issues and the impact to e-prescribing following the recent upgrade. Following recent change in community Phlebotomy contract interim measures introduced to support patients having bloods at APH and CGH sites, longer term solution being developed.

(iv) Medical & Acute – ED streaming to go live in September 2019, process for majority of specialties agreed, general surgery to be finalised. ECIST team to provide support to review length of stay which a particular focus on medical wards with patients above 21 days.

Note:

- *All Divisions to provide bed capacity/demand modelling at next TMB.*
- *Divisional reports to be more compelling to better inform TMB of divisional compliance concerns, challenges and positive progress.*

3. Quality and Performance Dashboard

- TMB received the revised Quality Performance Dashboard covering the 12 months ended 31st July 2019.
- There are currently 15/56 indicators outside tolerance.
- TMB noted the progress to date and the number of indicators that were now seeing improvement and/or coming under control
- Whilst progress is being made across a number of indicators TMB considered the matters of concern for escalation, in particular Infection Prevention Control (IPC), Nutrition and hydration (MUST) and completion of mortality reviews.

4. Safety Management Strategy Action Plan

- TMB received and endorsed the Safety Management Action Plan.
- The Committee noted progress against the plan to be monitored via Risk Management Committee.

5. Draft Values Based Recruitment Questions

- TMB reviewed and agreed the sample questions for recruiters to utilise during interviews.
- Values based recruitment questions to be cascaded through Divisions/Departments, circulation also to be provided via communications.

6. Consultant Replacement Process

- TMB considered and approved the process for funded replacement consultant posts including the 'Replacement Consultant Authorisation Form'
- Weekly Scrutiny Panel to review recent unsuccessful recruitment processes to establish if completion of authorisation form is required – may be an opportunity to review job plan.

7. M4 Financial Position

- TMB received and noted the financial position for the end of month 4.
- Members noted the underlying deficit of £0.8m and the key components relating to non pay - impact of MSK outsourcing and clinical supply costs. In addition the continued pay pressures - agency spend on consultants, cover for junior medical vacancies and bank costs for nursing.
- Review of 'full year' forecasting underway with Divisions to identify scale of risk and recovery actions required to meet the planned breakeven position. TMB to consider actions to mitigate the deficit.
- Members noted that if the Trust was unable to achieve a "break-even" position and therefore not able to access the 'control total' funding of £12m this would significantly impact the 2020/21 budget.

8. Business Cases

A. <u>Capacity Management Handheld Devices for Porters</u>

- TMB reviewed the business case and supported in principle the solution, this would be considered in conjunction with the wider Capacity Management Business Case in September 2019.
- Impact on other functions such as security and charging of devices, workforce related matters and a risk impact assessment to be completed.
- TMB to revisit the business case the September meeting.

B. <u>Acute Medicine Nursing Establishment Investment</u>

- TMB reviewed the business case and supported in principle.
- Other support services to be reflected in the proposal and then reviewed through the establishment review process prior to resubmission to TMB.
- TMB to revisit the business case at a future meeting.

C. <u>Resource for the Management of Medicines Shortages</u>

- TMB considered the business case and requested the Division to seek alternative solutions to fund investment eg increased CIP options.

Note: *Business Case template to be updated – include Chief Nurse to stakeholder engagement section and remove named individuals.*

9. Chair's Reports

- The following Chair reports were received and reviewed by TMB:
  - Patient Safety & Quality Board Report – 15/8/19
  - Risk Management Committee Report – 14/8/19

10. AOB

(i) Relocation of **Medical Staffing Service** – main service to operate from Clatterbridge site with on site presence at Arrowe Park located in the Education Centre.

(ii) **Infection Prevention Control (IPC)** – replacement programme of unserviceable kit in progress, items such as lockers, chairs and mattresses to be replaced. Review of options to establish capacity to support acceleration of estate refurbishment being considered. Divisions requested to identify clinical representatives to attend the IPC meeting.

(iii) **Capital Programme** – Trust received notification that due to increased capital funding for the Department of Health the organisation can now revert to its original capital plans. Therefore a review of the overall capital programme is underway to recommend how best to utilise the 2019/20 programme.

Written and summarised on behalf of the Chief Executive by:
Andrea Leather, Board Secretary
22nd August 2019

BOARD OF DIRECTORS	
Agenda Item	19
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	4.9.2019
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	PR2
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The ninth meeting took place on Wednesday 14 August 2019.

2. Key Agenda Discussions

2(a) Chair's Business

The Chair welcomed 2 colleagues from Ophthalmology with their staff story.

The Chair discussed the continuing Trust Board concern with the deteriorating sickness absence trend line. The considerable amount of improvement measures for short term and long term absence management put in place by the HR directorate was noted. The assurance gap remains the level of engagement and ownership (for the issue) at Divisional management level.

2(b) Staff Story

The committee received the Ophthalmology staff story from Helen Brislen, Operational Service Lead (Ophthalmology) and Gillian Ruddock, Clinical Service Lead (Ophthalmology). They described the considerable progress made with staff engagement and modernisation in Ophthalmology. These positive changes include an additional 80-100 patients seen every month, a > 10% improvement in referral to treatment (RTT) from April to August 2019 and a successful bid for GDE funding to become 'paper light'. The meeting was advised that the appointment of a full time Operations Manager played a key role in bringing about these positive changes to the department.

The committee warmly thanked the colleagues for their contributions and insights and encouraged them to continue to sustain the improvements made to date and to share the processes used with their colleagues in other departments.

2(c) Update on the WRaPT workforce planning tool pilot

The pilot in three specialties of Women & Children's Division was discussed with Andy Hanson, Associate Divisional Manager (Women and Children's). The overall implementation programme is reviewed at the Trust's Programme Board. It was noted that the project will benefit from a new Workforce Planning Coordinator from mid October.

2(d) Workforce Race Equality Standards

The (WRES) report was received from Sharon Landrum, Equality & Inclusion lead and approved by the Committee. The report is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

2(e) Workforce Disability Equality Standard (WDES)

The WDES is a mandated part of the NHS standard contract and is required to be completed by all organisations, The Trust has already commenced a journey to improve experiences for its disabled staff and therefore this comes as an additional opportunity to highlight any shortfalls and strive for improvements.

There are a number of areas that require attention. However, the key priorities are:

1) Supporting staff access to ESR
2) Encouraging and supporting staff to self-report on ESR if they have a disability
3) Promoting the importance of reasonable adjustments and ensuring support is available for managers to understand their responsibilities and how best to implement.
4) Heightened focus on support available for disabled staff and promoting opportunities to get involved, share their voice and look at new ways of working.

The Committee thanked Sharon Landrum for the considerable recent progress in the Equality & Diversity agenda at WUTH.

2(f) Respect at Work

The new 'Respect at Work' Group has held two meetings and has replaced the previous Bullying and Harassment Improvement Group. Three 'hot spots' were discussed, EBME / Decontamination, Microbiology and Radiology. A number of measures to be put in place by the group.

2(g) Safe Employment / Recruitment Quarterly Report

The Safe Employment Report was received by the Committee. The purpose of the report is to show the findings of the quarterly safe employment audit checks carried out on a sample number of records and explain what action is being taken to deal with any areas of noncompliance, so that assurance can be given.

The quarterly results for period ended 30 June 2019 (quarter 1) were reported. The areas of non-compliance have been addressed, but there continues to be a high number of local inductions not carried out and/or not recorded. This is being addressed with recruiting managers.

2(h) Health & Well Being Plan

The updated Health & Well Being Plan was described at the committee. The plan has been divided into three sections - mental health, physical health and the wellbeing environment. There was no major risk to report at this time as the three red RAG rated areas are expected to be addressed over the next month through the introduction of the employee assistance programme.

2(i) Draft Communication & Engagement Strategy

The Communications, Marketing and Engagement strategy was presented to the committee for consultation prior to going to the Trust Board on 3rd September 2019. The strategy sets out the direction of travel over the next two years and fully covers a proactive approach to communications marketing and engagement following the recent launch of the new WUTH vision.

2(j) Workforce KPIs

The Workforce KPIs were presented to the committee. The KPIs will be revised following feedback and the intention is to move to fewer more focused workforce performance metrics, which the Workforce Assurance Committee supported.

2(k) Board Assurance Framework

The Workforce Assurance Committee was asked to:

a) review the risks delegated to it by the Board
b) consider the assurances and mitigating actions
c) provide an assurance rating for each of the risk vectors (as defined in the guidance notes provided).

The committee consensus was to modify the delegated BAF Workforce Risk Assurance ratings to better reflect the current situation.

2(l) Update from the Workforce Steering Group

The Workforce Assurance Committee noted the content of the Chair's report.

3. Recommendations to the Board of Directors

To note the contents of the report and to recommend the changes in the BAF Workforce Risk Assurance ratings.

4. Next Meeting

25 September 2019

BOARD OF DIRECTORS	
Agenda Item	20
Title of Report	CQC Action Plan Progress Update
Date of Meeting	4.9.19
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 21ST AUGUST, 2019

1. PURPOSE

1.1.1 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 approved by the Board of Directors in May 2019.

2.2 We expanded the actions in the CQC Action Plan in May 2019 to incorporate improvement required following the unannounced inspection of urgent care facilities.

2.3 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 during March and May 2018, and again in May 2019 (outcome not rated). The outcome of the inspection in 2018 was as follows:

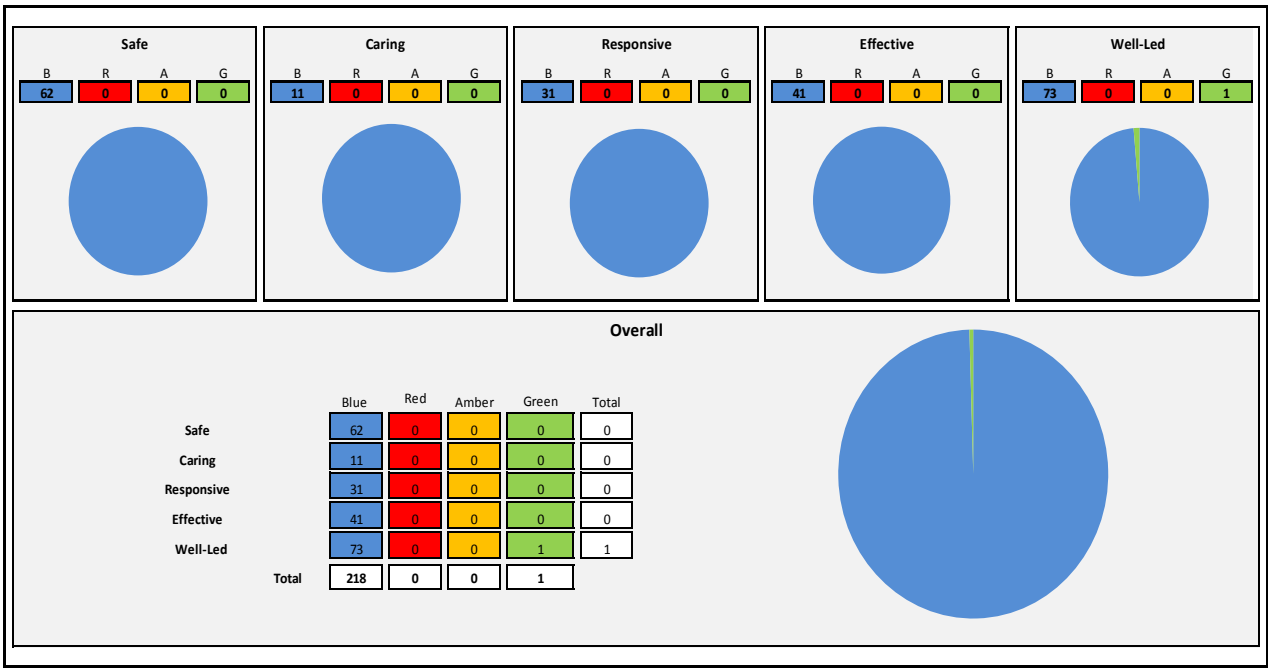
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

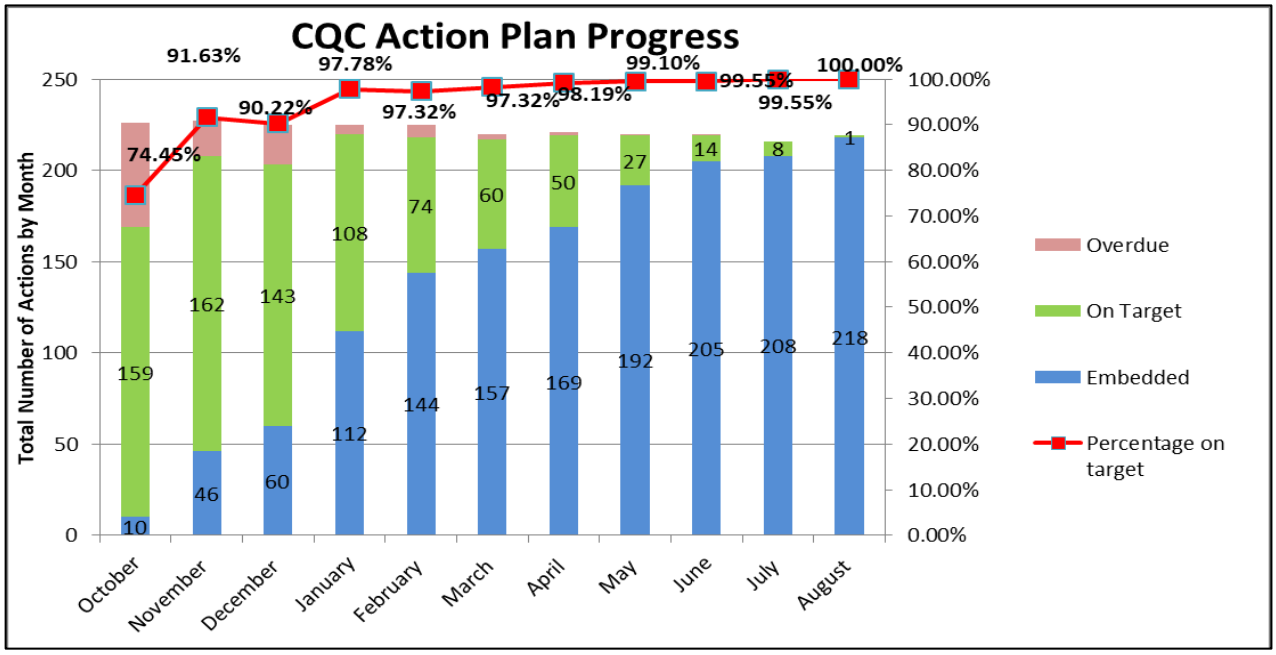
The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **220** specific actions/work-plans for implementation on or before **31st August 2019.**

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

4.0 CQC Action Plan Progress – 21st August 2019

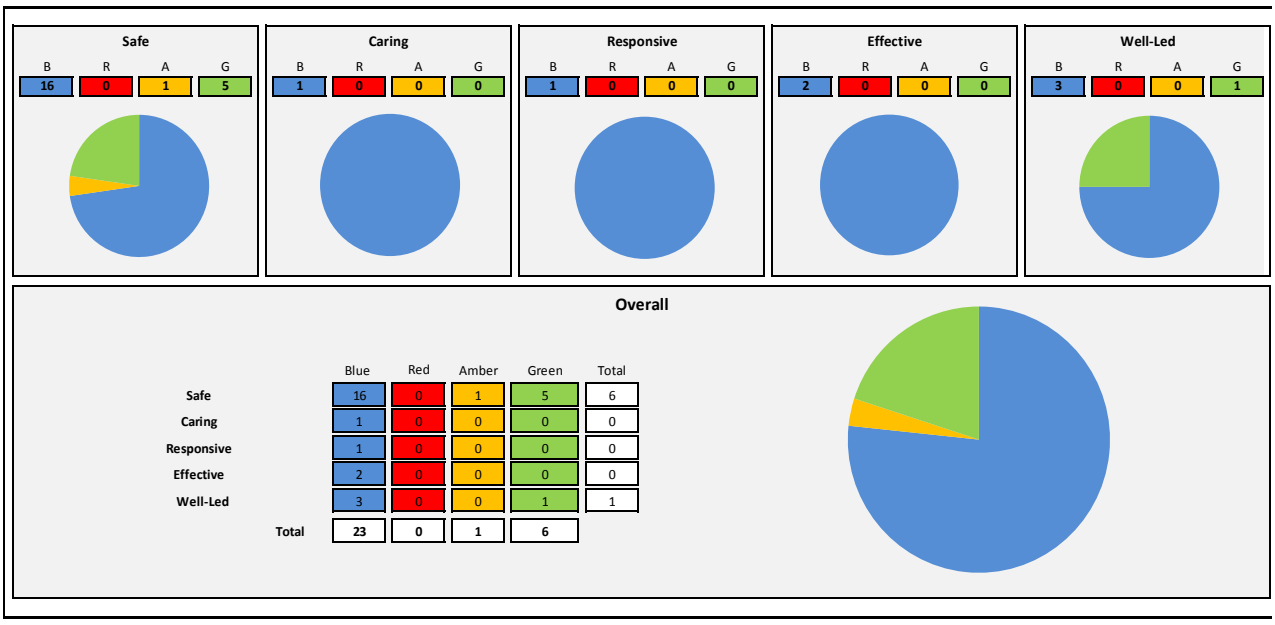
The graphs below summarises the current position of the original CQC action plan following review at its respective monthly confirm and challenge meetings. It is pleasing to report that there no overdue actions for this reporting period following trust Board decision to omit actions pertinent to patient flow from the CQC action plan. All 219 actions have been completed and 218 of these actions have been fully embedded and rated as Blue. The 1 Green action relates to a delay in launching the engagement strategy and is due to nursing priorities necessarily being focused upon the prevention and control of infections and managing patient flow. The acting Chief Nurse recognises that there is some delay in launching the strategy; although this is purposeful in order to allow him to consult more widely on the strategy.

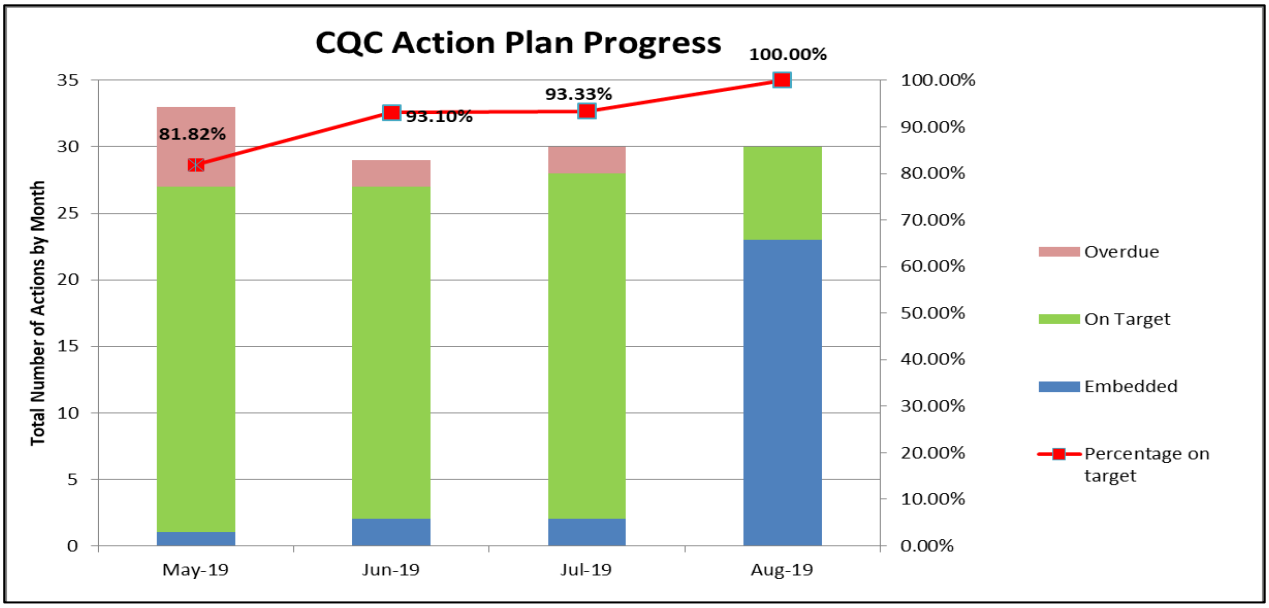




4.1 CQC Urgent Care Actions

The graphs below summarise the current position of the Emergency Department CQC action plan. There are 0 overdue action and one ‘at risk’ items for this reporting period.





5. EXCEPTIONS

The Urgent Care overdue actions concern the triage responsiveness of speciality reviews, streaming and paediatric trained nurses within ED compliance with RCPCH recommended staffing levels and are detailed in **Annex A(i).**

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 **5** 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:

- **AGREE** recommendation to remove patient flow related actions from CQC compliance reporting
- Note the progress being made to address CQC improvement actions;
- 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.

ANNEX A(i) - 2019 URGENT CARE ACTION PLAN

Number	Core Service eg. Trustwide / Corporate Medical Care, Etc.	Core Service	"Must Do / Should Do" Actions	CQC Regulation	Workstreams	Action	Director Lead	Operational Lead	Due Date	Completed Date	Comments	RAG
256	**Paediatric ED and APLS/PLS actions**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	15 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Ensure the availability of paediatric trained nurses in the Paediatric ED complies with RCPCH recommended staffing levels	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		12.08.19 - Awaiting agreed response to this issue form ED and W&C 11.06.2019 It was requested that ED staff make a decision on agreed way forward and devise an implementation plan 21.05.2019 - Clarification sought via CQC. Challenge not accepted. CQC confirmed that the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (June 2018) apply and as such the Emergency Department must ensure that it has 2 RSCN's on duty at all times (irrespective of the opening times of the Paediatric ED).	

ANNEX B (Embedded actions in August 2019)

Number	Core Service eg. Trust wide / Corporate Medical Care, Etc.	Core Service	"Must Do / Should Do" Actions	CQC Regulation	Workstreams	Action	Director Lead	Operational Lead	Due Date	Completed Date	Comments	RAG
226	CQC ED visit Treatment of disease, disorder or injury Care was not always person centred and did not always meet individual needs. Staff did not always make reasonable adjustments to the service to meet individual needs	Urgent And Emergency Care (Acute & Medical Division)	Must Do	9 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Review Privacy and Dignity arrangements for patients being cared for in corridors	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	02/05/2019	12.08.19 - Policy reviewed and new SOP in place. 11.06.2019 - Data to be submitted, action plan confirming how this will be sustained. 2/05/19. Addressed corridor through 2-week PDSA of a reverse cohort area using a mothballed ward adjacent to ED. 2-week trial 29th April, early signs (1st 3 days) shows a significant reduction in held NWAS crews. Interim arrangements have been put in place to support the flow of patients through the unit, however long term sustainable change will be achieved through delivery of patient flow improvement programme outcome 11.06.2019 - Limited assurance of sustainability. Week 7 57 patients have waited over 1 hour on corridor. Cubicle 11 as 'hot clinic' bereavement room and EDRU room closed off. Action: morning huddles standard agenda item to re-inforce messages around corridor care. SOP to be designed and assurance statement.	

228	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	11 – Person Centred Care, 12 – Safe Care and Treatment	Responsive	Ensure adequate risk controls are in place for patients who wait extended periods for triage	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	29/04/2019	11.06.2019 - Data on triage times to evidence sustainable. Data that shows breaches of 15 minutes. Split compliance and breaches against the total. The process of triage and adult assessment has been split from 9th April. IT updates took place last week. 2 x triage nurses. Split the role. One completes the Manchester triage, the other the adult initial assessment resulting in timely initial triage 21.05.2019 - This has been achieved since 29th April when Reverse Cohort Area was opened providing nursing staff with a dedicated area to enable triage to happen within 15minutes. Interim arrangements have been put in place to support the flow of patients through the unit, however long term sustainable change will be achieved through delivery of patient flow improvement programme outcome	
229	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	12 – Person Centred Care, 12 – Safe Care and Treatment	Effective	Ensure triage processes meet national best practice guidance	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019		12.08.19 - Action fully implemented and embedded 11.06.2019 - Data on triage times to evidence sustainable. Data that shows breaches of 15 minutes. Split compliance and breaches against the total. Significant improvements have been made, however the process needs embedding. 21.05.2019 - Manchester triage is done separately from ED assessment - commenced 9th April 19	
230	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	13 – Person Centred Care, 12 – Safe Care and Treatment	Effective	Split triage from assessment	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019		12.08.19 - Action fully implemented and embedded as above 11.06.2019 SOP as evidence 21.05.2019 - Manchester triage is done separately from ED assessment - commenced 9th April 19	

231	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	14 – Person Centred Care, 12 – Safe Care and Treatment	Well Led	Identify funding required provide 2 nurses allocated to walk in triage 12-12 7 days a week AND Pod to review acute nursing business case and AND Pod 1 to review bed management business case to establish funding to support the above	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	31/07/2019		12.08.19 - Action fully implemented and embedded 12.08.18 - August audit of 'Harm review' in ED 85% compliant 11.06.2019 - Operational budget - evidence. Agreed funding source and is WIP. DMT Review Business Case. Bed Management out of Scope. Acute Nursing - with finances end June agreement. Operationalised 3 months post. Deadline extended to July 19 from April 19 Triage improvements have been initiated and data demonstrates substantial progress made towards the 15-minute requirement. To achieve a sustainable staffing establishment for effective triage the deadline for preparing and agreeing a business case has been extended.	
232	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	15 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Once funding established recruit staff. As described above. Until agreed utilise current establishment	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	31/07/2019		12.08.19 - Action fully implemented and embedded 11.06.2019 - Recruitment on target for June 19 21.05.2019 PDSA will take place with CT to look at the feasibility of CT Nurse performing triage and streaming activities. May not be required pending outcome of PDSA	
233	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Must Do	16 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Ensure use of existing escalation process for triage waits when above 15 mins	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	11/06/2019	18.08.19 - ED SOP in Place - Action fully implemented and embedded 11.06.2019 SOP as evidence and when it was used data for compliance /date when used 21.05.2019 - Developed a SOP for Triage escalation.	

234	Deliver improvements in triage responsiveness	Urgent And Emergency Care (Acute & Medical Division)	Should Do	17 – Person Centred Care, 12 – Safe Care and Treatment	Safe	ED allocation book will always identify the triage nurse	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	11/06/2019	11.06.2019 - Does this action need to be on plan Complete. Allocation Board updated daily	
239	Streaming	Urgent And Emergency Care (Acute & Medical Division)	Must Do	22 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Ensure the triage process provides rapid evaluation of patient condition and priority for care in accordance with Manchester Triage guidelines and best practice nationally	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	11/06/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - Audit outputs required Complete subject to audit.	
240	Improve timeliness of specialty review	Urgent And Emergency Care (Acute & Medical Division)	Must Do	23 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Implement and embed existing internal professional standards for patients who need a speciality review - all speciality SOP's operational	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	31/07/2019		12.08.19 - Audit Completed 11.06.2019 - SOP/Data. Confirm meeting has taken place and agreed outcomes. Audit data on how many specialist review requested and how many undertaken within the standard Arrangements agreed for Medicine & Acute assessment areas. Conclusion required for Surgery and Women's & Children's. 21.05.2019 - AMD meeting to take place to discuss way forward. No confirmation that discussion has taken place and SOPs agreed and insitu for all assessment areas. 11.06.2019 - Inter professional standards NHSi and Warrington have been issued to specialities to agree and sign off at collective meeting end June 19. Standards agreed by end June 19 and implemented and operational immediately thereafter with periodic reviews	

241	Improve timeliness of specialty review	Urgent And Emergency Care (Acute & Medical Division)	Should Do	25 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Each speciality to audit response/ review times and address delays	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019		12.08.19 - Audit Completed Update 23.07.2019 Assurance required, not yet provided, regarding audit results for specialty response times following referral via ED. Action to be escalated to Medical Director. NHSI have developed inter professional standards for acute trust's to implement standards which support speciality response of 30 minutes to review a patient in ED. To support this process before the 'go live' date ED have requested a report from IT to establish current state. ED has also commenced breach analysis meetings with all specialities. WUTH plan to 'go live' with the standards on 6th August 2019. 21.05.2019 - Assurance required, not yet provided, regarding audit results for specialty response times following referral via ED. Action to be escalated to Medical Director.	
243	Improve timeliness of specialty review	Urgent And Emergency Care (Acute & Medical Division)	Should Do	27 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Redevelop facilities in the walk in centre and within ED to create capacity to manage patients on trollies awaiting assessment or admission	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	31/10/2019		12.08.19 - Plans in place to redevelop walk in centre to create additional capacity Query - is this our action to redevelop walk in? Do we manage the service? 21.05.2019 -Meeting to take place with architect to scope. Changes required to the physical estate/infrastructure may introduce some risk of slippage.	

244	Confidentiality / Medical Records		Should Do	28 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Raise awareness of records storage requirements on EDRU - all ED staff	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	30/04/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - Inspections/Huddles/ audits - assurance that this is happening and consequences when staff are not adhering Completed. Staff requirements reinforced. The notes trolley was in full working order (subsequently verified by GSU) but not operated correctly by staff which resulted in the technical IG breach at the time of inspection. Further checks planned to verify ongoing compliance on EDRU.	
245	Confidentiality / Medical Records		Must Do	29 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Raise awareness of information governance requirements when using electronic patient records all ED staff	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	30/04/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - Inspections/Huddles/ audits - assurance that this is happening and consequences when staff are not adhering Completed. Staff requirements reinforced. Further checks planned to verify ongoing compliance in ED..	
246	Confidentiality / Medical Records		Should Do	31 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Initiate daily ED and divisional leadership walkabouts in ED, EDRU and corridors to oversee and drive compliance	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	01/05/2019	30/04/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - Inspections/Huddles/ audits - assurance that this is happening and consequences when staff are not adhering - how do we know? 21.05.2019 - ED Senior Management presence daily. Assurance evidence requested.	

247	Security of Paediatric Emergency Department and Assessment Units		Must Do	32 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Activate security controls installed to prevent unauthorised access to Paediatric ED and Assessment Unit	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	30/04/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - How do we know that this will not be disabled? Complete. Verified. Remain GREEN for further 2 months to ensure that controls have not been de-activated by staff.	
248	Security of Paediatric Emergency Department and Assessment Units		Must Do	33 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Strengthen control to provide video intercom controlled access operated from the nurses station in paediatric ED	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	10/05/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - How do we know that this will not be disabled? Area now secure. Due date changed. Camera fitted 10th May. Remain GREEN for further 2 months to ensure that controls have not been de-activated by staff.	
249	Medical staffing in Emergency Department		Should Do	34 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Manage medical staffing rotas and oversee numbers of suitability of qualified doctors covering ED overnight	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/05/2019	11/06/2019	12.08.19 - Action fully implemented and embedded 11.06.2019 - Rotas to be submitted as evidence. retrospective submitted as further evidence rotas and evidence they were fulfilled as per original rota Rotas in place. Locums nest is being considered as part of contingency arrangements Confirmed medical staff numbers meeting requirements. Dependency on locum cover remains.	

257	Paediatric ED and APLS/PLS actions	Urgent And Emergency Care (Acute & Medical Division)	Should Do	16 – Person Centred Care, 12 – Safe Care and Treatment	Well Led	Verify that all ED consultants are in possession of a current Advanced Paediatric Life Support certificate take all steps necessary to address gaps	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	30/04/2019	12.08.19 - this requirement is part of the standard competency for ED consultants - 12.08.19 - Action fully implemented and embedded 11.06.2019 - Updated copy of compliance 21.05.2019 - Complete, subject to verification. Evidence requested.	
259	EDRU Actions	Urgent And Emergency Care (Acute & Medical Division)	Should Do	16 – Person Centred Care, 12 – Safe Care and Treatment	Caring	Provide and deliver customer care training to colleagues assigned to work in EDRU in order to ensure staff have the competencies and ability to communicate appropriately with relatives of patients	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019		12.08.19 - Action fully implemented and embedded Not assured. 21.05.2019 - 1. New EDRU sister started in post (band 6) 2. New ED shift leader managing EDRU (band 7) 3. Meet with HR regarding communication	
260	EDRU Actions	Urgent And Emergency Care (Acute & Medical Division)	Should Do	16 – Person Centred Care, 12 – Safe Care and Treatment	Well Led	Strengthen nursing leadership in EDRU	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/06/2019		12.08.19 - Action fully implemented and embedded 11.06.2019 - confirmation - establishment report 21.05.2019 - 1. New EDRU sister started in post (band 6) 2. New ED shift leader managing EDRU (band 7) 3. Meet with HR regarding communication	

215		Urgent And Emergency Care (Acute & Medical Division)	Should Do	12 – Safe Care and Treatment	Safe	Include EWS compliance on divisional and corporate dashboards	Executive Medical Director	*Mark HUGHES/Katie Whittle*	31/03/2019		12.08.19 - Agreed to use perfect ward on EWS in a reporting line in DPR from October 2019. 10th June 19 - Consider corporate dashboard. PL to look into this with John Halliday and Katie Whittle Patient trigger >7 what happened and audit	
177	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	Corporate / Trust-Wide Issues	Must Do	18 – Staffing, 19 – Fit and Proper Persons Employed	Well Led	Review mandatory training framework and monitor compliance against 'Core Ten' mandatory training topics All services to complete Training Needs Analysis (TNA) at Divisional level	Executive Director of Workforce	Divisional Triumvirate, Corporate Clinical Excellence Team, Leadership and Development Team	31/032019		ACTION: 21.11.2018 Core 10 mandatory training in place reporting to PSQB, Quality Committee and BoD through the Quality dashboard. Mandatory training - reduced to ten pieces of mandatory training requirements - Review undertaken Each area - description of staff and training that they require for their role All staff core undergo 10 Compliance report available for each area 05.02.2019 - All core ten mandatory training topics have been uploaded and TNA For role specific refinement is underway ongoing work to refine. Work continues and comms have been issued. To be picked up as part of DPR for role specific training compliance 02.05.2019 - Role specific TNA to be picked up with HR Business Partners to liaise with Divisions to create service level role specific TNA requirements. Run ESR report to submit as evidence 12.08.19 - Systems in place for monitoring core ten. Additionally all role specific training now identified on HR system by post number.	

	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.											

Board of Directors

Agenda Item	21
Title of Report	Board Assurance Framework
Date of Meeting	4th September 2019
Author	Andrea Leather, Board Secretary
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	There are gaps with mitigating action.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The attached report includes the following:

- A summary of the risks and their associated risk scores in the Board Assurance Framework (BAF)

- A detailed analysis of each risk and the associated actions to mitigate these.

NOTE: All updates have been highlighted and the key risk indicators are based on data as at the end of July 2019.

2. Next steps

The Board of Directors is asked to review and consider:

a) the updated assurances and mitigating actions
b) the assurance rating for each of the risk vectors as provided by the relevant Committee (as defined in the guidance notes provided).
c) the overall risk rating, with a particular focus on those risks where 'negative' assurance ratings have been provided.

3. Recommendations

The Board of Directors is asked to:

- approve amended the risk ratings
- approve assurance rating and updates as detailed in the report.

Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

This BAF includes the following primary risk scenario's that could, if not sufficiently mitigated, impact adversely on delivery of the Board's Strategic goals:

	Primary Risk Scenario's	Consequence	Likelihood	Current Risk Exposure	Change	Tolerable Risk	Gaps in control	Gaps in assurance	Lead Assurance Committee	Page No.
PR1	Demand that overwhelms capacity to deliver care effectively	5. V.High	5. V.Likely	**25 Significant**	⟺	**12 High**	Yes	Yes	FBPAC	2
PR2	Critical shortage of workforce capacity & capability	5. V.High	4. Likely	**20 Significant**	⟺	**12 High**	Yes	None identified	WAC	4
PR3	Failure to achieve and maintain financial sustainability	5. V.High	4. Likely	**20 Significant**	⟺	**8 Medium**	Yes	Yes	FBPAC	6
PR4	Catastrophic failure in standards of safety and care	5. V.High	4. Likely	**20 Significant**	⟺	**9 Medium**	Yes	Yes	Quality	8
PR5	A major disruptive event leading to rapid operational instability	5. V.Likely	3. Medium	**15 Significant**	⟺	**5 Medium**	Yes	None identified	FBPAC	10
PR6	Fundamental loss of stakeholder confidence	4. Likely	3. Medium	**12 High**	⟺	**5 Medium**	Yes	None identified	Board	12

Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Wirral University Teaching Hospital NHS Foundation Trust

How to use the BAF

The key elements of the BAF to be considered are:

- A simplified description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a system, trust wide
- and service level)
- A simplified way of displaying the risk rating (current residual risk and tolerable level of risk)
- Clear identification of primary strategic threats and opportunities within a 5 year horizon, along with the anticipated proximity within which risks are expected to materialise and the degree of certainty that the level of risk will change (**Intensifying** = risk level is expected to increase; **Uncertain** = unable to predict change; **Moderating** = risk level if likely to reduce)
- A statement of risk appetite for each risk, to be determined by the lead committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low risk options; **Cautious** = preference for low risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- The over-arching risk treatment strategy for each principle risk is identified (**Seek**; **Modify**; **Avoid**; **Accept**; **Transfer**)
- Key elements of the risk treatment strategy identified for each risk, each assigned to an executive lead and individually rated by the Lead Committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: **Level 1** Management (those responsible for the area reported on); **Level 2** Corporate functions (internal but independent of the area reported on); and **Level 3** Independent assurance (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales
- Relevant Key Risk Indicators (KRIs) for each strategic risk, taken from the Trust performance management framework to provide evidential data that informs the regular evaluation of exposure.

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the risk

Amber = Inconclusive assurance: the Committee is uncertain that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk is not being kept under prudent control

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

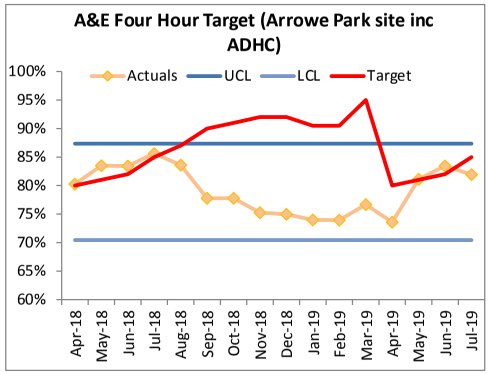
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

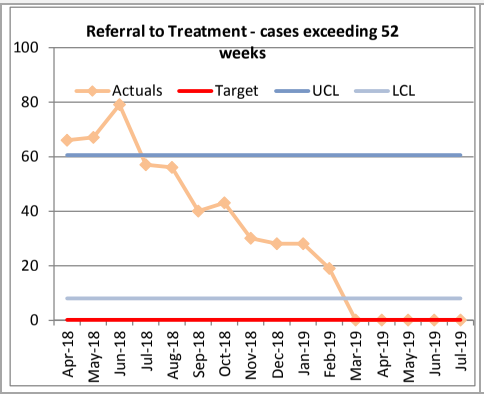
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that overwhelms capacity to deliver care effectively** A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards	**Executive lead**	COO	**Likelihood:**	5. V. Likely	3.Possible	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	4. High		
		Last reviewed	01/04/2019	**Risk rating**	**25. Significant**	**12. High**		
		Last changed	01/04/2019	**Anticipated change**	Intensifying			
Details of change	Updated contingency controls, assurances documented							

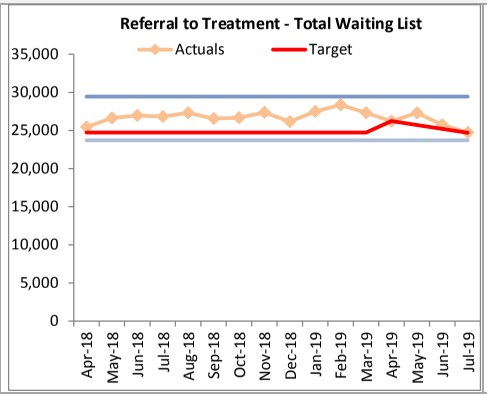
Risk Vector (what might cause this to happen)	**Primary Risk Treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Level & Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Threat: Exponential **growth in demand for care** caused by an ageing population (forecast annual increase in emergency demand of 4-5% per annum); -2% reduced social care funding and increased acuity leading to more admissions & longer length of stay **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency demand & patient flow management arrangements ▪ Winter capacity plan ▪ Access Policy in place ▪ Detailed operational plans agreed annually ▪ Activity based contract and commissioners ▪ Workforce model adjusted for planned activity ▪ ED Streaming ▪ Defined escalation areas (act as flood plane) during periods of exceptional pressure ▪ Discharge procedures ▪ Use of admission avoidance schemes ▪ Use of SHOP model medical review ▪ Ambulatory & Day case care **Contingency controls** ▪ Emergency preparedness (Surge plan) ▪ Expansion into corridor / designated escalation area ▪ Reverse cohort area expansion within A&E footprint implemented ▪ Quality matrons conduct patient safety checks for all patients in corridor/escalation area – reintroduce if required. ▪ Staffing plan for escalation	▪ Higher than expected length of stay (LOS) ▪ Normalised reliance upon escalation areas during pressure ▪ Insufficient daily discharges to deliver net patient flow ▪ Standards of care in corridors or escalation areas during periods of very high demand and very high bed occupancy ▪ Capacity and demand modelling inc. theatre utilisation ▪ Reliability of SHOP implementation	Patient flow transformation programme **SLT Lead:** MD/Transformation Lead **Timescales:** As per programme Review of outpatient processes **SLT Lead:** COO/ Transformation Lead **Timescales:** As per programme	**Level 1** ▪ Divisional performance reviews (monthly); ▪ Stranded patient reviews (2 per week) – focus on over 21 days ▪ Overall bed occupancy rate (daily) ▪ 52 week wait & size of waiting list ▪ Ambulance Handover times (daily) – improved NW Ambulance performance **Level 2** ▪ Q&P Dashboard (monthly); ▪ PFIG Report to Board (monthly); ▪ Transformation Board; ▪ Wirral A&E Delivery Board; **Level 3** ▪ CQC improvement oversight; ▪ System Improvement Board ▪ Limited scope external audit – Quality Account 2017/18 ▪ CQC unannounced inspection (March '18) ▪ Contract meetings ▪ MIAA Activity Data Capture – Limited Assurance	None identified	Positive
Threat & Opportunity: Operational **failure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort' **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board(UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of GP practice collapse on Wirral there would likely be surges in demand for secondary care	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of general practice in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of General practice in Wirral **SLT Lead:** COO **Timescales:** May 2019	Positive
Threat & Opportunity: Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board (UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of collapse, emergency procedures will govern the response	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing Review Contingency plans **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of neighbouring providers in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of neighbouring providers in the Wirral **SLT Lead:** COO **Timescales:** May 2019	Positive

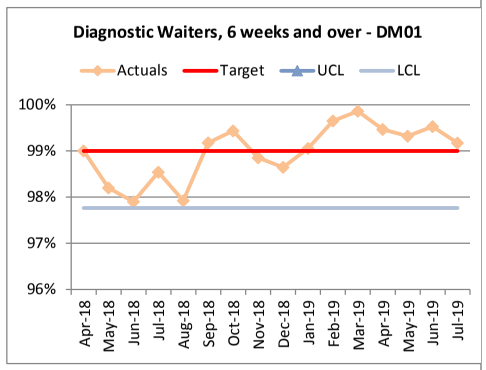
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

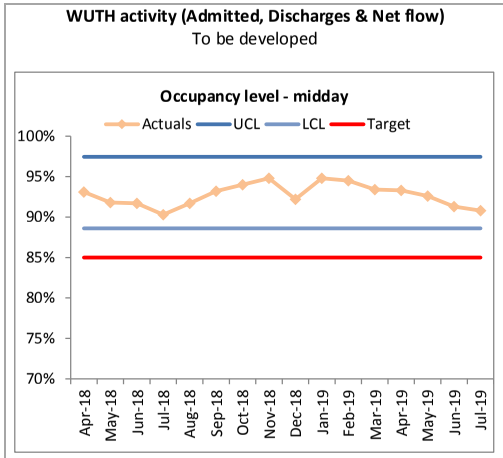
Key risk indicators (KRIs) –Data updated 21/08/19

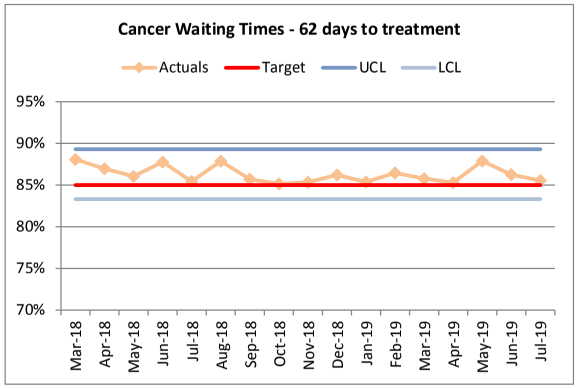


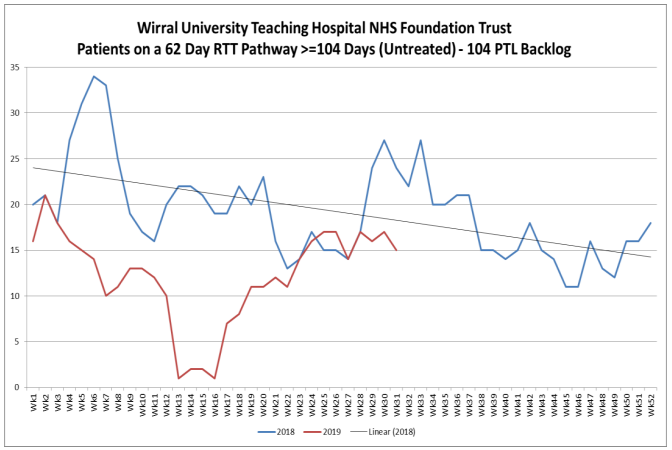












Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Strategic priority	I. PEOPLE: Supported empowered workforce II. PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	WAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 2: Critical shortage of workforce capacity & capability** A critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards	**Executive lead**	Dir. HR/Workforce	**Likelihood:**	5. V. likely	3.Possible	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	4. High	4. High		
		Last reviewed	01/04/2019	**Risk rating**	**20. Significant**	**12.High**		
		Last changed	01/04/2019	**Anticipated change**	Intensifying			
Details of change	Updated gaps in control, plans to improve control and assurances documented							

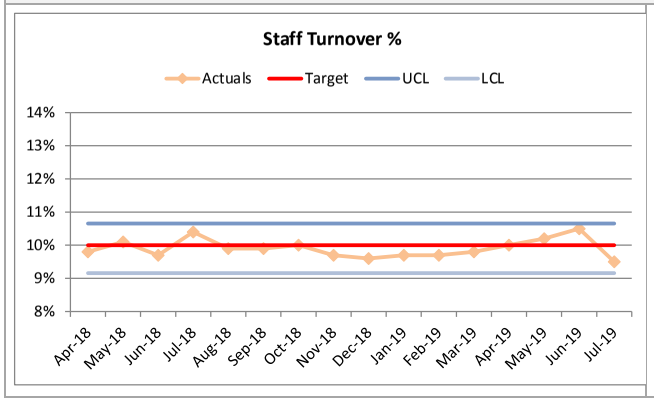
Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Level & Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Demographic changes (including the impact of Brexit and an ageing workforce) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition) resulting in critical workforce gaps in some clinical services **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ E-rostering and job planning to support staff deployment ▪ Vacancy management and recruitment systems & processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards & departments/ Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels ▪ 'No deal' EU Exit Planning Team – incl workforce planning – action cards/ global comms/ EU exit page on intranet ▪ Medical staffing & HR Teams in place ▪ Nursing & Midwifery recruitment & retention strategy ▪ Volunteer strategy ▪ Recruitment campaign (Band 5; CSW; Volunteers) ▪ Ward establishment review ▪ Change in pension rules	Divisional ownership and understanding of their workforce issues inc hard to recruit groups Lack of understanding re: the impact of age demographics on staff retention risk Vacancy rates / high locum use and hard to recruit medical posts Lack of control re: recruitment Impact for consultants re: tax implications Vacancy rates for nursing posts No workforce plan aligned to service strategy	Develop understanding & boost ownership through WF Steering group/ Divisional Performance reviews **SLT Lead:** Dir HR **Timescales:** Commence April '19 Bed modelling & specialty capacity/ demand review **SLT Lead:** COO **Timescales:** By end April '19 Medical Staffing Review **STL Lead:** Dir HR **Timescale:** June '19 Recruitment to be brought back in-house to enable greater control **SLT Lead:** Dir HR **Timescales:** Q4 (due to 6 mth notice) Establishment of Pension Working Group to consider options **SLT Lead:** Dir HR **Timescales:** Sept 2019 T&F group – recruitment B 5's **SLT Lead:** Ch. Nurse **Timescales:** July '20 Develop and approve workforce strategy and implementation plan by end of April '19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) ▪ Safe Staffing Report – recruitment (quarterly) ▪ Finance & Workforce Scrutiny meeting.(weekly) **Level 2** ▪ Workforce strategy & plan ▪ Quality and Performance dashboard- W/force metrics (monthly); ▪ Report of Workforce Assurance Committee to Board (Monthly); ▪ FBPAC reports (Monthly) ▪ EU exit paper presented to TMB and Chairs report to Board (Feb/ Mar '19) ▪ Workforce Key Performance Indicators (KPI's) **Level 3** ▪ Organisational Development Plan	None identified	Inconclusive
Threat: A failure to acquire or loss of of workforce productivity ***(attendance management)*** arising from a reduction in discretionary effort amongst substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint or workforce fatigue	▪ Staff Communication bulletin; Schwartz rounds ▪ Divisional action plans from staff survey ▪ Policies (Inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Leadership development programme / Duties of a doctor programme ▪ Executive & SLT visibility; Big debates; Ask the Exec Team ▪ Divisional staff support networks; Freedom to Speak up Guardians; Occupational Health Support (as required) ▪ Health & Wellbeing team in place ▪ Rewards & recognition i.e. annual staff celebration; cards	Staff survey results identify areas for further improvements Unsustainable levels of sickness absence	Strengthen and boost oversight of OD delivery via Workforce Assurance Committee **SLT Lead:** Dir HR **Timescales:** From April'19 External Sickness Management Solution Business Case to FBPAC **SLT** **SLT Lead:** Dir HR **Timescales:** From August'19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) ▪ Regular pulse checks starting June '19 ▪ Establishment of 'Respect' at Work Group (monthly) **Level 2** ▪ Workforce/ OD strategy & plan ▪ Quality and Performance dashboard- Workforce metrics (mthly); ▪ Report of Workforce Assurance Committee to Board (Monthly); ▪ Communications & Engagement Strategy (reviewed by Executive's for discussion at Board September 2019	None identified	Negative

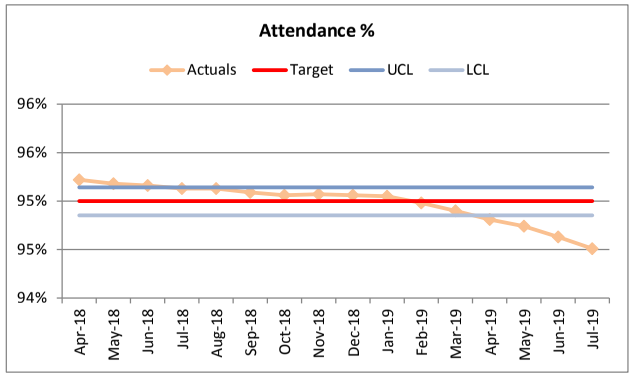
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

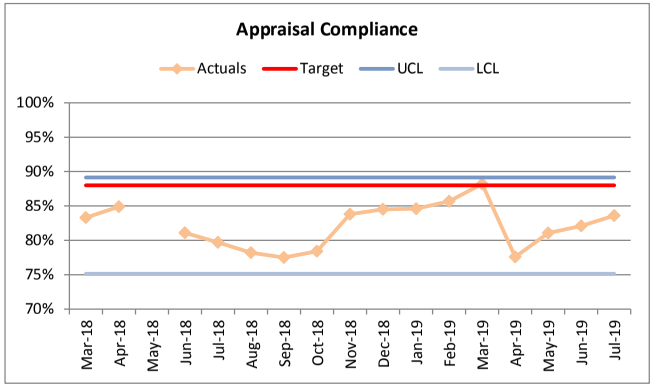
	▪ Attendance Management procedures		Effective manager programme roll-out **SLT Lead**: Dir HR **Timescale:** September 2019 Health & Well-being Programme. Introduction of Employee Assistance programme **SLT Lead:** Dir HR **Timescale:** September 2019	▪ Workforce Key Performance Indicators (KPI's) **Level 3** ▪ National Staff Survey (Mar 19); ▪ CQC Report (Mar '18); ▪ Medical engagement survey		
Proximity of threat 19/20 | 20/21 | 21/22 | 22/23 | 23/24 < | – | – | – | >	▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) ▪ The LHRP co-ordinated response	Limits to the extent contingencies can provide the state required in emergency	Test EPRR arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by Q3 '19	**Level 2** ▪ Resilience Assurance report to RMC (Mar; Sept 19) **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs; ▪ LHRP Assurance Process	None identified	
Threat: Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 < | – | – | – | >	▪ Induction; Mandatory & role specific training programmes; ▪ Corporate teams provide support and training as required ▪ Exercises to test business continuity and incident management plans including loss of technology ▪ ESR training record ▪ Protected budgets for training & development ▪ Practice educators	Difficulties in releasing staff from wards	Deliver 80% of mandatory training as an e-learning option for staff **SLT Lead:** HR Dir **Timescales:** By end Q1 '19 Individual responsibility – exploring personal ownership to complete mandatory training – 1st draft plan **SLT Lead:** HR Dir **Timescale:** June '19	**Level 2** ▪ Q&P Dashboard- Mandatory training (monthly); ▪ Report of Workforce Assurance Committee to Board (monthly) ▪ Launch of Values & Behaviours ▪ Workforce Key Performance Indicators (KPI's) **Level 3** Staff survey (Mar '19)	None identified	Inconclusive
		Effectiveness of mandatory training (knowledge & skill acquisition and transfer into practice)	Introduce knowledge acquisition tests for those – e-learning options available for practical skills-based training, BLS, test all staff at point of training. Review role of practice educators **SLT Lead:** HR Dir **Timescales:** By end Q1 '19			

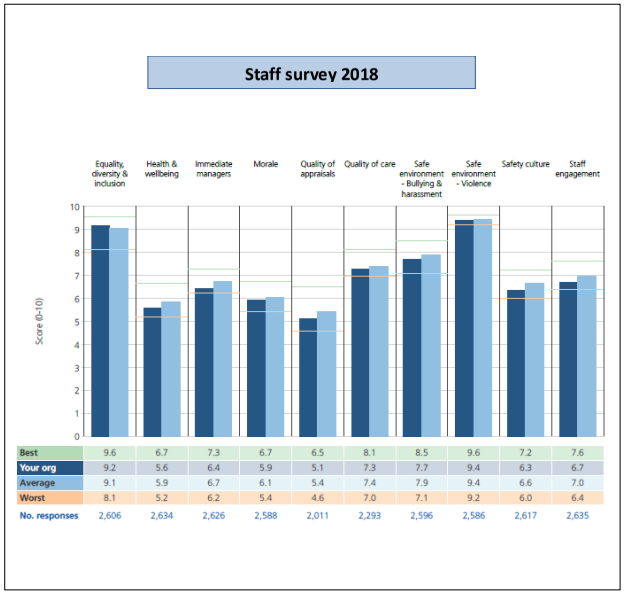
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Key risk indicators (KRIs) Data updated 21/08/19







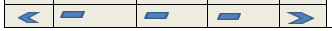


Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify / Transfer
Principal risk (what could prevent us achieving this strategic priority)	**PR 3: Failure to achieve and/or maintain financial sustainability** Inability to deliver the annual control total resulting in a failure to achieve and maintain financial sustainability.	**Executive lead**	Finance Dir.	**Likelihood:**	4. High	2. Unlikely	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	4. High		
		Last reviewed	01/04/2019	**Risk rating**	**20. Significant**	**8. Medium**		
		Last changed	01/04/2019	**Anticipated change**	Intensifying			
Details of change	Updated plans to improve control and assurances documented							

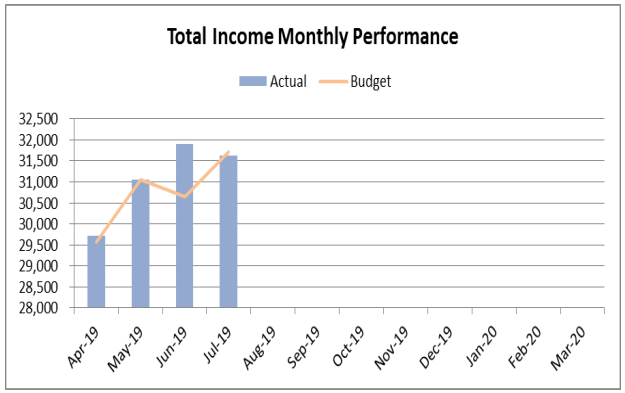
Risk Vector (what might cause this to happen)	**Primary risk controls** (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Increased cost & income volatility as a result of tariff changes; deteriorating condition of clinical estate; dependency on temporary staffing; growth in competition from the private health sector; contract penalties/ fines leading to uneconomic services **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Annual plan, including control total consideration; reduction of underlying financial deficit ▪ Contract terms reduce risk of income volatility as a result of block payment basis for Outpatients and support to underwrite Non-elective variation ▪ SFI's authorisation limit (scheme of delegation) ▪ Core financial control Policies / Procedures ▪ Access to Working Capital support ▪ Budgetary controls/Budget at Ward & Dept level ▪ Training for budget holders ▪ Procurement processes and Team ▪ Risk based annual capital planning process	▪ Not all budget holders have completed training ▪ Compliance with escalation as per SFI ▪ MTFM not yet agreed ▪ Effectiveness of budget management @Divisional/ Corporate/ Ward/ Dept ▪ Operational productivity impacting adversely on income and expenditure ▪ Robust capacity plan ▪ Job planning and e-roster ▪ Estates Strategy in development ▪ Unbudgeted expenditure, including that related to meet regulatory requirements arising in year without mitigating savings	Embed S/L reporting & establish steering group **SLT Lead:** MD **Timescales:** End of September '19 Robust capacity plan/ job planning and e-roster- add on required - efficient deployment of staff across organisation (IT solution) **SLT Lead:** Ch. Nurse **Timescales:** End of September '19 Ensure all budget holders receive refresher training on budget management & SF1 compliance **SLT Lead:** FD **Timescales:** End of July '19 Develop & agree MTFM **SLT Lead:** FD **Timescales:** End of July '19 Extra-ordinary controls including: • Weekly CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay) • Discretionary non-pay sign off escalation • Forecasting reviews based on issues and interventions **SLT Lead:** FD **Timescales:** End of July '19	**Level 1** ▪ Divisional risk reports to Risk Committee bi-annually; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Significant risk report to RMC (monthly); ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit; ▪ External audit; ▪ Signed contract with WHCC/NHSE	None identified	Inconclusive
Threat: Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ CIP planning processes and coordination of delivery ▪ Agreed CIP plans at Divisional and Dept level ▪ Access to Working Capital support ▪ Programme Board ▪ SRO's identified for CIP programme ▪ CIP planning; scoping; approval and initiation process in place with QIA and clinical sign-off ▪ CIP delivery oversight meeting ▪ Healthy Wirral System 5yr Recovery & Sustainability plan developed	▪ Unidentified CIP in year ▪ Effectiveness of oversight ▪ CIP planning only relates to current financial year	Develop & agree MTFM (linked to other Trust Strategies) **SLT Lead**: FD **Timescales:** End of Sept '19	**Level 1** ▪ Divisional reports to Programme Board; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit/ External audit;	None identified	Inconclusive

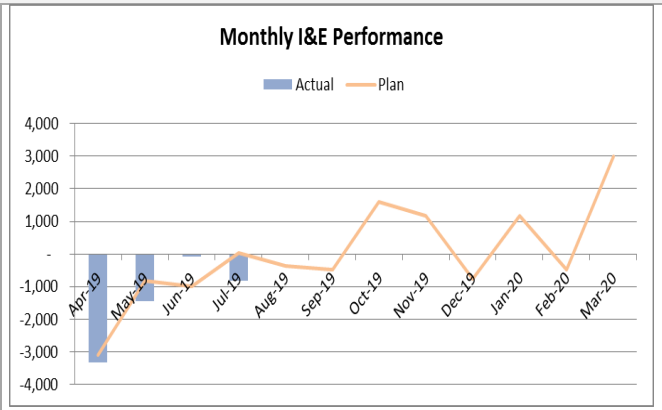
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

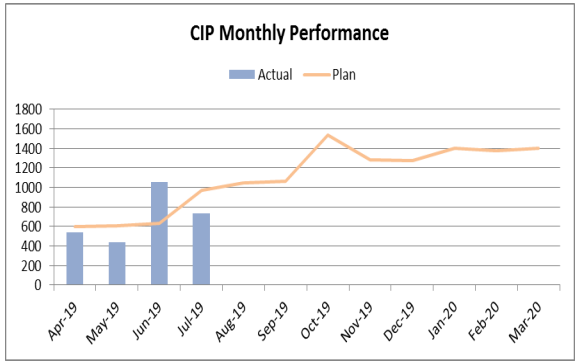
Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Treasury loan process/NHSI Capital approval process. ▪ Planned and preventative maintenance regime in place based on compliance ▪ Reactive maintenance regime to repair immediate issues as they arise with dedicated Budget for Backlog maintenance - circa £1.2 million ▪ Dedicated Capital Budget for improvement works on the Physical Environment- various.	▪ The condition of the current estate and ageing medical devices presents a significant maintenance and affordability burden in a restrained operations environment ▪ Restrictions on availability of central capital funding ▪ Review and identified area of capital programme that does not impact backlog maintenance – relates to Car Park.	Establish a trust wide 6 facet survey and report on the physical environment to identify areas of concern and replacement costs **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ Divisional risk reports to RMC (monthly) ▪ Backlog report presented to RMC -March 19; ▪ Compliance Audit undertaken (every 6mths) **Level 2** ▪ Significant risk report to RMC (monthly) **Level 3** ▪ PLACE audits (annually) ▪ 6 Facet survey ▪ Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	Inconclusive
Threat: Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Specialist H&S advisors & legal team employed ▪ Membership of CNST scheme ▪ H&S policies and procedures/ staff training ▪ Investigation processes; action planning and sharing lessons learnt to reduce likelihood of recurrence ▪ Clinical audit and effectiveness programme ▪ Other insurance policies	▪ Maturity of the safety management system is currently at 'emerging' level ▪ Limited monitoring of compliance with H&S requirements ▪ Restricted adaptive capacity ▪ Delayed responses to non-clinical incidents	Commission an independent safety management audit and develop a plan to take whatever steps are necessary to strengthen the Safety management systems **SLT Lead:** Dir Q&G **Timescales:**May 2019	**Level 2** ▪ H&S report to RMC (6 monthly) ▪ SIRG receives all claims/ RIDDOR incidents **Level 3** ▪ Authorised engineers reports; UKAS ▪ NHSR claims profile; MHRA inspection reports; HSE inspection/ Environmental Health inspections; CQC inspection reports		Inconclusive

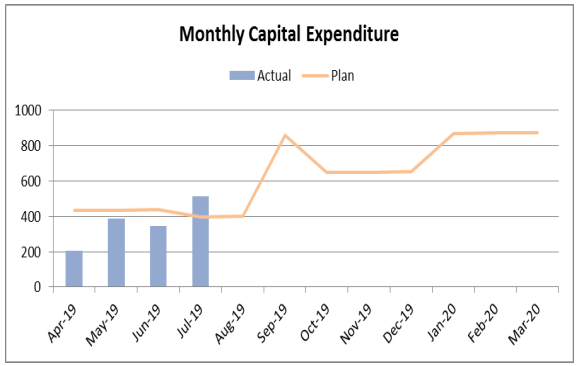
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

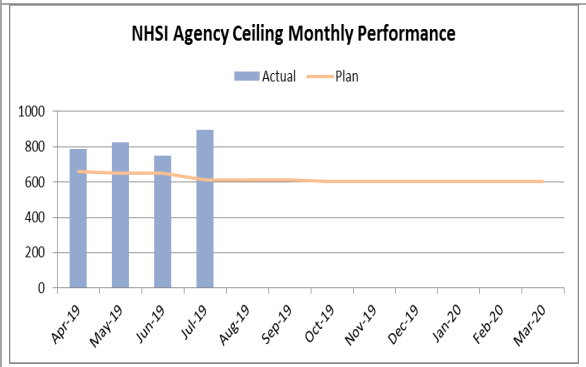
Key risk indicators (KRIs) Data updated 21/08/19











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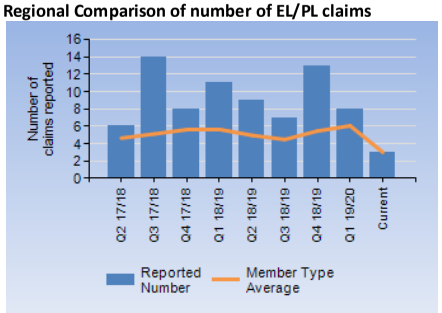
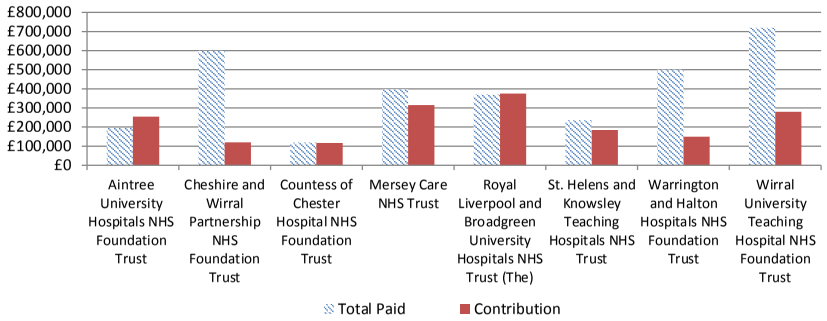
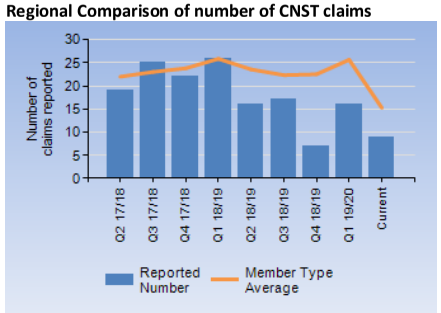
Regional Comparison of number of EL/PL claims



Regional comparison of RPST contribution and level of compensation paid



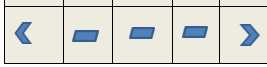
Regional Comparison of number of CNST claims



Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

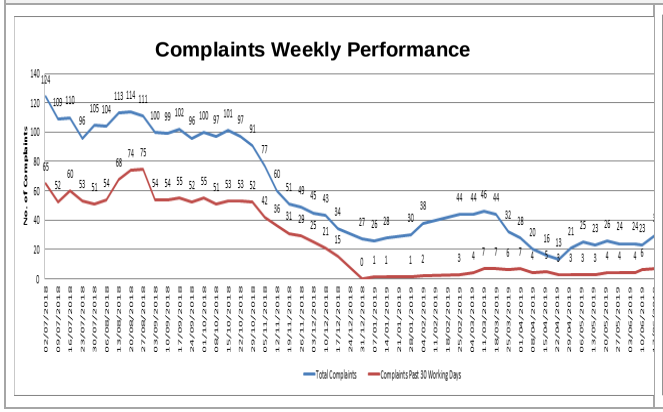
Strategic priority	PATIENTS: Pursuing quality improvement	**Lead Committee**	Quality	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 4: Catastrophic failure in Standards of Care** A Catastrophic failure in standards of safety and quality of patient care across the Trust resulting in multiple incidents of severe, avoidable harm and poor clinical outcome	**Executive lead**	Medical Director	**Likelihood:**	4. Somewhat likely	3. Possible	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	3.Moderate		
		Last reviewed	01/04/2019	**Risk rating**	**20. High**	**9. Medium**		
		Last changed	01/04/2019	**Anticipated change**	Uncertain			
Details of change	Updated gaps in control, plans to improve control and assurances documented							

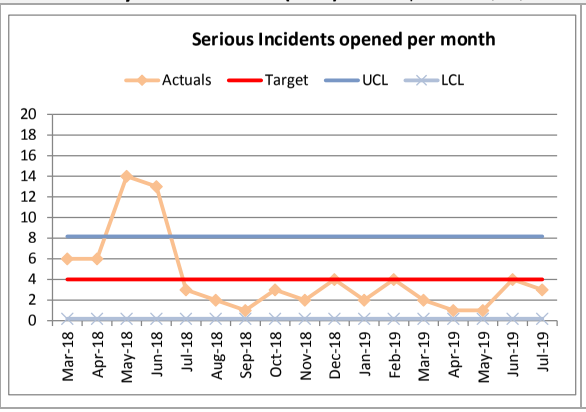
Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease (such as pandemic influenza; norovirus; infections resistant to antibiotics) that forces closure to one or more areas of the hospital and/or causes avoidable serious harm or death to service users **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Chief Nurse identified as DIPC • IPC service provided Trust wide by the IPC Team incl. seven day out of hour's on-call service; IPC Programme of work • Infection Prevention & Control policies/ procedures • Staff training • Antibiotic stewardship • Environmental cleaning Procedures / Standards in all areas • Decontamination standards – CSSD; Flu vaccination prog • Strict adherence to single use items • Bed occupancy managed by leads that attempts to minimise risk of cross contamination • Mattress decontamination / disposal & replacement	Unsustainable levels of bed occupancy (sufficient to control infections) Inadequate hand hygiene compliance in clinical areas (wards) Mattress replacement/ decontamination/ disposal Estate maintenance	Infection prevention control improvement plan to be fully implemented **SLT Lead:** Ch. N **Timescales:** August '19 Ward Managers prioritising areas for maintenance works to inform overall Estates Strategy **SLT Lead:** Ch. N **Timescales:** August '19	**Level 1** • Perfect ward/ ward accreditation audits; Divisional reports to IPORT • IPC task & finish group (weekly) to review actions **Level 2** • Infection Prevention & Control Performance Report to Board; Infection Prevention and Control - Improvement Plan – PSQB/Quality; Quality • Performance Dashboard; Weekly escalation report IPC specific; IPCG/ PSQB oversight • Outbreak meetings (weekly) – Public Health England/NHSI via telephone conference • **Level 3** • IPC Improvement plan; MIAA Internal audit reports; PHE reports • Invited Richard Cooke, microbiologist – Alder Hey to review plan	Lack of assurance re standard of cleaning **Action:** A review of hotel services to be undertaken **SLT Lead:** COO **Timescales:** End of Aug 19	Negative
A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including • Monthly Patient Safety & Quality Board (PSQB) with work programme aligned to CQC registration regs • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Clinical audit programme & monitoring arrangements • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe medical & nurse staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • CAS Implementation process • Mortality review policy & process • Real time review of incident reports and complaints handling	Current levels of mortality review and structured judgement review where these are indicated Timeliness of end to end VTE assessment through to treatment	Further develop & strengthen Learning from deaths process **SLT Lead:** MD **Timescales:** By end Q1 '19 Triangulation of mortality reviews – patient/carer experience, deaths in ED included **SLT Lead:** Deputy MD **Timescales:** By end Q2 '19 Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission. **SLT Lead:** MD **Timescales:** By end Q1 '19	**Level 1** ▪ Perfect ward/ ward accreditation audits (ongoing) ▪ FTT and electronic patient/relative feedback kiosks ▪ Primary Mortality Reviews + structured judgement reviews ▪ VTE Committee review with clinical lead **Level 2** ▪ Quality Performance Dashboard (monthly); ▪ PSQB reports (monthly) ▪ Quality Account (annual); ▪ KLOE inspections local inspections; ▪ Serious Incident Review Group (weekly) ▪ Safety Summits (monthly) **Level 3** ▪ CCG oversight of SI's (monthly) ▪ CQC Insight tool(monthly); ▪ Dr Foster updates; ▪ Internal Audit SI- significant assurance ▪ MIAA audit re safe staffing: Significant assurance ▪ Patient/ Staff surveys ▪ SHIMI / HSMR data ▪ MIAA Management of Complaints - Moderate Assurance	None identified	Positive

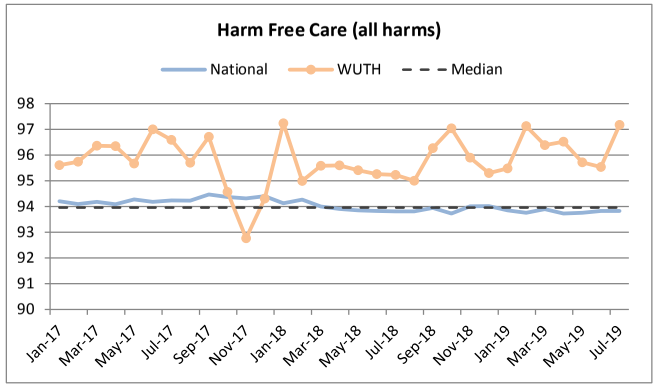
Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **Proximity of threat** 19/20 20/21 21/22 22/23 23/24 	**Key Measures** - We have the ability to measure metrics shown in the rest of the BAF eg VTE and MUST **Training** – end users are not provided access unless they are trained **Continuous improvement of the EPR** Response to divisions about usability and function	**Extended measures** There are other areas to monitor e.g fluid balance or IVs **Training** – adoption of a new way of training described in paper to WAC which includes regular updates **Innovation –** The way innovations are introduced into the Trusts needs more of a framework to manage priorities, costs and sustainability Unresolved imaging issues following 2018 Cerner update	**Cerner Optimisation** – address specific areas for improved usage **SLT Lead:** Dir IT & Info **Timescales:** 30/09/2019 **New Training** - adoption of a new way of training to be resourced and delivered **SLT Lead:** Dir IT & Info **Timescales:** 30 June 19 **End user Survey** and benchmark report on end user experience **SLT Lead:** Dir IT & Info **Timescales:** June 19 **In partnership with AHSN,** develop and approve model for innovation and adoption model **SLT Lead:** Dir IT & Info **Timescales:** By end Q1 '19 Technical solutions being trialled, alternative modality purchased (Carestream) **SLT Lead:** Dir IT & Info **Timescales:** By end of Q4 '20	**Level 1** • Digital Maturity assessments done as self-assessments with peer review • Competency based assessment of training / knowledge/skills • Perfect Ward assessments of compliance • Optimisation programme to be delivered by IT team **Level 2** MIAA Audits on use of the system and accuracy of data **Level 3** GDE audits for milestone payments HIMSS assessment	Currently no mechanism to determine success of training **Action:** **Measure objective** feedback e.g. immediately after training and again later **Introduce tests of knowledge** to see how many people know what they should. **SLT Lead:** Dir IT & Info **Timescales:** Sept 19	Inconclusive

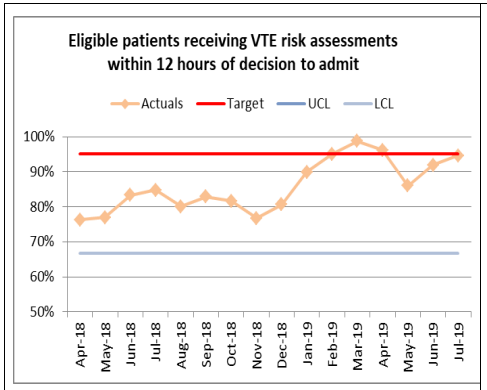
Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

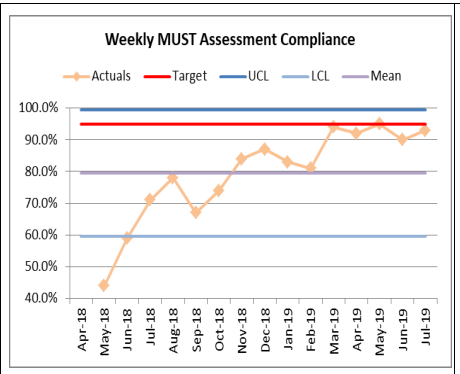
Key risk indicators (KRIs) - Data updated 21/08/19

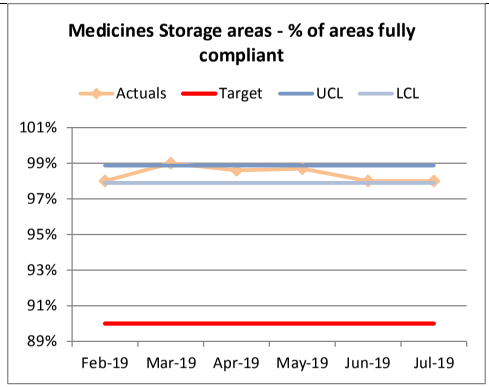


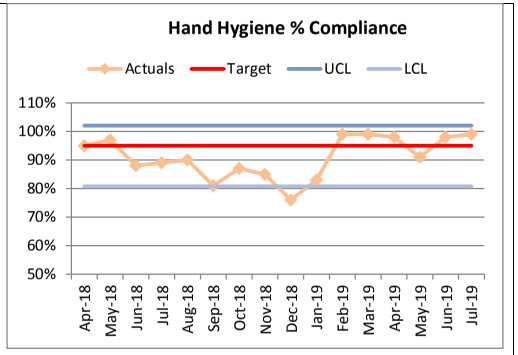


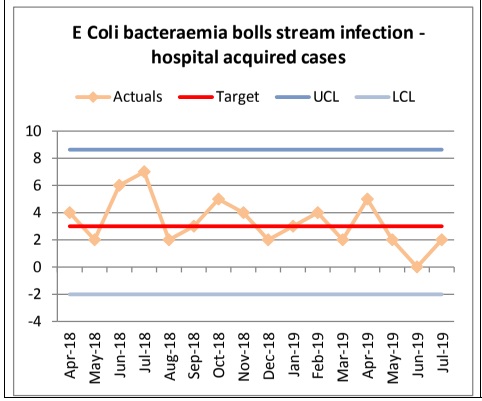


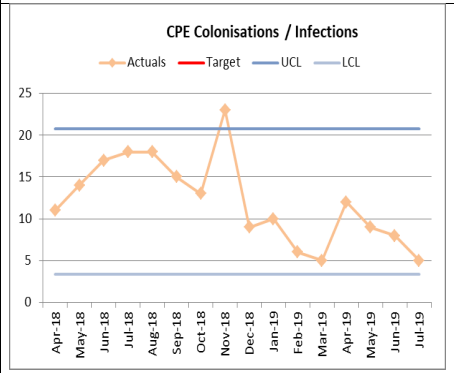


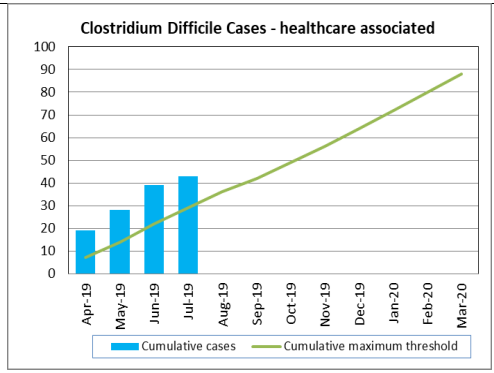


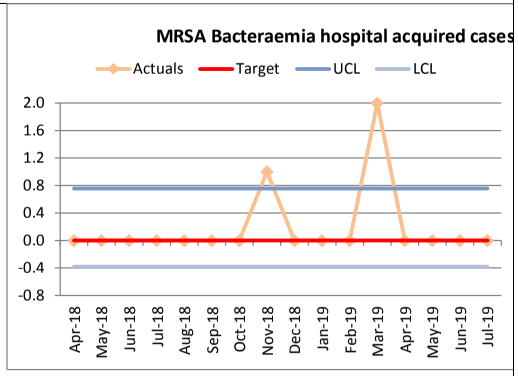












Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Strategic priority	ALL STRATEGIC OBJECTIVES	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 5: Major disruptive incident (leading to rapid operational instability)** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community	**Executive lead**	COO	**Likelihood:**	3. Possible	1. V. Unlikely	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	5. V. High		
		Last reviewed	01/04/2019	**Risk rating**	**15. Significant**	**5. Med**		
		Last changed	01/04/2019	**Anticipated change**	Intensifying			
Details of change	Updated plans to improve control							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: A large-scale **cyber-attack** that shuts down the IT network and severely limits the availability of essential information for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Data Security Assurance Framework (IGAF) • Fire wall controls • Access controls • VPN access • Anti virus and updates • Mandatory Data Security Training • Business Continuity plans & BIA – Divisional & IT specific • Pilot site unified cyber risk framework	Lack of co-ordination of incident response across region	Implement funded program to co-ordinate cyber security across the Mersey in liaison with NHS(E) **SLT Lead:** Dir IT & info **Timescales:** By end Q1 '19	**Level 1** ▪ IG & Clinical Coding Group **Level 2** ▪ Data Security and protection toolkit submission to Board; **Level 3** ▪ Business Continuity Confirm and Challenge NHSE; ▪ LHRP Assurance Process ▪ Cyber Essential Scheme Test Specification	None	Positive
Threat: A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels • Operational strategies & plans for specific types of major incident (e.g. fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) • Strategic, Tactical, Operational command structure for major incidents • Business Continuity, Emergency Planning & security policies • Power failure action cards • Business Impact assessments • Major incident plan and action cards	Deterioration of plant equipment & Fabric of building due to age of estate and availability of funding & extent of work required.	6 Facet survey commissioned. Interim report – August Board. Estate Strategy due September 2019. **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ EPRR Twice yearly report to RMC **Level 2** ▪ Monthly Significant Risk Report to Risk Committee ▪ EPRR annual report (Sept) ▪ Communication testing (every 6 months) **Level 3** ▪ EPRR Core standards compliance rating (+ve); ▪ Facet survey (May '19) ▪ MIAA Internal audit report – Emergency planning (May 19) ▪ April 2019 notification of NHSE review of EPRR core standards – Rating of "Substantial" assurance received for 2018/19	None	Positive
Threat: A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	▪ CAS alert system – Disruption in supply alerts ▪ Procurement ▪ Account Management ▪ Supplier Assurance ▪ Contingencies – Stock control ▪ 'No deal' EU Exit Planning Team established ▪ SRO & EU Exit lead identified for Exit preparation ▪ Risk assessment and business continuity planning	EU Exit Operational Readiness Guidance identifies a number of actions Trusts must take in preparation for Brexit	EU Exit planning team to review Operational guidance and ensure all actions completed within timescales **SLT Lead:** COO **Timescales:** As determined by Parliament (Review end Q1 '19) Brexit deferred to end October 2019	**Level 2** ▪ EU Exit paper to TMB (Feb 19) ▪ EU Exit preparation update to Board (Mar 19) ▪ EPRR Twice yearly report to RMC (Mar; Sept) ▪ EPRR Annual Report **Level 3** ▪ Letter of assurance, DoH		Positive

Key risk indicators (KRIs) Data updated 21/08/19

EPRR

Confirm and Challenge by NHS England Regional team and CCGs

September 2018:

Full Compliance

Substantial Compliance

Partial Compliance

Not Compliant

NHS Information Governance Toolkit — Department of Health

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 14.1 (2017-2018)	Published	77%	Satisfactory	n/a	n/a

NHS Digital — Estates Returns Information Collection, England, 2017-18

Publication date October 2018

RIDDOR incidents	30
Estates and facilities related incidents	184
Clinical service incidents caused by estates and infrastructure failure	111
Overheating occurrences triggering a risk assessment (No.)	8
Fires recorded	0
False alarms - No call out	34
False alarms - Call out	25

Cyber Security measures

Patching overview	Quantity	Compliance levels (Target 100%)
Desktop patching	4481	100%
Server Patching	275	94%
Anti Virus		Compliance levels (Target 95%)
Desktop	3925	99%
Server	275	98%

Inactive directory device accounts	May '19	July'19	Aug'19
60 days (Notice issues)	396	345	372
90+ days to be disabled	296	276	281
Web filtering			
Access requests authorised	25	18	20
Removable media			
Additions to the whitelist	0	0	0

Planned Preventative Maintenance performance measure – to be developed

Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Strategic priority	PARTNERSHIPS: Improve services through closer integration	Lead Committee	Board	Current risk exposure		Tolerable risk	Risk Treatment Strategy:	Seek, Modify, Accept
Principal risk (what could prevent us achieving this strategic priority)	**PR 6: Fundamental loss of stakeholder confidence** Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public	Executive lead	CEO	Likelihood:	3. Possible	1. V. Unlikely		
		Initial date of assessment	01/04/2019	Consequence	4. High	5. V. High	Risk appetite	Open
		Last reviewed	01/04/2019	Risk rating	12. High	5. Medium		
		Last changed	01/04/2019	Anticipated change	Uncertain			
Details of change	Updated primary risk controls and assurances documented							

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Source of assurance (& date) (Evidence that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap	Assurance rating
Threat: Changing regulatory demands (including potential impact of Brexit) or reduced effectiveness of internal controls resulting in failure to make sufficient progress on agreed quality improvement actions; Or widespread instances of non-compliance with regulations and standards **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Quality & corporate governance & internal control arrangements ▪ Conflicts of interest & whistleblowing management arrangements ▪ Routine oversight of quality governance arrangements & maintenance of positive relationships with regulators ▪ Formal notification process of significant changes (Relationship manager, CQC; Chief Inspector of Hospitals) ▪ Internal KLOE inspections in clinical areas ▪ Exec visibility & visits ▪ Clinical & management audit ▪ Policies and procedures ▪ External oversight from regulators via System Improvement Board	Compliance:- ▪ Infection prevention ▪ Medicines storage ▪ Estate Condition ▪ ED Triage within 15 mins arrival	As per CQC Action plan – refer to Board report	**Level 1** ▪ Ward accreditation metrics ▪ Managing Conflicts of Interest – New Policy **Level 2** ▪ CQC Action Plan Progress Report (actions identified in action plan 2018 complete) ▪ PSQB Report to Quality Committee ▪ Quality Performance Dashboard **Level 3** ▪ CQC Inspection report ▪ System Improvement Board minutes (NHSI/E)	None identified	Positive (Positive)
Threat: Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Communications department to handle media relations: ▪ Established relationships with regulators ▪ Trust website & social media presence ▪ Internal communications channels ▪ Continued public & stakeholder engagement utilising a wide range of consultation & communication channels; ▪ Involvement & Engagement Strategy Trust Board ▪ Surveys and Friends and Family Testing ▪ Consultation on proposed strategy and service changes	▪ No agreed Comms / PR Strategy	External support to develop Comms / PR Strategy **SLT Lead:** HR Dir **Timescales:** Autumn 2019	**Level 2** ▪ Communication / Press statements ▪ Communications & Marketing Strategy (Sept '19) **Level 3** ▪ CQC National patient survey; ▪ FFT recommendation ratings ▪ Healthwatch commentary ▪ OSC commentary ▪ NHS Choices ratings	None identified	Positive (Inconclusive)

Board Assurance Framework (BAF): 2019/20 (valid as of 21st August 2019)

Key risk indicators (KRIs) Data updated 21/08/19

Wirral University Teaching Hospital NHS Foundation Trust

CQC overall rating

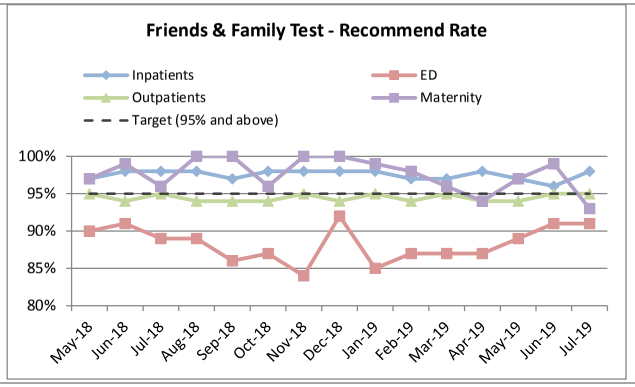
Requires improvement

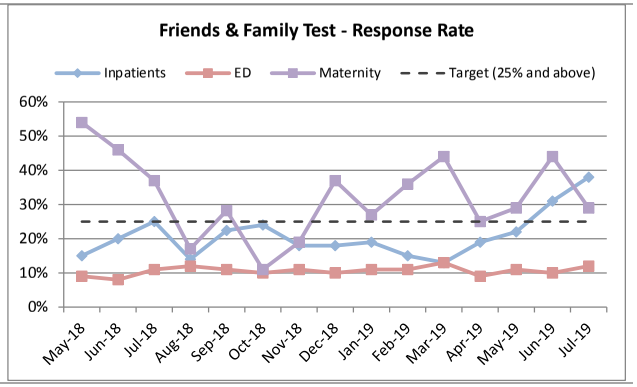
13 July 2018

Location level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Overall	RI 13/7/2018	RI 13/7/2018	G 13/7/2018	RI 13/7/2018	I 13/7/2018	RI 13/7/2018
Arrowe Park Hospital	RI 13/7/2018	RI 13/7/2018	G 13/7/2018	RI 13/7/2018	I 13/7/2018	RI 13/7/2018
Clatterbridge Hospital	RI 10/3/2016	G 10/3/2016	G 10/3/2016	RI 10/3/2016	RI 10/3/2016	RI 10/3/2016

NHS Choices – 21/08/19

	NHS.UK users rating	Care Quality Commission inspection ratings	Recommended by staff	Mortality rate (in hospital and up to 30 days after discharge)	Food: Choice and Quality
Arrowe Park Hospital (Remove)	175 ratings, Rate it yourself	Requires Improvement, Visit CQC profile	OK, Within expected range with a value of 69%	OK, Number of deaths within the expected range	OK, 78.69% Within the middle range
Clatterbridge Hospital (Remove)	37 ratings, Rate it yourself	Requires Improvement, Visit CQC profile	OK, Within expected range with a value of 69%	OK, Number of deaths within the expected range	OK, 66.11% Within the middle range





Inpatient Survey – to be added when released

Comms & Engagement KPI
To be developed

CQC Maternity Services patient survey – Published Feb 2019

Patient survey	Patient response	Compared with other trusts
Labour and birth	9.1/10	About the same
Staff	9.3/10	Better
Care in hospital after the birth	8.4/10	Better