Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

6 November 2019

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting of the Board of Directors

9am - Wednesday 6th November 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 – 2 October 2019	Board Secretary	Paper	4
6.	Board Action Log	Board Secretary	Paper	17
7.	Chief Executive's Report	Chief Executive	Paper	18
Quality and Safety				
8.	Patient Story	Head of Patient Experience	Verbal	N/A
9.	Infection Prevention & Control (IPC) Update	Acting Chief Nurse / Director of Quality & Governance	Paper	22
10.	6 Monthly Nurse Staffing Report	Acting Chief Nurse / Director of Quality & Governance	Paper	24
11.	National In-Patient Survey	Acting Chief Nurse / Director of Quality & Governance	Paper	34
Performance & Improvement				
12.	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce, Director of Quality & Governance and Acting Chief Nurse	Paper	40
13.	Month 6 Finance Report	Acting Director of Finance	Paper	76
14.	Long Term Plan Update	Acting Director of Finance	Paper	98
Workforce				
15.	Freedom to Speak Up [6 Monthly Update]	Sharon Landrum	Paper	110

Governance				
16.	Change Programme Summary, Delivery & Assurance Followed by Presentation from The 'Patient Flow' Programme	Joe Gibson Jane Hays-Green	Paper Presentation	127 N/A
17.	Report of Trust Management Board	Medical Director	Paper	148
18.	Report of Charitable Funds Committee	Chair of Charitable Funds Committee	Paper	152
19.	Report of Safety Management Assurance Committee	Chair of Safety Management Assurance Committee	Paper	160
20.	Business Case – Acute Medicine Nursing	Chief Operating Officer	Paper	162
21.	Medical Engagement Survey Outcomes	Medical Director	Paper	173
22.	CQC Action Plan Progress Update	Director of Governance & Quality / Acting Chief Nurse	Paper	175
23.	Board/Board Assurance Committees – Annual Meeting Cycle	Board Secretary	Paper	183
24.	Board Assurance Framework	Board Secretary	Paper	186
25.	Seven Day Services – Self Assessment Submission.	Medical Director	Paper	205
Standing Items				
26.	Any Other Business	Chair	Verbal	N/A
27.	Date of Next Meeting – 4 December 2019	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

2nd OCTOBER 2019

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

John Sullivan	Non-Executive Director (Vice Chair)
Janelle Holmes	Chief Executive
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director
Karen Edge	Acting Director of Finance
John Coakley	Non-Executive Director
Chris Clarkson	Non-Executive Director
Paul Moore	Acting Chief Nurse / Director of Quality & Governance

In attendance

Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Paul Charnley	Director of IT and Information
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
Steve Evans	Public Governor
Angela Tindall	Public Governor
Joe Gibson*	Project Transformation
Jane Kearley*	Member of the Public
Jennier Richardson	Member of the Public
Anne Pooke*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

Sir David Henshaw	Chair
Jayne Coulson	Non-Executive Director
Gaynor Westray	Chief Nurse
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 19-20/136	**Apologies for Absence** Noted as above.	
BM 19-20/137	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/138	**Chair's Business** The Vice Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Vice Chair informed the Board of Directors that key issues would be captured within items already contained on the agenda.	

Reference	Minute	Action
BM 19-20/139	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Workforce** – reported the launch of the NHS staff survey with a closing date of December. In addition the Trust has launched 'Spring Board' a women's development programme and 'Navigate' the development programme for male colleagues is due for launch next year. **Mr John Coakley – Non-Executive Director –** informed the Board of Directors of recent successful clinical appointments, with start dates to be negotiated. **Associate Medical Director, Women & Children's –** Mr Lund advised of recent concern regarding the use of Ward 54 as an escalation ward. The Medical Director reported that due to pressure on the system a Standard Operating Procedure (SOP) was in place that included Executive on call sign off for any such transfers to escalation areas to ensure the safety of all patients. **Mrs Sue Lorimer – Non-Executive Director –** informed that Board that following discussion at Finance, Business, Performance and Assurance Committee (FBPAC) and further scrutiny of options, a decision to renew Trust 'top-up' insurance policies for one year had been taken. Further investigations will take place during the next twelve months to establish the risk exposure if the Trust did not continue to purchase such policies. **Medical Director** – notified the Board of Directors that the medical engagement survey had now closed and the Board would be appraised of the outcome at a future meeting. ***The Board noted that although some members did not have detailed updates there were a number of topics already covered within agenda items.***	**NS**
BM 19-20/140	**Board of Directors** **Minutes** The Minutes of the Board of Directors meeting held on 4th September 2019 were approved as an accurate record with the exception of a typo on page 6 – removal of *'Nurse in their capacity as Acting Director of Infection Prevention Control (DIPC).'* **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 19-20/141	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including:	

Reference	Minute	Action
	• Together Awards – across eight categories • In Touch with the Board • EU Exit • Serious Incidents • RIDDOR Update • Health Minister visit • System meetings • Executive team recruitment The Board of Directors were informed of national awards and recognition in the following areas: Dementia, Maternity Services and a Florence Nightingale Award. The Board of Directors acknowledged the significant progress of the Ophthalmology department. This was underpinned with the opportunity to present at the national GIRFT event to outline improvements in the cataract pathway which has resulted in a reduction in patient waits and moved the Trust from being one of the worst performing to one of the best nationally. A primary factor for this is the close alignment of the operational and clinical leads along with the team being empowered to delivery change. ***The Board noted the information provided in the September Chief Executive's Report.***	
BM 19-20/142	**Patient Story** The Board were joined by Anne Pook who appraised the Board of Directors of her poor in-patient experience. Anne attended A&E following the onset of a severe headache and vomiting. A CT was carried out and she was transferred to a short stay ward and then to an escalation area within a Gynaecology ward. During the next couple of days her health deteriorated further and friends and family were concerned that her symptoms did not appear to be being investigated thoroughly. Following escalation of their concerns the on-call doctor reviewed her case who subsequently requested review by the stroke team. Recognising the seriousness of Anne's condition a further CT scan was ordered which identified a bleed on the brain and she was transferred to The Walton Centre. Anne expressed her disappointment with the level of care received, being so poorly and feeling ignored. Subsequently Anne has discussed her concerns at a meeting with a number of actions identified that have consequently been implemented to ensure this experience is not repeated. The Board thanked Anne for sharing her experience and providing the opportunity to improve the patient experience. ***The Board noted the feedback received from Mrs Pook.***	
BM 19-20/143	**Emergency Care Intensive Support Team (ECIST) Update** Chief Operating Officer introduce Karen McCraken, ECIST lead to provide a progress report regarding the streaming pilot currently being undertaken highlighting areas of good practice and those that the Trust could improve	

Reference	Minute	Action
	along with recommendations that will require the support of the wider health economy. The approach was appreciative enquiry initially, working alongside frontline and management teams. In summary there are two main concerns identified that required ECIST intensive support, a very over crowded Emergency Department (ED) and an inability to stream patients to other areas in conjunction with non existent primary care streaming, therefore impacting patient flow across the organisation. This compounded by the Trust having one of the highest 'long length of stay' performance indicators. Barriers across the health economy were identified namely due to an over complex system not working to the benefit of patients. Working with the ED team, operational plans were developed encompassing processes to stream patients in all specialities, it should be recognised that similar plans have since been implemented in other organisations to address similar issues. The A&E Board supported the approach and accepted that diagnostics within the community requires improvement. It was recognised that since implementation of the operational plans the wider health system were working together to address these matters. This was demonstrated recently when a 'call to action' introduced to address urgent concerns regarding long length of stay patients. For a period of two weeks senior leaders from all providers worked together to reduce the number of in-patients above 21 days length of stay. It was highlighted that although a significant number of patients had been moved out of hospital to appropriate care, as soon as these patients had been move other breached this threshold and therefore the numbers above the 21 days has not reduced significantly. The ECIST team observed the internal 'Board Rounds' and provided examples of ineffective practices currently in place and have identified a number of improvement actions for the Trust to implement. The ECIST lead recently attended the A&E Board to appraise them of the situation, it was realised that partners are now understanding the pressure on WUTH and the actions required by the system to deliver change. The Board emphasised the need for this to be the top priority for the system as it would drive quality, safety and financial benefits for all. It was stressed that the Trust is addressing processes that have been in place for a considerable length of time and therefore improvements will take time to embed. This review has been aligned to the 'patient flow' programme and future updates will be provided within the Change Programme report. The Board of Directors were advised that ECIST would continue to provide support to the system until the end of December. ***The Board noted the progress to date and acknowledged that although it may take some time for improvements to be embedded there were green shoots of change.***	

Reference	Minute	Action
BM 19-20/144	**Infection Prevention Control (IPC) Update – Outbreak of *Clostridium difficile*** A progress report concerning the outbreak of *Clostridium difficile (CDI)* was provided. The Board were provided assurance that substantial improvements have been made following the interventions implemented in recent weeks, such as environmental cleaning, hand hygiene and the correct use of policies and procedures to help keep risk under control. Although the Trust is above overall trajectory for quarters 1 and 2, the Board were provided assurance that as a consequence of a combination of interventions: environment, equipment, cleaning and policies and procedures as detailed in the report September had seen a significant reduction with three cases being reported. With effect from September the previous weekly outbreak meetings have been changed to bi-weekly due to the outbreak being brought under control. In the forthcoming weeks the Acting Chief Nurse in their capacity as Acting Director of Infection Prevention Control (DIPC) will consider standing down the 'outbreak' designation if performance continues on the improved trajectory. They reminded the Board that the risk remains high due to demand on the service and that Public Health England has also advised caution as they anticipate the trajectory may be not be linear. The Acting Chief Nurse / Director of Quality & Governance advised that going forward improvements will continue at pace until year end to ensure processes are embedded and IPC remains under control. The Chair of Quality Committee stated that in reviewing the IPC risks identified within the Board Assurance Framework the committee had considered reducing the overall risk rating to reflect improved performance. It was agreed that until the trends continue on a downward trajectory the score would remain the same. The Board thanked the teams for their continued hard work and effort to work towards better control of infection, prevention measures. ***The Board noted progress to date and the advice from the Acting Chief Nurse in their capacity as Acting Director of Infection Prevention Control (DIPC).***	
BM 19-20/145	**Learning from deaths quarterly report** The quarterly learning from deaths report was presented providing the Board of Directors with an update against compliance and the wider mortality agenda. Progress continues in further developing the mortality review process to ensure the opportunity for learning in optimised. For quarter one 75% of mortality reviews have been completed. The number of Structured Judgement Reviews (SJRs) undertaken has increased and further work is required to ensure all speciality reviews report into the Trust mortality processes. It was highlighted that documentation issues continue to be	

Reference	Minute	Action
	identified and actions to support improvement have been identified. The report also described the next steps to provide greater assurance. As previously mentioned the approach to the introduction of a medical examiner office is currently being considered. A job description is being developed, this along with the proposed approach and will be provided to the Board of Directors for approval. ***The Board noted the Learning from deaths quarterly report and the improvements made to ensure the process is optimised.***	
BM 19-20/146	**Health & Safety Quarterly Update** The report outlined an overview of Quarter 2 2019/20 Health & Safety performance and assurance activities, together with an update on progress against the Health & Safety action plan. Significant work has been undertaken to establish a framework by which health and safety can be effectively managed in line with ISO45001 and Divisions are currently progressing the actions from the inspection reports. The framework provides the building blocks to support implementation of health and safety processes across the organisation. The performance dashboard has now been replicated for Divisions and will require further development following feedback from Divisions to maintain H&S performance within their areas. The team continue to monitor the impact of increased reporting and the Director of Quality & Governance informed the Board that as a consequence of this an increase in RIDDOR reporting is likely. Chair of the Safety Management Assurance Committee congratulated the team for the significant progress made within a short period of time and the continued improvement trajectory. ***The Board noted the quarter 2 performance, the significant and rapid improvements made and the performance measures now available.***	
BM 19-20/147	**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 57 indicators with established targets or thresholds 21 are currently off-target or not currently meeting performance thresholds. Whilst improvement across a range of indicators continues the Board recognised slippage of some indicators particularly in the safe and responsive domains. 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: • Long length of stay – deterioration in performance is correlated to A&E and ambulance handover performance. System 'call to action' implemented and review to establish resilience to continue to support	

Reference	Minute	Action
	underway. The targeted reduction will be required to support winter pressures. • 4 hour A&E – as expected performance continued to dip in August impacted by long length of stay which is currently above the national average and therefore has an impact on this indicator. • Diagnostics – volumes higher than expected, robust weekly tracking implemented to monitor additional activity and requirements to support indicator achieving compliance. • RTT (18 weeks) – slight deterioration, impacted by opening of escalation beds leading cancellation of some day cases. • 12 hour ED waits – inconsistency in process for patients with mental health issues, revised admittance process agreed to reflect impact on an Acute Trust if a mental health provider is unable to identify a bed in time. This is the correct process for patients. • Friends & Family Test – in-patient satisfaction remains strong. National guidance has indicated the removal of reporting response rates with effect from 2020. • Infection Prevention Control (IPC) indicators – these indicators are covered within agenda item BM 19-20/144, earlier in the minutes. A project across Wirral implemented to review of negative bacteraemia, update to be provided at future meeting. • Same sex accommodation – whilst breaching this indicator, this was acknowledged as a tolerable risk mainly due to patient satisfaction with care. • VTE – this indicator is expected to achieve the 95% compliance threshold following ratification of all September data • Attendance management – progress against the actions reported in September is to be monitored by the Workforce Assurance Committee. Initial report of the First Care pilot reviewed at WAC meeting, reconciliation of data required to ensure clarity of performance. • Turnover – a breakdown provided with targeted actions identified eg training opportunities for clinical support workers. The Board recognised the first time of reporting 'zero' never events over the past twelve months and the significance of this achievement based on previous performance. The Acting Chief Nurse alerted the Board of the possibility increased risk in the number of falls being reported due to the mobilisation of patients. The Board were advised of additional initiatives introduced to address attendance management performance such as fast track referrals to MSK service, requests for counselling directed through the Employee Assistance Programme and Cheshire & Wirral Partnership supporting occupational health checks for recruitment process. ***The Board noted the current performance against the indicators to the end of August 2019.***	
BM 19-20/148	**Month 5 Finance Report** The Acting Director of finance apprised the Board of the summary financial position and at the end of month 5, the Trust reported an actual deficit of £7.1m versus planned deficit of £5.2m. However, this includes c£1.4m of	

Reference	Minute	Action
	non-recurrent support from Wirral Clinical Commissioning Group (CCG) to achieve the Trust planned position and allow the Provider Sustainability Funding and Financial Recovery Funding (PSF/FRF) to flow to the Trust and the system. The key headlines for month 5 include: • The underlying position is £3.3m worse than plan cumulative and £1.1m worse in month. • Income is broadly in line with plan with elective and day case activity worse than plan reflecting in year trend, however, obstetrics (including One-to-One transfers) and excess bed days is higher than plan. Non-PbR is lower than plan reflecting activity variation in Critical Care, Rehab and Welsh neonatal. • In month, pay is exceeded plan by (£0.8m). This has deteriorated from the previous run rate with a higher medical staff variance £0.1m (Jnr Dr handover and Gastro) and higher nursing adverse variance £0.2m (CSW's sickness, acuity and escalation areas). Jnr Dr expected to improve from Sept and doing a review of Gastro capacity and costs. • Cost Improvement Programme (CIP) delivered in month and year to date with £3.9m against a plan of £3.9m. The profile of the CIP increases in Quarter 2 and some slippage is expected. • Cash is £2.6m, 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 was deferred at national request and has subsequently been reinstated but the timeline to deliver means this would not be completed in 2019/20. A detailed forecast has been completed as at Month 4 which shows a full year effect of c£10m deficit including undelivered CIP. If CIP risks are mitigated and the full programme is delivered this would be c£7.7m deficit. This does not include the potential foregone PSF/FRF of £10.6m if the system support is not received. (Q2 £2.5m, Q3 £3.8m, Q4 £4.4m.) It assumes the planned closure of beds in October, no winter contingency and repayment of non-recurrent support. Further risk of CQUIN maybe an issue but expect system reinvestment on this. A breakdown of the unplanned and operational pressures, were detailed, along with undelivered CIP. This led to detailed discussions regarding some of the cost pressure elements such as waiting list initiatives, medical staffing including junior doctors and locums. The Board of Directors understood that a short to long term plan to mitigate pressures is being developed with identified operational leads. It was recognised that due to the complexities of reviewing and revising job plans this could not be addressed in year and would be within the long term plans. Further mitigations from One-to-One and Welsh income would reduce the deficit to (£6.9m). At Divisional level, the risks are in Medicine and Surgery and any further action on cost would be clinical and would need to be balance against patient safety and risk.	

Reference	Minute	Action
	The Acting Director of Finance highlighted that the position gives rise to a potential cash shortfall and conversations are being held informally with NHS Improvement in relation to additional cash support. **The Board noted the month 5 finance performance and approved the additional borrowing to support the forecast deficit.**	
BM 19-20/149	**Draft People Strategy 2019-22** The draft People Strategy 2019-22 is the three year roadmap that informs, describes and guides the many activities that will shape, build and sustain the Trust's workforce. The Strategy is underpinned by the comprehensive Organisational Development Plan approved last year and set the direction of travel. This will be refreshed to identify metrics to monitor progress and delivery of the People Strategy. The Workforce Assurance Committee is to monitor implementation and progress of the Strategy. **The Board approved the People Strategy and noted the existing Organisational Development plan is to be reviewed.**	
BM 19-20/150	**Influenza Plan** The Influenza Plan describes the Trusts Occupational Health Department plan for the 2019/20 campaign to ensure delivery of the CQUIN 80% target for frontline staff. It was acknowledged that vaccines had been delayed compared to the previous year although first batch of vaccines has now been received and prioritisation will be for staff working with at risk patients such as children and the elderly. Receipt of further vaccines would be after the UK exits the EU ie post October 2019. A further update will be provided to the Board in December. **The Board noted the 2019/20 Influenza Plan.**	**HM**
BM 19-20/151	**Change Programme Summary, Delivery & Assurance** Joe Gibson, External Assurance 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 reported that the scope has been amended to include the 'Hospital Upgrade Programme' and the 'World Class Administration of Patient Services' project will bring its Project Initiation Document (PID) to the October meeting whereupon it will be introduced to the scope. The Board of Directors were advised that the 'improving patient flow' rating had been suspended whilst the external support provided by ECIST is aligned. A review is to take place in December. The overall governance rating has seen a slight deterioration and SRO's are working with the teams to transact additional assurance within each	

Reference	Minute	Action
	programme. It was highlighted that it is not unusual for the governance rating to fluctuate during programme schedules. From October Joe Gibson is to attend meetings of each programme with a focus on individual plan elements to ensure overall delivery of programmes. It was acknowledged that once the new team is in place the additional resource for each programme should enable to Divisions to achieve completion of actions. The Digital Board is to consider the realignment of the GDE projects and as discussed previously elements of the 'Digital' work stream have been transferred to others as an enabler to transform programmes. ***The Board noted the Change Programme summary, delivery and assurance report.***	

BM 19-20/152	**Report of Trust Management Board**
	
	The Chief Executive provided a report of the Trust Management Board (TMB) meeting on 26th September 2019 which covered:
	
	• Quality & Performance Dashboard
	• Divisional updates
	• Infection Prevention Control (IPC) Improvement Actions Update
	• First Care – Absence Management Pilot
	• Workforce Reviews – Emergency Department Medical and Nursing staff
	• Month 5 Financial Position
	• Business cases:
	  ○ Capacity Management Handheld Devices for Porters
	  ○ Acute Medicine Nursing Establishment Investment (requires review by FBPAC with recommendation to approve option 2)
	  ○ Endoscopy – expansion to nursing workforce
	  ○ Bed Management Review
	  ○ Replacement of Cardiac Catheter Lab (recommendation that Board approve – note: FBPAC also considered at the September meeting)
	  ○ Three Phase Recovery (recommendation that Board approve – note: FBPAC also considered at the September meeting)
	  ○ Braun Containers
	• Chair reports from other meetings
	• Cheshire & Merseyside Pathology Network Collaboration
	• No Deal EU Exit.
	
	The Board noted the report of the Trust Management Board and approved Replacement of Cardiac Catheter Lab and Three Phase Recovery business cases.	

BM 19-20/153	**Quality Committee** Dr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the Quality Committee, held on 24th September 2019 which covered: • Serious Incidents and Duty of Candour	

Reference	Minute	Action
	• Infection Prevention & Control • CQC Action Plan • Quality Performance Dashboard • Wirral Individualised Safe-Care Everytime (WISE, Ward Accreditation). The Committee expressed concern at the shortfall in the 'organisation and management' domains of the Ward Accreditation report. The Acting Chief Nurse described the elements currently within the domain and explained that a review of the methodology for this domain was underway. ***The Board noted the report of the Quality Committee.***	
BM 19-20/154	**Finance, Business, Performance and Assurance Committee** Ms Sue Lorimer, Non-Executive Director, provided a report of the key aspects from the recent Finance, Business, Performance and Assurance Committee, held on 24th September 2019 which covered: • Month 5 finance report • Capital programme • Cerner Contract Update • Quality Performance Dashboard • Board Assurance Framework • Renewal of Trust Insurances • Medical Workforce Contract • Chairs report of the Finance Performance Group The Committee reviewed the Cardiac Catheter Lab replacement and the Three Phase Recovery business cases and recommended Board approval. ***The Board noted the Finance, Business, Performance and Assurance Committee report and approved Replacement of Cardiac Catheter Lab and Three Phase Recovery business cases.***	
BM 19-20/155	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee, held on 25th September 2019 which covered: • Staff story – Volunteer • Draft Workforce Strategy • Communications dashboard • Workforce Intelligence and KPI review • NHS Improvement – Lessons to improve staff disciplinary practices • Medical workforce contracts • Attendance Management – First Care pilot update • Recruitment Process Review Audit (MIAA) • Flu Plan update • Board Assurance Framework • Chairs Report of the Workforce Steering Group It was accepted that whilst the initial feedback of the First Care attendance	

Reference	Minute	Action
	management pilot was received, it should be recognised that it would be a number of months before the benefits would transpire. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 19-20/156	**Audit Committee** Mr Steve Igoe, Non-Executive Director, apprised the Board of the key aspects from the Audit Committee, held on 25th September 2019 which covered: • Internal Audit • Counter Fraud • External Audit • Financial Assurance Report • Financial systems • Risk Management. ***The Board noted the report of the Audit Committee.***	
BM 19-20/157	**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 based on the 2018 inspection. All 219 actions have been completed with 218 fully embedded. The exception is due to a delay launching the Patient Experience Strategy due within the next two weeks. The Urgent Care overdue action relates to the use of 'corridor care'. Although the Trust achieved a period of zero corridor care usage in early summer, it has again used corridor care in August and September albeit at significantly reduced levels. The action related to compliance with the RCPCH recommended staffing levels for paediatric trained nurses within ED is expected to conclude within the next four weeks. The Board reiterated acknowledgement of the achievement to complete all actions within the identified timeframes as clear demonstration of a success story for all involved. ***The Board noted the progress to date of the CQC Action Plan.***	
BM 19-20/158	**Board and Board Assurance Committee 2020 Schedule** The Board Secretary provided the proposed 2020 schedule of meetings encompassing Board, Assurance Committees and the management meetings that report to Trust Management Board. The scheduling of Board and Audit Committee in May 2020 is dependent on the Annual Report & Accounts timeframe yet to be confirmed. To enable clinical attendance at the Workforce Assurance Committee, this is	

Reference	Minute	Action
	to be scheduled on a Tuesday or Thursday. Discussion took place regarding the frequency of the Finance, Business, Performance & Assurance Committee to ensure pace and to facilitate the agenda. It was agreed to seek the views of member to change the frequency to monthly and report back to Board next month. **The Board of Directors approved the 2020 schedule of meetings with the amendments described above.**	**AL**
BM 19-20/159	**Governor Election Report** The Board Secretary apprised the Board of Directors of the current position in relation to the Governor election process currently underway. Of the four public constituencies that elections are being held, only one received nominations. A recommendation to the forthcoming Council of Governors will propose rolling over the three vacancies to the 2020 process. This would enable promotional activities with the support of the Communications team to be undertaken during the next twelve months to generate interest regarding the Governor role. **The Board of Directors noted the 2019 Governor election update.**	
BM 19-20/160	**Any Other Business** There were no items to report this month.	
BM 19-20/161	**Date of next Meeting** Wednesday 6th November 2019.	

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Chair

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Date

Board of Directors Action Log
Updated – 2nd October 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 02.10.19						
1	BM 19-20/139	Outcomes of the Medical Engagement Survey to be provided at a future meeting	**NS**	Complete	November '19	See agenda item 21
2	BM 19-20/150	Progress report of the Influenza Plan to be provided.	**HM**		December '19	
3	BM 19-20/158	Review frequency of FBPAC and report final schedule to next meeting	**AL**	Complete	November '19	See agenda item 23
Date of Meeting 04.09.19						
2	BM 19-20/122	Medical Examiner office – provide update following receipt of local guidance	**NS**	Approach of a medical examiner office being considered and job description being developed	December '19	
3	BM 19-20/124	Medical Staffing Short, medium and long term plan to be presented to FBPAC	**KE/HM**	Complete	October '19	Include for November FBPAC
Date of Meeting 01.05.19						
2	BM 19-20/028	Patient Experience Strategy under development	**PM**	Complete	October '19	Presented to PSQB

Board of Directors	
Agenda Item	7
Title of Report	Chief Executive's Report
Date of Meeting	6th November 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 October 2019.

Internal

CQC Unannounced Inspections and NHS England/Improvement Assessment

October has seen two unannounced inspections take place over a 6 day period. The CQC has reviewed 4 core services: Urgent and Emergency Care, Medicine and Acute, Children and Young People and Surgery.

In addition the 'Use of Resources' assessment was undertaken by NHS England/ Improvement. From this review the Trust will receive a 'Use of Resources' rating that the CQC will combine with their 'Quality' assessment. The combined rating is awarded by aggregating the trust-level ratings for CQC's current five quality key questions (safe, effective, caring, responsive, well-led) with the Use of Resources rating.

The final scheduled CQC review is the Well-led assessment. This will take place on 12th – 14th November 2019.

Staff Awards

The Staff 'Together' Awards event took place on **Friday 11th October** at Thornton Hall Hotel and Spa and was hosted by TV chef Simon Rimmer.

The event celebrated the outstanding work of the teams who are working together to provide the best possible patient care and experience. There were some truly amazing nominations highlighting the real dedication and compassion of the teams across the organisation.

The awards were aligned to the new Vision "Together we will" and reflected our Values: "**caring** for everyone"; "**respect** for all"; "embracing **teamwork"** and "committed to **improvement**." Nominations were received from across the hospital. The selection panel consisting of Executive Directors, Staffside and Governors reviewed the nominations and the winners are detailed below:

- Patient Choice Award – Ward 38
- Excellence in Patient Care – Highfield Midwifery Team
- 'Together we will' Team of the Year - Ophthalmology
- Non-clinical Team Award – Portering and Postal Team
- Innovation and Improvement Awards – Urology Cancer Nursing Service – Macmillan Nurses
- Partnership Award – GP/Hospital Integrated Clinical Pharmacists
- Trainee/Apprentice of the Year – Paige Campbell
- Volunteer of the Year – Margy Pierce of the Discharge Hospitality Centre.

Ward Accreditation

Congratulations to Wards 37 and 38 who are the first wards at the Trust to have achieved Level 3 (Green) as part of the WISE ward accreditation process.

The WISE (Wirral, Individual, Safe Care, Everytime) ward accreditation process involves wards being rated on their delivery of patient care across a number of domains.

This is a fabulous achievement for the wards, showing their commitment to continuous improvement and delivery of outstanding patient care.

Serious Incidents

The Trust declared 5 Serious Incidents in October 2019. These cases related to:

- A patient developing a pressure sore
- 2 x patient falls
- A baby born who required cooling post delivery
- A patient reaction to an administered medicine.

Full investigations are underway with the outcome report and any actions reported to the Quality Committee.

RIDDOR Update

The Trust reviewed 3 RIDDOR reportable incidents at the Serious Incident panel during October 2019. The incidents all related to members of staff, two were MSK injuries and one was from a slip, trip and fall. All have been investigated and reported to the Quality Committee.

Regional & Local

Unplanned Care Board

The Board continues to focus on aspects of both Urgent and Unplanned care. With the support of the Regulators and Wirral System Representatives, the Board was assured that all Organisations remain committed to the collaborative approach being taken to reduce long length of stay within the Acute Trust, thereby supporting overall patient welfare. It was also reaffirmed that Organisations are working collegiately with Primary Care colleagues to further improve a sustainable process of Patient triage and streaming, to ensure a patient is reviewed by the most appropriate pathway or specialisation. In preparation for Winter, the Board also agreed in principle, as a collaborative health economy and wider system, the Wirral Winter and Unplanned Care System Sustainability Plan 2019-20.

Additional Funding to enhance GP IT infrastructure and resilience arrangements

The Trust has received notification of additional funding to strengthen and support GP IT to ensure that it is sufficiently robust to keep pace with changing operational requirements and resilience to cyber threats. This resource will also support establishment of a stronger digital infrastructure platform to enable delivery of Digital First Primary Care and related ambitions within the Long Term Plan. The NHS Long Term plan and the new five year framework for GP contract reform place Primary Care Networks and general practice at the core of Integrated Care Systems (ICS) and local Strategic Transformation Partnerships (STPs) with access to a digital first primary care offer for patients enabled by the widespread adoption of technology.

System meetings

Following the alignment of NHS England/Improvement a quarterly Wirral System Assurance meeting has been established to reduce duplication and enable closer alignment and management of the wider health economy. The inaugural meeting took place on 25th September 2019 and focused on the broad themes of quality, performance, finance and strategy including the system response to the Long Term Plan.

The System Improvement Board continues to meet quarterly to monitor the improvement plans to support the Trust in improved CQC ratings.

National

General Election (Purdah)

As a General Election is planned to take place on 12th December 2019, the pre-election period, also known as 'purdah' will begin on 6th November 2019.

NHS England/Improvement has issued guidance to ensure all NHS staff are aware of the implications on communications activities during purdah.

The Trust has no decisions or announcements that would be impacted by the purdah guidance.

NHS App

Cheshire & Merseyside HCP is working with NHS Digital to connect the WUTH portal to national and regional services including the newly launched NHS App.

The NHS App will allow patients to book, view and cancel appointments at their GP surgery, order repeat prescriptions, set organ donation preferences and check symptoms. It is available 24/7 and also offers access to NHS 111 online meaning a patient does not need to wonder if they need urgent attention. A variety of new functions and services will be added in the coming months.

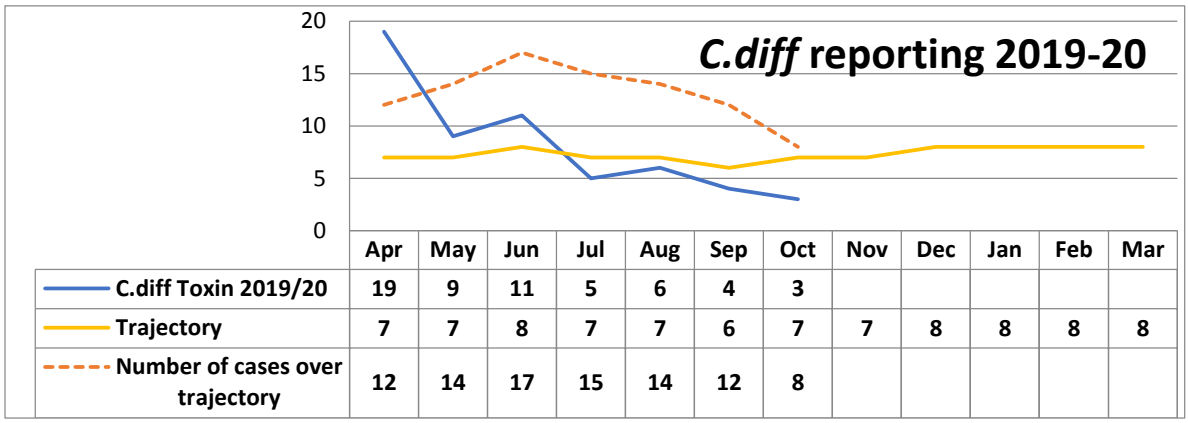
Janelle Holmes
Chief Executive
November 2019

Board of Directors	
Agenda Item	9
Title of Report	IPC – *Clostridium difficile* Update
Date of Meeting	6th November 2019
Author	Jay Turner-Gardner, Associate Director of Nursing for Infection Prevention and Control/ Deputy Director of Infection Prevention & Control
Accountable Executive	Paul Moore, Director of Quality & Governance and Acting Chief Nurse
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 4 Patient Safety and Quality
Level of Assurance • **Positive** • **Gap(s)**	Bronze
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To update and provide assurance to the Board The Board is asked to note this report
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No adverse equality impact identified

Clostridium difficile update – The story so far

Where we are now*……..*

The Trust started this financial year with an ongoing Outbreak of CDI which resulted in being over both monthly and cumulative trajectory for the first three months of the year. Whilst the Trust has remained under its monthly trajectory for the last 4 months the cumulative trajectory despite a reduction in deficit from 17 to 6 in the last 4 months and a 78.9 % reduction since April we continue to remain above trajectory.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C.diff Toxin 2019/20	19	9	11	5	6	4	3					
Trajectory	7	7	8	7	7	6	7	7	8	8	8	8
Number of cases over trajectory	12	14	17	15	14	12	8					

How did we get there *……..*

- Outbreak was declared Feb – April 2019
- Re-opened April 2019
- Typing of samples gave evidence of probable cross infection between patients and the patient's environment.
- Initially across 5 wards
- Extended trust wide July 2019
- Outbreak measures introduced June 2019
- Outbreak closed October 2019

What have we done *……?*

Environment - 'Infection prevention in the built environment' report to BOD detailing the challenges faced and the solutions to make improvements. 3 levels (options) of improvements agreed & commenced.
Equipment - Over 1,000 items of equipment - patient bed side chairs, tables, lockers, and visitor's chairs replaced.
Cleaning - Standards of cleaning along with the cleaning frequencies reviewed. Repair and maintenance of the estate along with the arrival of new patient equipment will allow for effective cleaning.
Policies and procedures – All reviewed more robust investigations of each incidence using an accountability framework.

What do we need to keep doing*? …...*

Clostridium difficile action plan

- Written by IP specialist – Now a live document
- Shared and owned by the Divisions
- Monthly updates discussed at Divisional IP meetings
- IP Team support and advise the Divisions on achieving compliance
- Exceptions reported to the monthly IPC committee

Recommendations*……*

Completion of the agreed initiatives introduced will promote and sustain a reduction in *Clostridium difficile* numbers, progress of which should be monitored via

- Bi-Monthly updates of all of the agreed ward environmental work plan to TMB from Estates
- Bi-Monthly CDI reports to TMB from Infection Prevention
- Monthly CDI action plan exceptions reports monitored by the IPCC

The Board is asked to

- note that the actions taken have been impactful and demonstrates continued improvement
- consider and support the recommendations as detailed in the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors	
Agenda Item	10
Title of Report	6 Monthly Chief Nurse Safe Staffing Report
Date of Meeting	6th November 2019
Author	Tracy Fennell – Deputy Director of Nursing Johanna Ashworth-Jones – Senior Analyst
Accountable Executive	Paul Moore – Acting Chief Nurse and Director of Quality and Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6
Level of Assurance • **Positive** • **Gap(s)**	Gaps • The Trust has a number of escalation areas not currently established. Positives • The Trust has met its safe staffing requirement in the period April – September 2019 • The Trust has introduced a performance management system for E-Roster KPIs.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Choose an item
Data Quality Rating	Choose an item
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No	No

1. Executive Summary

The report provides assurance that the Trust has maintained safe staffing requirements as set out by the National Quality Board within the reporting period April – September 2019. The paper notes an improvement in the CHPPD metric whilst recognising the challenges of staffing additional escalation areas that are not yet currently established.

In formulating our recommendation to the Board we have triangulated nursing staffing metrics reviewing these alongside a select group of quality indicators in order to identify and evaluate any actual adverse consequences.

In this paper we have demonstrated:

i. that rotas exist which have the ability to plan to deploy sufficient suitably qualified, experienced and competent staff to anticipated care needs;
ii. establishments have been determined and kept under review to ensure they take into account anticipated acuity and dependency;
iii. the appropriate application of guidance applied as part of the establishment reviews, alongside the use of professional judgement and evaluation of relevant quality measures (such as quality outcomes, staffing incidents);
iv. the Board have been kept regularly informed of safe staffing requirements during the course of the year; and
v. Staffing skill mix and Model Hospital indicators are reviewed and triangulated. In addition to the requirement to monitor Care Hours per Patient Day (CHPPD) the Trust also monitors closely ratios of registered nurses (RN) to patient, staffing skill mix ratios (RN to care support worker (CSW) ratio), rate of sickness/absence, vacancies and operational pressures in formulating professional judgement on the adequacy of staffing levels.

In our view the Board can be assured the Trust has met its obligations to ensure safe staffing during this period. There are some concerns that the need to open and keep open “escalation areas”, that do not currently feature in the current establishment puts pressure on the Trusts ability to achieve safe staffing, is leading to a reliance on minimum staffing levels increasing the workload in some areas. To counter this risk, steps are being taken to judiciously utilise bank/agency, as well as utilise non-ward based practitioners (who are current in their clinical skills and competent) to staff ward and escalation areas where required. In addition, we are increasing ward managers clinical shifts in order to support the release of staff to help cover escalation areas. As a last resort and in *extremis*, in the event that contingencies fail to mitigate the risk, a decision may be taken at Executive level to close capacity for the shortest possible time.

We are conscious that operating escalation areas (such as RCA/Ward43) without an agreed establishment, on the assumption that long length of stay interventions will reduce and enable escalation areas to be closed, could be costing more to staff those areas than might otherwise be the case if these areas were established. Further analysis regarding this point is being undertaken before advancing proposals for consideration.

2. Background

NHS Trusts have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined in the National Health Service (NHS) Constitution and the Health and Social Care Act (2012); which makes explicit the Trust Board's corporate accountability for quality. It is recognised that on-going pressures on NHS establishments require tough decisions to ensure services achieve best outcomes at a time of financial constraint.

The challenge for the Board is to ensure that this does not have an adverse impact on the quality of care for patients as well as staff experience, staff recruitment and retention (NHS Improvement 2018). Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation 18, Nursing and Midwifery Council (NMC) recommendations and NICE guidelines (2014).

The Carter report (2015) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS Trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. This crude metric is utilised to provide data for the 'Model Hospital' dataset however CHPPD does not account for skill mix, non-substantive staff (temporary/agency usage) or intensity of patient flow, all of which may impact on quality of care.

Trusts must comply with National Quality Board (NQB 2016) guidance that sets out expectations for nurse staffing levels to ensure the right staff, with the right skills are in the right place at the right time (Table 1).

3. Current position

i. Rotas exist which have the ability to plan to deploy sufficient suitably qualified, experienced and competent staff to anticipated care needs.

During the reporting period April – September 2019, it can be confirmed that every ward area has had and is using an electronic roster on the Allocate E-Roster platform whose template is mapped to the current establishment. These rosters are planned to deploy sufficient suitably qualified, experienced and competent staff to anticipated care needs.

We have developed a performance management framework to support the implementation of E-roster across the Trust. This framework provides a range of indicators which are supporting the Trust's efforts to achieve greater rota benefits and financial efficiencies. The E-Roster performance indicators have been developed and are currently being tested to ensure they are fit for purpose and can be produced within the Allocate Software (E-Roster software used by the Trust). When approved by the Chief Nurse, the E-roster performance indicators will be subject to review by the Workforce Steering Group, and assured by the Workforce Assurance Committee on the Board's behalf. This performance management framework will assist in leveraging cost improvement in line with model hospital expectations.

iii. Establishment reviews / budget setting.

The staffing establishment reviews have continued as planned, using a systematic approach that allows for enhanced triangulation and scrutiny led by the Chief Nurse. This review remains in line with NHSI guidance incorporating analysis and consideration of the following metrics:

- Acuity and Dependency
- Activity and additional capacity
- Red flags
- Patient experience metrics
- Harms metrics
- CHPPD/ fill rates
- Skill mix/ leadership
- Professional Judgement
- Professional body, RCN and local benchmarking
- Model hospital data

Acuity and dependency studies were undertaken over a 21-day period in Quarter 3 using the universally adopted and recommended tools below:

- Acuity and dependency tool: Shelford, Safer Nursing Care Tool
- Dependency tool developed by Professor Keith Hurst.

The results of these studies alongside the other metrics listed above assisted senior nurses to make consider and reach an informed decision on current establishment and any amendments necessary to ensure planned staffing levels are appropriate to meet the needs of the patients in each area. The outcome was also used by the Deputy Chief Nurse and Chief Nurse to challenge and test assumptions prior to sign off.

To guide decision making, staff applied minimum safe staffing standards as determined by the Chief Nurse in relation to staffing requirements. Those standards used are summarised below for ease of reference:

- The headroom is set at 23% in line with reductions in Core Mandatory Training/national benchmarking (Headroom includes an allowance to cover annual leave, absence, sickness and mandatory training completion);
- Ward managers are allocated as part of the roster 80% time for managerial and leadership activities and 20% direct clinical care;
- Every ward has a housekeeper and a ward clerk;
- Inpatient areas are reviewed against the benchmark skill mix split of 60:40 registered to unregistered nurse ratios; as outlined in Royal college of Nursing publication *Guidance on staff levels (2010)* this is the level to which adult inpatient establishments should not fall below unless specifically planned as a model of care. The ward establishments are planned for registered nurse to patient ratios as follows.

Day
1:1 in level 3 areas
1:2 in level 2 areas
1:6 in acute assessment areas
1:8 on general wards.

Night
1:1 in level 3 areas
1:2 in level 2 areas
1:6 in acute assessment areas
1:10 on general wards.

Establishment Review outcomes

The establishment review confirmed that some wards have been established below the 60:40 ratio after application of professional judgement. This occurs where the introduction of the band 4 role provides a skilled mixed that is planned to complement the registered nurse. The band 4 role has been built into the models of staffing with the following caveat:

- a quality impact assessment is undertaken every 6 months (completed June 2019);
- regular monitoring continues of quality metrics;
- band 3 and 4 staff only provide care to a cohort of patients that are overseen by a band 5 registered nurse.
- band 4 nursing associates are not moved from their base areas.

Minor changes have been recommended and agreed in the latest October 2019 establishment reviews and signed off by the Acting Chief Nurse; these changes remain largely cost neutral or, in some cases less cost, compared to the last establishment review.

iv. The Trust applies the application of guidance as part of the establishment reviews

The Trust uses professional judgement alongside an evaluation of relevant quality measures (such as patient outcomes, staffing incidents). Patient sensitive indicators that are used as a proxy indicator for safe staffing have been reviewed for the period April –September 2019 and the data illustrated in Table 2.

Table 2: Dashboard of relevant patient sensitive indicators. December 2018-September 2019

Trust Level Indicator	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Care hours per patient day (CHPPD)	≥6.1	7	7.3	7.2	7.2	7.2	7.3	7.4	7.3	7.7	7.5
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	≤0.24 per 1000 Bed Days (National target	0.13	0.17	0.14	0.13	0.18	0.22	0.09	0.09	0.09	0.18
Harm Free Care Score (Safety Thermometer)	≥95%	95.3%	95.5%	97.1%	96.6%	96.5%	95.7%	95.5%	97.2%	95.0%	97.0%
Serious Incidents declared (where staffing is the primary cause)	≤4 per month	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile (healthcare associated)	≤88 for WUTH FY19-20, as per mthly trajectory	2	7	10	5	19	9	11	4	6	4
MRSA bacteraemia - hospital acquired	0	0	0	0	2	0	0	0	0	0	0
Nutrition and Hydration - MUST completed at 7 days	≥95%	87%	83%	81%	94%	89%	95%	90%	93%	92.0%	96.0%
Hospital Acquired Pressure ulcers (Category 3 & 4) (Tissue Viability Data)		0	0	0	0	0	0	0	1	0	0
Hospital Acquired Pressure ulcers (Category 2) (Tissue Viability Data)		9	9	8	6	5	7	9	5	12	9
FFT Recommend Rate: Inpatients	≥95%	98%	98%	97%	97%	98%	97%	96%	98%	97%	96%
FFT Response Rate : Inpatients	≥25%	18.0%	19.0%	15.0%	13.0%	19.0%	22.0%	31.0%	38.0%	34%	30%
Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	TBC	118	178	153	157	162	195	180	178	184	166
Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	TBC	13	27	28	17	17	12	15	17	22	15
CD Audit (19 standards set by pharmacy local and national)	100%			96.0%	97.1%	97.8%	98.3%	98.1%	98.5%	98.0%	97.7%
PGD (Is PGD signage up to date?)		80.0%	76.7%	76.0%	87.9%	92.0%	86.8%	82.1%	76.7%	90.0%	84.0%
Number of reaudits which have shown improvement	100%				100% (n=2)		100%* (n=1)	50% (n=2)	100% (n=3)	TBC	TBC
Weekly Ward Sister Audits	90% (perfect score)	91.40%	92.40%	92.50%	92.30%	93.10%	94.10%	93.50%	94.70%	94.90%	94.40%

Quality review against staffing

The Trust noted an increase in CHPPD in Q2 reflecting the inclusion of allied health professionals in the metric in line with the new reporting requirements set out by NHS Improvement.

The Trust noted an increase in falls in September; these have been individually reviewed at the Trust weekly harm panel. One incident identified that 1 patient fall may have been avoidable if a 1:1 nurse had been requested (however this was not conclusive).No other incident identified staffing as a factor.

One grade 4 pressure sore was identified in July 2019, a confirm and challenge process led by the Acting Chief Nurse – staffing was not noted to be an influencing factor in review of this incident.

A higher number of grade 2 pressure ulcers were noted in quarter 2. These have been individually reviewed at the Trust weekly harm panel. Review identified patients had noted to have increased length of stay on trolleys due to the Emergency Department beds being utilised to open additional capacity. Additional beds have now been purchased to address this issue.

There has been a noted increase in the number of informal concerns. The National Inpatient Survey 2018 results identified only 12% of patients knew how to make a complaint /raise a concern. In line with the launch of the improved patient experience campaign signposting patients/ families to raise concerns/provide feedback via the Matron Helpline / Patient Experience liaison officer or via the Patient Experience Hub has encouraged and increased informal concerns. Staffing is not highlighted as a significant theme; main themes remain as waiting times and communication.

The Trust noted a peak in formal complaints in quarter 2 this is in line with seasonal variance, reflected similarly in previous years. The Trust has seen a reduction in formal complaints every month 2019/2020 compared 2018/2019.

Review of incidents

During September 2019 there were 99 staffing incidents of which related to Nursing and Midwifery this is an increase from AUG-19 (n=70) but a reduction on the previous year (n=124). The five highest reporting areas are noted to be SEU, Ward 11, M1, Ward 21 and Emergency Department.

Chart 1: Nursing and midwifery staffing incidents comparison 2015-2019

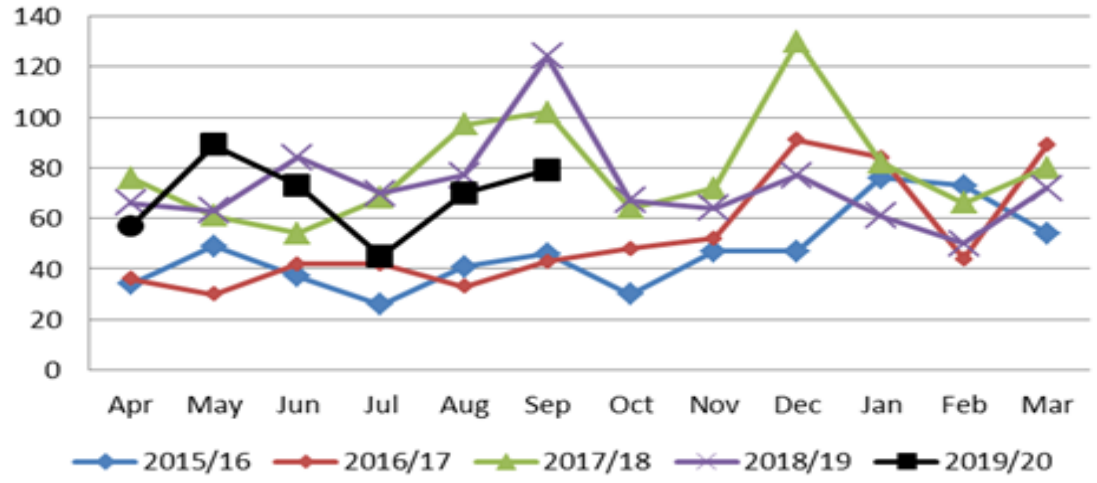


Table 3: Overview of areas with highest staffing incidents April 2019-September 2019.

High frequency incident reporting areas						
Area	**Apr 19**	**May-19**	**Jun -19**	**Jul - 19**	**Aug - 19**	**Sept 19**
Ward 20	7	9	9			
Ward 36	5					
Ward 21		7	8			5
Delivery Suite		7		8		
Colrectal		5				
Ward 18		5				
WAFU		5	5			
Ward 26		5				
Ward 25			5			
Children's			5			
M2 Ortho				5		
Ward 11					7	9
SEU					5	10
Theatre Recovery					5	
M1 Rehab						5

Monthly review of these incidents does not identify any specific theme, reasons include

- Sickness
- High patient acuity
- Staff moves
- Failure to cover from NHSP

v. The Board of Directors have been kept updated with 6 monthly safe staffing reports

Reports have been tabled at Public Board in:

June 2018
December 2018
June 2019
November 2019

vi. Staffing skill mix and model hospital indicators are reviewed and triangulated

As well as the triangulation throughout section (iii) the Trust is requested to benchmark CHPPD against Model Hospital, confirming the nursing workforce metric to be used by NHS providers is Care Hours per Patient Day (CHPPD) along with a Model Hospital dashboard. Recommendations from several key staffing reports indicate that CHPPD should be visible within staffing reports to provide a consistent measure for monitoring and benchmarking. The latest available CHPPD data in the Model Hospital Portal is December 2018.

WUTH Total (Sept 2019)	Peers (Size & Spend)	National
7.5	**8**	**8**

The Trust has remained consistent with the CHPPD metric during the previous 6 months (Range.2 CHPPD – 7.7 CHPPD), this figure is a mild increase on the previous 6 months (7- 7.3 CHPPD). The increase is attributed to the new requirements to report the number of care hours delivered to patients by the multidisciplinary workforce (pharmacy technicians, discharge trackers, physiotherapists, registered and unregistered nursing staff, occupational therapists) opposed to just nursing care hours.

In addition the requirement to monitor Care Hours per Patient Day (CHPPD) the Trust also monitors closely ratios of registered nurses (RN) to patient, staffing skill mix ratios (RN to care support worker (CSW) ratio), rate of sickness/absence, vacancies and operational pressures in formulating professional judgement on the adequacy of staffing levels.

This table can be seen in appendix 1.

4. Conclusion

The report concludes that the Trust has maintained safe staffing requirements as set out by National Quality Board within the reporting period April 2019 – September 2019. The Trust is able to demonstrate that it carefully monitors safe staffing constantly and triangulates using other intelligence to identify and evaluate any actual adverse consequences.

The Trust has demonstrated through this report:

vi. that rotas exist which have the ability to plan to deploy sufficient suitably qualified, experienced and competent staff to anticipated care needs;
vii. establishments have been determined and kept under review to ensure they take into account anticipated acuity and dependency;

viii. the appropriate application of guidance applied as part of the establishment reviews, alongside the use of professional judgement and evaluation of relevant quality measures (such as quality outcomes, staffing incidents);

ix. the Board have been kept regularly informed of safe staffing requirements during the course of the year; and

x. Staffing skill mix and Model Hospital indicators are reviewed and triangulated. In addition to the requirement to monitor Care Hours per Patient Day (CHPPD) the Trust also monitors closely ratios of registered nurses (RN) to patient, staffing skill mix ratios (RN to care support worker (CSW) ratio), rate of sickness/absence, vacancies and operational pressures in formulating professional judgement on the adequacy of staffing levels.

Therefore the paper invites the Board to conclude the Trust has met its obligations to ensure safe staffing during this period.

5. Recommendations

The Board of Directors is asked to:

1 Agree the standards in relation to staffing requirements to remain as they are;
2 Assess if the escalation areas are likely to remain open for the foreseeable future. To reduce staffing costs, it is recommend the Board consider the benefits of developing an establishment for those escalation areas should there be no realistic prospect of those areas closing within the next 3-6 months; and
3 Accept the assurance provided within this paper as evidence that the Trust has met its obligations as set out in safe staffing requirements.

Action required

The board is asked to:

1 Note the contents of paper
2 Consider and approve the recommendations made; and
3 Advise on any addition action required by the Board in relation to safe staffing.

Appendix 1

Staffing metric / quality oversight table

WUTH Staffing metrics and quality indicators Apr 19 - Sep 19

Division	Ward	Speciality	Funded establishment	CHPPD (Average)	RN:Pt Day	RN: Pt Night	RN:CSW	Average fill rate RN Day	Average fill rate CSW Day	Average fill rate RN Night	Average fill rate CSW Day	Staffing incidents (Total)	Average Sickness	Average Vacancy RN (WTE)	Average vacancy CSW (WTE)	Falls with Moderate and above harm (Total)	HAPU Grade 2 and above (Total)	MRSA (Total)	Cdif (Total)	Ecoili (Total)	Formal complaints (Total)	Informal concerns (Total)	FFT recommend rate (Average)	Ward accreditation	Additional comments
Surgical	10	Orthopaedics	43.83	7	1.6	1:10	47:53	83%	86.9%	99.6%	127%	1	4.79%	0.8	0.49	0	3	0	0	0	1	5	98%	2	
	11	Orthopaedics	40.96	8.2	1:6	1:9	44:56	88%	103.5%	86.7%	126.8%	24	8.68%	1.24	2.8	1	5	0	2	1	2	5	99%	2	
	12	Elective Orthopaedics	24.99	8	1:5	1:6	58:42	67%	95.4%	89.7%	116.5%	6	4.81%	0.01	2.68	0	1	0	0	0	0	1	100%	2	
	WAFFU	Orthopaedics	*	13.2	1:4	1:7	36:64	86%	113.8%	50%	214%	15	16.63%	0.63	0.98	0	0	0	0	0	0	2	100%	NA	
	M2 Ortho	Elective Orthopaedics	26.62	15	1:3	1:3	63:37	56%	77.9%	89.%	59.7%	17	2%	0.08	1.36	0	0	0	0	0	0	0	99%	2	
	SEU	Orthopaedics	44.01	11.7	1:4	1:5	57:43	103.7%	87.9%	84.6%	114.3%	23	8.87%	2.79	3.64	0	2	0	3	1	0	8	95%	2	
	Colorectal unit	Colorectal	45.24	5.9	1.6	1:9	54:46	89.5%	99.5%	102%	110.2%	7	3.82%	5.8	1.51	3	2	0	3	1	2	11	95%	2	
	18	Surgical	42.8	6.3	1:7	1:11	44:56	79.7%	99.6%	88.1%	131.5%	14	2.71%	5	1.09	0	3	0	2	0	0	10	98%	2	Corporate Review
	20	Urology	41.17	5.8	1:7	1:11	47:53	79.5%	103.6%	83.5%	162.8%	31	9.94%	4.47	5.15	0	3	0	1	1	1	10	98%	2	Corporate Review
	M2 Surg	Elective surgical	7.19	18.7	1:3	1:3	50:50	83.8%	85.7%	79.6%	78.4%	3	5%	0	0	0	0	0	0	0	0	3	100%	2	
Medical	21	DME / Rehab	42.1	4.8	1:7	1:11	47:53	90.3%	99.6%	87.5%	107.8%	31	4.96%	2.57	2.1	4	0	0	3	1	1	5	97%	2	
	22	DME / Rehab	39.75	5.3	1:8	1:13	48:52	83.1%	96.1%	80.1%	108.2%	7	3.26%	2.5	3	0	2	0	2	1	0	20	99%	2	
	23	Stroke - acute	42.79	7.9	1:6	1:8	49:51	82.9%	100.8%	99.5%	104.4%	4	2%	2.37	4.97	0	3	0	0	3	1	5	99%	2	
	27	DME / Rehab	40.69	5.6	1:9	1:13	44:56	73.6%	100.5%	73.1%	181.1%	5	11.36%	6.2	-0.41	0	3	0	2	0	1	9	100%	2	
	CRC	Stroke rehab / neurological	40.71	6.6	1:8	1:13	42:56	84.5%	101.1%	104.5%	99.2%	0	5.87%	3.75	1.32	0	0	0	1	3	0	3	86%	2	
	M1 Rehab	DME / Rehab	42.51	4.6	1:10	1:14	45:55	84.2%	100.3%	94.4%	100.6%	12	9.21%	7.2	-0.41	4	2	0	4	2	6	9	90%	1	Corporate Review
	24	Medicine	34.27	5.9	1:8	1:10	48:52	80.2%	76%	110.4%	100.8%	4	6.68%	5.85	-2.08	0	0	0	0	0	0	12	99%	2	
	25	IPC	41.15	7.5	1:8	1:10	35:65	67%	83.1%	67.8%	89.9%	12	20%	0.008	0.49	1	1	0	1	0	1	8	98%	2	
	26	Medicine	40.84	5.8	1:8	1:10	49:51	84.8%	100.2%	98.4%	131.1%	17	0.87%	1.4	0.27	0	3	0	3	0	1	10	96%	2	
	30	Haematology	38.57	6.4	1:5	1:9	57:43	90.2%	94.2%	77.4%	106.5%	4	2%	1.15	1.62	1	2	0	2	1	0	3	99%	2	
	32&CCU	Cardiology	67.7	5.8	1:6	1:7	62:38	80.2%	97.2%	92.2%	73%	0	7.81%	10	4.8	0	2	0	4	0	0	7	98%	2	
	33	Medicine	41.26	5.8	1:9	1:11	45:55	88.7%	96.3%	77.9%	101.9%	6	6%	12.42	4.09	1	3	0	3	0	1	16	95%	2	
	36	Gastro	50.23	5.5	1:7	1:11	50:50	93%	95.3%	89.1%	109.2%	11	0.56%	2.95	4.64	0	0	0	6	1	3	11	96%	1	Corporate Review
	37	Respiratory	71.53	5.6	1:9	1:9	50:50	100%	100%	100%	100%	1	0%	0	0	1	0	0	0	1	0	4	99%	NA	
	38	Respiratory		7.2	1:6	1:8	50:50	87%	97.5%	90.2%	99.4%	3	2%	12.28	3.26	1	0	0	3	0	3	13	100%	3	
	D1	Dermatology	22.52	12.8	1:3	1:5	50:50	100%	100%	100%	100%	0	0%	2.08	-0.32	0	0	0	0	0	0	0	100%	2	
	AMU / UMAC/ MSSW	Acute	*	9.3 6	1:5 1:9	1:6 1:9	50:50	72.2%	89.7%	94.6%	91.7%	16	8.18%	10.71	2.35	2	2	0	5	1	3	34	90%	2	Corporate Review
	OPAU	Assessment - DME	42.41	7.3	1:6	1:11	41:59	78.5%	114.1%	69.9%	113.6%	0	8.49%	1.56	0.25	0	3	0	1	1	2	14	98%	2	
	EDRU	Acute	16.52	7.9	1:4	1:5	64:36	87.7%	100%	90.4%	100.8%	0	2%	2.86	-0.55	0	0	0	0	0	1	1	97%	2	
Women's & Children's	Postnatal	Obstetrics	100.66	6.9	1:6	1:7	52:46	96.2%	88.8%	95.9%	67.2%	12	7.24%	-0.56	1.81	0	0	0	0	1	2	14	95%	NA	
	Delivery suite	Obstetrics		37.1	1:1	1:1	86:14	89.8%	99.6%	87.4%	99.2%	NA		0	0	0	0	0	0	0	0	1	99%	NA	
	54	Gynaecology	31.71	6.9	1:6	1:7	52:48	102.1%	103.3%	100%	201.7%	4	10.72%	2.48	-0.45	0	0	0	0	0	2	12	96%	2	
	Children's	Paediatrics	49.76	14.1	1:2	1:2	82:18	99.7%	98.7%	111.2%	85.8%	9	5.09%	3.2	1.38	0	0	0	1	0	0	2	97%	NA	
Diagnostic	HDU	Critical care	100.37	21.4	1:1	1:1	81:19	92.4%	80.2%	93.9%	78%	0	0%		-2.24	0	0	0	0	0	0	0	98%	NA	
	ITU	Critical care		37.6	1:1	1:1	91:09	72.4%	84.5%	76.1%	81.3%	9	6.13%	12.01	-1.16	0	0	0	1	0	1	3	98%	NA	

Board of Directors	
Agenda Item	11
Title of Report	Outcome of National Adult Inpatient Survey for Wirral University Teaching Hospitals
Date of Meeting	6th November 2019
Author	Tracy Fennell – Deputy Director of Nursing Johanna Ashworth Jones – Senior Analyst
Accountable Executive	Paul Moore – Acting Chief Nurse and Director of Quality and Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6
Level of Assurance • **Positive** • **Gap(s)**	Gaps • The Trust scored lower than national average on 4 questions • The Trust patient response rate was lower than the national response rate. Positives • Actions have been enacted, with evidenced improvements around some of the areas identified as needing improvement. • The Trust has improved its position from 2017 on two areas within the survey • The Trust performs higher than national average when offering support to recover from / manage a condition.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Choose an item
Data Quality Rating	Choose an item
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No	No

1. Executive Summary

The National Adult Inpatient survey was undertaken by Quality Health for Wirral University Teaching Hospital NHS Foundation Trust between September and December 2018. The survey had previously been undertaken and published in 2017. The results of this audit were published in June 2019.

This paper highlights the key areas to note where:

- **Where the Trust is better than other hospitals**

  After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?

- **Where the Trust has improved from 2017 data**

  Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

  Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- **Where the Trust is significantly improved on 2017 data**

  Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

  Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- **Indicators where there has been a reduction or static position in our 2017 raw data scores and a significantly reduced score in comparison with other QH Hospitals**

  How do you feel about the length of time you were on the waiting list before your admission to hospital?

  Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

  If you brough your own medication with you to hospital, were you able to take it when you needed to?

  How would you rate the hospital food?

  Were you offered a chohice of food?

  Did you get enough help from staff to eat your meals?

The Trust scored the same as other Trusts for 59 questions.

We would like to make the Board aware that the results of this survey have been reviewed and considered, with support from patient representatives, by the Patient & Family Experience Group. Their review has informed the production of an action plan in response, which is being implemented by staff and overseen by the Deputy Director of Nursing. We will ensure progress is maintained regularly by the Patient Safety & Quality Board and the Quality Committee, on the Board's behalf.

2. Background

The 2018 survey of adult inpatient's experiences involved 144 NHS acute trusts in England. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 2018 and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between September and December 2018.

Care Quality Commission (CQC) uses the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

Survey data assists CQC's Insight for inspectors by assessing of performance in a number of areas of care. NHS England use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care and hold them to account for the outcomes they achieve. NHS Improvement uses the results to inform their oversight model for the NHS.

461 Wirral University Teaching Hospital NHS Foundation Trust inpatients responded to the survey. The response rate for Wirral University Teaching Hospital NHS Foundation Trust was 38.1%.

National Inpatient Survey Report 2018

medicines

SCORE :

6.2/10 patients were able to self-medicate

information

SCORE :

1.2/10 Patients were informed how to write a complaint

8.5/10 Patients stated moves were explained in a way they understood

8.9/10 Patients stated they knew what was going to happen next when they left hospital

health care support

SCORE :

8.0/10 Patients got enough support from health care profiles to manage their conditions

nutrition

SCORE :

4.8/10 Patients reported food as 'good'

7.8/10 Patients were offered a choice of food

Better than other trusts

Worse than other trusts

What action have we taken?

medicines

- Launched self-medication policy for diabetic patients Jan 19
- Relaunch of full self-medication policy for all December 2019

information

- Launched matrons helpline to aid speedy resolution for families
- Rebranded Patient Experience Hub to encourage patient feedback
- Re-developed signposting on WUTH website to make it easier to find information on, e.g. how to make a complaint
- Introduced Patient Experience Liaison Officer role to resolve complaints quickly and, where possible, informally
- Tracking process for informal / formal concerns to speed up our responses

nutrition

- Introduced new menus and measured patient feedback via hand-held devices
- Introduced new heated food trolleys to ensure food is hot at the point of service
- Introduced Always Event for meal times to ensure the environment is conducive to good intake of meals
- Adopted John's Campaign to ensure carer's of patients with dementia can visit and support them outside of normal visiting hours
- Reviewed special diets menu to ensure all patients with special dietary requirements receive meals to meet their needs
- Introduced meal time buddy volunteers to assist vulnerable patients at mealtimes

4. Next Steps

A detailed action plan has been developed that is scrutinised at Patient and Family Experience Group (PFEG), and reviewed and approved by the Patient Safety & Quality Board. This is a large document which can be made available to Members on request via the Board Secretary. Implementation of the plan will be monitored by the Patient Safety and Quality Board and assured by the Quality Committee on behalf of the Board of Directors.

5. Conclusion

The paper concludes the Trust has received and taken account of actions necessary to improve feedback in the subsequent inpatient survey. The Trust has a mechanism to track ongoing actions and monitor outcomes in response to the feedback provided. The Trust notes some areas of improvement against last year's survey results in relation to information provided to patients.

6. Recommendations

The Board is asked to:

1 Note the contents of paper
2 Consider and approve the recommendations made; and
3 Advise on any additional action required by the Board in respect of patient satisfaction

Board of Directors	
Agenda Item	12
Title of Report	Quality and Performance Dashboard
Date of Meeting	6th November 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 September 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 57 indicators that are reported for September (excluding Use of Resources):

- 19 are currently off-target or failing to meet performance thresholds
- 30 of the indicators are on-target
- 8 do not yet have an identified threshold and therefore not rated

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

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.

Appendix 3 provides the current position on long term sickness absence (absences over 4 weeks) as at 31st October 2019. This provides a very clear picture on the issues that need addressing.

4. Next Steps

WUTH remains committed to attaining standards through 2019-20.

5. Conclusion

Actions to improve are noted in the exception reports on the qualifying metrics to 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 September 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

October 2019
updated 23-10-19

	Indicator	Objective	Director	Threshold	Set by	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.18	0.22	0.09	0.09	0.09	0.18	0.14	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (audit sample size 150)	Safe, high quality care	MD	≥95%	WUTH	82.9%	81.6%	78.4%	80.6%	89.9%	95.0%	98.7%	96.2%	86.0%	91.9%	94.6%	94.6%	96.1%	93.2%	
	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	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	96.4%	96.3%	96.8%	97.7%	97.6%	97.6%	97.1%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.4%	96.5%	95.7%	95.5%	97.2%	95.0%	97.0%	96.2%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	1	3	2	4	2	4	2	1	1	4	3	1	0	2	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	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	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
	Clostridium Difficile (healthcare associated)	Safe, high quality care	DoN	≤88 for WUTH financial year 2019-20, as per mthly maximum threshold	SOF	0	3	4	2	7	10	5	19	9	11	4	6	4	53	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	3	5	4	2	3	4	2	5	2	0	2	5	1	15	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	15	13	23	9	10	6	5	12	9	8	5	9	7	8	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	1	0	0	0	2	0	0	0	0	0	0	0	
	Hand Hygiene Compliance	Safe, high quality care	DoN	≥95%	WUTH	81%	87.0%	85%	76%	83%	99%	99%	98%	91%	98%	99%	100%	99%	99%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	DoN	0	WUTH	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
	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%	96%	98%	98%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥90%	WUTH	85.6%	90.4%	91.5%	91.4%	91.6%	92.8%	93.9%	93.6%	93.9%	93.7%	93.6%	92.9%	93.6%	93.6%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥90%	WUTH	82.2%	86.0%	87.2%	87.1%	87.6%	88.7%	90.7%	90.9%	91.0%	90.7%	90.4%	90.3%	91.2%	91.2%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥90%	WUTH	86.5%	87.2%	91.7%	91.4%	93.6%	92.6%	93.5%	91.4%	92.8%	91.5%	92.3%	90.3%	89.98%	89.98%	
	Attendance % (12-month rolling average) (*)	Safe, high quality care	DHR	≥95%	SOF	95.09%	95.06%	95.07%	95.06%	95.05%	94.98%	94.90%	94.81%	94.74%	94.63%	94.51%	94.40%	94.38%	94.38%	
	Staff turnover	Safe, high quality care	DHR	≤10%	WUTH	9.9%	10.0%	9.7%	9.6%	9.7%	9.7%	9.8%	10.0%	10.2%	10.5%	9.5%	10.6%	10.9%	10.9%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	Between 6 and 10	WUTH	7.1	6.9	7.1	7.0	7.3	7.2	7.2	7.2	7.2	7.4	7.3	7.7	7.5	7.38	

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October 2019
updated 23-10-19

	Indicator	Objective	Director	Threshold	Set by	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019/20	Trend
Effective	SHMI	Safe, high quality care	MD	Band to be 'as expected' or 'lower than expected'	SOF	97.22	–	–	103.12	104.92	106.06	107.49	107.88	107.35	–	–	–	–	107.35	
	HSMR *	Safe, high quality care	MD	≤100	SOF	92	92	97	97	98	99	99	97.3	96.3	–	–	–	–	96.3	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	86%	71%	56%	76%	78%	68%	64%	58%	38%	74%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	67%	74%	84%	87%	83%	81%	94%	92.0%	95.0%	90.0%	93.0%	92.0%	96.0%	93.0%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	16.4%	12.8%	15.7%	18.8%	16.1%	16.9%	16.1%	
	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	411	409	408	397	437	457	438	421	415	403	383	410	431	411	
	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	-	-	-	-	-	-	-	206	190	171	171	203	193	193	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.2	4.3	3.8	4.8	3.0	4.4	4.4	4.8	3.9	4.8	4.1	4.2	4.9	4.5	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.8	5.5	5.1	5.2	5.5	6.0	5.5	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	888	936	925	917	903	788	914	871	970	884	887	872	813	883	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	18	12	17	14	10	16	14	11	14	10	11	9	15	12	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	89.5%	86.3%	85.5%	88.5%	85.3%	80.9%	86.0%	

Quality Performance Dashboard

October 2019
updated 23-10-19

	Indicator	Objective	Director	Threshold	Set by	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	14	19	18	15	20	14	13	13	13	17	16	24	23	106	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	86%	87%	84%	92%	85%	87%	87%	87%	89%	91%	91%	92%	88%	90%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	11%	10%	11%	10%	11%	11%	13%	9%	11%	10%	12%	12%	11%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	97%	98%	98%	98%	98%	97%	97%	98%	97%	96%	98%	97%	96%	97%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	22%	24%	18%	18%	19%	15%	13%	19%	22%	31%	38%	34%	30%	29%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	94%	94%	95%	94%	95%	94%	95%	94%	94%	95%	95%	94%	94%	94%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	100%	96%	100%	100%	99%	98%	96%	94%	97%	99%	93%	92%	92%	95%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	28%	11%	19%	37%	27%	36%	44%	25%	29%	44%	29%	24%	23%	29%	

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Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

October 2019
updated 23-10-19

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Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2019-20	SOF	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	73.6%	81.1%	83.5%	81.9%	79.9%	75.6%	75.6%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	2	0	0	0	0	0	0	1	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	474	371	440	393	379	323	273	437	118	54	76	108	210	167	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% through 2019-20	SOF	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	79.04%	80.72%	80.12%	80.06%	79.89%	79.59%	79.59%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	26,556	26,862	27,367	26,157	27,506	28,367	27,309	26,223	27,317	25,733	24,733	24,846	24,721	24,721	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019-20	National	40	43	30	28	28	19	0	0	0	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	99.5%	99.3%	99.5%	99.2%	98.3%	99.1%	99.1%	
	Cancer Waiting Times - 2 week referrals (latest month provisional)	Safe, high quality care	COO	≥93%	National	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	91.9%	94.0%	94.0%	94.0%	93.3%	94.3%	93.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (latest month provisional)	Safe, high quality care	COO	≥96%	National	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	96.8%	96.5%	96.7%	97.1%	96.7%	97.3%	96.4%	96.8%	
	Cancer Waiting Times - 62 days to treatment (latest month provisional)	Safe, high quality care	COO	≥85%	SOF	85.7%	85.1%	85.3%	86.2%	85.4%	86.5%	85.8%	85.3%	87.9%	86.3%	85.7%	89.9%	88.3%	87.2%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	DoN	TBC	WUTH	155	119	165	118	178	153	157	162	195	180	178	184	166	177.5	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	DoN	TBC	WUTH	22	19	13	13	27	28	17	17	12	15	17	22	15	16	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	≥90%	National	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	4	2	3	2	2	1	3	4	4	4	1	2	2	3	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

October 2019
updated 23-10-19

	Indicator	Objective	Director	Threshold	Set by	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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%	100%	100.0%	
	Number of patients recruited to NIHR studies (**)	Outstanding Patient Experience	MD	700 for FY19/20 (ave min 59 per month until year total achieved)	National	42	38	57	38	43	41	59	31	31	49	50	37	50	248	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	77.5%	78.4%	83.8%	84.5%	84.6%	85.7%	88.2%	77.6%	81.1%	82.1%	83.6%	83.4%	82.7%	82.7%	

	Indicator	Objective	Director	Threshold	Set by	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019/20	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-3.340	-1.458	-0.098	-0.825	-1.498	1.468	-5.751	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-0.237	-0.630	0.914	-0.828	-1.106	1.972	0.085	
	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	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-6.0%	-6.8%	-5.2%	-4.1%	-7.2%	-5.0%	-5.0%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-19.5%	-26.8%	-15.6%	-46.4%	-8.2%	-24.3%	-24.3%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-14.0	-21.3	-15.9	-16.5	-17.4	-15.0	-15.0	
	Capital Programme		DoF	On Plan	WUTH	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	52.1%	31.0%	28.0%	14.7%	19.8%	64.2%	64.2%	

(*) Updated Metrics

Safe: Clostridium difficile

Metric Change

The monthly RAG rating amended to compare the number of cases in each month to the trajectory maximum for that month

(**) Updated Thresholds

Well-led : Number of patients recruited to NIHR

Threshold Change

Annual target revised to 700 for ful year 19/20 as per Local Research Network

Appendix 2

WUTH Quality Dashboard Exception Report Template as at October 2019

Safe Domain

Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Acting Chief Nurse

Performance Issue:

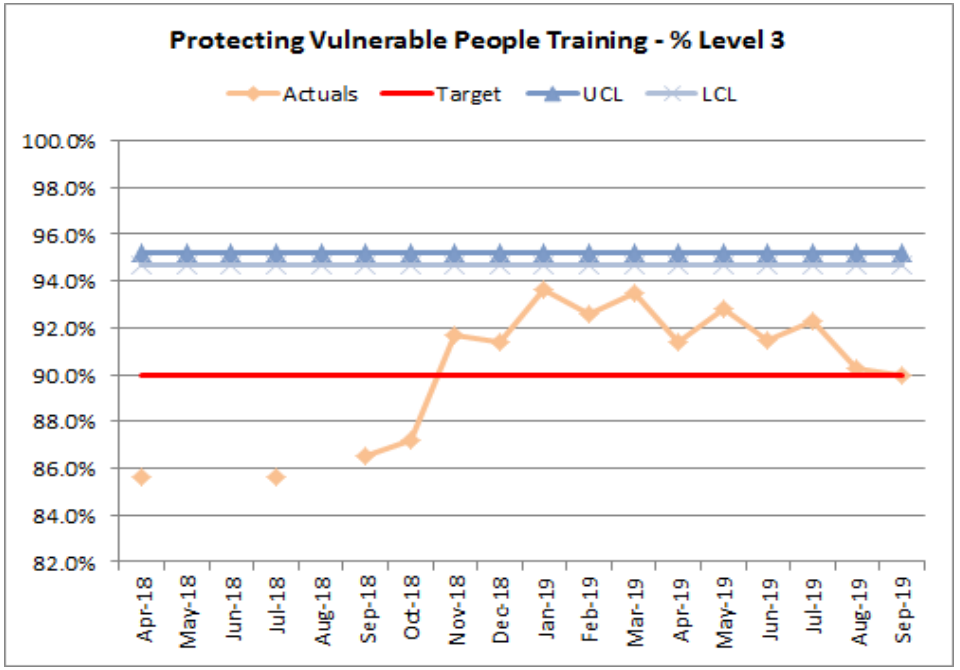
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has been regularly achieved this year, however August saw a reduction to just above the standard at 90.3%, and this has now dropped fractionally below in September at 89.98%. Training compliance for Levels 1 and 2 continue to be regularly achieved.

Action:

2 Additional training sessions for PVP 3 have been created in December. The PVP 3 training has also been relocated in the lecture theatre to accommodate more people on the training sessions. Divisions have trajectories to ensure the Trust target is achieved in October 2019.

Expected Impact:

It is expected compliance will be achieved in October 2019



Staff attendance % (12 month rolling average)

Executive Lead: Director of Workforce

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: Over the past 12 months the Trust has ensured that it has put in place the necessary support such as the Employee Assistance Programme, supportive new Attendance policy as well as ensuring that managers have been given the development in relation to people management skills.

The Trust is now putting in processes to make sure that sickness absence is being managed at a micro level throughout the organisation**.** As part of these management processes the HR team have adapted the governance database that has been used to track the CQC actions in order to monitor and address sickness absence.

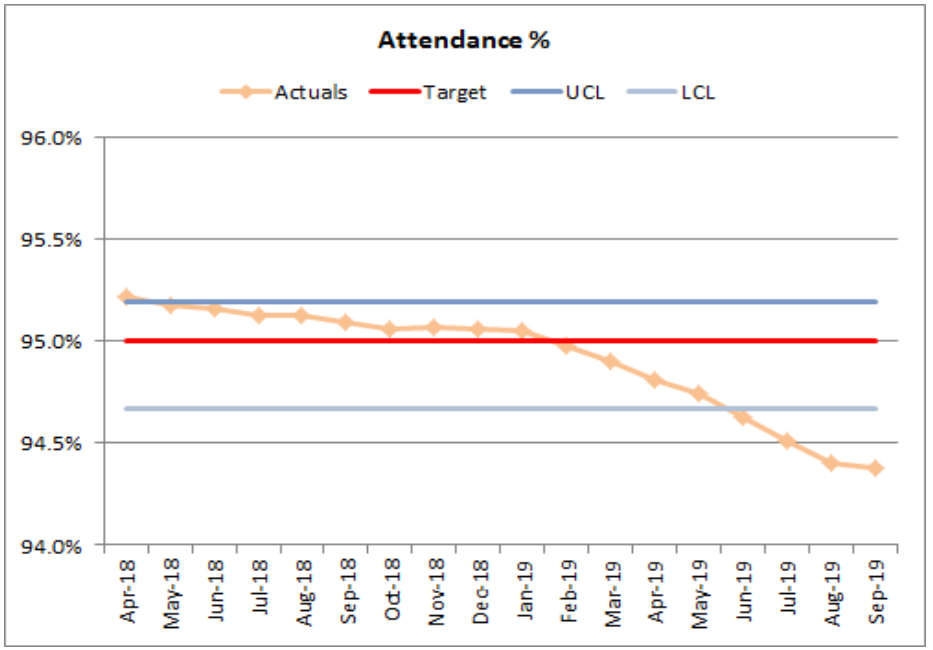
The document at **Appendix 3** provides the current position on long term sickness absence (absences over 4 weeks) as at 31st October 2019. This provides a very clear picture on the issues that need addressing.

The HRBPs are working proactively with managers in the divisions and departments which include supporting the arranging and attendance at review meetings as well as auditing the effective implementation of the policy.

The HRBPs are having monthly meetings with the Director of Workforce to go through each of the long term sickness cases in detail.

Expected Impact:

To improve the attendance rate and achieve the 95% attendance target



Staff turnover % (12 month rolling average)

Executive Lead: Director of Workforce

Performance Issue:

WUTH has an internal target set at a maximum 10% turnover of staff, calculated as a 12-month rolling average. The % has been increasing across 2019, with September showing a further increase to 10.9%.

In September there were 79 leavers. The 79 leavers included 17 Nurses, 4 Consultants and 15 Clinical Support Workers. Of the 79 leavers 27 of those fell into the category of dismissal, terminations of fixed term contract, ill-health, retirement or retire and return.

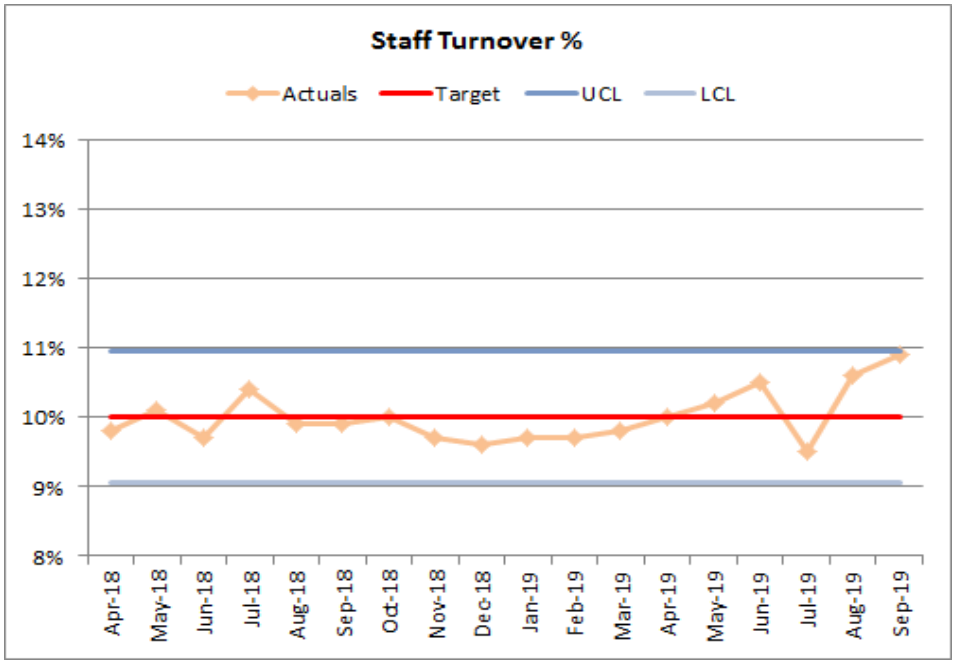
11 employees left to undertake further training and 9 relocated out of the area with 3 obtaining promotion. 18 leavers did not provide a reason.

Medicine and Acute followed by Surgery had the highest number of leavers in September.

Action:
Detailed below are some of the interventions being put in place by the divisions:

- Supper with the senior nurses
- Afternoon tea with matrons
- Bright ideas website
- Itchy feet meetings
- Registered nurse forum
- Careers clinics
- Establishing CSW educators
- Practice Educators now in place in ED, Medicine and acute.
- Matrons in Med & Acute have met with all staff who have resigned to fully understand why staff are leaving
- Divisions doing employee of the month, lots of thank you and praise on social media

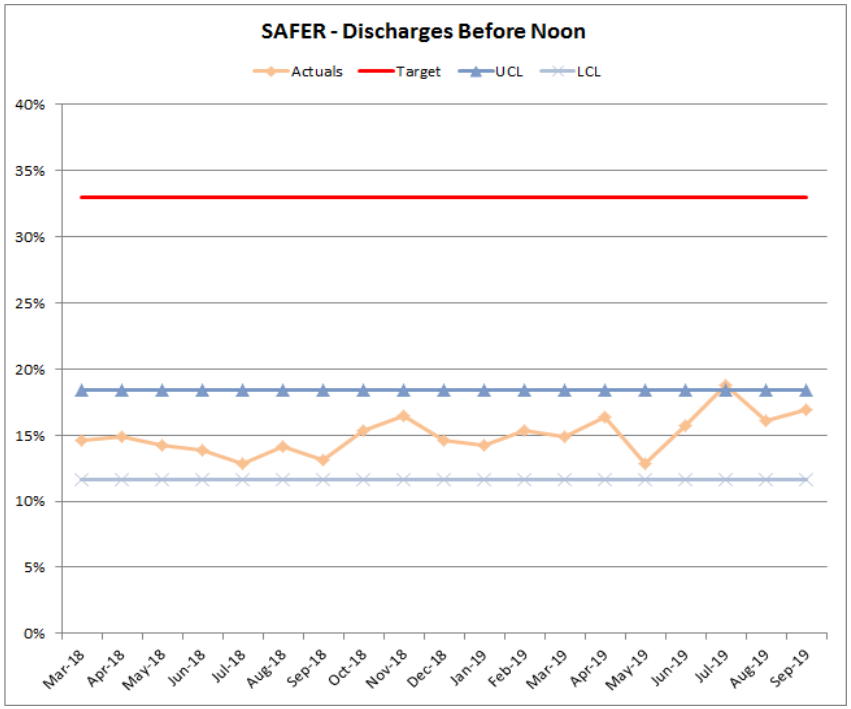
Expected Impact: To meet the target of 10%



Effective Domain

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 16%.
Action: Supported by ECIST the functioning of the integrated discharge team is being improved so that more pro-active planning is achieved. To assist with urgent care pressures physicians are being deployed to AMU and ED in the morning to prevent unnecessary short term admissions.
Expected Impact: It is not expected that 33% will be achieved, but consistent performance around 19% is anticipated which would place WUTH in the top quartile nationally for this indicator.



SAFER bundle: average number of patients in hospital for 7 days or more and 21 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, and for 21 days or more to a maximum 107. The numbers remain considerably above this target, with an average of 7 days or more at 431, and the number at 21+ days at 193.

Action:

New managerial arrangements have been put in place for the leadership of the integrated discharge team, and all system partners are prioritising their efforts around this indicator.

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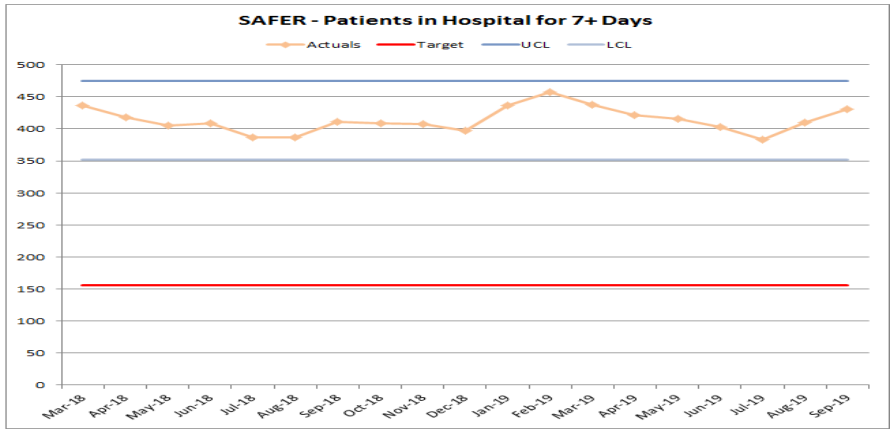
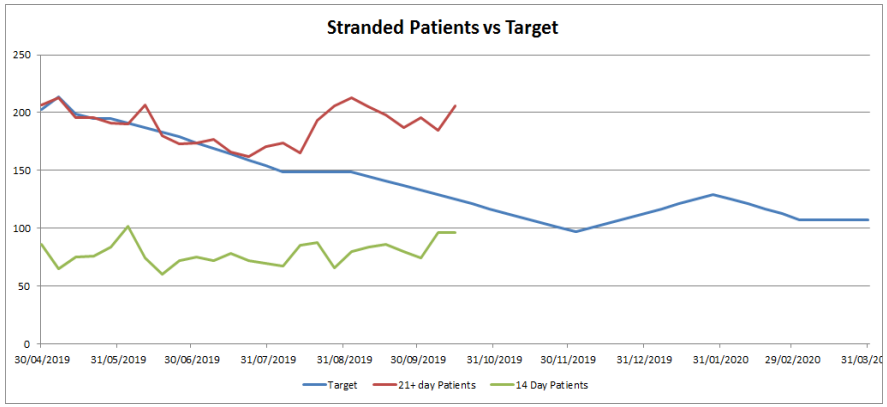
Expected Impact:

The system is committed to achieving the 107 figure by the end of November.





Caring Domain

Same sex accommodation breaches

Executive Lead: Acting 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:

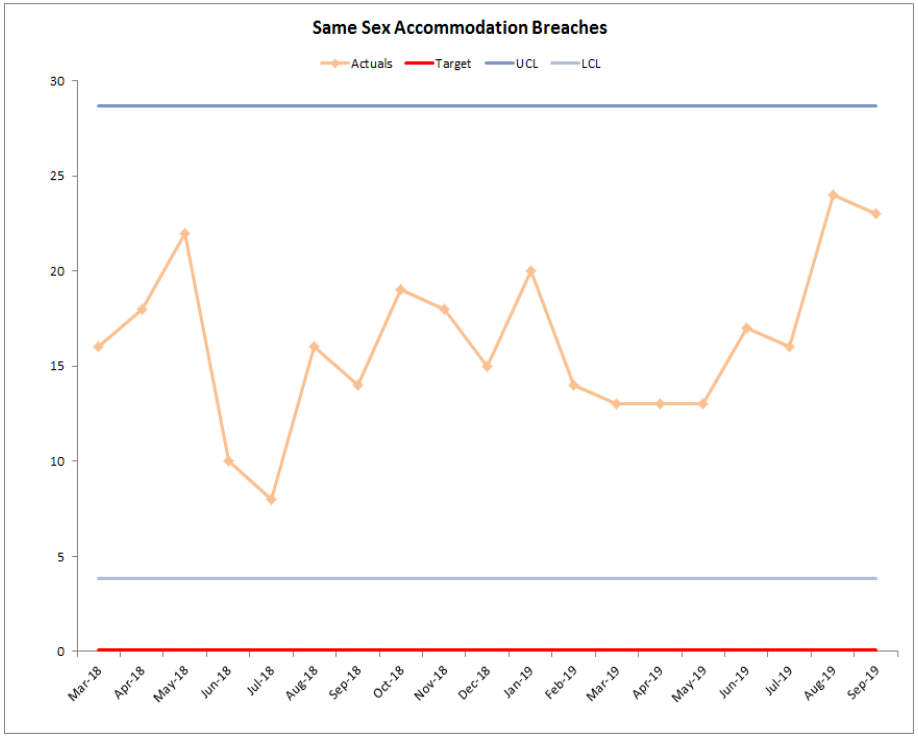
No acutely unwell patient has been refused admission to critical care or no surgery cancelled. Priority is given in bed management meetings to facilitate discharges when needed.

Patients and relatives who are delayed discharges have completed questionnaires to ensure they understand delays and the need to protect their privacy and dignity and place in side rooms if appropriate. No complaints have been received this year.

Staff ensure all specialist opinions /treatments continue whilst on the unit.

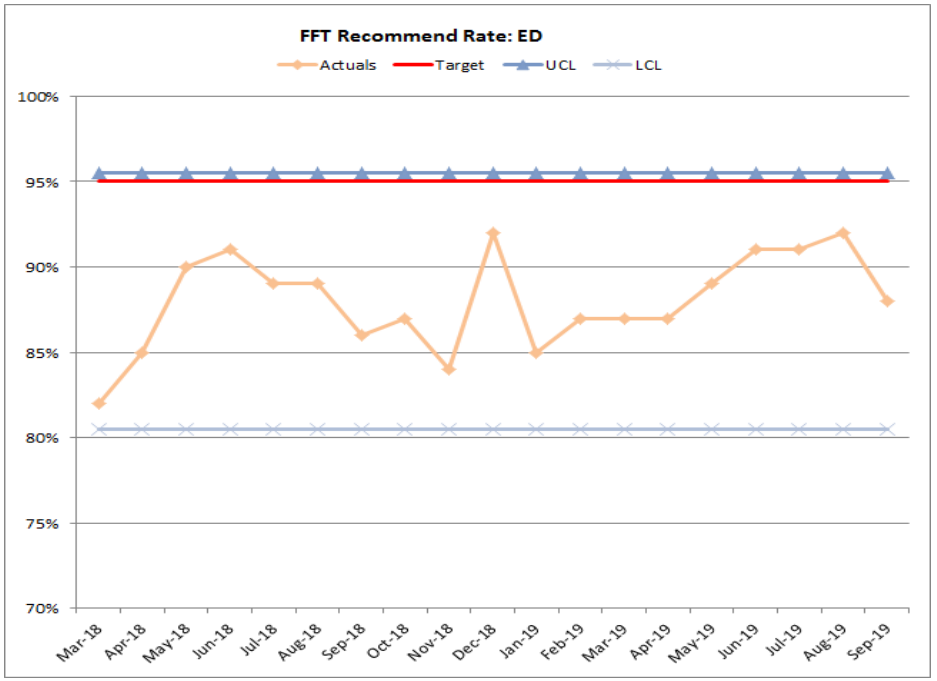
Expected Impact:

Patients continue to be safely cared for and the WUTH continues to work on ensuring patients are transferred out of Critical Care as soon as possible.



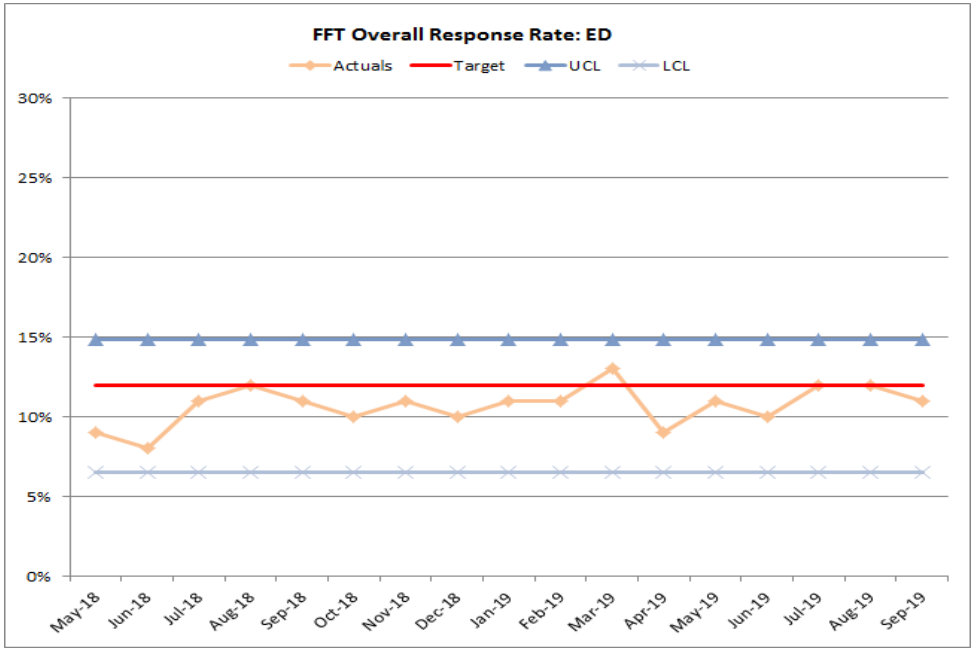
FFT recommend rate: ED

Executive Lead: Acting Chief Nurse
Performance Issue: A WUTH target is set at a minimum 95% recommend rate. The previous improvement in 2019-20 has reversed with September back down to 88%.
Action: Additional patient experience rounds have been introduced in times of pressure apologising for delays and offering refreshments following feedback of delayed waits and poor communication. The Emergency Department (ED) has 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 response rate: ED

Executive Lead: Acting Chief Nurse
Performance Issue: A WUTH target is set at a minimum 12% response rate for ED. Although achieved for July and August, September has slipped back slightly to 11%.
Action: Patient experience volunteers are targeting the area offering additional support to improve response rates within the department. Patients are being encouraged to respond to the text service to provide valuable feedback
Expected Impact: The Trust is expected to achieve the target of 25% in November 2019.



FFT recommend rate: Outpatients

Executive Lead:

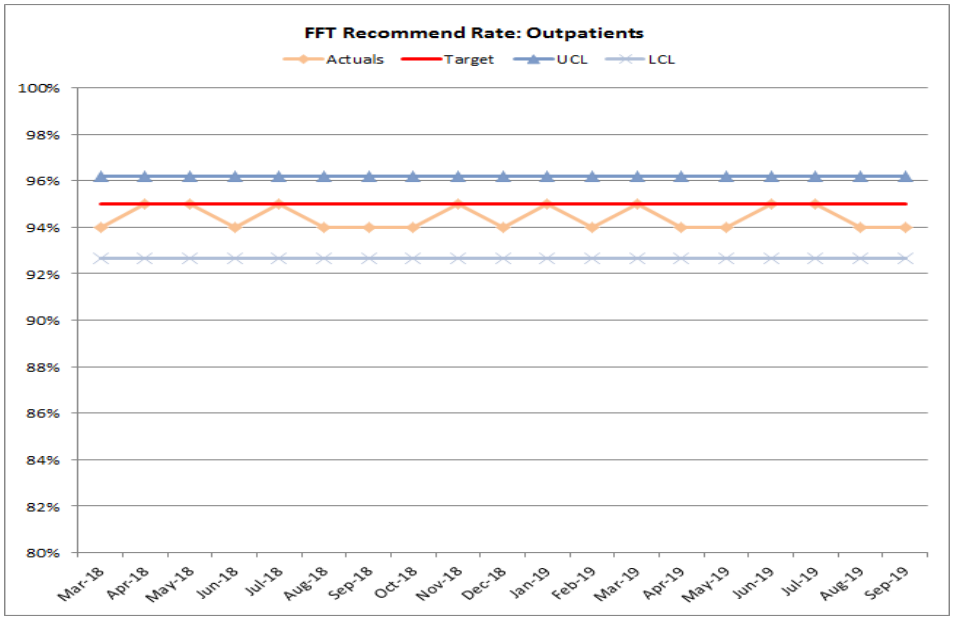
Acting Chief Nurse

Performance Issue:

A WUTH target is set at a minimum 95% recommend rate. The under-achievement last month has continued with September also at 94%.

Action:
Additional patient experience rounds have been introduced in times of pressure apologising for delays, a focus has been made to improve communication for patients in the department. Outpatient flow is also being modernised to improve patient experience through assessment stations and phlebotomy centres reducing delays for patients. These actions were initiated following feedback of delayed waits and poor communication.

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



FFT recommend rate: Maternity

Executive Lead: Acting Chief Nurse

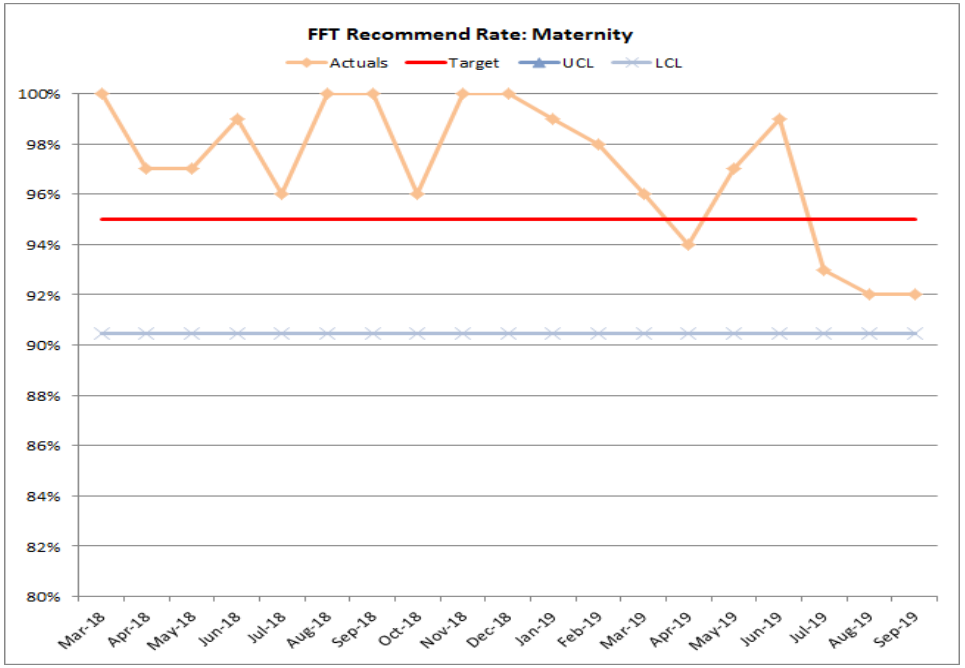
Performance Issue:

A WUTH target is set at a minimum 95% recommend rate. This has not been achieved since June, with the latest position for September at 92%.

Action:
Due to the need to understand why women would not recommend the Maternity service it has been necessary to undertake a deeper dive to identify and address any reasons/recurring themes as to why women would not recommend the Maternity service. The following actions have been taken:

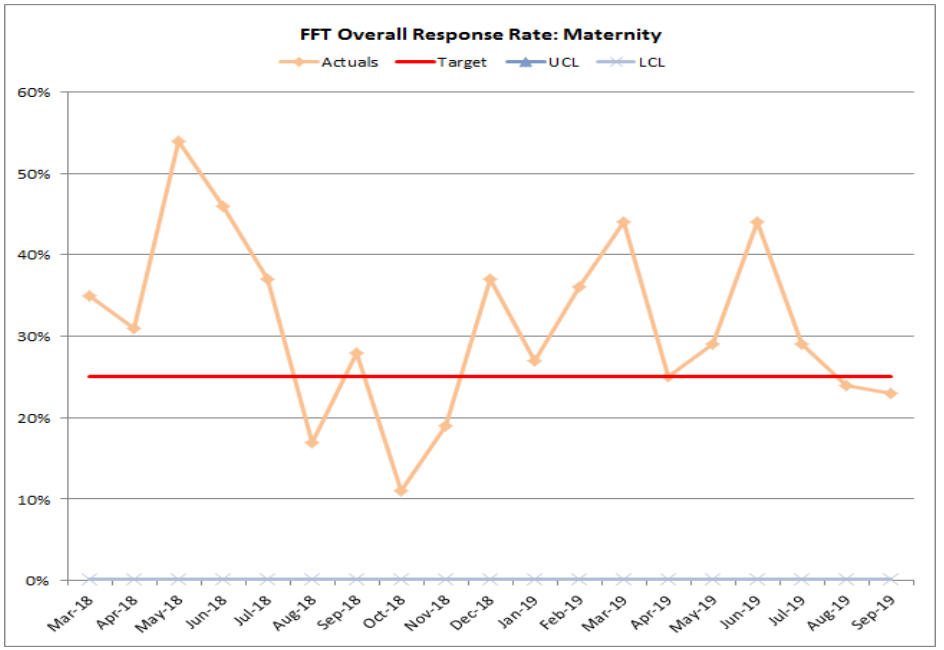
- Learning with patient questionnaires (LWPQ) are given to women to complete with reporting of any cause for concerns identified. These are communicated to staff with identified improvements required.
- A touch screen kiosk has been installed in the maternity ward which gives women the opportunity to complete a bespoke questionnaire providing feedback on their experience and identifying any concerns. A weekly report is generated from this and feedback provided to the ward to support an understanding of any wider issues impacting on the woman's experience, with a view to addressing any concerns identified.
- The Maternity ward is to be included in the weekly Trust FFT response rate report that is circulated as a reduction in the response rate over the last two months has been noted.
- The availability of a new Ipad for women to complete the FFT electronically has been introduced to support an increase in response rates.
- Self medication uptake has reduced over the past few months – women are to be further encouraged to self-medicate as a lack of timely analgesia at times has been identified
- The Maternity Voices Partnership Lead has visited the Maternity Ward to identify any areas for improvement and meets wit the Divisional Leads regularly to provide service user feedback.
- Ensure lessons learnt from concerns raised are included on the Divisional LEAP improvement plan and communicated to staff.
-

Expected Impact:
It is anticipated that there will be an overall improvement in care delivered to women on the Maternity ward which will be reflected in an increase in the overall recommend rate in the Maternity FFT.



FFT response rate: Maternity

Executive Lead: Acting Chief Nurse
Performance Issue: A WUTH target is set at a minimum 25% response rate. Although regularly achieved earlier in Maternity earlier in the year, September at 23% has continued the deterioration seen in August.
Action: Patient experience volunteers are targeting the area offering additional support to improve response rates within the department
Expected Impact: The Trust is expected to achieve the target of 25% in November 2019.



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. Performance continues to be a challenge being both below trajectory at local and system level.

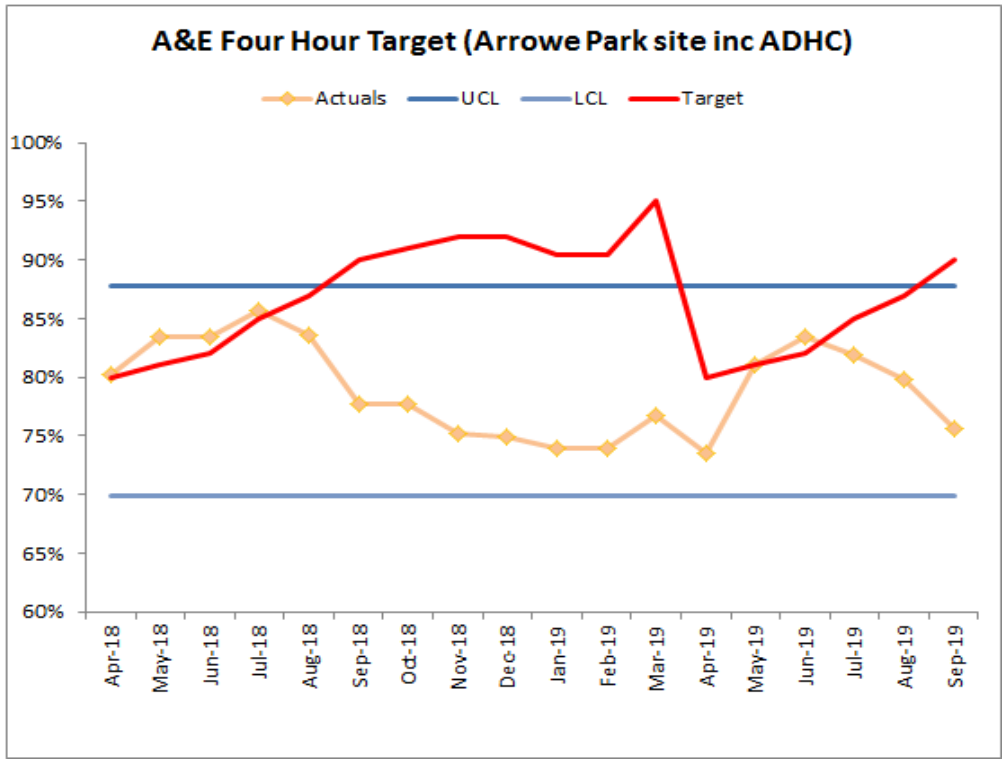
Action:

With expert support being provided by ECIST the immediate focus is on two key areas of priority:

- To maximize streaming to the co-located walk in centre
- To reduce the number of over 21 days LOS patient in the acute hospital

Expected Impact:

1. An increase in streamed patient equivalent to 20% of total attendances at A&E by December.
2. A 40% reduction in the number of over 21 day patients by the end of November



Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has a trajectory agreed with NHSI for 2019-20 to maintain at 80% of patients waiting on incomplete Referral to Treatment pathways to be under 18 weeks. This has been regularly achieved since May however the slight shortfall in August was repeated in September at 79.59% primarily due to elective cancellations as a result of urgent care pressures.

Action:

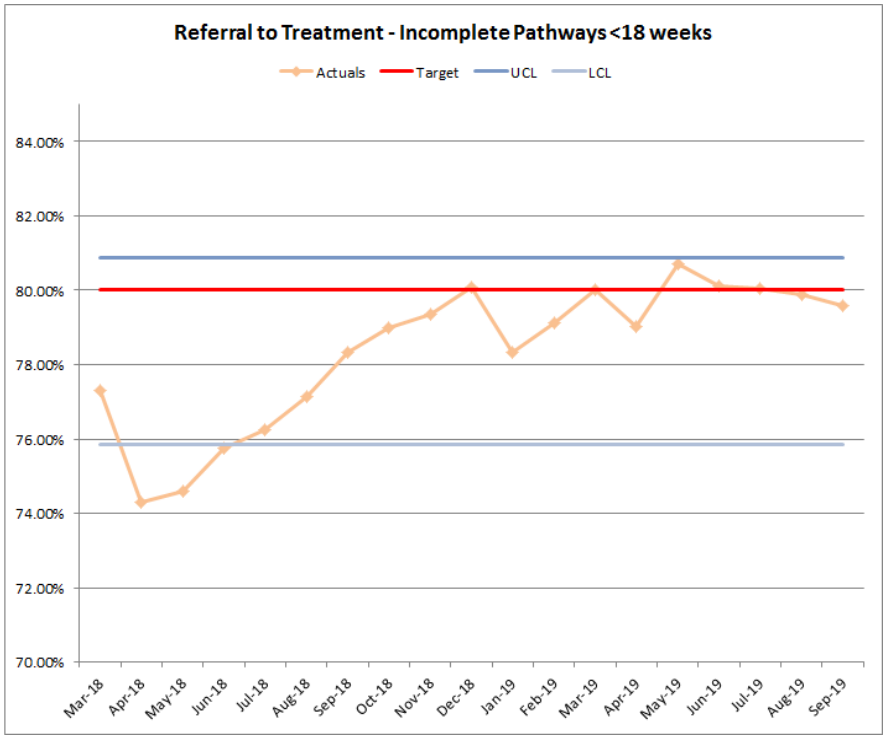
Activity that is able to be transferred to Clatterbridge is being actioned, and elective priorities are reviewed on a daily basis against the criteria of:-

1. Cancer
2. Clinically Urgent
3. Long Waiting times

As a final mitigation the Division of surgery are looking at a short term capacity solution such as the independent sector, until such time as the stage 3 recovery solution is on line at the end of February.

Expected Impact:

The overall waiting list size is being maintained in line with trajectory and zero over 52 week waiters are being incurred. A return to RTT access standard will be achieved when the corresponding improvement in urgent care is delivered.



Well-led Domain

Number of patients recruited to National Institute for Health Research studies

Executive Lead: Medical Director

Performance Issue:

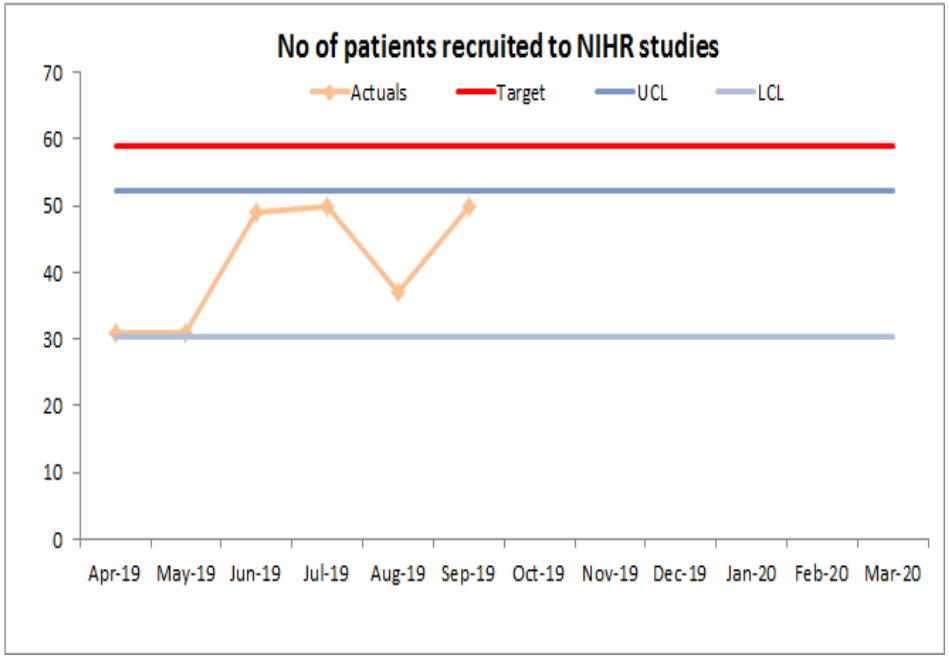
Following discussions with the Local Research Network, the initial internally set WUTH target of recruiting 500 patients to National Institute for Health Research (NIHR) studies in 2019-20 has been amended to 700. This new target is based on the average number of participants recruited over the past 5 years at the Trust. The revised trajectory is set at a target 59 per month until the annual 700 is reached.
This has not been achieved in any month this year so far, though September is back up to previous levels with 50 recruited.

Action:

- To continue to work with the Local Research Network to try to find high recruiting studies.
- To increase recruitment to studies already open.
- New Research Divisional Leads to take part in NIHR research.
- New Research Divisional Leads to encourage more consultants to take part in research.
- Appointment of 2 academic consultant post

Expected Impact:

- Successful implementation of the above should see recruitment increase to target.
- Lack of increase in recruitment could potentially impact on research funding from the Local Research Network.



Appraisal compliance %

Executive Lead: Director of Workforce

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 82.7%.

Medicine and Acute are the division with the lowest % of appraisal undertaken (80%). However it appeared that 20 medics were non-compliant on the report despite them being compliant. This has now been rectified.

We have approximately 80 areas across the Trust that have 100% compliance this includes some of our wards such as ward 38.

Action:
Appraisal compliance is regularly being tracked through the monthly divisional performance reviews. The other actions being taken are as follows:

All inpatient areas have all been given a trajectory to reach 100% compliance by end of the year

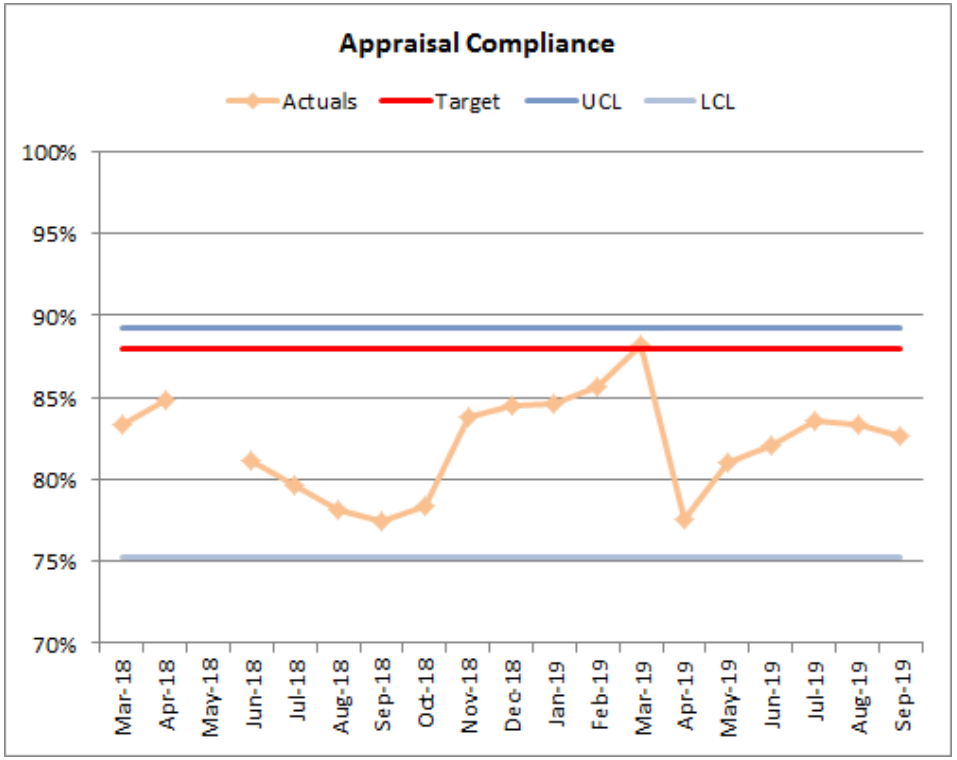
The Med& Acute Divisional Director of Nursing has separated acute care into separate areas to support the management and accountability. Already there has been an improvement with AMU.

Booklets are issued every 3 months for ward sisters to complete all outstanding areas and they are provided with a colour compliance chart so they can also target ambers before they expire.

All ward sisters are aware of this new ESR appraisal process and ensure that everyone has completed new process as of the 31st October 2019.

Expected Impact:

To achieve the 88% target in all divisions

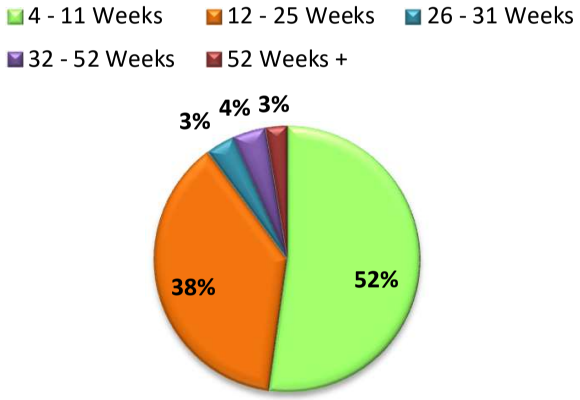


Trust Level

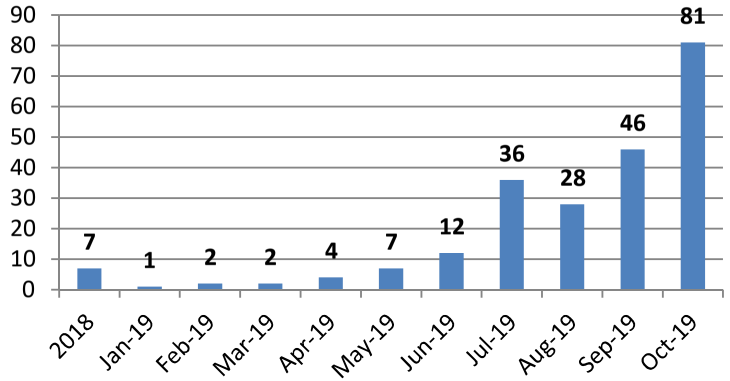
Current Open Cases: 226

October 2019

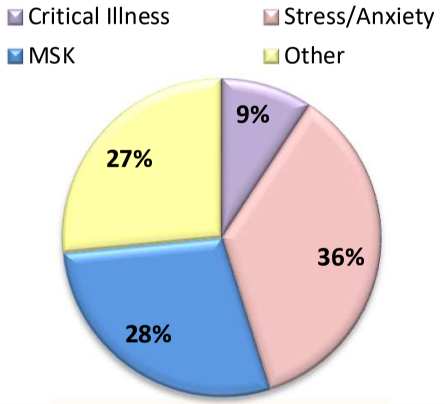
Sickness Length



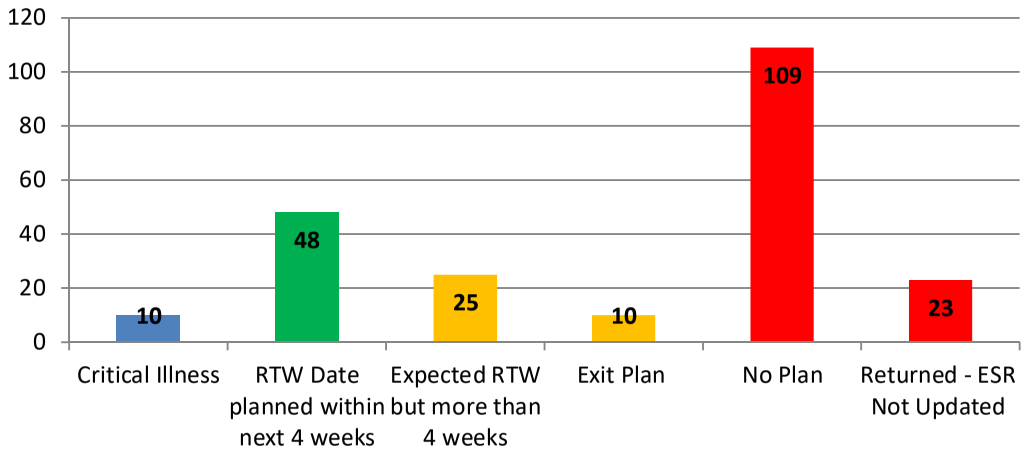
LTS Cases Commended by Month



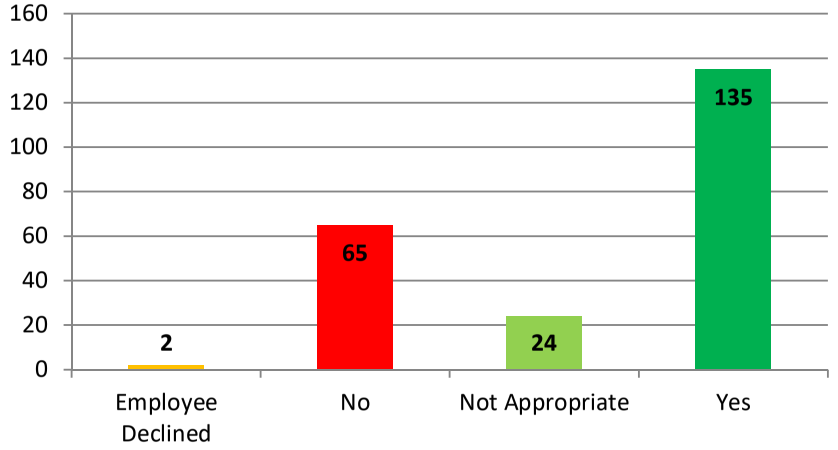
Sickness Reason



Case Management



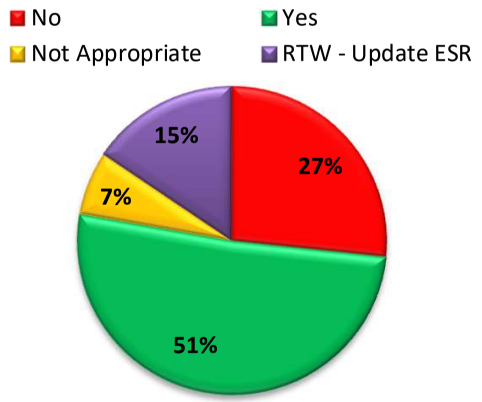
Occupational Health / EAP Referral



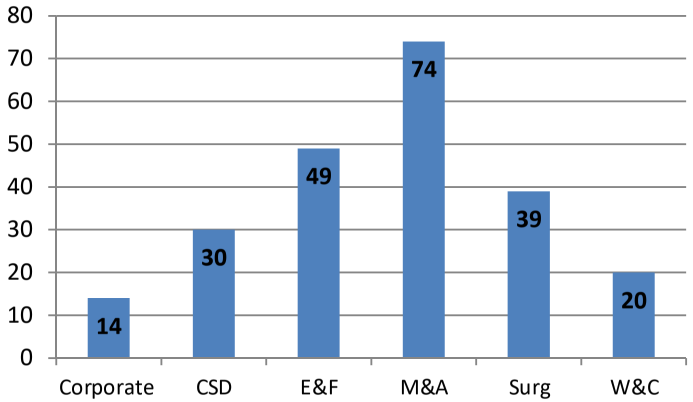
Trust Level

October 2019

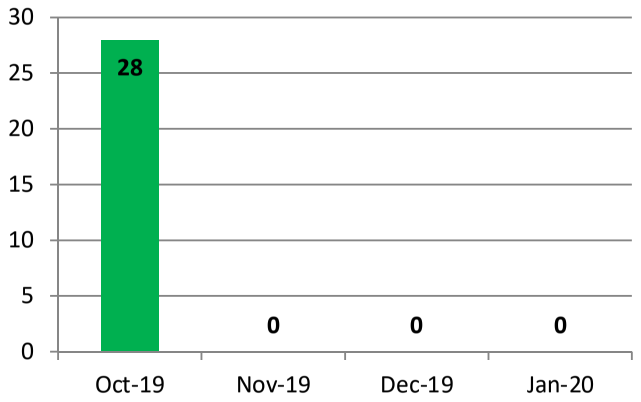
Meeting with Line Manager Taken Place



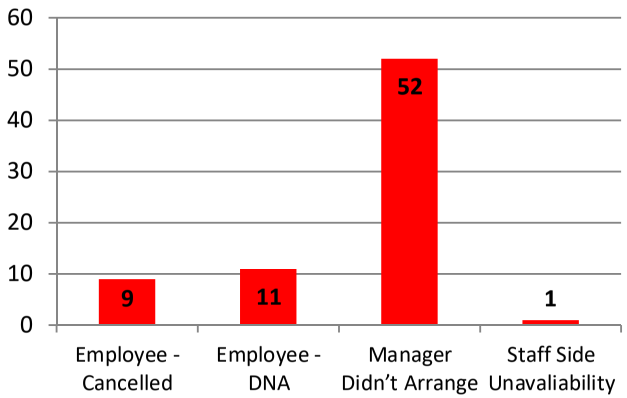
Sickness Cases By Division



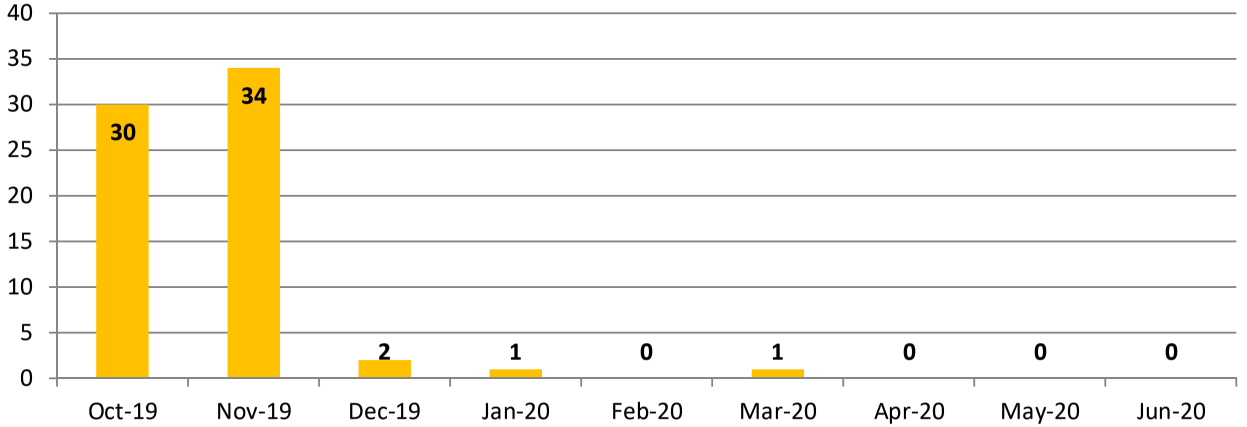
Actual Return to Work



Reason Last Meeting Didn't Take Place



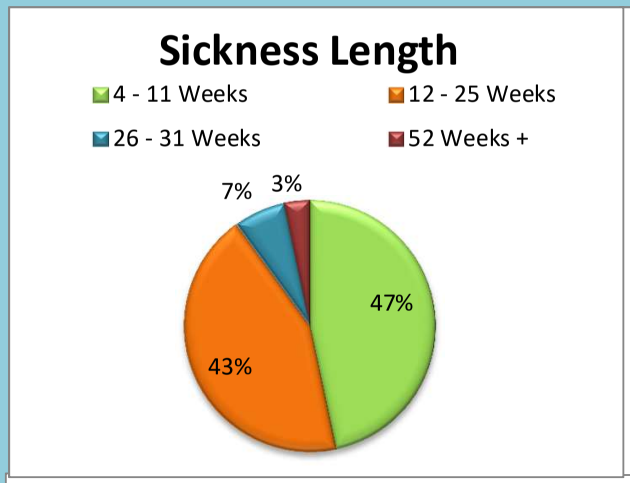
Anticipated Return To Work

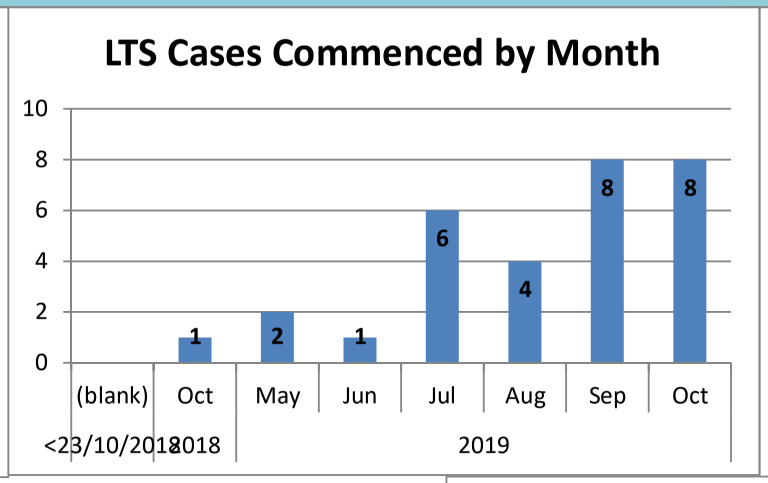


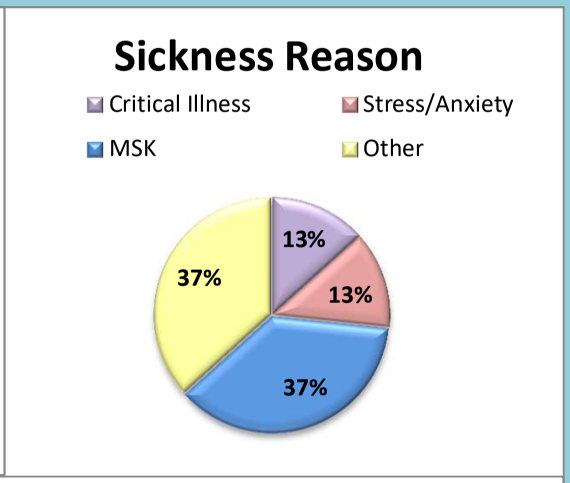
Clinical Support & Diagnostics Division

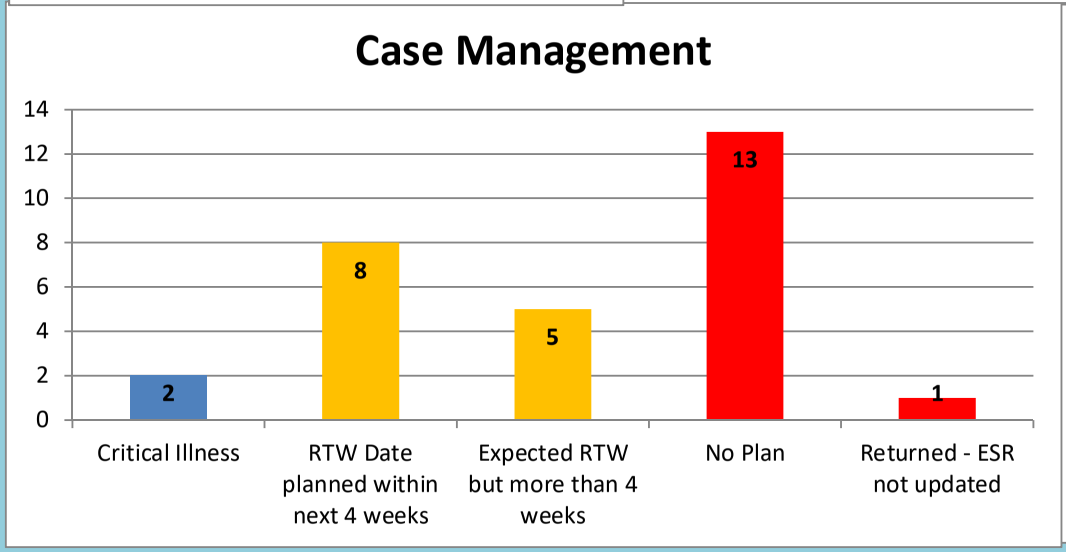
Current open cases: 30

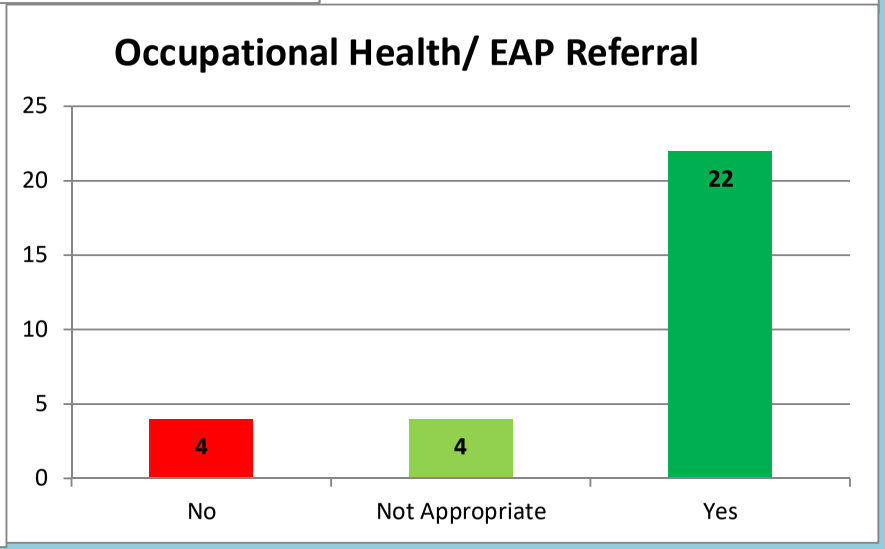
October 2019





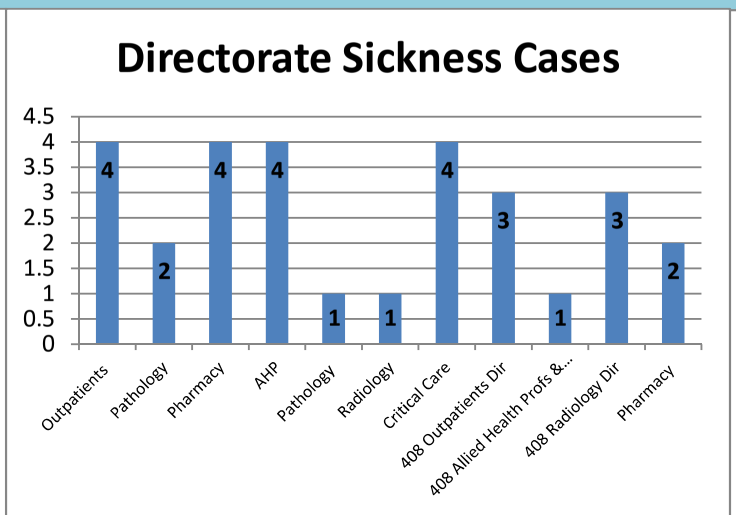


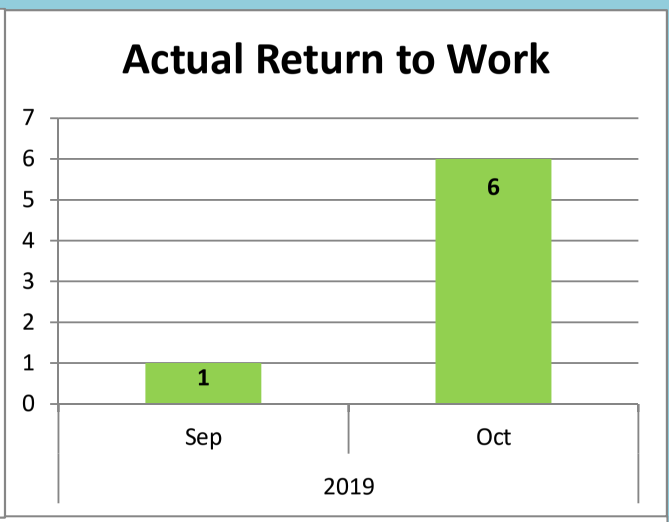


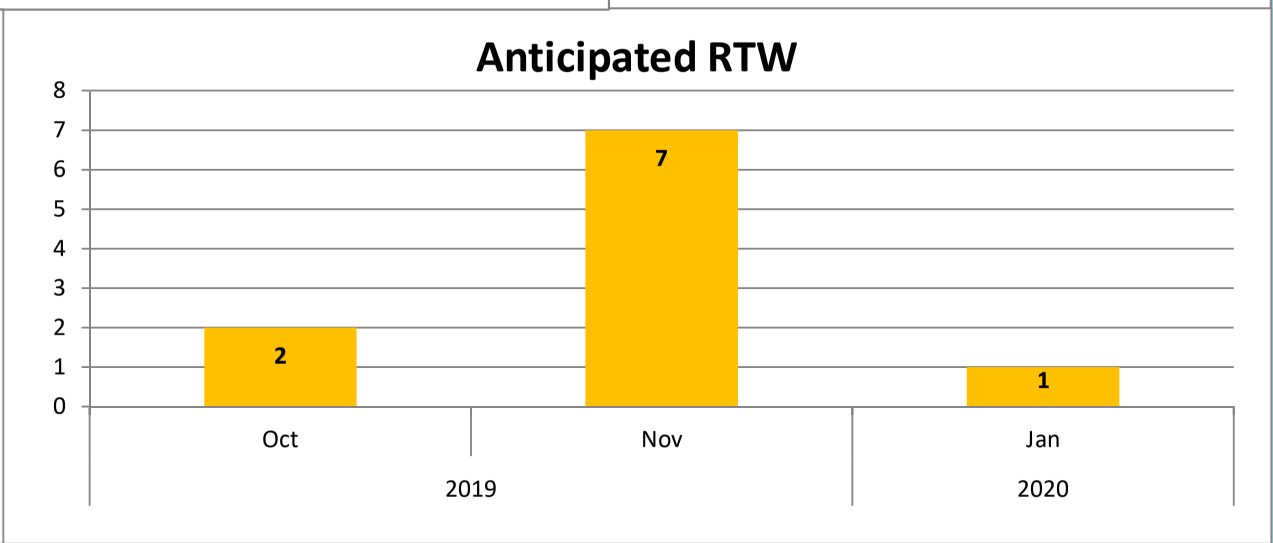


Clinical Support & Diagnostics Division

October 2019





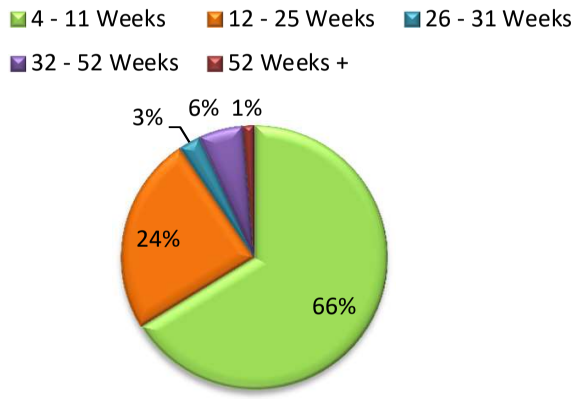


Medicine & Acute Division

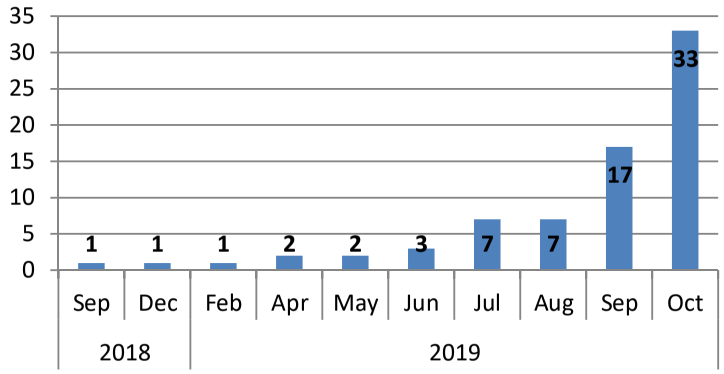
Current open cases: 74

October 2019

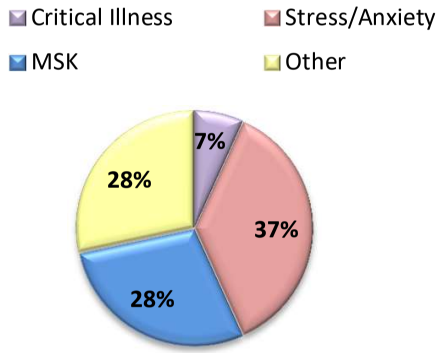
Sickness Length



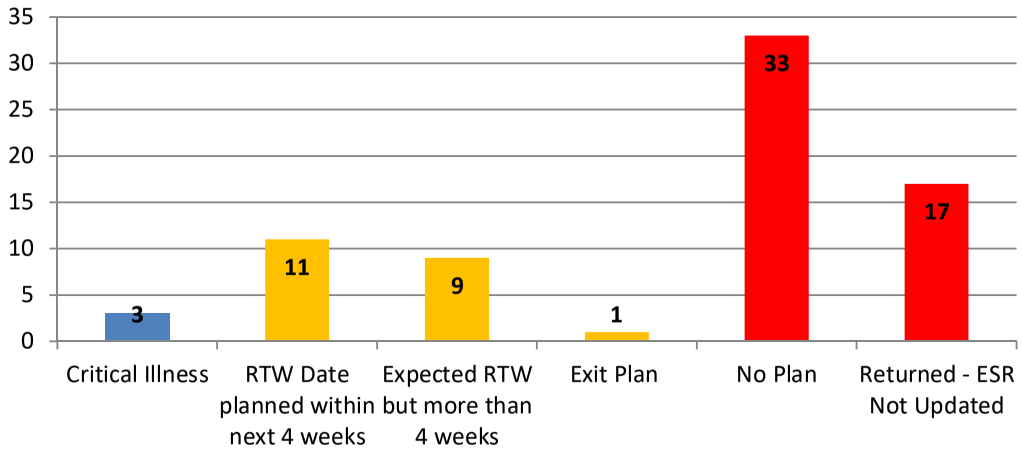
LTS Cases Commenced by Month



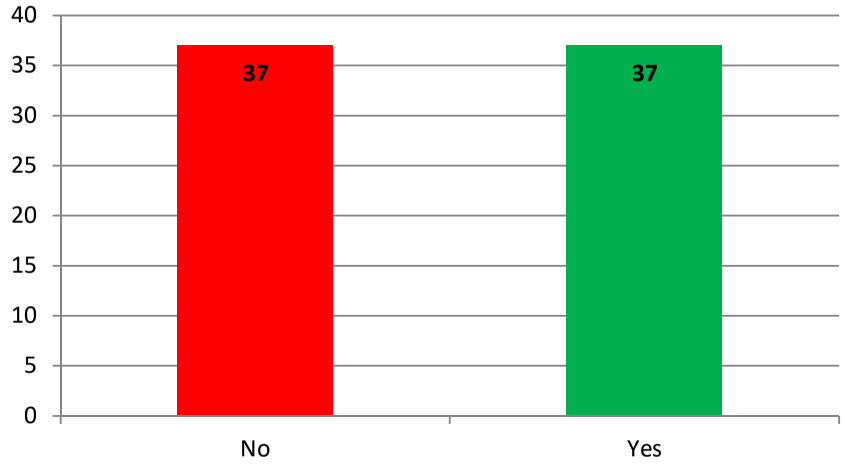
Sickness Reason



Case Management



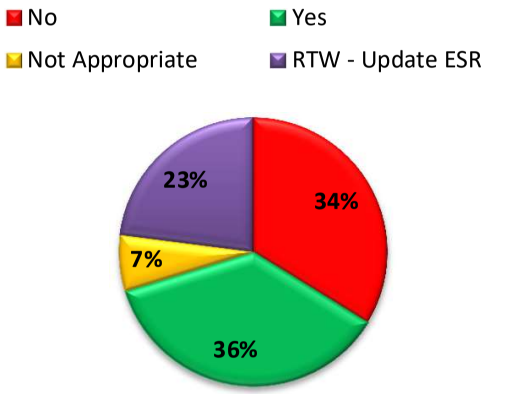
Occupational Health / EAP Referral



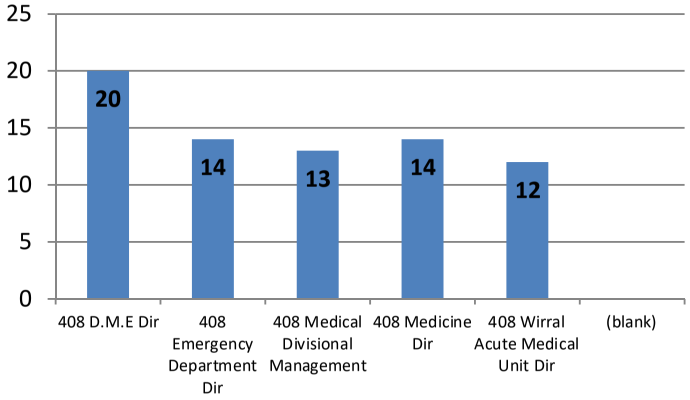
Medicine & Acute Division

October 2019

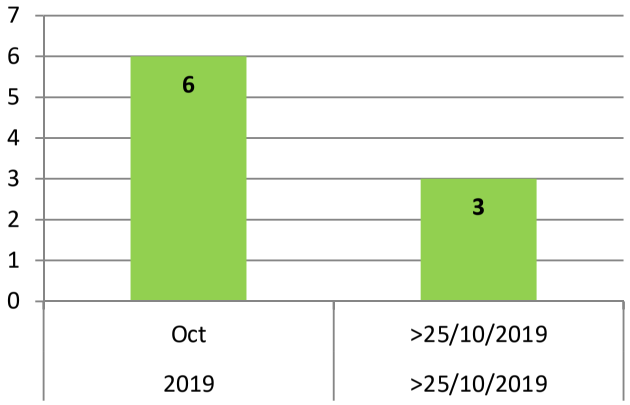
Meeting with Line Manager Taken Place



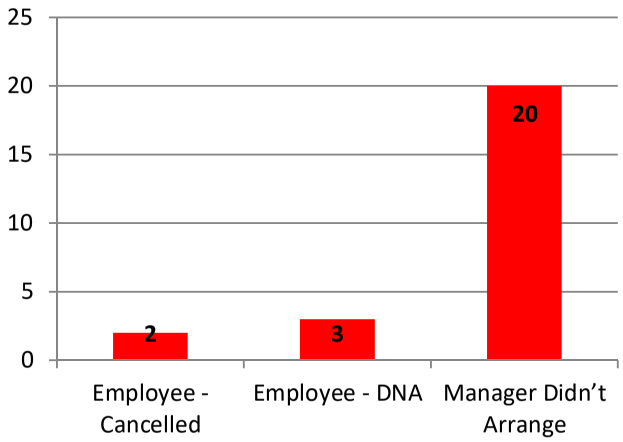
Directorate Sickness Cases



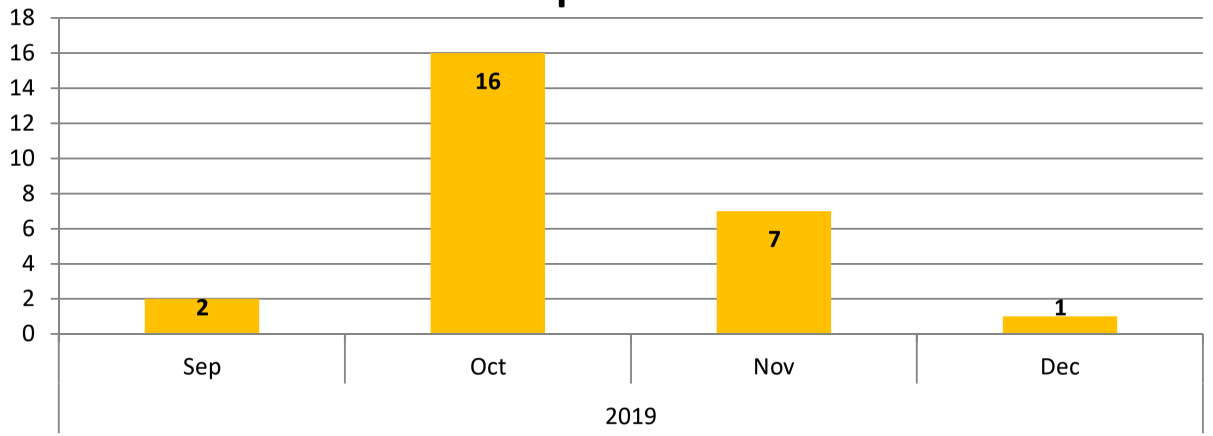
Actual Return to Work



Reason Meeting Didn't Take Place



Anticipated RTW

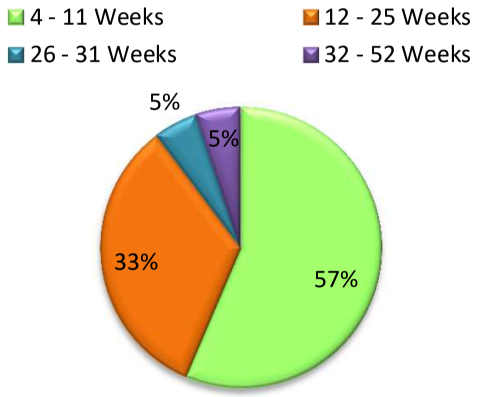


Division of Surgery

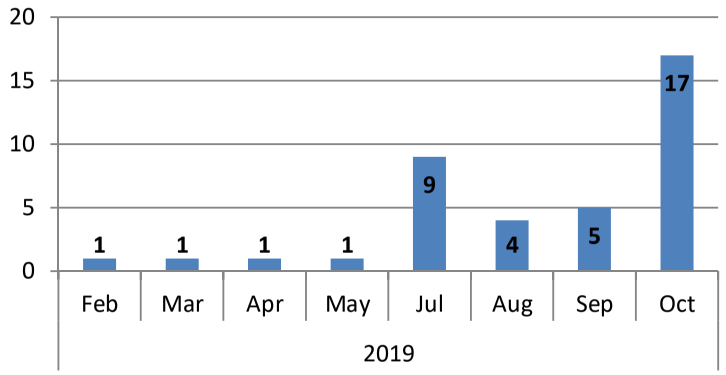
Current Open Cases: 39

October 2019

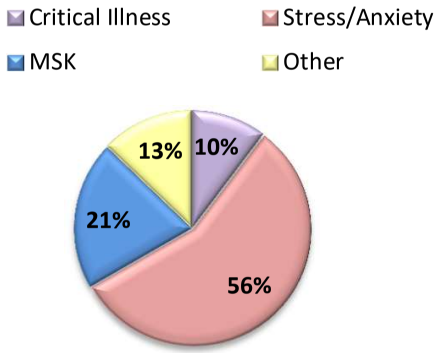
Sickness Length



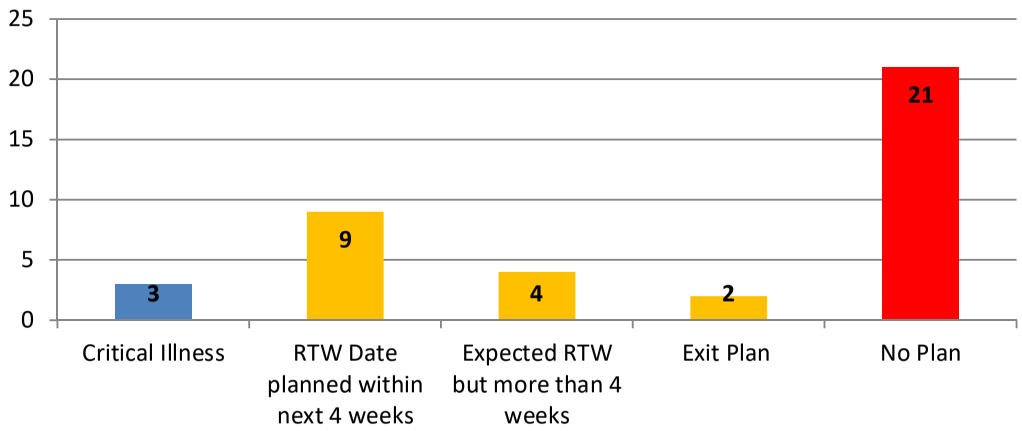
LTS Cases Commenced by Month



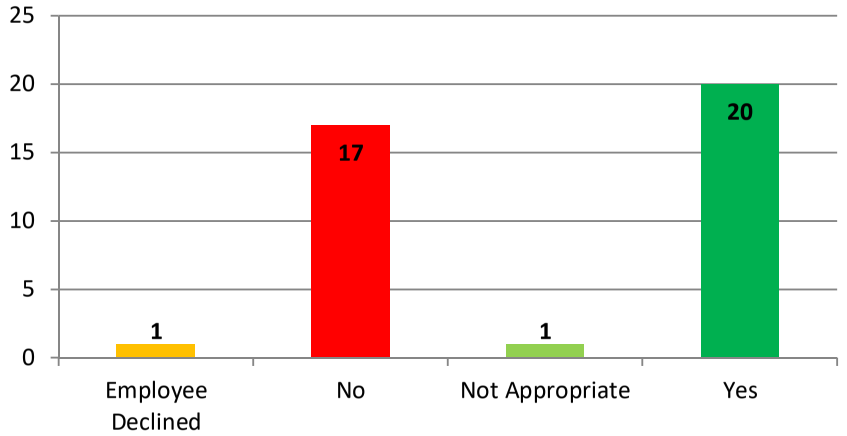
Sickness Reason



Case Management



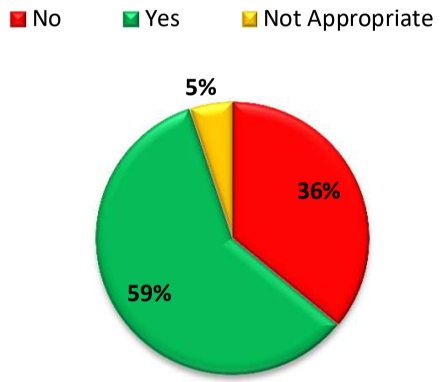
Occupational Health / EAP Referral



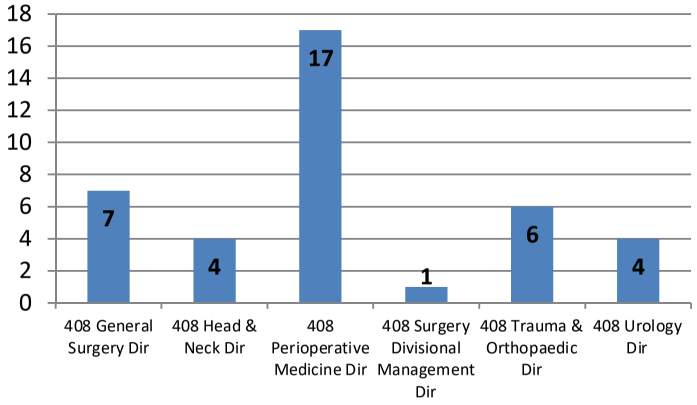
Division of Surgery

October 2019

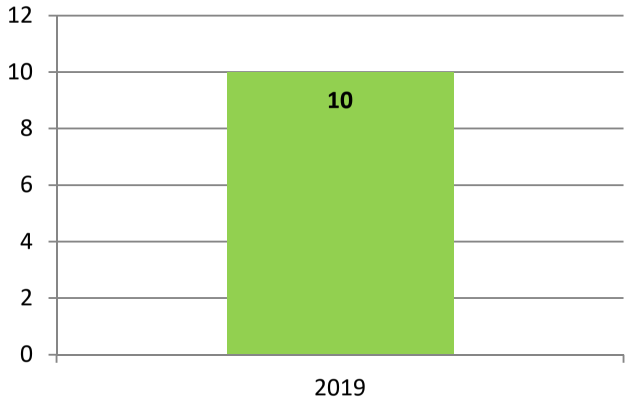
Meeting with Line Manager Taken Place



Directorate Sickness Cases

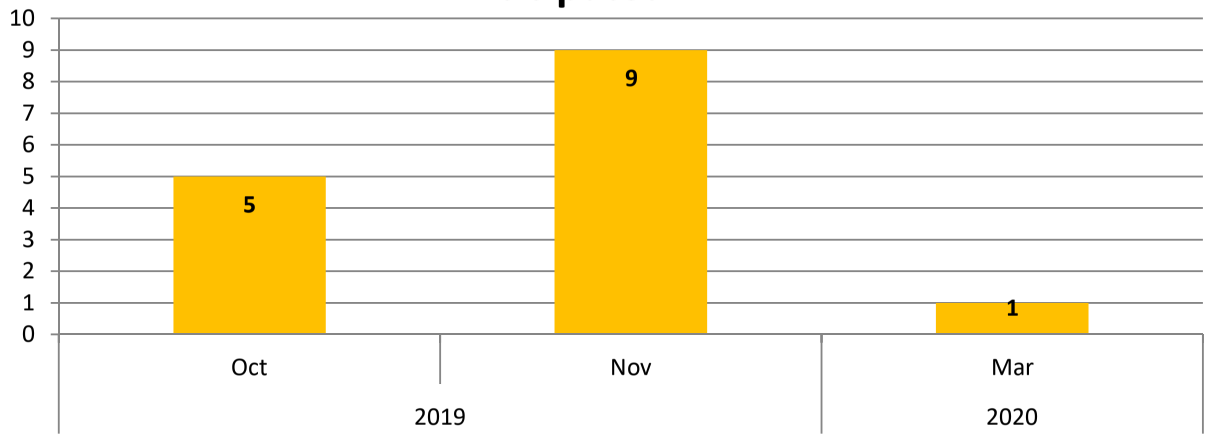


Actual Return to Work



Reason last Meeting Didn't Take Place

Anticipated RTW

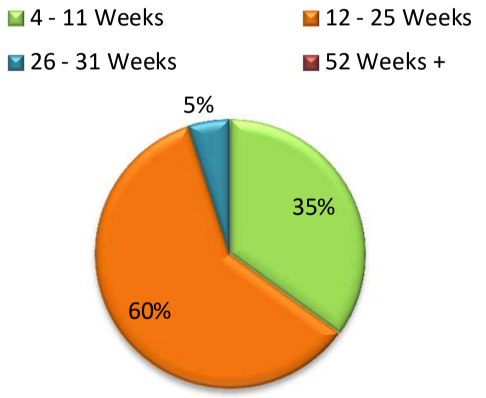


Women & Children's Division

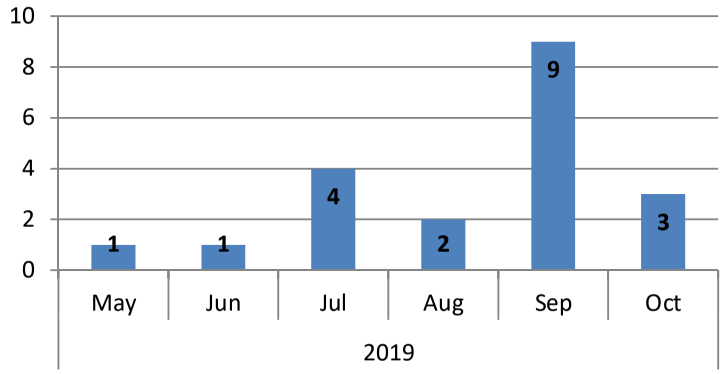
Current Open Cases: 20

October 2019

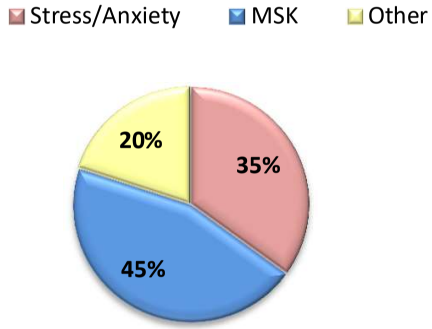
Sickness Length



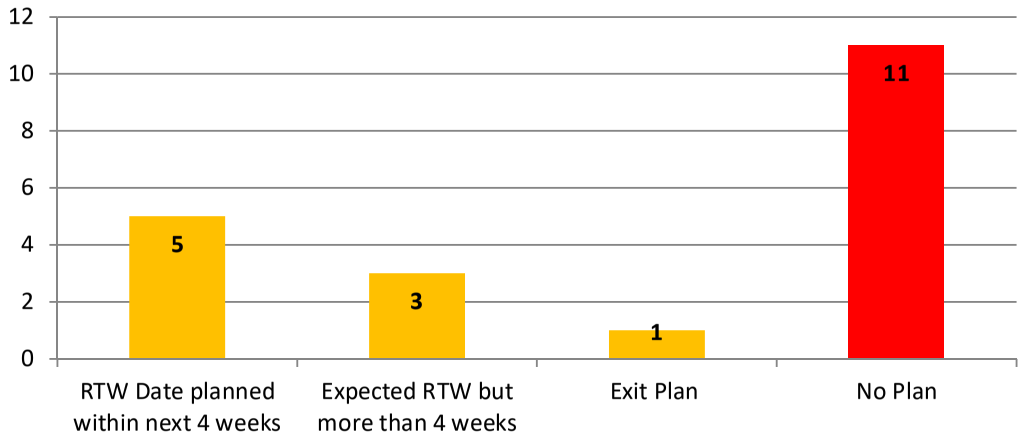
LTS Cases Commenced by Month



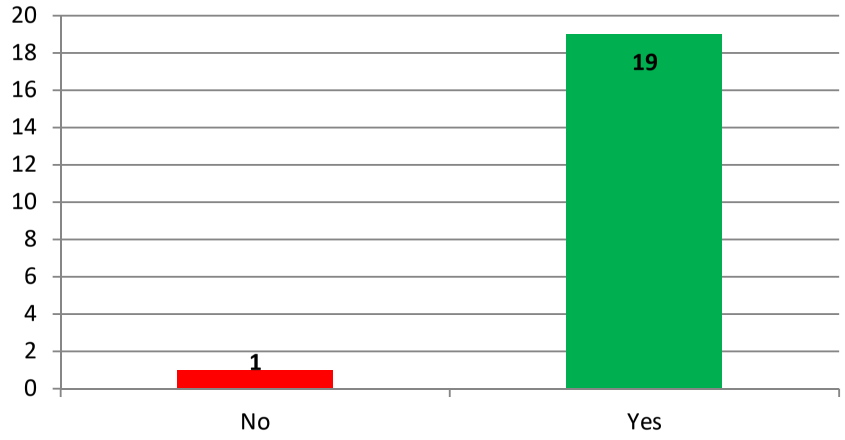
Sickness Reason



Case Management



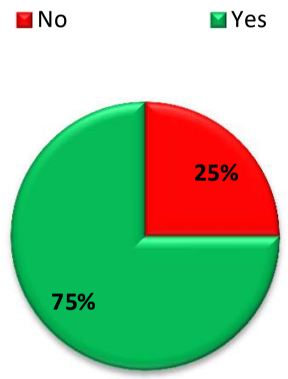
Occupational Health / EAP Referral



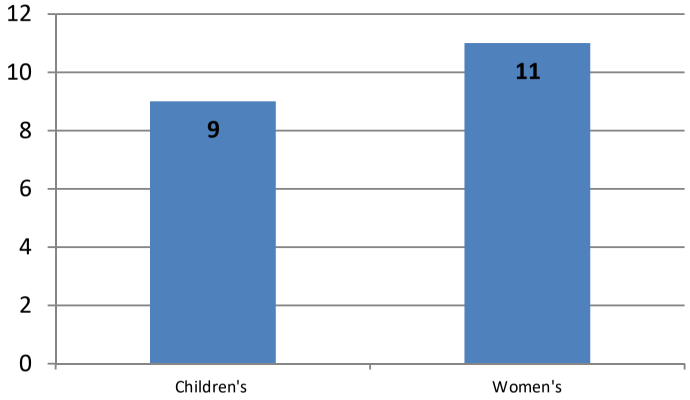
Women & Children's Division

October 2019

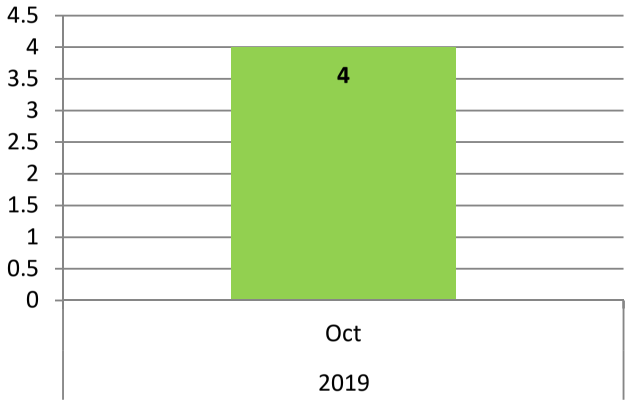
Meeting With Line Manager Taken Place



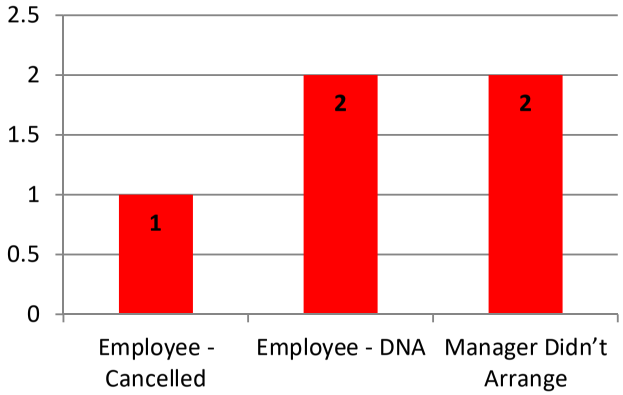
Directorate Sickness Cases



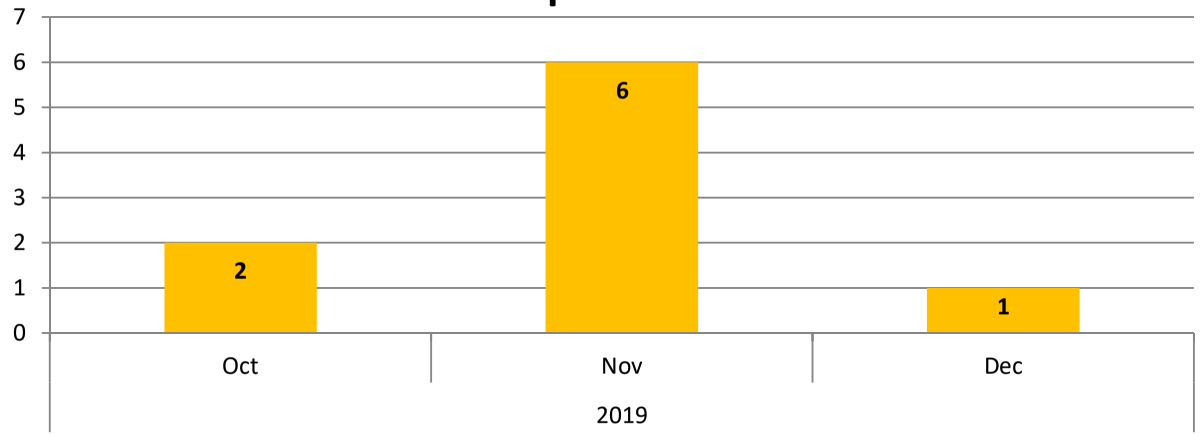
Actual Return to Work



Reason Last Meeting Didn't Take Place



Anticipated RTW

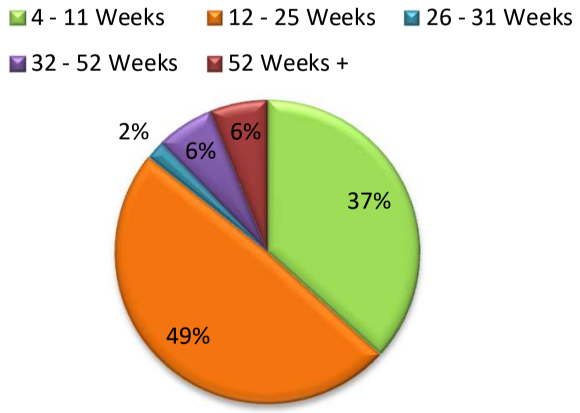


Estates & Facilities

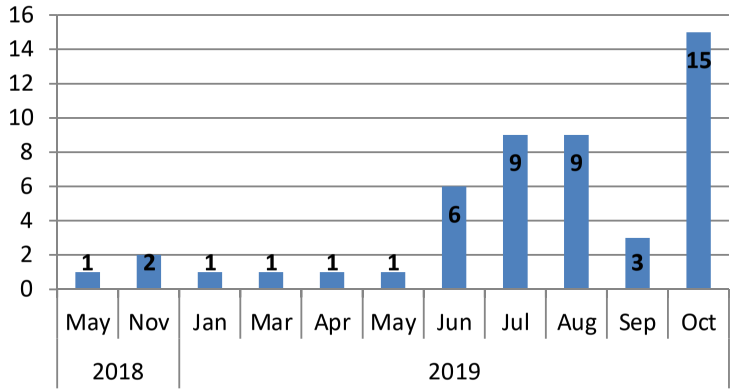
Current Open Cases: 49

October 2019

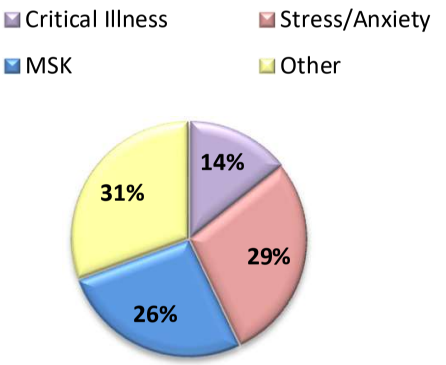
Sickness Length



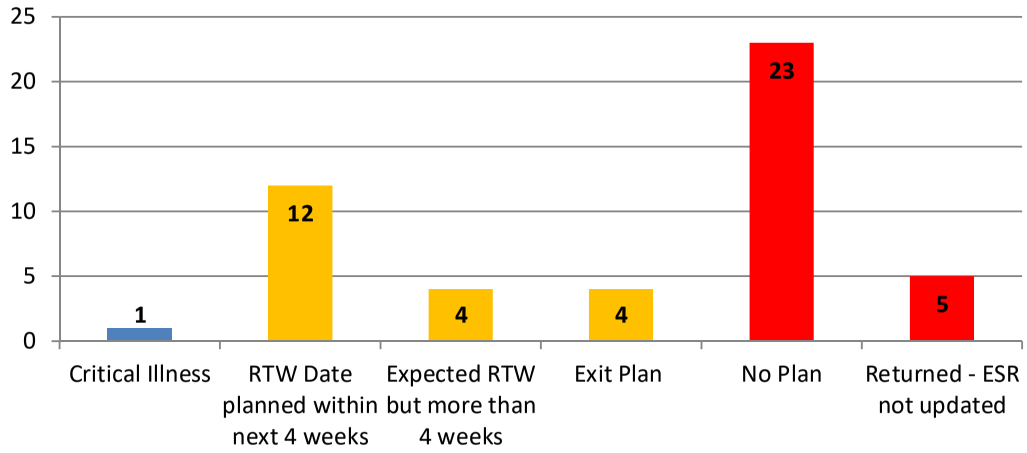
LTS Cases Commenced by Month



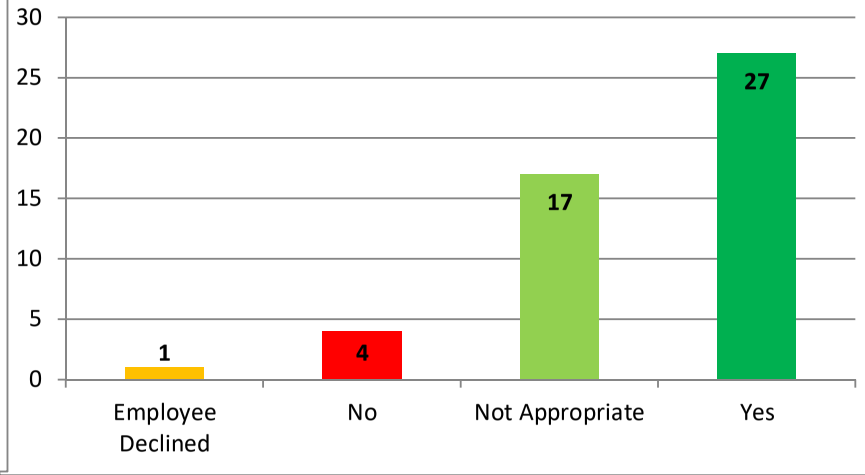
Sickness Reason



Case Management

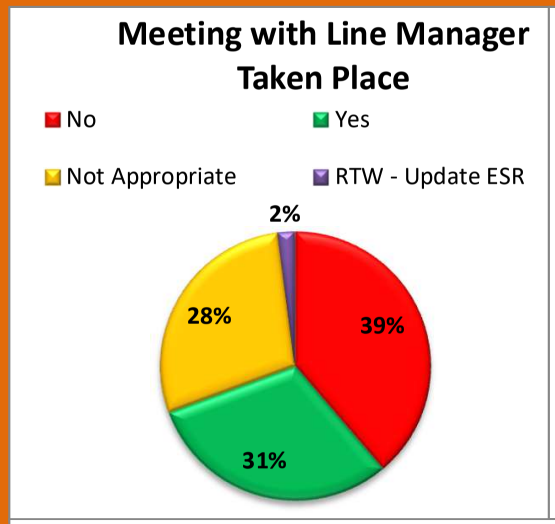


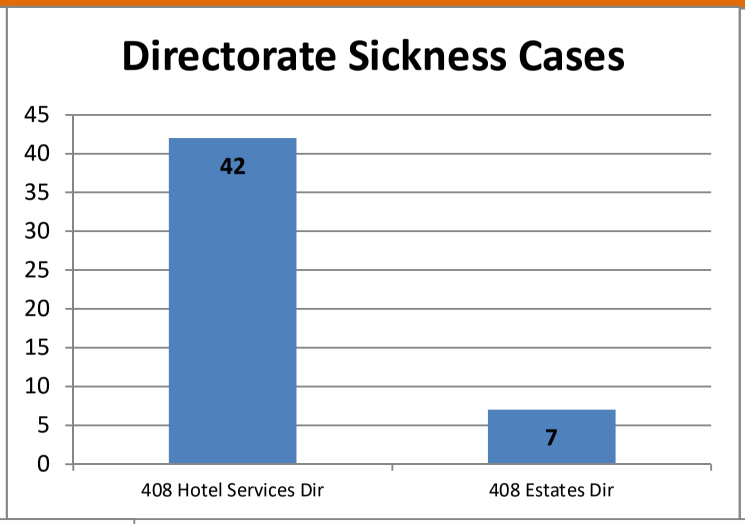
Occupational Health / EAP Referral

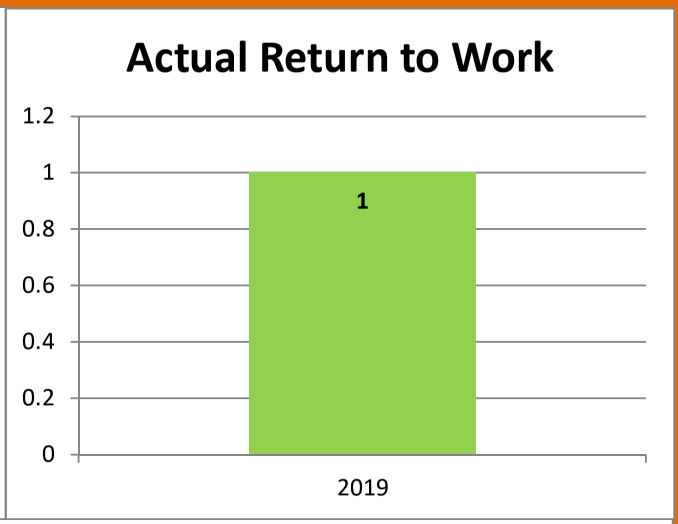


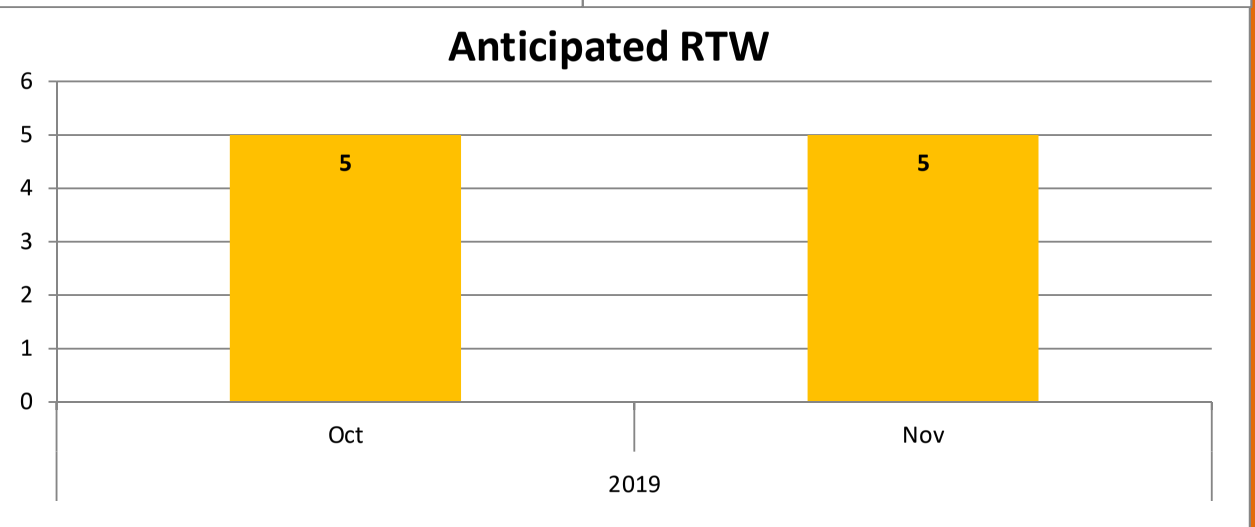
Estates & Facilities

October 2019







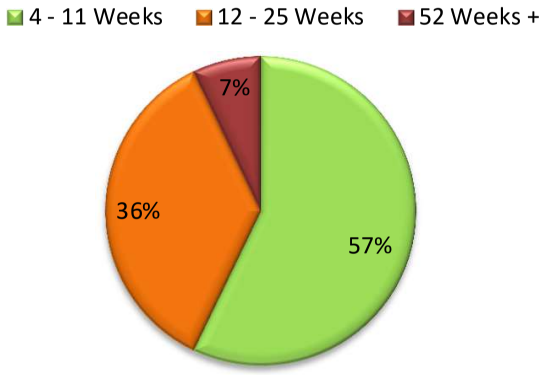


Corporate Services

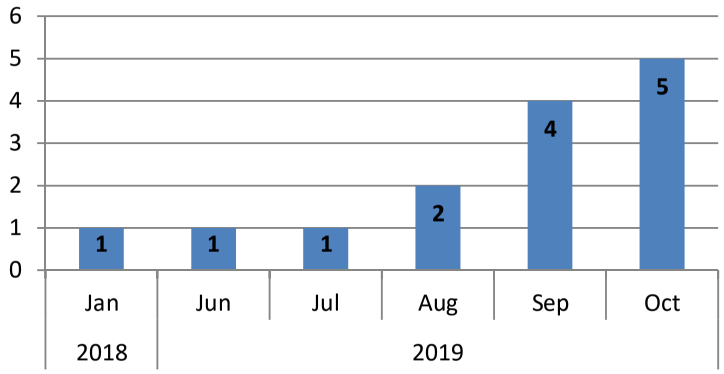
Current Open Cases: 14

October 2019

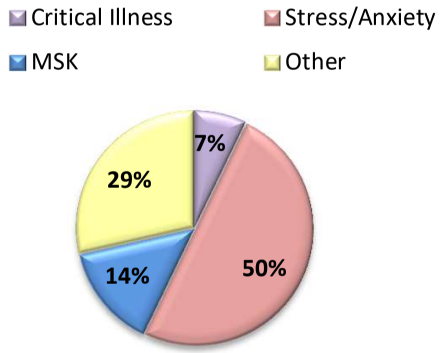
Sickness Length



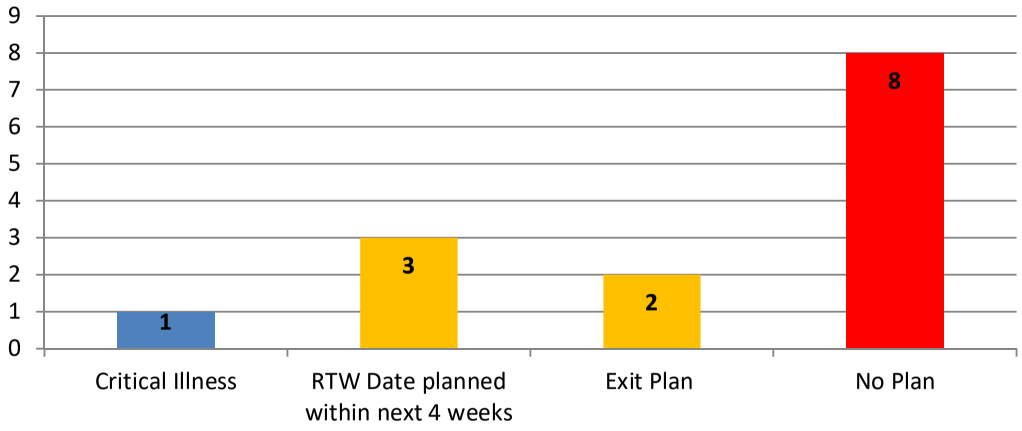
LTS Cases Commenced by Month



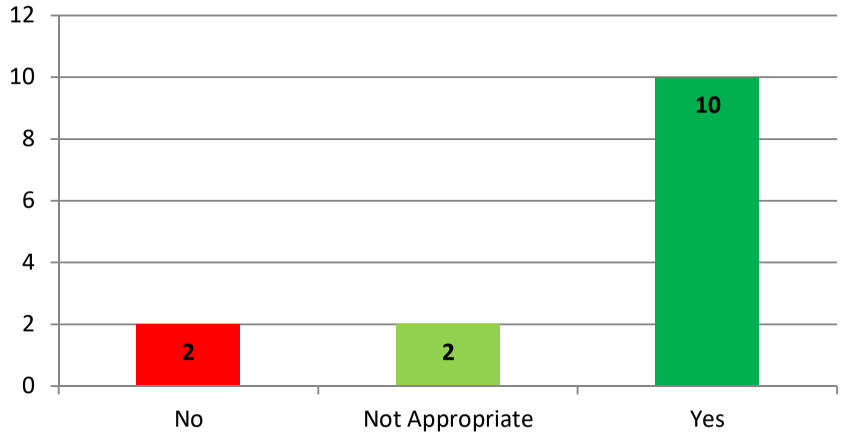
Sickness Reason



Case Management



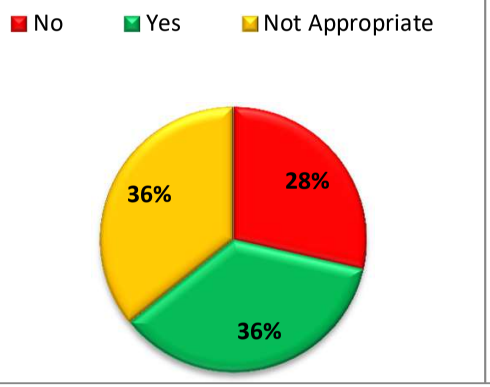
Occupational Health / EAP Referral



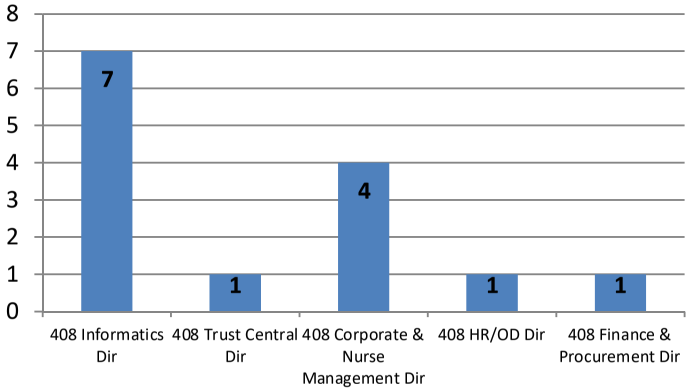
Corporate Services

October 2019

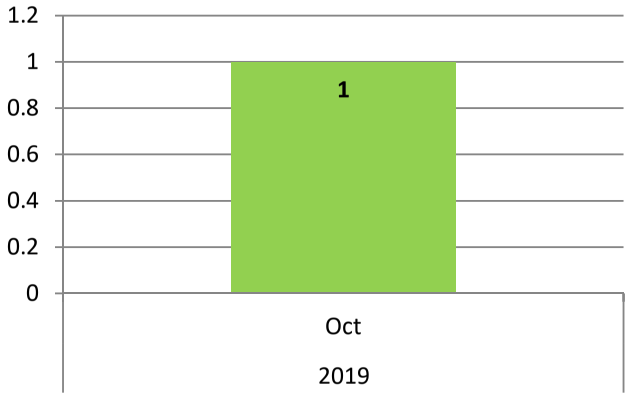
Meeting with Line Manager Taken Place



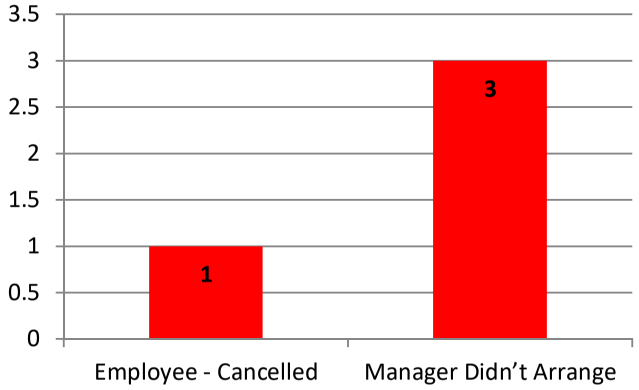
Directorate Sickness Cases



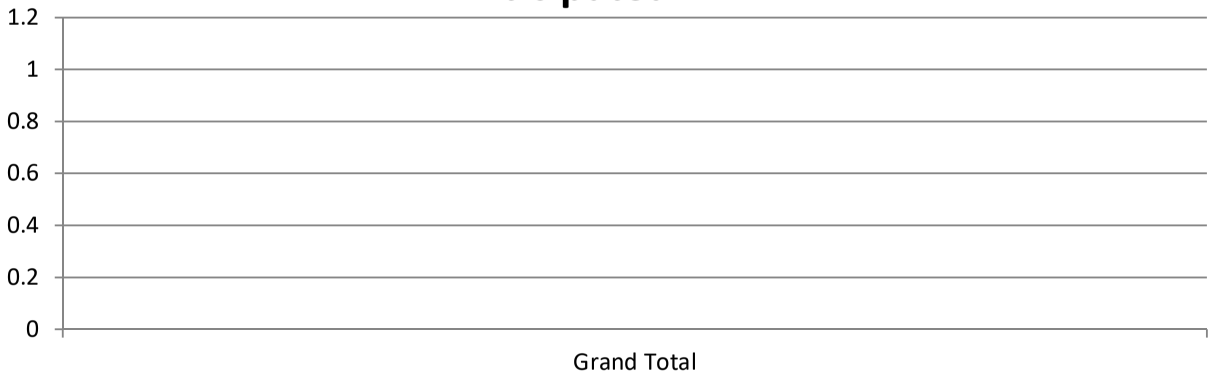
Actual Return to Work



Reason Last Meeting Didn't Take Place



Anticipated RTW



Board of Directors	
Agenda Item	13
Title of Report	Month 6 Finance Report
Date of Meeting	6th November 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 6 Finance Report 2019/20

Contents

1. Executive summary

The Control Total issued by NHSI to the Trust for 2019/20 was a "breakeven" position. Delivery of this enabled 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 included a CIP requirement of £13.2m.

The following summary details the Trust's financial performance during September (Month 6).

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.

On that basis for Mth 6 the Trust's planned an operational deficit of (c£0.5m), actual performance was a deficit of (c£1.2m), an adverse performance against plan of (c£0.7m).

This is reflected in the cumulative performance position, the YTD plan is a deficit of (£5.7m), and the actual position was a deficit of (c£9.7m), therefore a variance of (c£4.0m).

To support the Trust in delivering operational and transformational improvements the CCG have released "accelerated" support to the Trust of £1.4m in Qtr 1, and £2.7m in Qtr 2.

Including the additional support the Trust delivers a "break-even" position, and has access to FRF/PSF funding of £1.9m in Qtr 1, and £2.5m in quarter 2.

1.1 Key Headlines

- The key components of the quarterly and monthly position are:

	Qtr1 £m	Mth 4 £m	Mth 5 £m	Mth 6 £m	YTD £m
Depreciation	(0.3)	(0.1)	(0.1)	(0.1)	(0.6)
VAT (medical locums)	(0.3)	(0.0)	0	0	(0.3)
Aseptic Unit - closure	(0.2)	(0.0)	(0.0)	(0.0)	(0.2)
Divisional Restructure	(0.1)	0	0	0	(0.1)
18/19 Costs	(0.1)	0	0	0	(0.1)
Pay Pressures	(0.4)	(0.3)	(0.8)	(0.7)	(2.2)
Income	1.4	(0.1)	0	2.7	4.0
Non Pay Pressures	0	(0.3)	(0.1)	0	(0.4)
TOTAL	**0**	**(0.8)**	**(1.1)**	**1.9**	**0**

- Pay costs exceeded plan by a further (c£0.7m) in September, increasing the year to date overspend to (c£2.8m). The drivers of the pay position are multi-faceted; nurse bank costs increased due to increased sickness, improved shift "fill" rates, the commencement of nursing staff into substantive posts which were previously vacant, continued medical staff pressures, double-running costs during the junior doctor August

rotation and staffing of escalation beds. Increased Consultants costs to cover gaps and pressures in ED. Premium costs had also been incurred earlier in the year to cover shortfalls in the Junior Drs. rotas; however this has been partially mitigated following the recent (August) rotation.

- Non pay costs were as planned. Tight controls have been enacted since late June to manage other operational costs.

- Operationally patient-related income is broadly in-line with plan. Although elective activity under performed, this has been offset by over performance in emergency activity in Women's and Children's specialities and excess beddays. In addition, non elective activity is below expected activity levels, however, this is mitigated by the application of local contract terms. The position includes additional maternity pathway income for patients transferring to WUTH following the decision taken by the Directors of One to One Ltd to place the company into Administration in July 19.

- The accelerated funding from Wirral CCG will be adjusted in the quarter 4 position. The Trust forecast outturn position is (c£12.9m), this is discussed further in Section 7 of this report

- Cash balances at the end of September were £2.7m which was c£0.5m higher than plan. This is due to 19/20 opening cash being above plan (£2.5m), EBITDA and donations above plan (£0.5m), capital cash below plan (£4.3m), PDC received below plan (£0.5m) and controlled variances in the working capital cycle (£6.3m).

- Based on the forecast position, it is anticipated further borrowings of £4.0m will be needed in November 2019 to maintain ongoing liquidity in 2019/20. The Board is asked to approve this and further draw-downs as required within the DHSC deficit limit, to maintain ongoing liquidity in 2019/20.

- Cost improvements/efficiencies delivered YTD amount to c£4.7m, although this is slightly below plan (c£0.2m). The position is significantly ahead of previous years and reflects the focus within the Trust and the effects of the weekly monitoring meetings.

- Year to date capital spend is behind the original plan by c£2.9m; however a capital programme review has been undertaken to provide assurance that the forecast spend of £7.9m will be achieved.

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

2. Financial performance

2.1 Income and expenditure

Month 6 Financial Position	Budget (Mth 6) (£m)	Actual (Mth 6) (£m)	Variance (£m)	Year To Date Budget (£m)	Year To Date Actual (£m)	Variance (£m)	*M4 Forecast Variance (Mth 6) (£m)*	*Actual Variance (Mth 6) (£m)*	*Variance (£m)*
NHS income from patient care activity	26,702	26,806	104	160,264	160,543	279	*183*	*104*	*(79)*
Non NHS income from patient care	472	322	(150)	2,802	2,371	(432)	*(17)*	*(150)*	*(133)*
Other income	3,724	3,774	50	21,792	21,887	95	*13*	*50*	*37*
Total Income	**30,898**	**30,902**	**4**	**184,858**	**184,800**	**(58)**	***179***	***4***	***(175)***
Employee expenses	(21,362)	(22,026)	(664)	(129,373)	(132,143)	(2,771)	*(555)*	*(664)*	*(109)*
Operating expenses	(9,690)	(9,761)	(71)	(59,218)	(60,353)	(1,135)	*(416)*	*(71)*	*345*
Total expenditure	**(31,052)**	**(31,788)**	**(735)**	**(188,590)**	**(192,497)**	**(3,906)**	***(971)***	***(735)***	***236***
Non Operating Expenses	(350)	(347)	3	(2,104)	(2,105)	(0)	*4*	*3*	*(1)*
Actual Surplus / (deficit)	**(505)**	**(1,232)**	**(728)**	**(5,837)**	**(9,801)**	**(3,964)**	***(788)***	***(728)***	***60***
Reverse capital donations / grants									
I&E impact	21	15	(6)	125	81	(44)	*0*	*(6)*	*(6)*
Surplus/(deficit) incl. PSF/FRF	**(484)**	**(1,217)**	**(734)**	**(5,712)**	**(9,720)**	**(4,008)**	**(788)**	**(734)**	**54**
Accelerated support from Wirral CCG	**0**	**2,700**	**2,700**	**0**	**4,050**	**4,050**			
Adjusted Surplus/(deficit)	**(484)**	**1,483**	**1,966**	**(5,712)**	**(5,670)**	**42**			

- Actual costs exceed plan in month and year to date.
- Overall the Trust delivered against the forecast position. This is discussed further in section 4.
- Medical bank costs have continued reflecting sickness and maternity leave cover.
- Nurse vacancies rates have reduced from the previous year, in addition high levels of sickness in some areas has resulted in the further use of bank nurses to maintain safe staffing levels across the wards and this has been facilitated by an improvement in bank fill rates. Vacancies remain in non-clinical areas and have non-recurrently supported the delivery of CIP.
- Some pressures are non recurrent, and controls continue in relation to authorisation of non-core medical staffing costs, all non-stock orders are now approved by Divisional Directors or Executive Directors only.
- Financial control is supported by the weekly "scrutiny panels" lead by Executive Directors, which review non-clinical vacancies, non-core pay spend, discretionary non pay spend, the consultant agency 'hotlist' and tracking of CIP deliverables. In addition, all Medical rota pressures are escalated to Divisional Directors for approval.

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£0.6m) 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 6 Budget Reconciliation	**Breakdown by Budget Type**		
	Income £'000	**Expenditure £'000**	**Deficit £'000**
Base Budget 19/20	184,592	(190,429)	(5,837)
CIP - Increase Clinical Income Oral Surgery	75	(75)	0
Extra Day adjustment value	(84)	84	0
NNU Block adjustment	35	(35)	0
PbR excluded drugs, devices & bloods adjustment	(219)	219	0
Non Recurrent Income Targets	332	(332)	0
Realignments (inc CIP)	127	(127)	0
M6 Closing Budget	184,858	(190,695)	(5,837)
Net Trustwide (Increase)/Reduction	**266**	**(266)**	**0**

2.3 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	641	535	(106)	3,803	3,294	(509)	2,337	1,793	(544)	13,702	12,793	(909)
Daycase	3,522	3,555	33	21,252	21,289	37	2,352	2,334	(18)	14,114	14,288	174
Elective excess bed days	275	238	(37)	1,664	1,792	128	75	59	(16)	454	453	(1)
Non-elective	3,718	3,509	(209)	22,452	21,696	(756)	8,043	8,088	45	49,196	49,163	(33)
Non-elective Non Emergency	455	491	36	2,461	2,676	215	1,003	1,094	91	5,455	5,901	446
Non-elective excess bed days	1,024	1,309	285	6,214	7,654	1,440	279	346	66	1,686	2,037	351
A&E	7,058	7,724	666	43,371	45,870	2,499	1,215	1,276	62	7,465	7,640	175
Outpatients	25,580	25,387	(193)	151,905	148,302	(3,603)	3,044	3,041	(3)	18,084	18,117	33
Diagnostic imaging	2,440	2,725	285	14,464	15,818	1,354	182	187	5	1,083	1,092	9
Maternity	512	565	53	2,925	3,202	277	452	450	(3)	2,679	2,806	127
Non PbR							6,475	6,479	4	39,086	38,722	(364)
HCD							1,210	1,210	(0)	7,691	7,691	(0)
CQUINs							186	186	0	1,117	1,117	0
PSF/FRF/MRET							1,357	1,358	1	7,525	7,525	0
Total NHS Clincial Income	45,227	46,038	812	270,513	271,593	1,081	28,209	28,244	35	169,336	169,344	8
Other patient care income							183	2,895	2,712	480	552	72
Non-NHS: private patients & overseas							50	17	(33)	240	183	(57)
Injury cost recovery scheme							89	30	(59)	535	358	(177)
Total income from patient care activities							28,531	31,186	2,655	170,591	170,437	(154)
Other operating income							2,367	2,404	37	14,267	14,363	96
Total income							30,898	33,590	2,692	184,858	184,800	(58)

- Overall patient-related income is broadly in-line with plan.
- Elective performance has continued to underperform, predominantly due to decreased activity in Orthopeadics and casemix in other specailities. The cumulative underperformance relates to Clinical Haematology, Colorectal, Upper GI, Urology and T&O offset by over performance within Gastro., Ophthalmology & Gynaecology.. The Orthopaedic under performance has been mitigated by the MSK block benefit of £1.7m. It should be noted some of the underperformance is due to reduced bed availability, reflecting increased length of stay of emergency patients.
- Non-Elective (NEL) is underperforming in month driven mainly by a reduction in activity. In-line with the contractual agreement for NEL cumulatively c£2.7m has been included reflecting the contract terms with Wirral CCG.
- The Maternity pathways performance position includes £0.1m relating to One to One midwifery patient transfers.
- The underperformance in Non-PbR is largely driven by reduced adult Critical Care bed days, and Neonatal bed days.

2.4 Pay

Pay costs exceed plan by (£0.7m) in month, increasing the cumulative overspend to (c£2.8m).

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

STAFF GROUP	MONTH 6 (£'000)			CUMMULATIVE (£'000)		
	BUDGET	Actual	VARIANCE	BUDGET	ACTUAL / FORECAST	VARIANCE
CONSULTANTS	3,530	3,790	(260)	20,195	21,844	(1,649)
OTHER MEDICAL	2,345	2,549	(204)	14,267	15,267	(1,000)
TOTAL MEDICAL	**5,875**	**6,339**	**(464)**	**34,462**	**37,110**	**(2,649)**
NURSING & MIDWIFERY	6,039	5,867	172	36,688	35,790	898
CLINICAL SUPPORT WORKERS	1,952	2,191	(239)	12,100	13,455	(1,355)
TOTAL NURSING	**7,991**	**8,057**	**(67)**	**48,788**	**49,245**	**(456)**
AHP'S, SCIENTIFIC & TECH	2,761	2,833	(72)	16,749	17,003	(254)
ADMIN & CLERICAL & OTHER	4,735	4,797	(62)	29,374	28,786	588
TOTAL SUPPORT STAFF	**7,496**	**7,630**	**(133)**	**46,122**	**45,788**	**334**
TOTAL	**21,362**	**22,026**	**(£664)**	**129,373**	**132,143**	**(£2,771)**

- The tables below details all substantive and non-core spend by staff category, profile of budget, actual costs and year to date variance.

Medical Staffing			
Period	£m Budget	£m Actual	£m Variance
Mth 1	5,792	6,137	(£345)
Mth 2	5,748	6,153	(£405)
Mth 3	5,755	6,205	(£450)
Mth 4	5,663	6,096	(£433)
Mth 5	5,629	6,180	(£551)
Mth 6	5,875	6,339	(£464)
TOTAL	34,462	37,110	(£2,649)

Nursing & CSW			
Period	£m Budget	£m Actual	£m Variance
Mth 1	8,591	8,482	£109
Mth 2	8,071	8,180	(£109)
Mth 3	8,186	8,188	(£1)
Mth 4	8,040	8,153	(£113)
Mth 5	7,909	8,185	(£276)
Mth 6	7,991	8,057	(£67)
TOTAL	48,788	49,245	(£456)

AHP's (Scientific & Tech) and A&C/Other			
Period	£m Budget	£m Actual	£m Variance
Mth 1	8,100	8,073	£27
Mth 2	7,752	7,425	£327
Mth 3	7,678	7,570	£109
Mth 4	7,534	7,518	£16
Mth 5	7,562	7,573	(£11)
Mth 6	7,496	7,630	(£133)
TOTAL	46,122	45,788	£334

Note: The increase in budget and actual cost for Nursing and Other staff pay grade in Mth 1 reflects the AFC pay award for 2019/20.

- The spend on Consultants reflects 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. The agency consultant 'hotlist' as previously mentioned is reviewed monthly to monitor progress and explore alternative models if possible to mitigate the premium cost.
- Other medical pressures reflect shortfalls in the trainee grades during the February 2019 rotation. Following that rotation there was a "gap" of 31.00 wte across the Trust; this has reduced to 13.00 wte following the favourable rotation in August. However here has been an increase in maternity leave within this group, resulting in a further gap of 5.00 wte.
- Although Nursing and midwifery is underspent YTD and in month, the position does reflect the commencement of staff into previous vacant substantive posts and the support for escalation areas. To note the budget for nursing will vary dependent upon the number of nights, weekends and bank holidays in the month affected enhanced pay.
- The Clinical Support Worker category includes non-registered nursing grades that are in clinical areas, and trainee nurse associates. The overspend in this group of staff was previously mitigated by underspends in qualified nursing costs. However the position shows the continued reliance on this group of staff to support patient acuity, cover sickness and staffing support for escalation areas.
- Within the year to date position there is (c£0.3m) of undelivered CIP in relation to workforce schemes, including Non-ward based nursing and e-rostering.
- Pay costs for Allied Health Professionals have increased in month, this relates to "preceptorship" training for the recent in-take of trainee Pharmacists, this is a one-off cost.
- The position in relation to administrative and infrastructure posts reflect vacancies which have supported the non pay overspends in certain areas. In Month 2 & 3, capitalisation of IT costs to GDE assets resulted in a favourable variance. The movement in September reflects the transaction of CIP, albeit non recurrently.

The table below details pay costs by category for September 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	(243,696)	(20,396)	(19,554)	841	(123,817)	(117,406)	6,411
Bank	(254)	(20)	(986)	(966)	(137)	(5,736)	(5,599)
Medical bank	(3,101)	(251)	(644)	(393)	(1,641)	(3,832)	(2,191)
Agency	(7,415)	(612)	(762)	(150)	(3,791)	(4,679)	(888)
Apprenticeship Levy	(1,000)	(83)	(81)	3	(500)	(492)	8
Total	(255,467)	(21,362)	(22,026)	(664)	(129,885)	(132,143)	(2,258)

- Although the underspend in substantive costs increased further, this is at a reduced rate than previous months, reflecting the commencement of staff into previously vacant posts. This has partially offset the increase in non-medical bank staff costs, which have increased compared to the previous months.
- Agency costs exceed the NHSI cap by (c£0.9m) as at the end of September. 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). The remaining pressure of c£0.1m per month relates to consultant costs in 'difficult to recruit posts'.
- A "deep dive" into the Medical pay costs has been undertaken as requested by the FPBAC committee in July; an action plan has been formulated and is being progressed, led by the Director of HR/Workforce.

Waiting List Initiatives (WLIs)

Detailed below is the spend incurred year to date relating to WLI sessions undertaken, number of patients seen, and costs incurred for both Inpatients and Outpatients by Division.

Inpatients	No. of Sessions	No. of patients	Total Costs (£)
Surgery	290	848	159,690
Medicine	319	1,768	171,896
W&C	1	8	563
Clinical Support	4	14	2,113
TOTAL	**614**	**2,638**	**334,262**

Outpatients	No. of Sessions	No. of patients	Total Costs (£)
Surgery	515	4,415	282,406
Medicine	99	793	45,362
W&C	89	336	49,363
Clinical Support	31	294	17,469
TOTAL	**734**	**5,838**	**394,600**

- The combined year to date actual costs for both inpatients and outpatients is (c£0.7m). The budget available to manage WLI requirements to deliver national cancer standards to Mth 6 is £0.3m, therefore an overspend of (c£0.4m).
- On average c£0.1m is spent on WLI on a monthly basis.
- The main specialities in Surgery where WLI have been undertaken are Urology and Colorectal to deliver 62 day cancer standards.
- Within Medicine, additional sessions have been needed to ensure delivery of key access waiting time standards in Gastro, Endoscopy and Dermatology.

- Additional Breast outpatients sessions have been done in Women's and Children's to deliver cancer 2 week access standards.
- Clinical Support includes the Radiology sessions to support the above.

Unfunded areas including escalation

The table below details actual cost incurred year to date relating to unfunded areas and the utilisation of escalation beds.

Unfunded areas including escalation beds	Number of unbudgeted beds open	Utilisation in 2019/20	Configuration of nursing staff required	Actual cost of nursing staff utilised (Mth 1-6) £000	Actual cost of medical staff (Mth 1-6) £000	Staffing source (agency/bank/ locum)	Total Expenditure (Mth1-6) £000
Reverse Cohort Area	12 trolleys	From 1st May 2019 (as and when required)	2 .00 wte Nurses 2.00 wte CSW 24/7	229	44	Combination of bank/agency	273
Ward 26	4 beds	Used for Medical outliers throughout 19/20 when needed	1 .00 wte Nurses 1.00 wte CSW	29	0	Bank	29
Ward 36	2 beds	Used for Medical outliers throughout 19/20 when needed	1 wte CSW	47	0	Bank	47
Ward 1	20 beds	Used for Medical outliers throughout 19/20 when needed	2.00 wte Nurses 2.00 wte CSW (20 patients) 1.00 wte Nurses 1.00 wte CSW (>20 patients)	112	71	Bank	183
Fluid Room	2 trolleys 2 lounge chairs	From July 2019 (Mon - Friday)	1.00 wte Band 6 Nurse	22	0	Transfer of substantive staff	22
Ward 54	4 beds	Used forSurgical outliers throughout 19/20 when needed	1.00 wte CSW (nights) 1.00 wte Nurses (Mon-Fri) 1.00 wte CSW (Sat-Sun)	70	0	Combination of bank/agency	70
TOTAL				**509**	**115**		**624**

- Ward 26, 36, 1 and 54 are recognised escalation areas and are only used based upon need.

- The Reverse Cohort Area (RCA) was opened in May 2019 to eliminate the use of corridors for care and improve ambulance turnaround times. The RCA is used as escalation and during "in hours" is staffed by a rota from all divisions. Out of hours is provided by planned use of NHSP, which are deployed in ED should RCA not be needed. As escalation areas are opened as and when needed, NHSP costs are incurred to ensure safe staffing levels are maintained.

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	(33,933)	(2,756)	(2,738)	18	(17,124)	(17,245)	(121)
Supplies and services - general	(4,575)	(375)	(385)	(11)	(2,281)	(2,362)	(81)
Drugs	(23,547)	(1,865)	(1,810)	55	(11,694)	(11,591)	104
Purchase of HealthCare - Non NHS Bodies	(7,477)	(619)	(719)	(100)	(3,765)	(4,154)	(389)
CNST	(12,948)	(1,128)	(1,128)	0	(6,769)	(6,769)	0
Consultancy	(0)	(0)	(30)	(30)	(0)	(196)	(196)
Other	(25,694)	(2,185)	(2,116)	69	(13,065)	(13,096)	(31)
Total	(108,175)	(8,927)	(8,926)	1	(54,698)	(55,411)	(713)
Depreciation	(9,219)	(763)	(835)	(72)	(4,520)	(4,942)	(422)
Total	(117,395)	(9,690)	(9,761)	(71)	(59,218)	(60,353)	(1,135)

- Non pay expenditure excluding depreciation exceeds plan by (c£0.7m) year to date, the in-month position is breakeven.
- Clinical supplies costs cumulatively are showing a pressure and largely reflect increased activity and acuity in key specialities, the year to date position also includes theatre loan kit costs some of which relate to 2018/19. The savings associated with the national procurement changes are not being fully delivered and represent a pressure of c£0.1m YTD.
- Purchase of healthcare non-NHS overspend relates to outsourcing costs with sub-contractors to manage waiting times as part of the MSK service. Within Radiology, the cost reflects capacity constraints and the use of outsourcing for reporting.
- Consultancy costs continue in-month largely to support transformation and governance. It is anticipated this spend will reduce in future months and is offset by vacancies in these areas.
- The "Other" category above incorporates a number of areas, including energy, interpreter fees, Divisional restructure implications, re-branding costs etc. There are over/under spends across a number of categories, all areas of discretionary spend are reviewed in detail at the monthly scrutiny panel the position includes the benefit of c£0.3m in relation to a non-recurrent energy rebate.

2.6 CIP Performance

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	In Year Forecast Fully Developed £k	In Year Forecast Variance £k	In Year Forecast In Progress £k	In Year Forecast Total £k	In Year Forecast Variance £k
Transformation										
Patient Flow	Antony Middleton	711	628	(83)	1,500	1,417	(83)	0	1,417	(83)
Theatre Productivity	Antony Middleton	398	227	(171)	1,000	555	(445)	274	829	(171)
Outpatients	Antony Middleton	482	482	0	1,000	1,000	0	0	1,000	0
Demand Management	Antony Middleton	77	0	(77)	500	0	(500)	500	500	0
Digital	Paul Charnley	48	20	(28)	123	88	(35)	19	107	(16)
Sub total - transformation		**1,716**	**1,357**	(358)	**4,123**	**3,060**	(1,063)	**793**	**3,853**	(270)
Quipp & Cross cutting workstreams										
Workforce	Helen Marks / Tracy Fennell	438	186	(252)	1,333	346	(987)	715	1,060	(273)
CNST	Antony Middleton	0	0	0	653	590	(63)	0	590	(63)
GDE	Paul Charnley	131	131	0	500	500	0	0	500	0
Endoscopy	Antony Middleton	0	0	0	150	0	(150)	50	50	(100)
Meds Management	Pippa Roberts	214	230	16	568	539	(28)	29	569	1
Procurement	Karen Edge	146	198	52	526	424	(101)	95	520	(6)
Tactical and transactional										
Divisional and Departmental	Divisional Directors	2,261	2,589	328	5,328	4,642	(686)	739	5,381	53
Total		**4,906**	**4,692**	(214)	**13,181**	**10,101**	(3,079)	**2,422**	**12,523**	(658)

- The table above details the CIP delivery by programme including the business as usual (BAU) departmental schemes.
- There is a slight shortfall in the delivery of the CIP target for Mth 6.
- Transformational schemes are (£0.4m) behind plan, work continues within Divisions to progress these going forward. Both patient flow and theatre productivity work programmes are offset against a matching growth reserve allocated to the Divisions during budget setting so has no impact on the overall financial position, this is in-line with the principles agreed at the beginning of the year.
- 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.
- Workforce schemes – this includes, nurse e-rostering roll-out, a review of non-ward based nursing, and a review of medical staff rotas and job plans. Work is on-going and progressing within all three areas. Although there is currently a shortfall against the plan as shown above. This predominately reflects the extent of the reviews and time taken to fully understand the opportunity. Progress is reviewed on a weekly basis. Divisions are scoping new schemes to deliver any potential shortfall in the total workforce scheme.
- Drugs/Medicines Management and procurement schemes are marginally above plan and are forecast to deliver the full year target. Further opportunities are being explored by both the Pharmacy and Procurement teams, to mitigate any shortfalls in other areas.

- The BAU schemes continue to over-perform, this includes a significant amount of 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%	-18.7	4	-15.0	4	-30.4	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	0.3	4	0.5	4	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-3.1%	4	-3.0%	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	0.1%	1	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	0.0%	1	23.0%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**2**

UoR rating summary

- The Trust has overspent against the agency cap. Approximately 50% of this £0.3m relates to 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 remaining pressure relates to consultant costs in 'difficult to recruit posts'. This should reduce going forward as the Trust has recently recruited 7.00 WTE consultants substantively.
- The *Distance from financial plan* metric is currently above plan as a result of the year to date EBITDA position.
- The month 6 UoR rating is 3 overall, which matches the 2019/20 plan UoR rating of 3.

4. Forecast

As discussed at the previous Board meeting a full month by month forecast to the end of the year was completed and presented to FBPAC at its meeting on the 26th September.

The current forecast outturn position is (c£11.4m) which was based on the July 2019 position.

The table below details the operational position which shows a deficit of (c£7.0m), including mitigations/risks assumed at the time.

As the "control total" will not be delivered the Trust would lose access to PSF/FRF of c£4.4m. Hence this would increase the overall deficit to (£11.4m)

WUTH 2019/20 Forecast outturn	(£m)
Operational Deficit as at Mth 4	(10,099)
Risks/Mitigations	
CIP	2,300
Wales activity	300
One to One	400
Mth 5 shortfall	100
Further operational pressures Mth 7-12	0
Winter	0
OPERATIONAL FORECAST OUTTURN	**(6,999)**
Loss of PSF/FRF Q4	**(4,383)**
ADJUSTED FORECAST OUTTUIRN	**(11,382)**

The above forecast position includes:

- Full achievement of the CIP programme of £13.2m, current unidentified or at risk schemes total £2.3m.
- Repayment of the "accelerated" support from Wirral CCG – in quarter 4
- Includes PSF/FRF payments upto and inclusive of Q3 of £8.1m.
- Assumes all CQUIN targets are achieved - £3.7m.
- Assumes the closure of Wd 24, in-line with the Business Case to fund the step down facility opened in November 2018 on the Clatterbridge site, reduction in cost of (£0.8m). Based on current operational pressures this is high risk and unlikely to be achieved.
- Does not assume any additional cost implications to manage "Winter", based on the current demand on services and most likely need over the remaining year, the trust has raised with system partners additional pressures of c£0.4m arising which will need to be supported. BCF monies are being explored for funding.
- The original plan set at the beginning of the year, assumed no additional cash support in 19/20 would be required. However based on the current forecast deficit, there will be a requirement to request additional cash support in November. The forecast cash position is closely monitored to ensure there is sufficient notice to engage effectively with DHSC/NHSI.

Assuming there is some support from the system to fund Winter, as a minimum the Ward closure not occurring and a recognition of £0.7m of CIP slippage will increase the deficit above to (c£12.9m).

Risks

- The main area of risk is the delivery of CIP, limited progress has been made in the last month.
- Further deterioration in costs as a result of operational pressures, with escalation capacity being fully utilised to maintain patient safety. In addition, elective activity is being compromised with cancellation of activity which will affect income.
- The above risks are currently being closely monitored, CIP is reviewed weekly.
- The Trust will adjust the forecast position in-line with NHSI protocol at the end of quarter 3.

Performance against Mth 6 Forecast

The table below details the actual performance for September (Mth 6) against the forecast.

Month 6 Financial Position	M4 Forecast Variance (Mth 6) (£m)	Actual Variance (Mth 6) (£m)	Variance (£m)
NHS income from patient care activity	183	104	(79)
Non NHS income from patient care	(17)	(150)	(133)
Other income	13	50	37
Total Income	**179**	**4**	**(175)**
Employee expenses	(555)	(664)	(109)
Operating expenses	(416)	(71)	345
Total expenditure	**(971)**	**(735)**	**236**
Non Operating Expenses	4	3	(1)
Actual Surplus / (deficit)	**(788)**	**(728)**	**60**
Reverse capital donations / grants I&E impact	0	(6)	(6)
Surplus/(deficit) incl. PSF/FRF	**(788)**	**(734)**	**54**

- Overall the forecast for Mth 6 (September) has been achieved.
- Income was below forecast mainly in Gynaecology, due to unforeseen “special” leave and also in Urology and Oral. A number of patients were cancelled due to bed pressures.
- This was partially offset by over performance in XSBD due to increased LOS of patients and increased A&E activity.
- Non pay costs were below forecast due to drug and clinical supplies, mainly due to reduced activity and acuity.
- Outsourcing costs were also below plan due to reduced activity.

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.
- The Trust's borrowings arrangement with DHSC is such that the Trust is expected to borrow to match deficits. The Board is asked to approve above-plan borrowing of £4.0m in November 2019, and further draw-downs as required within the DHSC deficit limit, to maintain ongoing liquidity in 2019/20. The final draw-down relating to 2019/20 is forecast to occur in quarter one of 2020/21.
- 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.
- Following the reinstatement of the Trust original Capital spend plan of £9.1m, the capital program has been reassessed and a forecast of £7.6m advised to NHSI.
- Due to the lead time involved in the delivery of the Car Park Scheme, this will be deferred to 2020/21. NHSI have advised that they are currently not aware of any capital programme restrictions in going forward that would prevent this scheme being in-

cluded in 2020/21, although new controls for capital may be developed. As the Trust is funding this internally the Trust will have to manage its working cash balances appropriately across 2019/20 and year end to ensure there is sufficient resource available for this in 2020/21.

- Of the remaining programme minor adjustments have been made, which have been approved by FPBAC.

6. Conclusion

The Trust has delivered the financial plan for Qtr1 and Qtr 2 with non-recurrent accelerated support of c£4.1m from Wirral CCG. This reflects the continued operational challenges facing the Trust, with a key factor being resourcing capacity to maintain flow, which has continued in Mth 6. The Trust has had a favourable increase in the number of WTE junior doctor following the recent (August) rotation, and also in the recruitment to substantive Consultants vacancies. This will support the position going forward although there remain a number of vacant consultant posts that require agency cover to maintain service provision. The Trust level of nursing vacancies has reduced compared to 18/19, and in addition has improved "fill" rates for gaps in rota's. Both of which will support achievement of safe staffing levels in clinical areas. However high sickness rates and acuity in certain key areas is impacting the Nursing pay costs.

Despite the multi-faceted approach in managing operational costs, based on the year to date position the Trust does not anticipate the control total target of "break-even" for 2019/20 will be achieved.

The operational forecast outturn based on the Mth 4 (July) actual position is a deficit of (c£7.0m), as the control total will not be delivered the Trust will not be able to access the PSF/FRF allocation of c£4.4m for quarter 4. In addition, the Ward closure is not anticipated to occur and recognising some degree of CIP risk will increase the deficit to (c£12.9m).

It was noted within this position there are risks,

- CIP delivery
- Further operational pressures – escalation areas remain open and are extended
- Winter impact on elective income

The forecast assumed the escalation areas would not be required, this is now recognised as unlikely and will impact the Trust by a further (c£0.4m). The Wirral system has acknowledged this is partially due to the effectiveness of the current residential care provision. Funding sources are being explored by Healthy Wirral partners to support the Trust.

The Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan. The cost improvement plan for 19/20 is £13.2m, although this is challenging, the Trust has made good progress and has weekly internal monitoring in place to maintain focus and pace in delivery, the month 6 position was slightly behind plan. These meetings are chaired by the Chief Executive.

The 19/20 plan is also 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 whilst managing the operational pressures.

The Trust is fully engaged with the Wirral System to support, develop, progress delivery of the finance recovery plan for the "Place". The Trust has been transparent with partners as to the financial position and challenges facing the Trust.

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

Karen Edge
Acting Director of Finance
November 2019

Board of Directors	
Agenda Item	14
Title of Report	Long Term Plan
Date of Meeting	6th November 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

Trust Long Term Plan

Contents

1. Executive summary

The NHS long-term plan published in January 2019 set out a vision for the next ten years which included a programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed NHS five-year revenue settlement.

This Implementation Framework released in June 2019, set out the approach for Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) to create five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24.

The requirement was that plans should be based on realistic workforce assumptions and should deliver all the commitments within the Long Term Plan.

The strategic plan captures the overall financial, activity, and workforce articulation of the long term plan.

This paper details the “Improvement Trajectories” expected for the Trust from 2019/20 to 2023/24, including central support allocations from the Financial Recovery Fund (FRF).

In addition, it sets out the Trust actual operational plans going forward, developed from the recurrent pressures for 2019/20, anticipated growth, and CIP including the “additional” requirement for Trusts/CCGs in financial deficit of 0.5%, and the overall position for the Wirral system.

2. Background

Publication of this Implementation Framework began the process of strategic system planning. System plans for delivery through to 2023/24 are required, with an initial submission in September 2019 and a final submission by mid November 2019. It is anticipated plans will fully align across organisations within each system so that they can subsequently be translated into organisational plans for 2020/21, which will be required in early 2020. The collection process, support offer, and timescales are set out below.

Milestone	Date
Interim People Plan published	3 June 2019
Publication of the Long Term Plan Impleamentation Framework	June 2019
Main technical and supporting guidance issued	July 2019
Initial system planning submission	End of September 2019
System plans agreed with system leads and regional teams	Mid November 2019
Further operational and technical guidance issued	December 2019
Publication of the national implementation programme for the Long Term Plan	December 2019
First submission of draft operational plans	Early February 2020
Final submission of operational plans	By end March 2020

The expectation is that all organisations will work together with local regional teams (including Specialised and Direct commissioning) to agree a coherent and aligned plan. Regional teams (NHSI/E) will work with the System to agree a realistic and stretching bottom line position (and corresponding allocations from the Financial Recovery Fund) in each year. "*Financial recovery plans, consistent with the local system plan, will be required for each provider organisation and CCG not in financial balance"*

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

In October 2019, NHSI/E released financial improvement trajectories and indicative Financial Recovery Fund (FRF) allocations to Trusts/CCGs for the purposes of strategic planning. Including the additional support.

The table below details the Trusts trajectories over the next 4 years

WUTH Financial Improvement Trajectories	**2020/21 (£m)**	**2021/22 (£m)**	**2022/23 (£m)**	**2023/24 (£m)**
Baseline excluding FRF/PSF/MRET	(18.8)	(16.2)	(14.2)	(11.8)
MRET funding	6.3	6.3	6.3	6.3
Adjustments for financial impacts	0.7	0.2	0.4	0.5
Additional Performance improvement requirements	1.9	1.9	1.9	2.0
Trust Financial Improvement trajectory pre FRF	(9.9)	(7.9)	(5.6)	(3.1)
Indicative FRF allocation	9.9	7.9	5.6	3.1
Indicative Trust financial trajectory (plan)	0	0	0	0
Year on Year improvements required	2.6	2.6	2.1	2.3

Two key assumptions included in the trajectories from NHSI/E for the Trust are:

1. **The 2019/20 control total (excluding PSF/FRF/MRET) of (£18.8m) was correct.**
   This was based on the Trust FOT at 2018/19 Mth 8 of (£25.0m) adjusted for changes in tariff structure, CNST and additional 0.5% CIP for Trust in deficit. In reality the Trust actual outturn position was a deficit of (£31.5m) exluding the retrospective VAT charge for medical locums and year-end technical adjustments.

2. **The 19/20 plan of a "breakeven" will be delivered**
   Based on the year to date position and the continued escalation pressures the Trust is not forecasting a break-even position.

The expectation of NHSI is for Organisations to consider the trajectories in the development of the strategic plans and they should be reflected in the final plans due to be submitted in mid-November.

3. 2019/20 to 2020/21 Bridge

	£,000	
2019/20 Control Total Plan (excl MRET/PSF/FRF)	**(18,804)**	
MRET	6,282	
PSF/FRF	12,522	
Net Control Total Plan (incl MRET/PSF/FRF)	**0**	
2020/21		
Reversal of PSF/FRF in 19/20	(12,522)	
Non Rec CIP in 19/20	(3,600)	*See table below for details (table a)*
Recurrent cost pressures	(7,000)	*See table below for details (table b)*
Total Recurrent pressures to c/f into 20/21	**(23,122)**	
Recurrent Opening deficit in 20/21	**(23,122)**	
Tariff uplift	5,558	*As per national assumptions*
Inflationary cost pressures	(10,213)	*As per national assumptions*
Other cost pressures	(1,092)	*Increased cost of Cerner*
NHSE Spec Comm (Net growth and QUIP impact in allocation)	271	
2020/21 - System assumption for activity growth to be managed via productivity improvements in theatres and transformation in outpatients.	0	*Indicative WUTH share £3.0m*
CIP	6,139	*Annual national tariff efficiency factor of 1.1%, + 0.5% additional*
Operational Closing Deficit 2020/21	**(22,459)**	
Non Rec FRF	9,940	
Closing Deficit 2020/21	**(12,519)**	
Additional to CIP to deliver trajectory	12,519	
NHSI trajectory	**0**	

Growth is assumed to be delivered via productivity improvements, therefore the inherent CIP plan is c£9.1m; this equates to 2.4% in total.

Table A – Non recurrent CIP delivered in 2019/20

Non Recurrent CIP 19/20	£000s	
Pay	(2,400)	*Workforce transformation including medical non-core, non ward based nursing, & non recurrent vacancies*
Non Pay	(1,100)	*Energy credits, Population Health, Endoscopy managed services & savings on maintenance contracts*
Income	(100)	
Non Rec CIP in 19/20	**(3,600)**	

Table B – Recurrent pressures

Recurrent Pressures	£000s
Depreciation	1,200
Future Operating Model - Procurement	300
Outsourcing costs for MSK	500
Unplanned escalation costs	1,200
WLI	800
Junior Doctor Pressures	1,000
Hard to recruit posts - Medical	2,000
Total recurrent pressures	**7,000**

Note: Medical staffing costs were expected to be mitigated in 2019/20 through nursing vacancies – this flexibility has not materialised due to reduced vacancies/inceased fill rates and therefore a recurrent pressure is anticipated in 2020/21.

It is further recognised that a number of these pressures whilst recurrent in 2020/21 are a productivity opportunity which could be mitigated by local and system action.

4. WUTH 5 year plan 2019/20 to 2023/24

The tables below detail the WUTH position as articulated in the LTP including FRF and with options in regard to the level of CIP deliverable and the position against the NHSI trajectory of break-even. All options include the requirement to deliver core CIP elements of 2.4%:

- 1.1% National efficiency expectation to fund inflation
- 0.5% National expectation for providers in deficit to counter reduction in FRF
- 0.8% Healthy Wirral expectation for management of activity growth to fund system recovery

Option 1 - The tables below show the WUTH position assuming no additional CIP is delivered.

	2020/21	2021/22	2022/23	2023/24
	Plan	Plan	Plan	Plan
Operational Closing Deficit	(22,459)	(20,998)	(19,058)	(17,303)
Non Rec FRF	9,940	7,870	5,560	3,120
Closing Deficit	**(12,519)**	**(13,128)**	**(13,498)**	**(14,183)**

	2020/21	2021/22	2022/23	2023/24
	Plan	Plan	Plan	Plan
CIP 1.6%	6,139	6,206	6,245	6,289
System managed growth	3,000	3,000	3,000	3,000
Total CIP	**9,139**	**9,206**	**9,245**	**9,289**
CIP Target	2.4%	2.3%	2.3%	2.3%

Option 2 – The table below details the WUTH position assuming the additional CIP to deliver trajectory is delivered in 2020/21

	2020/21	2021/22	2022/23	2023/24
	Plan	Plan	Plan	Plan
Operational Closing Deficit	(22,459)	(8,479)	(5,930)	(3,805)
Non Rec FRF	9,940	7,870	5,560	3,120
Closing Deficit	**(12,519)**	**(609)**	**(370)**	**(685)**
Additional CIP to deliver trajectory	12,519	609	370	685
NHSI trajectory	**0**	**0**	**0**	**0**
Additional CIP (assuming growth is absorbed through productivity)	3.4%	0.2%	0.1%	0.2%

	2020/21	2021/22	2022/23	2023/24
	Plan	Plan	Plan	Plan
CIP 1.6%	6,139	6,206	6,245	6,289
System managed growth	3,000	3,000	3,000	3,000
Additional CIP to deliver trajectory	12,519	609	370	685
Total CIP	**21,658**	**9,815**	**9,615**	**9,974**
CIP Target	5.8%	2.6%	2.5%	2.6%

Option 3 - The tables below detail the WUTH position assuming 3% CIP is delivered recurrently each year

	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Operational Closing Deficit	(22,459)	(18,846)	(14,412)	(10,147)
Non Rec FRF	9,940	7,870	5,560	3,120
Closing Deficit	**(12,519)**	**(10,976)**	**(8,852)**	**(7,027)**
Additional CIP to achieve a 3% target	2,152	2,493	2,510	2,391
	(10,366)	**(8,482)**	**(6,342)**	**(4,637)**

	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
CIP 1.6%	6,139	6,206	6,245	6,289
System managed growth	3,000	3,000	3,000	3,000
Additional CIP to achieve a 3% target	2,152	2,493	2,510	2,391
Total CIP	**11,291**	**11,700**	**11,755**	**11,680**
CIP Target	3.0%	3.0%	3.0%	2.9%

5. Wirral 5 year System Position

LTFP Modelling (Draft Submission)	2020/21	2021/22	2022/23	2023/24
Surplus / (Deficit) excluding PSF/FRF	**Plan**	**Plan**	**Plan**	**Plan**
WUTH (incl MRET)	(22,459)	(20,998)	(19,058)	(17,303)
WCT	44	46	109	193
CWP (Proportion)	(66)	51	227	407
WCCG	(7,735)	1,194	8,425	14,325
Total	**(30,216)**	**(19,707)**	**(10,296)**	**(2,378)**
PSF/FRF (WUTH only from 20/21)	9,940	7,870	5,560	3,120
Net Surplus / (Deficit) after PSF/FRF	**(20,276)**	**(11,837)**	**(4,736)**	**742**

The above table shows the position of the Wirral system over the period of the LTP and with the mandated level of efficiency for providers.

- After reciept of FRF the Wirral system returns to financial balance at the end of the term of the plan (2023/24). The level of FRF reduces over the period with an expectation of an increase in the level of efficiency of 0.5% year-on-year above the national assumption.
- The plan assumes the delivery of the agreed Wirral system Financial Recovery plan which has the key assumption of CCG annual increases in allocation funding inflation, with growth being managed within existing resources of providers (productivity) and through the prevention strategies outlined in the Healthy Wirral plan.
- The outcome at the end of the planning timeframe is a deficit prior to FRF of (c£17m) at WUTH, relatively balanced positions for WCT and CWP and a surplus of c£14m for WCCG.
- The position for WUTH over the planning period after receipt of FRF remains relatively constant from (£12.5m) deficit in 2020/21 to (£14.2m) deficit in 2023/24 reflecting the adverse position at the start of LTP period.

6. Assumptions and Risks

System Assumptions

- Adjustments for tariff, pay, non pay, etc in line with national assumptions
- BAU CIP at 1.6% plus no growth funded for providers with balance of allocation going to bottom line within CCG
- New Investment into HW Transformation at £1m per annum
- Additional Cerner recurrent pressure of £1.1m in 2020/21, £0.25m in 2021/22 and 2022/23
- Underlying system pressure of (c£30m), an increase (c£16m) on top of 2019/20 (c£14m) risk adjusted deficit going into 2020/21
- Does not include increased investment to H&CP for transformation

Risks

- The plan does not move at sufficient pace to assure regulators of the ability of the Wirral system to return to financial sustainability
- The plan sees a disproportionate allocation of the system deficit to WUTH which as a result would lead to increases in borrowing requirements and risks in funding investment in quality and addressing the critical infrastructure risks the Trust faces.

7. Conclusion/Recommendation

The Trust is fully engaged with the Wirral System to support, develop, progress and deliver the financial recovery plan for the "Place". The Trust has been transparent with the other partners as to the financial position and challenges facing the Trust.

The basis of the trajectories for 2020/21 to 2023/24, assumes two points

1. The 2019/20 control total (excluding PSF/FRF/MRET) of (£18.8m) was correct.

2. The 19/20 plan of a "breakeven" will delivered

The actual 2018/19 outturn was (c£31.5m) excluding retrospective VAT for medical locums and year end technical adjustments. In addition the Trust is not forecasting a break-even position for 2019/20.

Aligning the Trust LTP for 2020/21 to 2023/24 to the trajectories suggested by NHSI/E would require the Trust to deliver additional CIP over and above the CIP already included in the plans of c£6.1m (1.6%). The Trust under the Healthy Wirral Financial Recovery Plan has committed to absorbing growth through improved productivity, leading to a further inherent CIP of c£3.0m (0.8%), which is subject to delivery of the Healthy Wirral programme and action by all partners. Therefore the total CIP requirement for 2020/21 would be c£21.7m (6%).

The Trust has a record of delivery of CIP of between 2%-3% and it is proposed that anything further would be unrealistic and should not be committed to.

In addition, the allocation of the deficit between the system partners is not equitable with the deficit primarily residing in the WUTH position for the duration of the planning timeframe. This creates a number or financial and governance risks for WUTH and does not create the right environment in terms of aligned incentives for system partners to deliver the joint objectives.

It has been agreed at the Healthy Wirral Partners Board that proposals for sharing risk and gains across the system and through the LTP timeframe should be received and agreed and will be actioned into contracts from 2020/21.

The Executive Board is asked to note the contents of this report and agree to the submission of the LTP as shown which does not deliver the trajectories suggested by NHSI of a "break even" position over the next 4 years.

Karen Edge
Acting Director of Finance
November 2019

Board of Directors	
Agenda Item	15
Title of Report	Freedom to Speak Up Guardian Update Report (including data for Q1 & Q2 2019/20)
Date of Meeting	6 November 2019
Author	Sharon Landrum, Freedom to Speak Up Guardian / Diversity & Inclusion Lead
Accountable Executive	Helen Marks, 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**	To note
Data Quality Rating	Bronze
FOI status	Yes
Equality Impact Assessment Undertaken • **Yes** • **No**	Yes

1. Executive Summary

The purpose of this report is to provide the Board with a review of Freedom to Speak Up (FTSU) matters and associated issues across the Trust.

The Board is asked to note the contents of this report and approve the action plan attached.

2. Background

Guidance issued by the National Guardians Office (NGO) in July 2019 ("Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts") states that the Board should

receive regular updates, at least every 6 months, regarding the Freedom to Speak Up (FTSU) agenda. It highlights that reports should be presented by the FTSU Guardian.

This report is an interim six month report, which incorporates data for quarter 1 and quarter 2 of 2019/20, with data presented in a way that maintains the confidentiality of individuals who speak up.

Further "Supplementary Information on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts" has been produced by the NGO in July 2019 and this report seeks to include information deemed essential to provide Board assurance and enhanced oversight.

We currently have an interim Lead Guardian arrangements in place and currently have two guardians. We are currently recruiting two additional Guardians, one of whom will be from the medical staff

3. Key Issues

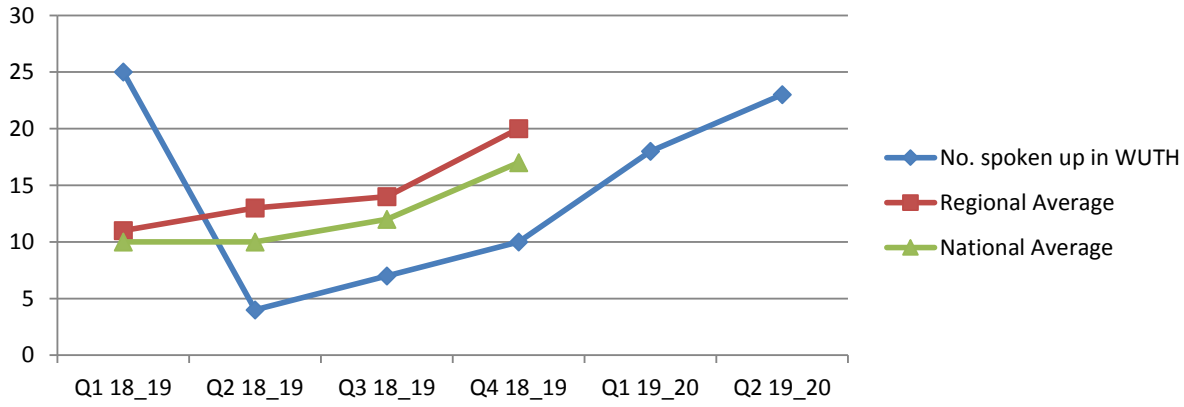
In 2018/19 the FTSUGs received 46 cases, which is a reduction on the previous year; (56 cases in 2017/18 were raised). So far this year, as at 30 September 2019, 41 cases have been received by Guardians so far. This therefore indicates an increase in the number of people speaking up this year. However, it is viewed positively that staff feel comfortable to raise concerns and as an organisation, we actively encourage them to do so.

Data is submitted to the National Guardians Office on a quarterly basis and 2019/20 data has not yet been formally published. The following charts show data for both quarters along with a comparison between WUTH and numbers received locally and nationally.

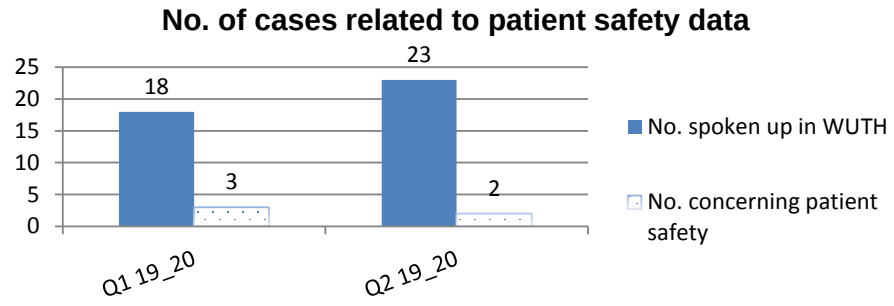
Number of WUTH cases compared both at a regional and national level

As published by National Guardian Office	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Total 2018/19	Q1 2019/20	Q2 2019/20	Total so far 2019/20
Wirral UTH	25	4	7	10	46	18	23	41
Regional Average	11	13	14	20	58	No data yet		
National Average	10	10	12	17	49			

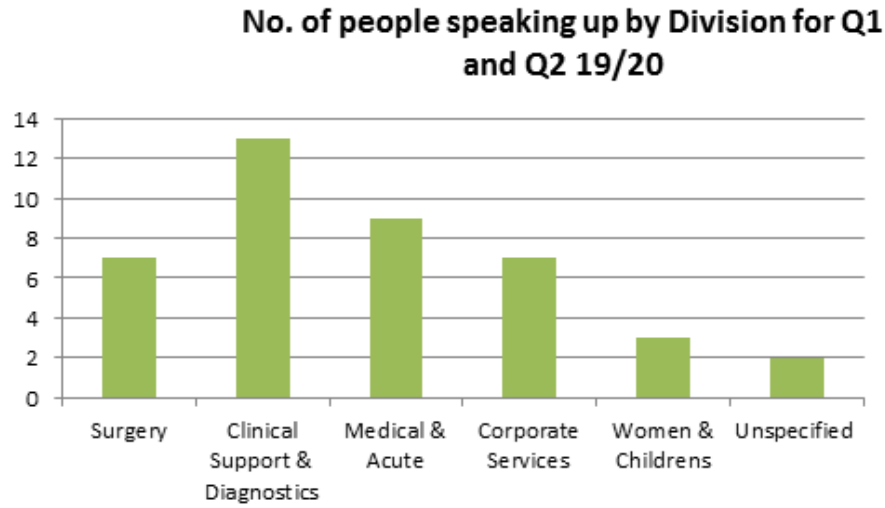
No. of cases received at WUTH compared to regional and national averages



The following chart highlights the number of cases concerning patient safety, which has reduced slightly within Quarter 2. In comparison to the number of concerns raised, those related to patient safety are relatively small which could suggest the effectiveness of other systems such as incident reporting, Safety Summits and learning from incidents. It is more likely that patient safety issues would be raised via the incident reporting system.



The chart below shows the number of people speaking up during quarters 1 and 2 of 2019/20 broken down by division:

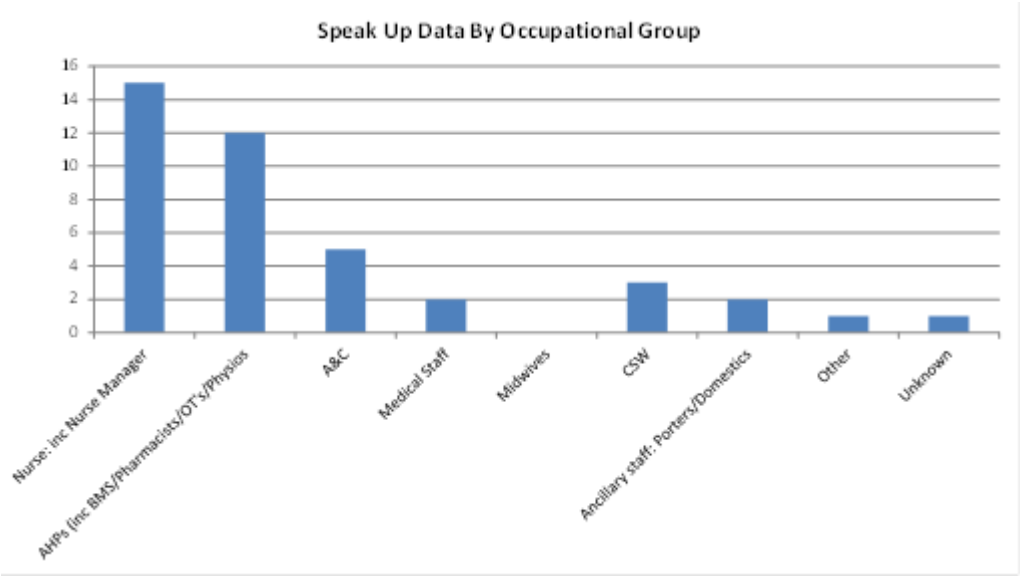


The number of concerns raised in each division for Q1 and Q2 19/20 is highlighted below as a percentage of the number of staff in each division for comparison. This represents 0.65% of the total number of staff. For the purpose of this report, Estates and Hotel Services is included within Corporate Support Division but will be separated in the next report.

Division	# Staff in Division & Trust	% staff raising concerns for each Division
408 Clinical Support Div	1328	0.97%
408 Corporate Support Div	1381	0.50%
408 Medical and Acute Specialties Div	1580	0.56%
408 Surgery Div	1206	0.58%
408 Women and Children's Div	705	0.42%
Grand Total	**6200**	**0.66%**

Whilst less than 1% of the staff within Clinical Support, it is the Division with the highest number of concerns raised. We know that Health Care Scientists scored low for overall staff engagement in the 2018 National Staff Survey and that there is an organisational restructure and TUPE arrangement being put in place in Microbiology creating some discontent.

The chart below details the number of people speaking up in Q1 and Q2 broken down by occupational group.



Note: The categories used reflect those reported to the National Guardian Office in our quarterly returns

Seven anonymous complaints have been received by the Guardians so far this year, the majority of whom were from the same department. Actions are being taken in this area.

Data capture has commenced to review length of time cases are open with FTSU Guardians for and will be reported on from Q2 19/20 moving forwards. For this quarter, the average length of time cases were open for was 3.1 weeks.

Barriers to speaking up

Staff at FTSU training are asked what they see as a barrier to speaking up. This may be based on experience or perceptions:

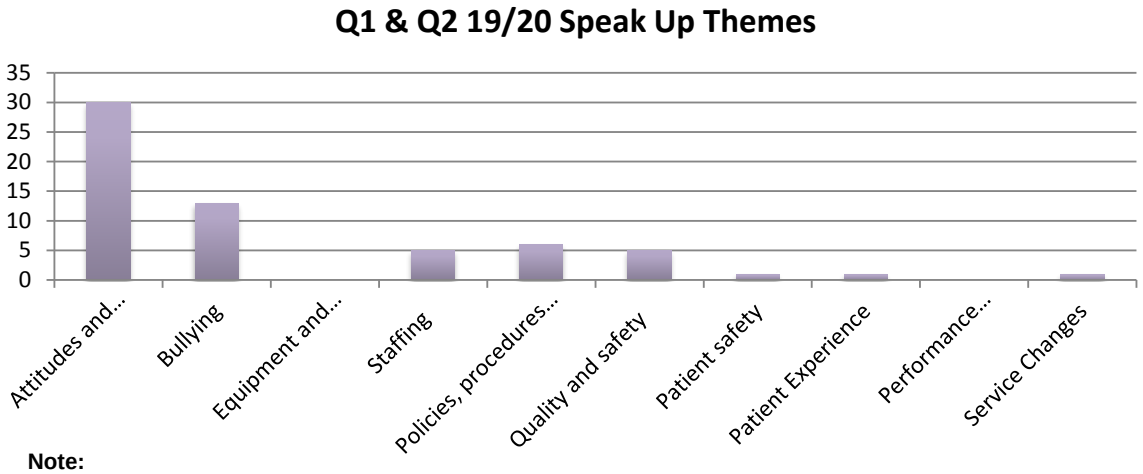
- Fear of repercussions, particularly where there are linked personal and/or professional relationships and particularly for students who may need to be signed off by the person they're concerned about
- Fear that nothing will change
- Easier for people not to
- Fear of looking silly / worried about what others think
- Wanting to avoid conflict / not wanting to hurt people's feelings or cause them detriment
- Time i) to report ii) timing of reporting and being in the right place to do it

4 Assessment of Issues Raised

4.1 Themes

Attitude and behaviour continues to be the most reported theme of those concerns raised. Bullying has been separated out to ensure closer monitoring.

The following themes have been identified in the chart below:



Note:
Many concerns have more than one theme so the numbers in the chart will not correlate with the number of cases raised

All concerns raised to the FTSU Guardians have been referred to the appropriate level of management for action, although, in some cases the Guardians have been asked by the individual not to take any action and have asked the Guardian for advice only. In cases where a patient safety issue has been identified, the employee has been advised that the Guardians must escalate the concern and have done so accordingly.

In some cases issues have been resolved by explaining or clarifying issues to the individual, such as points of policy for example. Often cases just require signposting the individual for advice or support from a specialist, or expert.

Analysis of guardian data and reports will be developed further to indicate which staff only needed signposting and those, how many resulted in disciplinary action or serious incident investigations.

Much has been done in the last 12 month to improve the culture across the Trust, including the engagement and launch of our new values and behaviours, inclusion of values and behaviours in the recruitment, induction, training and appraisal processes, continued communication of behaviours expected, Respect at Work training and the new Respect at Work Group in partnership with Trade Unions. Additionally cultural reviews have been undertaken or are in progress in a number of areas in the last 12 months (M1, Cardiology, IDT, Maxillo Facial) all of which have improvement plans. The Cultural work for the Emergency Department and Opthalmology have been completed and the latter contributed to Ophthalmology achieving this Years Together Team of the Year award. The work on cultural reviews assists staff in raising concerns.

4.2 Lessons learned and improvement actions

4.2.1 Reporting Error - Concern had been raised that a recent falls incident had not been reported. Following a review, it transpired that the incident had been reported as a patient accident and not as a fall and a reporting error had therefore occurred. Feedback was arranged with the reporter and their attendance at a subsequent serious incident review panel was facilitated to show the openness of reporting incidents and to allow the individual to speak to the Clinical Lead for falls.

4.2.2 Investigation Support - Concern had been raised regarding the appropriate involvement and support of administrative staff that may be supporting investigative processes including disciplinary and grievance procedures.

On further review of the concerns, administrative staff are not always factored in to interview planning and preparation in terms of availability and current work commitment; personal

connection with those involved or the themes to be discussed and support offered when faced with difficult circumstances.

A series of actions have been identified and linked in to the Respect at Work Group and is forming part of a wider workstream to improve key elements of the disciplinary process, also linked to findings from the Amin Abdullah enquiry. Guidance for investigators will be developed and will include feedback received from those who have spoken up.

Reminders sent to all HR colleagues and those involved in investigative procedures, to consider the impact, suitability and support that may be necessary for note and minute takers, along with consideration to be given to the use of an interview recording option.

4.2.3 Inclusion of support staff – Concerns raised regarding the lack of inclusion of support staff e.g. Domestic colleagues who need to attend to patients with specific needs including those at risk of specific infections. Whilst good progress has been made in some areas with signs placed on doors where infections may be prevalent, managers must ensure inclusion of domestic and additional support staff in huddles to ensure staff are fully briefed so as to ensure adequate and appropriate protection is used and to better prepare those who are required to support.

4.3 Local Reporting Changes

Due to recommendations by the NGO, the Trust has now commenced reporting on length of time cases are open and data for Q2 19/20 is included within this report.

In Q3 19/20 we will also see the introduction of a new data capture sheet that can be utilised by Guardians to capture data from reporters, including whether the reporter would feel able to speak up again. This information is now requested by the NGO and so will be captured by WUTH Guardians moving forwards.

4.3.1 **National Reporting –** In recent national FTSU Guardian Surveys, findings highlighted that guardians in organisations rated Outstanding by the Care Quality Commission were more positive in their perceptions of the speaking up culture. To ensure speaking up becomes business as usual, the National Guardians Office (NGO) was asked by Simon Stevens to help measure how free nurses, doctors and other staff felt to raise concerns at different organisations. As a result, the NGO compiled a FTSU Index which, whilst based on a sample of staff and holds additional limitations (students, volunteers and others are not included), does provide a comparison between NHS organisations.

Scoring is based on CQC ratings and findings from the 2018 National Staff Survey regarding how comfortable staff feel in raising concerns.

The index was designed to support improvements within Trusts and encourage Trusts to “buddy up” and learn areas of good practice from those with higher scores.

The table below highlights the overall FTSU Index scores:

FTSU Index Score for 2018

National and Acute Trusts	**FTSU Index**			
	2015	**2016**	**2017**	**2018**
National	75%	77%	77%	78%
Acute Trusts	75%	76%	76%	77%

WUTH’s 2018/19 score was 73% and as such, falls below the national and Acute Trust averages. The Trust will be undertaking an external review supported by the Liverpool Women’s Hospital following advice from the National Guardians Office to understand how we can improve.

5 Additional actions taken to improve the FTSU culture

5.1 FTSU Training

FTSU Training was introduced in April 2018. It is recognised that it will take time to reach all staff. Following concerns regarding low levels of compliance for staff at level 1 and capacity to deliver the required number of sessions; level 1 training is now available via national e-learning. Face to face training sessions are now at level 2 and therefore only required for managers and leaders. This session also encompasses level 1 knowledge requirements. The requirements are now incorporated into the Role Specific Training Matrix and managers and Divisions now receive quarterly compliance and alert reports as well as individual notifications for staff via the electronic staff record (ESR) system. Training has been arranged for hard to reach ancillary staff at flexible times.

Compliance for FTSU training as at 30 September 2019 is 47.96% for level 1 and 22.72% for level 2.

Both available Guardians are now supporting a programme of training sessions and additional places have been made available. Despite staff being booked in, the sessions have not been fully attended for a variety of reasons such as operational pressures, attending the wrong venue etc. This is therefore under review and we will also be seeking an e-learning solution to support the face to face training at level 2.

Further to best practice guidance issued by the NGO, a further level (level 3) has also been created and recently added to the Role Specific Training Matrix, specifically for our senior leaders who are defined as including executive board members (and equivalents), Non-Executive Directors, and Governors. An initial session has already been delivered, with further plans in progress to integrate requirements in to board level programmes.

Involvement in the delivery of FTSU sessions has been incorporated into the new guardian role overview and will be included as part of the role for newly identified Guardians.

It is proposed that a target it set for completion by April 2021 and Level 2 training will be and integrated into the Effective Manager Programme.

5.2 Raising the Profile of Speaking Up within the Trust

Speaking Up and the role of the FTSU Guardian forms part of the staff induction process (including junior doctors) and FTSU training is now included as one of the Trust's role specific training elements and new monitoring processes will support identification of areas of low compliance.

Unfortunately the Trust lost FTSU Guardian as they have now taken up an alternative post outside of the organisation. The Trust is therefore looking to identify 2 further Guardians to join the FTSU team.

We are currently recruiting to a wider network of FTSU Champions via expressions of interest to support the work of the Guardians and improve awareness of FTSU and overall improvement of speaking up within the Trust. Role overviews for Guardians and FTSU Champions have been developed and reviewed by Staffside and initial promotion of the opportunities has been circulated throughout Triumvirates in the first instance. Overviews are attached at Appendix 1.

We currently have eight champions identified including a number in Hotel Services as recommended by staff side representatives, a medical representative and additional interest in becoming a FTSU Guardian. There will be a formal launch of the new guardians and champions in November 2019.

A briefing session will take place with all new Champions and an ongoing support programme will be included.

Leaflets and posters were refreshed in 2018/19, however further revision will take place as soon as new Guardians are identified. New materials will also include reference to the new Champion role and will be supported by a variety of Trust-wide promotional mechanisms and communication channels.

5.3 Review of FTSU Arrangements and Action Plan

Further to NGO guidance for Boards the Trust has internally reviewed its processes to ensure it is up to date and in line with best practice issued by the NGO.

The Trust conducted a self-review in 2018 which has also been recently reviewed for 2019 and gaps identified. The overarching FTSU action plan has therefore been updated to reflect new best practice and guidance, along with findings identified locally and a copy is attached at appendix 2.

We also requested a review by the NGO of practices at WUTH but it was suggested that we seek a review from a neighbouring Trust as the NGO only undertake a review in Trust's where concerns have been raised by reporters about the Speak Up process in individual organisations. The Trust has now linked with Liverpool Women's Hospital who will be undertaking an external review of practices at WUTH and this will be undertaken in the next few weeks. The purpose is to understand what is working well at WUTH and where we can improve.

Advice has also been sought from the NGO and the Trust's action plan has been sent to NHSi.

6 Summary

The Trust has seen a positive increase in the number of staff who have spoken up this year, with 41 cases received so far, as opposed to 46 for the whole of last year.

The Trust has worked hard to improve the culture within the organisation and as attitudes and behaviours have continued to feature as a key theme for staff speaking up, a number of actions have been taken by the Trust to improve this as detailed in section 4.1.

New guidance from the NGO has been reviewed and incorporated within Trust practices so far and where gaps have been identified, these have been included within the overarching action plan attached (appendix 2).

Updates have been made to reporting templates and processes, so as to capture more information and be able to provide additional data and greater assurance on areas such as length of time cases are open for and whether staff would feel able to speak up again.

We are recruiting to additional guardians and are progressing with the establishment of a Champions network. The Trust will see positive promotion of this development from November.

The Trust has scored lower than the Acute Trust average within the recently announced FTSU index, however scores are based on CQC ratings and National staff survey results. The National Staff Survey and CQC Inspection for WUTH are currently in progress for 2019. .

FTSU training has been reviewed and further work will be done to address compliance levels through e-learning and integration into the Effective Manager Programme. It is proposed that a target it set for completion by April 2021 this will be 3 years post commencement.

The Trust continues to link with regional and national FTSU partners.

Regular Guardian meetings have been reinstated to monitor progress against the improvement plan, share learning and update on best practice and developments.

7 Next Steps

Future reports will continue to include the FTSU action plan to ensure progress towards achievement of the areas outstanding and to ensure a greater overview of the issues, challenges and progress made.

Two new FTSU Guardians are in the process of being identified and a network of FTSU Champions is being established with promotion of this planned for November 2019.

FTSU Level 3 training to become integrated within the Board Level programme and delivered for senior leaders. Further work on developing e-learning is in progress as well as e-learning solutions for Respect at Work training.

Progress buddy system with local Trust and complete external review of processes.

8 Recommendations

The Board is asked to note the contents of this report and to approve the revised action plan.

Members are asked to review the NGO “Guidance for Boards”.
https://www.cqc.org.uk/sites/default/files/FTSU_guidance_0.pdf and consider their individual roles and responsibilities to improving the speaking up culture within the organisation along with identifying any additional actions that may be required ensure they are assured of progress in this area.

Freedom to Speak Up Guardian

Wirral University Teaching Hospital NHS Foundation Trust

Freedom to Speak Up Champion (FTSU)

Role Overview

Are you passionate about helping to create a culture of openness and honesty at WUTH?
Do you believe in and demonstrate our Trust values and behaviours?

Do you have excellent communication skills, and show empathy and compassion for others?

As part of the development of the Trust's commitment to growing an open, honest and transparent culture, we are looking for staff to support the work of the FTSU Guardians.

FTSU Champions will play an important role in:

Responsibilities:

- Working with others within the Trust to develop a culture where speaking up is recognised and valued
- Being a point of contact for staff who require advice about how to Speak Up
- Encouraging staff to raise their concern at the earliest opportunity
- Instilling confidence that concerns will be listened to and acted upon
- Directing staff to the Freedom To Speak Up Guardians
- Promoting the Freedom To Speak Up Service to staff
- Supporting distribution of FTSU promotional material throughout the Trust
- Must be able to demonstrate behaviours consistent with the Trust's behavioural standards, its values and key priorities

Qualities and attributes:

- Passionate about creating a culture of openness and honesty
- Demonstrate excellent communication skills
- Show empathy and compassion to others
- Have personal resilience

You will receive training and have the support of the FTSU Guardians in carrying out your role.

This role is a voluntary role and is undertaken in addition to your existing role in the Trust. You will therefore need your managers support to enable you to fulfil this role.

For more information on this role, please contact: wih-tr.RaisingConcerns@nhs.net

Freedom to Speak Up Guardian

Wirral University Teaching Hospital NHS Foundation Trust

Freedom to Speak Up (FTSU) Guardian

Role Description

Role Overview
To develop a culture where speaking up is recognised, encouraged, valued, supported and safe.

Highly visible role in promoting the processes and acting as point of contact for all staff within the Trust who wish to raise a concern regarding malpractice, wrongdoing or any other concerns, enabling them to do so safely.

Support the development of a supportive and transformational leadership culture that is open, welcomes challenge and responds quickly to issues raised.

Key Responsibilities
Highlight any issues raised that represent an immediate risk to the safety of patients or service users to the FTSU Executive Lead and/or an appropriate member of the senior Management Team or Chief Executive on an immediate basis to identify appropriate and immediate course of action.

Feedback soft intelligence and any concerns that might lead to underlying issues to the FTSU Executive Lead.

Raise concerns externally if appropriate action is not taken by the Trust in line with Trust and National Policy.

Ensure mechanisms in place that enable staff to raise concerns are monitored for effectiveness.

Safeguard the interests of those raising a concern, ensuring there are no repercussions to them immediately or in the longer term.

Compliance with the Data Protection Act and Information Governance requirements.

Key Duties/Tasks
Act as point of contact to enable staff to raise concerns and acting on them by:

- Ensure investigative processes are undertaken in a timely way
- Escalating concerns raised to the appropriate level (Line manager, divisional manager, Executive Director of Workforce/FTSU Executive Lead, Chief Executive or other member of the Trust's Senior Management Team as appropriate)
- Signposting the member of staff to the appropriate person for advice and support eg Human Resources, Occupational Health, Staff Side representative
- Ensuring staff understand the boundaries for certain concerns raised in terms of escalation and confidentiality ie. Where serious risk or harm may be caused, the FTSU Guardian would need to take immediate action within risk management process.
- Documenting concerns raised and action taken in a central, confidential database.
- Ensure feedback to those who have raised a concern regarding actions taken.
- Facilitating all complex and difficult discussions with individuals who may require support when reporting a concern.

Meet with members of the Trust's FTSU Team on a regular basis regarding FTSU activity, any emerging themes, actions taken and escalation of concerns raised that need decisions/ownership by the Trust.

Work with staff side representatives to develop a partnership that is focused on supporting staff to raise concerns.

Ensure a range of contact mechanisms to the staff guardians are clear, communicated to staff and accessible to all.

Analyse data and identify trends arising from concerns raised and conclusions.

Support the provision and delivery of regular reports as required to Executive Directors , Trust board, and relevant Committees.

Support the development of an appropriate network of FTSU Guardians and Champions.

Participate in awareness raising across the Trust of the importance of speaking up, the FTSU Service and how to access it. This includes may include involvement in Speak Up training sessions, promotional stands and walkabouts as required.

Help to create an operational leadership culture that is open, welcomes challenge and responds quickly to issues raised.

Act as a critical friend to review and monitor the adoption of the Trust's Core Values, making recommendations for HR processes (recruitment, induction, appraisal and training).

Keep up to date with best practice regarding the FTSU agenda, and ensure linked in with the National Guardians Office, local and national FTSU Guardian networks.

Support monitoring and review of the effectiveness of the FTSU Service.

This role is a voluntary role and is undertaken in addition to your existing role in the Trust. You will therefore need your managers support to enable you to fulfil this role.

Appendix 2

Freedom to Speak Up Guardian Action Plan 2018-20
Updated following 2018 Self Review utilizing NGO self assessment tool

Overview – Improving our culture of openness and enabling our staff to raise concerns, acting on them and feeding back. This action plan takes into consideration National Guardian's Office Guidance, Care Quality Commission Requirements, internal review findings and recommendations 2017 and learning from case review (Southport and Ormskirk NHS Hospital Trust)

	Objective	Action	Ownership	Deadline RAG	Progress – 7 October 2019
1	Review governance and reporting structures for FTSU Guardians	1.1 Develop business case to implement FTSU Lead role and service development action plan	FTSU Guardians	April 2018 Green	Agreed with Executive team
		1.2 Review reporting and accountability arrangements for FTSU Guardians at WUTH	FTSU Guardians DOW	Oct 2019 Green	Reviewed with FTSU Guardians and Director of Workforce(DOW). Further reviewed in line with NGO self assessment tool.
		1.3 Develop and agree reporting and accountability of FTSU Guardians to CEO and accountability and reporting to Trust Board	FTSU Guardians DOW	March 2018 Green	Agreed FTSU Guardian to report directly to CEO. FTSU role is also H&WB Manager reporting to Deputy Director of Workforce Intelligence and for FTSU, can report any time to CEO. Further reviewed in discussion with CEO 10/10/19 to align with national guidance. Regular meetings and open door policy in place.
		1.4 Arrange regular meetings between CEO and FTSU Lead, NED and Exec Lead	FTSU Guardian	March 2018 Green	Monthly meetings arranged with CEO and open access agreed. Planning in place for regular update with CEO, Chair, FTSU Lead, NED and Exec Lead. Meeting arranged with NED and these will be regular.
		1.5 Check Trust's Raising Concerns Policy is fully compliant with national requirements	FTSU Lead	June 2018 Green	Policy reviewed and live in Feb 2019
		1.6 Ensure all Board reports are presented via the FTSU Lead	FTSU Lead	As required Green	Seconded FTSU lead prior to recruitment to substantive post April 2018. FTSU Lead will present all Board reports. Annual report 2018/19 presented in 2019. Lead Guardian to presenting month review report to Trust Board in November 2019.
		1.7 Recruit to Lead Guardian role following NGO guidance and Trust recruitment policy	CEO DOW	April 2018 Green	FTSU Lead seconded prior to recruitment process. Seconded post substantiated in 2018. Need to consider recruitment process for future guardians
		1.8 Link with another NHS Trust to allow buddy system for review of processes and external Guardian reporting option	FTSU Guardians	Dec 2019 Amber	Discussed approach to service review with National Guardian's office. Links made with Liverpool Womens Hospital and received positively and supporting buddy approach. Met with Lead Guardian from Liverpool Womens and review to commence.
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**

2	Standard Operating procedures are in line with NGO requirements and expectations	2.1 Review current standard operating procedures to ensure they are fit for purpose and aligned with national guidance	FTSU Lead	July 2018 Green	Policy updated in 2018 and shared with NHSi. Processes included in the policy
3	Raise Awareness of FTSU Guardians and the Speak Up agenda across the organisation	3.1 Review and update the 2017 Communications Plan	FTSU Lead	May 2018 Green	Worked with an agency to create a highly visible campaign to deliver the communications plan. Completed.
		3.1.1 Ensure communication materials are up to date	FTSU Lead	December 2019 Amber	Further changes to be made re promotional materials in Q3 2019 due to role changes. Website information updated in the meantime
		3.2 Create a schedule of promotional events and communications throughout the year	FTSU Lead	May 2018 and on going	Linked to communications plan and national campaigns. Further communications distributed during National Speak Up Month October 2019 Promotion stands, market stalls on induction, drop in sessions and walkabouts held in 2019.
		3.3 Ensure availability of FTSU Guardian awareness leaflet and distribute to staff	FTSU Lead Communications	Dec 2018 Green	Leaflet distributed via trust communications Jan 2018. FTSU Guardians provided with supply for walkabouts, meetings and visits. Due to role changes, leaflet updated and amended (May 2018) in line with communications campaign and distributed.
		3.3.1 Ensure promotional leaflet is up to date	FTSU Lead Communications	December 2019 Amber	Leaflets to be revised as a Guardian has left – consideration to be given to generic leaflet. Raised with Communications team and awaiting next steps. Website information updated
		3.4 Develop new FTSU Guardian posters and pull up banners for all guardians and place around organisation	FTSU Lead Communications	July 2018 Green	Part of high visibility communication campaign, with agency support Completed
		3.5 Ensure website is up to date	FTSU Lead Communications	Oct 2019 Green	Reviewed and updated and further amendments to be made due to role changes in 2018 and further reviewed and updated Oct 2019
		3.6 Use Trust communication channels on a regular basis (STW/In Touch etc,) to promote the raising concerns process	FTSU Lead Communications	On going Green	Trust communications have taken place via eg STW, then In Touch. Comms promoting FTSU Month October and drop ins and walkabouts organised
		3.7 Ensure all FTSU Guardians have access to promotional materials	FTSU Lead	April 2018 Green	Agreed with Communications Team re new posters for development. Leaflets provided.
		3.8 Consider Divisional champions or advocates to promote FTSU	FTSU Lead Divisions	December 2019 Amber	Agreed approximately 30 champions will be identified. Expressions of interest minimal in first stage of advertising. Re advertised Sep 2019 with names coming forward. Targeted approach used for Facilities and meetings to be held to discuss further. Medical

					Champion identified.
		3.9 Include FAQs and feedback with lessons learned in communications including webpages	FTSU Lead	December 2019 Amber	Not yet completed. Link being placed on webpages to direct staff to NGO information and guidance. Lessons learned in guardian report to Board November 2019.
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**
4	Develop and implement a FTSU training plan for all staff and vulnerable groups	4.1 Develop and implement a training plan to include: • Develop and submit a refreshed training plan for approval at Education Governance Group for 2 levels of training • Ensure revised training content includes how to raise a concern and handling concerns • Review content of national e-learning • Approve training plan at Education Governance Committee	FTSU Lead	July 2018 Green And review 2019	• Presented to Ed Governance meeting 28/3/18. Agreed will go into Essential training as L1 and L2 programme. (Essential training now role specific training requirements) • Agreed with DOW and Ed Gov as stand alone programme. Level 1 training – all staff, Level 2 training for managers. • Training programmes now available and advertised • Need to do further work to ensure inclusion of bank and agency workers, governors, temporary staff, sub contractors. • Presented training to Foundation Doctors • Developed L3 training for directors/board in line with new national guidance October 2019 • Flexible training offered for ancillary staff in hard to reach roles
		4.2 Update content of training in induction for new staff on the raising concerns policy and process	FTSU Lead	July 2018 Green	Ensure this includes general induction, foundation induction and non foundation induction. Completed
		4.3 Identify vulnerable staff groups and ensure training content is provided	FTSU Lead	On going Green	Eg volunteers, BAME, students, D&I network groups Partially completed. FTSU training in place and for medical students. FTSU Champions being identified to support some vulnerable groups FTSU part of new induction programme market stalls. FTSU Champions linked to D&I staff networks
		4.4 Evaluate effectiveness of training annually	FTSU Lead	May 2019 Green	Training Review completed and advice taken from NGO. Reviewed completions and moved level 1 to national e-learning to increase awareness. Introduced Level 3 training October 2019. Need to evaluate impact linked to staff survey results. Positive feedback received from attendees.
		4.5 Ensure all FTSU Guardians have completed relevant training	FTSU Lead	April 2018 Green	NGO training, Records management completed Lead Guardian attends regional and national updates/meetings. Best practice to be shared across guardian team via meetings. Places limited for national

					programme and dates requested for programme. Guardian office supported reinstatement of previous guardian with existing. On waiting list for update training
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**
5	Ensure reporting, monitoring and escalation process is assured	5.1 Establish regular guardian meetings • Monthly FTSU Guardian Meetings • Review ToR of monthly meeting	FTSU Guardians	Monthly Green	Meetings were established and active but stopped. Meetings to be re-established in October 2019.
		5.2 Regular meetings with CEO regarding key issues	FTSU Lead	Green	Regular meetings in place and open door policy
		5.3 Ad hoc meetings as required with any director as part of the escalation process	FTSU Guardians	As required Green	Taking place as required
		5.4 Review database for effectiveness, accuracy and completeness for assurance, in line with National Guardians Office (NGO) recommendations	FTSU Lead	September 2018 Green	Worked with IT to develop
		5.5 Ensure database is up to date and complete to enable accurate confidential reporting and monitoring.	FTSU Lead	September 2018 Green	Database used to formulate reports and monitor progress
		5.6 Database to be amended to reflect contacts with Board/CEO	FTSU Lead	September 2018 Green	Database updated Working with IT to develop
		5.7 Liaise with IT to look at how database can be automated	FTSU Lead	January 2018 Green	Completed Jan 2018
		5.8 Explore how data can be triangulated with other sources to identify hot spot areas/areas of concern	FTSU Lead	March 2019 Red	No current progress Meeting with Director of Quality and Governance 4/11/19 to discuss best approach
		5.9 Ensure all reporting requirements are met: • Annual and 6 monthly Report - Trust Board • Quarterly report Quality Committee • Quarterly report to Workforce Steering Group • Quarterly external reporting for publication to National Guardian's Office for specified data/activity • Regular report to PSG	FTSU Lead	As required Amber	Reviewed. Reports to Workforce Group and Board in line with NHSi Self Review completed in August 2018 Annual and six monthly report submitted to Trust Board and quarterly reports produced, however content to be updated to reflect NGO recommendations. Reports to board to include organisational learning/KPI's in policy Need to consider with Director of Quality and Governance the reporting mechanisms Meeting with Director of Quality and Governance 4/11/19 to discuss reporting at Quality Committee
		5.10 Undertake external review of FTSU processes at WUTH	External FTSU Guardian	January 2020 Amber	Agreed FTSU Guardian at Liverpool Womens to undertake external review of FTSU at WUTH to include:

					• Policy and processes at WUTH • Review of sample of cases • Identify if detriment has been suffered as a result speaking up
	Objective	**Action**	**Ownership**	**Deadline**	**Progress7 October 2019**
6	Ensure the Trust is up to date with national and local guidance, policy and best practice	6.1 Guardians to attend regional and national events/meetings	FTSU Guardians	On going Green	Lead Guardian attends regularly
		6.2 Ensure feedback from regional and national meetings at monthly meeting to share current approaches and learning		On going Green	Monthly meetings now re-established. Guardians are in regular contact
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**
7	Ensure all FTSU Guardians have the resources they need to carry out their role effectively	7.1 FTSU Office/base and resources available • Provide dedicated office in appropriate environment • Computer • telephones, bleep, dedicated email • promotional materials	FTSU Lead	Oct 2019 Amber	Office, telephone, office equipment in place identified. New telephone and bleep needed and under order.
		7.2 Recruit to FTSU Lead following NGO guidance and Trust recruitment policy	FTSU Lead	April 2018 Green	FTSU Lead seconded and substantiated in 2018. Need to consider recruitment process for future guardians
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**
8	Ensure support is available for staff who raise concerns	• Occupational Health • Trade Unions • Human Resources • Mediation • Senior leadership	FTSU Lead	Ongoing Green	Support available and communicated
	Objective				
9	Senior Managers and Executive directors are able to reflect on the impact of their behaviours	9.1 Mechanisms in place to capture: • Appraisals in place • 360 feedback available • Reverse mentoring to be established • Staff Survey • Staff and patient feedback	Managers and Executive directors	March 2020	New guidance from NGO July 2019
	Objective	**Action**	**Ownership**	**Deadline**	**Progress 7 October 2019**
10	Evidence available for CQC assurance under standard 17 Good Governance	• Review CQC evidence	FTSU Lead	Quarterly Green	Current evidence reviewed

Board of Directors	
Agenda Item	16
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	6th November 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 23 October 2019 – that where appropriate the 'Digital' content has now been vested, as work-streams, into the priority programmes of change. The 'Workforce Transformation' programme has now been moved into focus as one of the main pillars of the programme and further projects will be added to the pillar ('Medical Staffing' and 'Specialist Nursing' are currently being proposed). The 'World Class Administration of Patient Services' project will bring its Project Initiation Document to the November Programme Board whereupon it will be formalised 'in scope'.

Otherwise, the Executive Team continues to direct enhanced focus on the three large **priorities** 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

Four of the six 'live' programmes are green rated for governance, with two attracting an amber 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 shows four programmes showing amber for delivery with two rated as red. For the sake of clarity, amber ratings remain 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 and risk.

1.3. Ratings Suspended

The Flow Programme, as decided by the Programme Board, has had assurance ratings suspended while the programme is reviewed. Revised proposals will be presented to the November Programme Board. The Wirral West Cheshire Pathology Alliance also remains 'suspended' pending a decision to proceed with the programme of change.

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 and Hospital Upgrade Programme

Recruitment into the new 'Hospital Upgrade Programme' has been initiated. Work stream leads have been identified and the roles for a Programme Director, Head of PMO and Project Manager will be advertised in November and should be in post by calendar year end.

Three of the six new starters in the Service Improvement Team have arrived and 'on boarding' is going well. The new team will reach its full establishment of nine – see Appendix One – by 2 Dec 19.

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 23rd October 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 7 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.

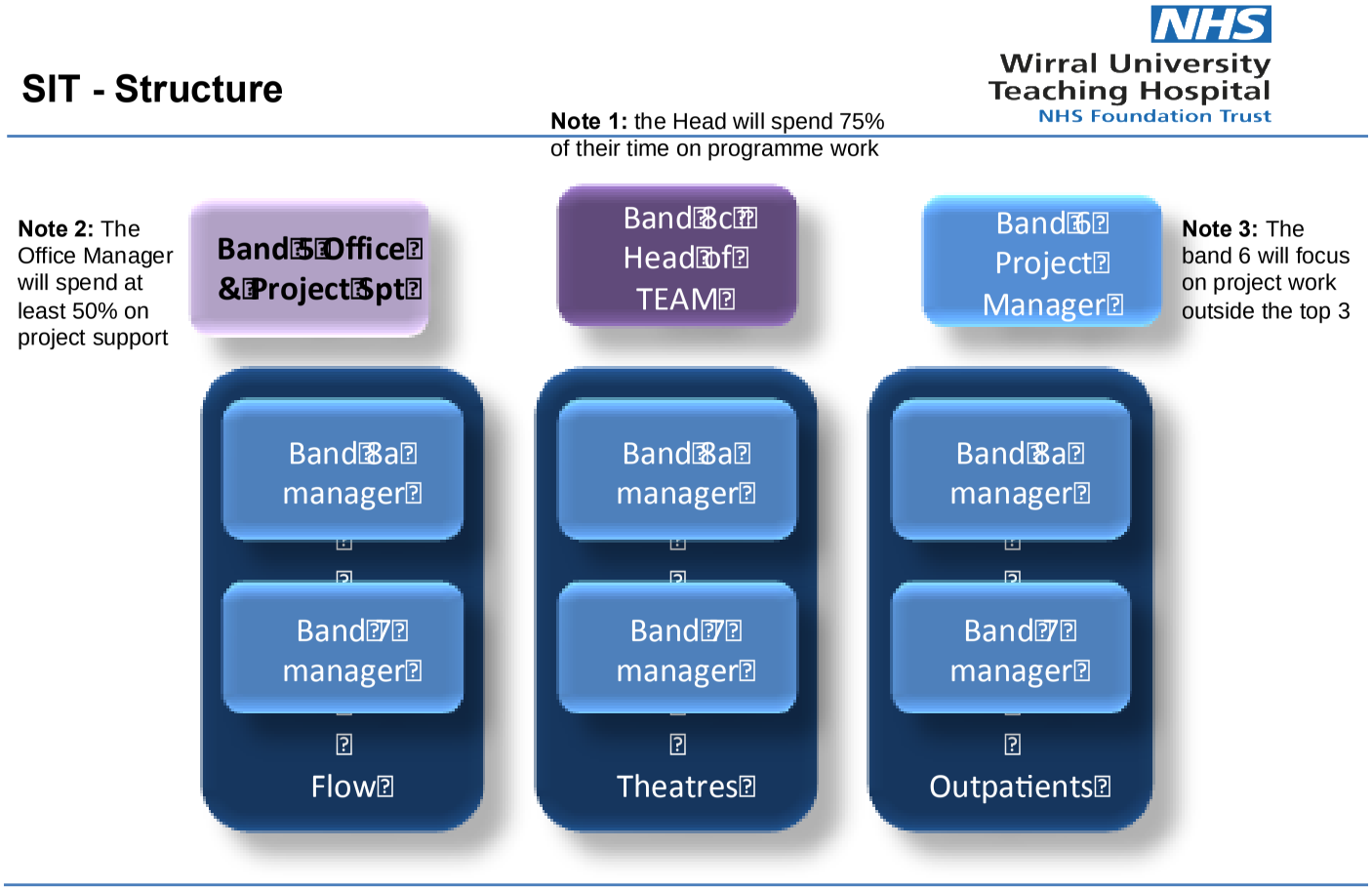
The first two pages (slides **10 and 11**) of the Change Programme Assurance Report provide a summary of each of the 3 Priority Projects and highlights key issues and progress.

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 / Executive Sponsors 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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P Priority Project

S Suspended Project

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WUTH Trust Board of Directors

Programme Board – CEO Chair

Improving Patient Flow
SRO - Nikki Stevenson

- P Front Door — **Lead: Shaun Brown**
- P Back Door — **Lead: Shaun Brown**
- P Command Centre — **Lead: Shaun Brown**

Operational Transformation
SRO - Anthony Middleton

- P Perioperative — **Lead: Jo Keogh**
- P Outpatients — **Lead: Alistair Leinster**
- Diagnostics Demand Management — **Lead: Alistair Leinster**
- World Class Administration of Patients — **Lead: Mel Aldcroft**

Hospital Upgrade Programme
SRO – Anthony Middleton

- Programme Management
- Financial Management
- Communications & Engagement
- People
- Care Pathways
- Building

Workforce Transformation
SRO – Helen Marks

- Workforce Planning — **Lead: Ann Lucas**
- Medical Staffing Improvement Project — **Lead: TBC**
- Specialist Nursing — **Lead: TBC**

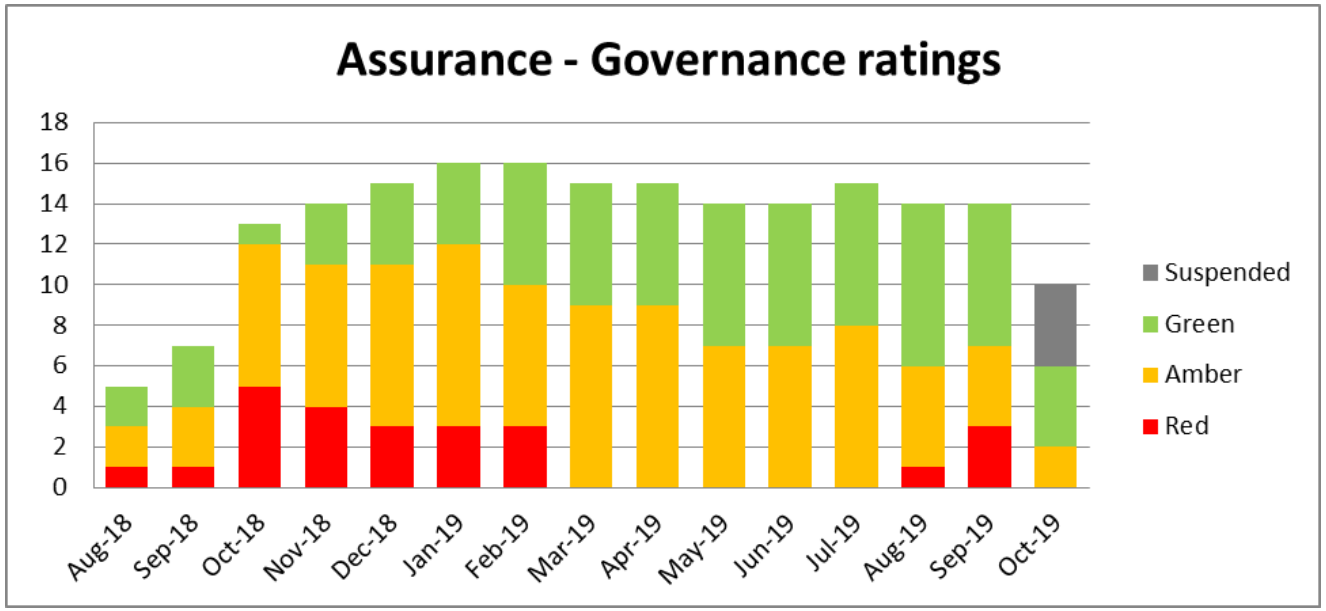
Partnerships (GDE Enabled)
SROs - per programme

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

Change Programme Assurance Report - Trust Board Report - October 2019

S Brimble – Office Manager & Project Support

Wirral University Teaching Hospital NHS Foundation Trust



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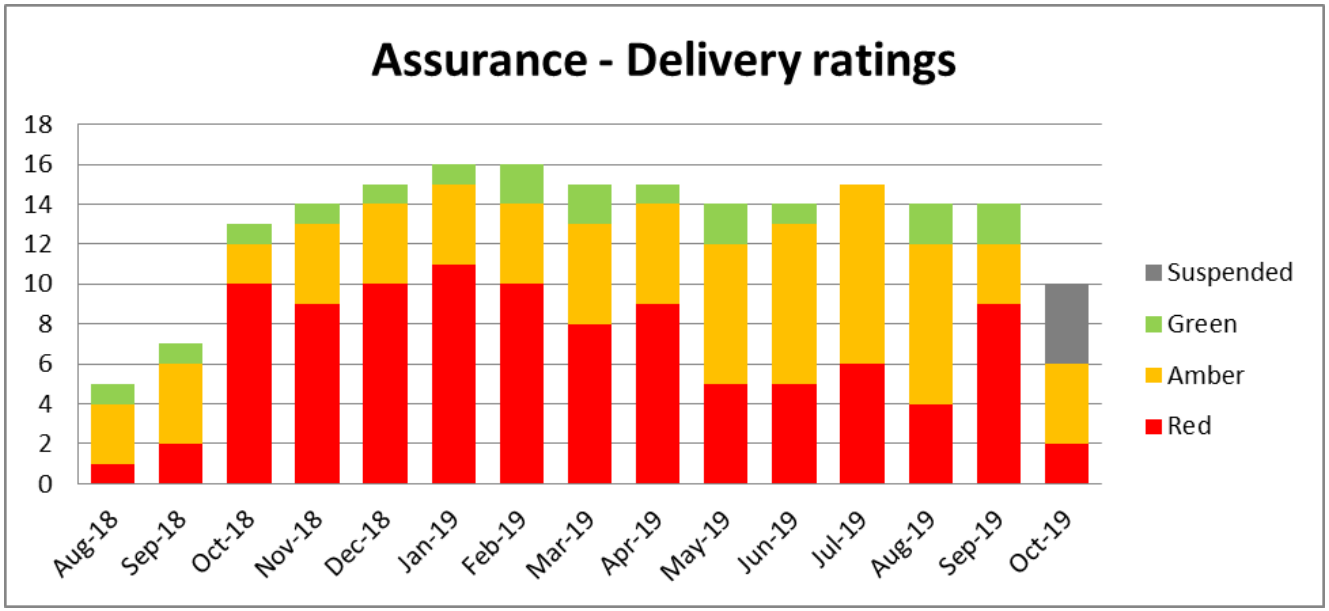
NHS Foundation Trust



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Priority Projects Highlight Report - Metrics

Senior Responsible Owners

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

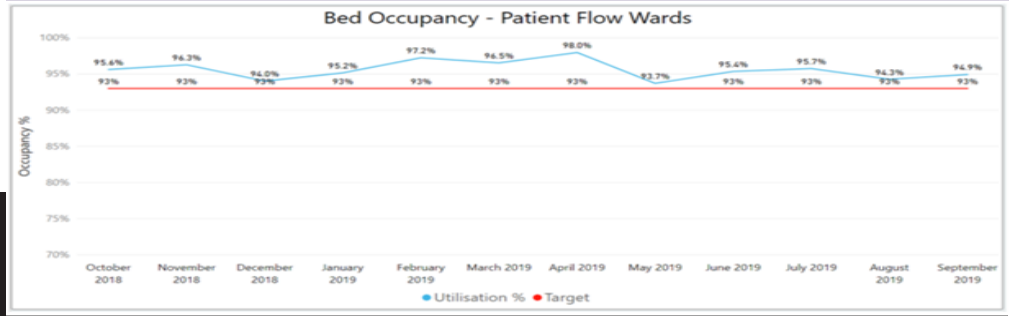
Overall Governance	Overall Delivery	Plan to Turn Green
Suspended	Suspended	

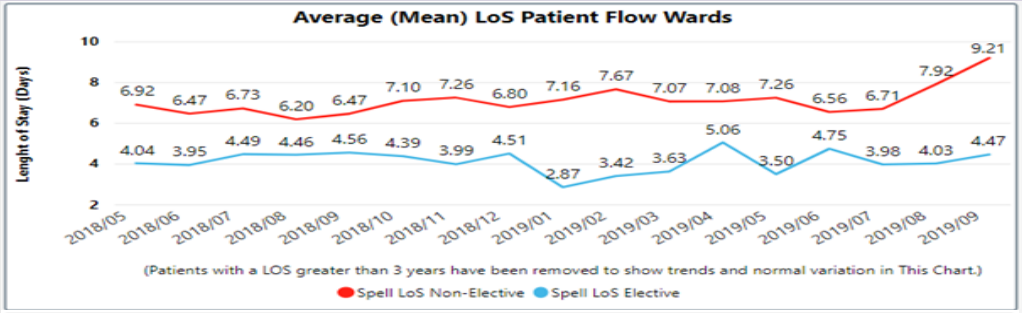
3 things you need to know

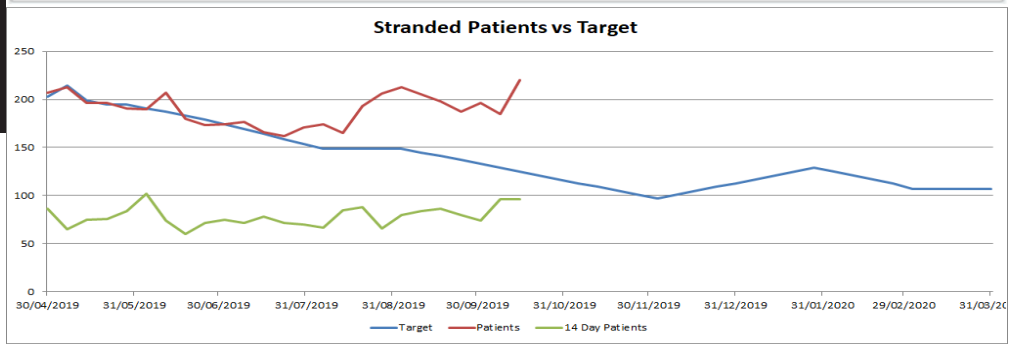
Front Door: Streaming: High level of specialty engagement. Collaborative streaming with WCT has recommenced (WUTH- complex streaming, WCT-simple streaming) . M&A Assessment Redesign: Nursing business case approved at TMB.

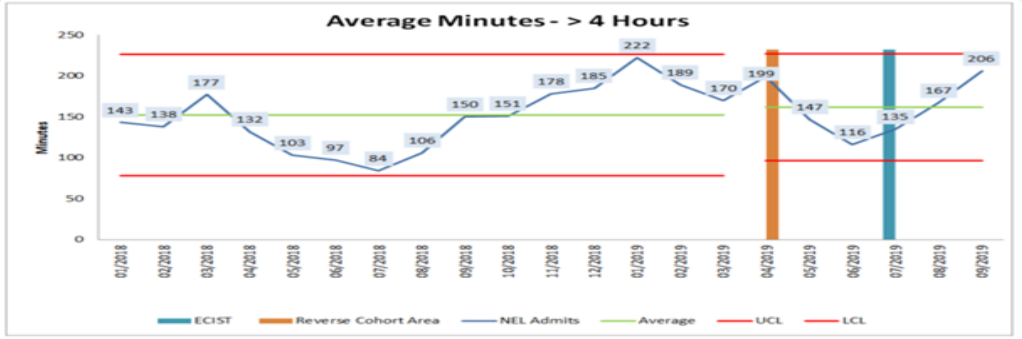
Back Door: Accelerated Discharge: Call to Action discharged 50% of longest stay patients reflected in increased mean LOS as calculation uses closed episodes . Quality Matrons/ADNs now leading on LLOS reviews for wards. IDT: Additional senior management support to lead IDT seconded in from 21/10

IT Enablers: Capacity Management project technical kick off with Cerner starts 11th November.
LaunchPoint: Training on hold as Trust review the Decision to Admit process internally. Some build issues still to resolve but no 'show stoppers' and nothing that impacts training delivery. Go live of 18th Nov at risk - impact assessment to be completed









Escalation

21 day+ patients are not decreasing in line with trajectory despite high level of senior input into expediting their discharge.
Organisational readiness for Capacity Management go live in March 2020

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

Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	Milestone plan updated. Exception report submitted to Programme Board September.

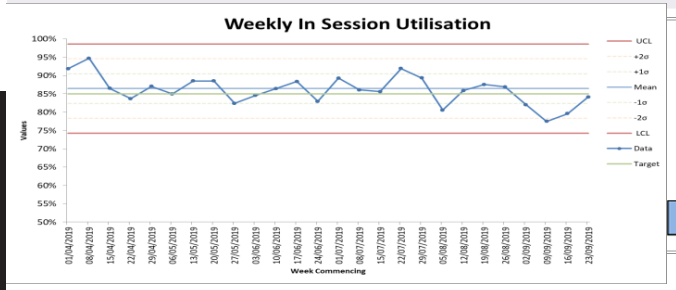
Four things you need to know

Main Focus: Three phase recovery options have been presented to the Executive Team with a decision approved in principle. Weekly meetings arranged with a planned delivery date of February 2020. Virtual Reality demonstration of the new unit to be experienced next week.

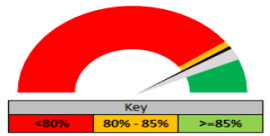
Theatre Scheduling System phase 1 delivered with a demo to Perioperative teams. Commencing phase 2 in November with training and operational delivery.

Pre-op has moved from SEAL to OPD, with some incidents being reported around privacy. Colorectal successfully moved to CGH with a view to moving to BAU.

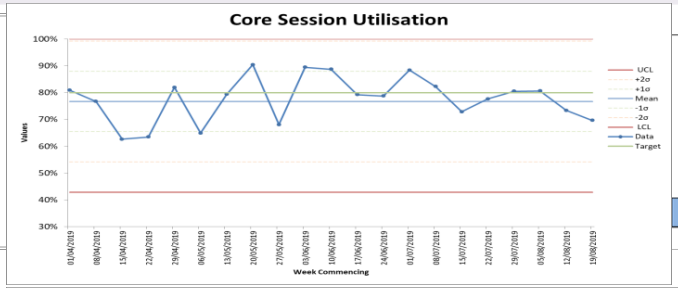
KPI Performance improved in September, the two areas of concern In session and on the day Cancellations are linked and are as a result of beds, 117 patients for non clinical reason.



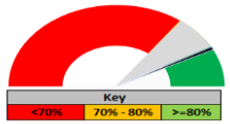
In-Session Utilisation



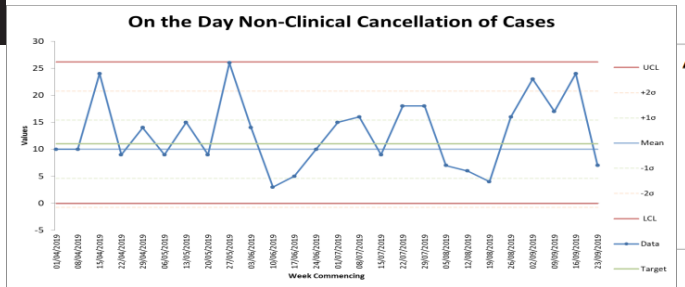
In Session utilisation (Monthly Average %)	Aug	Sept
	85.3%	80.9%



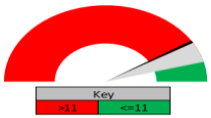
Core Session Utilisation



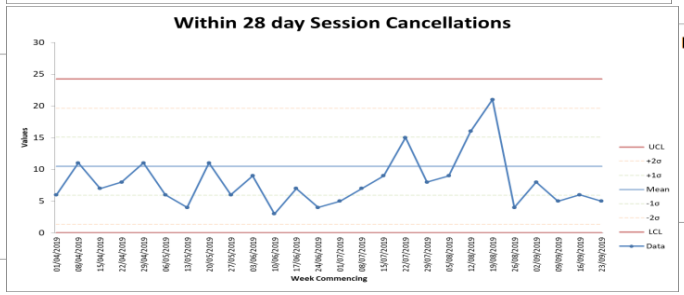
Core session utilisation Target 80% of 52 week capacity	Aug	Sept
	70.5%	84.0%



Avg On the Day Cancellation of Cases



Case Cancellations on the Day – Reduce to a Daily Avg of 11	Aug	Sept
	9.5	18.1



Late Cancellation of Sessions

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

July	42
August	53
September	27

Escalation

Support in securing 3 fixed rooms in main OPD Monday to Friday AM &PM

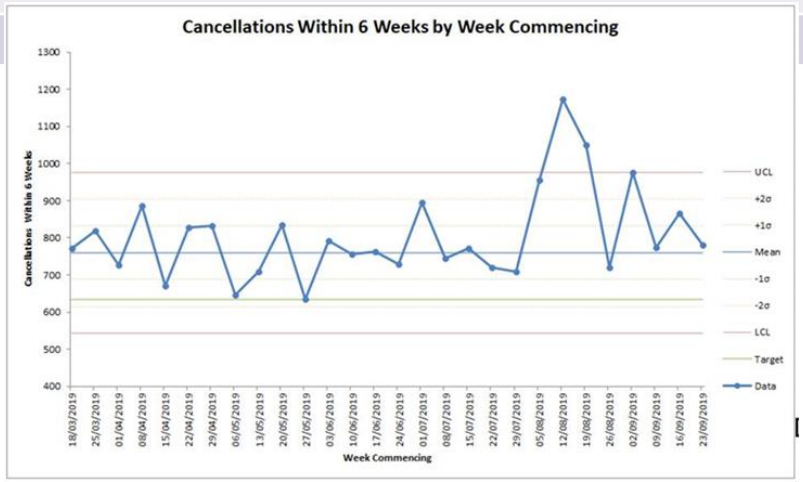
Highlight Report – Outpatients
Reporting Period – September 2019
Programme Lead – Alistair Leinster

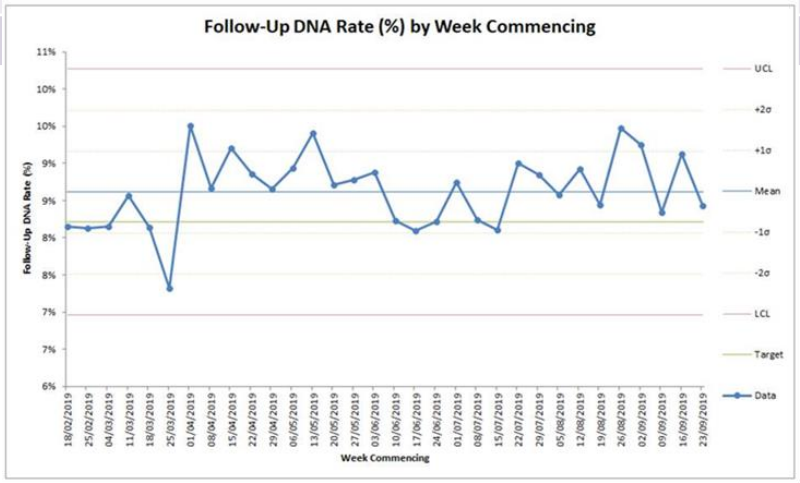
Overall Governance	Overall Delivery	Plan to turn green
Green	Amber	KPI's to be reviewed and PID updated. Milestone Plans to be reviewed and updated with Workstream Leads.

Things you need to know

Future of Wirral Outpatients engagement workshop with DDs, DMs and Clinical Leads 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 held 18/10/2019 .

Deadline 15th November (4 weeks post workshop) for specialties to have identified opportunities within their area for providing non face to face activity.





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

Escalation

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Programme Assurance Ratings

Joe Gibson
16 October 2019

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Suspended	Delivery	Suspended

- For the Flow programme the key metric '21day + LoS' is now in excess of 50% above target (as at 28 Oct 19).
- The Programme Board elected to suspend assurance ratings of the programme to allow programme managers to assist with the rapid operational measures being taken to improve the situation.
- The Flow Programme will be presenting revised proposals to the Programme Board on 20 November 2019 with an initial proposal for 3 projects to cover:
    - Front Door
    - Back Door
    - Capacity Manager

Perioperative Medicine Improvement	Governance		Delivery	

For the Perioperative programme, of the 6 benefits defined in the PID, 4 are being measured and reported to Programme Board (and Trust Board). Recommendations:

- Ensure the other 2 benefits are reported
- Ensure reporting of the benefits is accompanied by an explanation of progress
- Benefits should have not only a start date but also a date by which the benefit is expected to be achieved and sustained

The Gantt Chart states that 91 actions have been completed while 21 remain to be completed. Of these, 15 actions are due to complete by Nov 19 and the remaining 6 by Feb 20.
Recommendations:

- Ensure that the current plan will deliver and sustain the stated benefits
- Extend current plan if needed to assure benefits
- Monitor and update the plan week-by-week
- Walk through open actions at each team meeting and hold action owners responsible for delivery
- Escalate issues to the Operational Transformation Steering Group

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance		Delivery	

Of the 6 benefits defined in the PID, 3 are being measured and reported to Programme Board (and Trust Board). Recommendations:

- Ensure the other 3 benefits are reported
- Ensure reporting of the benefits is accompanied by an explanation of progress
- Benefits should have not only a start date but also a date by which the benefit is expected to be achieved and sustained

The Gantt Chart states that 19 actions have been completed while 46 remain to be completed. Of these, 37 actions are due to complete by Nov 19 and the remaining 9 by Jan 20.
Recommendations:

- Ensure that the current plan will deliver and sustain the stated benefits
- Extend current plan if needed to assure benefits
- Monitor and update the plan week-by-week
- Walk through open actions at each team meeting and hold action owners responsible for delivery
- Escalate issues to the Operational Transformation Steering Group

Programme Board Action

The Programme Board of 23 October considered the assurance recommendations, as outlined above, concerning the Perioperative and Outpatients programmes (the Programme Board was already aware of the issues encountered by the Flow programme). The Programme Board has requested that each of the three priority programmes bring a comprehensive 12-18 month forward looking plan to the Programme Board in January 2020.

Workforce Planning - Programme Assurance Update – 16 October 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a revised PID v0.2 dated 16 Mar 19 has been drafted with benefits described; moreover, a revised PID is in the process on being prepared to address the current issues with 'definition' of benefits and timescales. **2. & 3.** There is now some evidence of regular meetings with divisions up to 12 Aug 19 in terms of diary invitations but no recent minutes or notes of project team meetings; however, an inaugural (dedicated) project team meeting was planned for 15 October 2019. **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 a trackable Gantt chart; however, there is an absence of evidence on SharePoint to support the milestone delivery (e.g. Review PILOT and assess lessons learnt; future states modelled - completed April 19). **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 but not reviewed for 3 months, 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	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.											

Command Centre - Programme Assurance Update – 16 October 2019

Exec Sponsor	Programme Lead	Service Improvement 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. The business case for 'Capacity Management Devices' dated 12 Aug 19 was approved at the interim PFIG 12/08/19; however, issues around storage/charging are yet to be resolved. **2. & 3.** Evidence of documented project meetings is available up to the action log updates post the meeting of 30 Aug 19 and ToRs are also in evidence. **4.** Evidence of widespread stakeholder engagement with clinical groups is thin; a more compelling communications and engagement effort (see Plans from May 19) will be required. **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, several of 4 to 5 months. **7.** As described above, there are no metrics as yet for the benefits to be measured. **8 & 9** There is a RAID Log showing the date of risks last reviewed as 30 Aug 19. **Most recent assurance evidence submitted 8 Sep 19.**

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

Perioperative Medicine Improvement – Programme Assurance Update – 16 October 2019

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Jo Keogh	TBC	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 1 Oct 19; an action log is now in place to assist governance. 4. There is evidence of wider stakeholder engagement uploaded but this ceases (8 Jul 19) with the May-July Divisional Newsletter; more recent evidence is required. A communications plan is now available but is not being tracked. 5. The QIA has now been revalidated. 6. The revised plan, dated 1 Aug 19 - as re-baselined by means of an Exception Report to the May Programme Board - is showing red ratings across some 30% of milestones. 7. KPIs are developed in the PID; the performance reported to Operational Transformation Steering Group on 14 Oct 19 shows 2 of the 4 KPIs red rated. 8 and 9. Evidence in place concerning risk and issue management and the 'date of last review' for most risks is 12 Oct 19. **Most recent assurance evidence submitted 15 Oct 19.**

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

Outpatients Improvement - Programme Assurance Update – 16 October 2019

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

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 2 Sep 19. **4.** There was a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan - Apr 19 but this shows no signs of being actively tracked and is now out of date. **5.** The signed QIA has been submitted. **6.** A detailed Gantt chart has now been produced, uploaded 10 Sep 19, to cover 2019/20 following approval of the revised PID; the tracking is not up to date across workstreams with undefined delays. **7.** Only 2 of the 6 KPIs defined in the PID are being reported and both are off track; the main KPI, achievement of plan, is reported as a 3% year-on-year increase but in not systematically reported to SharePoint. Dials for metrics, with thresholds, and a clear read across to PID targets would be beneficial. **8 and 9.** There is a comprehensive RAID Log in evidence with risks and issues last uploaded on 9 Sep 19. **Most recent assurance evidence submitted 10 Sep 19.**

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

Diagnostics Demand Management - Programme Assurance Update – 16 October 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 dated 15 May 19 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 Oct 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 but this ceases in 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, updated 2 Oct 19, on which tasks have been updated and which shows delays to some milestones. **7.** There is now benefit reporting against two metrics (compared to the six detailed in the PID) and one is green, the other amber rated; the CIP target is being reported as on track. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 14 Aug 19. **Most recent assurance evidence submitted 2 Oct 19.**

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

Healthy Wirral: Medicines Optimisation - Programme Assurance Update – 16 October 2019

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

Independent Assurance Statement

1. PIDs have now been uploaded for: 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 with benefits either partly defined or cross-referred to the GDE SoPB. **2.** HW Medicines Safety and Governance highlight report for Q2 is available together with the Pan Mersey Formulary Implementation highlight report for September 2019. **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 stakeholder engagement and comms by means of presentations and meetings. **5.** EA/QIA signed off 18 Mar 19. **6.** There is now a detailed milestone plan, v4, recently uploaded; however, most milestones for Aug and Sep 19 remain 'open' (status not clear). **7.** Benefits are shown in a range of reports, uploaded to Sep 19, covering: Adalimumab Biosimilar; Biosimilar Uptake; Etanercept Biosimilars; Infliximab Biosimilars; Lucentis Data; Rituximab Biosimilars. Lost opportunities numbers are shown but overall benefits (numbers) unclear. **8 and 9.** There is a monthly risk and issues log in place and updated to Sep 19 (although it is in non-standard format) with 'date of last review' as Aug 19. **Most recent assurance evidence submitted 11 Oct 19.**

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

Board of Directors

Subject:	Agenda Item 17 Proceedings of the Trust Management Board held 31.10.2019	**Date:**	6th November 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 M6 outturn.**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care – 18 week Referral to Treatment, Long Length of Stay 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 31/10/2019. 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 – new theatre schedule to be launched w/c 4th November along with the new electronic, in-house developed, theatre scheduling system. Concerns raised regarding the awarding of Orthotics contract, CCG have agreed 'standstill' period to enable negotiations to continue. Also discussions continue in relation to any future tender processes. Tender for Three Phase Recovery underway, preferred bidder to be identified with works due to start shortly.

(ii) Medical & Acute Streaming and Long Length of Stay continue to be key the focus with measures implemented to address under performance and no compliance of agreed trajectories. Wards 37 and 38 rated 'green' across all IPC metrics. With effect from 1st December the Walk in Centre (WIC) at APH will be classed as UTC. Plans for WIC to provide Point of Care Testing and xrays for minor illnesses. Following the JAG reaccreditation for Endoscopy in October, the services has received a recommendation for a 'straight pass.'

(iii) Women & Children's - Breast Cancer 2 week wait remains challenging - referrals are increasing and review commenced to improve the operating model for new and follow up appointments. Six month locum consultant recruited to improve capacity starting in January. Child Information System (CHIS) – Wirral Community Trust have lost the public health tender for CHIS – this represents a risk for our antenatal and newborn screening service, mainly regarding newborn as the team rely on links with this service for their failsafe systems around coverage. Following meeting with Public Health England on the 11th November, this will be added to risk register to reflect operational risks. System dialogue underway regarding increasing demand on Perinatal Mental Health Services with a view to scoping the service across the whole healthcare system.

(iv) Diagnostics and Clinical Support - Aseptics – MHRA inspector assessing the ASU Manufacturing Special's Licence underway. Development of staffing plan and service redesign in AHP due to pressures within Pharmacy and AHP. Contract Performance Notice received in relation MSK service, requiring action plan and improved performance in relation to waiting times across MSK specialties.

(v) Estates & facilities – Fire door replacement programme, upgrade to fire panels and devices in progress. Minor works programme completed on wards 36, 22 and 25 and underway on ward 32 with CCU to follow. Timeline of Clatterbridge Cancer Centre services received, impact assessment for WUTH being reviewed. Attendance remains a focus with management plans in place for all long term sickness.

3. Quality and Performance Dashboard

- TMB received the revised Quality Performance Dashboard covering the 12 months ended 31st September 2019.
- There are currently 19/57 indicators outside tolerance.
- TMB noted the progress to date and the number of indicators that were now seeing improvement and/or coming under control

4. Bed Capacity Model Update

- TMB received a progress report on the Bed Capacity Model.
- Concerns raised regarding the effectiveness of the system, actions to address concerns to be reviewed by Divisional triumvirates with speciality leads.

5. Chronic Pain Service Update

- Significant capacity and access issues remain. WUTH has recently appointed a Consultant Pain Specialist but Consultant vacancies remain. There is a national shortage of such specialists. TMB requested report to November meeting to consider the option for a nurse- delivered, consultant-led service.

6. Medical Equipment Risk Assessment Report

- TMB received a report regarding Radiology Fixed Equipment Planning to show plans in place to sort the ageing equipment.
- Prioritisation based on risk to be considered to inform 2020/21 capital programme and longer term replacement programme. TMB to consider proposal at its meeting in January 2020.
- TMB supported immediate interventions to maintain X-ray machines at VCH and St Caths (approx. £20k).

7. 6 Facet Survey

- TMB received a summary of findings of 6 facet survey.
- An Estate Strategy to be developed aligned to Clinical Strategies and other corporate strategies such as Quality and People Strategies which will then inform the Trust Strategy.

8. Diversity and Inclusion Annual Report

- TMB received and noted the Diversity & Inclusion Annual Report 2018/19 including the Strategy Action Plan.
- TMB recognised that progress to date has demonstrated the Trust is one of the most improved in diversity nationally and this is supported by external partners.
- TMB considered the recommendations outlined in the report and encouraged senior leaders to champion colleagues to ensure personal information contained with ESR is up to date and model inclusive leadership in day to day activities.

9. AHP Recruitment and Retention Plan

- TMB received a report outlining the AHP Recruitment and Retention Plan to address the high level of vacancies being experienced and highlighted the national and local challenges affecting the recruitment and retention of therapists.
- TMB were advised that a number of interventions are in place to mitigate the impact on patient care.
- TMB considered and supported the action plan as detailed in the report. The actions will be monitored through the workforce dashboard provided at Divisional Performance Reviews and the Workforce Assurance Committee.

10. Lessons Learnt to Improve People Practices

This item was deferred until November meeting.

11. Education Review

- TMB received and noted the current provision of education and training and significant achievements in relation to education and development as well as areas for development over the next 2-3 years and beyond.
- The next steps as outlined in report including promoting career pathways and work with schools and colleges were supported.
- TMB considered implications for education and development linked to strategic priorities of the Trust.

12. Medical Agency and Locum Pay Rates

- TMB received a report outlining the proposals to develop a standard rate of pay for medical locums and agency workers that can be used throughout the Trust.
- TMB considered and agreed the approach to the collaboration work being undertaken by Cheshire & Merseyside to standardise rates for all partners and therefore supported signing up to the Memorandum of Understanding to progress this work.
- TMB requested additional detail regarding internal standardisation of locum pay rates to consider differentials between ED and rates offered by other specialties and providers. In principle it was agreed that a reduced rate that remained competitive was supported. A report is to be provided at the November meeting.

13. Month 6 Finance Update

- TMB received and noted the financial position for the end of month 6.
- Members were advised that the Trust has accessed an additional £4m of CCG funding to support the position non-recurrently. This would need to be repaid in Q4.
- Members noted the importance to maintain forecast position agreed at end of month 4.
- TMB acknowledged slippage of some of CIP programme and the need to progress gaps to improve the financial position.

14. Chair's Reports

- The following Chair reports were received and reviewed by TMB:
  - Patient Safety & Quality Board Report – 11/10/19
  - Risk Management Committee Report – 9/10/19
  - Finance & Performance Group 22/10/19

15. TMB noted the update relating to a No Deal EU Exit.

Written and summarised on behalf of TMB Chair by:
Andrea Leather, Board Secretary
5th November 2019

Board of Directors	
Agenda Item	18
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	6 November 2019
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Charitable Funds Committee 29 October 2019

This report provides a summary of the progress of the Charitable Funds Committee which met on 29 October 2019.

1. Head of Fundraising Report

The Committee was once again pleased to see continued progress for WUTH Charity, and for the Tiny Stars appeal in particular. Key developments are as follows.

- Recruitment of a second Community and Events Fundraiser.
- Significant development of the Charity's volunteer base.
- Recent press and social media coverage.
- Recent events, such as the Zumbathon and Car Wash.
- Planned events for Q3/4 and beyond, such as the 80s Disco Night, Charity Carol Service and Ladies Lunch, and a variety of on-site festive events (see Appendix 1).
- A number of developed 'leads' for grants and community / corporate support.

The Committee was delighted to see the official **Tiny Stars video**, as previewed at the Staff Awards. This is due for official release at 5pm on Friday 1 November 2019, supported by the Head of Fundraising's promotional campaign.

Please visit wuthcharity.org or view it via social media - @wuthcharity. To lend your support to the Tiny Stars campaign please 'like' and 'share' the video as much as possible.

2. Finance Report

The income, expenditure and closing positions as at 30 September 2019, for each of the Charity's funds, were presented and reviewed. The Committee acknowledges that several funds are currently below the balance stated in the Charity Reserves Policy, and is sighted on the measures being undertaken to address this.

3. Governance and compliance matters

- Cycle of Business – the Committee is reverting to a quarterly cycle to ensure the Fundraising function has sufficient support.

- *Fundraising and Income Guidance* and the *Expenditure Guidance* policy documents were lightly refreshed and reapproved. The new versions have been presented for upload to the staff website.

- The *Treasury Management Policy* and *Reserves Policy* were also reapproved with agreed amendments.

4. Royal Voluntary Service (RVS)

The Committee received an update on the issues experienced to date by the Charity Team and predecessors in securing the release of accumulated funds from RVS. The Trust-RVS arrangement is without contract, but the two tea bars at APH generate net incomes which have been designated / restricted to the Trust. The accumulated fund is approximately £250k.

The Charity Team has flagged that Board-level involvement is now required, to liaise directly with RVS's Board of Trustees, to progress the matter further. A meeting with RVS's Chief Executive is being organised.

5. Other business

The Committee thanked the Assistant Director of Finance – Financial Services for their support since 2016 in relaunching the Charity, and leading its fundraising, compliance and finance functions to date.

6. Recommendations to the Board of Directors

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

- The continued progress made across a number of key work-streams.
- The RVS matter which has been escalated by the Charity team for resolution.
- The Charity's events, planned for Q3/4 and beyond (Appendix 1).
- The release of the Tiny Stars promotional video.

Planned events

Wirral University Teaching Hospital NHS Foundation Trust

80s Disco Night

50 + attending

- Raffle
- Best dressed prize
- Photo booth
- Karaoke
- Buffet

Tiny STARS Neonatal Appeal WUTH Charity

Appendix 1

Cantemus Choir at Calday

- Raffle
- Mulled wine and mince pies

Tickets available from the Charity Office or online:

www.justgiving.com/fundraising/TinyStarsCarolService

WUTH Charity
Wirral University Teaching Hospital
Registered charity no. 1050469

Festive events

- Choir performances
- Chapel services at APH/CGH
- Charity Christmas stalls
- Rotary collections with sleigh
- Winter raffle draw

WUTH Charity
Wirral University Teaching Hospital
Registered charity no. 1050469

Ladies Lunch

- With special guest: Welsh soprano Elin Pritchard
- Drinks reception and stalls
- Two course meal
- Raffle

Tickets £35 per person
(discount for full table)

WUTH Charity
Wirral University Teaching Hospital
Registered charity no. 1050469

2020 calendar

Wirral University Teaching Hospital
NHS Foundation Trust

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Large			Ladies Lunch	April Fools Comedy Night	Abseil / Zipwire	Golf Day Duck Race	Summer Ball	*Arrowe Park event*	Colour Run		Sports Lunch	Santa Dash Carol Service
Medium	*Ward activity roll out*		Zumba	Fashion Show Car Wash			Car Wash		Zumba			Christmas Fair
Small (onsite)	Dave Badley - *half marathon row challenge*	Valentines Bake Sale	Cycle Challenge	Easter Bake Sale	Treadmill Challenge		Cycle Challenge BIG TEA		Rowing Challenge BAKE OFF	Halloween Bake Sale	Tree Lights Switch On	Choirs, Jumper Day, Bake Sale etc.
	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle	Raffle
3rd Party	Wirral Winter Half			London Marathon		Coastal Walk			Tough Mudder	Staff Awards Mayors Ball (tbc)		

Tiny STARS Neonatal Appeal
WUTH Charity

WUTHCharity wuthcharity.org

BOARD OF DIRECTORS	
Agenda Item	19
Title of Report	Report of the Safety Management Assurance Committee
Date of Meeting	6th November 2019
Author	Steve Igoe, Chair
Accountable Executive Director	Paul Moore, Acting Chief Nurse / Director of Quality & Governance
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Audit Committee
Data Quality Rating	
FOI status	Chairs report may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The Committee met on 8th October 2019 and received a full update on a range of matters.

2. Key Agenda Discussions

1. The Committee received a report from the Chair of the Health and Safety Committee. The report noted:

    a. Positive engagement from the various attendees.
    b. 6 Riddor related injuries, the majority of which related to manual handling.
    c. An analysis of EL and PL claims.
    d. A briefing on needlestick injuries.

e. An issue related to the carriage of dangerous goods, in this case infectious materials. It was noted that an action plan had been developed to be shared at the next H&S group. It was noted that the response needed to be proportionate and risk based.
f. Assurance that the actions noted in relation to radiography in the 2018 CQC inspection had been resolved.
g. Positive assurance as regards Fire Safety Management but recognising that there was still some way to go.

2. The Committee then considered the Quarter 2 Health and Safety update and dashboards. In particular the Committee noted:

    a. A range of similar issues to those covered in 1) above were further re-stated in this report.
    b. Given the claims noted above re manual handling the Committee discussed the availability and engagement with manual handling training across the Trust.
    c. There was an acceptance, if not expectation, that given the enhanced emphasis and awareness across the trust of H&S issues an increase in reporting of such incidents was to be expected.
    d. Time was spent reviewing and discussing the various divisional and operating unit dashboards. The Committee felt that an appropriate time it would value a "deep dive" into individual reports, perhaps done at a location in division where key personnel could be part of the discussion.
    e. The Committee recognised the continued positive progress in the area.

3. A report on control of contractors was presented. The report was warmly welcomed and provided positive assurance about management and control of contractors on site. A specific issue was raised as to whether any contractors on site were or should be DBS checked if they were to be working in areas where they might be alone with a child or vulnerable adult. It was agreed that this issue wasn't currently covered but would be considered as a matter of urgency.

4. The Committee warmly welcomed the submission for RoSPA recognition in the light of the strong progress made by the Trust over recent months. The submission is to be made by 31 January 2020 and will require a strong evidential base to underpin it. All colleagues agreed to assist with the process, particularly noting the work in HR on issues relating to wellbeing and sickness and absence.

3. Next Meeting

The next Safety Management Assurance Committee meeting will be held on 5th November 2019.

Board of Directors

Agenda Item	20
Title of Report	Business Case – Acute Medicine Nursing
Date of Meeting	6th November 2019
Author	Harriet Franks
Accountable Executive	Paul Moore, Acting Chief Nurse and Director of Quality & Governance Anthony Middleton, Chief Operating Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

WUTH BUSINESS CASE TEMPLATE

Business Case Title	Acute Medicine Nursing Establishment Investment
Division	Medical & Acute
Author	Harriet Franks
Clinical Lead	Judith Cull Phil Lawrenson Helen Morris
Executive Sponsor	Paul Moore - Director of Quality & Governance

Approvals requested:		
Meeting	**Date**	**Agreed to Proceed**
Divisional Management Team (DMT)	18th September 2019	Yes
Trust Management Board (TMB)	26th September 2019	Yes
Finance & Performance Group (FPG)	Free Text	Choose an item.
Finance, Business & Performance Assurance Committee (FBPAC)	Free Text	Choose an item.
Trust Board (Board)	Free Text	Choose an item.

Approvals required:					
Investment value	**DMT**	**TMB**	**FPG**	**FBPAC**	**Board**
<£50k	✔	✔	✔		
£50k-£250k	✔	✔	✔	✔	
>£50k	✔	✔	✔	✔	✔

Stakeholder engagement:		
Job Title	**Name**	**Date Approved**
Divisional Director, M&A	Shaun Brown	29.07.19
Divisional Director, Surgical	Jo Keogh	09.09.19
Divisional Director, W&C	Andy Hanson	11.09.19
Divisional Director, DCS	Alistair Leinster	17.09.19
Associate Director of Informatics	Paul Charnley	17.09.19
Associate Director of Estates	Glen Adams	18.09.19
Head of Income Contracting	Jo Stewart	17.09.19
Capital Accountant	Tom Williamson	Free Text

CONTENTS PAGE

BUSINESS CASE

1. Executive Summary

The Royal College of Physicians (RCP) undertook an invited service review of Acute medicine in November 2018 with detailed post-review feedback. Acute Medicine has developed an action plan to review and deliver the recommendations. The paper will focus on the recommended review of the nursing and admin establishment within the Acute Medical Unit (AMU) which includes Urgent Medical Assessment Centre (UMAC) and Medical Short Stay Ward (MSSW).

The AMU consists of 23 beds and the UMAC (formerly Ambulatory Care Unit), a medical admissions unit consisting of 20 chairs and 5 trolley spaces. MSSW is a 20 bedded ward and is part of the Acute Medicine nursing establishment but not the medical establishment; it is historically clinically managed by a consultant Endocrinologist and consultant in Stroke Medicine. All three units have a high turnover of patients and high acuity levels. Delivering high quality patient care and excellent patient experience is a priority for Acute Medicine. To achieve this, the current nursing and admin establishment has been reviewed and additional funding is requested.

This business case describes the nursing and admin model to be developed over the next year, which requires extra funding of £830k per annum. The Division seeks approval to utilise the funding allocated within M&A Division's budget in 19/20 (£900,000) specifically for Acute Medicine nursing improvements to recruit to the additional posts detailed within this business case.

2. Case for Change

The RCP recommended that nurse staffing for the acute service, and particularly for the existing UMAC, should be modelled using the RCP acute care toolkit. These have been utilised for the proposed staffing models.

In addition, the report highlighted that UMAC was historically insufficiently staffed, and this has created immense pressures on the nursing workforce who frequently have to pull nursing resource from AMU and MSSW to ensure safe nursing care is provided. The RCP report also recommended a

dedicated nurse coordinator and a consistent nurse triage role within UMAC to ensure patient safety, experience and flow in and out of the unit seamlessly.

The UMAC was opened in July 2016, creating a purpose built clinical space for all GP acute medical referrals to be accepted, assessed and treated. The UMAC has 8 clinic rooms, 8 ambulatory next day appointments for admission avoidance, 20 ambulatory chairs and 6 trolleys for GP referrals and patients from the Emergency Department (ED). Unfortunately, no funding for nursing staff was built into the acute medicine nursing budget at that time and has since created an on-going cost pressure. This has impacted on quality, safety and patient experience, and contributed to an inability to recruit and retain staff across AMU, UMAC and MSSW.

To ensure safe staffing, AMU and MSSW nurse staffing is pulled across to support UMAC. As a result, staffing UMAC has often been at the detriment of AMU and MSSW as this has required nurses to be pulled from AMU and MSSW to staff UMAC, resulting in a reduced nurse to patient ratio and below that of the guidelines set out by Society of Acute Medicine (SAM workforce planning considerations for acute medical units: A guidance paper and toolkit, 2011):

- 1:4 for patients on trolleys (currently 1:6 at APH).
- 1:6 for patients in beds (currently varies between 1:6, 1:7 or 1:8 within AMU/MSSW depending on staffing levels, and if UMAC has been bedded down overnight without extra staffing).

2.1 Nursing investment benefits

- Standardise nurse to patient ratio to 1:6 across AMU and MSSW will improve patient experience.
- Improve Recruitment and Retention by providing extra senior nurse support and a nurse educator.
- Improve Hospital Acquired Patient Harms and Safety Indicators/ Red Flags.
- Improve Care hours* per patient day (CHPPD): AMU/MSSW is out of range compared to the model hospital data. The funding will allow for the two units to be in a shared model which will achieve the CHPPD recommendation in table 1.

*Care hours are currently not recorded for UMAC as this is not considered an inpatient area.

	AMU	MSSW
Average CHPPD	**9.3**	**5.9**
Model hospital speciality comparison	**7.49**	**7.49**

Table 1: Benchmarking CHPPD

- Improve sickness rate of 8.3% in 2018 (Trust target is 4%).
- Turnaround a disappointing acute staff survey results in 2019.
- Ensure patient experience is improved
- Improve appraisals and Mandatory training compliance:

2.2 Benchmarking - The department completed a regional scoping exercise to benchmark against other acute units (including both UMAC and AMU) to establish their nurse to patient ratio (Table 2). Trusts had varying degrees of nurse to patient ratios, however all were greater than the ratio at WUTH.

	2019
Countess of Chester	AMU 51 beds, 1:6 + co ordinator ACU 8 beds with chairs, 1:7 depending on flow
The Royal Liverpool	AMU 31 beds, 1:5 ratio + 2 co ordinators. Drops to 1:6 overnight GPU area 1:5 or 1:6, 4 trolleys, 8 recliners.
Aintree University Hospital	AMU 1:6 ratio + co ordinator and 1:2 for enhanced care area.
Arrowe Park Hospital	AMU Varies between 1:6 and 1:7 ratio. UMAC 1:10, chaired area 1:6, trolley area

Table 2: Benchmarked Acute Medicine nursing staff levels

2.3 Admin and Clerical Staffing

The current establishment is not in line with the unit's surges and peaks in demand. UMAC GP referrals and attendance to the unit continues after 20.15hrs without a ward clerk. This results in nursing staff providing cover for clerical duties. When they are busy there are significant delays to register patients which creates a lack of oversight for hospital clinical co-ordinators as to the true capacity within UMAC and can cause delays to patient care and treatment.

2.4 Demand

Since the opening of the UMAC in 2016, demand has continued to grow with the unit seeing an increase in GP referrals year on year.

3 Options

3.1 Option 1 - Do nothing i.e. no change to staffing establishment but increase uplift value to 23%

This option has no alteration to the staffing model apart from an increase of the uplift value to 23% from 20% to bring in line with the standard Trust nursing uplift percentage. This would require an additional £68.7k.

Band	WTE	£k
Band 7	-	-
Band 6	0.26	10
Band 5	1.00	32
Band 4	-	-
Band 3	0.36	8
Band 2	0.90	19
Total	2.52	69

Table 3. Uplift to 23%

3.2 Option 2 – Investment will provide the following benefits:

- Triage nurse, 5 days per week, 13.30 – 02.30, covering peak periods of activity. This will ensure timely triage of patients arriving on the unit during times of surges. (Recommended by RCP). ***Benefit current waits exceeding 15 minutes for triage will be highlighted. This will ensure that acutely unwell patients are identified in a timely manner thus giving assurance for safety for all patients attending the unit.***

- A UMAC coordinator for 07.45-02.30, 7 days per week. (Recommended by RCP**).** ***Benefit: a senior nurse will have an overarching view and responsibility for patient flow and decision making on the unit and will liaise with ED and bed management closely to ensure efficient patient flow, whilst supporting the junior nurses. This will provide safe and efficient flow in and out of the unit.***
- A ward co-ordinator (which will cover both AMU & MSSW) 24 hours, 7 days per week. ***Benefit: a senior nurse will have an overarching view and responsibility for patient flow and decision making on the unit and will liaise with bed management and the base wards closely to ensure efficient patient flow, whilst supporting the junior nurses. This will provide safe and efficient flow in and out of the unit.***
- Additional 1.68 WTE ward clerks. This will enable AMU and MSSW to provide a dedicated ward clerk 07.45-20.15 7 days per week. UMAC will have a dedicated ward clerk 07.45 – 02.30 7 days per week. ***Benefit: nursing will no longer need to admit arriving patients. This frees up time to deliver high quality patient care.***
- Additional 7.19 WTE band 5 nurses to provide a 1:6 ratio across AMU and MSSW. Patients on MSSW are often still under an assessment pathway; this will ensure they benefit from the same nursing resource as AMU. ***Benefit: MSSW is often directly admitted to via ED and used as an acute unit and overflow of AMU. The investment will provide a 1:6 nursing ratio across AMU and MSSW which, in turn, will have a positive impact on reducing patient harm as well as efficient patient flow in and out of both units and also timely discharges.***
- Additional 1 WTE Band 7 ward manager posts. Acute Medicine has three dedicated areas, UMAC, AMU and MSSW. A dedicated ward manager is required for each area, as during times of annual leave, one ward manager isn't able to cover 50+ bedded area. ***Benefit: Three WTE Band 7 ward manager posts will ensure cover during annual leave and, in addition, provide senior presence for evening and weekend shifts. This will enhance the nursing leadership resulting in a positive impact on staff engagement, morale, recruitment and retention.***
- CSW provision for the daily ambulatory clinic. Currently Acute Medicine pull a CSW from inpatient nursing establishment to cover the clinic. Benefit: ***Increasing the CSW workforce will have a positive impact on reducing patient harm as well as efficient patient flow in and out of both units, as they wont be pulled away from their clinical area to provide cover for the clinic.***

- Funding for 2 WTE housekeepers to cover the three areas (currently not part of budget establishment). ***Benefit: improving overall environment which will impact positively on IPC and release time for the CSW's to provide patient care.***
- Investment in Band 3 establishment for 24 hour period to support staff across all 3 units. ***Benefit: this role will support the actual patient moves to the base wards, which can often be delayed when the unit is busy.***
- 1 WTE band 6 nurse educator. There are over 100 WTE nursing staff across UMAC, AMU and MSSW, ***Benefit: A nurse educator will improve compliance against mandatory training, facilitate roll-out of triage training and develop the extended skills required for nurses working in a direct admissions area. This enhanced focus on education have a positive impact on recruitment and retention, whilst ensuring the unit has a workforce fit to deliver the high quality acute care that the unit strives to. This will also have a positive impact on the staff survey results.***

Total of £830k investment is requested, full nursing establishment is provided in Appendix 1**.** Option 2 includes:

	Current		Proposed		Investment	
Band	WTE	£k	WTE	£k	WTE	£k
Band 7	2.00	105	3.00	182	1.00	77
Band 6	10.30	473	12.41	570	2.11	97
Band 5	40.04	1,587	47.23	1,849	7.19	262
Band 4	-	-	4.08	128	4.08	128
Band 3	14.28	371	21.47	583	7.19	212
Band 2	36.06	1,031	36.97	1,045	0.91	14
Housekeeper	-	-	2.00	40	2.00	40
Total	**102.68**	**3,567**	**127.15**	**4,397**	**24.47**	**830**

Table 4. New Model of Nursing UMAC, AMU and MSSW.

To note, the investment outlined is calculated assuming mid point for nursing staff. The investment of £830k presents the full year effect.

4 Detailed Analysis

4.1 Nurse Staffing

Table 5 demonstrates the actual current nursing staffing roster across the three units.

Area	Early	Late	Night
UMAC	1 B6 1 RN 2 CSW	1 B6 3 RN 3 CSW	1 B6 2RN (twi) 1B3
AMU	1 B6 4 RN 4 CSW	1 B6 4 RN 4 CSW	 4 RN 4 CSW
MSSW	3 RN 3 CSW	3 RN 3 CSW	2 RN 3 CSW

Table 5. Acute Medicine nursing roster template.

4.2 Financial Impact

Investment required for staffing is outlined in the Financial Summary below, PYE makes an assumption that the business case will be approved by 1st November for recruitment to begin and with start dates from 1st January 2020;

Financial Summary		PYE (£k)	FYE (£k)
Clinical Income			
Elective		0	0
Daycase		0	0
Non-elective		0	0
Outpatients		0	0
Pathway Payments		0	0
Non-PbR		0	0
Sub-total; Clinical Income		**0**	**0**
Divisional Income			
Additional activity		0	0
Other income		0	0
Sub-total; Divisional Income		**0**	**0**
Total; Income		**0**	**0**
Pay Expenditure:	WTEs		
Medical staff	0.00	0	0
Nursing staff	22.47	(198)	(790)
Other Clinical Staff	0.00	0	0
Admin & Clerical Staff	2.00	(10)	(40)
Sub-total; Pay Expenditure	**24.47**	**(208)**	**(830)**
Non-Pay Expenditure			
Direct Costs		0	0
Indirect Costs		0	0
Overheads		0	0
Sub-total; Non-Pay Expenditure		**0**	**0**
Total; Expenditure		**(208)**	**(830)**
Total; Net Expenditure		**(208)**	**(830)**

5 Implementation & Delivery

Estimated timescales for recruitment are 6 to 12 months for Band 5 staff nurse roles and 3 to 6 months for all other roles.

Currently between UMAC, AMU and MSSW there are 3.98 WTE Band 5 vacancies, there is a risk that if additional funding is approved the unit may be unable to recruit to these positions. To mitigate against this there are ongoing processes to improve vacancy rates. Initiatives include holding nurse recruitment days; indeed previous Acute Medicine recruitment open days in November 2018 and March 2019 were successful, resulting in 9 nurses being recruited across both days. In addition, the unit will develop a new education competency framework to help with staff retention, and ensure rolling adverts for nursing posts to continue recruitment drive.

In addition, the Division wishes to highlight that another recommendation within the RCP review was for Acute Medicine to review the bed base for AMU and work to develop a high dependency (HD) area. The development of a HD area forms part of Acute Medicine's strategy but, in recognition that getting the correct nurse staffing levels in Acute Medicine needs to be the first priority and will take time to achieve, is not something the Division wishes to develop until after the nurse staffing levels set out in the business case are achieved. To create a HD area will require further additional investment in Acute Medicine's MDT staffing; consequently a further business case will be developed and submitted to TMB when the Division is in a position to take this proposal forward.

6 Conclusions & Recommendations

This business case recommends the staffing model and funding of £830k as highlighted in option 2.

APPENDICES

- **Appendix 1** – Ward Templates

ACU AMU MSSW OPTION 2 YEAR 1 10.

References

Royal College of Physicians and SAM (2019) *Standards for Ambulatory Emergency Care.*

SAM (2011). *Workforce Planning considerations for acute medical units: a guidance paper and toolkit.* SAM: London

Board of Directors	
Agenda Item	21
Title of Report	Medical Engagement Survey
Date of Meeting	6.11.2019
Author	
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**	For Noting
Data Quality Rating	Gold - externally validate
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The Medical Engagement Scale (MES) survey was completed in October 2019. This showed a marked improvement compared to 2017. Seven of the ten MES scales were rated in line with the medium relative engagement band and three MES scales were rated in line with the high relative engagement band compared to external norms. These 3 scales were:

- Having Purpose and Direction
- Participation in Decision Making
- Work Satisfaction

This brief summary is for noting.

2. Background

In 2017, the MES survey showed all ten MES scales fell within the lowest relative engagement band compared to the external norms. In the interim, there have been changes in leadership and culture. Specifically, the Trust has focused on leadership development (for example, the Top Leaders programme), and expected values and behaviours through extensive engagement with staff. The MES survey was, therefore repeated in 2019 to reassess senior clinician engagement

There has been a 42% MEI improvement in overall medical engagement. There have been large percentage improvements in medical engagement with respect to all of the MES scales between the 2017 and the 2019 MES surveys. In particular, the three largest overall changes have occurred with respect to:-

- Having Purpose & Direction 48% Improvement
- Participation in Decision-Making & Change 44% Improvement
- Climate for positive Learning 42% Improvement

Medical staff with managerial responsibility were highly engaged with respect to nine of the ten MES scales

3. Key Issues/Gaps in Assurance

In some areas of the Trust there are residual low levels of medical engagement notably in the Surgical division and acute areas within the Medicine and Acute division (ED, AMU and stroke). SAS doctors also reported low levels of engagement

4. Next Steps

The priorities will be:

1. To maintain high levels of engagement in those reported areas.
2. To develop an action plan to address specific staff groups, or specialties, with low levels of engagement

5. Conclusion

Medical engagement has improved significantly, although the views of medical staff are not consistently positive across the Trust. This will be addressed in order to enhance medical engagement further.

6. Recommendations

The Board of Directors notes the paper.

BOARD OF DIRECTORS	
Agenda Item	22
Title of Report	CQC Action Plan Progress Update
Date of Meeting	6th November 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	To be confirmed.
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for **assurance** to the Board **The Board is invited to receive and consider this report**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 30TH OCTOBER, 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	

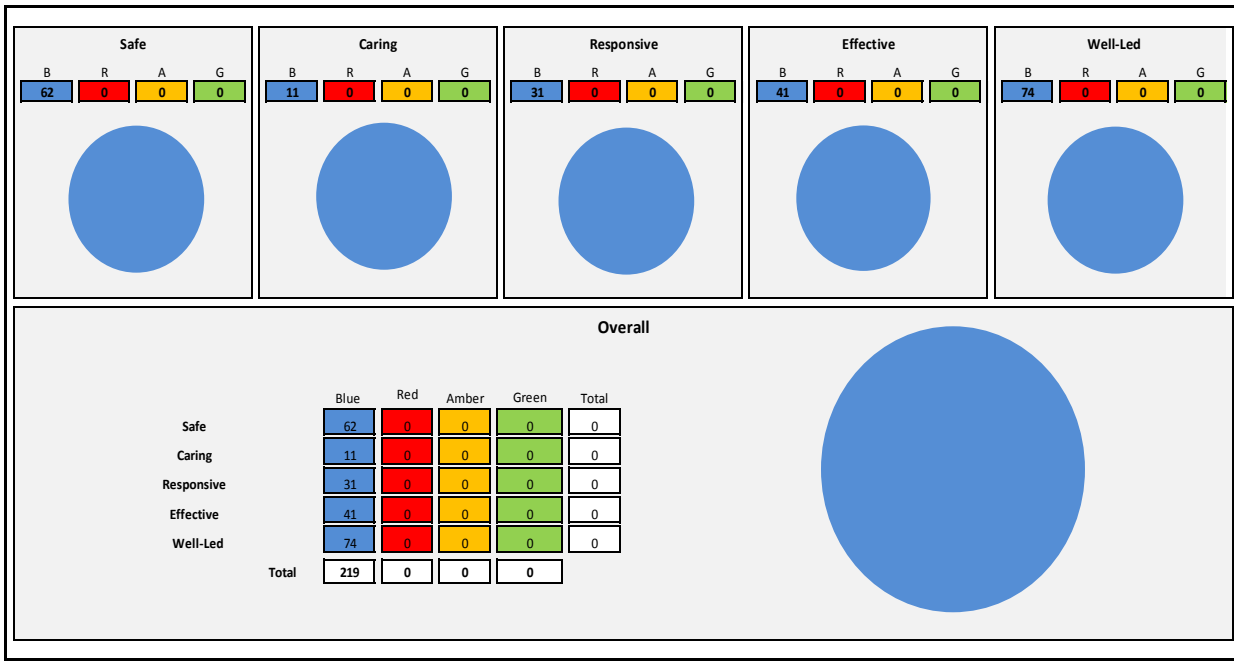
The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **220** specific actions/work-plans for implementation on or before **31st August 2019.**

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

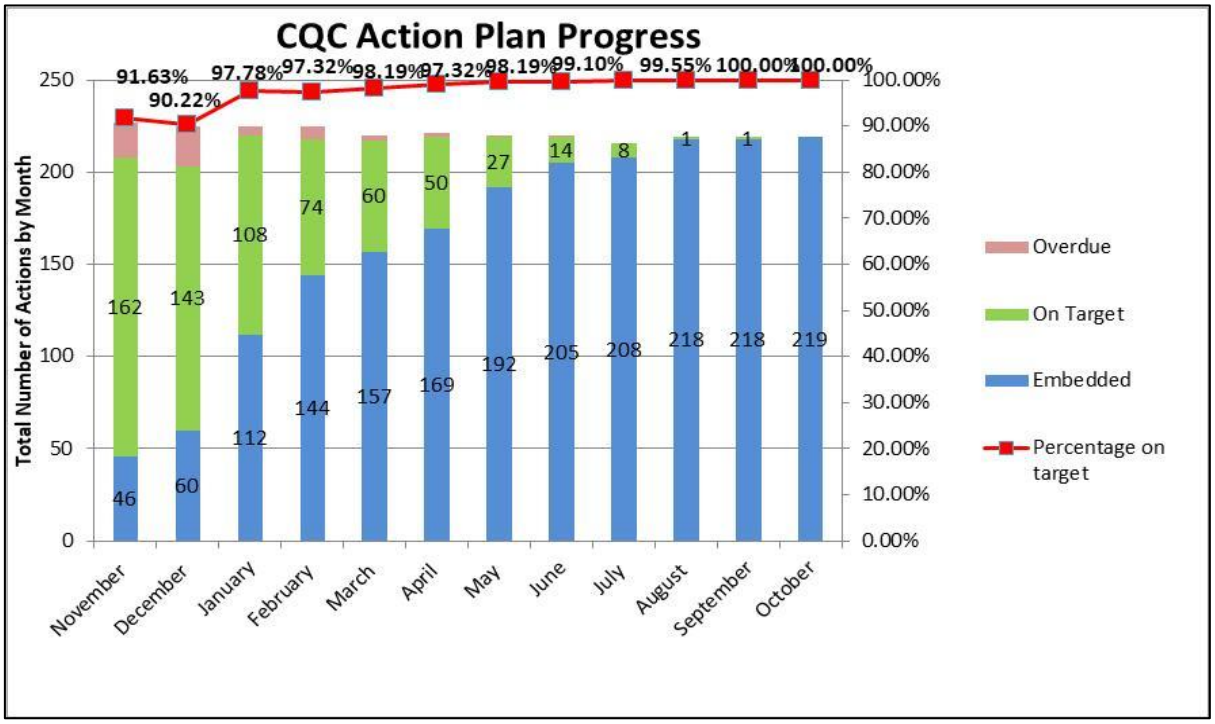
4.0 CQC Action Plan Progress – 30TH OCTOBER 2019

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 all 219 of these actions have been fully embedded and rated as Blue.

The main action plan is now fully completed with all actions embedded (Blue Rated).

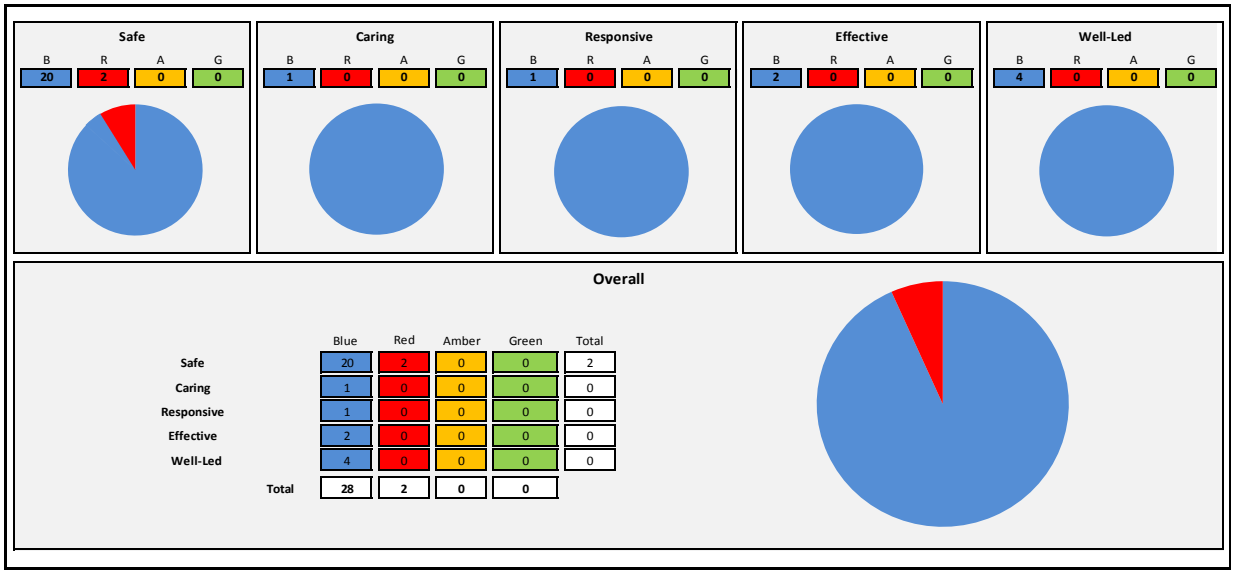


Embedded - (3 months plus compliance)
Completed
On track
At Risk

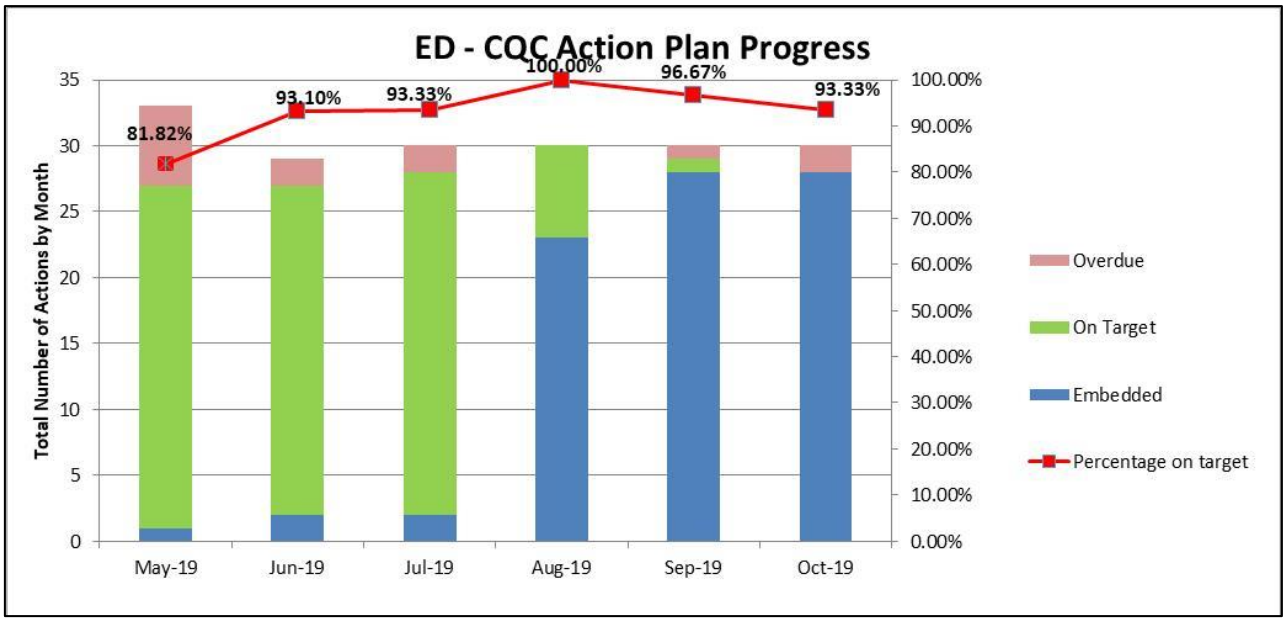


4.1 CQC Urgent Care Actions

The graphs below summarise the current position of the Emergency Department CQC action plan. There are 2'at risk' items (red rated) for this reporting period. First is 227 which relates to corridor care and was red rated last month; the second is specialist paediatric nurses in ED which has breached its target completion date of 30th September.



Embedded - (3 months plus compliance)
Completed
On track
At Risk



5. EXCEPTIONS

The Urgent Care at risk action (RED Rated) relates to the use of *'Corridor Care'.* Although the Trust achieved a period of zero *Corridor Care* usage in the early summer, it has again used *Corridor Care* in August and September, although at significantly reduced levels (90% reduction from peak usage) – see **Annex A (i).**.

The action relating to compliance with the RCPCH recommended staffing levels for paediatric trained nurses within ED had a target completion date of 30 September, which has now breached.

The Division have agreed an appropriate management approach for this action and it is expected that this will be completed before the end of November 2019, wherein this action will be concluded, subject to the necessary approvals from the Divisional triumvirates (Medicine & Acute/ Women's & Children).

It should be noted that there is internal disagreement on the efficacy and practicality of the RCEM Guideline relating to the 24/7 provision in ED of specialist paediatric nursing staff; and further clarification on this issue is being sought from the regulator.

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 1 additional action 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:

- 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 e.g. 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
227	**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)	Should Do	10 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Cease routinely treating patients in corridors (except for mass casualty events or extreme and unpredictable surges in demand for urgent care)	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**24.09.19** - Although use of corridors has fallen significantly from 2018 (90% reduction and is for a shorter period) - Corridor care is being used at low levels on a regular basis. **12.08.19** - Increase in capacity within majors. Winter planning creating additional 40 beds. **11.06.19** - How confident in PFIG programme that this will be delivered by September 19 **02.05.19**: 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 **11.06.19** - RCA has had a positive impact but this has been flagged as a risk ACTION: Graph to show improvement trajectories	
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		**26.09.09 -** The Divisional triumvirate have agreed approach to management of this action .Details of management plan will be available before the 30/09/19 **12.08.19** - Awaiting agreed response to aco this issue form ED and W&C **11.06.19** - It was requested that ED staff make a decision on agreed way forward and devise an implementation plan **21.05.19** - 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 October 2019)

225	**ENGAGEMENT** **The trust should ensure that engagement with staff, patients and the public is improved.** **Surgery :** **The service should consider patient engagement in future service developments.**	Corporate / Trust-Wide Issues	Should Do	17 – Good Governance	Well Led	Develop and launch an engagement strategy	Executive Director of Workforce	Assistant Director of Organisation Development, Head of Patient Experience, Head of Communications.	31/03/2019		**26.09.09** The Divisional triumvirate have agreed approach to management of this action. Details of management plan will be available before the 30/09/19 We will develop a staff engagement strategy - Helen to do a paper We will develop a patient engagement strategy - Gaynor to do a paper **09.04.2019** Draft engagement strategy is in place - now needs to be consulted with other parties and will be approved at WAC **02.05.2019** - External review of draft strategy is taking place. Strategy will then be issued for consultation. **12.08.19** - Awaiting confirmation of engagement strategy launch	

Board of Directors	
Agenda Item	23
Title of Report	2020 Schedule of meetings
Date of Meeting	6th November 2019
Author	Andrea Leather, Board Secretary
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Choose an item
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The 2020 schedule of meetings encompasses Board, assurance meetings and the management meetings that report into Trust Management Board (TMB). Where possible I have tried to hold Assurance Committees that have similar members, particularly in relation to NED's attendance trying to combine the frequency of visiting the Trust.

Following discussion at the October 2019 Board of Directors meeting it was agreed to review the scheduling of some Committees:

- Finance, Business, Performance Assurance Committee – increase frequency to monthly to ensure pace and to facilitate the agenda. The proposed dates included in the revised 2020 schedule have been agreed with members of the Committee.
- Workforce Assurance Committee – move to Tuesday or Thursday to ensure clinical engagement, this has been actioned in the revised schedule.

As a reminder for members of the Board, for the majority of the year the Board meetings will be held on the first Wednesday of the month with the following exceptions:

- **January 2020** – due to a number of factors this will be held as per the 2019 schedule on the last Wednesday of the month, 29th January 2020.

- **February 2020** – there will be no Board meeting this month due to the timing of the January meeting.

- **May 2020** – will require an additional meeting to sign off the Annual Report & Accounts (based on the 2019 guidance the deadline for submission is likely to be Wednesday 27th May 2020) therefore it is proposed to hold the meeting on Tuesday 26th May as single agenda item.

There is a possibility that Finance, Business, Performance & Assurance (FBPAC) currently scheduled for 23rd January 2020 may be required to be rearranged, this will be dependent on the timeframe for submission of the annual plan.

Note: Safety Management Assurance Committee is a time limited meeting and therefore has only been scheduled until end of quarter 1.

2. Next Steps

Following approval, the finalised schedule will be circulated along with timings and venue details, where possible calendar invites by the PA who supports the meeting.

3. Recommendations

The Board of Directors is asked to:

- approve the revised 2020 schedule of meetings

Schedule of Meetings 2020

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan	BH			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S	SAFETY MAN CTTE AUDIT CTTE	2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		W'FORCE CTTE TMB	CHAR FUNDS CTTE	*FIN BUS PERFORM / Q&S CTTE		S	S			BOARD		
Feb	S	S						S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S	SAFETY MAN CTTE	2 x DIVISION PERFORM REVIEW CoG	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		TMB	RESERVED DAY	FIN BUS PERFORM		S		
March	S			BOARD			S	S		CLINICAL CARE STEERING GROUP		RISK MAN CTTE	PAT SAFE & QUAL BOARD	S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		SAFETY MAN CTTE/ W'FORCE CTTE	FIN BUS PERFORM / Q&S CTTE	TMB		S	S		
April	BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD	BH	S	S	BH	2 x DIVISION PERFORM REVIEW CoG	PROG BOARD AUDIT CTTE	0 x DIVISION PERFORM REVIEW		S	S		RESERVED DAY	TMB	SAFETY MAN CTTE		S	S		FIN BUS PERFORM			
May		S	S			BOARD		BH	S	S		RISK MAN CTTE	PROG BOARD	PAT SAFE & QUAL BOARD	TMB	S	S	SAFETY MAN CTTEE	2 x DIVISION PERFORM REVIEW	AUDIT CTTE (conf with Ex Audit)	2 x DIVISION PERFORM REVIEW	FIN BUS PERFORM / Q&S CTTE	S	S	BH	BOARD (am) W'FORCE CTTE				S	S
June			BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW	TMB	S	S		SAFETY MAN CTTEE		FIN BUS PERFORM	RESERVED DAY	S	S		
July	BOARD			S	S						S	S		RISK MAN CTTE CoG	PROG BOARD	PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW		2 x DIVISION PERFORM REVIEW		S	S		W'FORCE CTTE / CHAR FUNDS CTTE	FIN BUS PERFORM / Q&S CTTE	TMB	
Aug	S	S			BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S			PROG BOARD	FIN BUS PERFORM		S	S				TMB		S	S	BH
Sept		BOARD			S	S		RISK MAN CTTE / CLINICAL CARE ST GROUP		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW	RESERVED DAY	S	S		AUDIT CTTE / W'FORCE CTTE		TMB		S	S		FIN BUS PERFORM / Q&S CTTE	AMM	
Oct			S	S			BOARD			S	S			RISK MAN CTTE		PAT SAFE & QUAL BOARD	S	S	CoG	2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		CHAR FUNDS CTTE TMB	CoG & BOARD AWAY DAY	FIN BUS PERFORM		S
Nov	S			BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW	RESERVED DAY	S	S		AUDIT CTTE / W'FORCE CTTE	FIN BUS PERFORM / Q&S CTTE	TMB		S	S		
Dec		BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S			PROG BOARD	TMB		S	S		FIN BUS PERFORM			BH	S	S	BH			

Board of Directors

Agenda Item	24
Title of Report	Board Assurance Framework
Date of Meeting	6th November 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 September 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) Overall risk rating for 'Primary Risk 4' – likelihood reduced to 3 – following stand down of 'outbreak' designation.
d) 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.

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 28th October 2019)

NHS
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.

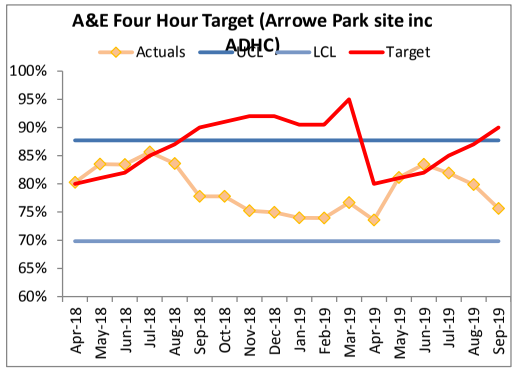
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

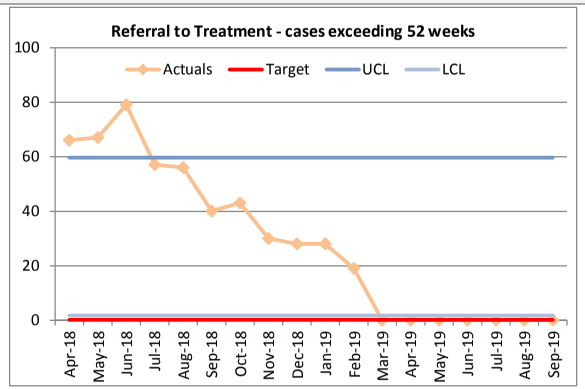
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that 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	24/09/2019	**Risk rating**	**25. Significant**	**12. High**		
		Last changed	28/10/2019	**Anticipated change**	Intensifying			
Details of change	Updated gaps in assurance/action to address gap and assurances documented							

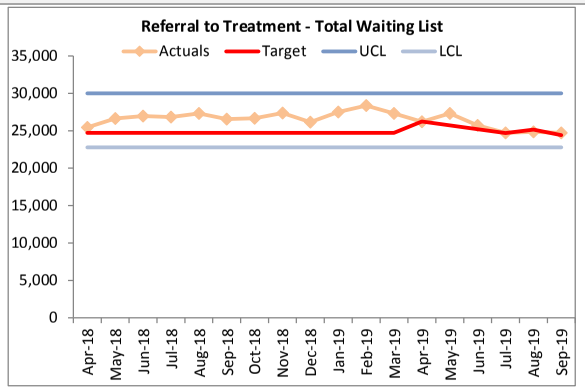
Risk Vector (what might cause this to happen)	**Primary Risk Treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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** (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 change programme Review of outpatient processes **SLT Lead:** COO/ Transformation Lead **Timescales:** As per change 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 ▪ Change Programme report to Board of Directors (monthly) **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	Internal performance metrics to highlight organisational risk **Action:** A request to be made to review the internal metrics within the 'responsive' domain	Negative
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	Inconclusive
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 ▪ A&E Board (monthly)	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	Positive

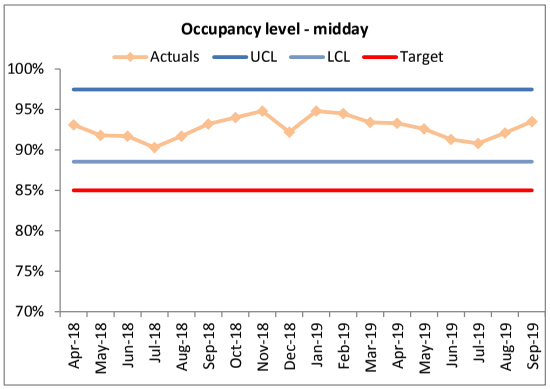
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

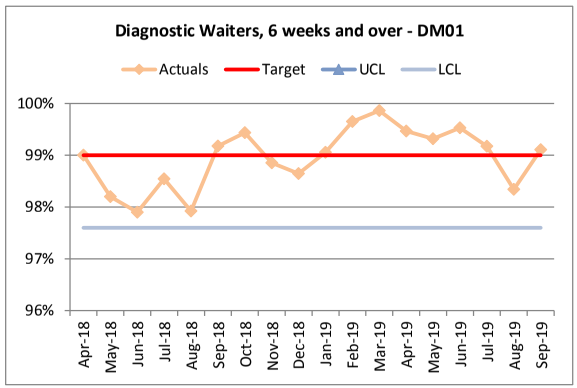
Key risk indicators (KRIs) – Data updated 28/10/19

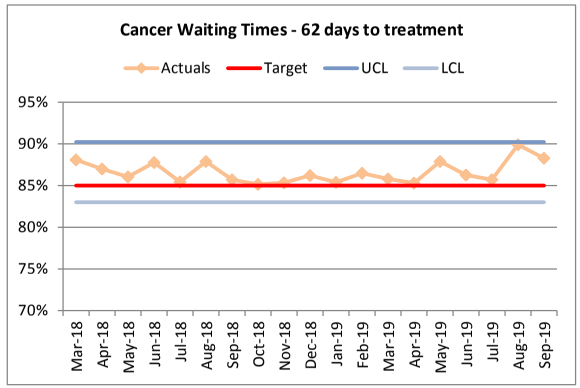




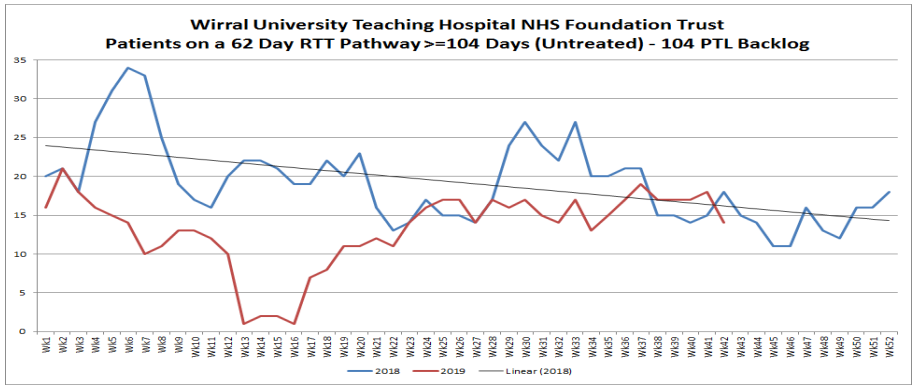








WUTH activity (Admitted, Discharges & Net flow)
To be developed



Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 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	25/09/2019	**Risk rating**	**20. Significant**	**12.High**		
		Last changed	28/10/2019	**Anticipated change**	Intensifying			
Details of change	Updated gaps in control, plans to improve control and assurances documented							

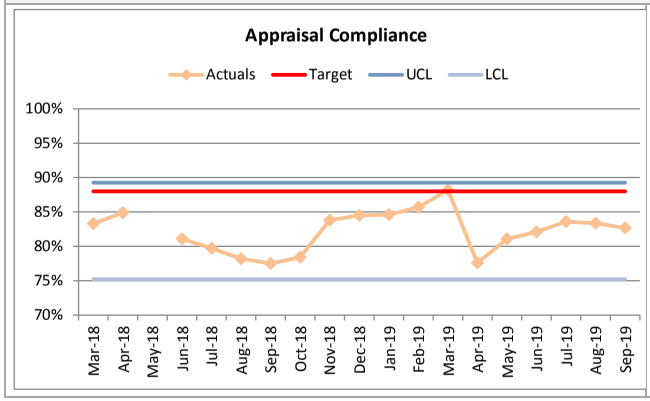
Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 workforce issue inc hard to recruit groups ▪ Medical staffing review ▪ Workforce Strategy and Implementation Plan ▪ Vacancy rates for nursing posts monitored through T&F Group	Vacancy rates / high locum use and hard to recruit medical posts	Bed modelling & specialty capacity/ demand review **SLT Lead:** COO **Timescales:** Sept '19 (TMB)	**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) ▪ Medical Staffing Action Plan Steering Group established (frequency to be agreed) **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 ▪ MIAA Safe Nurse Staffing (Substantial) ▪ MIAA Recruitment Process Review (Substantial)	None identified	Negative
		Lack of control re: recruitment	Recruitment to be brought back in-house to enable greater control **SLT Lead:** Dir HR **Timescales:** Q4 (due to 6 mth notice)			
		Impact for consultants re: tax implications	Establishment of Pension Working Group to consider options (inc national consultation on reforming pensions) **SLT Lead:** Dir HR **Timescales:** Sept 2019			
		Zero hour contracts in relation to doctors and employment tribunal claims	New contract being issued – in line with legal requirements **SLT Lead:** Dir HR **Timescales:** Sept 2019			
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 ▪ Attendance Management procedures ▪ Oversight of OD delivery via Workforce Assurance Committee ▪ Introduction of Health & Well-being Programme and Employee Assistance Programme	Unsustainable levels of sickness absence	Pilot for External Sickness Management Solution **SLT Lead:** Dir HR **Timescales:** until Jan 2020	**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) ▪ Business case for External sickness management solution ▪ Pilot of external sickness management solution – report Sept '19 ▪ Exception Report – Board of Directors (Sept '19) **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 ▪ Workforce Key Performance Indicators (KPI's) **Level 3** ▪ National Staff Survey (Mar 19); ▪ CQC Report (Mar '18); ▪ Medical engagement survey	None identified	egative
			Effective manager programme roll-out **SLT Lead:** Dir HR **Timescale:** September 2019			

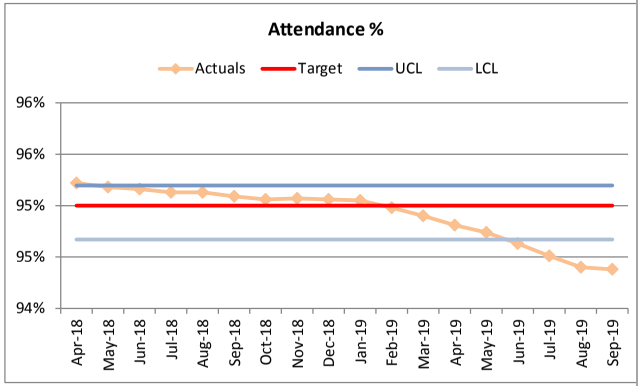
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

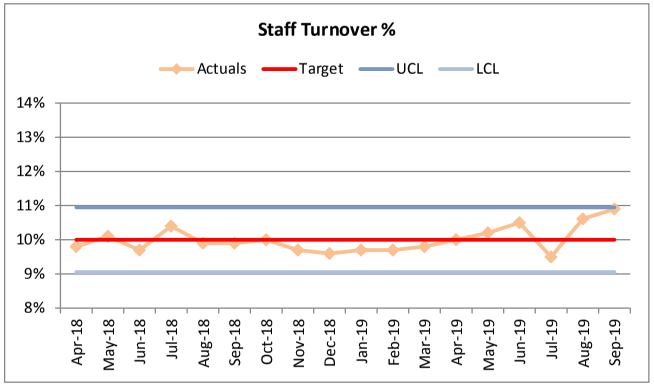
Proximity of threat 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) ▪ The LHRP co-ordinated response.	Limits to the extent contingencies can provide the state required in emergency	Test EPRR arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by end Q4 '20	**Level 2** ▪ Resilience Assurance report to RMC (Mar; Sept 19) ▪ EPRR Assurance Statement of Compliance **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	**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			

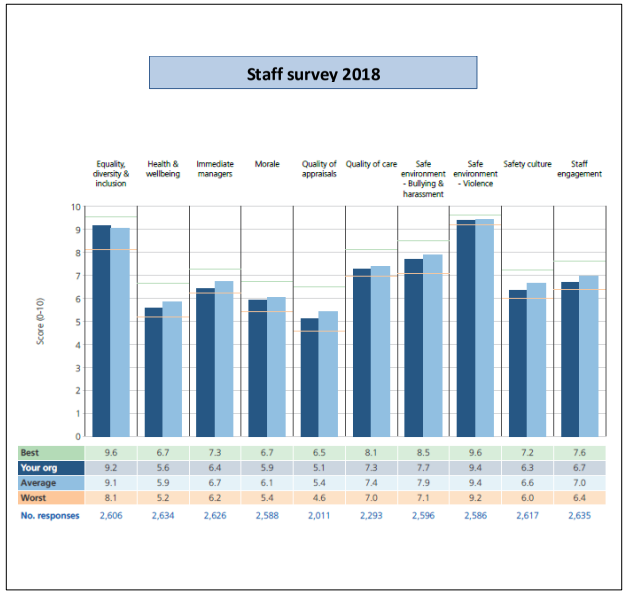
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

Key risk indicators (KRIs) Data updated 28/10/19



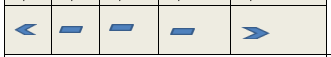






Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

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		
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	4. High	**Risk appetite**	Open
		Last reviewed	24/09/2019	**Risk rating**	**20. Significant**	**8. Medium**		
		Last changed	28/10/2019	**Anticipated change**	Intensifying			
Details of change	Updated plans to improve control and assurances documented							

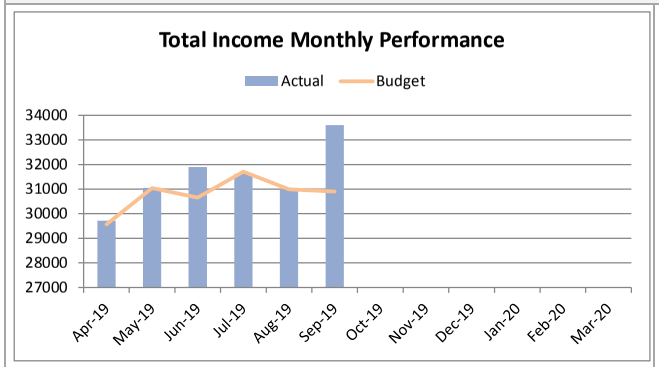
Risk Vector (what might cause this to happen)	**Primary risk controls** (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable 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 ▪ Embedded service line reporting ▪ Courses throughout the year provided for Budget holders ▪ Introduction of extra-ordinary controls: CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay); Discretionary non-pay sign off escalation; Forecasting review based on issues and interventions	▪ 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	To acquire and review assurances against the 12 e-roster standards for each Division Note: enhance control against standards where indicated **SLT Lead:** Ch. Nurse **Timescales:** End of September '19 Develop & agree MTFM **SLT Lead:** FD **Timescales:** End of Q4 Development of System Financial Recovery Plan (FRP) **SLT Lead:** FD **Timescales:** Sept '19	**Level 1** ▪ Divisional risk reports to Risk Committee bi-annually; ▪ E-roster data reviewed at Workforce Assurance Committee (quarterly) ▪ Weekly CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay) **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	Negative
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 Q4	**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	Negative

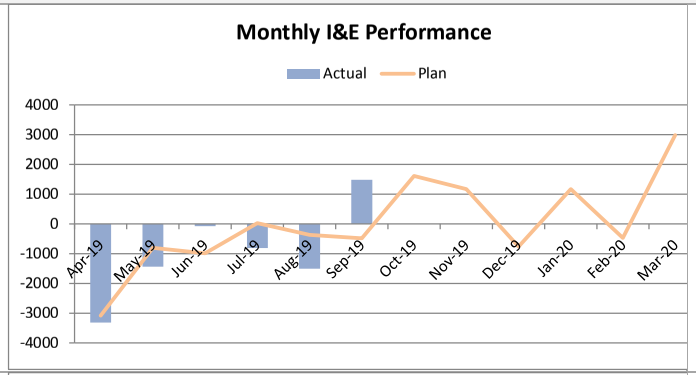
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

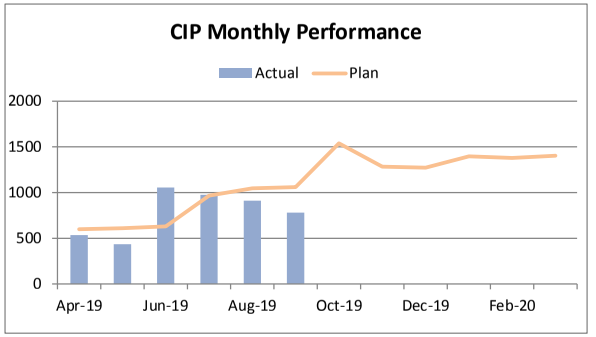
Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Treasury loan process/NHSI Capital approval process. ▪ Planned and preventative maintenance regime in place based on compliance ▪ 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.	Draft Estate Strategy to be developed informed by 6 facet survey **SLT Lead:** COO **Timescales:** Oct '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 – Board of Directors – Aug '19 ▪ Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	Positive
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 ▪ Safety Management Strategy	▪ 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		**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 ▪ Independent safety management audit (Arcadis)		Inconclusive

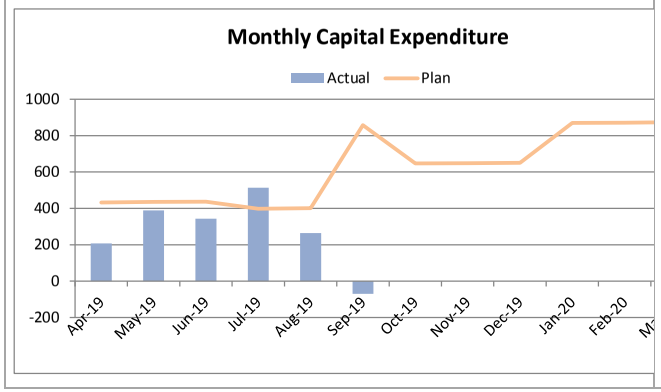
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

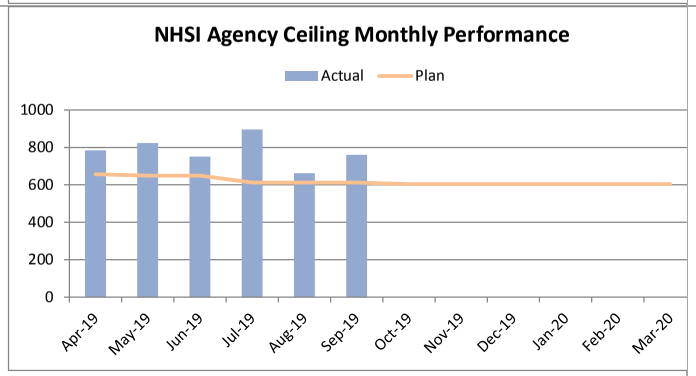
Key risk indicators (KRIs) Data updated 28/10/19



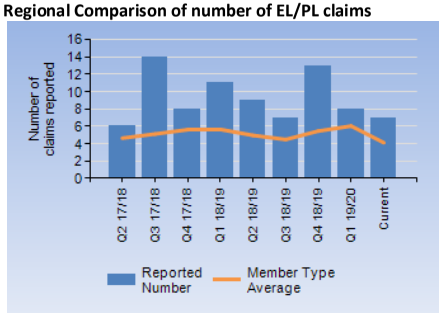




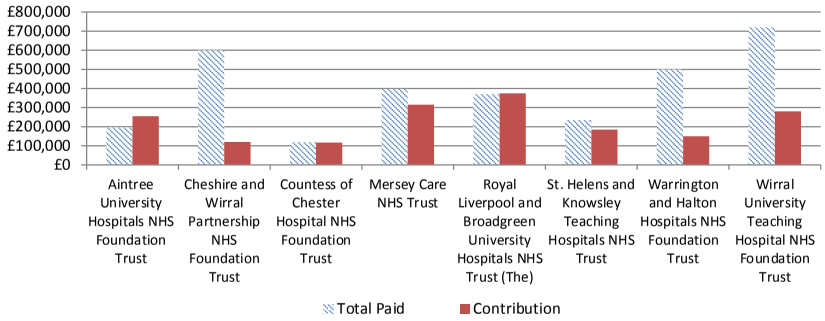




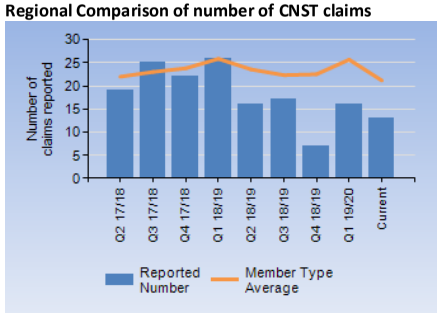
Regional Comparison of number of EL/PL claims



Regional comparison of RPST contribution and level of compensation paid

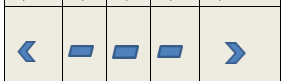
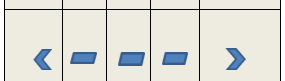


Regional Comparison of number of CNST claims



Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 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	24/09/2019	**Risk rating**	**20. High**	**9. Medium**		
		Last changed	28/10/2019	**Anticipated change**	Uncertain			
Details of change	Updated gaps in control, plans to improve control and assurances documented							

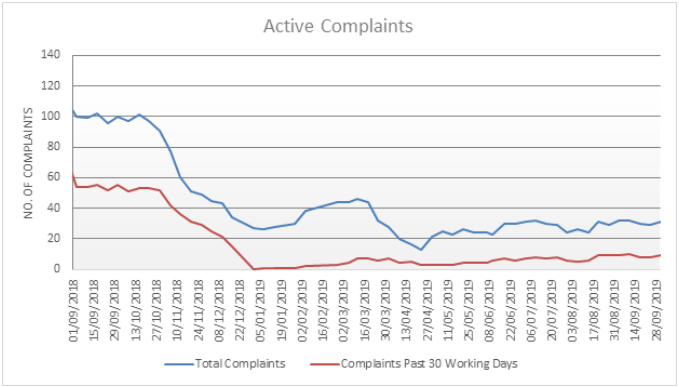
Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 • Robust Infection Prevention Control plan in response to *Clostridium difficile* outbreak • Ward Managers prioritising areas for maintenance works to inform overall Estates Strategy			**Level 1** • Perfect ward/ ward accreditation audits; Divisional reports to IPORT • IPC task & finish group (weekly) to review actions • Standing item on Board agenda (monthly) **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 IPC Action Plan reflects changes in cleaning practice – reported to Board Sept '19	Inconclusive
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 • Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission	Current levels of mortality review and structured judgement review where these are indicated	Triangulation of mortality reviews – patient/carer experience, deaths in ED included **SLT Lead:** Deputy MD **Timescales:** By end Q2 '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; ▪ MIAA 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

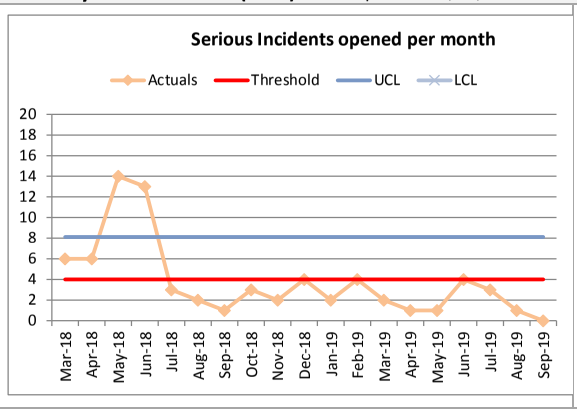
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

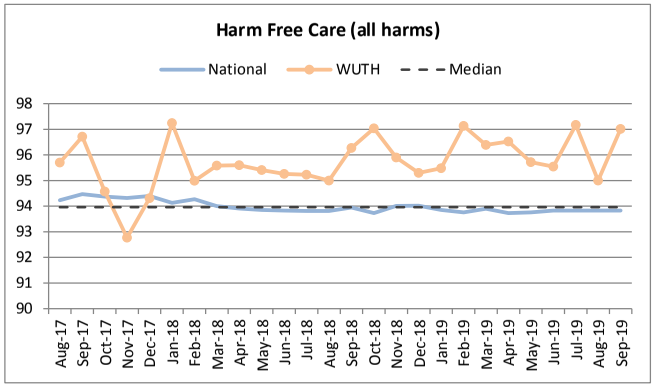
Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	**Key Measures** - We have the ability to 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:** end Q4 **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 Note: delay due to upgrade concerns **Timescales:** Oct '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 • MIAA Activity Data Capture (Limited assurance)	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. NB. Test to be agreed by end Sept. **SLT Lead:** Dir IT & Info **Timescales:** Sept 19	Inconclusive

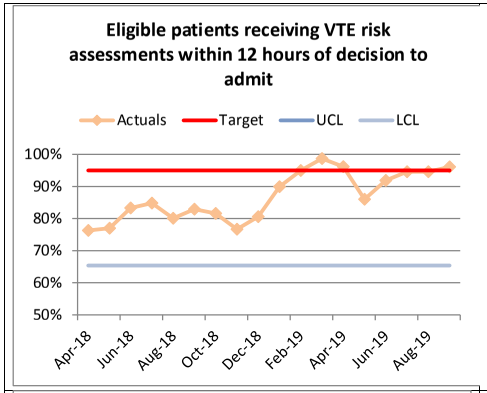
Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

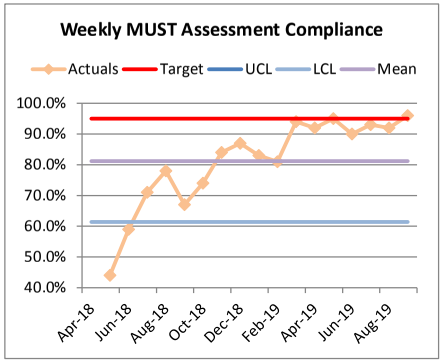
Key risk indicators (KRIs) - Data updated 28/10/19

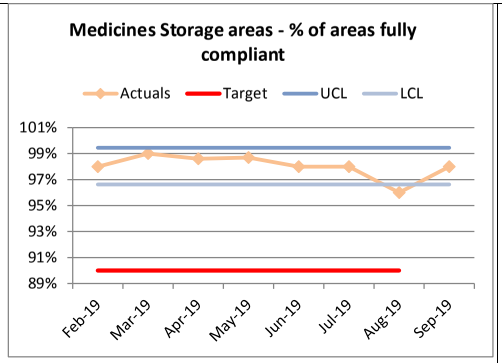


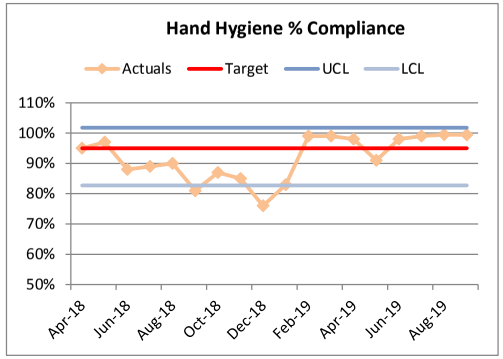


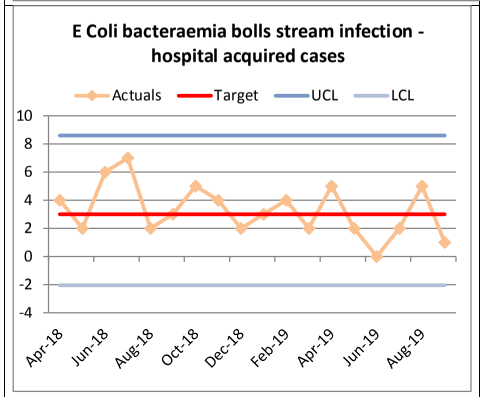


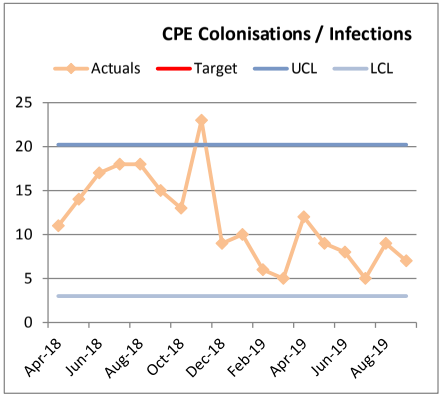


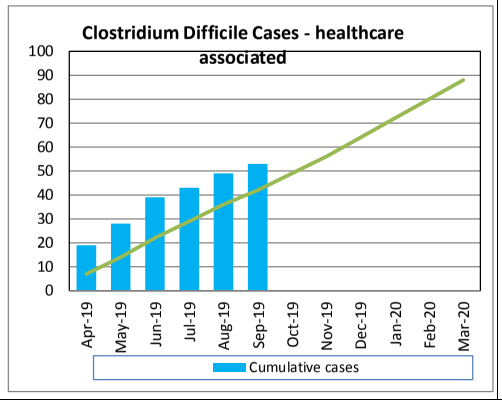


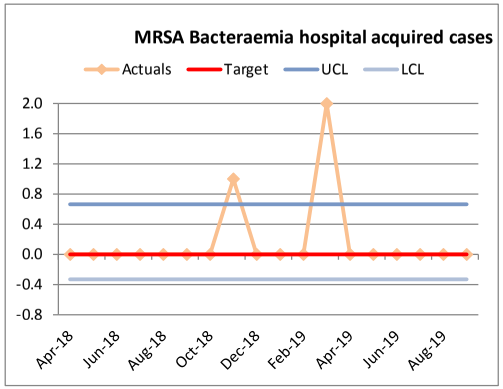












Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

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	24/09/2019	**Risk rating**	**15. Significant**	**5. Med**		
		Last changed	28/10/2019	**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 Note: awaiting notification of central funding	**Level 1** ▪ IG & Clinical Coding Group ▪ Cyber Security Progress Report to FBPAC (Sept '19) **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 ▪ National Cyber Essential Certification (Board of Directors – Sept '19)	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 end September 2019. **SLT Lead:** COO **Timescales:** Oct '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 Report to Risk Management Committee (Sept '19) ▪ EU Exit preparation update to Board (Mar 19) ▪ EPRR Twice yearly report to RMC (Mar; Sept) ▪ EPRR Annual Report (Sept '19) ▪ EPRR Compliance Statement (Sept '19) **Level 3** ▪ Letter of assurance, DoH		Positive

Key risk indicators (KRIs) Data updated 28/10/19

EPRR

Confirm and Challenge by NHS England Regional team and CCGs

September 2019:

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	4213	96%
Server Patching	274	80%
Anti Virus		Compliance levels (Target 95%)
Desktop	4213	97.8%
Server	274	91.8%

Inactive directory device accounts	Mar '19	May'19	July'19	Oct'19
60 days (Notice issues)	48	396	345	17
90+ days to be disabled	79	296	276	100
Web filtering				
Access requests authorised	20(AV)	25	18	32*
Removable media				
Additions to the whitelist	0	0	0	4**

Planned Preventative Maintenance performance measure – to be developed

Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 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	25/09/2019	**Risk rating**	**12. High**	**5. Medium**		
		Last changed	28/10/2019	**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 ▪ Delivery of all elements of 2018 CQC inspection 'must do and should do's'	Compliance:- ▪ Infection prevention ▪ Medicines storage ▪ Estate Condition ▪ ED Triage within 15 mins arrival	Deliver all elements of 2019 Urgent & Emergency care CQC inspection 'must do and should do's' **SLT Lead:** DoQ&G **Timescales:** Dec 2019 Development of Estates Strategy following receipt of 6 facet survey **SLT Lead:** COO **Timescales:** Autumn 2019	**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) ▪ 6 Facet Survey (Aug 2019)	None identified	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 | | | 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 Note: Draft Strategy to be discussed at Workforce Assurance Committee (November '19)	**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

Board Assurance Framework (BAF): 2019/20 (valid as of 28th October 2019)

Key risk indicators (KRIs) Data updated 28/10/19

CareQuality Commission

Wirral University Teaching Hospital NHS Foundation Trust

CQC overall rating

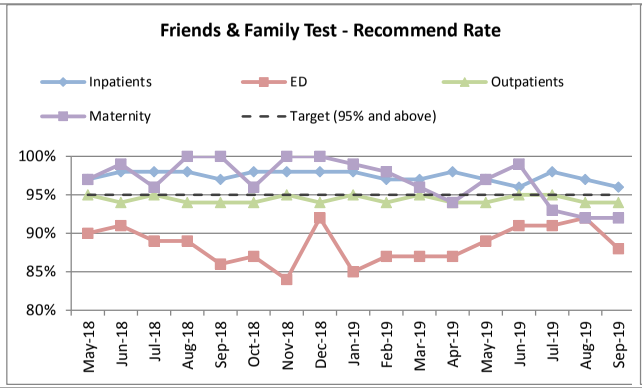
Requires improvement

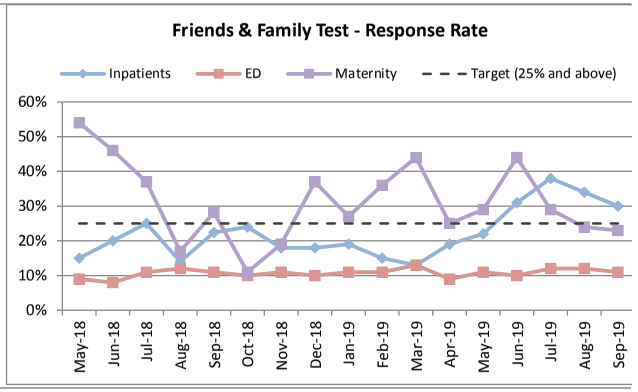
13 July 2018

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 – 28/10/19

	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					
Tel: 0151 678 5111, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE, 1.0 miles away	n/a Data not available	Requires Improvement Visit CQC profile	OK Within expected range with a value of 69%	OK Number of deaths within the expected range	OK 79.69% Within the middle range
Clatterbridge Hospital Remove					
Tel: 0151 334 4000, Clatterbridge Road, Bebington, Wirral, Merseyside, CH63 4JY, 5.0 miles away	n/a Data not available	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

Board of Directors

Agenda Item	25
Title of Report	Seven Day Service Provision (Board Assurance Framework)
Date of Meeting	6th November 2019
Author	Mike Ellard, Deputy Medical Director Nicola Stevenson, Medical Director
Accountable Executive	Nicola Stevenson, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1: Demand that overwhelms capacity to deliver care effectively PR4: Catastrophic failure in standards of safety and care
Level of Assurance • **Positive** • **Gap(s)**	There are gaps with mitigating action.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This reports summaries the Trust's proposed November submission data for Seven Day Hospital Services to NHSI and NHS England

Key findings for the 4 priority standards are:

i. Clinical Standard 2: specifies that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

   We are not meeting this standard

ii. Clinical Standard 5: Hospital Inpatients must have scheduled seven -day access to consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients**.**

   We are compliant with this standard (minor variance; see further information within key issues and gaps)

iii. Clinical Standard 6: Hospital inpatients must have 24-hour access seven days a week to key consultant-directed interventions that meet the specialty guidelines, either on – site or through formally agreed network arrangements with clear written protocols

   We are compliant with this standard

iv. Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate).Once a clear pathway of care has been established , patients should be reviewed by a consultant at least every 24 hrs unless it has been determined it would not affect their pathway.

   We are partially meeting this standard

2. Background

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services ('providers') to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on **four priority** standards identified in 2015 with the support of the Academy of Medical Royal Colleges
To replace a survey, which was used previously, a Board Assurance framework (BAF) has been developed to ensure provider boards have direct oversee of reporting of this work and progress.

3. Key Issues/Gaps in Assurance

i. Clinical Standard 2; consultant-directed assessment

Non-Compliant

Weekday			
Month	No. reviewed	Review within 14 hours of DTA	Review within 14 hours of DTA
Jul-19	69	39	57%
Aug19	91	55	60%
Sep19	88	57	65%
		Overall	61%

Weekend			
Month	No. reviewed	Review within 14 hours of DTA	Review within 14 hours of DTA
Jul-19	41	18	44%
Aug19	29	14	48%
Sep19	40	20	50%
		Overall	47%

This figure is obtained from a point prevalence audit within the trust based on approximately 120 patients (excluding maternity).

Clinicians within the trust have been supporting the Medical Director to improve patient flow within the organisation. There has been a PDSA to standardise and optimise the flow of patients who attend the ED to the appropriate care setting through a 2 week test of clinical streaming for both ambulatory and ambulance conveyed patients attending ED.

It is possible that there may be a record of non-compliance when patients are following a clinical agreed pathway, based on national guidance and do not warrant a consultant review. Clinical pathways for assessment/ treatment (developed based on national guidance) are not evident when reviewing patient notes.

A previous audit undertaken on patients presenting through the Emergency General Surgery is awaiting formal review from clinicians to ascertain the if this would significantly alter the audit result.

ii. Clinical Standard 5, access to Diagnostics services

Compliant

Variation - We remain assessed as compliant apart from slight variation within access to echocardiogram which has the following arrangement:

- Informal arrangement with on call cardiology consultant.
- Critical Care Consultant capability to support in emergency

iii. **Clinical Standard 6 Access to consultant directed interventions**
Compliant

iv. **Clinical Standard 8 : All patients with high dependency needs should be seen and reviewed by a consultant twice daily**
Non – complaint

A point prevalence audit was undertaken to review patients in the critical care area. This took place at end of Qter2 2019/20. 25 patients were reviewed to ascertain consultant review for the first 5 days of their episode of care on Critical Care. Over the five days the compliance was 83%.

This has been reviewed with the CSL who has agreed with the findings and confirmed similar findings on our own audit. He was confident that patients are reviewed as a minimum of twice daily, often more when microbiology ward rounds and response to clinical change are taken into account. Job plans ensure that consultants are present from 0800 to 2100 to allow for 2 resident ward rounds per day and also ensure consultant review within 12hrs of admission. There are 2 potential failings. Poor documentation (either a review took place with no clinical change and therefore not documented or a trainee has documented without providing supporting evidence of consultant involvement) or difficulty identifying when a patient transitions from level 2 to level 1 and therefore no longer requires the twice daily review. He is confident patient care is not being compromised

Lung Support Unit has daily review by consultant with dedicated register review at the weekend.
Coronary care has daily consultant review 7 days with second delegated review in the weekday only.

4. Conclusion

The Trust is partially compliant with the four priority seven day service provision.

5. Recommendations / next steps

- Risk entry reflective of this assessment to be added
- Discussion with consultant colleagues and reinforce good practice in regard to documentation.
- Review of consultant job plans
- Continued focus on patient flow improvement programme; ensuring that patients are all admitted via assessment areas will provide a timely consultant review
- Gap analysis to ascertain what is needed to achieve the standards consistently across the Trust.

The Board is asked to

- note that the report and actions identified to mitigate areas non compliance.