Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

2 December 2020

together we will

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
12.30pm - Wednesday 2th December 2020
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21 184	Apologies for Absence	Chair	Verbal	N/A
20/21 185	Declaration of Interests	Chair	Verbal	N/A
20/21 186	Patient Story	Chief Nurse	Video	N/A
20/21 187	Minutes of Previous Meeting – 4 November 2020	Chairman	Paper	1
20/21 188	Board Action Log	Interim Director of Corporate Affairs	Paper	10
20/21 189	Chair's Business	Chair	Verbal	N/A
20/21 190	Key Strategic Issues	Chair	Verbal	N/A
20/21 191	Chief Executive's Report	Chief Executive	Paper	12
Performance & Improvement				
20/21 192	Quality and Performance Dashboards & Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	16
20/21 193	Financial Report including CIP	Chief Finance Officer	Paper	40
20/21 194	CQC Compliance and Action Plan Quarterly Update	Chief Nurse	Paper	56
20/21 195	Winter Plan 2020/21	Chief Operating Officer / Chief Finance Officer	Paper	91
Governance				
20/21 196	Annual Quality Account	Chief Nurse	Paper	117
20/21 197	Safe Staffing Report	Chief Nurse	Paper	171
20/21 198	6 Monthly Acuity and Dependency Nurse Staffing Report	Chief Nurse	Paper	179

20/21 199	Infection Prevention and Control – COVID 19 Update	Chief Nurse	Paper	186
20/21 200	Sickness Absence Report	Director of Workforce and OD		199
20/21 201	Diversity and Inclusion Annual Report	Director of Workforce and OD	Paper	203
20/21 202	Change Programme Summary, Delivery & Assurance	External Programme Assurance	Paper	225
20/21 203	Chair's Report – Audit Committee	Committee Chair	Paper	256
20/21 204	Chair's Report – Quality Committee	Committee Chair	Paper	259
20/21 205	Chair's Report – Finance, Business Performance and Assurance (FBPAC)	Committee Chair	Paper	260
20/21 206	Chair's Report – Charitable Funds	Committee Chair	Paper to follow	262
20/21 207	Chair's Report – Workforce Assurance Committee	Committee Chair	Paper	265
20/21 208	Trust Management Board Update	Chief Executive	Paper	269
20/21 209	Communications Monthly Board Report	Director of Communications and Engagement	Paper	273
20/21 210	Calendar of Meetings 2021/22	Interim Director of Corporate Affairs	Paper	278
20/21 211	Any Other Business	Chair	Verbal	N/A
20/21 212	Date of Next Meeting – 27 January 2021, via MS Teams	Chair	Verbal	N/A
20/21 213	**Exclusion of the Press and Public** To resolve that under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.			

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

4 NOVEMBER 2020

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 12.30 and Concluding at 15.00

Present

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

In attendance

Joe Gibson*	External Programme Assurance
Jacqui Grice	Director of Workforce
Jill Hall	Interim Director of Corporate Affairs
Sharon Landrum*	Diversity and Inclusion Lead
Jonathan Lund	Associate Medical Director, Women's and Children's Division
Chris Mason	Chief Information Officer
Oyetona Raheem	Interim Deputy Trust Secretary (Minutes)
Sally Sykes	Director of Communications & Engagement
Eileen Hume*	Public Governor

Apologies

John Coakley	Non-Executive Director
Mrs Jayne Coulson	Non-Executive Director
Simon Lea	Associate Medical Director, Diagnostic and Clinical Support
Ann Taylor	Staff Governor
Angela Tindall	Public Governor

*Denotes attendance for part of the meeting

Reference	Minute	Action
20/21 157	**Apologies for Absence**	
	Apologies for absence were noted as detailed in the attendance list above. The Chairman reported that he had been in touch with Angela Tindall, Lead Governor who had been unwell and that Angela had been in very good spirit. He acknowledged the presence of Eileen Hume, another Governor who was in attendance. The meeting conveyed their best wishes to Angela and wished her a speedy recovery.	
20/21 158	**Declarations of Interest**	
	There were no Declarations of Interests.	
20/21 163	**Patient Story**	

Reference	Minute	Action
	The Board viewed a video from a patient, who talked about her experience of being treated at WUTH. The patient has a learning disability (autism) and wanted to talk to the Board about how the Trust could make communicating with someone with a learning difficulty less worrying and confusing. The patient reflected on how she had been spoken to by medical professionals in the past and how this had made her more afraid or anxious because they used long words, medical language and terminology. Some tools were put in place by the WUTH specialist Learning Disability Nurse, Lauren Binks, including coloured cards to help the patient let doctors know when she understood things or when they needed to give her more explanation. This made the patient feel more in control and helped her understand the treatment she was receiving. The Board found the patient's story really insightful as a demonstration of person-centred care and the need to make adjustments for our patients to help them understand their condition and treatments. The video will be shared with staff and used in our staff training programme as part of the improvement we seek in transforming care for people with learning disabilities.	
20/21 176	**Change Programme Summary, Delivery & Assurance**	
	Mr. Joe Gibson talked the meeting through the change programme report and highlighted that there had been slight deterioration in governance ratings while delivery ratings had seen more significant deterioration. Mr. Gibson also gave detailed updates on the three priority areas of the programme delivery i.e. Outpatients, Flow and Theatres. He added that a flow vision had been developed and widely consulted on but needed a comprehensive schedule of work to deliver the vision including setting of priorities, phasing and resourcing. Mr. Gibson advised that Theatres had developed clarity and coherence as evidenced by the results that were gradually coming through. Outpatients had continued to exceed national targets but had some gaps in quality of assessment. John Sullivan asked if there was a clear understanding of the root causes of the capacity management that had made it impossible to achieve 100% accuracy. The Chief Operating Officer gave explanations on the challenges of knowing when beds became available and the length of time it took to clean the beds. A series of audits had been introduced to identify the issues on daily basis and actions were being taken at ward level. It was suggested that the use of bar code technology to manage bed capacity be considered as a future option. The Chief Information Officer explained some of the limitations of using this type of technology for capacity management. The Director of Strategy & Partnerships advised that the Programme Board had agreed to refocus the programme from January by providing more	

Reference	Minute	Action
	support for individual projects. He advised that there were plans to introduce quality improvement, productivity efficiency CIP and a real comprehensive workforce programme. The Chairman expressed concern about the inadequate progress in patients flow vision which had been identified as very critical to the Trust. The Chief Operating Officer gave explanations on the improvement works that had been undertaken. He advised that additional senior leaders had been allocated and the division had been split into two for effective monitoring. Discussions were held on the root causes of delay in declaring vacant beds during which it was recognized that to achieve higher occupancy rate required a whole team effort and cultural change. It was also recognized that the flow vision had the focus of the Executive team and that a clear vision of what needed to be achieved had now been established. **RESOLVED:** **a. That the report be NOTED and** b. **That the Board keep patients flow in view as a matter of concern.**	
20/21 171	**Freedom To Speak Up 6 Monthly Update**	
	Sharon Landrum, the Lead FTSU Guardian presented the update report and data which showed that increasing number of staff had been speaking up including members of the BAME. She also highlighted how the Trust had been responding positively and how serious issues had been escalated. Sue Lorimer noted that 22 people had spoken up during Q3 of the previous year and wanted to know if there were specific issues that gave rise to such a high number. The Lead FTSU Guardian replied that management had been aware of an issue in a particular division and that the matter had been investigated. The actions taken appeared to have been effective as no further complaints had been received from that division. **RESOLVED:** **That the Board NOTED the report.**	
20/21 159	**Chair's Business**	
	The Chairman briefed the Board on some key observations following his attendance at a recent regional Chairs meeting. The collaborative work between the Chairs and Chief Executives of partner organisations had been going well and feedback from Wirral in particular had been positive all round. The Chairman added that interview sessions had been held with Chairs of individual organisations' to obtain ideas on future priorities and governance structure for the integrated system. John Sullivan asked if there was tracking data for social care capacity in relation to hospital capacity as the two tend to be closely related. The Chief Operating Officer gave explanations on how the relevant information was shared on daily basis by the Health and Social Care Incident Command forum to which he belonged. The forum comprised of Public Health, Local Authority, Community Trust and some organisations from the voluntary sectors. Some of the information usually shared, which had helped officers to overcome capacity issues included 'homes closed or opened', 'packages of care' and 'backlogs of ready for discharge patients'.	

Reference	Minute	Action
	RESOLVED: **That the Board NOTED the Chair's business.**	
20-21/160	**Key Strategic Issues**	
	There were no strategic issues to report	
20/21 161	**Minutes**	
	Minutes of the meeting held on 7 October 2020 were approved as an accurate record.	
20/21 162	**Board Action Log** The Board reviewed the action log noting that items had either been actioned or were on the agenda.	
20/21 164	**Chief Executive's Report**	
	The Chief Executive talked the Board through her report and highlighted the changes to the COVID-19 report since the report was published. Rates in part of the NW had started to slow down and in some areas by as much as 33%. It was generally believed that Tier 3 restrictions had been having some impact. Despite the restrictions, NW bed occupancy had remained high at around 99%. The government had announced a national lockdown due to commence the following day (5th November). There had been a one-off voluntary staff swabbing event during which 3276 staff members had been swabbed with a 1.5% positivity rate. John Sullivan asked if there was anticipation that some staff members would be unable to come to work as a result of the national lockdown. The Director of Workforce advised that staff members who had been shielding were likely to receive another letter directly from NHS advising them to speak to their employers on jobs they could do from home. As the information had just been received, the process had begun to find out how many staff members it might impact on so that divisions and corporate teams could come up with alternative plans. The Medical Director advised that having been in Tier 3 lockdown for some time with restricted liberties, there had been an impact on mental health for some staff members. Some psychological support was being provided. There had also been issues relating to alcohol abuse within the community in general. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
20/21 165	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard for their respective areas. The Chief Operating Officer highlighted the fall in A&E 4 hour standard during September and how the matter had been addressed. He advised that recognition had been received for the Winter Plan. The Winter Plan would be	**AM**

Reference	Minute	Action
	brought back to the next Board with detailed information to give a thorough understanding of additional investments, management of COVID-19, non-COVID-19, recovery and re-start against the backdrop of workforce challenges. The Chief Operating Officer also advised that there had been significant pressures again in Ambulance Handover. Additional support had been brought in and the position had improved in the last couple of weeks. Elective surgery had seen 80% improvement on the RTT. He highlighted that apart from Mid-Cheshire, the Trust was presently the only non-specialised Trust that had met the 52 weeks wait period across the NW. Good progress had been made on reduction of backlog in cancer. John Sullivan asked if elective surgery was prioritised based on time on waiting list or clinical needs. The Chief Operating Officer gave explanations on how the surgeons' had classified elective procedures into different levels of priorities and that clinical priority had always been the driver. The Medical Director advised that research had been going well and that 1218 patients had been recruited to what was mostly Public Health England's studies on COVID-19. 152 patients had been recruited to the recovery study by NHS on effect of Remdesivir and aspirin in COVID-19 treatment. The Chief Nurse gave updates on steps that have been taken to achieve Trust's target in the Protecting Vulnerable People (PVP) training at Level 3. In answer to a question from John Sullivan, the Chief Nurse explained that the Trust had met the 90% threshold for PVP Level 1 training in the previous year. No concerns had been received in the integrated learning report about falling behind in any of the mandatory training. The Director of Workforce provided updates on staff sickness and turnover reports highlighting areas of significant concerns and remedial actions that have been taken. Some of the key points were that WUTH did not achieve the target minimum attendance rate of above 95% in September and there had been a significant increase in sickness absence due to mental health issues. **RESOLVED:** **The Board of Directors received and NOTED the Quality and Performance Dashboard, together with associated Exception Reports, for the period to 30 September 2020.**	
20/21 166	**Month 6 Finance Report 2020/21**	
	The Chief Finance Officer (CFO) presented the month 6 financial report which showed that the overall position had continued to break-even in-line with NHSI's expectations. She highlighted the additional funding that had been received including "Income guarantee support" to support the lower levels of activity presenting in the Trust during September of c£3.9m; revenue costs incurred in responding to the COVID-19 pandemic of c£0.9m and "additional top-up funding" of c£1.9m compared with £0.4m in the previous month. She highlighted the cumulative level of income support received in the year to date, noting that this was non-recurrent and that next year's finance regime was not yet known. The CFO also briefed the Board about having to revise the original forecasts	

Reference	Minute	Action
	for the capital expenditure due to slippage in the original programme. Progress had been made in the delivery of some of the capital projects which had focused on areas that were critical to get through the winter and the COVID-19 pandemic. The new forecast underspend in the capital programmes was given as £3.6m. The CFO informed the Board about a significant transaction which had taken place during the month. The transaction related to NHS Trusts debt due to the Loan Board which the government had written off. The loan which amounted to £83m for WUTH had been converted to public dividend capital on which interest will be payable and would be a cost pressure to the Trust. However, the new financial arrangement meant that the loan principal will not need to be repaid. Following a question on the adequacy of the plan for month 7 to 12, by John Sullivan, the CFO advised that all forecasts were based on realistic expenditure levels for the remainder of the year taking winter, COVID-19 and reset into account. Sue Lorimer also pointed out that the 2019/20 underlying deficit had been funded this year, so breakeven should be achievable. John Sullivan requested that some urgency be put into designing internal roles that were needed to deliver the Trust's Capital programme. The Director of Strategy & Partnerships provided information on the interim arrangements and future plans to improve internal capacity of the Capital team. **RESOLVED:** **That the Board NOTED the report.**	
20/21 167	**Consultant Revalidation & Appraisal Annual Report**	
	The Medical Director presented the annual report which had been circulated for prior reading. She highlighted the deferral rate for appraisal which had been comparatively low. **RESOLVED:** **That the Board NOTED and CONFIRMED the report.**	
20/21 168	**Learnings from Deaths Quarterly Update**	
	The Deputy Medical Director presented the learning from deaths quarterly update. He advised that the report had been presented to both the PSQB and TMB and that the action plans were progressing. The main concern had been around the SHMI rate which was a calculation to reflect the number of deaths versus number of expected deaths. The data for April had shown the number of deaths to be higher than expected. It had been identified that the higher death rate shown was a result of quality of the documentation as well as the quality of coding particularly at the point of admission. IT training would be organised to improve the quality of coding as well as a programme of education of the clinicians. The Board discussed the need to further probe into the cause of the increased SHMI rate to ensure that nothing had been overlooked including making enquiries with other Trusts.	

Reference	Minute	Action
	RESOLVED: **That a higher level of assurance be presented to the next Board.**	**NS**
20/21 169	**Review of Interim Governance Arrangements**	
	The Board received the proposal for interim governance arrangements for the Board and Committee meetings as detailed in the attached appendices to the report. **RESOLVED:** **That the Board APPROVED the interim governance arrangements.**	
20/21 170	**Monthly Safe Staffing Report**	
	The Chief Nurse presented the staffing report for Month 6 which provided the Board with a review of nurse staffing levels. She highlighted that RN Band 5 vacancy rate had continued to increase and there was an emerging risk of increase in Care Support Worker vacancies. She highlighted some of the local and external recruitment efforts to ensure that minimum staffing levels were met and advised that from the next Board, the report would be presented in a dashboard format. John Sullivan expressed concern about the significant increase in the number of 'following application of professional judgement' rated as Amber and requested further assurance in this respect. The Chief Nurse gave explanations on how staffing level was flagged up automatically on the system when the staffing level fell below the agreed standard. She expressed confidence that a robust system was being developed. In response to another question, the Chief Nurse acknowledged the concern about vacancy rates and was hopeful that the situation would start to improve from the next report in December. **RESOLVED:** **That the Board NOTED the report.**	
20/21 172	**Infection Prevention and Control Annual Report 2019-2020**	
	The Board received the Annual Report which provided details of the Infection Prevention team including the successes achieved during the year and future action plans. The Board was informed that there had been a total of 89 cases of *Clostridium difficile* infection (CDI). Analysis of each incidence had indicated that only 22 were avoidable due to lapses in care. Despite the large protracted outbreak at the beginning of the year, there had been a year end reporting of 1 above target which had been an outstanding achievement and the closest the trust had been to achieving its CDI target for 6 years. **RESOLVED:** **That the Board NOTED the report.**	
20/21 173	**IPC Board Assurance Framework**	

Reference	Minute	Action
	The Board received the IPC Board Assurance Framework including details of planned actions to address the few areas rated as 'limited assurance'. **RESOLVED:** **That the Board NOTED the report.**	
20/21 174	**NHS People Plan 2020/21 – Gap Analysis**	
	The Board received the report of the NHS People Plan 2020/21 – Gap Analysis which provided an overview of work undertaken in response to the National People Plan and the next steps. The Director of Workforce advised that the plan had been discussed with the various divisions and that the feedback was that the priorities should be Health & Wellbeing and Equality and Diversity. The Board discussed the need to prioritise cultural change as this was needed to drive the direction and improvement for the Trust. The Director of Strategy & Partnerships highlighted some of the planned work on Culture and Leadership that would be picked up in April 2021. **RESOLVED** **That the Board of Directors APPROVED the People Plan 2020/21**	**MS**
20/21 175	**Progress Against Enforcement Undertakings**	
	The Board received the report of progress against the revised enforcement undertakings issued by NHS Improvement on 24 July 2020. The Board discussed the need to seek clarification on the current status of the additional licence condition that was imposed by NHSI in 2018. **RESOLVED:** **That the Board NOTED the report.**	**JH/Chair**
20/21 177	**Report of Safety Management Committee**	
	The Board received the report of the Committee which provided a summary of business conducted during a meeting of the Safety Management Assurance Committee held on 28 October 2020. The Committee Chair advised that discussions at the Committee had provided some comfort that the right things were being done. **RESOLVED** **That the Board NOTED the report.**	
20-21/178	**Report of the Trust Management Board (TMB)**	
	The Board received the report which contained some of the business conducted during the TMB held on 27 October 2020. **RESOLVED** **That the Board NOTED the report.**	

Reference	Minute	Action
20-21 179	**Communications and Engagement Monthly Report**	
	The Board received the report of activity in the areas of staff engagement and communications, the NHS Staff Survey, media and social media, charitable fundraising and stakeholder relations. **RESOLVED:** **That the Board NOTED the report.**	
20/21 180	**Board Assurance Framework (BAF)**	
	The Board received the BAF which provided an overview of all the risks currently recorded on the BAF and outlined movement of all risks recorded in line with Quarter 2 reporting period. The Interim Director of Corporate Affairs advised that the new BAF which would be aligned to the six Strategic Objectives and Priorities would be presented to the Board in February 2021. **RESOLVED:** **That the Board NOTED the report.** **That the Board APPROVED the content of the Board Assurance Framework as presented.**	
20/21 181	**Staff Flu Vaccination Programme - Winter 2020/21**	
	The Board received the report which provided an overview of how the annual staff flu vaccination programme was being delivered, the challenges faced in doing so and the progress made to date. It also included details of a self-assessment against NHS England's best practice checklist for seasonal flu campaigns. The Director of Workforce updated that about 3,500 staff members had been vaccinated so far which represented 54.66%. The Chief Executive had sent emails to staff members to request information about those who had received the flu vaccine from other sources like their GPs. **RESOLVED:** **That the Board NOTED the report and to endorsed the 'Best Practice Checklist'.**	
20/21 182	**Any other business** None	
20/21183	**Date of Next Meeting** Wednesday 2 December 2020, via MS Teams	

……..……
Chair

……..
Date

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

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 04.11.20						
1	BM20-21/165	Present a detailed Winter Plan to the Board	**AM**		December 2020	On Agenda
2	BM20-21/168	Present a Mortality Report at Board's Request	**NS**	Detailed work has been undertaken regarding the SHIMI including consultation with colleagues throughout the UK. The issues around SHIMI are multi-factorial and work is being undertaken to triangulate with other mortality indices including HSMR, and national audits such as ICNARC, SSNAP and MiNAP to ensure patient safety is assured. Clinical reviews are being undertaken into diagnostic areas which show higher SHIMI indicators. Work is also being undertaken to ensure data quality. In view of the complexity of the work required, a detailed report will be provided to January Board	January 2021	
3	BM20-21.174	Update the Board on progress regarding work on the new strategy on Culture and Leadership	**MS**		April 2021	Not due
4	BM20-21/175	Seek clarification on the status of the additional license condition that was imposed by NHSI in 2018.	**JH**			

Date of Meeting 07.10.20						
1	BM20-21/138	Report on risks on non-compliance of Mandatory Training	**JG**		December 2020	Report to come via next Workforce Assurance Committee Chair's report
2	BM20-21/138	Sickness absence report outlining long term and short term absence related to COVID-19	**JG**		December 2020	On Agenda
3	BM20-21/142	Report on recruitment to include flexible working initiatives	**JG**		December 2020	Report to come via next Workforce Assurance Committee
Date of Meeting 04.03.20						
1	BM 19-20/237	Discussion at future Board meeting regarding internal productivity to support financial sustainability	**CW**		July 2020	April '20 – agreed to defer until Q2 following stabilisation of COVID activities.

Board of Directors	
Agenda Item	20-21/191
Title of Report	Chief Executive's Report
Date of Meeting	2 December 2020
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 2020.

1. Reset and Recovery

Planned care activities continue to be monitored against phase 3 national plans, and are being delivered with the optimum focus on Covid-19 safety.

The Phase 3 national expectation was that recovery plans should deliver the following %'s of activity in comparison with the same period last year assuming no second wave of Covid-19.

Whilst the Trust has not delivered the national trajectories, current performance delivery is against a back drop of a second wave of Covid-19. Despite this performance, recovery plans continued to improve .

Activity	National	Agreed Trust Trajectory	Actual	Variance
Outpatients	100%	87%	84%	-3%
Daycase	90%	85%	73%	-12%
Inpatients	90%	87%	73%	-14%

The forecast position for November shows further improvements across all three points of delivery

2. Asymptomatic Staff Testing pilot

In October 2020, the Trust was nominated as one of thirteen NHS organisations in the North West of England to participate in the asymptomatic Covid-19 staff testing pilot. This pilot aimed to identify asymptomatic Covid-19 positive staff across the organisations, through the swabbing and testing of staff using the Covid-19 PCR test.

The pilot commenced on Wednesday 21st October 2020 and concluded on Monday 2nd November 2020. Across this period, the Trust established a command centre approach and swabbed 3276 staff, primarily from clinical, clinical support and frontline areas.

Of the 3276 staff who were tested 45 staff received Covid-19 positive results and were referred to occupational health and isolated in line with government guidance. At the conclusion of the pilot, the Trust showed an asymptomatic Covid-19 positivity rate of 1.4%, which was one of the lowest rates across the pilot group.

	Tested	Positive	Void	Positivity Rate
Asymptomatic Pillar 2	3276	45	25	1.4%

Following further guidance, the Trust is preparing to commence routine asymptomatic swabbing of staff in line with the national directive from December 2020.

3. Vaccination & Distribution Hubs

WUTH has been chosen as a Trust able to host Covid-19 vaccinations for its staff, and potentially other local providers, as we have both the license and specialist freezer capacity that allows storage of the Pfizer Courageous vaccine. Matthew Swanborough and Jacqui Grice are the Executive Leads responsible for the delivery of the Distribution hub and staff vaccination programme respectively.

To enable & monitor the vaccination programme, the Trust is working with key partners on installation of the booking & monitoring software. Subject to the release of the national training programme , the software availability and the vaccine being approved, the expectation is to be able to start vaccinating staff by the second week in December. The service will be delivered over a minimum of 6 days a week and is expected to continue through to February and the hub service at Clatterbridge through to March.

A local recruitment campaign has been underway for several weeks to recruit additional vaccinators and administrators to run what is a staff intensive programme.

4. Trust Strategy 2021/26

Following the launch of the 2021-26 Trust Strategy in October 2020, the Trust has produced a one page summary, for use across the organisation and with our partners and patients. This sets out the key objectives and priorities for the Trust over the next five years.

The Trust has continued with the development of the specialty level Clinical Service Strategies, with 29 specialty workshops being held with clinical and operational teams and services. The remaining three workshops are due to be held in early December 2020.

Following each of these workshops, the Strategy Team has been working with individual clinical teams to draft their clinical service strategies. Twelve of these strategies have been completed to date and are due to be reviewed and approved at the next Trust Management Board meeting in December 2020.

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

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

5. Campus Master Planning

In line with agreed plans the Trust tendered for external architectural and consultancy support to assist with the development of the campus master plan for Clatterbridge General Hospital, working in conjunction with campus partners and Wirral Council. The Trust is currently evaluating the tender submissions and planning to award in early December, with the successful bidder commencing with Trust in January 2020.

6. External review of Estates compliance

The Trust has commissioned an external review of statutory Estates compliance to help identify any gaps current processes and any areas for development. The review will be undertaken by Archus who have significant expertise in NHS estates compliance assurance reviews. The findings and any actions from this assessment will be reviewed by the Health and Safety Committee and reported to the Board of Directors at a future meeting.

7. EU Exit Transition Period (TP)

The NHS has developed an operational response to EU Exit, which is being led by Professor Keith Willett, Strategic Incident Director. In line with this response, the Trust is reviewing the work previously undertaken in preparation for EU Exit. The Trust has reconvened the EU Exit Planning Team, which is overseen by the EU Exit Senior

Responsible Officer (SRO), Anthony Middleton Chief Operating Officer. This team will support the Trust's preparedness prior to 31 December and subsequently the incident management stage in January 2021. To date the Trust has not identified any significant risks during this process. The Trust has also participated in the two EU Exit TP workshops chaired by Professor Willett and the Wirral EU Exit Coordination Group chaired by the Wirral Council, to ensure that the Trust has informed, safe and robust plans in place.

In January 2021 EU Exit TP will form part of the incident management response alongside Covid-19 and Winter in line with the NHSEI Framework.

8. Serious Incidents

In October 2020 two serious incidents were declared. One incident related to a delayed diagnosis due to a misinterpretation of an X-Ray; and one patient fall resulting in fracture. In both cases Duty of Candour has been undertaken and a full detailed investigation into the facts has been initiated to ensure learning is identified and appropriate improvement actions are implemented.

9. RIDDOR Update

There were no RIDDOR reports to the HSE in October

Janelle Holmes
Chief Executive

Board of Directors	
Agenda Item	20-21/192
Title of Report	Quality Performance Dashboard
Date of Meeting	2nd December 2020
Author	WUTH Information Team, Corporate Nursing and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

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

2. Background

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

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

3. Key Issues

Of the 47 indicators that are reported for September (excluding Use of Resources):

- 20 are currently off-target or failing to meet performance thresholds
- 21 of the indicators are on-target
- 6 do not have an identified threshold or are not rated

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

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

4. Next Steps

WUTH remains committed to attaining standards through 2020-21.

5. Conclusion

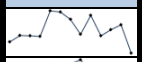
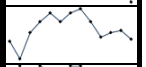
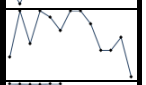
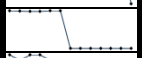
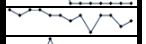
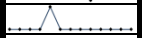
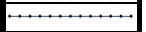
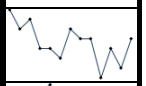
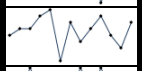
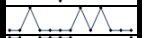
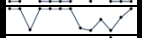
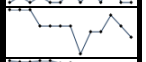
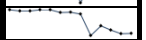
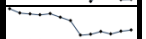
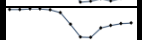
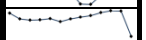
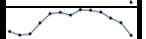
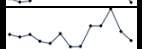
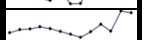
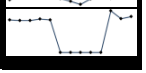
Actions to improve are noted in the exception reports on the qualifying metrics to provide monitoring and assurance on progress.

6. Recommendation

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

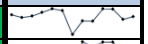
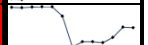
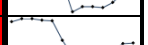
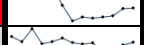
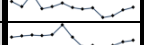
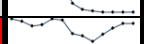
Quality Performance Dashboard

November 2020
Upated 20-11-20

	Indicator	Objective	Director	Threshold	Set by	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.09	0.13	0.13	0.13	0.32	0.31	0.25	0.14	0.29	0.13	0.18	0.21	0.00	0.17	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	94.9%	94.1%	95.3%	95.8%	96.2%	95.8%	96.2%	96.4%	95.8%	95.1%	95.3%	95.4%	95.0%	95.6%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.1%	97.8%	97.3%	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.2%	97.2%	97.4%	96.8%	97.4%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	96.5%	95.7%	95.1%	95.2%	97.0%	96.9%	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	5	4	5	5	4	4	3	4	1	4	4	2	3	21	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	0	2	0	0	0	0	0	0	0	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	≤88 WUTH maximum from 2019-20 retained, with a varying trajectory of a max 6 to 8 cases per month	SOF	8	6	7	4	4	3	6	5	5	1	4	2	5	28	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 77 for financial year 2020-21, with a varying trajectory of a max 6 or 7 cases per month	WUTH	5	6	6	8	9	1	7	4	6	8	5	3	7	40	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	1	0	0	0	0	1	0	1	0	0	0	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	99.1%	99.0%	99.5%	99.0%	99.6%	100.0%	99.5%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	0	1	0	0	2	0	2	0	4	0	0	8	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	99%	99%	99%	96%	96%	96%	96%	91%	95%	95%	98%	96%	94%	95%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	92.4%	91.2%	91.2%	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	75.9%	72.9%	73.2%	78.8%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	88.3%	85.5%	84.9%	84.4%	85.0%	82.8%	80.6%	71.4%	71.8%	73.5%	72.1%	73.9%	74.5%	74.0%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	87.5%	88.1%	89.7%	89.5%	86.7%	79.9%	51.5%	19.7%	19.0%	42.0%	48.3%	53.2%	54.7%	54.7%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.33%	94.14%	94.10%	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.41%	94.40%	93.58%	93.58%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	93.99%	93.82%	93.87%	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.63%	94.41%	93.81%	94.66%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.86%	0.77%	0.86%	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.94%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	11.0%	11.3%	11.3%	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.1%	12.7%	12.6%	12.6%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	7.7	7.6	7.55	7.9	7.7	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	9.9	8.0	8.5	8.5	

Quality Performance Dashboard

November 2020
Upated 20-11-20

	Indicator	Objective	Director	Threshold	Set by	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	97.8%	97.2%	97.5%	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.0%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH				96%	94%	95%	93%	98%	97%	98%	98%	96%	96%	96.5%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	17.2%	17.1%	19.3%	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	18.6%	17.8%	17.7%	19.0%	
	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	443	441	444	446	448	383	174	209	210	202	239	309	305	305	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	194	208	207	200	198	108	35	54	48	53	59	92	95	95	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.0	3.6	4.6	3.4	3.6	3.9	3.5	3.4	3.5	2.8	2.9	3.4	3.6	3.3	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.8	5.0	5.2	5.1	5.2	6.7	4.8	3.4	3.6	3.3	3.6	4.1	4.4	3.9	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	1118	1057	1080	1115	1006	827	667	870	941	1016	1012	1014	1007	932	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	10	13	11	16	16	23	6	2	1	0	National reporting suspended	National reporting suspended	National reporting suspended	2	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	82.9%	81.0%	77.3%	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	75.6%	79.3%	79.2%	73.9%	

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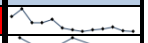
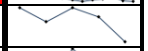
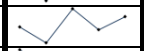
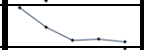
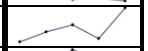
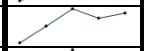
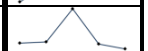
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	17	26	10	10	14	4	2	0	2	3	5	1	0	13	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	87%	84%	87%	85%	80%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	11%	10%	11%	10%	11%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	97%	96%	97%	97%	97%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	33%	29%	27%	27%	27%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94%	94%	94.5%	94.1%	95.0%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	91%	94.8%	99%	97%	98%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	CN	≥25%	WUTH	22%	22%	33%	22%	20%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		

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	Indicator	Objective	Director	Threshold	Set by	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2020-21	SOF	72.7%	70.8%	72.1%	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	85.0%	76.9%	71.6%	71.6%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	1	33	95	40	24	21	0	0	0	0	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	170	366	431	198	76	80	148	84	82	78	92	162	264	130	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	79.03%	78.09%	78.10%	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	51.30%	59.76%	65.66%	65.66%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	24,368	23,597	23,233	22,988	23,207	22,350	21,284	21,288	21,383	23,034	24,486	24,212	22,945	22,945	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	0	0	0	0	0	15	56	200	413	616	733	806	777	777	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.5%	99.2%	99.1%	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	83.5%	88.8%	90.5%	72.6%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	95.0%	93.7%	94.4%	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	89.3%	92.6%	94.6%	91.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	–	–	94.4%	–	–	93.4%	–	–	90.2%	–	–	92.48	-		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	96.7%	97.0%	97.1%	97.2%	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	94.8%	92.1%	95.9%	95.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	–	–	96.9%	–	–	97.6%	–	–	98.6%	–	–	92.44	-		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	85.0%	87.5%	85.9%	85.9%	85.9%	86.0%	87.4%	86.2%	82.1%	80.7%	78.6%	82.6%	73.7%	81.6%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	–	–	86.1%	–	–	85.9%	–	–	85.3%	–	–	80.68	–		
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	TBC	WUTH	193	195	148	186	160	125	74	99	119	143	124	183	178	131	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	TBC	WUTH	31	13	10	8	16	14	7	8	15	11	18	22	20	14	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	100%	86%	88%	100%	100%	100%	100%	100%	96.3%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	3	0	3	0	1	0	1	5	1	0	2	1	1	

Quality Performance Dashboard

November 2020
Upated 20-11-20

	Indicator	Objective	Director	Threshold	Set by	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21	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 FY 20/21 (ave min 59 per month until year total achieved) - target retained from 19/20)	National	56	48	41	55	49	117	326	181	151	87	31	124	318	1218	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	83.8%	81.4%	80.9%	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	81.3%	84.3%	76.3%	73.0%	73.0%	

	Indicator	Objective	Director	Threshold	Set by	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.088	-0.488	-9.543	-0.668	-2.929	2.377	0.00	0.00	0.00	0.00	0.00	0.00	0.74	0.744	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-1.507	-1.638	-8.755	-1.818	-2.445	-0.589	0.00	0.00	0.00	0.00	0.00	0.00	0.35	0.348	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	3	3	3	4	4	4	2	2	2	2	2	2	2	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	-10.6%	-11.5%	-11.4%	-18.1%	-18.1%	-17.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	-24.7%	1.8%	-8.4%	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	21.9%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-14.6	-10.9	-14.1	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.0	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	61.7%	57.2%	54.4%	53.8%	50.7%	74.8%	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	41.8%	

(*) Updated Metrics

Metric Change

(**) Updated Thresholds

Threshold Change

Wirral University Teaching Hospital NHS Foundation Trust

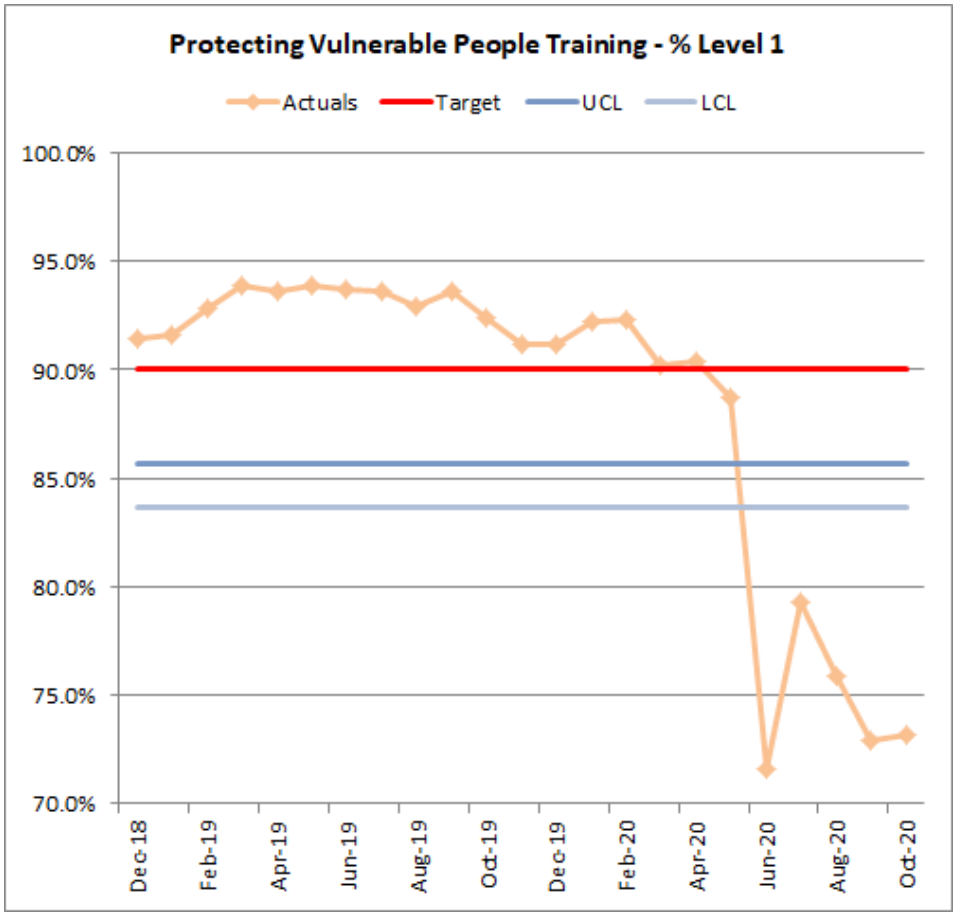
Appendix 2

WUTH Quality Dashboard Exception Report Template as at October 2020

Safe Domain

Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse
Performance Issue: WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been deteriorating and is at 73.2% for October 2020.
Action: Protecting Vulnerable People (PVP) training is an online package that can be accessed by staff at any time. Although a slight improvement has been noted in October 2020 this is less than expected on the agreed trajectory's that are monitored via the Safeguarding Assurance Group reporting to Patient Safety Quality Board. In October staffing has been increasingly challenging due to the impact of the National Track and Trace system reducing attendance in a number of staff groups. Divisions are taking a risk based approach to release staff working with vulnerable adults and children to attend Level 3 training as a priority. A paper will be presented to Workforce Steering Group in November 2020 to explore further solutions to improve compliance.
Expected Impact: There is an expectation that PVP level 1 training compliance will increase in quarter 4 which will be dependent upon divisional capacity and demand during the COVID 19 pandemic period.



Protecting Vulnerable People Training - % Compliant Level 2

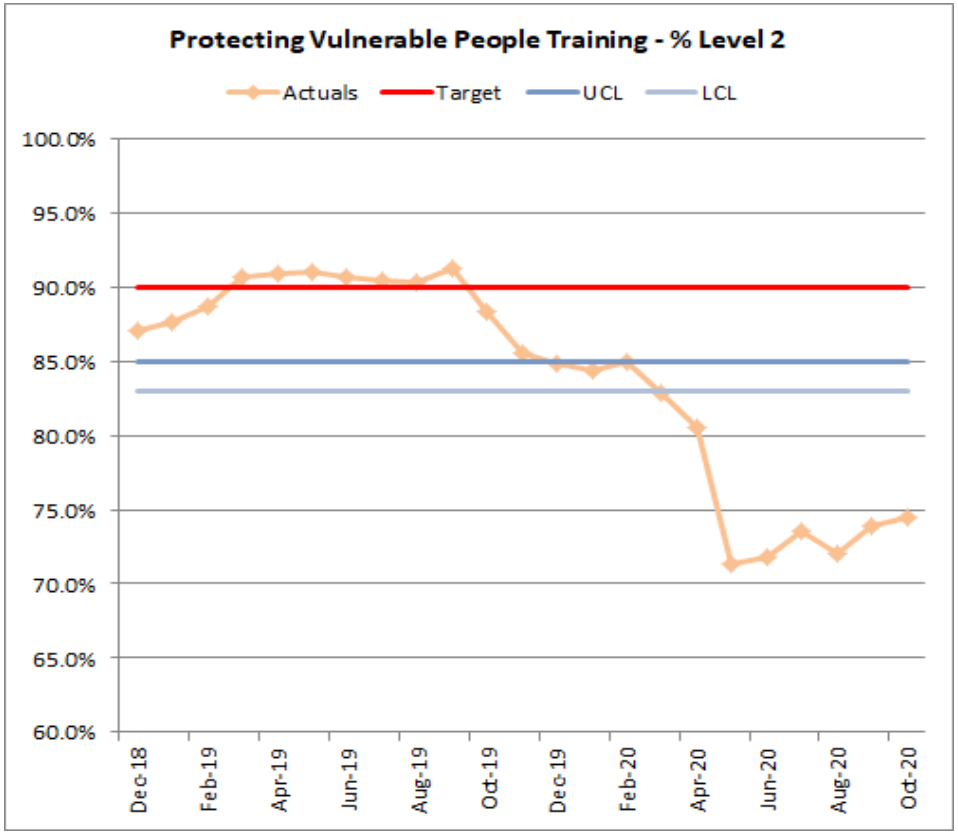
Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been deteriorating and not achieved since September 2019 except for September 2020. October figure was at 74.5%.

Action:
Level 2 Protecting Vulnerable People training (PVP) is an online package that can be accessed at any time. The divisions continue to take a risk based approach in improving safeguarding training compliance across the Trust. This approach results in the planned release of staff working with high risk patient groups to attend higher levels of PVP training. To bridge the gap in knowledge for staff that are presently unable able to access training, safeguarding awareness is being monitored through Perfect Ward audits and the Wise Spot Check Programme. Any areas of concern identified are supported with bespoke training and practical support from the Trust Safeguarding Team.

Expected Impact:
PVP level 2 training compliance will increase in quarter 4 however this is expected to be a gradual improvement moving to full compliance in quarter 4.



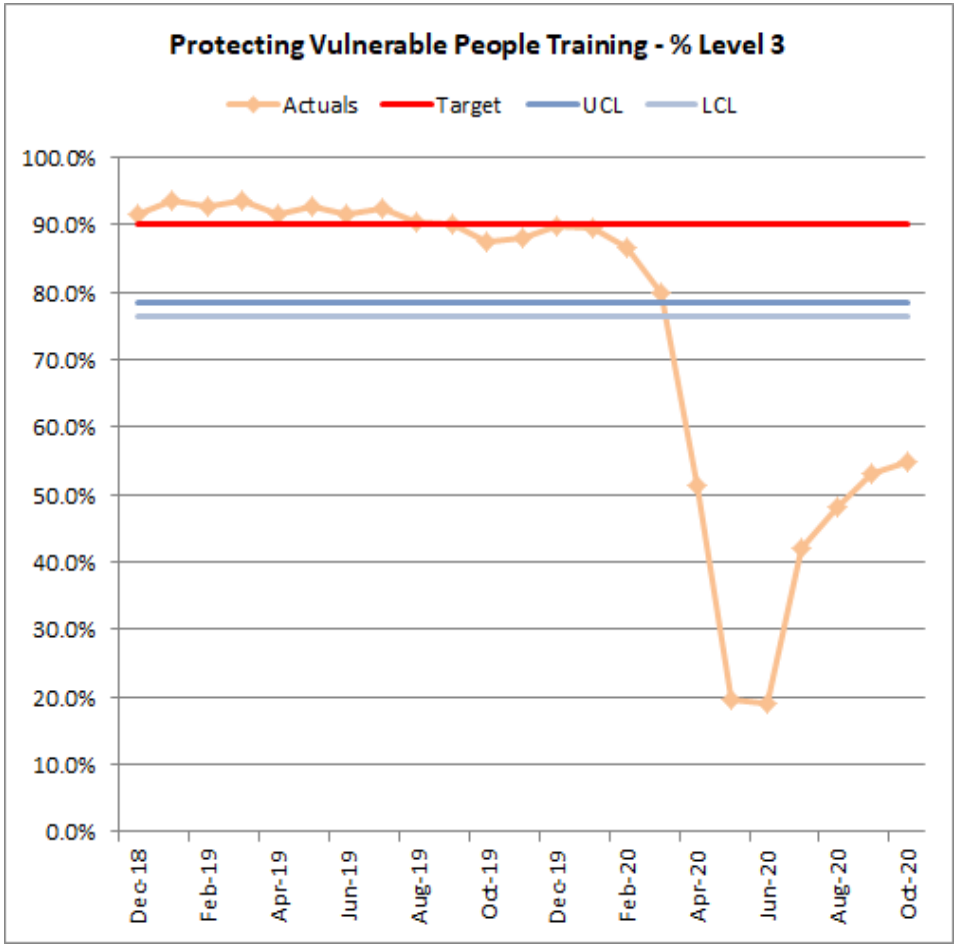
Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead:
Chief Nurse

Performance Issue:
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has not been achieved since August 2019, though October continued the improvement up to 54.7%.

Action:
There has been a continued increase in the number of staff accessing Level 3 training providing a steady improvement in compliance. This improvement is in line with the introduction of the E-Learning element of Protecting Vulnerable Adults Level 3 (PVP) training. Due to the limited availability of large venues available to host the face to face component of the training, trajectories had been set based on available capacity (33 staff per session). Sadly due to the impact of the National Track and Trace Programme reducing attendance in a number of staff groups 'did not attend' (DNA) rates have significantly increased. The Associate Director of Safeguarding is presenting a paper to the Workforce Steering Group in November 2020 to explore strategies to further increase compliance. The Safeguarding Team continue to monitor risks in staff knowledge gaps through Perfect Ward Audits , quality monitoring of MCA applications and the Wise Spot Check Programme additional bespoke support is applied where necessary to support staff working with vulnerable adults and children.

Expected Impact:
PVP level 3 training compliance will increase month on month moving to full compliance in quarter 1 2021.



Staff attendance % (in-month rate)

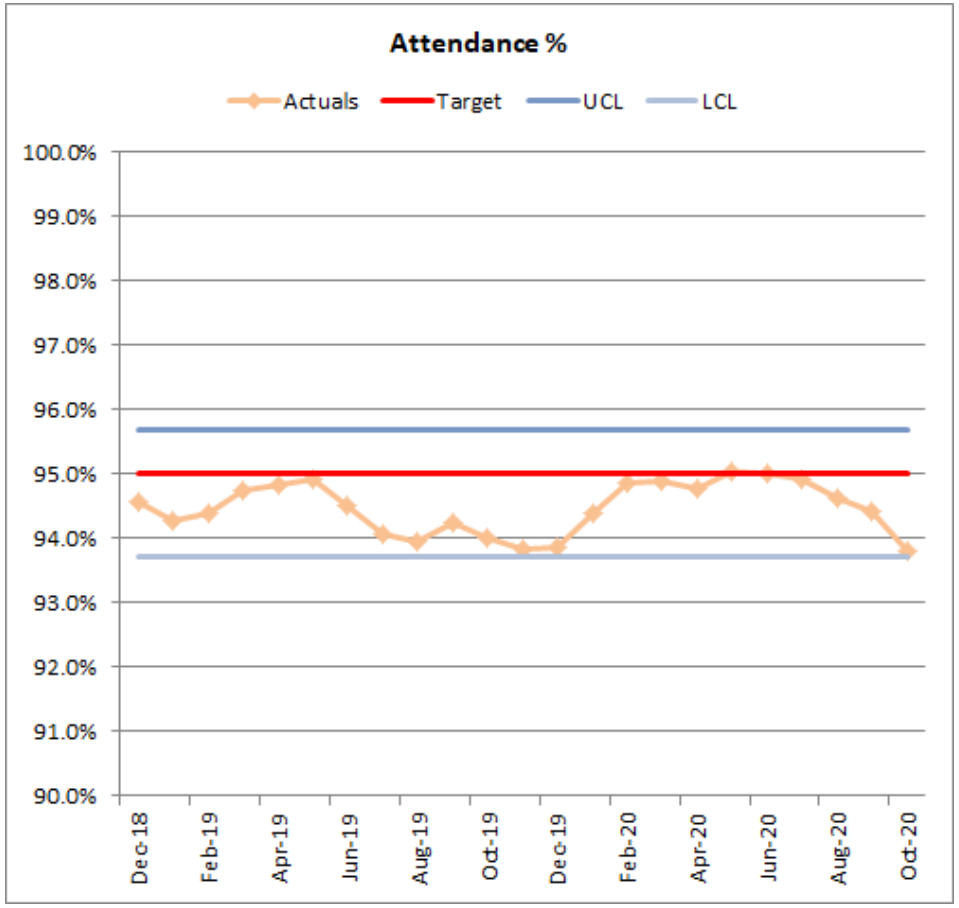
Executive Lead: Director of HR / OD

Performance Issue:
The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12 month period. Between the period of April-October 2020 sickness absence rates have been outside the tolerated threshold. In month sickness for October 2020 was 6.19% and the rolling 12 month rate for the same month was 6.42%. The reported figure for the same month in 2019 was 6.01% for in-month sickness absence and 5.68% for the rolling 12 month period.

It is important to provide the context however of the unprecedented Pandemic in 2020. Therefore when examining the split between Covid and non-Covid related absence to provide a true comparison to 2020 and 2019 figures, sickness in October 2020 in month is 5.14% and rolling absence is 5.51%. The same period last year was 6.01% and 5.68% respectively. This demonstrates a reduction in like for like sickness absence across the two periods.

When reviewing the split of sickness absence between long and short term absence between April and October 2020, the impact of the Pandemic in April is clearly evident in the data. Between May and September, long term absence is higher than short term absence. The impact of the second wave of Covid-19 has again tipped the balance in October to an increased proportion of absence being due to short term sickness.

Typically, short term absence is more difficult to manage; sourcing cover to fill gaps at short notice is difficult and can feel unsettling to other members of the team. Managers are strongly encouraged to complete return to work discussions following every episode of sickness absence in order to offer a balance of support and challenge. It is proven that this valuable conversation is one of the main drivers of improved sickness absence in an organisation.



Data evidences the variation in compliance with completion of return to work discussions across the organisation which is being mitigated by provision of regular weekly reports to Executive Directors and Divisional Triumvirates to provide check and challenge to improve the position.

When examining absence reasons data, it is clear that the sickness reason consistently giving the greatest impact on absence levels across this period was Anxiety, Stress, Depression. Reflecting the experience of the Covid-19 Pandemic, Cold, Cough, Flu was significantly high in April and May 2020, and overall through the period is a significant contributor to overall absence levels.

Historically, Musculoskeletal (MSK) problems have been significantly higher than tolerated thresholds and additional interventions have been put in place to improve the support offering to staff. A fast referral to a MSK lead within Occupational Health has had a positive impact; this absence reason equates to 7.08% of the overall absence figure for October 2020 but is significantly improved from the same month last year.

That said, the position between April and October 2020 has deteriorated in relation to sickness absence due to this issue so clearly there is still work to do in this area. 3.77% of staff cited MSK as the reason for their absence in April however this has almost doubled in October 20.

Sickness absence due to Anxiety or Mental Health has always been a large proportion of the overall absence in the Trust. This worsened significantly over the summer months, but is now starting to improve again. When viewed overall it means approximately one third of staff absence is reported as being due to mental health issues.

The Trust Employee Assistance Programme has been widely and regularly communicated to staff recently as a reminder of the support available. Additional in-house Psychology support has also been sourced. Due to the Covid-19 Pandemic and resultant impact on staff who may experience Post Traumatic Stress Disorder (PTSD) the Trust has also commissioned support through Red Poppy so staff can be referred for specialist intervention.

Action:

Across the divisions, managers are working with support from the HR Services Team to progress complex sickness absence cases. A number of long term cases have been referred to management hearings for resolution between October and November, following delays to case management due to a national pause in processes due to the COVID-19 Pandemic.

Some service areas, for example Estates and Facilities, manage additional challenges in relation to misconduct due to non-compliance with policy. This manifests in lack of engagement by staff with managers and the Occupational Health team and this behavior is managed robustly on a case by case basis with support from the HR Services Team.

HR Business Partners are working with Divisional triumvirates and Workforce Information Hub colleagues to identify and target hot spots with a view to undertaking departmental audits and progressing recovery plans to support an improvement in sickness absence.

A start chamber approach has commenced to review long term sickness absence cases <4 months on an individual basis. This seeks to map an action plan to either support staff back to work or to conclude employment in line with policy where a return to work within a reasonable timescale is not anticipated.

Workshops for staff at bands 1 and 2 and their managers commenced in October 2020 with a view to improving levels of morale and engagement, underpinning Trust values and encouraging a culture change whereby staff feel able to bring their best selves to work and can identify solutions to their health and wellbeing.

A review of the Occupational Health service is taking place to ensure the service is resilient through winter and is able to support staff and managers. The successful impact evidenced by the introduction of the fast-intervention service for MSK staff is being scoped out to include those absent with reasons of back pain. Staff wellbeing is also a key area of

focus for the Workforce directorate with a number of initiatives in place including management coaching, wellbeing hubs/ wobble spaces for staff and debrief sessions to support staff psychological safety. Resources are being increased on a temporary basis within the HR Services Team to ensure appropriate support is available to managers in the divisions to manage sickness absence. One HR Business Partner is dedicated specifically to a Trust wide deep dive and review of approaches currently in place across the Trust together with examination of the policy, processes and gap analysis to support a strategy for improvement.
Expected Impact: Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over the next quarter.

Gram Negative Bacteraemia

Executive Lead: Chief Nurse

Performance Issue:

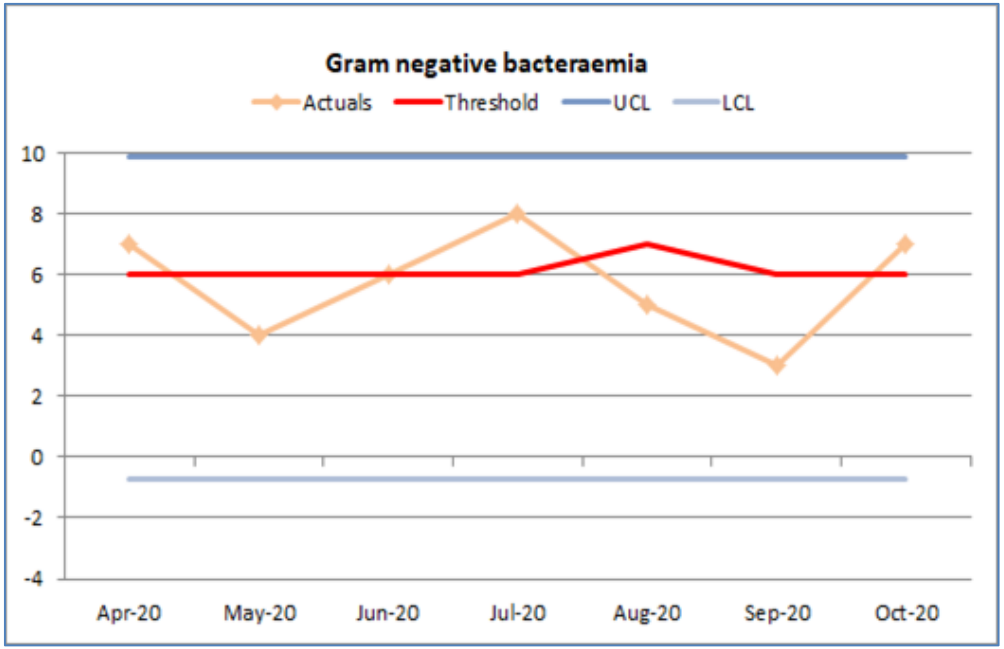
The current national ambition is to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections (E*scherichia coli (E. coli)*, *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella (Klebsiella* spp.) by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data set). To meet this requirement a threshold/maximum of 77 cases is set for 2020-21, with a varying trajectory of maximum 6 or 7 cases per month. In October there were 7 cases reported against a maximum trajectory of 6. There has been a reduction of 61.54% in *Klebsiella* and a 3% reduction in *E-coli* when compared to the same period last year, *Pseudomonas* remains the same. Overall there has been a 20% reduction. The cumulative number to the end of October is 40 cases, which is 3 under overall trajectory. Further improvement is required to ensure we meet the national ambition.

Action:

An increased scrutiny of all Gram–Negative Bacteremia incidence is in place to identify common themes, the outcomes of the Multi-Disciplinary Team investigations are then presented at Divisional Infection Prevention Control (IPC) Meetings for further scrutiny and challenge ensuring resulting action plans are being delivered. Divisional IPC meetings also monitor compliance monthly regarding high impact interventions ensuring relevant training and education and practices are in place to reduce incidence. Lessons learnt are shared at local ward safety huddles and Trust wide at the monthly Trust wide infection Prevention Control Group.

Expected Impact:

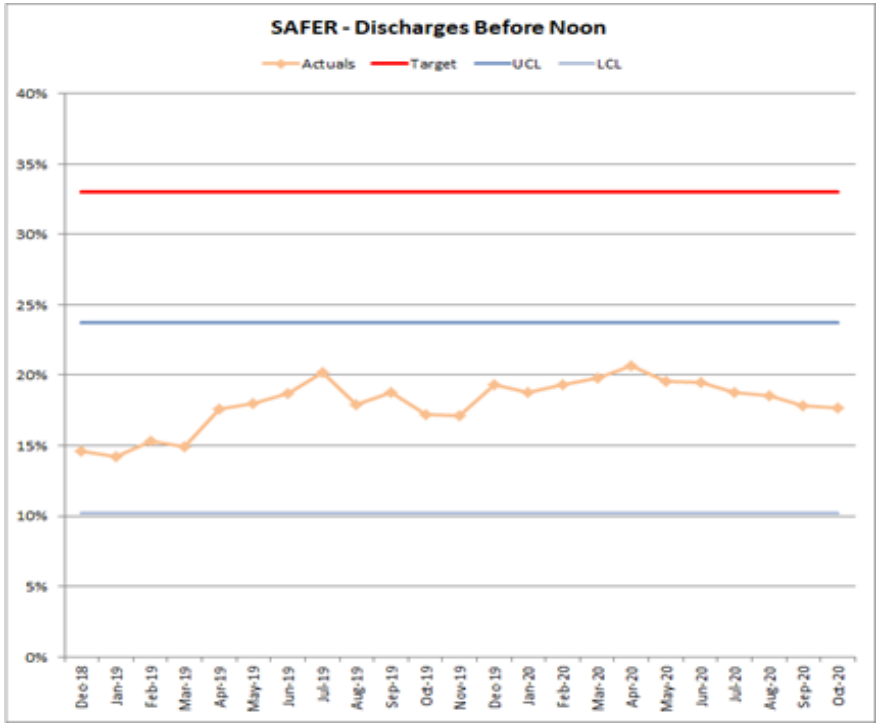
Continuing our targeted interventions will promote reduction in the instance of all gram negative bacteremia which will be reflected in the overall reduction to ensure the monthly threshold is not exceeded.



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. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%.
Action: The patient flow improvement programme contains a key workstream around ward processing and has been implemented across a number of medical wards and has begun roll out in surgery. Operational controls have been put into place to ensure ward rounds have commenced as planned, and is comprehensively staffed by senior decision makers.
Expected Impact: During October 33% of discharges were delivered by 1.57pm.



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 had been set to reduce the number of patients in hospital for seven days or more to a maximum 156. The internal target for 21 days or more has been set at the outset of COVID to a revised maximum 52.

Action:

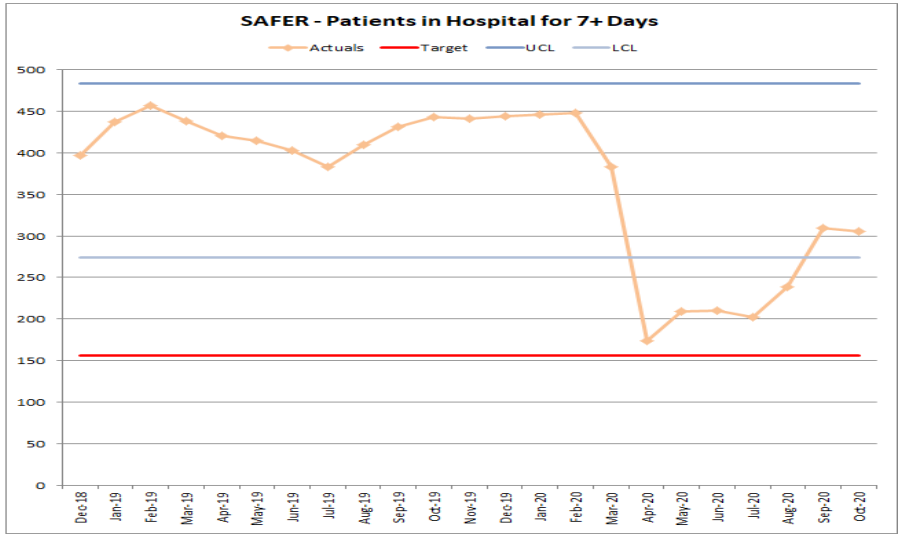
The Wirral system has daily discharge cell meetings as part of the COVID response to expedite all ready to be discharged patients from the acute sector, and the health and social care cells with executive oversight have been stepped back up to daily.

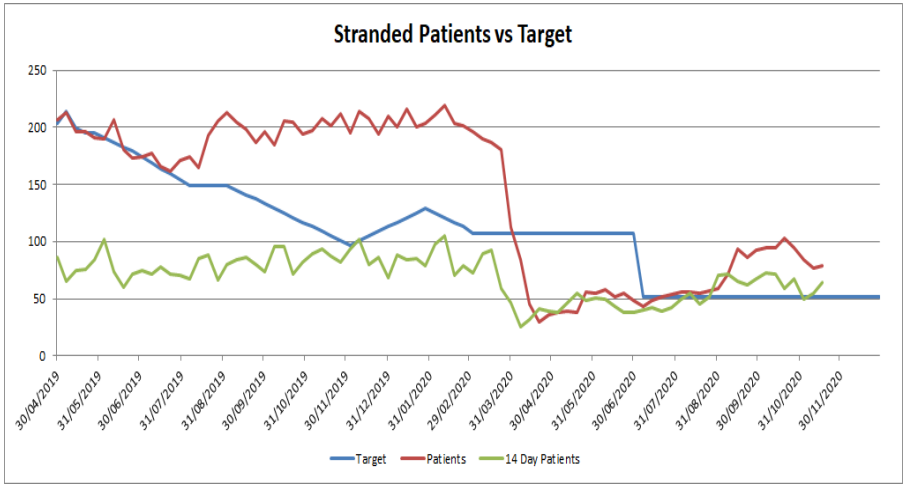
Both the medicine and surgery divisions now perform twice weekly LLOS reviews across all wards, which now feeds into the discharge cell to ensure integrated discharge work lists are accurate.

Following a “firebreak” event at the start of November which judged patients against the national criteria to reside guidance this has now been incorporated into an initial weekly event for winter, moving ultimately to the normal daily process

Expected Impact:

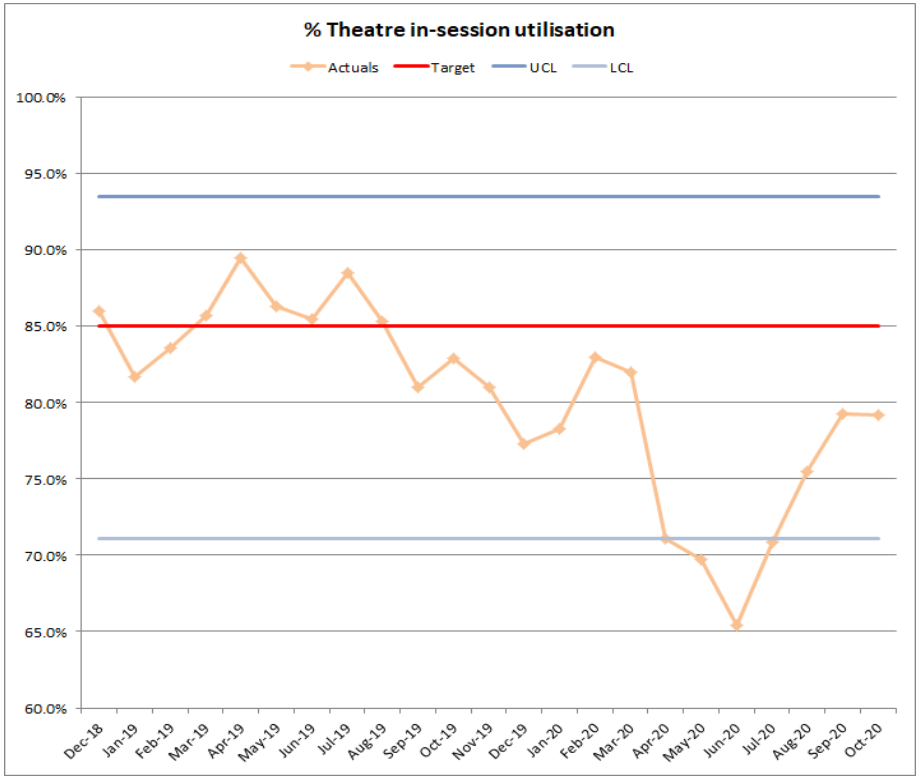
The aim is to achieve no more than 90 LLOS patients throughout winter, with internal resource focused on that, and the Wirral system triggers and governance complimenting the response where needed.





Theatre in session utilisation %

Executive Lead: Chief Operating Officer
Performance Issue: The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. During the first wave of COVID 19 urgent planned care activities were maintained by throughput reduced. Since the phase recovery and reset has begun rates have increased.
Action: Theatres are now increasing activities and there is a focus on ensuring booking ahead for up to 6 weeks as the elective restart program commences. Utilisation has increased on both the Arrowe Park and Clatterbridge sites.
Expected Impact: It is expected that previous levels of core utilisation will be attained except where theatre sessions require the higher level of PPE and cleaning associated with patient and procedures as a result of safe COVID management.



Responsive Domain

4-hour Accident and Emergency Target (including Arrowe Park Walk in Centre)

Executive Lead: Chief Operating Officer

Performance Issue:

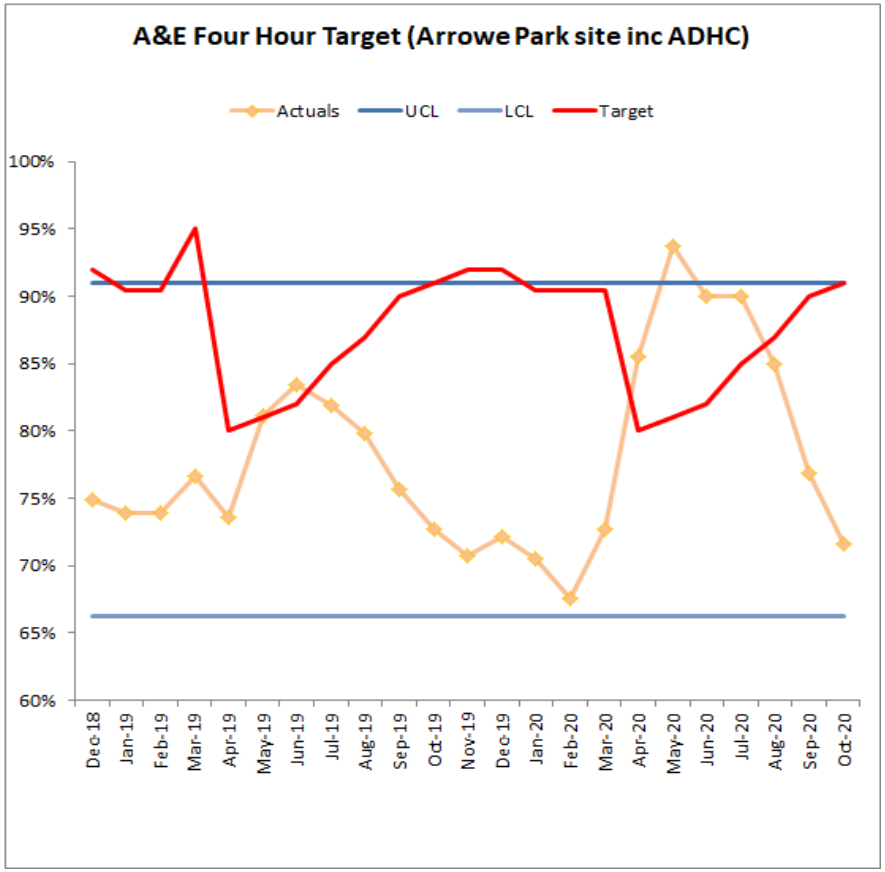
Performance during the first wave of COVID resulted in much reduced attendances, lower bed occupancy due to faster discharge and reduced elective activities creating better flow. From September ED attendances have returned to similar levels to last year and elective activities have been restarted, with occupancy levels at circa 95%.

Action:

The ED footprint has been redesigned to reflect the management of COVID and Non Covid patients, and pathways from admission have been implemented.
Real time “incident” management systems of daily bronze meetings and have been reintroduced and Wirral health and social care cells have been stepped up to unblock barriers to discharge.
For the remainder of 2020/21 the Division of Medicine has been split and bolstered with senior leadership to create bandwidth to focus on ED and Assessment, and Medical specialty wards.

Expected Impact:

The above measures are targeted to improve performance and maintain a zero approach to 12 hour trolley waits.



Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks.

The position at the end of October 2020 was 90.5%, continuing the sustained improvement across recent months.

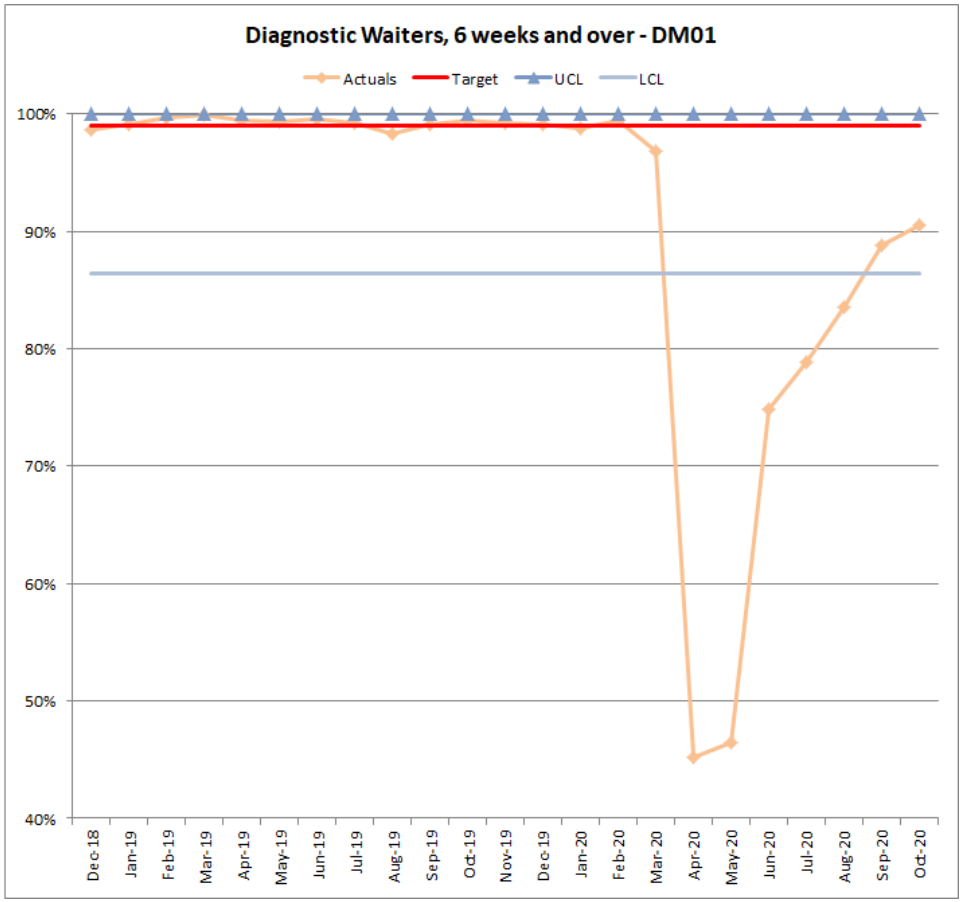
Action:

The recovery in diagnostic waits continues, and measures have put in place to safely manage the procedures, clinical environment and patient waiting rooms.

The primary modality not delivering the standard is Endoscopy where a significant backlog has been created through the pandemic. Sessional delivery is now to pre-Covid delays with additional weekend sessions being run to offset the COVID safety measures employed with these clinical procedures.

Expected Impact:

During the restart and recovery of diagnostic services clinical priority has been the absolute aim. It is recognised that waiting times for routine testing has been impacted, but it is improving month on month.



Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

Performance Issue:

There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks.

The position at the end of October 2020 was 90.5%, continuing the sustained improvement across recent months.

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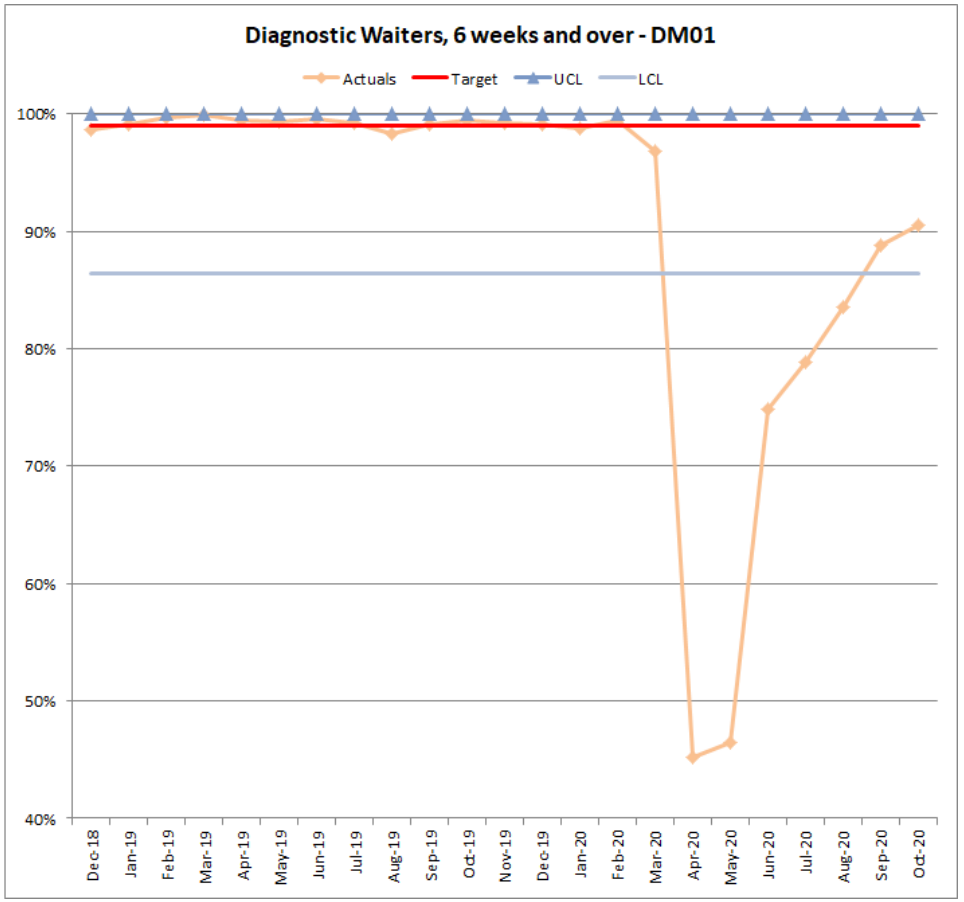


Well-led Domain

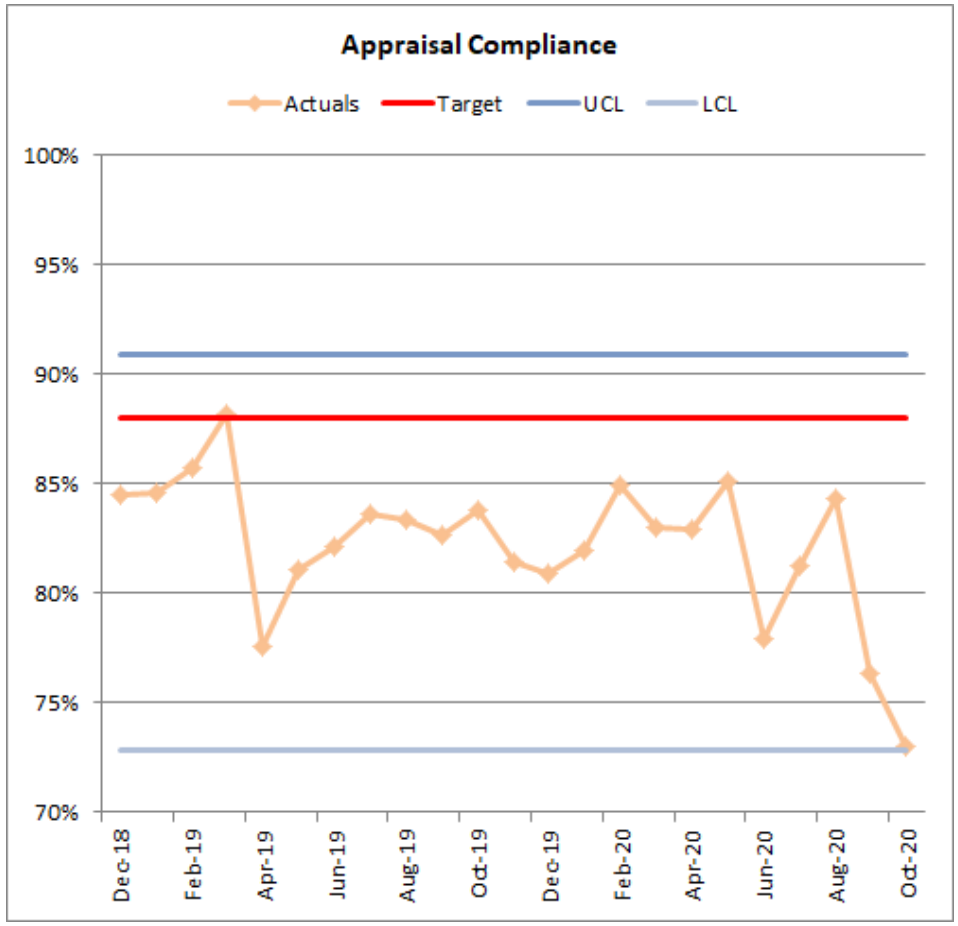
Appraisal compliance %

Executive Lead: Director of HR / OD

Performance Issue:

The target for staff having an annual appraisal is 88%. This standard has not been achieved since March 2019; a significant deterioration was seen in June but subsequently improved in Jul and Aug 20 but rates have dropped again to 73% in October 2020. This level sees compliance at its lowest level since March 2019.

Division	May 2020	July 2020	August 2020	October 2020	Focus areas to improve compliance
Clinical Support	85.15%	74.59%	78.08%	64.39%	Various areas across the Division
Corporate Support	73.47%	63.91%	68.81%	86.47%	Number of Teams
Estates & Facilities	84.13%	76.49%	88.58%	86.47%	Estates
Medicine and Acute	87.76%	87.71%	88.58%	72.17%	ED, Med Division Management
Surgery	87.36%	88.56%	88.89%	76.40%	Surgical Div Management
Women's and Children's	89.75%	84.33%	86.5%	68.32%	Women's
Overall Trust	**85.11%**	**81.25%**	**84.28%**	**73.0%**	



The national cessation of the exemption for completion of appraisals for the Medical and Dental staff group during COVID-19 has impacted on the overall figure negatively and will take time to recover.

No Divisions have achieved the KPI target of 88%. There has been a significant improvement from Corporate Support (17.66%) and Estates and Facilities have

dropped slightly by 2.11% to 86.47%. The Clinical Divisions have all seen significant reduction with the lowest performing Divisions being Women's and Children's at 68.32% and Clinical Support at 64.39%. The most significant reduction (18.18%) in the last month is for Women's and Children's. For the Clinical Support Division, compliance has steadily declined from 85.1% this year and has seen a reduction of 13.69% from September to October 2020.

Surgery and Medicine and Acute Divisions were both above the compliance target of 88% last month but have both significantly dropped this month (88.89% to 76.40% for Surgery and 88.58% to 72.17% for Medicine). With continued elective activity as well as the 2nd wave of the pandemic on the acute medical areas, the operational impact cannot be underestimated.

The impact of this is that over one third of staff have not had the opportunity to review their performance, objectives and development needs with their manager as a protected conversation within the expected timeframes.

It is fair to note that the operational impact of COVID-19 has significantly contributed to this reduction, which includes the number of staff who took annual leave after the first wave, the second wave of the pandemic and the continuation of elective activity with subsequent inability to release staff to support COVID areas.

The above coupled with anticipated workforce gaps and winter pressures will be a risk to achievement of compliance before the end of the 2020/21 financial year.

Managers are sent alerts via ESR and monthly compliance reports are available via a shared folder under secure access due to GDPR regulations and identified managers have been given access and supported through this change.
Individual staff and managers receive alerts via ESR email notifications that their appraisal is due.

Action:
Workforce compliance data has been made available to managers on request via Divisions to enable them to manage complicate for their areas.

Department managers are expected to act on compliance alert reports by making arrangements for their staff appraisals to take place and by committing to

a quality discussion with staff members.

The Deputy Director of OD will be working with the Divisional Management Teams to confirm Divisional actions being taken to address low levels of compliance in specific areas, and seek the support of the HR Business Partner and OD Team in delivering against these. Check and challenge discussions take place at a divisional triumvirate and exec team level at the monthly Divisional Performance Review meetings.

A new team appraisal process has been developed and will be offered to all areas as an alternative.

We are currently dovetailing the appraisal with the Wellbeing Conversation recommended as part of the People Plan.

Medical appraisals will be monitored as a priority following the national cessation of the pause for this staff group during the first wave of the Pandemic.

A quality review of appraisals is underway and a review of the bespoke appraisal process developed for Estates and Facilities Division will take place in Q4.

Risks associated with non-completion of appraisals include impact on performance and finance by effective use of resources. Staff may not have clarity regarding their roles, responsibilities, personal objectives and skills and knowledge development may not be achieved to enable effective delivery of their roles. This is likely to impact on the outcome of the national staff survey in terms of the extent to which staff feel valued and supported and overall staff engagement score. The staff survey is due to finish at end Nov 2020.

A recovery plan will be developed.

Expected Impact:

- 31/3/21 to complete the quality review and deliver recovery plan of appraisal compliance.
- The forecasted impact of the second wave of COVID-19 and operational winter pressures is expected to impact on achievement of compliance and this will be factored into the recovery plan.

Board of Directors	
Agenda Item	**20-21/193**
Title of Report	**Finance Report for the period ending 31st October 2020**
Date of Meeting	2nd December 2020
Authors	Robbie Chapman Julie Clarke John McManus
Accountable Executive	Claire Wilson Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	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 7 Finance Report 2020/21

Contents

1. Executive summary

1.1 The overall M7 performance position is a surplus of £0.8m; this represents a favourable variance of £0.4m from the plan submitted to NHSI for the second half of the year.

1.2 The M7 position includes:

- The system top up fund of £3m, a COVID-19 fund of £1.8m and a growth fund of £0.2m as agreed from the Cheshire & Merseyside Health & Care Partnership.
- "Income guarantee support" to offset the reduced level of clinical activity in the Trust estimated to be c£3.7m.
- Revenue costs in relation to COVID-19 of £0.8m (YTD £8.3m).
- Other non- COVID-19 (business as usual) expenditure has continued to grow over the last few months due to the focus on the restoration of the elective programme however it still remains below the trajectory set by NHSE/I submitted in our plan.

1.3 The Trust no longer receives "additional top-up" funding to ensure break-even. Instead the Trust receives system funds for top up, COVID-19 and growth from Cheshire and Merseyside Health & Care Partnership. These funds are on a fair share basis calculated using each Trust's turnover.

1.4 The COVID-19 spend in M7 is broadly consistent with the previous period at £0.8m (the run rate was £1.3m Apr-Sep). We had planned for a increase in expenditure in October 2020 but despite an increase in admissions from September we have not seen an increase in costs.

1.5 Cash balances at the end of October 2020 were £44.8m; reflecting the accelerated cash payments made to providers to support their liquidity position. NHSI have committed to payment of block income in advance for the 2020/21financial year.

1.6 The Trust's formal cost improvements/efficiencies program has been "paused" to enable it to focus on responding to the pandemic, this is in line with the removal of the national efficiency requirement by NHSI. However, productivity improvements that have been made to support the COVID-19 response are being developed further and the Trust are working with the Healthy Wirral system partners on areas which can further support system capacity as part of the phase 3 recovery reset.

1.7 Capital spend for 2020/21 can be sub-divided into three key work streams:

- Operational capital spend - following the re-submission of the draft plan in May which addressed both the slippage of the 2019/20 plan, and the impact of the C&M capital limit on the 2020/21 plan for WUTH, the annual plan is £11.2m.
- Additional national allocations for Critical Infrastructure (£1.4m), A&E (£1.4m), Restoration of Cancer Services (£0.8m), and Critical Care (£0.7m).
- Capital requirements to support the local response to COVID-19 19.

Capital expenditure is detailed in section 6.

2. Background

2.1 As previously reported, in March 2020, NHSE/I implemented financial arrangements for the period between 1 April and 30 September 2020 as a result of COVID-19. A key part of these changes included a nationally determined monthly 'block contract' payment and where necessary, 'top-up' payment designed to cover costs. The payments were based on an average of the Mth 8 - 10 activity in 19/20 with a top-up payment to reflect the difference between this figure and actual costs.

2.2 M7 was the first period of the new funding regime that will be in place until the end of the year. The main features of the new system are as follows:

- Systems have been issued with 'funding envelopes' which are the equivalent to the current block and prospective top-up payments and a system-wide COVID-19 funding envelope.
- There is no longer a retrospective payment mechanism. Providers and CCGs are expected to achieve financial balance within these envelopes.
- Whilst systems will be expected to breakeven as a whole, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

2.3 'Block payments' will be adjusted depending on delivery against the activity restart goals aimed at accelerating the return of non-COVID-19 health services which include:

- Restoring full operation of all cancer services
- Recovering the maximum elective activity possible making full use of the capacity available.

2.4 The performance trajectories within restart goals are as follows:

- Delivering a minimum of 80% of 2019/20 activity for both inpatient electives and for outpatient/daycase procedures. This rose to 90% in October 2020.
- Achieving 90% of 2019/20 activity levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October 2020.
- Delivering 100% of 2019/20 activity for first outpatient attendances and follow-ups (face to face or virtually) from September through to March 31 2021.

2.5 The Trust submitted a revised plan for the remainder of the year in October; this forecast a small surplus of £0.2m at year end, albeit with a surplus of £0.4m at M7.

2.6 All organisations are expected to demonstrate clear governance arrangements are in place for approval and all costs are properly accounted for through the period. Audits will be undertaken to ensure appropriate accounting rigour is applied.

3. Dashboard, overview and Risks

3.1 Mth 7 Performance Dashboard

		Current Period			Year to date		
		Budget	Actual	Variance	Budget	Actual	Variance
I&E Performance (£'000)	On Plan	396	782	386	396	782	386
NHSI UoR rating	On Plan		2	2		2	2
NHSI Agency Performance (£'000)	NHSI cap	698	614	84	4,624	3,599	1,025
Capital spend (£'000)	On Plan	1,574	677	(897)	9,121	3,815	(5,306)

3.2 Risk summary

3.2.1 Risk 1 - Operational Management of the position

- Going forward delivering the M7 – M12 'break- even' plan under the new financial re-gime of the agreed system funding envelopes across Wirral and Cheshire & Mersey.
- Delivering activity trajectories on scheduled care whilst managing COVID-19 and winter activity - this is being progressed through the weekly activity meeting taking place with the Divisional teams and the Chief Operating officer.
- Ensuring all revenue COVID-19 -19 spend is accurately recorded, this is reviewed as part of the monthly reporting cycle and analysed in detail, and assumptions are "stress tested" internally. The reported position is submitted to NHSI where national and regional finance teams perform analytical reviews and reasonableness test for all COVID-19 costs as part of the overall assurance process.

3.2.2 Risk 2 – Cash

- Formal confirmation has been received that the cash regime in place to support pro-viders in the first half of this financial year, will continue for the remainder of this fi-nancial year. Trust forecasting has assumed block payments for 2021/22 will revert to their usual pattern of receipt (in month) in March 2021 and therefore cash balanc-es are expected to significantly reduce by year end.

3.2.3 Risk 3 – Capital Expenditure

- Divisions submitted refined Capital plans and risk assessed schemes for approval at the end of May 2020 and this has enabled a revised capital programme for the year to be agreed. In year delivery of this programme will be monitored by the Capital Management Group (CMG) and assurance oversight provided through the Capital Assurance Committee.

- The Trust has recently been allocated additional funding for A&E, critical infrastructure repair, and restoration of cancer services. This will be a challange to deliver over the winter period if COVID-19 activity continues to grow. However, schemes have been identified, and the teams are focussed on these as key priorities.
- The revised capital plan for 2020/21 is dependent upon the delivery of a significant level of estates work and will require careful planning to ensure that operational capacity is not disrupted at key pressure points in the year.
- Additional project resource has been mobilised in order to accelerate delivery of the estates elements of the programme, however, longer term, the capacity of the Capital team needs to be reviewed in the light of the significant increase in the size and complexity of the capital programme

4. Financial Performance

4.1 Income and expenditure

4.1.1 For M1 – M6, under the NHSE/I funding regime the Trust has delivered the expected break-even position, with "additional top-up" funding of £2.9m in 6 months. This top up funding has now ceased and the Trust is expected to achieve break-even to plan under the agreed system funded envelope.

4.1.2 For M7 the Trust has received a system top up fund of £3m, a COVID-19 fund of £1.9m and a further £0.2m of growth as agreed from the Cheshire & Merseyside Health & Care Partnership.

4.1.3 Costs associated with COVID-19 were broadly in line with September. This is £0.5m less than the plan submitted to NHSI. Despite the increase in admissions in M6 and M7 we have yet to incur expenditure at the levels seen in the first peak earlier in the year. This is explained in more detail within the divisional reports in Section 5. The total year to date expenditure associated with COVID-19 is £8.3m.

4.1.4 Other non COVID-19 expenditure continues to grow due to the restoration of the elective programme. For M7 the expenditure was largely on plan overall. Further explanation is included in more detail within the divisional reports in Section 5.

Table 2: Financial position for the period ending 31st October 2020

Month 7 Financial Position	Budget (Mth 7)	Actual (Mth 7)	Variance	Year To Date Budget	Year To Date Actual	Variance
NHS income from patient care activity	27,447	23,807	(3,641)	193,042	138,328	(54,714)
Income Guarantee	0	3,718	3,718	0	54,157	54,157
National & System Top Up / Growth	3,213	3,213	0	18,584	18,585	1
Additional Top up - Retrospective M1- M6	0	0	0		2,930	2,930
System & National Covid 19 fund	1,909	1,868	(41)	1,909	1,868	(41)
Non NHS income from patient care	325	218	(107)	3,068	2,410	(658)
Other Operating income	2,251	2,208	(43)	17,458	14,315	(3,143)
Total Income	**35,144**	**35,030**	**(114)**	**234,061**	**232,593**	**(1,468)**
Employee expenses	(22,752)	(22,935)	(183)	(156,981)	(154,689)	2,292
Operating expenses	(10,342)	(10,187)	154	(72,473)	(66,626)	5,847
Covid 19 costs	(1,315)	(825)	490	(1,315)	(8,267)	(6,952)
Total expenditure	**(34,409)**	**(33,948)**	**461**	**(230,769)**	**(229,582)**	**1,187**
Non Operating Expenses	(327)	(324)	3	(2,883)	(2,292)	591
Surplus / (deficit)	**409**	**759**	**350**	**409**	**719**	**310**
Reverse capital donations / grants I&E impact	(13)	23	36	(13)	63	76
Surplus/(deficit) - Control Total	**396**	**782**	**386**	**396**	**782**	**386**

4. Financial Performance

Table 3: Income analysis for the period ending 31st October 2020

	Current month			Year to date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Elective & Daycase	4,177	3,391	(786)	29,860	13,333	(16,527)
Elective excess bed days	82	177	95	582	305	(277)
Non-elective	8,423	7,886	(537)	59,342	46,222	(13,120)
Non-elective Non Emergency	973	1,050	77	6,888	7,052	164
Non-elective excess bed days	355	81	(274)	2,495	818	(1,677)
A&E	1,273	1,081	(192)	8,989	7,461	(1,527)
Outpatients	3,014	2,453	(561)	21,350	12,683	(8,667)
Diagnostic imaging	187	172	(15)	1,323	801	(521)
Maternity	481	386	(95)	3,381	3,100	(282)
Non PbR	7,213	5,747	(1,466)	50,324	37,924	(12,399)
HCD	1,256	1,262	6	9,050	8,790	(260)
CQUINs	189	189	0	1,329	1,329	0
National & System Top up Funds	3,213	3,213	0	18,584	21,515	2,930
Income Guarantee	0	3,722	3,722	0	54,158	54,158
Total income from patient care (SLAM)	30,836	30,810	(26)	213,498	215,493	1,995
Other patient care income	2,006	1,948	(58)	2,538	2,435	(102)
Non-NHS: private patients & overseas	7	16	9	88	19	(70)
Injury cost recovery scheme	42	48	7	476	331	(145)
Total income from patient care activities	32,891	32,823	(68)	216,600	218,277	1,677
Other operating income	2,253	2,208	(46)	17,461	14,316	(3,145)
Total income	35,144	35,030	(114)	234,061	232,593	(1,468)

4.2 Pay

4.2.1 Overall pay costs (excluding COVID-19) were overspent by (£0.2m) in M7 and are £2.3m underspent YTD. Table 4 below details pay costs by staff group. More detail is explained in the divisional reports in section 5.

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

Pay analysis (exc Covid)	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
Consultants	(44,813)	(3,700)	(3,957)	(258)	(25,120)	(25,154)	(34)
Other medical	(32,323)	(2,692)	(2,580)	112	(18,052)	(17,567)	485
Nursing and midwifery	(74,767)	(6,065)	(6,018)	47	(42,849)	(41,973)	876
Allied heath professionals	(15,800)	(1,321)	(1,295)	26	(8,821)	(8,741)	80
Other scientific, therapeutic and technical	(6,158)	(534)	(525)	9	(3,432)	(3,499)	(67)
Health care scientists	(12,485)	(1,041)	(1,021)	19	(7,138)	(7,124)	14
Support to clinical staff	(52,453)	(4,220)	(4,053)	167	(29,599)	(28,787)	812
Non medical, non clinical staff	(37,400)	(3,097)	(3,396)	(299)	(21,349)	(21,253)	95
Apprenticeship Levy	(1,039)	(83)	(89)	(6)	(622)	(591)	31
Total	(277,238)	(22,752)	(22,935)	(183)	(156,981)	(154,689)	2,292

4. Financial Performance

Table 5: Pay analysis by pay type (excluding COVID-19 costs)

Pay analysis (exc Covid)	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	(247,586)	(20,697)	(20,978)	(281)	(140,338)	(143,125)	(2,787)
Bank	(12,368)	(772)	(805)	(33)	(7,143)	(4,746)	2,397
Medical bank	(7,622)	(597)	(493)	104	(4,350)	(3,205)	1,145
Agency	(8,623)	(603)	(571)	32	(4,529)	(3,022)	1,507
Apprenticeship Levy	(1,039)	(83)	(89)	(6)	(622)	(591)	31
Total	(277,238)	(22,752)	(22,935)	(183)	(156,981)	(154,689)	2,292

4.3 Non pay

4.3.1 Non pay expenditure, excluding depreciation and COVID-19 costs, is below plan by £0.1m in M7 (£5.8m YTD). This is analysed in Table 8 and explained in detail within the divisional reports in section 5.

Table 8: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	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	(36,030)	(2,865)	(2,685)	180	(20,765)	(17,067)	3,699
Supplies and services - general	(5,185)	(404)	(375)	29	(3,071)	(2,436)	634
Drugs	(23,622)	(1,967)	(1,880)	87	(13,671)	(12,644)	1,027
Purchase of HealthCare - Non NHS Bodies	(7,234)	(537)	(570)	(33)	(4,392)	(3,404)	987
CNST	(12,894)	(1,079)	(1,079)	0	(7,499)	(7,553)	(53)
Consultancy	(411)	0	(0)	(1)	(411)	(0)	411
Other	(31,928)	(2,588)	(2,726)	(138)	(16,763)	(17,293)	(530)
Total	(117,303)	(9,440)	(9,316)	124	(66,573)	(60,397)	6,176
Depreciation	(10,430)	(902)	(871)	31	(5,900)	(6,229)	(329)
Total	(127,733)	(10,342)	(10,187)	154	(72,473)	(66,626)	5,847

4.4 Costs incurred to manage the local response to COVID-19

4.4.1 **COVID–19 revenue costs**

4.4.1.1 In M7 an additional £0.8m costs for both pay and non-pay were incurred in respect of COVID-19. The YTD spend is £8.3m. The revenue cost impact of COVID-19 is collected and submitted to NHSI as part of routine monthly reporting to allow national cost tracking.

4.4.1.2 For the purposes of ascertaining COVID-19 costs, NHSI have issued detailed guidance as to the "allowable" cost that can be assigned. This means organisations should ***include*** the following:

- The costs of specific COVID-19 policies, directives or nationally approved business cases. This includes the costs of workforce initiatives put in place to enable the expansion of services to deal with the expected increase in demand as a result of COVID-19 (Paragraph 3.1);
- Costs that are a consequence of policies relating to COVID-19 but don't directly relate to the treatment of COVID-19 patients (e.g. paying sick pay at full pay for all staff)
- Some of the above can be subjective and hence Trusts are required to record assumptions.

4. Financial Performance

4.4.1.3 Costs included within the Trust's returns to NHSE/I in respect of COVID-19 are detailed further in the Table 9 below.

Table 9: YTD COVID-19 revenue costs

Month 7 Covid Position (£k)	Apr (M1)	May (M2)	Jun (M3)	Jul (M4)	Aug (M5)	Sep (M6)	Oct (M7)	Year to Date
Medical Staff	(263)	(386)	(204)	(199)	(37)	(165)	(84)	(1,337)
Other Clinical Staff	(367)	(626)	(574)	(560)	(126)	(293)	(272)	(2,818)
Non Clinical Staff	(182)	(52)	(47)	(105)	(37)	(58)	(32)	(513)
Total Pay	**(812)**	**(1,065)**	**(824)**	**(863)**	**(200)**	**(516)**	**(388)**	**(4,668)**
Clinical Supplies	(189)	(591)	70	(99)	(122)	(68)	(42)	(1,041)
Other Non Pay	(556)	(140)	(333)	(627)	(233)	(273)	(395)	(2,557)
Total Non-Pay	**(746)**	**(731)**	**(263)**	**(726)**	**(355)**	**(341)**	**(437)**	**(3,599)**
Total Covid Expenditure	**(1,558)**	**(1,796)**	**(1,087)**	**(1,589)**	**(555)**	**(857)**	**(825)**	**(8,267)**

4.4.1.4 In M7 a further c£0.4m was spent on pay costs, directly associated with COVID-19. This represents a marginal reduction from M6, which included the one-off charge for backdated doctor pay.

4.4.1.5 Non pay costs associated with COVID-19 were £0.4m in M7, an increase from the previous month as a result of increased admissions but lower than earlier months that saw significant one-off expenditure to create a COVID-19 secure environment.

4.4.1.6 Appendix 2 details COVID-19 related costs incurred by category for both pay and non pay expenditure by NHSI category.

4.4.2 COVID-19 Capital costs

Claims totalling £0.9m in respect of medical and IT equipment purchased in Phase 1 of the Covid-19 response during April and May 2020 have been submitted to NHSI.

The Trust has recently been awarded £1.4m for Urgent and Emergency Care (UEC), £1.4m for Critical Infrastructure Risk Repairs (CIR), £0.8m for Restoration of Cancer Services, and £0.7m for Critical Care capacity upgrades.

5. Financial Position

6.1 Statement of Financial Position (SOFP)

Actual as at 31.03.20 £'000		Actual as at 30.09.20 £'000	Actual as at 31.10.20 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	159,876	159,772	(104)	↓
14,029	Intangibles	13,425	13,335	(90)	↓
723	Trade and other non-current receivables	661	627	(34)	↓
176,244		**173,962**	**173,734**	**(228)**	↓
	Current assets				
3,991	Inventories	3,966	3,961	(5)	↓
24,375	Trade and other receivables	20,980	16,920	(4,060)	↓
0	Assets held for sale	0	0	0	→
5,931	Cash and cash equivalents	42,851	44,426	1,575	↑
34,297		**67,797**	**65,307**	**(2,490)**	↓
210,541	**Total assets**	**241,759**	**239,041**	**(2,718)**	↓
	Current liabilities				
(41,874)	Trade and other payables	(44,782)	(39,159)	5,623	↑
(3,000)	Other liabilities	(32,601)	(34,747)	(2,146)	↓
(85,234)	Borrowings	(1,088)	(1,107)	(19)	↓
(2,926)	Provisions	(2,350)	(2,860)	(510)	↓
(133,034)		**(80,821)**	**(77,873)**	**2,948**	↑
(98,737)	**Net current assets/(liabilities)**	**(13,024)**	**(12,566)**	**458**	↑
77,507	**Total assets less current liabilities**	**160,938**	**161,168**	**230**	↑
	Non-current liabilities				
(2,588)	Other liabilities	(2,534)	(2,525)	9	↑
(6,274)	Borrowings	(5,733)	(5,728)	5	↑
(7,304)	Provisions	(7,205)	(6,693)	512	↑
(16,166)		**(15,472)**	**(14,946)**	**526**	↑
61,341	**Total assets employed**	**145,466**	**146,222**	**756**	↑
	Financed by Taxpayers' equity				
80,106	Public dividend capital	164,268	164,268	0	→
(65,492)	Income and expenditure reserve	(65,530)	(64,773)	757	↑
46,727	Revaluation reserve	46,727	46,727	0	→
61,341	**Total taxpayers' equity**	**145,465**	**146,222**	**757**	↑

- Current borrowings have reduced following the repayment in September 2020 of £83.9m of DHSC loans, funded by the issue of new Public Dividend Capital.
- Following the conclusion of negotiations with Wirral CCG historic debt and underperformance credits have been cleared in October resulting in significant reductions in both Trade Receivables and Trade Payables.
- Cash and other current liabilities (deferred income) have increased significantly in year due to the early receipt of NHS Block income under the amended NHSI financial regime. This advanced payment will continue for the remainder of the 20/21 financial year. It is expected funding flows will return to their usual timings for the 21/22 financial year.

5. Financial Position

6.2 Capital Expenditure – October 2020

	Full Year Budget			Full Year Forecast		YTD	
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual	Distance to Go
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Total Internally Generated Funding	10,740		10,740	10,740	0	6,911	
PDC (Public Dividend Capital) - UTC	500		500	420	80	0	
PDC - COVID-19	0	925	925	925	0	279	
PDC - Critical Infrastructure Repair	0	1,434	1,434	1,434	0	0	
PDC - Urgent & Emergency Care	0	1,441	1,441	1,441	0	0	
PDC - Restoration of Cancer Services	0	792	792	792	0	0	
PDC - Critical Care	0	664	664	664	0	0	
PDC - Cyber Security	0	40	40	40	0	0	
External Funding - donations/grants	0	132	132	132	0	0	
Total funding	**11,240**	**5,428**	**16,668**	**16,588**	**80**	**7,190**	
Expenditure							
Prior year(s) capital commitments	3,526	(180)	3,346	3,243	103	1,700	1,543
Estates	4,383	(391)	3,992	1,385	2,607	97	1,288
Informatics	575	(93)	482	501	(19)	180	321
Medicine and Acute	300	186	486	484	2	20	464
Clinical Support and Diagnostics	369	306	675	676	(1)	37	639
Surgery	1,363	231	1,594	1,318	276	323	995
Women and Children's	0	67	67	67	0	23	44
Other	0		0	0	0	0	0
Contingency[2]	224	(183)	41	0	41	0	0
UTC / Hospital upgrade programme	500	(80)	420	420	0	177	243
COVID-19 response	0	925	925	986	(61)	986	0
Critical Infrastructure Repair	0	1,434	1,434	1,129	305	0	1,129
Urgent & Emergency Care	0	1,508	1,508	1,665	(157)	155	1,510
Restoration of Cancer Services	0	792	792	792	0	0	792
Critical Care	0	664	664	0	664	0	0
Cyber Security	0	40	40	47	(7)	21	
Donated assets	0	132	132	132	0	96	36
Total expenditure (accruals basis)	**11,240**	**5,358**	**16,598**	**12,845**	**3,753**	**3,815**	**9,004**
Capital programme funding less expenditure	**0**	**70**	**70**	**3,743**	**(3,673)**	**3,375**	
Capital expenditure	11,240	5,358	16,598	12,845		3,815	
NBV asset disposals	0	0	0	0		0	
Donated assets	0	(132)	(132)	(132)		(96)	
CDEL impact	**11,240**	**5,226**	**16,466**	**12,713**		**3,719**	

- The BAU capital plan of £11.24m has been increased by a number of PDC funded capital awards increasing the trust total capital plan to £16.6m. These awards include £0.9m re COVID-19 phase 1 response, £1.4m re Critical Infrastructure Repairs, £1.4m re Urgent & Emergency Care to improve patient flow through A&E, £0.8m Restoration of Cancer Services, and £0.7m re Critical Care.
- A review of the capital programme was completed in September and identified a likely net £3.6m slippage against plan which has been reported to the Cheshire & Mersey as well as NHSI. The slippage in BAU activity is largely driven by pressures to maintain operational capacity forcing postponement of a number of major schemes such as ward upgrades £1.2m.
- The £1.4m Urgent & Emergency Care scheme is currently on track to complete mid-January. The excess of forecasted costs over PDC award are being funded from BAU slippage.
- A significant refurb of Critical Care facilities (£1.4m) is being funded from the Critical Care PDC award (£0.7m) in combination with part of the Critical Infrastructure Repairs award (£0.7m). Enabling works are planned to complete by February 21 with the main build commencing in March. Approximately £1m of activity is expected to slip into 2021/22.
- Actual YTD capital spend totals £3.8m, largely due to Covid-19 response (£1.0m) and schemes brought forward from 2019/20 (£1.7m). Orders are with suppliers for a further £5.3m of the £9.0m distance to go, the most significant individual schemes being Urgent & Emergency Care upgrade £1.2m, Cath Lab Refurb £0.9m, community radiology equipment £0.4m and monitoring equipment £0.6m.

5. Financial Position

6.3 Statement of Cash Flows – October 2020

	Month Actual £'000	Year to date Actual £'000
Opening cash	**42,851**	**5,931**
Operating activities		
Surplus / (deficit)	757	719
Net interest accrued	16	137
PDC dividend expense	309	2,164
Unwinding of discount	(1)	(8)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	1,081	3,011
Depreciation and amortisation	871	6,229
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	0	(96)
Changes in working capital	147	35,043
Investing activities		
Interest received	3	12
Purchase of non-current (capital) assets [1]	(522)	(5,153)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	0	96
Financing activities		
Public dividend capital received	0	84,163
Net loan funding	0	(84,392)
Interest paid	0	(378)
PDC dividend paid	0	0
Finance lease rental payments	(6)	(41)
Total net cash inflow / (outflow)	**1,575**	**38,495**
Closing cash	**44,426**	**44,426**

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

Cash summary

- Financing activities reflect the receipt of PDC funding to allow repayment of the Trust's revenue support and working capital loans in September.
- Cash balances have increased significantly in year due to the early payment of NHS Blocks with a corresponding increase in deferred income shown within 'changes in working capital'. In addition the cash position is helped by the lower than expected level of capital expenditure to date.
- Due to this 'accelerated' funding and the current break-even financial positon the Trust has not had to seek additional financial support to fund the remaining impact of the 2019/20 deficit as expected. The early payment of block income is now expected to remain throughout 2020/21 and will reduce the likelihood in year support in the form of additional PDC.
- This position is being closely monitored by the Financial Services team which actively manages the net working capital position to maintain liquidity and minimise finance costs.

5. Financial Position

6.4 Treasury and working capital

Borrowings summary October 2020

	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 20	Loan Repayment Sept 20	Loan Balances Oct 20	Forecast Repayment 20/21	Forecast Closing Balances Mar21
	£'000	Years	%	£'000	£'000	£'001	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	(375)	3,000	(375)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	(133)	3,715	(133)	3,583
3. Interim revolving working capital support	23,289	5	3.50	23,289	(23,289)	0	0	0
4. Uncommitted interim revenue support	40,389	3	1.50	40,389	(40,389)	0	0	0
5. Uncommitted interim revenue support	20,206	3	3.50	20,206	(20,206)	0	0	0
	97,884			91,107	(84,392)	6,715	(508)	6,208

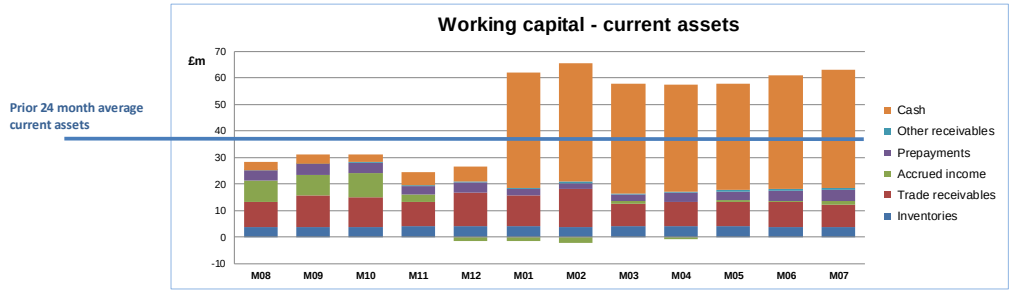
This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

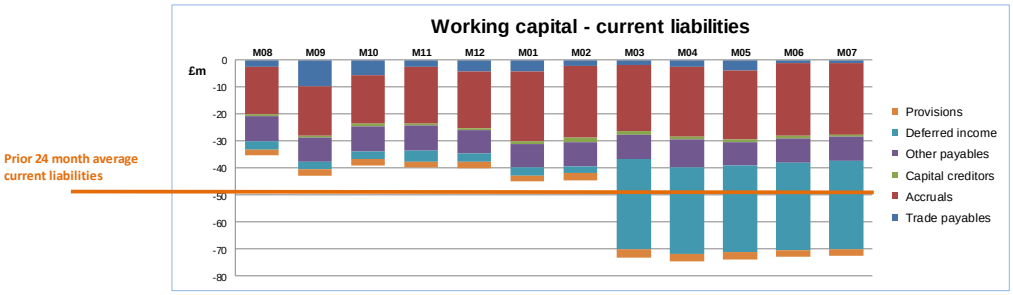
Loan funding

- As part of reforms to the NHS cash regime £83.9m of Trust interim revenue support and working capital loans were repaid on 23rd September 2020, funded by the issue of additional Public Dividend Capital.
- Interest charges on these loans prior to repayment have also been waived in 2020/21.
- The Trusts remaining borrowings, comprising capital loans, will remain on their existing terms and will be repaid at £1.0m per year.

Working capital profiles by month

2020/21 working capital shows the impact of early NHS Block receipts. The profiles below show month 7 working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.





5. Financial Position

6.5 Single oversight framework

UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-15.8	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.2	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	-19.0%	1
	Overall NHSI UoR rating				**2**

UoR rating summary

- The liquidity rating of 4 remains unchanged from the 2019/20 year end position, although the repayment of £83.9m loans in September has significantly improved the metric from the position seen in previous months.
- The capital service capacity metric has improved from a 4 in 2019/20 to a score of 1, due to the year-to-date surplus position and the cessation of interest charges on all but capital borrowings.
- The month 7 UoR rating is 2 overall. The main driver is the on plan surplus under the interim financial regime.

8. Appendices

At the end of M7, the Trust is reporting a surplus of £0.7m against a planned surplus of £0.4m.

This variance is attributed to lower than expected spend in respect of COVID-19 and lower clinical activity levels than the agreed recovery trajectory.

The Trust will continue to work closely with the local Wirral System and regional colleagues with the HCP to ensure the Trust delivers improved performance against the activity trajectories required as well as securing sufficient capacity to manage winter levels of non-elective demand, increasing COVID-19 activity and take steps to continue to restore the elective programme.

Recommendations

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

Claire Wilson
Chief Finance Officer
November 2020

Wirral University Teaching Hospital
NHS Foundation Trust

20-21 194 CQC Action Plan Quarterly Report

Board of Directors

CQC Action Plan -2020 (quarterly update report)

Board of Directors	
Agenda Item	20-21/194
Title of Report	CQC Compliance and Action Plan 2020 – Quarterly update
Date of Meeting	2nd December 2020
Author	Jacqueline Robinson, Associate Director Governance Emma Charmley, Quality and Safety Analyst
Accountable Executive	Hazel Richards, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR4 Catastrophic failure in standards of safety and care PR6 Fundamental loss of stakeholder confidence
Level of Assurance • **Positive** • **Gap(s)**	Continued progress against CQC Action plan demonstrated. Actions being taken to ensure continued progress and oversight during period of escalation to maintain momentum. Some actions have passed the expected time for completion but this is due to the unexpected impact of the COVID-19 response, however all Executive leads and Divisional Triumvirates are aware and significant progress continues across all areas.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

Following the publication of the CQC inspection report on 31 March 20, the Trust has made significant progress in both the response to requirements and recommendations made. Divisions; Corporate and Executive teams reviewed the CQC findings and developed action plans to address the 31 must do's and 76 should do's and 351 actions to support achievement of full compliance and continued improvement identified.

Progression of the CQC Action Plan is well underway and assurances provided through the confirm and challenge meetings, with evidence of implementation provided by Triumvirates. During this time divisions have been very responsive for requests of information for assurance. Appendix 1 displays the updates received for the CQC action plan as of 4th September with further updates to be provided through PSQB and in the next quarterly report to Board.

This paper provides a quarterly update as to progress against the CQC action plan and highlights:-

- overdue actions;
- completed actions and level of assurance

The paper provides the position as of 04/11/2020. At this point there were:-

- 2 must do actions overdue;
- 8 should do actions overdue;
- 7 actions embedded (the outcome of the action has been in place for >= 3 months).

Of the 107 overall requirements, 60 have all actions completed so therefore 56% of the action plan has been achieved.

There has been a 12.6% increase in October of actions assured with evidence provided for the Must Dos and Should do's.

Subsequent meetings and updates have been received and this will be reflected in the next quarterly report provided to the Board.

2. Background

The CQC inspected the Trust during October and November 2019 and the final report was published on 31 March 2020.

a. The quality improvement action plan (for Must do's) has 122 specific actions/work-plans for implementation on or before 31st March 2021.

b. The quality improvement action plan (for Should do's) has 229 specific actions/work-plans for implementation on or before 30th April 2021.

The CQC inspection report was utilised to support the Trusts consideration of which areas we need to improve. In developing the action plan the following areas of consideration were included:-

- What was the outcome we hoped to achieve (referencing the CQC must/should do's; regulatory requirements; clinical expertise) i.e. how can we improve safety and quality for our patients
- What changes (actions) will lead to the improvement
- How will we monitor the actions are being implemented
- What resources will we require to make the change

Confirm and challenge meetings are held with each Division on a monthly basis and are attended by:-

- Members of the Governance Support Unit
- Divisional Triumvirate
- Deputy Chief Nurse
- Deputy Medical Director
- Divisional governance leads

Divisions provide evidence against each of their actions appropriate to the stage in the cycle for that particular action.

Members of the 'Confirm and Challenge' meetings RAG rate each action as follows:-

Embedded	The action has been completed and reviewed; it is embedded and there is evidence that the desired outcome has been consistently met and has been tested.
Completed & Assured	The action is completed and assurance has been given by way of evidence
Completed	Verbal assurances that action has been completed
On track	Action is on track with target date
At risk	Action is at risk of not meeting its target date
Overdue	Action is overdue

An exception report is presented each month to PSQB and a quarterly report which provides assurances against all actions is also provided.

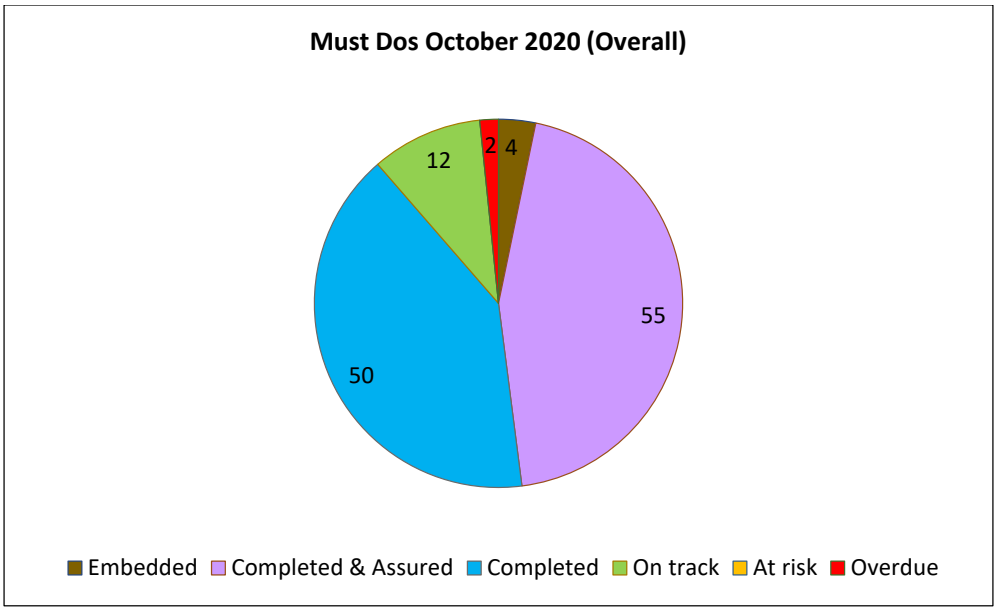
3. Key Issues/Gaps in Assurance

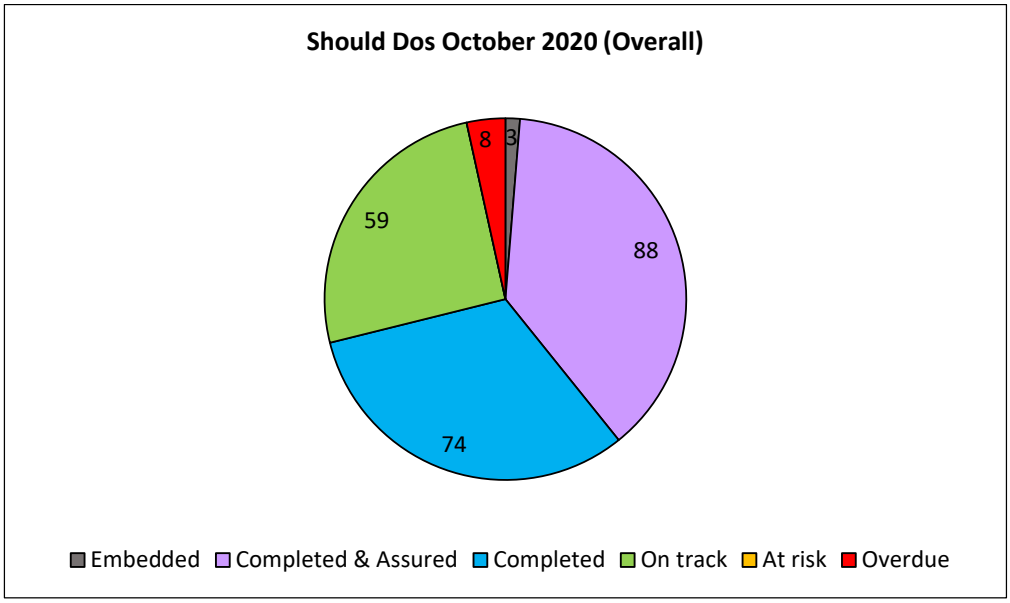
Governance and Assurance of CQC Action Plan during period of escalation (Covid-19 response and winter increase activity)

- To date Divisions have engaged with the confirm and challenge process however due to the impact of responding to Covid-19 pandemic in terms of activity levels and staffing challenges, changes are required to the process to ensure assurance of progress.
- Patient flow actions may be completed however these are changing in light of COVID activity, the test will be when they are embedded if they meet the desired outcome.
- Evidence still required of completed actions to be assured.
- Extraction of other assurance data currently already available which evidences that the actions have been embedded and improvements have been seen e.g. examples of information – see appendix 1

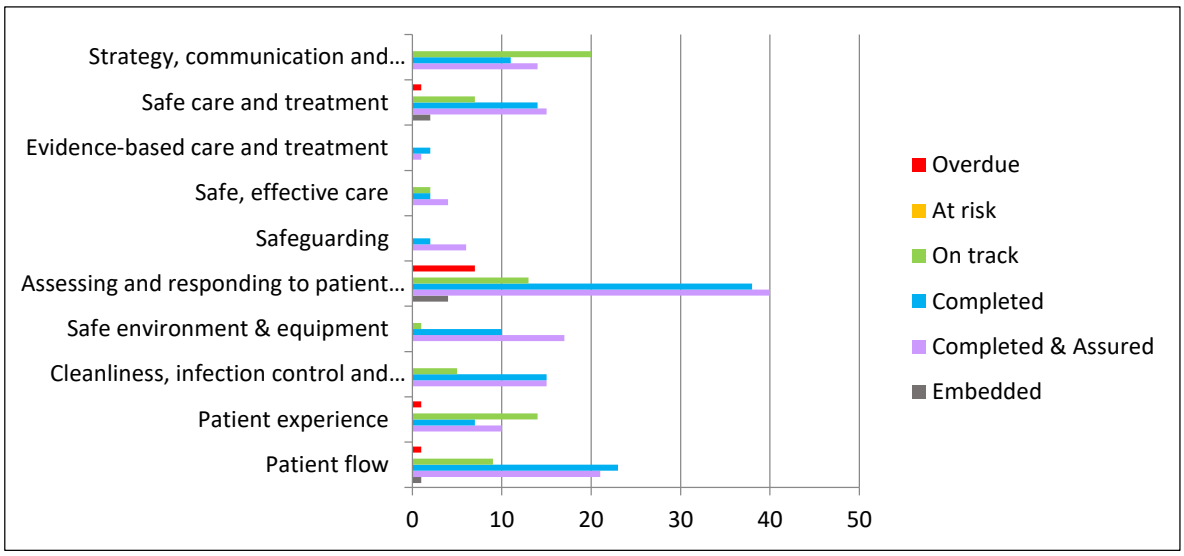
The use of resources report will be monitored at Executive level and is to be kept separate from the CQC Action Plan following discussions.

The graphs below summarises the current position of the CQC action plan as of 04/11/2020.





Actions have been grouped into key themes as well as CQC domains. Themes are subjectively identified and the crossover between themes is challenging e.g. to separate risk, patient safety and effective care:



*It should be noted that there were a number of actions identified for each regulatory requirement. An overdue action therefore does not indicate a lack of progress but an indication that one element of the plan for that specific regulation has been delayed.

4. Next Steps

- Progress updates have been provided for 5 actions identified as overdue which indicate these actions are now complete. On receipt of evidence these will be updated for inclusion in the next report.

5. Conclusion

Overall there has been significant progress made with the CQC Action Plan with 56% of all actions completed despite the impact of responding to the COVID-19 pandemic.

6. Recommendations

The Board of Directors is requested to note the progress made against the CQC Action plan and confirm sufficient assurance received.

Appendix 1 – CQC Action Plan updated as of 4th November

Ref	Key theme	Specific area	MUST Do/Should Do	Actions taken to meet regulation	Exec lead	Operational lead	RAG Status	Assurance
M01	Patient flow	Trustwide	The trust must ensure that improvements are taken to ensure that patients have timely access to care and treatment. Regulation 17(2)	1. Evaluate and Review Patient Flow Improvement Group (PFIG) structure and refocus with three key workstreams focusing on Assessment areas ('Front Door' w/s), Stranded patients ('Back Door' w/s) and roll-out of Capacity Manager tool ('Cap Man' w/s).	COO	Divisional Director - M&A/ Interim Deputy Chief Operating Officer	**Completed & Assured**	PFIG
	Patient flow			2. Deliver all components of workstreams governed by the Transformation Programme/Patient Flow Improvement workstream with overdue actions escalated to Trust Board through PMO assurance processes			**On track**	
	Patient flow			3. Review bed management agenda and SOP to ensure OPEL actions and triggers are reviewed and appropriate responses made by the Chair of the Bed meeting and these are recorded. To be audited by Bed management matron quarterly and reported to PFIG			**Completed**	
	Patient flow			4. Integrate bed management and Bronze command functions incident command meetings to encompass whole urgent care pathway management			**Completed**	
	Patient flow			5. Utilisation of support from NHSE and ECIST to introduce a single management structure for the Integrated Discharge Team ensuring effective command and multiagency collaboration in facilitating effective flow.			**Completed & Assured**	PFIG
	Patient flow			6. Development of Weekend Discharge SOP and criteria led discharge policy to facilitate 7 day discharges			**Completed & Assured**	Quality Dashboard
M02	Patient flow	Trustwide	The trust must continue to work with stakeholders to improve treatment times and referral to treatment times - Regulation 17(2)	1. Introduction of system wide Command Centre during periods of exceptional demand	COO	Wirral System Lead for Discharge	**Completed & Assured**	Wirral Planned Care Board
	Patient flow			2. Ensure consistent Executive presence at Wirral Planned Care Board			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			3. System Lead for discharge to be appointed and responsible for leading on collaboration and partnership working between Health and Social Care.			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			4.Development of system-wide dashboard to ensure a single source of robust capacity and demand data across the system.			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			5. Introduction and evaluation of multi-agency approach to Frailty at the Front Door pilot to prevent avoidable admissions of frail patients			**Completed**	
M03	Patient flow	Urgent and emergency services	The service must reduce delays in decision to admit times (Regulation 12)	1. Integrate 'ED LaunchPoint' software into Cerner to enable the implementation of ED senior clinician decision to admit rights and ensure effective governance	COO/ Medical Director	M&A Triumvirate	**Completed**	
	Patient flow			2. Proposal of ED senior clinician decision rights approved and implemented			**Completed & Assured**	

	Patient flow			3. IPSS Standards being utilised (see M10)			On track	
	Patient flow			4. Reinstatement of Senior multi-professional leadership hourly huddles to monitor; respond and escalate appropriately to ensure decision to admit delays are reduced			Completed	
M04	Patient flow	Urgent and emergency services	The service must improve the effectiveness of internal professional standards for patients who need a specialist review. Together with improving specialist review times. (Regulation 12)	1. Development of Intraprofessional Standards highlighting the turnaround time for specialist input from referral by ED and establish monitoring arrangements to ensure adherence to the agreed turnaround times.	Medical Director	AMD - M&A	Completed	
	Patient flow			2. Internal ED streaming pathways agreed and rolled out for all accepting specialties.			Completed & Assured	ED Today Live Dashboard Bi Portal
	Patient flow			3. Establish direct access pathways to assessment areas e.g. Orthopaedic Outpatient Minor Injuries Unit; gynae assessment unit to allow increased same day emergency care and direct streaming of specialist patients from ED to improve specialist review times.			Completed & Assured	ED Today Live Dashboard Bi Portal Patient FIRST
	Patient flow			4. Development of an Enhanced Frailty team ED in reach pilot evaluated and established as business as usual			Completed	
	Patient flow			5. ED and Bed Bureau to refresh the 4 and 12 hour tracking responsibilities to ensure delays (including Mental health patient delays) are highlighted and escalated prospectively in timely manner.			Completed & Assured	ED Today Live Dashboard Bi Portal Patient FIRST
M05	Patient flow	Medical care services	The service must ensure patients have timely access to care and treatment.(Regulation 17)	1. Implement Divisional requirements of the Trustwide Patient Flow Improvement workstreams (see Mo1)	COO	Divisional Director - M&A	On track	
	Patient flow			2. Explore viability of bringing key diagnostic tests in-house e.g. Capsule Endoscopy / Cardiac MRI. Alongside developing mitigations if not viable			Completed	
	Patient flow			3. Review admission criteria and Implement SOP for transfer of patients to M1 Rehab, which includes collaborative approach to acceptance of appropriate patients.			Completed	
	Patient flow			4. Introduce CAS / RAS services in a number of specialties e.g. gastro / renal / sleep / haematology (electronic triaging system for new referrals)			Completed	
M06	Patient flow	Medical care services	The service must ensure patient care is planned effectively to reduce length of stay (Regulation 17)	1. Establish IDT processes to identify delays in discharge of patients as a result of lack of suitable support packages / and availability of T2A beds and share appropriate data on a regular basis to the Commissioners to inform decisions on their commissioning intentions to procure rehabilitation and assessment bed based services from a single provider with improved KPI's on transfers of care and length of stay.	COO/ Medical Director	Wirral system lead for discharge	Completed & Assured	SAFER BUNDLE: % of discharges taking place before noon

M07	Patient flow	Medical care services	The service must ensure patient care is planned to effectively reduce the number of patients moved between wards at night (Regulation 17)	1. Launch of capacity management to enable clinically appropriate moves to occur within daytime hours and to allow data collection of moves overnight	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Divisional Director, M&A	**Embedded**	Capacity Management Wirral Millennium
	Patient flow			2. Increase HCC establishment to provide 24/7 support for timelier moves of patients in hours			**Completed & Assured**	
	Patient flow			3. Senior nurse late/twilight rota put into place to support out of hours.			**Completed & Assured**	Med & Acute Shared Drive
	Patient flow			4. Establish bed management process that will facilitate early pull of patients from assessment areas to base wards to create vacant capacity in assessment areas for out of hours new admissions			**On track**	
M08	Patient flow	Medical care services	The service must ensure effective discharge planning take place for patient (Regulation 17)	1. Review discharge policy to ensure all changes made as a result of improvement work are encapsulated and communicated to staff	COO	Divisional Director M&A	**Completed & Assured**	Discharge Policy KPIs
	Patient flow			2. Discharge process at APH to be rolled out to CBH site with Discharge Co-ordinator, Social Worker % Discharge Tracker working together to support the MDT in a co-ordinate approach to discharge			**Completed**	
	Patient flow			3. Workflow in powerchart to enable medics to document if a patient is medically fit for discharge or not and outstanding actions required highlighted on board rounds.			**Completed**	
	Patient flow			4. Introduce Red to green methodology to track progression of patient interventions to ensure timely progression through pathways in areas identified as having unnecessary delays and establish tracking processes and assurance processes to monitor improvement			Overdue	Progress update provided
	Patient flow			5. A live record of all medically optimised patients to be available on the Trust Business Intelligence portal and used by the System Lead and Integrated Discharge team as a daily discharge worklist to ensure effective discharge planning.			**Completed & Assured**	Bi Portal
	Patient flow			6. A Command and Control model to be established in the Integrated Discharge team with hourly updates reported into the Command Centre to ensure appropriate escalation of any delays to discharge.			**Completed**	
	Patient flow			7. Implement weekly MD/COO meetings to oversee Divisional LLOS progress			**Completed**	

M09	Patient flow	Medical care services	The Service must act to reduce referral to treatment times particularly for gastroenterology, dermatology and rheumatology services (Regulation 12)	1. Additional Clinic Capacity for Early Inflammatory Arthritis patients to be established	COO	Divisional Director M&A	**Completed**	
	Patient flow			2. Outpatient redesign to be undertaken to include booking of diagnostics pre-first attendance, patient initiated follow-up, virtual clinics.			**Completed & Assured**	Programme Board
	Patient flow			3. Triumvirate to lead a review of clinical capacity within Gastroenterology by reviewing resources available and activity plans to increase productivity and identify potential gaps.			**Completed**	
	Patient flow			4. Implement clinical assessment service for Gastroenterology			**Completed**	
	Patient flow			5. Triumvirate to lead a review of clinical capacity within Dermatology by reviewing resources available and activity plans to increase productivity and identify potential gaps.			**Completed**	
	Patient flow			6. Pilot and evaluate referral assessment service (dermatology)			**Completed**	
	Patient flow			7. Agree a system wide trajectory to achieve national RTT standards			**Completed**	
M10	Patient experience	Urgent and emergency services	The service must improve standards of privacy and dignity for patients cared for in the emergency department. (Regulation 9)	1. Minimise ED delays increasing risk of patients being accommodated in the emergency department corridors areas for extended periods of time by:- -A) Ensuring internal and external streaming in place at front door and ATN 24/7. - B) Focussing on 4 hour targets - C) Embedding huddles and ED action cards	COO/ Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director M&A/ Divisional Director Nursing M&A	**Completed & Assured**	Quality Dashboard
	Patient experience			2. Embed and sustain inter professional standards to ensure delays in ED are escalated and kept to a minimum			**On track**	
	Patient experience			3. Develop a SOP for periods of escalation that describes the standards to be maintained for safety, privacy and dignity			**Completed & Assured**	Quality Dashboard
M11	Cleanliness, infection control	Medical care services	The service must ensure all staff follow infection prevention and control measures and implement effective processes to prevent and control outbreaks of	1. Develop and approve IPC Strategy with operational plan	Chief Nurse, Executive Director	Divisional Director of Nursing Med & Acute/ Associate	**Completed**	

	and hygiene		infection. (Regulation 12)		for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Director of Nursing for Infection Prevention & Control/Deputy DIPC		
	Cleanliness, infection control and hygiene			2. Develop and approve estates capital plan to support IPC improvements			**Completed**	
	Cleanliness, infection control and hygiene			3. Re-establish and reinvigorate the IPC link nurses.			**Completed**	
	Cleanliness, infection control and hygiene			4. Review of Trustwide c-Diff action plan and works / equipment replacement programme and completion of all priority actions			**Completed**	
	Cleanliness, infection control and hygiene			5. Additional IPC training and guidance for matrons to support IPC management and oversight			**Completed**	
	Cleanliness, infection control and hygiene			6. Divisional IPC meeting minutes to include evidence of tracking of IPC action plans; RCA's and themes from Exec review panel			**Completed & Assured**	Monthly IPC meeting
M12	Cleanliness, infection control and hygiene	Medical care services	The service must ensure all premises and equipment are clean. (Regulation 15)	1. Review decontamination policy and ensure all medical devices are included;	Chief Nurse, Executive Director for Midwife	Divisional Director of Nursing Med & Acute / Director of Estates & Facilities / Associate	**Completed**	

	Cleanliness, infection control and hygiene			2. Review IPC Governance arrangements to ensure that the cleanliness of all medical equipment is included and results of IPC audits are reviewed and acted upon with senior leadership oversight	ry and Allied Health Professionals, Director of Infection Prevention & Control/ COO	Director of Nursing for Infection Prevention & Control	**Completed & Assured**	Perfect Ward
	Cleanliness, infection control and hygiene			3. In conjunction with Hotel Services establish standardised process for cleaning of curtains and develop SOP for ward managers guidance.			**Completed**	
	Cleanliness, infection control and hygiene			4. All areas and equipment identified by CQC cleaned, repaired or included within replacement program			**Completed**	
M13	Safe environment & equipment	Medical care services	The service must ensure all premises and equipment are suitable for purpose and properly maintained. (Regulation 15)	1. Re-establish scheduled H&S audits across all wards/ department and embed escalation processes for delayed critical repairs through H&S exception reporting process.	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control /	Divisional Director of Nursing Med & Acute / Director of Estates & Facilities / H&S Manager	**Completed & Assured**	Bi Portal
	Safe environment & equipment			2. Division to carry out an audit of all bathrooms and showers and add to capital requests for consideration; ensuring the audits are embedded within matrons audits for on-going monitoring			**Completed**	
	Safe environment & equipment			3. Change ward layout with M1 to provide a designated dining / activity room where the therapists undertake group sessions on a daily basis			**Completed & Assured**	H&S Committee
	Safe environment & equipment			4. Undertake risk assessment of M1 in accordance with Workplace (Health Safety & Welfare) Regulations 1992 and ensure control measures to effectively mitigate risks are implemented to ensure safe environment for staff and patients			**Completed**	
	Safe environ			5. M1 Temporary heating solutions deployed with additional bedding stocked on ward if required.			**Completed & Assured**	H&S Committee

	ment & equipment							
	Safe environment & equipment			6. Revise Terms of Reference for the Medical devices and equipment group to ensure that processes are robust and assurances received that all equipment is suitable for purpose; on an appropriate maintenance and replacement schedule and that Divisions are appropriately represented			**Completed & Assured**	Clinical Procurement Group attendance
M14	Safe environment & equipment	Medical care services	The service must ensure oxygen is stored in line with health and safety best practice guidance (Regulation 15)	1. Audit medical gas cylinder usage (annual rolling programme) to identify any deficiencies in storage and implement any changes in storage requirements	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Supported by H&S manager/ Lead Director of Pharmacy/ Director of Estates & Facilities	**Completed & Assured**	Bi Portal
				2. Incorporate medical gas storage audit as part of perfect ward audits and include performance on the H and S performance dashboards			**Completed & Assured**	Bi Portal
				3. Risk assessment and standard operating procedure to be reviewed and circulated throughout Trust to ensure all ward/ dept managers understand the requirements for storage of oxygen and process for removal of oxygen cylinders			**Completed & Assured**	Bi Portal
M15	Safe environment & equipment	Medical care services	The service must ensure all portable equipment is tested regularly. (Regulation 15)	1. All wards and departments to carry out a check of when electrical equipment (including emergency equipment) was last checked for electrical safety and liaise with EBME to ensure PAT's are brought up to date	COO/ Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention &	Divisional Director of Nursing Med & Acute / Director of Estates & Facilities / H&S Manager/ Head of EBME	**Completed & Assured**	
	Safe environment & equipment			2. Estates and EBME to develop a process for tracking portable equipment which will inform a schedule for when portable electrical equipment is due for testing and its location so that PAT's are carried out when required			**Completed & Assured**	H&S Committee
	Safe environment & equipm			3. Implement Standard Operating Procedure for ward managers to ensure guidance and agreed checking process for electrical safety is implemented.			**Completed & Assured**	H&S exception report
	Safe environment & equipm			4. Risk assessment and usual frequency for Portable appliance testing of equipment to be shared with all wards/ departments			**Completed**	

	ent				Control			
M16	Patient experience	Medical care services	The service must ensure the confidentiality of patients is maintained at all times in the discharge lounge. (Regulation 17)	1. The discharge to assess team to be permanently relocated out of the Discharge Hospitality Centre	COO	Divisional Director Medicine and Acute	**Completed & Assured**	Perfect Ward
	Patient experience			2. All staff to be reminded of the importance of confidentiality			**Completed & Assured**	Perfect Ward
	Patient experience			3. Develop a Perfect Ward audit for discharge lounge incorporating IG and confidentiality	Director of IT and Information	Divisional Director of Nursing Med & Acute	**Completed & Assured**	Perfect Ward
M17	Assessing and responding to patient risk & safety	Medical care services	The service must ensure staff complete risk assessments and associated care plans for patients. (Regulation 12)	1. Mandatory question to be added to the incident reporting module in Ulysses Safeguard to prompt staff to confirm that risk assessment has been reviewed following an incident	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Deputy Director of Nursing	**Completed**	
	Assessing and responding to patient risk & safety			2. Nutrition & Hydration specific dashboard to be uploaded to the nursing Business Intelligence (BI) portal			**Completed & Assured**	Bi Portal
	Assessing and responding to patient risk & safety			3. Inclusion of 24 hour MUST compliance will be included in the Trust Quality Dashboard.			**Embedded**	Quality Dashboard
	Assessing and responding to patient risk &			4. improvement workstream for Nutrition and Hydration group to include key improvement area of 'the quality completion of MUST and compliance of Dietitian care planning'.			**Completed & Assured**	N&H Dashboard
	Assessing and responding to			5. Ward profiles for falls to be developed and targeted action plans developed for priority areas which will include targeted falls prevention training			**Completed & Assured**	Bi Portal - Falls Profile

	patient risk & safety							
	Assessing and responding to patient risk & safety			6. Identify all CSW's to undertake the care certificate and establish a programme of training			**Completed**	
	Assessing and responding to patient risk & safety			7. Review of harms panel to improve compliance with care bundles (including risk assessment) by increased focus on areas where trends, themes and patterns are identified and ensuring targeted action plans are developed, monitored and implemented			**Completed & Assured**	CLIPPE
	Assessing and responding to patient risk & safety			8. Raise staff awareness of personal accountability for completion of risk assessments			**Completed**	
M18	Assessing and responding to patient risk & safety	Medical care services	The service must ensure that staff share key information, in line with trust policy, when handing over the care of patients who are medical outliers or moved into escalation areas.	1. Explore the option of a revised electronic handover	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Deputy Director of Nursing	**Completed**	
	Assessing and responding to patient risk & safety			2. Review of SBAR handover template to ensure it meets patient and service needs and re-circulate for use until electronic handover can be implemented			**Completed & Assured**	SNMT
	Assessing and responding to patient risk & safety			3. Implement and monitor compliance with intentional rounding on escalation areas			No escalation areas since last winter – so currently unable to assure – will continue to monitor	

	Assessing and responding to patient risk & safety			4. Review Standard Operating Procedure for escalation areas to ensure handover of information and completion of risk assessments is included			**Completed**	
M19	Assessing and responding to patient risk & safety	Medical care services	The service must ensure that patients who are medical outliers or moved into escalation areas receive regular senior medical reviews. (Regulation 12)	1. Development of SOP to ensure all staff are aware of the requirements for medical review of medical outliers and patients in escalation areas and escalation processes including at weekends	Medical Director	Deputy medical Director/ AMD M&A	**Completed & Assured**	Medical Outlier audit
	Assessing and responding to patient risk & safety			2. Inclusion of medical outliers in the 7 day audit to monitor appropriate senior medical reviews			**Completed & Assured**	Medical Outlier audit
	Assessing and responding to patient risk & safety			3. Ensure that all appropriate patients are admitted via assessment areas to provide a timely consultant review.			**Completed**	
	Assessing and responding to patient risk			4. Review use of ward 25 (isolation ward) and ensure access to a relevant specialist consultant			**Completed**	
	Assessing and responding to patient risk & safety			5. Implement process whereby the manager of the day highlights any patient who has not been seen by the speciality team on the outlying wards/ escalation areas as per weekly medical rota for speciality teams in the outlying wards.			**Completed**	
M20	Safeguarding	Medical care services	The service must ensure there is an effective system to track and monitor deprivation of liberty safeguards applications.	1. Safeguarding team to provide divisions with daily list of patients who are subject to a Deprivation of Liberty safeguard with expiry dates, to increase ward staff awareness of delays to Local Authority approvals of DoLs and the legal framework already in place to manage this	Chief Nurse, Executive	Associate Director of Nursing for Safeguarding	**Completed & Assured**	Daily List

	Safeguarding		(Regulation 17)	2. Ward managers to identify expiry of Deprivation of Liberty at each ward Board round from the list provided by Safeguarding	Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control		**Completed & Assured**	Huddles audit
	Safeguarding			3. Develop audit process to ensure sufficient assurance regarding Safeguarding teams processes and report within Safeguarding reports to PSQB			**Completed**	
M21	Safe, effective care	Medical care services	The service must act to ensure performance is monitored effectively and there are clear plans to improve patient outcomes. (Regulation 17)	1. Convene a joint meeting to review SNAPP results and analyse the data. Draw up plan, with staff engagement, and set review and target date.	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director Nursing - M&A	**Completed**	
	Safe, effective care			2. Review Therapy Outcome Measures (TOMs) data; setting targets for improvement and linking in with SNAPP results.			**Completed**	
	Safe, effective care			3. Review Speech and Language Therapies service performance against local targets, exploring good practice and implementation			**Completed & Assured**	SSNAP
	Safe, effective care			4. Evaluate the robustness of governance arrangements for clinical audits and strengthen arrangements to ensure assurance as to the development and progression of action plans to address areas identified for improvement (including measures to improve patient outcomes)			**Completed & Assured**	SSNAP
M22	Safe, effective care	Surgery	The service must ensure that staff comply with all aspects of the surgical safety checklist. (Regulation 12)	1. External peer review to be arranged by AMD - Action reviewed MIAA are now doing a review	Medical Director	Divisional Director of Nursing - Surgery	**On track**	
	Safe, effective care			2. Leadership team to ensure the Trust's arrangements for Safer Surgery is strengthened, specifically including NATSSIPs; LOCSSIPs and compliance with all aspects of the safer surgery checklist.			**Completed & Assured**	WHO Safer Report to be presented at PSQB

	Safe, effective care			3. Increased observational audits to be undertaken until the required level of assurance is obtained, results of the audits to be reviewed by Clinical Service leads and appropriate actions are taken to drive improvements.			**Completed & Assured**	WHO Safer Report to be presented at PSQB
M23	Cleanliness, infection control and hygiene	Surgery	The service must ensure that it reduces its number of surgical site infections. (Regulation 12)	1.Develop strategy with CD's across the division and DIPC/IPC Team.	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Triumvirate - Surgery	**On track**	
	Cleanliness, infection control and hygiene			2. Implement targeted infection prevention/wound management improvement plan for the post-operative care management in all surgical wards			**On track**	
	Cleanliness, infection control and hygiene			3. DDN/AMD to set up an MDT function to review all potential surgical site infections and ensure appropriate actions are implemented to reduce them.			**On track**	
	Cleanliness, infection control and hygiene			4. Learning to be cascaded through local quality boards and safety summits.			**On track**	
	Cleanliness, infection control			5.Triumvirate to lead a review of clinical capacity to ensure effective audit and improvement activities for SSI's can be undertaken.			**Completed**	
	Cleanliness, infection control			6. Extend SSI audit across all quarters to gain accurate information to inform actions to be implemented to reduce SSI's			**Completed**	

	and hygiene							
M24	Safe environment & equipment	Surgery	The service must ensure that the pre-operative assessments area is improved to make it appropriate for staff and patients. (Regulation 15)	1. Pre-operative assessment area to be re-located to a more suitable location.	COO	Associate Director of Health Care Professions- Perioperative Medicine & Critical Care; Divisional Director - Surgery	**Completed & Assured**	Programme Board
	Safe environment & equipment			2. Fit & Well Questionnaires to be rolled out reducing the demand for face to face			**Completed**	
M25	Patient flow	Surgery	The service must implement clear plans, with set timescales and actions, to improve patients access to care and to achieve their timely discharge from hospital. (Regulation 17)	1. Implement Divisional requirements of the Trustwide Patient Flow Improvement workstreams (see Mo1)	MD	Divisional Triumvirate Surgery	**On track**	
	Patient flow			2. Divisional Triumvirate to work with IT to make Estimated Discharge Date (EDD) a mandatory field within Cerner Millennium.			**On track**	
	Patient flow			3. AMD to ensure that all Consultants agree and document EDD during ward rounds.			**Completed**	
	Patient flow			4. AMD and DDN to initiate board rounds across surgery - to be agreed with all CD's.			**Completed**	
	Patient flow			5. Establish 3 Phase recovery plan to enable the division to maintain the elective programme all year round as the day case facility will now be within the theatre recovery footprint. This will negate the need for ward 1 and reduce the number of cancelled operations			**Completed**	
M26	Safeguarding	Children's and young people's services	The service must comply with the national information sharing standard designed to safeguard children who were looked after or in protection. (Regulation 13)	1. Managers in ED, PAU, Children's ED, Children's ward, Maternity triage and community midwifery coordinators to identify staff requiring access to CPIS and ensure this is enacted	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Preventi	Director of Nursing & Midwifery – Women's and Children's Division Associate Director of Nursing for Safeguarding	**Completed & Assured**	Safeguarding PSQB
	Safeguarding			2. Training to be delivered for all identified staff in ED, PAU, Children's ED, Children's ward, maternity triage and community midwife coordinators, which will be supported by safeguarding team and additional face to face sessions will be offered.			**Completed**	

					on & Control			
M27	Assessing and responding to patient risk & safety	Children's and young people's services	The service must undertake the required patient risk assessments including pain, nutrition and pressure area assessments and implement a robust process for the monitoring of care and treatment received by patients. (Regulation 12)	1. Cerner awareness & navigation session to be included on the paediatric essential training day all staff to attend	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Director of Nursing & Midwifery – Women's and Children's Division; Divisional Quality & Safety Specialist	**Completed & Assured**	
	Assessing and responding to patient risk & safety			2. Create a perfect Ward Children's Harms Prevention Audit , that includes pain assessment review			**Completed & Assured**	Perfect Ward
	Assessing and responding to patient risk & safety			3. Create an audit cycle to assess compliance with completion of mental health and wellbeing assessments of children and young people			**Completed**	
M28	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service must ensure the risk to patients of MRI induced burns is mitigated by the development and implementation of a policy or standard operating procedure for staff to follow in the event of such an incident. (Regulation 17)	1. SOP for MRI induced burns to be approved and uploaded to staff intranet	Medical Director	Associate Medical Director Clinical Support and Diagnostics; Dr Simon Lea/ Consultant Radiologist	**Embedded**	Huddle book
	Assessing and responding to patient risk & safety			2. Ensure effective communication to all relevant staff			**Embedded**	Huddle book
M29	Evidence-based care and treatment	Diagnostics	The diagnostic imaging service must ensure that policies and procedures are evidence based and where appropriate linked to relevant professional guidelines. (Regulation 17)	1. Review all policies and procedures to ensure all are evidence based and where appropriate linked to relevant professional guidelines	Medical Director	Operation and Performance Manager for Radiology	**Completed & Assured**	Intranet

M30	Safe care and treatment	Outpatients	The service must ensure that the trust standard operating procedure is followed when decontaminating equipment. (Regulation 12)	1. Process to be revised to ensure ET tubes are no longer pre-cut and remain in their original sealed packaging and placed in a sealed tray which is dated.	COO Medical Director Chief Nurse	Matron of Ophthalmology/ Associate Director of Nursing for Infection Prevention & Control/ CSSD lead	**Completed & Assured**	Perfect Ward
	Safe care and treatment			2. Establish Trust-wide audit and reporting process for monitoring adherence to the trust standard operating procedure for decontaminating equipment			**Completed & Assured**	Perfect Ward
M31	Safe care and treatment	Outpatients	The service must ensure that flooring in the ophthalmology department is compliant with infection control guidance. (Regulation 12)	1. Repair flooring	COO	Director of Estates & Facilities	**Completed & Assured**	Bi Portal
S01	Strategy, communication and engagement	Trust wide	The trust should ensure it takes measures to ensure executive visibility in services is increased	1. Introduction of bi-monthly listening events led by the Chief Executive and Executive Directors.	Chief Executive/Director of Workforce/Director of Strategy & Partnerships/Medical Director /Chief Nurse/Chief Operating Officer/ Dir IT	Communications Team	**Completed**	
				2. Posters detailing Executive Team members to be mounted on notice boards throughout the Trust			**Completed**	
				3. Executive Directors to participate in Corporate Induction sessions			**Completed**	
				4. Executive Directors to carry out regular informal walk arounds, including joining the monthly Chief Nurse visits. Visits to be recorded in a register held by the Board Secretary.			**Completed**	
S02	Strategy, communication and engagement	Trust wide	The trust should ensure that the overall five-year strategy is reviewed and refreshed where appropriate	1. Strategic Framework approach developed	Director of Strategy & Partnerships	Head of Strategic Planning	**Completed & Assured**	
				2. Strategic Plan workshops held			**Completed & Assured**	Board bulletin
				3. Drafting of 2021-26 Strategy			**Completed & Assured**	
				4. Board approval of Trust Strategy			**Completed & Assured**	Published In Touch Bulletin

S03	Safe care and treatment	Trust wide	The trust should ensure that mortality reviews are undertaken in a timely way	1. Update 'Learning from deaths' policy	Medical Director	Deputy Medical Director	**Completed & Assured**	
				2. Weekly Mortality review group to be established			**Embedded**	
				3. Strengthen timeframe for completion of SJRs to 28 days, which will be monitored and reported against			**Completed & Assured**	
				4. Weekly Mortality review group to review how best learning is to be disseminated			**Completed & Assured**	
				5. Appoint Medical Examiner officer			**Embedded**	
S04	Strategy, communication and engagement	Trust wide	The trust should ensure that culture within the trust is improved across all services	1. New Values and Behaviours team development session offered to support teams experiencing challenges.	Director of Workforce	Deputy Director OD. Director of Communications and Engagement	**Completed & Assured**	Chris Lloyd - ensuring sessions are still taking place
				2. Ensure values and behaviours posters are available in all departments.			**Completed**	
				3. Review and refresh actions of Respect at Work Group.			**On track**	
				4. Revisit approach to 'Just Culture' and implement.			**On track**	
				5. Strengthen terms of reference for cultural reviews to ensure timeliness of actions is clear and relevant managers are accountable for timely completion of actions and feedback to staff.			**Completed & Assured**	Culture reviews
				6. Incorporate updates of cultural review action plans into Directorate/Divisional Review meetings			**Completed**	
				7. Include managers responsibility and guidance related to compassionate leadership and culture into a new managers toolkit.			**On track**	
				8. Include welcome from CEO in Corporate Induction virtual programme for 2020			**Completed & Assured**	
				9. Undertake temperature check with staff to understand if we are living our values and what we need to do more of.			**On track**	Corporate Induction
				10. Increase number of FTSU Guardians and BAME representations in FTSU structure			**Completed & Assured**	Freedom to Speak Up
				11. Review current wellbeing support, continue to provide this and engage with staff to identify what needs to be continued in medium to longer term and provide this on prioritised and value basis.			**Completed & Assured**	In Touch bulletin
				12. Review our values based annual awards with staff and improve based on feedback so that they feel valued for their contribution.			**On track**	
				13. Establish leadership forum as Think Tanks or Alumni to work on improvements needed across services, inclusive of behaviours and how to challenge poor behaviours.			**On track**	

				14. Continue to deliver the leadership and management development framework inclusive of compassionate leadership, 360 feedback and coaching and promote this.			On track	
S05	Strategy, communication and engagement	Trust wide	The trust should consider ways in which engagement with the wider public is improved.	1. Increase links with Community Advisory Group run by Merseyside Police.	Director of Workforce/Chief Nurse	Deputy Director OD. Director of Communications and Engagement Deputy Chief nurse	On track	
				2. Host Equality Group Conferences to engage with community, building on the inaugural Transgender Conference with community groups held in 2019.			On track	
				3. Work with Healthwatch to focus on EDS2 requirements and Equality Analysis			On track	
				4. Host open days and events to support recruitment and engagement.			On track	
				5. Work proactively with the Divisions to gain and promote good news stories internally and externally from staff or patients and families			On track	
				6. Continue to work with and expand our links with local community forums such as ill-health prevention and wellbeing (including alcohol/smoking/weight/drugs related issues			On track	
				7. Work with universities and colleges to support the education agenda, research activity, work experience and recruitment			On track	
				8. Utilise themes from patient stories, complaints and concerns to inform service improvements			On track	
S06	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure there are enough suitably qualified doctors in the emergency department to meet patient need	1. Perform ED medic staffing capacity and demand analysis utilising ECIST tool and benchmark against peers. ECIST tool undertaken to inform workforce planning - next steps agree numbers by hour.	Medical Director	Deputy divisional director and Head of Urgent Care	Completed	
				2. Develop CESR business case			Completed & Assured	
				3. Recruit to CESR post			On track	
				4. Develop business case for additional ED consultants to compensate for middle grade gaps			Overdue	Progress update provided
				5. Recruit NHS ED locum consultant for 6 months in interim			Completed & Assured	
S07	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that all staff Complete mandatory training	1. Nursing - Recruit to department educator to work alongside staff and ensure mandatory training completed.	Chief Operating Officer	Deputy divisional director and Head of Urgent Care	Completed & Assured	November PSQB
				2. Ensure Nurse educator is trained in CPR for local training delivery.			Completed & Assured	November PSQB
				3. Develop trajectory to achieve mandatory training compliance.			Completed	
				4. Establish nursing workforce monthly meeting to commence with new ADN/matron to embed and sustain compliance			Completed	
				5. Ensure Consultants Complete all mandatory training.			Completed	
S08	Assessing and responding to	Urgent and emergency	The service should ensure that all documentation is fully completed	1. Review of use of paper within the department to reduce requirement and transfer to electronic reporting where possible	Chief Nurse	Deputy divisional director and Head of Urgent	Completed & Assured	November PSQB
				2. Removal of CAS cards and ensure documented on Electronic Cerner system			Completed & Assured	November PSQB

	patient risk & safety	services		3. Establish process for monitoring discharge summary		Care ADN for ED	**Completed**	
				4. Nursing documentation compliance audits carried out monthly to monitor patient risk assessments			**Completed & Assured**	November PSQB
				5. Launchpoint implemented (which includes patient safety checklist)			**Completed & Assured**	November PSQB
				6. Monitor implementation of Launchpoint and patient safety pathways			**Completed & Assured**	November PSQB
S09	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that records trolleys are locked when not in use	1. Remove CAS cards.	Chief Nurse	Deputy divisional director and Head of Urgent Care ADN for ED	**Completed & Assured**	November PSQB
				2. Install locked storage trolley in EDRU. Install lock on room that will store storage trolley			**Completed & Assured**	Bi Portal
				3. Install lock on room for storage trolley			**Completed & Assured**	Bi Portal
S10	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that patients have access to call bells at all times	1. Reconfigure department to increase number of low risk majors space.	Chief Nurse/Chief Operating Officer	Deputy divisional director and Head of Urgent Care ADN for ED	**Completed**	
				2. Implement Clinical Decisions Unit			**Completed**	
				3. Roll out of launch point and safety checklist reviewed, to ensure that call bells and reach are included.			**Embedded**	ED Safety PSQB Paper August
S11	Cleanliness, infection control and hygiene	Urgent and emergency services	The service should ensure that all areas are clean and tidy in the department	1.Improvement plan for infection control developed	Chief Nurse/Chief Operating Officer	ED Triumvirate Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Head Estates	**Completed & Assured**	November PSQB
				2. ED triumvirate commenced weekly review of department with infection control and IPC audit completed monthly to address issues			**Completed & Assured**	November PSQB
S12	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that all patients risk assessments are fully completed in the emergency department	1. Safety checklist to be implemented,	Chief Nurse/	ADN for ED	**Completed & Assured**	November PSQB
				2. Monitor implementation of Safety checklist			**Completed & Assured**	November PSQB
				3. Nurse educator to develop nurse competencies for risk			**Completed & Assured**	November PSQB
				4. Roll out nurse competencies for band 5			**On track**	
				5. Roll out nurse competencies for band 6			**On track**	
				6. Roll out nurse competencies for band 7			**Completed**	
				7. Launch point rolled out to enable completion of assessment			**Completed**	

S13	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that there are effectively managed governance and performance systems in place.	1. Introduce safety huddles every 2 hours and include a Senior ops/nurse, ED sister, lead consultant. (See S17	Chief Operating Officer	ED Triumvirate	**Completed & Assured**	November PSQB
				2. Monitor implementation/ compliance of Safety huddles process			**Completed & Assured**	November PSQB
				3. Establish breach meetings with specialities (See S17)			**Completed**	
				4. Each speciality to develop escalation processes which will link to the inter professional standards (See S17)			Overdue	Progress update provided
				5. Develop Directorate Performance Reviews to provide Division with assurance on processes. (See S17)			**Completed**	
				6. Urgent care action plan developed with 4 partner organisations			**Completed**	
				7. Monitor completion of urgent care improvement action plan			**Completed**	
				8. Patient breaches who are awaiting review collected and analysis for themes reviewed			**Completed**	
S14	Safe environment & equipment	Medical - CBH	The service should review the two wards and where appropriate set out a plan to improve the environment, equipment and space for rehabilitation services being delivered.	1. Review the environment, equipment and space for rehabilitation and identify areas for improvement.	Chief Operating Officer	ADN for rehab Estates AHP Directorate manager	**Completed**	
				2. Develop designated dining / activity room where the therapist undertake group sessions on a daily basis.			**Completed & Assured**	
				3. Ensure robust activities timetable in place once the unit reopens			**Completed**	
S15	Assessing and responding to patient risk & safety	Medical - CBH	The service should ensure that there is local ownership of risks and actions across all areas of the hospital.	1. Introduce a weekly risk meeting to discuss and review previous risks/incidents that have occurred.	Chief Nurse	Divisional governance lead Divisional ADN	**Completed**	
				2. Introduce monthly risk meeting to ensure risk register up to date, validate and appropriate scoring applied to incidents and ensure timely management of incidents, rapid reviews for SI Panel.			**Completed**	
				3. Governance lead and ADNs develop a development plan for ward managers to improve knowledge and skills regarding risk management.			**Completed & Assured**	
				4. Senior nurse presence (Matron or AND) at Clatterbridge site to support Ward Sisters			**Completed**	
S16	Patient flow	Medical - CBH	The service should ensure that there is timely access and discharge from services at the hospital	1. WUTH to work with WCCG around developing their commissioning intention to procure rehabilitation and assessment bed based services from a single provider with improved KPI's on transfers of care and length of stay	Chief Operating Officer	AHP Directorate manager	**On track**	
				2. Develop system Lead for D/C role to support the Divisional Triumvirate with daily monitoring of all patients with a LLoS of 20+ days (subsequently 14 and then 7 days).			**Completed & Assured**	
				3. Work with healthcare economy partners to develop urgent care improvement plan.			**Completed & Assured**	
				4. Work with healthcare economy partners to commission redesigned intermediate care model			**Completed & Assured**	

S17	Patient experience	Medical - CBH	The service should consider how all healthcare professionals work together consistently to benefit patients	1. System Lead for D/C to support the Divisional Triumvirate with daily monitoring of all patients with a LLoS of 20+ days (subsequently 14 and then 7 days).	Chief Operating Officer	System wide discharge lead	**Completed & Assured**	
				2. Work with healthcare economy partners to develop urgent care improvement plan.			**Completed & Assured**	
				3. Work with healthcare economy partners to commission redesigned intermediate care model			**On track**	
S18	Safeguarding	Medical - CBH	The service should consider how best to have an effective track and monitoring of deprivation of liberty safeguarding applications	1. Ensure all DOLs / MCA and best interests are contacted electronically on Cerner and subsequently followed up by the safeguarding team, contacting the ward prior to the end of the agreed Dols.	Chief Nurse	Associate Director of Nursing for Safeguarding Named Nurse Safeguarding Adults	**Completed & Assured**	
				2. Develop process for DOLS being discussed at ward level daily by nurse in charge			**Completed & Assured**	
S19	Patient experience	Medicine	The service should consider the availability of information leaflets for health promotion.	1. Undertake a review of health promotion leaflets available and ensure they are available for patients and relatives to access and read throughout the Division	Chief Nurse	Divisional Nurse Director	**On track**	
				2. Undertake review of the current guidance to authors of the Patient Information leaflets - review to include Version / Detail / Author / Intended Reader / Content and availability of health promotion leaflets			**On track**	
				3. Development of a Trust Wide approval and distribution process (Standard Operating Procedure)			**Completed**	
				4. Promote the Trust website which has a link to all national leaflets and in electronic library suite (Ido) which complies with easy read etc.			**On track**	
				5. Closer working with hospital library heritage system to ensure dates for information doesn't expire			**On track**	
S20	Safe care and treatment	Medical - APH	The service should act to improve completion rates for mandatory training for nursing and medical staff. It should ensure relevant staff complete intermediate life support training.	1. OD Team to work with Medical and Acute Division leads and training subject leads to develop a plan to ensure they understand and act on monthly compliance reports and staff are able to access training.	Director of Workforce	M&A Triumvirate Deputy director of OD	**Completed**	
				2. M&A Division Managers to plan and allocate block of time to staff to complete mandatory training.			**Completed**	
				3. Identify staff non compliant and any trends related to this and how this may be supported on an individual or team basis.			**Completed**	
				4. Improve mandatory training compliance to meet Trust standard of 90%.			**On track**	
S21	Safe care and treatment	Medical - APH	The service should ensure plans to provide substantive staffing numbers in the acute medical assessment unit are actioned and embedded	1. Increased establishment by recruiting to funded posts that were approved in Acute medicine nursing business case.	Chief Nurse	M&A Triumvirate	**Completed & Assured**	
				2. Implemented daily staffing meetings conducted with the Senior nursing team to ensure safe staffing levels maintained as in line with the SSOT			**Completed & Assured**	
				3. Utilise NHSP as backfill for both vacancies and sickness.			**Completed & Assured**	

S22	Safe care and treatment	Medical - APH	The service to act to minimise the number of times nursing staff are moved to cover escalation areas and areas outside of their speciality.	1. Maintain check and challenge meetings to ensure all areas are compliant with standards agreed in KPS for E -Roster and ensure actions are completed within the agreed time scale.	Chief Nurse	Senior Nursing team	**Completed**	
				2. Accountability and responsibility to be delegated to the Divisional Nurse Leadership Team to ensure all shifts have an agreed total number of staff and skill mix as shown by the establishment templates			**Completed**	
S23	Safe care and treatment	Clinical Support and diagnostics	The service should ensure sufficient allied health professional staff are deployed to ensure patients receive the right care and treatment	1. Review use of resources, pathways and implement use of electronic roster for staff to ensure staff are allocated appropriately to areas of greatest clinical need	Chief Operating Officer	AHP Directorate Manager	**Completed**	
				2. Complete business case for resources required for consideration by trust management board.			Overdue	Progress update provided
				3. Development of AHP staffing resource reporting via Trust 'BI Portal' to monitor referral to assessment time and other key metrics.			**Completed**	
S24	Safe care and treatment	Medical - APH	The service should ensure that all patients have their care pathway reviewed by relevant staff and consultants, especially those on escalation wards.	1. Close ward 1 as escalation area.	Medical Director	AMD for Medicine	**Completed & Assured**	
				2. Utilise opportunity presented by reduced demand due to COVID to stop admitting to outlier wards			**Completed & Assured**	
				3. Increase weekend consultant cover to ensure all sick patients and potential discharges reviewed			**Completed**	
S27	Assessing and responding to patient risk & safety	Medical - APH	The service should ensure patients care plans reflect individual needs and preferences	1. Complete baseline assessment of care plans in all in-patient areas	Chief Nurse	Associate Director of Nursing	**On track**	
				2. Develop Options Appraisal regarding the development of a long term electronic process for care planning standardisation and assurance moving forward			**On track**	
S28	Strategy, communication and engagement	Medical - APH	The service should ensure plans to deliver the divisional strategy are robust and align with the organisational strategy	1. Review and refresh Divisional strategy following approval of Trust wide Strategy to ensure it is effective and in alignment	Chief Operating Officer	Divisional Director of Medicine	**On track**	
				2. Devise roll out plan to ensure effective communication and engagement with all staff			**On track**	
				3. Develop plans to ensure implementation			**On track**	
S29	Strategy, communication and engagement	Medical - APH	The service should act to provide opportunities for all staff to engage with the organisation and contribute to service improvement and development	1. Ensure medical staff have the opportunity to engage with Divisional management team through Directorate Performance Reviews and Senior Clinicians Forum to identify and contribute to service improvement and development	Director of Workforce	M&A Triumvirate Director of Communications and Engagement	**Completed**	
				2.Develop future leaders, with quality improvement skills, through utilising WUTH's Top Leader's Programme.			**Completed & Assured**	
				3. Establish registered nurse and Clinical Support worker forums to engage with staff group and encourage involvement with improvement and development work			**Completed & Assured**	

				4. Development of link nurse programmes to support awareness and involvement of staff in improvement and development initiates			On track	
				5. Establish schedule of away days which incorporate a focus on service improvement and development			Completed & Assured	
S30	Cleanliness, infection control and hygiene	Surgery	Surgery should ensure that staff adhere to infection prevention control practices	1. Matrons to undertake infection control training to enable them to work alongside the infection prevention and control team to monitor standards across all clinical areas, supporting and educating staff. (See M23)	Chief Nurse	Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Divisional ADN	Completed	
				2. Increased auditing to be introduced including weekly ward manager hand hygiene audits, matrons in undertake twice monthly opposed to monthly in all clinical areas. (See M23)			Completed & Assured	
				3. Isolation area for patients presenting with infections incorporated in the new 3 stage recovery. (See M23)			Completed	
				4.'I am clean stickers' to be applied to all equipment following decontamination (See M23)			Completed & Assured	
S31	Cleanliness, infection control and hygiene	Surgery	The service should continue to develop its surveillance of surgical site infections	As per CQC 'must do' action plan -M23	Chief Nurse	Divisional ADN	On track	
S32	Assessing and responding to patient risk & safety	Surgery	Surgery should review the reasons for increasing sickness rates within the nursing teams and develop a long-term action plan	1. Monthly sickness review meetings with the HR Manager; ADN, Matron and Ward Managers, to be established. Ensuring that staff sickness is managed in line with Trust policy.	Director of Workforce/Chief Operating Officer	Divisional ADN	Completed & Assured	
				2. Surgical Matron to hold staff surgeries enabling staff to discuss any work related concerns, professional development and progression.			Completed & Assured	
				3. Continued promotion and awareness of Employee Assistance Programme. Use of Staff support group to provide themes for addressing.			Completed	
S33	Assessing and responding to patient risk & safety	Surgery	The service should review the reasons for the increasing turnover rates and vacancy rates for medical staff and develop a long term action plan	1. A proactive plan to be developed to fill any gaps with known vacancies submitted to panel at least 3months in advance with over recruitment if possible.	Medical Director	Divisional Director of Ops, Associate Medical Director	Completed	
				2. Short term gaps to be filled by additional hours where appropriate with agency staff			Completed	
				3.For persistent gaps, the division will skill mix and appoint Advanced Nurse Practitioners or Specialist Nurses.			Overdue	Progress update provided
S34	Assessing and responding to	Surgery	Surgery should consider introducing a standardised agenda for safety huddles which includes specific opportunities to	1. Pilot a new standardised patient safety huddle template within the Division	Chief Nurse	Divisional ADN	Completed & Assured	
				2. Evaluate the pilot to ensure the standardised template meets the improvement objectives and is approved for roll out across the Division			Completed & Assured	

	patient risk & safety		discuss incident, complaints or compliments.	3. Roll out of agreed standardised patient safety huddle template to be completed.			**Completed & Assured**	
S35	Assessing and responding to patient risk & safety	Surgery	The service should ensure that staff complete nutritional and hydration assessments	1. Completion of risk assessments (including MUST) to be added to the standardised patient safety huddle to be used in conjunction with the M Page on Wirral Millennium.	Chief Nurse	Divisional ADN	**Completed & Assured**	
				2. Compliance of fluid balance for specific patients to be undertaken			**Completed & Assured**	
				3. Nutrition and hydration fluid balance metrics to be reviewed as standing agenda item of nutrition and hyrdration working group			**Completed**	
				4. Trust wide compliance of fluid balance for specific patients to be undertaken			**On track**	
				5. Each division to have a nutrition and hydration lead			**On track**	
				6. Development of new hydration training package			Overdue	
				7 .Additional safety huddle to be undertaken at 15:00 to ensure that all identified actions have been completed.			**Completed & Assured**	
S36	Safe care and treatment	Surgery	The service should continue to discuss ways to improve patient outcomes	1. Cross reference with GIRFT Review recommendations for ENT and Urology, (recognising Urology is a Regional Cancer Centre)	Medical Director	Associate Medical Director	**On track**	
				2. Review laparotomy audit results and associated action plan			**Completed & Assured**	
				3. Benchmark of Orthopaedic readmission from the national Joint Registry			**On track**	
				4. Use of the laparotomy audit to identify areas of concern for General Surgery.			**Completed & Assured**	
S37	Patient experience	Surgery	The service should improve the patient and family room areas to provide more information regarding health promotion and services for people at the hospital and within the community	1. A health promotion topic of the month to be introduced across the division led by a Matron. Schedule to be agreed through the divisional quality board in line with national events such as 'smoking cessation', nutrition & hydration week.	Chief Nurse/ Medical Director	Divisional ADN	**On track**	
				2. Additional information regarding health promotion and services available for people at the hospital and within the community to be available in the patient and family room			**On track**	
S38	Assessing and responding to patient risk & safety	Surgery	The service should continue to monitor adherence with Deprivation of Liberty Safeguards documentation requirements	1. DOLs documentation and expiry dates to be included in the new standardised patient safety huddle template.	Chief Nurse	Divisional ADN	**Completed & Assured**	
S39	Assessing and respond	Surgery	The service should consider ways to make the surgical wards more dementia friendly.	1. Dementia lead identified for the division (Matron).	Chief Nurse	Divisional ADN Matron dementia	**Completed & Assured**	

	ing to patient risk & safety			2. Baseline audit and gap analysis to be undertaken to identify improvements required against national standards and development of an approved action plan.			Overdue	
S40	Strategy, communication and engagement	Surgery	Surgery should continue to monitor staff adherence to the trust's values and behaviours	1. Review of staff survey results for the Division and development of action plan to ensure continued improvement and monitoring of staff's adherence to the Trust's values and behaviours	Director of Workforce	Surgery Triumvirate, Director of Communications and Engagement	**Completed**	
S41	Safe care and treatment	Children's and young people's services	Children and young people services should take steps to improve staff compliance with mandatory training and ensure that staff are provided with adequate training to undertake their role effectively.	1. Improve compliance of mandatory training to 90% for nursing and medical staff	Director of Workforce	W&C Triumvirate	**On track**	
				2. Mandatory training compliance reviewed as part of appraisal for medical staff, APNP's and ANNP's. Ensure medical staff appraisals are completed within the frame of 12 months.			**On track**	
				3. Specific Children's training day to be co-ordinated & all Children's nursing staff to attend, review compliance with same & ensure compliance >90%.			**Completed**	
				4. Send the training spreadsheets/compliance reports to CL's and CD's to action and oversee compliance with mandatory training.			**Completed & Assured**	
S42	Cleanliness, infection control and hygiene	Children's and young people's services	Children and young people services should improve the standard of infection, prevention, control and cleanliness within it.	1. PW Audit (IPC) to be undertaken monthly in NNU with IPC Team	Chief Nurse	W&C Triumvirate, Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC	**Completed**	
				2. Divisional IPC Meetings with Nurse & Consultant IPC Lead to review IPC audits			**Completed & Assured**	
				3. Introduction of revised dashboard for NNU to include incidents of infection with umbilical lines/other lines; staff compliance with ANNT and other care metrics.			**Completed & Assured**	
				4. All staff to attend IPC mandatory training with review of compliance monthly to >90%.			**On track**	
				5. NNU Leads (Matron and CL) to undertake monthly walkabout of NNU to identify any concerns re environment and to ensure progress with IPC improvement plan.			**Completed & Assured**	
				6. IPC Team on the NNU to include Practice Development Lead who will lead on improvement including improvement work on CLABSI (Reducing the rate of line infections in the neonate)			**Completed & Assured**	
				7. Recruitment of a Practice Development Nurse Lead.			**Completed**	
S43	Safe environment & equipm	Children and young people	The service should ensure that routine equipment checks are undertaken consistently, the safe storage of supplies within the	1. Finalise plan for potential expansion of the NNU, aligned to the Divisional Strategy and identify Exec lead.	Chief Nurse/Chief Operati	W&C Triumvirate, Associate Director of	**On track**	

	ent		neonatal area and the service continues to work towards meeting the national guidance on minimum cot space.	2. Weekly audit of equipment checklist in PAU to ensure compliance.	ng Officer	Nursing for Infection Prevention & Control/Deputy DIPC Estates	**Completed & Assured**	
				3. Undertake a review of stock requirements and ensure only stock required is located on wards to enable effective storage			**Completed & Assured**	
S44	Safe environment & equipment	Children's and young people's services	The service should review the provision of resuscitation equipment between the neonatal and maternity departments and ensure that availability of resuscitation equipment is in line with expectations	1. Undertake a review of the provision of resuscitation equipment between neonatal and maternity department	Chief Operating Officer	W&C Triumvirate	**Completed & Assured**	
				2. Ensure all staff are aware that the adult defibrillator is stored for use on Delivery Suite in the event of an adult collapse.			**Completed & Assured**	
S45	Assessing and responding to patient risk & safety	Children's and young people's services	The service should seek to fill medical vacancies within the neonatal department.	1. Undertake a workforce review with the Neonatal ODN to identify future roles of workforce including the role of the Physician Associate with development of a workforce plan.	Director of Workforce/Medical Director	W&C Triumvirate	**On track**	
				2. Review of MTI workforce to ensure full compliance with competencies and training compliance.			**On track**	
				3. Review of ANNP workforce and ensure clear progression to Tier 1 and Tier 2 Medical staff rotas.			**On track**	
S46	Safe care and treatment	Children's and young people's services	Children and young people services should continue to work in reducing the occurrence of medicine errors.	1. Thematic review of medication errors to be undertaken and action plan developed to address any issues highlighted presented at September MSOP	Chief Nurse/ Medical Director	Divisional Pharmacist Lead	**Completed**	
				2. Spot Check and Audits to be undertaken to review compliance with expectations for medication administration via Perfect Ward		W&C Triumvirate	**Completed**	
				3. Standardise the process for managing medication incidents across neonatal and children's services			**Completed**	
				4. Embed the PCIF into the medication incident investigations			**Completed**	
				5. Encourage medical trainees and junior nurses to attend CIF meeting to encourage reporting of incidents and enbed the systems approach to incident management			**Completed & Assured**	
S47	Evidence-based care and treatment	Children's and young people's services	Children and young people services should look at ways to improve achieving the standards of the National Paediatric Diabetes Audit such as annual test for albuminuria and thyroid function.	1. Diabetes Audit - Gap analysis to be undertaken against audit standards	Chief Nurse/ Medical Director	W&C Triumvirate/Governance Lead	**Completed**	
				2. Establish monthly CG Meeting with attendance from all areas to ensure sufficient engagement and effective implementation of improvement plan			**Completed**	
S48	Patient flow	Children's and	The service should look at ways of reducing patients re-admitted	1.QI Project to be undertaken specifically focussing on reducing readmissions in Diabetes (Linked to action S47)	Chief Nurse/	Directorate Lead for QI	**On track**	

		young people's services	following an emergency admissions and multiple readmissions of diabetic and epileptic patients	2. Development of epilepsy passport to support with epilepsy management	Medical Director	project	On track	
S49	Strategy, communication and engagement	Children's and young people's services	The service should work in collaboration with other provider to ensure appropriate assessment of children and young people attending with symptoms of acute mental health illness.	1. Ensure staff and service users have opportunity to be involved in strategy development which will include key areas within the service such as mental health of children and young people.	Medical Director	W&C Triumvirate in conjunction with ED	Completed	
				2. Liaise with ED to ensure the process of mental health assessments for Children and Young people attending ED, but are not admitted, is child appropriate and robust			Completed	
				3. Reference M27 must do action plan '3. Create an audit cycle to assess compliance with completion of mental health and wellbeing assessments of children and young people '			Completed	
S50	Patient experience	Children's and young people's services	The service should consider ways to improve support and advice given to children and young people to lead healthier lives.	1. The voice of the child group will consider ways to improve support and advice given to children and young people to lead healthier lives and provide input into the improvement	Chief Nurse	Deputy nurse W&C Triumvirate	On track	
				2. Fabio Frog (patient feedback tool) will be further utilised to inform improvement plan including COPD as an area of consideration.			On track	
				3. Gap Analysis of CQC patient survey to be undertaken			On track	
				4. Ensure improvement plan is developed and is reviewed for compliance with progress at the CG meeting.			On track	
S51	Patient experience	Children's and young people's services	The service should consider tailoring the entrance to the women's and children's department to the needs of children accessing its service.	1. Undertake a review of the main entrance to W&C Hospital to consider whether it can be tailored to the needs of children accessing its service	Chief Operating Officer	W&C Triumvirate	Completed	
				2. Review the entrance to the children's ward to determine whether any further changes required to ensure it meets the needs of children accessing its service and implement changes			Completed	
				3. Ensure specific information and directions are detailed in the entrances for children and that this is child friendly			Overdue	Progress update provided
S52	Safe care and treatment	Children's and young people's services	The service should continue with plans to recruit additional play specialists to increase the establishment within the service	1. Business cases to be completed to increase the number of play specialists in the hospital to support OPD out of the W&C Hospital	Chief Nurse	ADN for Children's Service W&C Triumvirate	Completed	
S53	Patient experience	Children's and young people's services	The service should review the suitability of all areas used by children and young people within the hospital outside of the dedicated children's service and ensure it has oversight of these patients	1. Development of an improvement plan that incorporates all areas outside of the W&C Hospital where children visit for appointments.	Chief Nurse	ADN for Children's Service W&C Triumvirate	On track	
				2. Ensure those area leads are involved in TWISCH to ensure that such areas are child focused.			Completed	

				3. Ensure attendance by all divisions at TWISCH meeting.			Completed	
				4. Gap analysis of Facing the Future standards to be discussed at the TWISCH and CG meeting and progress regarding W&C improvements noted within improvement plan to be monitored			Completed	
S54	Patient experience	Children's and young people's services	The service should review the format and language availability of patient information offered	See also S19 1. Review of patient information leaflets currently available and identify those for translation	Chief Nurse	ADN for Children's Service W&C Triumvirate Deputy chief nurse	Completed	
				2. IT to undertake a review of the ethnic minority/languages spoken by service users in determining which languages to use for the translated documents.			On track	
S55	Assessing and responding to patient risk & safety	Children's and young people's services	The service should ensure that all children are reviewed by a consultant within 14 hours of admission.	1. Gap Analysis of rota (medical) to identify shortfall in staffing to ensure that all children are reviewed by a consultant with 14 hours of admission.	Medical Director /Chief Nurse	W&C Triumvirate	Completed	
				2. Pathways developed to standardise care of those patients who do not require a 14 hour review by Consultant but will be monitored by Junior Doctors and ANPS.			Completed	
				3. Risk Register to be utilised to ensure oversight of any non compliance of the Division.			Completed	
				4. Identify robust process to ensure escalation of instances where a consultant review hasn't taken place in 14 hours and appropriate response framework including undertaking harms reviews.			Completed	
				5. Ensure changes to the rota to support compliance - where this is not possible review risk of non compliance and ensure on the Divisional Risk Register for review and monitoring			Completed	
S56	Assessing and responding to patient risk & safety	Children's and young people's services	The service should ensure initial health assessments for looked after children are undertaken within the designated timeframes.	1. Deep dive auditing to capture compliance of internal processes and identify gaps/breach in statutory timeframes	Chief Nurse	Associate Director of Nursing for Safeguarding	Completed & Assured	
				2. Development of live dashboard to provide real time assurance			Completed & Assured	
S57	Safe care and treatment	Children's and young people's services	Children and young people services should continue to consider ways to resolve issues with transitional pathways for patients with complex care needs	1. Transition policy to be reviewed with CCG and Local Authority	Chief Operating Officer	W&C Triumvirate	On track	
				2. Review of Transition Policy at AHCH to identify good practice and gaps in service provision at WUTH.			On track	

S58	Strategy, communication and engagement	Children's and young people's services	The service should find ways to include the patient voice, community groups, and relevant stakeholders in developing its strategy and services.	See actions for S50/51	Chief Nurse	W&C Triumvirate	On track	
S59	Strategy, communication and engagement	Children's and young people's services	Children and young people services should ensure all staff have an understanding of and know how to access guardians such as freedom to speak up and Caldicott.	1. Staff to have increased awareness of FTSU guardians and training	Director of Workforce	W&C Triumvirate	Completed & Assured	
				2. Ensure actions from 2019 cultural survey are implemented and evaluated			Completed & Assured	
S60	Assessing and responding to patient risk & safety	Children's and young people's services	Children and young people services should continue to develop sepsis pathways within in and ensure it is represented appropriately at trust wide steering groups.	1. Undertake audit of compliance with the sepsis pathway	Medical Director	W&C Triumvirate	On track	
				2. Develop an electronic version of the Sepsis pathway on Cerner			On track	
				3. Child health representation on Trust wide Sepsis steering group			Completed	
S61	Cleanliness, infection control and hygiene	Surgery	The service should follow standard operating procedures when using cleaning products	1. Install COSHH cupboards in treatment room / laser room	Chief Nurse	Divisional AD N	Completed & Assured	
				2. Ensure guidance displayed for suitable PPE and training given to those who utilise it			Completed & Assured	
				3. Product representative to attend unit for training			Completed & Assured	
S62	Safe care and treatment	Outpatients	The service should continue to maintain paper record security whilst in the main outpatient department	1. Communicate with staff to remind them of their responsibilities in regards to security of patient records whilst working towards becoming paperless.	Director of IT and Information	OPD Manager	Completed & Assured	
				2. Establish paperless outpatient project group to reduce reliance on paper records within the Outpatient Department.			Completed & Assured	
S63	Patient experience	Surgery	The service should consider installing a hearing loop at the ear, nose and throat clinic	1. Install additional hearing loop in clinic	Chief Nurse	Divisional ADN	Completed & Assured	
S64	Safe environment & equipment	Surgery	The service should follow trust process for maintaining equipment in ophthalmology.	1. Review PAT testing schedule in line with electrical safety guidelines.	Chief Operating Officer	Director of Estates & Facilities	Completed	
				2. Develop and maintain an equipment record, including PAT testing information, and store locally			Completed	
				3.Alert estates to any due PAT testing			Completed	

S65	Patient flow	Outpatients	The service should continue to monitor and improve referral to treatment times for all specialities within outpatients.	1. Develop an action plan around the RTT standards in line with Executive Led Transformational Change Programmes for Outpatients and perioperative medicine which are progressing.	Chief Operating Officer	Surgery / D&CS Divisional Director	**Completed & Assured**	
S66	Cleanliness, infection control and hygiene	Outpatients	Outpatients should address the infection risk of assessing patients in a room with a sluice hopper.	1. Remove sluice hoppers from patient assessment rooms.	Chief Operating Officer	OPD Manager Estates	**Completed**	
S67	Safe environment & equipment	Diagnostics	The diagnostic imaging service should ensure that standard MRI safety labels are used on equipment within the MRI unit to identify equipment that is MRI Safe or MRI Not Safe.	1. Ensure MRI safety labels are placed on equipment in use within the MRI unit to indicate if equipment is MRI safe or not safe.	Chief Operating Officer	Radiology services manager Health & Safety	**Completed & Assured**	
S68	Patient experience	Diagnostics	The diagnostic imaging service should consider the benefits of providing more distraction toys or books for children in the waiting areas	1. Risk assess toy provision within the Radiology waiting room in line with IPC guidance, to inform decision to purchase this equipment.	Chief Nurse	Radiology services manager	**Completed & Assured**	
S69	Safe environment & equipment	Diagnostics	The diagnostic imaging service should, in line with evidence-based practice and the requirements for the control of substances hazardous to health, ensure that sluice rooms and cleaning cupboards are kept locked when not in use.	1. Ensure sluice rooms and cleaning cupboards are kept locked when not in use, communicate and remind staff of the importance of this.	Chief operating officer	Radiology services manager	**Completed**	
S70	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider the benefits of having regular band seven experience scheduled on night shifts.	1. Undertake a review of the current staffing rota in line with service requirements.	Chief Nurse	Radiology services manager	**Completed & Assured**	
S71	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should ensure that appropriate changing facilities are in place so that patients are not left alone in controlled areas when not undergoing a scan	1. Undertake a review of the facilities available within the CT department to identify any areas/rooms potentially suitable to re-purpose as designated changing facilities for patients.	Chief Operating Officer	Radiology services manager, Health & Safety	**On track**	
				2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal.			**Completed & Assured**	

S72	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider the benefit of including awareness of Gillick competency Guidelines in relevant mandatory training.	1. Training needs analysis of diagnostic imaging staff to be undertaken to review specifically consent treatment	Medical Director	Radiology services manager	**Completed**	
S73	Safe, effective care	Diagnostics	The diagnostic imaging service should consider if there would be any benefits in implementing quality assurance sampling of a percentage of images and reports to support the early identification of discrepancies or quality concerns	1. Design and implement formal QA programme.	Chief Nurse/ Medical Director	Radiology services manager	**On track**	
S74	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider how it could minimise the risks of delayed identification of deteriorating persons in the MRI waiting room	1. Review feasibility of camera or other mechanism to provide visibility of waiting room for outpatient attendees	Chief Nurse/Chief Operating Officer	Radiology services manager, Health & Safety	**Completed**	
S75	Patient experience	Diagnostics	The diagnostic imaging service should consider how it can improve the privacy and dignity for patients in the CT changing/inpatient waiting area.	1. Undertake a review of the facilities available within the CT department to identify any areas/rooms potentially suitable to re-purpose as designated changing facilities for patients. (See S71) 2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal. (See S71)	Chief Nurse/Chief Operating Officer	Radiology services manager, Divisional ADN Health & Safety, Estates	**On track** **Completed & Assured**	
S76	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider how it can effectively support the further reporting development of radiographer staff in reporting on common types of CT scans	1. Continue to develop reporting Radiographers through rolling programme of plain image reporting to release Radiologists to undertake more complex reporting images.	Chief Nurse	Radiology services manager	**Completed**	

Board of Directors	
Agenda Item	20-21/195
Title of Report	Winter Plan 2020/2021
Date of Meeting	2 December 2020
Author	Anthony Middleton, Chief Operating Officer
Accountable Executive	Anthony Middleton, Chief Operating Officer
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	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
Data Quality Rating	Bronze – qualitative data
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This report provides the final version of the Winter Surge – Operational Plan for 2020/21 and a supporting financial schedule of the additional resources in place to meet the expected increase in demand.

2. Background

The Trust has developed a plan to meet both the increased demand of COVID as well as the seasonal pressures expected through the winter period.

The plan is integral to the Wirral wider system plan and demands have been modelled on both national guidance and locally developed business intelligence supported by the Venn modelling tools.

Schemes developed to meet the increased demand have been subject to clinical and operational sign off and subject to Executive check and challenge of impact, quality, delivery and affordability.

3. Winter - Surge Operational Plan (Appendix 1)

The plan contains the following key sections:

- Governance and Command Arrangements
- Current Bed Configurations
- Summary of Services deployed across Divisions, to include:
    - Senior leadership cover
    - Medical Staff cover
    - Nursing Staff cover
    - Departmental specific cover
- Covid / Winter plan schemes and Contingency
- Surge Planning arrangements:
    - Nurse Staffing
    - Medical Staffing
    - Critical Care Bed Plans
    - Bed configurations scenarios in the event of high covid occupancy

4. Winter Plan 2020/21Financial Analysis (Appendix 2)

The schedule set out the detail of the additional resource required to meet the expected demands and is split across 5 distinct sections:

1	Covid :	Schemes provided from Spring 2020
2	Winter/Covid:	Schemes provided from Spring 2020 and bolstered for Winter
3	Winter:	Additional schemes to meet winter demands
4	Other:	Schemes matched to CQC action plan or improvement programme
4	Contingency:	Schemes only to be mobilised as part of contingency

5. Recommendations

The Board of Director's is asked to note both the Surge plan document and financial impact of the additional schemes which have been included in the Trust financial plan for the second half of the financial year..

Wirral University Teaching Hospital
NHS Foundation Trust

Winter – Surge Operational Plan 2020/21
Version 1.1

Contents

Introduction

This document provides a single source of reference for the Wirral University Teaching Hospital's winter and surge plans for 2020/21.

It aims to provide a clear understanding of how the provision of capacity to meet patient demands through a traditionally highly pressured period has been planned for, and the response for any change in demand that may arise.

Clearly the impact of COVID-19 has been marked during the current year and therefore scenarios for COVID demand has been built into the bed configuration set out in the document, along with any workforce aspects for the major staff group of nursing. Escalation plans for other staff groups are available at local level.

Response Governance and Command Arrangements

Background

Since early March 2020, the Trust has been operating a Command and control model as part of the Covid-19 response.

This has included the centralisation of governance, the development and delivery of a COVID clinical model, the reconfiguration of wards and beds, the expansion of staff wellbeing systems, the reduction of elective surgery and transformation of outpatients

Purpose

This section sets out the key components of the WUTH COVID response command structure, detailing the key groups and decision making bodies, roles and functions of each group as well as the reporting lines.

In addition, the document details the key tasks across this stage, which will run for a period of five months, from the 10th November 2020 to the 31st March 2021.

Current Trust Command Structure

As part of the COVID response, the Trust has operated a command structure that can be seen at figure 1. This has been adjusted over the last eight months to support rapid decision making and now includes the following:

- Gold Command – CE Chair
- Silver Command – D/CE Chair
- Bronze Command – DD chair (rotation)
- Clinical Advisory Group – D/CE Chair
- Bed Meetings - Manager of day
- Environmental Group – Director of Estates Chair
- Workforce Group – Director of Workforce Chair

These groups and committees are focused on either reporting, information sharing and communications, collaboration or key task delivery.

As part of these changes, trigger levels have been introduced to support on site management and response to increase COVID cases and winter pressures.

Fig 1

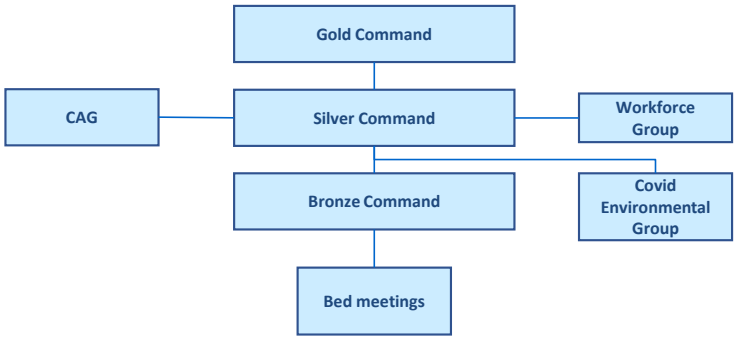


Table 1 below details the key triggers for each level. Movement between each level will be based upon changes in two or more internal measures. These will be reviewed on a weekly basis by Gold Command

Table 1

Trigger Type	Level 1	Level 2	Level 3
APH Bed Occupancy	<85%	85%-90%	90%+
Critical Care Bed Occupancy	<60%	60%-80%	80%+
Number of COVID+ patients	<70	70-100	100+
OPEL rating	OPEL 1	OPEL 2	OPEL 3
Staff Absences	<10%	>10%	>15%
National EPRR Level	L3	L4	L4

Table 2 portrays the command Group and Chair arrangements and frequency determined by the triggers.

Table 2

Command	Chair	Frequency		
		Level 1	Level 2	Level 3
Gold	CEO	Weekly	Twice weekly	Daily (week days)
Silver	Deputy CE	Twice Weekly	Thrice weekly	Daily (inc. weekends)
CAG	Deputy CE	Twice weekly	Thrice weekly	Thrice weekly
Workforce Group	Director of Workforce	Fortnightly	Weekly	Weekly
Bronze	DD Chair	Daily	Twice Daily	5 times daily Align with Bed meetings Nominated Director attendance
Bed Meetings	Capacity Director	5 times daily	5 times daily	Merge with Bronze
Covid Environmental Group	Director of Estates	Fortnightly	Fortnightly	Weekly

External COVID Response Groups and Committees

Table 3 demonstrates the external NHS and government COVID response Groups and Committees in with Trust representation.

Table 3

Area	Level	WUTH Attendee	WUTH Alternate Attendee
Wirral Health and Care System Strategic Care Cell	Place	Chief Executive	Executive Medical Director/ Director of Strategy
Wirral Health and Social Care Cell	Place	COO	Nominated DD/ Deputy COO
Wirral CAG	Place	Executive Medical Director	Deputy Medical Director
Wirral STAC	Place	Deputy Medical Director	Deputy Medical Director
Wirral Covid Inequalities Group	Place	Deputy Medical Director	Deputy Medical Director
C&M Gold Command	C&M	COO	Nominated DD/ Deputy COO
C&M Provider CEO Collaboration Group / Hospital Cell	C&M	Chief Executive	Director of Strategy
C&M Daily Critical Care Network	C&M	Deputy Medical Director	Director of Critical Care

Area	Level	WUTH Attendee	WUTH Alternate Attendee
C&M Provider COO COVID Group	C&M	COO	Nominated DD/ Deputy COO
C&M Chief Nurses Group	C&M	Chief Nurse	A/D of Nursing
C&M Clinical Priorities Group	C&M	Executive Medical Director	Deputy Medical Director
C&M Flu Vaccination/HR Directors Group	C&M	Director of Workforce	A/Director of Workforce
C&M Vaccine Working Group	C&M	Director of Strategy & Partnerships	Director of Pharmacy
Asymptomatic Staff Testing Pilot Group	Region	Director of Workforce	A/Director of Workforce
NW CEO Briefing	Region	Chief Executive	Executive Medical Director
NW Medical Director Regional Update	Region	Executive Medical Director	Deputy Medical Director
NHS England CEO Briefings	National	Chief Executive	Executive Medical Director

Current Position

In line with national guidelines the Trust is cohorting patients together according to their level of risk and likelihood of COVID.

The wards/departments in the hospital have been categorised and identified by four colours for ease, red, amber, green and silver.

The wards/departments where patients with known COVID are nursed are called red, Amber wards are for patients where there is a high suspicion of COVID-19 and green wards are for low suspicion of COVID-19.

Silver wards/departments are for patients coming in for elective surgery who have been screened for COVID at pre-op and have a very low/ no suspicion of COVID.

Dependant on the risk at each area this dictates the level of PPE required. Staff are trained to ensure they wear the correct PPE as recommended by PHE.

Table 4

Ward colour codes	
No suspicion of COVID-19 Elective only	SILVER
COVID-19 confirmed	RED
High suspicion of COVID-19	AMBER
Low suspicion of COVID-19	GREEN

Bed Configuration

The ward configuration displayed below is the actual position as at the 13th November with COVID positive occupancy levels at circa 10% of overall bed stock.

Table 5

APH	Ward Name	Current Beds	Side Rooms	Speciality
CRITICAL CARE	ITU	12	4	Critical care
	HDU	6	2	Critical care
ASSESSMENT	EDRU/CDU	10	0	ED
	AMU	27	7	EM
	RRU/MSSW	6		EM
	WARD 19/OPAU	24	0	DME
INPATIENT	CCU	7	0	Cardiology
	WARD 21	29	5	DME
	WARD 22	21	5	DME
	WARD 23	26	4	Stroke
	WARD 24	23	1	Gen Med
	WARD 25	23	15	Gen Med / Respiratory
	WARD 26	29	3	Endocrinology
	WARD 27	29	3	DME
	WARD 30	23	22	Haematology/Palliative Care
	WARD 32/HAC	29	5	Cardiology
	WARD 33	26	4	Gen Med / Cardiology
	WARD 36	36	5	Gastro / Gen Med
	WARD 37	8	0	Renal
	WARD 38	27	7	Respiratory
	LSU	10	0	Respiratory
	WARD 11	25	13	Ortho Trauma
	WARD 10	15	4	Gen Med /Surgery
	WARD 14B	10	0	Non-elective
	WARD 17 SEU	20	4	Surgical Emergency Unit
	WARD 18	30	4	Surgery / Gen Med
	WAFFU	8	4	Trauma
	WARD 20	29	3	Surgery
	WARD 12A	16	10	Surgery / Gen Med

APH	Ward Name	Current Beds	Side Rooms	Speciality
	WARD 14 Elective	19	11	Elective Colorectal/Urology/ENT
	WARD 54 Elective	4	4	Elective
	WARD 54 Gynae	10	0	Surgery

Table 6 provides the bed configuration at the CBH site as at 01/11/20

Table 6

CBH	Ward Name	Current Beds	Side Rooms	Speciality
	CRC	32	11	Rehab
	M1	20	4	Med Optimised
	M2	30	3	Ortho and Surgical Elective

Summary of current bed configuration

Table 7

RED	AMBER	GREEN	SILVER
72	43	513	53

Table 8

Area	Beds
Critical Care	18
Non-Elective	610
Elective	53
Total G&A	681

Services to Clatterbridge

From October 19th 2020 the Elective Orthopaedic services currently utilising Ward 12 at the Arrowe Park site has temporarily relocated to Clatterbridge and accommodated on Ward M2.

To accommodate the increases in services provided at Clatterbridge the Theatre plan and resourcing have been extended to full capacity and the ward will increase to a full 7 day provision.

There was a small element of Daycase activity which needed to be displaced from Clatterbridge which has been provided at APH, admitted and discharge via SEAL and utilising the 3rd stage recovery area.

The Trust has a work programme in place examining the short to medium term use of Clatterbridge, primarily aimed at configuration from the 1st April 2021, but is also involved in regional discussions to determine whether capacity could be increased at the Clatterbridge ahead of that timeframe.

Oxygen

During wave 1 the medical oxygen capacity for the site was upgraded from 1300 litres per minute to 5000 litres per minute. This upgrade proved more than capable of meeting the overall oxygen needs of the site which currently averages 900 litres per minute.

The upgrade also improved the overall infrastructure and design of the supply to ensure that the levels of oxygen able to be supplied to an individual ward or service area, was increased.

The resilient supply of oxygen to key areas is as below, and now meets the maximum number of patients requiring oxygen support that can be safely managed in a clinical area as agreed by the Trust clinical advisory group:

- A standard ward can accommodate 8 devices at 75 litres per minute
- ITU can accommodate 8-10 devices at 75 litres per minute.
- HDU and Eye Theatre Recovery distribution system can deliver capacity of 900 litres per minute respectively
- Ward 25 (main covid ward) has sufficient 02 in place for high flow oxygen/CPAP in all areas

Divisional Summary of Services In and Out of Hours

Acute Division

Divisional Senior Cover

Table 9

	Operational	Nursing	Medical
Weekday	Divisional Director/Deputy	Divisional Director Nursing/Deputy	Associate Medical Director/Deputy
Weekend/BH	On-call Manager/Bronze Commander	Matron (Staffing)	Specialty Consultant On-call

Emergency Department

Table 10

	Weekday	Saturday/Sunday/BH Direct Patient Care (DPC) Top Consultant (TC)
ED Consultant	08:00-08:00 On Call (15:00-00:00 DPC) 08:00-11:00 DPC 08:00-12:00 TC 08:00-16:00 DPC 09:00-17:00 DPC 11:00-19:00 DPC 12:00-16:00 TC 14:00-22:00 DPC	0800-0800 On Call (1500-0000 DPC) 12:00-21:00 DPC 08:00-13:00 DPC 09:00-18:00 DPC
ED Shift Leader	1 Shift leader 24/7	

Medical Specialty Division

Divisional Senior Cover

Table 11

	Operational	Nursing	Medical
Weekday	Divisional Director/Deputy	Divisional Director Nursing/Deputy	Associate Medical Director/Deputy
Weekend/BH	On-call Manager/Bronze Commander	Matron (Staffing)	Specialty Consultant On-call

Hospital Clinical Coordinator Cover

Table 12

	Hospital coordinator Team 24 hour cover	
Week day	07:45 -20:15 19:45-08:15 16:00- 00:00	Band 7 & Band 6 Band 7 & Band 6 1 Band 7
Weekend / BH	07:45 -20:15 19:45-08:15 16:00- 00:00	Band 7 Band 7 & Band 6 Band 6/7

Patient Transport & Discharge Lounge

The Discharge Lounge functions from 08:00 to 20:00 to support timely safe discharges. Dedicated transport services are available every day by way of 2 vehicles between the hours of 10:00 and 21:00. Age UK continues for provide support to the transport service.

Surgical Division

Divisional Senior Cover

Table 13

	Operational	Nursing	Medical
Weekday	Divisional Director/Deputy	Divisional Director Nursing/Deputy	Associate Medical Director/Deputy
Weekend/BH	On-call Manager/Bronze Commander	Matron (Staffing)	Specialty Consultant On-call

Emergency Surgeon Cover

The Emergency Surgical Team cover the Emergency Surgery Unit 08:00 to 20:00 weekdays and till 13:00 weekends and bank holidays. All non-elective cover is provided by the on-call surgical teams. Emergency operating continues on a 24/07 basis.

M2 orthopaedic ward remains opens 24/7 with M2 surgery closing Friday evening/Saturday morning through to Monday morning.

Women & Children's Division

Divisional Senior Cover

Table 14

	Operational	Nursing	Medical
Weekday	Divisional Director/Deputy	Divisional Director Nursing/Deputy	Associate Medical Director/Deputy
Weekend/BH	On-call Manager/Bronze Commander	Maternity Bleep Holder/ W&C Manager on-call	Specialty Consultant On-call

Clinical Support Division

Divisional Senior Cover

Table 15

	Operational	Nursing	Medical
Weekday	Divisional Director/Deputy	Divisional Director Nursing/Deputy	Associate Medical Director/Deputy
Weekend/BH	On-call Manager/Bronze Commander	Departmental Leads	

Clinical Support Services

The wards and departments are supported in and out of hours by the following Clinical Support Services.

Table 16

	Weekday	Weekend/Bank Holiday
Cellular Pathology	08:00-17:30	Closed
Phlebotomy	07:00-17:30 (Mon-Thu) 07:00-17:00 (Fri)	07:00 – 12:00
Mortuary Service	08:00-16:00	On-Call Technician
Microbiology	24/7	24/7
Blood Sciences	24/7	24/7
CT	07:45- 20:15	07:45- 20:15
MRI	07:15- 19:45	07:15- 19:45
US	08:30-17:00	Con On-Call

	Weekday	Weekend/Bank Holiday
Interventional Radiology	08:30-17:00	Con On-Call
Pharmacy Team	09:00-18:00 (09:30-18:00 Wed) AMU support until 21:00 On-call pharmacist available 18:00-09:00	09:00-16:00 On-call pharmacist available 16:00-09:00
AHP Teams	Inpatient areas 08:00-16:30 ED/Assessment areas 08:00-18:30	

Approved winter schemes

The table below provides details of additional resources that have been established to support the safe delivery of services and meet the demands of COVID, Winter pressures and quality improvement programs. The final entry (Ward 1) highlights a contingency arrangement in the event of unforeseen demand.

Specialty	Proposal	Purpose	Type	Band
General Medicine	Increase of 4 CPAP Beds - Ward 25	COVID	Nurse	Band 5 & 2
Emergency Department	ED Nursing - Senior Nurse, Quality Shift Leader	COVID	Nurse	Band 7
Emergency Department	ED Nursing	COVID	Nurse	Band 5 & 2
General Medicine	Ward medics - W18, M1 20 - 40 beds, Respiratory impact.	COVID/Winter	Medic	Consultant Junior
Emergency Department	3 wte ED NHS Locums	COVID/Winter	Medic	NHS Locum Consultant
Domestics	Increase in cleaning during winter	COVID/Winter	Domestics / Porters	Band 2
Medicine & Surgery	Covid patient safety nurses	COVID/Winter	Nurse	Band 6
Laboratory Medicine	Covid & Flu Testing (BMS & Spec Reception)	COVID/Winter	Healthcare Scientist	Band 4 & 2
Pharmacy	Escalation Ward Cover (W18) (Pharmacist)	COVID/Winter	Pharmacist	Band 8a
General Medicine	Medical admissions- increased medical cover	Winter	Medic	Consultant/Junior
Pharmacy	Extended 7 Day Pharmacy Cover - assuming 70% fill rate on locum shifts	Winter	Pharmacist/HCS	Band 8a & 5
Emergency Department	ED Nursing - Nurse coordinating ED initial assessment	Winter	Nurse	Band 6
Pharmacy	PTWR Support (Pharmacist) - assuming 70% fill rate on locum shifts	Winter	Pharmacist	Band 8a
Diabetes / Gen Med	Ward 26 - 4 escalation beds	Winter	Nurse	Band 5 and 2
Gynaecology	Ward 54 - 4 escalation beds	Winter	Nurse	Band 5 and 2
Emergency Department	Site Team CSW	Other - Patient Flow	CSW	Band 2
Therapies	Unplanned Care Evening Cover (incl. Frailty & Discharge Lounge)	Other - CQC	AHPs	Band 7 & 6
Therapies	Evening & Weekend Ward Cover (OT, Physio, SALT & Dietetics)	Other - CQC	AHPs	Band 6, 5 & 2
Therapies	Escalation Ward Cover (W18) (OT, Physio & Assistant, SALT, Dietetics)	Other - CQC	AHPs	Band 6, 4 & 2
Emergency Department	ED 4 Hour Tracker	Other - CQC	Admin	Band 4

Specialty	Proposal	Purpose	Type	Band
Therapies	Discharge Pathway Therapy Support	Other - CQC	AHPs	Band 4
General Medicine	Ward 1 - 21 Beds *	Contingency	Ward nurses and medics	

Patient Flow Improvement Initiatives

Long Length of Stay (LLOS) reviews:

Three times weekly LLOS reviews now take place in the Acute and Medicine Specialty Divisions, with twice weekly LLOS reviews within Surgical Division. The reviews take an MDT, action- focused approach to assessing and agreeing actions to overcome the discharge delays of its inpatients

Firebreak Events:

The Acute, Medicine Specialty and Surgical Division now participate in weekly 'Firebreak' events over the course of winter.

On one day per week each medical and surgical ward have an identified ward liaison officer (from a pool of Directorate Managers, Associate Director of Nurses and Discharge trackers) attending morning ward round and afternoon huddle to support in:

- identification of patients who no longer meet the standard 'Criteria to Reside'
- identifying and enacting solutions to discharge delays for ready for discharge patients on 'pathway 0'

A Command Centre is in place for each event staffed by Divisional Directors, the Wirral Lead of Discharge and a lead from IDT, Radiology, Therapy and Pharmacy available for escalation of discharge delays respective to their areas.

Surge Planning

Workforce

Nurse Staffing

Each morning the Associate Directors of nursing undertake a staffing review with ward managers and matrons, with a similar review undertaken each evening by the hospital site coordinators. The objective is to action mitigations for unplanned absence and changes in operational pressures. Any staff moves are authorised, logged and documented in the Safe Staffing Oversight Tracker (SSOT).

Further daily staffing reviews are undertaken each evening by the hospital site coordinators to ensure staffing plans prescribed during the day are sufficient to meet the needs of patients on each ward area during the night shift. Any changes required are enacted and documented in the SSOT.

Where solutions are more complex, the safe staffing escalation policy (The triggers set out in table 10) is enacted to ensure adequate arrangements are made immediately and senior nurse leaders are alerted to support organisational cross-divisional response to any emerging risk.

Table 18

Triggers
Level 1 indicates that the Trust is operating within normal parameters. • **Staff sickness < 10 %** • **Day time nurse ratios 1:8** • **Night time ratios: 1:10** • **ED :15 RNs (days)** • **ITU/HDU - Ratio 1: 1 or 2 (staff to patient)** **Depending on proportionality** **Although identified as working at Level 1 the situation requires close monitoring and plans require development to support episode when Wards and Departments move to Level 2 or Level 3**
Level 2 indicates that the Trust is operating outside of normal parameters and that if unchecked care would become compromised • **Staff sickness >10 %** • **Day time nurse ratios > 1:8** • **Night time ratios > 1:10** • **ED >12 RNs** • **ITU/HDU Ratio 1:2 (staff to patient)** **At Level 2 senior nurses are required to agree actions to progress from speciality action plans**
Level 3 indicates that the Trust is operating outside of normal parameters and that if unchecked care would become significantly compromised – this could be considered a major incident • **Staff sickness > 15 %** • **Day time nurse ratios > 1: 12** • **Night time ratios: > 1: 15** • **ED > 9 RNs** • **ITU/HDU 1: 3 (Staff to patient ratio)** **All actions require Chief Nurse sign off**

Medical Staff

All Medical wards are covered by a specialty team and have senior reviews on a daily basis. The Medicine Specialty Division perform a morning spot check on each ward to confirm morning presence of a senior clinician. All patients will receive a morning board round and ward round (Monday-Friday). On weekends any new, sick or potential discharge patients receive a senior review.

All medical Specialty wards also receive a daily senior review and the Division performs a daily check on Cerner to confirm medical outliers have been reviewed.

If any gaps in medical cover are identified, the Divisional operational management team will work with specialties and Medical Staffing to ensure cover identified.

Acute Medicine provide daily consultant level input to support ward cover on AMU, in-reach into ED to manage the post take and take, and input into UMAC. If there are gaps identified in Acute consultant capacity or a surge in demand the Acute Physician of the Day (APOD) will liaise with the Medicine Manager of the Day (MOD). The MOD will work with the Divisional operational management team to identify additional medical cover to support Acute Medicine.

Critical Care Surge Plan

Critical Care capacity will be managed in conjunction with the wider Critical Care Network. This relate to a Critical Care surge plan to ensure safe delivery of escalation capacity in event of increase in demand above current capacity. This includes identified area for escalation, along with associated triggers for use of escalation capacity.

The Critical care capacity at Arrowe Park is 18 beds overall, configured across 2 units of 12 beds and 6. There are 7 side rooms available and in real time the configuration is managed to provide safe service to patient requiring differing levels of care, and COVID and non COVID separation.

Surge capacity of 6 additional beds in the ophthalmic theatres has been identified with nursing establishment, training of theatre staff and leadership enhanced to support all 3 areas should it be required.

Should capacity be required beyond this point then mutual aid is provided by the coordination of overall capacity across Cheshire and Merseyside via the daily critical care network meeting.

In the event of surge into ophthalmic theatres, mutual aid would be sought across Cheshire & Merseyside via the Gold Command daily meeting.

Ward Configuration

The Trust has modelled the impacts of increased COVID occupancy within the Trust to 20% and 30% levels in line with national directive and determined how wards would be configured in this event and what services would be withdrawn in clinical priority order.

The 2 scenarios are highlighted below, and have been agreed with lead clinical and operational teams from across the Trust.

20% COVID Occupancy

At 20% COVID occupancy :

- Critical care escalates to Ophthalmic Theatres
- Loss of up to 2 Elective wards with routine (P3 and P4) elective activity affected
- Mutual aid would be sought from the Cheshire & Merseyside hospital cell

Table 19

	Ward Name	Current Beds	Side Rooms	Speciality
CRITICAL CARE	ITU	12	4	Critical care
	HDU	6	2	Critical care
	OPH THEATRE	6	0	Critical care
ASSESSMENT	EDRU/CDU	10	0	ED
	AMU	27	7	EM
	MSSW	6	0	EM
	WARD 19/OPAU	24	0	DME
INPATIENT	CCU	7	0	Cardiology
	WARD 21	29	5	DME
	WARD 22	21	5	DME
	WARD 23	26	4	Stroke
	WARD 24	23	1	Gen Med
	WARD 25	23	15	Gen Med / Respiratory
	WARD 26	29	3	Endocrinology
	WARD 27	29	3	DME
	WARD 30	23	22	Haematology
	WARD 32/HAC	29	5	Cardiology
	WARD 33	26	4	Gen Med / Cardiology
	WARD 36	36	5	Gastro / Gen Med
	WARD 37	8	0	Renal
	WARD 38	27	7	Respiratory
	LSU	10	0	Respiratory
	WARD 11	25	13	Ortho Trauma
	WARD 10	15	4	Gen Med /Surgery
	WARD 17 SEU	20	4	Surgical Emergency Unit
	WARD 18	30	4	Surgery non-elective/Medical Outlier
	WAFFU	8	4	Trauma
	WARD 20	29	3	Surgery
	WARD 12	16	10	Surgery non-elective/Medical Outlier
	WARD 14 Elective	19	11	Elective Colorectal/Urology/ENT
	WARD 14	10	0	Non-elective - Surgery

	Ward Name	Current Beds	Side Rooms	Speciality
	WARD 54 Elective	4	4	Elective
	WARD 54 Gynae	10	0	Non-elective Surgery

Table 20

	Ward Name	Current Beds	Side Rooms	Speciality
	CRC	32	11	Rehab
	M1 CBH	20	4	Med Optimised
	M2	30	3	Non-elective step down

Table 21

RED	AMBER	GREEN	SILVER
101	88	439	53

Table 22

Area	Beds
Critical Care	18+6
Non Elective	628
Elective	53
Total G&A	681

30% COVID Occupancy

At 30% COVID occupancy:

- Elective program i.e. urgent and cancers (P1 and P2) would be affected
- Mutual aid for urgent and cancer activity would be sought via the Cheshire & Merseyside hospital cell

Table 23

	Ward Name	Current Beds	Side Rooms	Speciality
CRITICAL CARE	ITU	12	4	Critical care
	HDU	6	2	Critical care
	OPH THEATRE	6	0	Critical care
ASSESSMENT	EDRU/CDU	10	0	ED
	AMU	27	7	EM
	RRU/MSSW	6	0	EM
	WARD 19/OPAU	24	0	DME
INPATIENT	CCU	7	0	Cardiology
	WARD 21	29	5	DME
	WARD 22	21	5	DME
	WARD 23	26	4	Stroke
	WARD 24	23	1	Gen Med
	WARD 25	23	15	Gen Med / Respiratory
	WARD 26	29	3	Endocrinology
	WARD 27	29	3	DME
	WARD 30	23	22	Haematology
	WARD 32/HAC	29	5	Cardiology
	WARD 33	26	4	Gen Med / Cardiology
	WARD 36	36	5	Gastro / Gen Med
	WARD 37	8	0	Renal
	WARD 38	27	7	Respiratory
	LSU	10	0	Respiratory
	WARD 11	25	13	Ortho Trauma
	WARD 10	15	4	Gen Med /Surgery
	WARD 17 SEU	20	4	Surgical Emergency Unit
	WARD 18	30	4	Surgery non-elective/Medical Outlier
	WAFFU	8	4	Trauma
	WARD 20	29	3	Surgery
	WARD 12	16	10	Surgery non-elective/Medical Outlier
	WARD 14A	19	11	Non-elective
	WARD 14B	10	0	Non-elective - Surgery
	WARD 54	14	5	Non-elective - Surgery

Table 24

	Ward Name	Current Beds	Side Rooms	Speciality
	CRC	32	11	Rehab
	M1 CBH	20	4	Med Optimised
	M2	30	3	Non-elective step down

Table 25

RED	AMBER	GREEN	SILVER
101	88	492	0

Table 26

Area	Beds
Critical Care	18+6
Non-Elective	709
Elective	0
Total G&A	681

Risk and Mitigation

The following risks have been identified with mitigating actions described. These risks and mitigations will be reviewed constantly throughout winter period.

Table 27

Item	Risk	Mitigation	Governance
1	System-wide improvement schemes fail to deliver impact	• System-wide 'triggers points' agreed to escalate and redirect resources where required	• Health & Social Care Group
2	Insufficient acute bed capacity to meet demand	• Trust Escalation Policy • System-wide agreed 'Operational Pressures Escalation Levels' (OPEL) actions	• Daily Bronze Command
3	Patients remaining in hospital who no longer require acute care facilities	• Twice weekly LLOS reviews • Daily ward round • Criteria to reside applied to all Board Rounds • Firebreak events	• Health & Social Care Group • Daily Bronze Command • Daily Discharge Cell

Item	Risk	Mitigation	Governance
4	Emergency Department attendances and admissions exceed planning assumption	• Cancellation of SPA • 2 hourly huddles • Mobilise additional locums or nursing staff • Implement ED escalation plan • Quality & Safety huddles – 2 hourly • System call	• Daily Bronze Command • Daily ED Senior Team Meetings
5	Increase in social care admissions due to social care breakdown	• MDT Rapid Response Team	• Health & Social Care Group • Daily Discharge Cell
6	Lack of uptake for seasonal flu vaccination	• Trustwide Weekly update • Proactive engagement with staff	• Daily Bronze Command • Divisional Triumvirate Meetings • Senior Nurse Management Team
7	Workforce – lack of staff	• Nurse staffing plans • Medical staffing plans • Trust Escalation Policy • Workforce Triggers • Trust Severe Weather Plan • Divisional Business Continuity Plans • Trust Infection Control Policy • Outbreak meetings	• Outbreak Meetings • Workforce Group • Bronze Command • Silver Command

Item	Risk	Mitigation	Governance
8	Reduced elective programme due to urgent care pressures	• Planned Care Command Centre	• Cheshire &Merseyside Gold Command • Cheshire & Merseyside Daily COO Meetings

Other Operational Plans

This plan will be supported by the Christmas and New Year Plan that details the support specific to this period.

Winter Plan 2020/21: Financial Analysis

No	Division	Specialty	Proposal	Purpose	Type	Band	Hours	Days	WTE	WTE above M8/9/10 Run Rat	Start Date	End Date	Gross Expenditure 20/21 Total £k	Expenditure 20/21 Above Run Rate M8-10 19/20 Total £k
1	Medicine	General Medicine	Increase of 4 CPAP Beds - Ward 25	COVID	Nurse	Band 5 & 2			8.15	8.15	1st Oct	31-Mar	61	61
2	Medicine	Emergency Department	ED Nursing - Senior Nurse, Quality Shift Leader	COVID	Nurse	Band 7	12 hours	7	2.73	0.73	1st Jan	31-Mar	61	9
3	Medicine	Emergency Department	ED Nursing	COVID	Nurse	Band 5 & 2			11.71	-	5th Jan	31-Mar	69	-
COVID Sub Total									22.59	8.88			190	70
4	Medicine	General Medicine	Ward medics - W18, M1 20 - 40 beds, Respiratory impact.	COVID/Winter	Medic			7	5.40	5.40	1st Oct	31-Mar	331	331
5	Medicine	Emergency Department	3 wte ED NHS Locums	COVID/Winter	Medic	NHS Locum Consultant			3.00	3.00	1st Oct & 15th Nov	31-Mar	145	145
6	Estates/Hotel Servi	Domestics	Increase in cleaning during winter	COVID/Winter	Domestics / Porters				10.00	10.00	1st Oct	31-Mar	120	120
7	Medicine & Surgery		Covid patient safety nurses	COVID/Winter	Nurse	Band 6	11 hr shift		2.64	2.64		31-Mar	70	70
8	Clinical Support	Laboratory Medicine	Covid & Flu Testing (BMS & Spec Reception)	COVID/Winter	Healthcare Scientist	Band 4 & 2			1.50	1.50	1st Oct	31-Mar	25	25
9	Clinical Support	Pharmacy	Escalation Ward Cover (W18) (Pharmacist)	COVID/Winter	Pharmacist	Band 8a			0.50	0.50	1st Nov	31-Mar	16	16
COVID / Winter Sub Total									23.04	23.04			707	707
10	Medicine	General Medicine	Medical admissions- increased medical cover	Winter	Medic	Consultant/ Jur	17.00 to 20.00	7	1.12	1.12	1st Nov	31-Mar	64	64
11	Clinical Support	Pharmacy	Extended 7 Day Pharmacy Cover - assuming 70% fill rate on locum shifts	Winter	Pharmacist/HCS	Band 8a & 5			1.12	1.12	1st Nov	31-Mar	34	34
12	Medicine	Emergency Department	ED Nursing - Nurse co-ordinating ED initial assessment	Winter	Nurse	Band 6	14.00 to 02.00	7	2.73	2.73	1st Jan	31-Mar	32	32
13	Clinical Support	Pharmacy	PTWR Support (Pharmacist) - assuming 70% fill rate on locum shifts	Winter	Pharmacist	Band 8a	09.00 to 13.00	7	0.30	0.30	Mid Nov	31-Mar	13	13
14	Medicine	Diabetes / Gen Med	Ward 26 - 4 escalation beds	Winter	Nurse	Band 5 and 2	07.45 to 20.15	7	4.08	-	1st Jan	31-Mar	38	-
15	Womens & Childre	Gynaecology	Ward 54 - 4 escalation beds	Winter	Nurse	Band 5 and 2	24 hours	7	5.28	-	1st Oct	31-Mar	90	-
Winter Sub Total									14.63	5.27			271	143
16	Medicine	Emergency Department	Site Team CSW	Other - Patient Flow	CSW	Band 2	14.00 to 0.00	7	2.28	1.28	15th Nov	31-Mar	10	5
17	Clinical Support	Therapies	Unplanned Care Evening Cover (incl. Frailty & Discharge Lounge)	Other - CQC	AHPs	Band 7 & 6			3.80	3.80	1st Dec	31-Mar	61	61
18	Clinical Support	Therapies	Evening & Weekend Ward Cover (OT, Physio, SALT & Dietetics)	Other - CQC	AHPs	Band 6, 5 & 2			3.90	3.90	1st Dec	31-Mar	56	56
19	Clinical Support	Therapies	Escalation Ward Cover (W18) (OT, Physio & Assistant, SALT, Dietetics)	Other - CQC	AHPs	Band 6, 4 & 2			2.70	2.70	1st Dec	31-Mar	33	33
20	Medicine	Emergency Department	ED 4 Hour Tracker	Other - CQC	Admin	Band 4	12.00 to 0.00	7	2.73	2.73	15th Nov	31-Mar	23	23
21	Clinical Support	Therapies	Discharge Pathway Therapy Support	Other - CQC	AHPs	Band 4			2.00	2.00	1st Dec	31-Mar	21	21
Other Sub Total									17.41	16.41			204	199
22	Medicine	General Medicine	Ward 1 - 21 Beds *	Contingency	Ward nurses and medics			7	41.58	3.00	1st Jan	31-Mar	422	92
Contingency Sub Total									41.58	3.00			422	92
									119.25	**56.61**			**1,794**	**1,211**

* a measure for mitigation if Trust cannot maintain 90 maximum super stranded patients - expenditure not included in forecast

Board of Directors Meeting

Quality Account 2019-20 (Final Draft)

Board of Directors	
Agenda Item	20-21/196
Title of Report	Quality Account report 2019-20 (Final Draft)
Date of Meeting	2nd December 2020
Author	Jacqueline Robinson, Associate Director of Quality Governance Clare Brown -Clinical Effectiveness manager Katy Williams –Quality and Safety Analyst
Accountable Executive	Hazel Richards ,Chief Nurse /DIPC and Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Patient Safety and Quality
Level of Assurance • **Positive** • **Gap(s)**	Positive progress demonstrated against 2019/20 priorities
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

Quality Accounts are required by the Health Act 2009 and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations').

There have been revisions to quality account deadlines for 2019/20, due to the COVID pandemic, including:-

- no fixed deadline by which providers must publish their 2019/20 quality account but a recommended deadline of the 15 December;
- suspension of the requirement by foundation trusts to complete a Quality report, therefore some elements which are requirements of the Quality Report have been removed;
- NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20.

Despite these amended timescales the Quality Account is still required to present data from 1st April 2019 till 31st March 2020.

Quality accounts should be provided to stakeholders (for 'document assurance' as required by the quality accounts regulations) in good time to allow scrutiny and comment. A Draft Quality Account was:-

- Presented to the Trusts Patient Safety Quality Board (PSQB) on the 9th September 2020 and subsequently the Trusts Quality Assurance Committee on the 29th September 2020.
- Shared with Wirral CCG on the 8th October;
- Shared with Healthwatch and Adult Care and Health Overview and Scrutiny Committee.

Responses have been received from Wirral CCG and Healthwatch and are attached to the Quality Account. Adult Care and Health Overview and Scrutiny Committee have acknowledged receipt and it is anticipated comments will be received before the final deadline.

The Quality Account has been developed with significant input and consultation with relevant leads from within the Trust and where possible feedback received from external stakeholders has been incorporated into the final Draft presented with this paper.

2. Background

Quality Accounts are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations').

Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer. It allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to the public.

A Quality Account consists of three separate parts. Parts 1 and 2 are set out in regulations; part 3 allows the Trust to make the Quality Accounts more meaningful to our stakeholders, with information relevant to our services.

A Quality Account must include:

- a statement from the Chief Executive summarising the quality of NHS services provided;
- The Trusts priorities for quality improvement for the coming financial year (including progress update on those priorities identified in last year's Quality Account);
- a series of statements from the Board for which the format and information required is set out in regulations; and
- a review of the quality of services provided by WUTH. The recommendation is to consider these in terms of the three domains of quality: patient safety, clinical effectiveness and patient experience.

Due to the COVID-19 pandemic there has been a suspension of the requirement by foundation trusts to complete a Quality report; therefore some elements which are requirements of the Quality Report have been removed in this year's Quality Account.

Providers of NHS healthcare are usually required to publish a quality account to their organisation's profile on the NHS website by 30 June each year, however due to the COVID-19 pandemic there is no fixed deadline by which providers must publish their 2019/20 quality account this year. However it is recommended that the Quality Account is uploaded by 15 December 2020.

The final Draft Quality Account must be received and approved by the Board prior to publication.

3. Key Issues/Gaps in Assurance

3.1 Review of the Priorities for Improvement 2019/20

The 2018/19 Quality Account identified the following priorities for improvement targets for 2019/20:-

Priority 1 – Patient flow through the Trust

- Reduce bed occupancy to 93% by October 2019
- Reduce length of stay (using model hospital definition of Length of stay)
- Reduce the numbers of medically optimised patients not discharged

Some improvements were seen but not consistently maintained on a month by month basis. End of year position was affected by COVID-19, however the Trust has committed to learning from any new patient pathways which have been developed during the pandemic which may reduce hospital admissions and length of stay moving forward.

Priority 2 - Improve our patient's nutrition and hydration

- 95% compliance with MUST assessments at seven days, by the end of quarter 4
- Establish Baseline metric with regard to fluid balance assessment

Significant improvement seen and targets achieved.

Priority 3 - Reduce Pressure ulcers in patients who are cared for in the Trust

- Zero tolerance of avoidable pressure ulcers at grades 3 and 4
- 50% reduction in the number of grade 2 pressure ulcers, compared to the 2018/19 year end position.

WUTH undertook a deep dive into its pressure ulcer prevention work during 2018 and identified a number of quality improvements; which progressed through a quality improvement action plan 2018/19. Improving reporting and data systems and the development of a comprehensive database master file (TVT Masterfile) that incorporates data from all entry sources formed part of this improvement programme and was implemented during Q4 2019/20. This has resulted in a fully auditable trail monitoring patients who present with skin damage on admission or develop skin damage during their stay at WUTH. However, it also has resulted in the inability to draw direct comparisons to previous year's data.

3.2 Proposed priorities for 20/21

Trusts are required to establish priorities for the following year within their Quality Account; it is recommended that these are considered in terms of the three domains of quality: patient safety, clinical effectiveness and patient experience.

The following priorities have been identified.

A Positive Patient Experience

FFT recommend rate :inpatients	≥95%
FFT recommend rate :outpatients	≥95%

Care is Progressively Safer

Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses		≤0.24 per 1000 Bed Days
Reducing hospital acquired infections	Hospital Acquired Clostridium difficile	≤ 88
	No Hospital Acquired MRSA Bacteremia	Zero tolerance
Pressure Ulcers - Hospital Acquired Category 3 and above		Zero tolerance
Nutrition and Hydration - MUST completed at 7 days Nutrition and Hydration - MUST completed within 24 hours of admission		≥95% ≥95%

Care is Clinically Effective and Highly Reliable

Mortality Review: Avoidable factors associated with mortality	≤2%

4. Feedback from Stakeholder

Wirral CCG and Healthwatch have both reviewed and provided commentary on the Trusts Quality Account and this is provided in Appendix 1 and 2 of the Quality Account. Due to a restructure within the local authority commentary from the Adult Care and Health Overview and Scrutiny Committee is delayed this year but is expected prior to the upload date of the 15th December 2020.

Consideration of feedback from Wirral CCG and Healthwatch has been undertaken and amendments made to the Quality Account to reflect this feedback (highlighted in Quality Account for ease of reference).

5. Next Steps

- Feedback from the Adult Care and Health Overview and Scrutiny Committee to be received.
- Quality Account to be uploaded to the Trusts intranet by 15th December 2020.

6. Conclusion

There have been some changes in requirements this year due to the impact of COVID-19. These changes include a change to the statutory timeline for submission; no requirement for review by external audit; removal of content linked to the quality report which is not required this year.

The Quality Account provides an overview of progress made on priorities and audit activity for 2019/20. It also established priorities for 20/21.

7. Recommendations

The Board of Directors is requested to review and approve the attached Draft copy of the Quality Account for upload on the 15th December 2020.

Part 1: Foreword

It is with enormous pride in our staff and volunteers that I introduce the Quality Account Report for 2019/20. I am immensely proud of the progress made to build upon and strengthen the foundations for high quality care at Wirral University Hospitals NHS Foundation Trust (WUTH). The achievements outlined in this report are even more remarkable when viewed alongside the challenges faced by front line teams.

Overall we have made excellent progress on quality, governance, risk and leadership. In 2019/20 we developed a 3-year Quality Strategy which sets out clearly our ambition to be rated 'Outstanding' by the Care Quality Commission by the end of 2022. We have identified a range of quality goals across four distinctive quality campaigns: (i) a positive patient experience; (ii) care is progressively safer; (iii) care is clinically effective and highly reliable; and (iv) our services stand out. To support the delivery of our Quality Strategy we have identified a multi-disciplinary group of staff who undertook specialist training to become quality improvement pioneers, to provide additional support to teams as they continue on the improvement journey.

A new Vision and Trust Values were launched during the year and improvements in quality of services were highlighted in a Care Quality Commission (CQC) inspection report published in March 2020. The Trust vision and values were derived through engagement and interaction with staff, stakeholders and members of the public. The Vision 'Together we will' was launched, along with a new set of Values: 'Caring for everyone', 'Respect for all', 'Embracing Teamwork' and 'Committed to Improvement'. These are underpinned by a positive set of Behaviours for all staff to adhere to which are communicated through visual displays throughout our hospitals and in our recruitment process and materials.

The Trust's positive improvements were highlighted in the inspection report which followed visits by Care Quality Commission (CQC) in November 2019. WUTH has made substantial progress to comply with regulations since the previous inspection in 2018, particularly within the 'safe' and 'well-led' domains of the CQC regulatory framework. The Trust was successful in demonstrating significant improvement in medicines management, medical engagement, leadership development and governance. The overall rating remained at 'Requires Improvement' but showed how the organisation is on course to improve ratings further going forward.

I would like to acknowledge a small example of some the services here at WUTH which received recognition in 2019/20.

The work of our urology department made us the only trust in Manchester, Merseyside and Cheshire, to successfully meet the 'Getting It Right First Time' (GIRFT) target of primary ureterostomy and laser of stones for acute colic. Thanks to the purchase of a new laser and training, the team can now treat emergency patients on admission with acute colic.

Our Endoscopy service who have achieved JAG (Joint Advisory Group) accreditation following their JAG visit. The JAG Assessors awarded our unit a straight pass, which is a fabulous achievement.

Our Macmillan Urology Service at WUTH won the Cancer Nursing category at the national Nursing Times Awards. They won the award for the innovative changes that have been made to the service which have improved patient experience.

Our Maternity Services whose work led to the Trust being awarded 'Best Performing GAP Trust'. The aim of GAP (Growth Assessment Protocol) programme is to ensure all maternity staff are trained in assessing risk affecting foetal growth and that appropriate antenatal

measure are taken to prevent or reduce foetal growth restriction. The Trust has a Growth clinic service led by a foetal medicine specialist and a team of high risk midwives. We are now the top performing organisation in the country in this area.

Throughout 2019/20 some improvements were beginning to be seen from the significant work undertaken to manage patient flow, with the Trust performing well to deliver cancer and diagnostic targets, and to reducing to zero the number of people waiting more than 52-weeks for treatment. However in early March 2020, in response to the spread of the COVID-19 virus across the world, the NHS declared a Level 4 incident, this has impacted on waiting times moving into 2020/21 however we are working extremely hard to address this and utilizing learning from any new patient care pathways which have been developed during the pandemic to support our continued commitment to reduce hospital admissions and length of stay.

Finally I am pleased to confirm that the Board of Directors has reviewed the 2019/20 Quality Account and can confirm that it is an accurate and fair reflection of our performance.
Janelle Holmes

Chief Executive Officer

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1 (a) Review of the Priorities for Improvement 2019/20

This section of the report tells you how The Trust performed against the priorities that the Trust set itself in 2019/20. In 2019/20, The Trust identified 3 priorities focused on improving patient safety, clinical effectiveness and patient experience.

Priority 1 – Patient flow through the Trust

Effective patient flow remains challenging. The Trust invested heavily in exploring ways we can improve patient flows across the local health system so that patients admitted, treated and discharged can be cared for in a safe and efficient manner.

The Trust has engaged and accessed support from the Emergency Care Intensive Support Team (ECIST) to help teams learn and apply evidence-based practices to support and enable better patient flows through the health system locally.

To support the programme of work associated with lowering length of hospital stays, with the support of ECIST, The Trust has implemented the following initiatives:

- A 'Perfect Board Round', which also incorporates the SHOP prioritisation model (Sick, Home, Other Patients). The MDT team identify patients expected to be discharged in 48 hours ensuring preparations are made for discharge that day or before 12 the next day. This roll out was initiated at the end of February 2020.
- Introduced more focussed scrutiny and review of patient's whose stay is longer than 21 days in an attempt to identify the underlying barriers to discharge and address them.
- Introduction and testing of new electronic capacity management system which will help provide real-time visibility of bed utilisation thereby enabling better coordination of patient transfers from assessment areas to definitive care areas to ultimate discharge
- A single management structure for the Integrated Discharge Team has been established. Considerable progress has been made and these changes have led to greater stakeholder involvement and collaboration between system partners; improved staff morale and increased discharge rates for complex patients when compared to 18/19 performance.

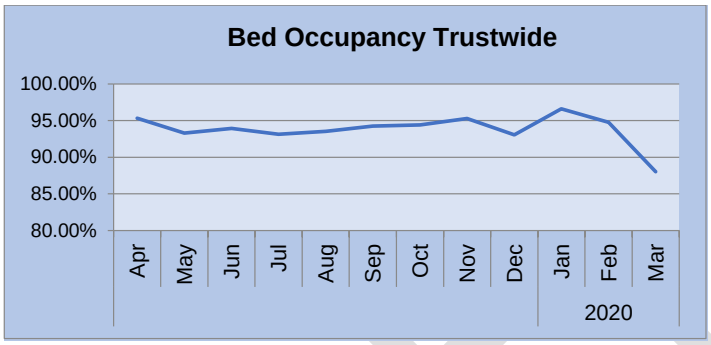
A pilot of Criteria-led discharge commenced in February to plan for, in advance, and enable weekend discharges. This area of work, subject to evaluation of pilot sites, will promote weekend discharge by ensuring that any patient who is identified at the Thursday afternoon huddle by the multidisciplinary team as a potential for discharge during the weekend to have an agreed discharge criteria determined in advance which, if met, will enable nursing and/or allied healthcare practitioners to execute the agreed discharge plan without the need for further medical review.

The Trust aims to fully involve patients and where the patients agree, their carers /relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care. Arrangements are set out within the Trust's Discharge policy and work continues to develop mechanisms to improve both the experience for patients; monitoring and assurance.

Progress against agreed targets in 2019/20:

i. Reduce bed occupancy to 93% by October 2019

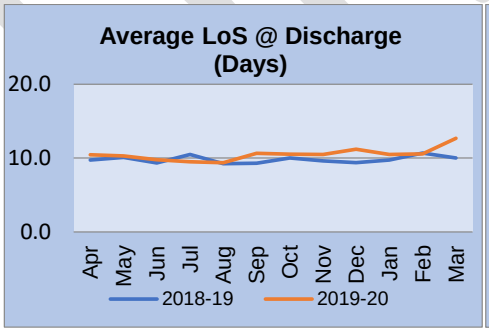
Whilst the average bed occupancy for the year is at 93.1% we are not yet seeing this being maintained on a month by month basis. During Qtr 4. Preparedness measures for Covid-19 Pandemic resulted in lower occupancy in the later months of Qtr 4. It is difficult to speculate whether this will be sustained, however the Trust has committed to learning from any new patient care pathways which have been developed during the pandemic which may reduce hospital admissions and length of stay.

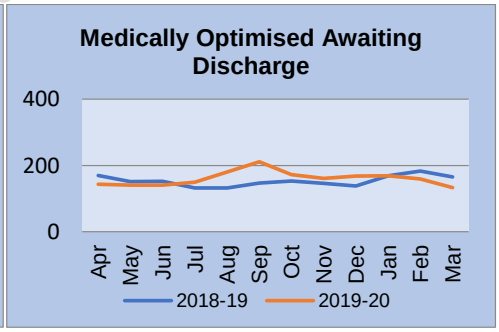


ii. Reduce Length of stay and the numbers of medically optimised patients not discharged

Reducing the number of long stay 21+ day patients across the Trust has been intractable and remains a significant challenge, with a static position of approximately 200 patients being maintained since the end of October.

Despite the challenges associated with reducing length of stay for medically optimised patients with a length of stay in excess of 21 days, it is encouraging that there has been a continued downward trend in overall length of stay since the end of October for long stay patients (over 21 days).





Priority 2 - Improve our patients' nutrition and hydration

During 2019/2020 the Trust prioritised improvement in compliance with completion of the Malnutrition Universal Screening Tool (MUST) on admission and reassessed every seven days for people with an extended hospital stay.

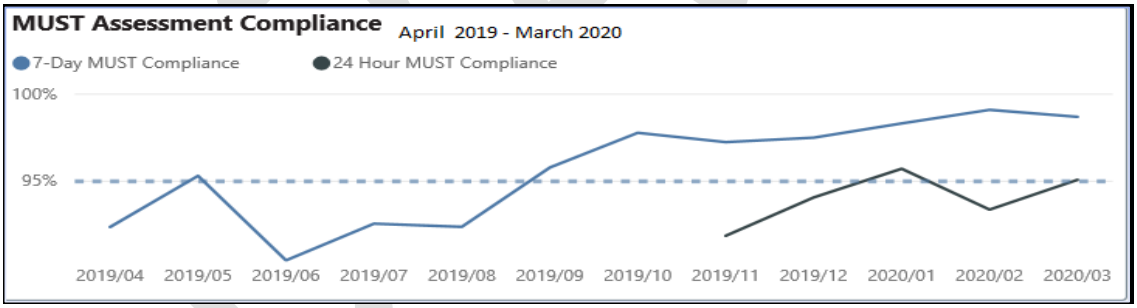
Significant improvements have been achieved within nutrition and hydration over the last 18 months. MUST compliance has increased from 67% to over 95% (national standard) and has been consistently achieved for the last 6 months, demonstrating excellent staff engagement in improving patient care and safety.

Menu changes have resulted in improved patient satisfaction although there is still work to do. Improvement in specialised diets has resulted in better choices for patients with long-term conditions.

Mealtime observations; Matron quality checks and the introduction of the 'water jug white lid' initiative for patients that require additional support all contribute to overall assurance that patients have access to and are assisted with (where required) fluids.

Progress against agreed targets in 2019/20:

i. **95% compliance with MUST assessments at seven days, by the end of quarter 4.**
Following implementation of plans to improve, supported by enhanced scrutiny and accountability on a case-by-case basis, The Trust achieved >95% compliance in September 2019 and this has been maintained thereafter for the remainder of 2019/20. The Trust initiated a full improvement plan where any areas identified as non-compliant were requested to attend Harms panel with a rationale as to why the breach occurred. This Harms Panel approach supports active and shared learning from areas that have implemented effective processes to ensure compliance sharing their methodology. In Quarter 4 we moved our focus to ensuring MUST assessment within 24 hrs of admission. The table below demonstrated our compliance and improvement.



ii. **Establish Baseline metric with regard to fluid balance assessment**
The Quality Strategy indicates that the Trust had to establish a baseline for Fluid balance compliance during 2019/20. In Qtr. 2 baselines were established for the completion of charts and calculation of positive or negative balance for specific patient cohorts. Overall compliance for all patients cohorts report has been challenging to establish. The Trusts improvement plan for nutrition and hydration includes work on establishing this baseline for all cohorts of patients who require fluid balance.

The improvement work scheduled for delivery in year-2 (2020/21) in The Trust's Quality Strategy is designed to lift compliance to levels at or above 95% for relevant patient cohorts we have been able to identify baselines for as well as establishing baseline for all appropriate patient cohort's .

As a digital exemplar organisation, The Trust is striving to provide an automated compliance data report from our electronic patient records. Progression has been made with a change of remit; this has now been adopted as a Quality Improvement project.

The Trust has consecutively achieved 100% compliance as monitored via Perfect Ward with ensuring that patients have fluids in reach.

Priority 3 - Reduce pressure ulcers in patients who are cared for in the Trust

WUTH undertook a deep dive into its pressure ulcer prevention work during 2018 and identified a number of quality improvements; which progressed through a quality improvement action plan 2018/19. Progress was reported quarterly to PSQB throughout 2019.

A review of the action plan 2019 demonstrated the following key achievements:

- Development of care bundles and monitoring of associated KPIs
- Introduction of falls and braden assessments in the Emergency Department,
- Introduction of harms panel to review pressure ulcer incidence and identify themes for learning
- Launch of a multi-disciplinary steering group
- Development of a Business Intelligence (BI) portal to show compliance of pressure ulcer care bundles
- Pressure ulcer component developed and incorporated in ward accreditation programme
- Recruitment of a tissue viability specialist nurse

In January 2020 the Tissue Viability action plan was reviewed and revised, identifying a need to strengthen robust data systems. A comprehensive database master file was created, that incorporates data from all entry sources including:

- The original tissue viability files that included telephone and Cerner referrals to the Tissue Viability Service (previously used to inform Trust data)
- Safeguarding incident reporting system (to include safeguarding referrals and complaints)
- New Cerner tissue viability referrals made via Cerner following the discontinuation of the original tissue viability file
- Data from the national Safety Thermometer point prevalence audit

The creation of the TVT Master file has provided the Trust with a fully auditable trail monitoring patients who present with skin damage on admission or develop skin damage during their stay at WUTH. The TVT master file also provides the additional benefit of:

- Tracking to ensure each pressure ulcer has an associated incident report on the Ulysses incident reporting system
- Tracking the validation of all pressure ulcers by a suitably trained and competent practitioner
- Ability to track unstageable pressure ulcers to ensure a weekly review is undertaken in line with national recommendation
- Ability to identify priority patients for review by the specialist tissue viability nurse
- Ability to track activity of tissue viability service and approved tissue viability practitioners (Appendix 2)

- Ability to report pressure ulcers on admission (POA)
- Ability to report medical device related pressure ulcers

The Trust reported an end of year position of two category 3 and two category 4 hospital acquired pressure ulcers.

- Hospital acquired

Hospital Aquired 2019 /20																	
Category 4			Category 3			Category 2			Category 1			Unstageable			DTI		
Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total
2	0	2	2	0	2	87	7	94	28	190	218	21	4	25	93	3	96
Device-related Category 4			Device-related Category 3			Device-related Category 2			Device-related Category 1			Moisture Lesion					
Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total	Validated	non-validated	Total			
0	0	0	0	0	0	4	6	10	0	2	2	5	2	7			

Whilst the creation of the TVT Database has delivered significant benefit it unfortunately has resulted in the inability to draw direct comparisons to previous year's data

2.1 (b) Looking forward to 2020/21: What our priorities are, and how we are planning to achieve on these.

In May 2019 the Trust launched its 3 year Quality Strategy after extensive consultation with staff and analysis of the previous year's quality performance data.

The Quality Strategy sets out four key campaigns each with over-arching goals and a number of key outcomes which provides the road map, setting out a clear direction and ensuring a shared and co-ordinated approach to ensuring patient focused, high quality care.

Year 1 of the Quality Strategy (2019/20) has focussed on establishing systems to ensure effective measurement and establishing baselines. Progress is monitored through the Quality Dashboard and a Quarterly report on progress is reported through the Trusts Patients Safety and Quality Board; and through the Quality Assurance Committee.
The below measures set out key Trustwide quality targets which are our priorities for 20/21

A Positive Patient Experience

The Trust are committed to delivering a model of care that is genuinely patient centred and making progress towards models of care developed in partnership with service users. Whilst the Friends and Family recommended rates below have been identified as targets for 20/21 the Trust will continue to seek and utilize wider sources of patient experience feedback to deliver positive assurances as to the positive experience outcomes of our patients.

FFT recommend rate :inpatients	≥95%
FFT recommend rate :outpatients	≥95%

Care is Progressively Safer

Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	≤0.24 per 1000 Bed Days
Reducing hospital Hospital Acquired	≤ 88

acquired infections	Clostridium difficile	
	No Hospital Acquired MRSA Bacteremia	Zero tolerance
Pressure Ulcers - Hospital Acquired Category 3 and above		Zero tolerance
Nutrition and Hydration - MUST completed at 7 days		≥95%
Nutrition and Hydration - MUST completed within 24 hours of admission		≥95%

Care is Clinically Effective and Highly Reliable

Mortality Review: Avoidable factors associated with mortality	≤2%

In Mid-March 2020 a COVID-19 global pandemic was declared. It is therefore anticipated that significant work associated with managing this risk and priority actions to ensure the safety of staff and patients whilst maintaining the quality of service will be included within the 20/21 Quality Account.

2.2 Statements of Assurance

During 2019/2020 Wirral University Teaching Hospitals NHS Foundation Trust provided and or subcontracted the 74 relevant health services.

Wirral University Teaching Hospitals NHS Foundation Trust has reviewed all data available to them on the quality of care in 74 all of these relevant health services.

The income generated by the relevant health services reviewed in 2019/2020 represents 100% of the total income generated from the provision of relevant Health Services by The Trust for 2019/2020.

National Audits

During 2019/2020 46 national clinical audits and 2 national confidential enquiries covered relevant health services that WUTH provides

During that period WUTH participated in 98% national clinical audits and 100% national confidential enquires of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Wirral University Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2019/2020 are as follows:
Assessing Cognitive Impairment in Older People / Care in Emergency Departments
BAUS Urology Audit Cystectomy
BAUS Urology Audit Nephrectomy
BAUS Urology Audit Percutaneous Nephrolithotomy
BAUS Urology Audit - Radical Prostatectomy
Care of Children in Emergency Departments
Case Mix Programme (CMP)
Elective Surgery - National PROMs Programme
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit programme (FFFAP)
Head and Neck Audit (HANA)
ICNARC National Cardiac Arrest
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit
Major Trauma Audit
Mandatory Surveillance of bloodstream infections and clostridium difficile infection
Maternal, Newborn and Infant Clinical Outcome Review Programme
Mental Health - Care in Emergency Departments
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia (Care in general hospitals)

National Audit of Seizure Management in Hospitals (NASH3)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management Heart failure MINAP
National Diabetes Audit – Adults
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Gastro-intestinal Cancer Programme (NBoCA)
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit
National Ophthalmology Audit (NOD)
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
National Smoking Cessation Audit
NCEPOD Dysphagia in Parkinson's
NCEPOD in hospital care of out of hospital cardiac arrest
Parkinson’s Audit
Perioperative Quality Improvement Programme (PQIP)
Sentinel Stroke National Audit programme (SSNAP)
Serious Hazards of Transfusion: UK National Haemovigilance Scheme
Society for Acute Medicine's Benchmarking Audit (SAMBA)
UK Cystic Fibrosis Registry

The national clinical audits and national confidential enquiries that Wirral University Teaching Hospitals NHS Foundation Trust participated in, and for which the data collection was completed during 2019/2020 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit	**Case % of Submission**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	164 cases
BAUS Urology Audit Cystectomy	Continuous data Monitoring
BAUS Urology Audit Nephrectomy	
BAUS Urology Audit Percutaneous Nephrolithotomy	
BAUS Urology Audit - Radical Prostatectomy	
Care of Children in Emergency Departments	260 cases
Case Mix Programme (ICNARC)	Continuous data Monitoring
Elective Surgery - National PROMs Programme	Continuous data Monitoring
Endocrine and Thyroid National Audit	Continuous data Monitoring
Falls and Fragility Fractures Audit programme (FFFAP)	Continuous data Monitoring
Head and Neck Audit (HANA)	*Trust agreed participation however audit ceased in July 2019*
ICNARC National Cardiac Arrest	No Trust participation
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Continuous data Monitoring
Major Trauma Audit	Continuous data Monitoring
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Continuous data Monitoring
Maternal, Newborn and Infant Clinical Outcome Review Programme	Continuous data Monitoring
Mental Health - Care in Emergency Departments	126 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	525 cases % reported against National aggregate not yet available. Continuous data monitoring in Trust
National Audit of Breast Cancer in Older People (NABCOP)	Continuous data Monitoring
National Audit of Care at the End of Life (NACEL)	Continuous data Monitoring
National Audit of Dementia (Care in general hospitals)	Continuous data Monitoring

National Audit of Seizure Management in Hospitals (NASH3)	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Continuous data Monitoring
National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management Heart failure MINAP	Heart Failure – 770 cases 81% compared to National aggregate MINAP – 431 cases 110% compared against National aggregate
National Diabetes Audit – Adults	
National Early Inflammatory Arthritis Audit (NEIAA)	
National Emergency Laparotomy Audit (NELA)	197 cases 100%
National Gastro-intestinal Cancer Programme (NBoCA & NOGCA combined)	NBoCA – 277 cases 117% compared against National aggregate NOGCA – 172 >90%
National Joint Registry (NJR)	Continuous data Monitoring
National Lung Cancer Audit (NLCA)	Continuous data Monitoring
National Maternity and Perinatal Audit (NMPA)	3288 98.4%
National Neonatal Audit (NNAP)	Continuous data Monitoring
National Ophthalmology Audit (NOD)	1237 99%
National Paediatric Diabetes Audit (NPDA)	Continuous data Monitoring
National Prostate Cancer Audit	Continuous data Monitoring
National Smoking Cessation Audit	100 cases
NCEPOD Dysphagia in Parkinson's	4 cases sampled by NCEPOD
NCEPOD in hospital care of out of hospital cardiac arrest	4 cases sampled by NCEPOD
Parkinson’s Audit	Continuous data Monitoring
Perioperative Quality Improvement Programme (PQIP)	Continuous data Monitoring
Sentinel Stroke National Audit programme (SSNAP)	Continuous data Monitoring
Serious Hazards of Transfusion: UK National Haemovigilance	Continuous data

Scheme	Monitoring
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Continuous data Monitoring
UK Cystic Fibrosis Registry	Continuous data Monitoring

The reports of 35 national clinical audits were reviewed by the provider in 2019/20 and Wirral University Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided

Audit	Outcomes /Action
BAUS Urology Audit - Cystectomy	The Trust has introduced robotic surgery which has improved the length of stay and the patient experience. The Trust is continually reviewing processes to improve the efficiency of data collection. As a regional center, capacity can sometimes be challenging but there is continued work around improving capacity which would impact positively on cancer waiting times performance
BAUS Urology Audit - Nephrectomy	The department continues to offer a high standard of service with outcomes matching or exceeding national benchmark standards. The Trust has also recently invested in a laparoscopic ultrasound machine, allowing robotic partial nephrectomy to be safely offered to patients with more difficult tumours. The Trust is continually reviewing processes to improve the efficiency of data collection. As a regional center capacity can sometimes be challenging but there is continued work around improving capacity which would impact positively on cancer waiting times performance
BAUS Urology Audit - Percutaneous Nephrolithotomy	The percutaneous nephrolithotomy audit shows that The Trust continues to practise to a satisfactory standard with no outlying measures. The Trust is also fully compliant with the new urology cancer services specification in terms of numbers of complex procedures undertaken
BAUS Urology Audit - Radical Prostatectomy	The majority of prostatectomies are performed using robotic surgery. This has improved the length of stay and the patient experience. The Trust is continually reviewing processes to improve the efficiency of data collection. As a regional center capacity can sometimes be challenging but there is continued work around improving capacity which would impact positively on cancer waiting times performance
Case Mix Programme (CMP)	Both low risk and 'all-category' Risk Adjusted Mortality figures are in 'green' Better than expected survival for patients with pneumonia and pre-existing metastatic disease. Management of pneumonia with non-invasive support is highly effective, and those that progress to invasive ventilation are more likely to be true poor responders

	The Trust faces challenges with a high proportion of patients remaining in critical care once they are ready for discharge. The unit is looking at improved pathways should patients require direct discharge home from the critical care area.
Elective Surgery - National PROMs Programme	The Trust continues work to improve capacity
Falls and Fragility Fractures Audit programme (FFFAP)	NHFD – 2nd out of 15 units in the NW re: Best Practice Tariff NHFD - 90 day mortality improved into “normal distribution range” Above national average of patients not developing pressure NHFD - Performance against time to theatre 76.3% against national result 69.2%. Training for juniors and the percentage of pre-operative block has increased markedly since Feb 2019 Above national average for preoperatively medical assessment rate (below national aspirational standard) Improvements are required in vison and delirium assessment Falls medication been identified as requiring further review through use of IT and education. Cascade lessons learnt through safety huddles Continued education and support for staff NHFD - Fast track policy being reviewed with “reverse co-hosting” in ED and identified patients fast tracked to WAFFU (Wirral Acute Femoral Fracture Unit) Plans to increase the availability of pre-op and the timeliness of post op physiotherapy
Major Trauma Audit	Success that chest physiotherapy are involved with patients within the ED Development of simulations of major haemorrhage with multiple specialties involved. Activation through emergency switch phone number. Discussion at Trust trauma meeting regarding standardisation of PCA administration. Current rib fracture guidelines updated. Chest injury guidelines regarding CT use and discussion with major trauma centre.
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	The Trust surveillance has yielded that contamination of sampling is the causal factor in positive culture results. Improvements in education and sampling are underway. Following a number of C. Difficile cases in 2019/20 a number of enhanced controls such as enhanced cleaning regimes, estates review, hand hygiene and patient moves have been put in place.
Maternal, Newborn and Infant Clinical Outcome Review Programme	All perinatal mortality and morbidity cases are reviewed and action plans are created, all stillbirths from previous year reviewed to identify reoccurring themes. Outcomes are shared with staff Review of data showed the Trust to be Compliant with 7 recommendations; 2 were not applicable; 4 required action

	The Trust has put the following actions in place • During 2016 the neonatal deaths were not being reported using the PMRT tool as a separate tool was being utilised – Consistent use of PMRT tool • The Trust histology department to identify a link perinatal pathologist • Facilitate close working between MBRRACE-UK and the Perinatal Mortality Review Tool (PMRT) • Introduction of SBL Bundle 2.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	The Trust were pleased to note improvements in • COPD practice tariff performance (met target for 3 quarters and best in region). • Good oxygen prescribing figures and excellent access to spirometry results. The Trust has identified the following actions: - Improve and speed up access to Non-invasive ventilation for patients with exacerbations of COPD. (used in the most severe cases) - Ongoing IT work to automate and standardise the process of smoking cessation referral and treatment.
National Audit of Breast Cancer in Older People (NABCOP)	Documentation of whole tumour size was found to be inconsistent, the MDT coordinator now ensures this information is captured and entered as part of the MDT. The Trust is working to utilise the NABCOP fitness assessment tool in older patients consistently.
National Audit of Care at the End of Life (NACEL)	The Trust achieved above national benchmark in:- ○ Recognition of the dying phase ○ Involving those close to the patient in decision making ○ View that hospital was the 'right' place for the person to die ○ Symptom control prescribing rates above national means. ○ Documented evidence of care and support provided to family/others at the time of death and immediately after death ○ Documented evidence that the patient had an individualised care plan ○ Specialist palliative care input during the final admission ○ Patient treated with compassion ○ Use of clinically assisted hydration (CAH) ○ Use of the subcutaneous route for CAH The Trust agreed the following actions • Encourage adherence with our Trust's agreed 'care in the last days of life' framework • Roll-out boards above beds stating named nurse and consultant • Improve communication within and between ward teams e.g. board round processes and implementation of AMBER care bundle. • Develop operational plan to deliver WUTH Palliative & End of Life Strategy 2019-2022

National Audit of Dementia (Care in general hospitals)	The Trust achieved above national average for the following: o Governance o Nutrition o Discharge o Staff rating for communication o Care rating of patient care • Improvements were required in delirium assessment and we are utilising I.T. to prompt assessment of delirium with compliance reporting • We will continue to look for opportunities for continued education and raising awareness across locality
National Audit of Seizure Management in Hospitals (NASH3)	Data has not yet been published. The National committee is establishing how results will be presented and disseminated to Trusts
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	The Trust is meeting most of the indicators and the following actions are seeking to address gaps: • Development of epilepsy passport which is patient / family held • Improve links with schools for information contained in children's HCP to be available within health records
(NCAP) - Cardiac Rhythm Management - Heart Failure - MINAP	The Trust is actively recruiting device consultants and operators. Plans are in place with bed bureau to improve prioritisation of critical care step downs
National Diabetes Audit – Adults	We have completed this this after a gap of non-participation therefore previous years data is not available
National Early Inflammatory Arthritis Audit (NEIAA)	This audit picked up the challenges in regard to referral to treat time to with consultant capacity reduced. The Trust has initiated greater clinic capacity to address the gap.
National Emergency Laparotomy Audit (NELA)	The Trust has made substantial progress in meeting the process of 'care standards' and performance, with improvements, was seen across all measures. - The Trust has continued to further reduce our risk adjusted - Mortality from 7.9% to 7.1%, despite the national average mortality rate remaining static this year at 9.6%. - The Trust has promoted the use of Risk Assessment Tools to assess criteria for critical care admission with has improved admission for those with a risk factor - A pilot of care of the elderly reviews has now established as a service , increasing proportion of reviews taking place for 7% to 70% - Strengthened the escalation use of emergency theatre
National Gastro-intestinal Cancer Programme (NBoCA)	The Trust has demonstrated good measures for the following: - Low 30 day readmission rates - Below average 2 year mortality rates

	- Good data completion The Trust has taken the following actions for improvement: • Bowel school to support enhanced recovery pathway and reduce length of stay • Pre-habilitation programme to optimise patients' fitness for surgery and improve outcomes, reduce hospital stays and time to full recovery
National Joint Registry (NJR)	The Trust was 'Better Than Expected' in 8 recorded metrics; 'As Expected' in the other 2 metrics; no 'Worse than Expected' performance in the hip and knee metrics at either site. The surgeon performance data shows no surgeons currently performing hip and/or knee arthroplasty are an outlier with regards 90 day mortality or revision rate. Appears to be excellent systems in place for the capture and submission of eligible NJR procedures No current actions are in place
National Lung Cancer Audit (NLCA)	Implementation of NOLCP, IT driven, nationally used as case study of good practice The Trust intends to: - undertake a review of the number of radiological diagnoses - Improve proportion of patients seen by a Cancer specialist nurse
National Maternity and Perinatal Audit (NMPA)	All findings except breast feeding rates were comparable or better than national means. Breast feeding support remains a focus of improvement – especially on discharge form hospital.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Audits findings are under review
National Ophthalmology Audit (NOD)	Overall, the audit findings are favourable, indicating high quality surgery is being delivered to NHS patients, specifically, no outlying centres or surgeons have been identified. **Concerns** The trust has put in actions to improve collection of post-operative VA measurements at both pre and postoperative time points
National Paediatric Diabetes Audit (NPDA)	The Trust identified the following: - Median HbA1c improved from 68 to 64 mmol/mol - 100% compliance with HbA1c and BMI check in clinics - Improvement in key care processes from previous year - notably thyroid and albuminuria checks - Improvement in additional health checks e.g. 4+ HbA1c, ketone testing, sick day rules, flu vaccine recommendation - 100% compliance with care at diagnosis - Significant reduction in emergency hospital admissions from 12.1%

	to 5.2% (national average 6.2%) The Trust identified the following actions for improvement: - Structured education - Annual Reviews - Weekly Patient Huddles - Development of an App for new patient education - Dedicated QI time - Improving staffing in specialist nurses, admin and psychologists - Ward staff training - Pump starts - Monitoring HbA1c trends as adjusted mean, although improved this still requires further improvement.
National Prostate Cancer Audit	Maintain or improve the quality of data through MDT collection. The Trust is Continuing with the implementation of the prostate cancer pathway
National Smoking Cessation Audit	The Trust was recognised as having an excellent smoking cessation service that offers a wide array of smoking cessation interventions **Further actions required:** • Training for frontline staff • Approval of PGD to support non-medical prescribing • Update electronic smoking assessment • Link Millennium with Wirral stop smoking service database (pending shared governance agreement) • Identify designated lead Consultant for smoking cessation
NCEPOD participation: - Dysphagia in Parkinson's - NCEPOD in hospital care of out of hospital cardiac arrest	Data collection completed. All NCEPOD studies put on hold due to COVID-19 before year end. There will be no report for review before submission of 2019-20 Quality Account
Parkinson's Audit	The following results were identified: - The mean time between referral and initial assessment was lower than the National - 100% of physiotherapy notes included an action/goal plan and Parkinson's-specific outcome measures. - 1/3 of Patients were not seen within the service standard waiting time. - 71 % of patients concerned about falls. **Actions identified:** - Undertake capacity review at Clatterbridge Rehab Centre and Victoria Central Hospital - Develop a 'strength and balance' class to support patients
Perioperative Quality Improvement	**Actions** Quality and process improvement in surgery directed toward the

Programme (PQIP)	prevention of postoperative complications.
Sentinel Stroke National Audit programme (SSNAP)	The Trust achieved 9 out of the 10 indicators, an improvement by one indicator from the last Audit in 2016 and places the Trust in the top 3% in England; and the top 4% for England, Wales & Northern Ireland. The audit demonstrates that are gaps are around speech therapy provision
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	The Trust is in the process of upgrading equipment for blood sample labelling and re-educating staff on how to use the equipment correctly and safely Two pathways have been developed for incorrect blood sample labelling. One is for when staff make labelling errors. The second is when there is a more serious error that is reportable to SHOT - it is a wrong blood in tube incident that is a potential for the patient receiving an incompatible unit of blood. Transfusion Associate Circulatory Overload (TACO) is the biggest cause of morbidity and mortality related to transfusion. The Trust has developed and introduced an electronic risk assessment/checklist that staff ordering red cells or plasma have to complete before they can place the order. It alerts the staff to any patients that may be at risk for TACO and gives them recommendations/management plan to try and prevent TACO from occurring.
UK Cystic Fibrosis Registry	**Successes** • Largest CF network clinic • Results are comparable to AH and national results • New treatments now available including trikafta which we hope will further improve life expectancy • CF registry is a significant work load for the nurses but is a very powerful tool to drive up standards of care

The reports of 18 local clinical audits were reviewed by the provider in 2019/2020. Wirral University Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided

Audit	Action
Fall out rate of nephrostomy tube	The Trust improved patient information leaflets on discharge to include more information on correct dressings thus supporting patients on discharge and helping to prevent readmission to hospital.
High PSA Prostate specific antigen virtual clinic power point	Patients are now redirected to a virtual clinic rather for high PSA. There are now associated MRI slots for patients who are referred to the high PSA clinic.
Review of emergency theater	A small minority of cases are commenced after midnight .The audit demonstrated that improvements in documentation is required to able to

times	see if these cases are justifiably commenced after midnight
Factors affecting Increase LOS in patients treated for uncomplicated appendicitis.	The audit was able to demonstrate reasons for the factors affecting length of stay , including theater curfew for non-urgent , imaging availability , no clear discharge criteria A pathway is being created to treat uncomplicated appendicitis which would utilse more effective use of resources such as diagnostic imaging, hot clinics. Training to ANP would include clinical decision making regarding uncomplicated appendicitis.
Peri-operative hypothermia	Patients who going to undergo certain operative procedures are at high risk of perioperative hypothermia. These patients include major orthopedic patients, colorectal patients and now pathways are in place for them to receive pre warming prior to theater via a warming gown.
Clinical evaluation of acute diabetic foot and the appropriate management and referral following assessment	All diabetic foot patients are now seen on Post take ward round by a consultant TWR
Measuring Nutritional Care: screening, nutritional care processes, outcomes and patient experience	The Trust has seen good improvements of MUST completion especially the frequency and timeliness. The trust has developed education sessions to new clinical staff
CMCCN Quality Standards audits	The trusts critical unit partakes in Quality standard audits and a key action this year is to reinvigorate how the results of these are cascaded and quality improvement work prioritized as necessary.
WHO checklist in interventional radiology	The Who checklist for interventional radiology is being reviewed to ensure it lends itself to less ambiguous checking. The trust is also reviewing the use of the EPR to utilised as an enabler for the WHO checklist.
Inhaler audit	The trust is going to improve the increase the number of inhaler technique reviews that are completed. order sets for inhalers to be checked for accuracy to reduce concurrent prescribing of inhalers
Improving Patient Safety of Acute Care Lumbar Puncture	A safety checklist has been developed within the Trusts EPR trust wide Transition to utilizing atraumatic lumbar puncture needles trust wide
Secondary Prevention of Myocardial Infarction audit	The is developing template standards to improve documentation within the discharge summaries

Management of croup	The trust changed its Recommended dose of dexamethasone to 0.3mg/kg for croup and asthma after finding non standardised steroid dosing. Improved guidelines to include severity scoring system
Anorexia Nervosa Admission to Inpatient Services Audit	The trust has sought ways to improvement the documentation and availability of patient information leaflets Some inpatients were not seen by a dietician throughout their stay. The trust has sought ways to improve this
Association between USS findings of fluid and fibroids and endometrial cancer	The trust has updated its clinical guideline regarding Ultra sound guidelines. This reflects national findings and recommendations.
Management of Hyperemesis Gravidum	The Trust improved its education on this by inclusion in the clinical induction of midwives

Participation in Clinical Research

During 2019/2020 614 participants receiving NHS services provided by The Trust were recruited to participate in research approved by a research ethics committee. This demonstrates The Trust's continued commitment to research in order to provide evidence to improve treatment and the quality of care for our patients. The Trust also confirmed capacity and capability for 43 new studies; 38 of these have adopted by National Institute for Health Research (NIHR).

Research within The Trust is supported by a small administrative team (3 WTE), 9 Research Nurses (7 WTE) and a Research Midwife (0.7 WTE). Much of the research involves collaboration with the North West Coast Clinical Research Network and academic and industry institutions. The Research Department works closely with pharmacy, pathology and radiology to ensure that The Trust has the capacity and capability to set up and effectively run our studies.

The research portfolio continues to be clinically diverse including: anesthetics, cancer, colorectal, critical care, gastroenterology, haematology, orthopaedic, pediatrics, reproductive health, renal, respiratory, rheumatology, stroke, surgery and vascular studies.

In 2019/20 34 new articles written by WUTH staff, published in professional journals were identified (as listed on PubMed, Medline and EMBASE). New publications are recorded and disseminated across the organisation in order to share new knowledge. This shows The Trust's commitment to improving outcomes for patients, staff professional development and also to making a wider contribution to healthcare on a national level.

CQUIN

A proportion of Wirral University Teaching Hospital (WUTH) income in 2019/2020 was conditional on achieving quality improvement and innovation goals agreed between WUTH and the following Commissioners:

- Wirral Clinical Commissioning Group (WCCG)
- NHSEI – Specialised Commissioning

The total value of the income attached to delivery of the goals is included in the table below:

Commissioner	Year	CQUIN Value	CQUIN Achieved
NHSI/WCCG	2018/19	The amount of income in 2018/19 conditional on achieving quality improvement and innovation goals is £6.887m.	
WCCG	2019/2020	£3,227,677 of WUTH income in 19/20 was conditional on achieving quality improvement and innovation goals agreed between WUTH and Wirral CCG for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.	WUTH reached a year end agreement with WCCG that included all elements of the Contract. Revised arrangements for NHS contracting and payment during the COVID-19 pandemic (NHSEI 26 March 2020 ref: 001559)
NHSEI	2019/2020	£127,645 of WUTH income in 19/20 was conditional on achieving quality improvement and innovation goals agreed between WUTH and NHS England for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.	Full

Further details of the nationally mandated CQUINs for Acute Trusts, including rationale behind them, for example, how they fit with national strategies are available electronically at:

Commissioner	Year	Link
Clinical Commissioning Group CQUINs	2018/19	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/
Clinical Commissioning Group CQUINs	2019/20	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/
Prescribed Specialised Services CQUINs	2018/19	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-1

Prescribed Specialised Services CQUINs	2019/20	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Care Quality Commission

Wirral University Teaching Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Wirral University Teaching Hospital NHS Foundation Trust has the following conditions on registration:-

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

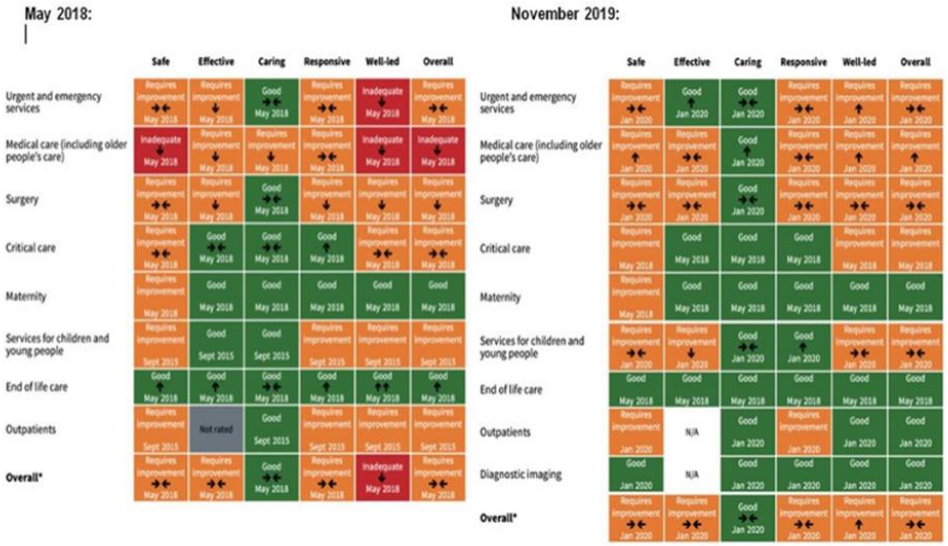
The Care Quality Commission has not taken enforcement action against Wirral University Teaching Hospital NHS Foundation Trust during 2019/20.

WUTH participated in a routine well-led inspection by the CQC covering the whole Trust during 2019/20. The inspection took place over October and November 2019, with results published on Tuesday 31st March 2020.

During the visit the CQC inspected urgent and emergency services, medical care, surgery, children's and young people's services, out patients and diagnostic services provided from Arrowe Park Hospital and medical care at Clatterbridge hospital. The well-led aspect of the overall trust leadership was also included.

The CQC inspection report reflects the substantial progress made since the previous inspection in 2018 to ensure compliance with regulations, particularly within the safe and well-led domains; and the demonstrable improvements in medicines management, medical engagement, leadership development and governance.

The CQC rated the Trust as 'Good' overall for caring and Maternity, End of Life and Diagnostic Imaging Services were also rated as good. Whilst the overall Trust rating remained as 'Requires Improvement' a comparison between the CQC ratings tables from the 2018 inspection and the 2019 inspections demonstrates the progress made and provides assurance the Trust remains on course to improve ratings further going forward.



Freedom to Speak Up

WUTH developed the role of Freedom to Speak up (FTSU) Guardians in 2015 prior to National guidance being issued by Sir Robert Francis. Since then, the Trust has been significantly involved in shaping National policy and guidance around this agenda and has been working hard to improve the speaking up culture within WUTH.

Two FTSU Guardians are currently in place, with plans underway to recruit more as soon as possible. 2 March 2020 also sees the launch of a new network of FTSU Champions. It is expected that FTSU Champions will work within their service areas, supporting the FTSU Guardians and promoting and encouraging staff to speak up.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact a Freedom to Speak Up Guardian and will also be signposted to relevant support services as necessary.
The profile of the FTSU Guardian in the Trust remains prominent and a variety of Trust wide communication mechanisms are utilised to promote the importance of speaking up and the support available, including leaflets, pull up banners and articles within the Trust's in-touch magazine. Guardians form part of the staff induction process (including junior doctors) and FTSU training is now required for all staff at a level appropriate for their role, with compliance continuing to increase and subject to standard Trust monitoring processes. Guardians conduct walkabouts within areas to heighten visibility and are linked to departmental cultural reviews as additional support.

Staff can speak up to FTSU Guardians in confidence and plans agreed together about how best to move forwards. Staff can access FTSU Guardians anonymously; however this can prevent effective management of the circumstances, due to insufficient information and does prevent feedback and support to the individuals concerned. The Trust has seen a reduction in the number of anonymous concerns raised as staff are feeling more confident to approach FTSU Guardians or local management teams.

FTSU Guardians maintain confidential records relating to information spoken up about and refer concerns to the most appropriate person e.g. Human Resources, management teams or staff side colleagues. Where further investigation is required, this is conducted independently by a senior and suitably trained person from elsewhere in the organisation if required. Progress is fed back to the

reporter along with any outcomes or actions taken. FTSU Guardians monitor actions and outcomes, and will escalate circumstances if concerns still remain.

The service has seen a positive increase in the number of staff speaking up with 106 people speaking up in 2019/2020 as opposed to 46 last year. Attitudes and behaviours continue to be the most reported theme and 12 concerns are linked with patient safety (as opposed to 16 last year).
There are also other sources of advice and support for staff who have concerns. These include: tutors (for students and trainees); Practice Education Facilitators; the Human Resources department; Trade Unions and professional bodies; Occupational Health and Employee Assistance Programme. Whilst, these services might not necessarily be able to investigate the concerns themselves, they can, for example, advise the employee about their rights, or support them if they are suffering stress because of the issue, so employees may wish to involve them in addition to contacting the Guardians.

Regular reports are produced and submitted to a variety of Trust management Committees to ensure appropriate monitoring takes place of speaking up data, potential trends and themes and that the Trust is capturing and sharing any lessons learned. Data is also submitted quarterly to the National Guardians Office to ensure wider monitoring of speak up process and now also includes where staff feel they have suffered detriment as a result of speaking up and data is submitted to the National Guardians Office as required for further monitoring.

Finally, staff have the right to raise issues with external regulatory bodies if they still do not feel comfortable to go through internal channels. These include: the National Speak Up Helpline, Care Quality Commission (for issues about patient safety and the quality of clinical services); NHS Improvement (for issues about finance and corporate governance); Health Education England (for education and training issues) and NHS Protect (where there are suspicions of fraud and corruption).

Hospital Episode Statistics

WUTH submitted records during 2019-20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data

which included the patient's valid NHS number was:
99.9% for admitted patient care
99.9% for outpatient care and
99.3% for accident and emergency care.

which included the patient's valid General Medical Practice Code was:
99.9% for admitted patient care;
99.9% for outpatient care; and
99.9% for accident and emergency care.

Information Governance

Information Governance (IG) ensures processes and safeguards are in place to support the appropriate use of personal data. Any risks relating to IG are contained within the Trust monitoring and reporting mechanisms. They are reviewed by the Information, Information Governance and Clinical Coding Group (IIGCCG). The IIGCCG oversees that the Trust maintains compliance with relevant legislation and good practice and escalates anything of note to the Risk Management Committee.

The Trust achieved 'Substantial Assurance' in February 2020 for the required annual audit of the Data Security and Protection Toolkit (DSPT) which was undertaken by Mersey Internal Audit Agency.

The submission date for the DSPT has been extended owing to the current COVID-19 situation. Therefore the DSPT will not be submitted until September 2020.

Highlights from the work programme for the year have included embedding the legal requirement for data protection impact assessments into the Trust's information sharing and information risk processes and encouraging a more data security savvy culture through continued education and awareness.

Clinical Coding

Accurate clinical coding is essential to the provision of effective healthcare at local and national level. It drives financial flows, informs payments and is critical to intelligent commissioning through the provision of epidemiological data that truly reflects the health and care needs of the nation.

In 2019/20 the Trust continued to commission an external audit programme from the Clinical Coding Academy at Merseyside Internal Audit Agency (MIAA). Two audits have been conducted by MIAA across the year. This provided significant assurance.

The first of these was an audit of General Medicine coding performed in September 2019 with overall accuracy of our coded data reported as:

- 89.44% for primary diagnosis
- 95.57% for secondary diagnosis
- 97.44% for primary procedure
- 92.31% for secondary procedures

A second audit was performed on Respiratory Medicine in January of 2020. The overall accuracy of our coded data is reported as:

- 92.50% for primary diagnosis
- 95.35% for secondary diagnosis
- 93.88% for primary procedure
- 95.24% for secondary procedures

These external audits were supplemented with additional internal audits throughout the year. We have two Approved Clinical Coding Auditors in post. The Trust was not subject to the Payment by Results clinical coding audit during 2019/2020.

The Trust will be taking the following actions in 2020/2021 to continue to improve data quality:

- Work with colleagues throughout the trust to improve the quality of our coded data with particular emphasis on clinician engagement and the improvement of documentation around coding for deceased patients.
- Continue to commission external clinical coding audits with expansion of our internal audit programme.
- Ensure the continual development of clinical coding staff, as well as ensuring all staff receives relevant feedback at individual and team level as appropriate.

The department has trained two trainee staff throughout the year and appointed two (1.5 wte) accredited clinical coders. Two members of staff passed the National Clinical Coding Qualification (UK) in March 2019 and a further one sat the Qualification in September 2020. This year one trainee

clinical coder left immediately after the initial training course, two accredited clinical coders have moved to Team leader roles at neighbouring Trusts and our Approved Experienced Clinical Coding Trainer moved to a role at NHS Digital as a Classifications advisor.
Trained clinical coders are a scarce resource and their recruitment continues to be challenging for the service as a whole.

Learning from deaths

During 2019/20 1542 Wirral University Teaching University patients died. This compromised of the following number of deaths which occurred in each quarter of that reporting period

366 in the first quarter;
336 in the second quarter;
352 in the third quarter;
488 in the fourth quarter.

By 31.03.20 802 case record reviews and 107 investigations have been carried out in relation to 1542 deaths.
In 909 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was

319 in the first quarter;
250 in the second quarter;
165 in the third quarter;
175 in the fourth quarter.

2 representing 0.13% of the patient's deaths during 2019/20 are judged to be more likely than not to be due to problem in the care provided to the patient.
In relation to each quarter, this consisted of:

0 Representing 0% for the first quarter

0 Representing 0% for the second quarter

0 Representing 0% for the third quarter

2 Representing 0.13% for the fourth quarter

These number have been estimated using the structured judgement methodology together with the serious incident framework, learning disability reviews based on the LEDER review tool, and perinatal mortality review tools.

Summary of learning, actions The Trust has undertaken and the impact of the relevant actions

Learning	Actions Implemented	Impact
Delay in discharging frail and elderly patients often results in their deterioration.	The Trust ran a 2 week pilot in March. The pilot demonstrated successfully This successfully demonstrated improvements in turning patients around at the front door. necessarily safe to. Avoiding admitting admit frail older patients and avoiding hospital acquired deconditioning.	Hospital avoidance and less deconditioning of frail and elderly patients More integrated community services The trust presented

	The Trust launched the Hospital at Home (H@H) Service in conjunction with the Rapid response team and Teletriage team – providing IV antibiotics, SC fluids, oxygen and palliative medications as appropriate for frail older people who may not want to come into hospital and prefer for treatment to be provided at home / care homes. Referrals come from stakeholders such as GPS NWAS Daily Teleconference Virtual Ward Rounds occur in the morning, discussing all the patients who are in the virtual ward and advising on management plans and reviewing results. These are shared with relevant community teams	the tele triage / hospital at home service services nationally at the British Geriatric Society conference and the Tele triage service has won multiple national and regional awards.
Specialty reviews to report into trust mortality processes	Endoscopy, Surgery and Haematology providing reports	Increased percentage of higher level reviews noted and opportunities increased for shared learning
Improve Quality of Admission Diagnoses	Any CUSUM alerts are reviewed within the Mortality Review Group Specialty diagnoses folders	Accurate documentation results in appropriate coding diagnosis
Improve Communication with system partners on DNCPR	Millennium solution for documentation in place	GP now will receive copy of DNCPR in addition to primary copy being with patient
Bereavement / Carer feedback not assured	Bereavement team escalated to Dep MD concerns and now to be superseded by medical examiner programme	Full compliance with medical examiner standards
Warfarin drug interaction	Communication to all medical staff re INR on all patients at time of admission	In progress
Nosocomial patient to patient COVID transmission	COVID bed management policy with no step down from red ward areas	In progress
The use of vasopressors for maintaining blood pressure if fluid replacement insufficient	Critical Care learning via audit meeting	In progress
Consider sepsis early as a differential diagnosis with prompt commencement of antibiotics	Shared learning through safety summit and communication	In progress

Seven day service -

The Seven Day Hospital services programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. The standards are intended to improve the care given to patients by enabling early and consistent senior decision making along with other urgent services. Ten clinical standards for seven day services were developed in 2013 through the seven day Forum, of which four were identified as national priorities for implementation by 2020 on the basis of their potential to positively affect patient outcomes.

Standard 2 - Time to first consultant review
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 – standard 90%

Standard 5 – Access to diagnostic tests
Hospital inpatients must have scheduled 7 day access to specialist diagnostic services including magnetic resonance imaging (MRI), echocardiography and endoscopy.

Standard 6 – Access to consultant-directed interventions
Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant directed interventions, either on-site or through formally agreed networked arrangements. These interventions include: interventional radiology, interventional endoscopy, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention and cardiac pacing.

Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others
All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by consultant at least once every day, seven days a week, unless it has been determined that this would not affect the patient's care pathway. Standard 90 %

As National benchmarking is no longer available and trusts are encouraged to self-assess utilising assurance framework. WUTH continues to monitor performance against the Seven Day Services Clinical Standards and implement the new Trust Board Assurance Process, which commenced in February 2019.
Our current self-assessment for 2019/20 is

CS2	CS5	CS6	CS8
	Compliant	Compliant	Compliant

WUTH performance assesses against these standards utilising point prevalence audit, reviewing jobs plans and service availability,
Although we are not reaching the 90 % compliant for consultant review, there is evidence from clinical colleagues that documentation both of a consultant review or documentation of an agreed clinical pathway is a factor in non-compliance.
The table below demonstrates the improvements throughout 2019/2020

CS2	Qtr 2	Qtr 3	Qtr 4
Weekday	**61%**	**70%**	**75%**
Weekend	**47%**	**60%**	**70%**

The following actions have been put in place to further improve compliance

Action	Rational
Streaming process to be embedded in ED to allow early identification and transfer of patients requiring specialty review	Streaming process to be embedded in ED to allow early identification and transfer of patients requiring specialty review
Improvements in documentation of consultant review documentation	Audit of non-compliance of CS2 found that consultant review was being undertaken but documentation was not always held with the patient record
Changes to 1st Consultant review process to encourage documentation of need for ongoing daily Consultant review	Some improvement in performance can be gained via change in documentation of consultant agreed pathways
Detailed gap analysis within specialty to ascertain resource required to meet CS2	Some improvement in performance can be gained via change in practice but consistent performance >90% against CS2 may require increased Consultant presence at weekends or out of hours

Core Indicators

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All Trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS Trusts. The Trust may have more up-to-date information for some measures; however, only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.
Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data source.

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
1 - Preventing People from dying prematurely							
	SHMI value and banding (most recent data available to August 2019)	01/02/2019 -31/01/2020	1.12 Banding 2 'As Expected'	1.00	0.68	1.20	1.07 Banding 2 'As Expected'
	Percentage of deaths coded for palliative care	01/02/2019 – 31/01/2020	49	37	9	59	43
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (Dr Foster). Wirral University Teaching Hospital has taken the following actions to improve this indicator and so the quality of it services by Strengthening The Trusts mortality review process, by reviewing policy , meeting schedules and the cascade of learning						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
3 - Helping people to recover from episodes of ill health or recover from injury							
	Patient Reported Outcome Measures - Primary Hip Replacement Surgery	April 2019 – September 2019 (Provisional)	0.413	0.459	-0.382	0.95	
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health. Wirral University Teaching Hospital continually takes the following actions to improve this indicator and so the quality of it services by Delivering a number of actions to improve patient experiences following surgery.						
	Patient Reported Outcome Measures - Primary Knee Replacement Surgery	April 2019 – September 2019 (Provisional)	0.229	0.342	-0.104	0.841	

	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health. Wirral University Teaching Hospital continually takes the following actions to improve this indicator and so the quality of it services by Delivering a number of actions to improve patient experiences following surgery.							
	Percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital after admission	2018- 2019	<16 years	19.3	13.1	1.8	69.2	16.9
			>16 years	13.1	12.3	2.1	57.5	13.4
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The data is consistent with Dr Foster's standardised ratios for re-admissions. The data is monitored monthly by the Trust Board. Wirral University Teaching Hospital continually takes the following actions to improve this indicator and so the quality of it services by Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
4 - Ensuring people have a positive experience of care	The Trusts Responsiveness to personal needs of its patients	2018-19	66.8	67.3	58.9	85	68.3
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The data is submitted monthly to NHS England and the Trust actively encourages completion Wirral University Teaching Hospital intends to taken, and has taken the following actions to improve this indicator and so the quality of it services by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and innovative technology						
	Staff recommend the Trust as a provider of care to their family and Friends	2019	67.9%	70.5%	39.7%	87.4%	65.7%
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: An independent provider, Quality Health, provides the data.						

	Wirral University Teaching Hospital has taken the following actions to improve this percentage score and so the quality of it services by Engaging with all our staff to develop our Vison and values set. Creating and Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Freedom to Speak Up champions available for staff to access

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
5 - Treating and caring for people in a safe environment and protecting them from avoidable harm	Patients admitted to hospital who were risk assessed for venous thromboembolism	Q3 2019-20	97.7%	95.2%	71.6%	100%	97.1%
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: • The data is submitted monthly to NHS England Wirral University Teaching Hospital has taken the following actions to improve this percentage score, and so the quality of its services, by • Developing a tool within the Millennium system to monitor VTE Assessments • Developing an alert within the Millennium system to encourage clinicians to fulfil the assessment requirements						
	Rate of C.difficile infection (hospital onset)	2018/19	30.3	12	0	80	21.2
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: • Review of the data collection process and the introduction of a sign off process to validate the data Wirral University Teaching Hospital has taken the following actions to improve this percentage score, and so the quality of its services, by developing a CDI action plan that brings together all the Multi-disciplinary teams including Estates and Facilities that addresses the maintenance and repair of the built environment involving fixtures and fittings and also the replacement of damaged patient shared equipment- chairs, tables and bed side lockers; these initiatives support both improvements in the standards of cleaning and the effectiveness of the cleaning , education of the staff regarding roles and responsibilities regarding preventative measures to avoid infection has been paramount in empowered the staff to initiate local improvements that are measurable by the reduction in the numbers of infections reported.						
	Patient safety incidents	Apr-Sep 2019	No: 6442 Rate: 49.9	6276	1392	21685	No: 6362 Rate: 48.2
	Percentage of		8	19	0	95	16

	patient safety incidents that resulted in severe harm or death.						

Wirral University Teaching Hospital considers that this data is correct for the following reasons:

- Wirral University Teaching Hospital considers that this data is correct for the following reasons
  - The Trust actively promotes a culture of open and honest reporting within a culture of fair blame.
  - The data has been validated against National Reporting and Learning System (NRLS)
  - Each patient safety incident is reviewed for accuracy prior to upload to NRLS
  - Wirral University Teaching Hospital has taken the following actions to improve this number and rate and so the quality of it services by
    - Undertaking comprehensive investigations of incidents resulting in moderate or severe harm and utilising varying forums for learning such as safety summit, huddles , and Trust Comms including a Safety Bulletin .
    - Providing staff training in incident reporting and risk management.
    - Monitoring through the serious incident review group and patient safety board
    - Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported. insert description of actions)

Part 3

3.1 Overview of the Quality of Care and Performance

2019/2020 was a year characterised by an unstinting, simultaneous focus on: implementing actions to address concerns identified in the 2018 CQC inspection; rebuilding quality governance capacity and capability to address compliance challenges; and designing and commencing implementation of our 3-year quality strategy to advance improvement endeavors. Overall, this has been a busy, but successful year.

Serious Incidents

We are committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence:

- weekly meetings are held within the Trust to ensure these conversations take place.
- PSQB and the Quality Assurance Committee provides assurance on the follow up of incidents and the implementation of learning, including undertaking more detailed reviews of any areas of concern identified.
- Safety Summits where staff were invited to share and listen to lessons learnt from both incidents and patient feedback were held throughout the year and supported by a patient safety bulletin to ensure all of our staff are able to learn from our experience.

Never Events

The NHS Never Events list provides an opportunity for commissioners, working in conjunction with trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained surgical items, wrong site surgery, and wrong implants.

We have reported two Never Events during 2019/20 under the following categories:

- Retained foreign object post procedure
- Wrong site surgery

Both of the Never Events were fully investigated by the trust and learning has been discussed through the appropriate routes with the CCG. Further detail about the learning from these Never Events and other Serious Incident investigations is discussed regularly with the CCG to support a learning culture.

Quality Strategy

In 2019/2020 the Trust designed and commenced implementation of a 3-year Quality Strategy. By 2022 it is our goal to have made significant improvements in quality. We understand this represents an intensifying challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks. We are guided by what is right for people who use our services; this Quality Strategy unashamedly reflects our ambition for sustainable, high value, high quality services delivered in partnership with other health and social care providers across Wirral and beyond. As we progress we anticipate a much closer alignment between quality, activity and financial planning to boost our combined efforts to deliver safe, effective and financially sustainable services in the longer term. The challenges that lie ahead are demanding and will require creative adaptation within the Trust and across the wider health and social care system in order to meet them. By investing in improvement expertise to advance quality and developing our teams to lead, learn, and continuously improve, we have positioned the Trust to act as system leader for quality. The driving force behind our new approach to quality is partnership:

(i) united by shared quality goals - a partnership which brings about much closer integration across the health and social care system to deliver safer and more sustainable clinical services.

(ii) a partnership with patients which seeks to put them more in control of their own care – promoting self-management and involving them in service developments and decisions about their care; and

(iii) through our workforce strategy a partnership with staff that fosters an open, inquisitive, responsive and learning culture. We have grasped the opportunity to deliver care that is not just great, but the best care that can be provided.

We have identified a number of colleagues who have received specialised training from our partner Advancing Quality Alliance (AQuA) to act as 'Improvement Pioneers' with the aim of developing our own internal capability going forward to deliver continuous improvement for patients and staff.

The Quality Strategy comprised four campaigns:

(i) Campaign 1 – A Positive Patient Experience;
(ii) Campaign 2 – Care is Progressively Safer;
(iii) Campaign 3 – Care is Clinically Effective and Highly Reliable
(iv) Campaign 4 – We Stand Out.

The tables detailed the desired outcomes as well as the targeted thresholds for year 1

Campaign 1 – A Positive Patient Experience;

Key Outcome	Actions undertaken and next steps
Focus on explaining care in an understandable way	The Trust utilised different patient engagement mechanisms during 2019/2020. This was to enable more patient feedback, utilisation of iPad, kiosks and utilised our volunteer workforce to support this.
Engage and involve people in planning and delivering their care	
Service users will be active participants of PSQB, Quality Committee and Divisional Governance Groups	The Trust was grateful for the support of HealthWatch, who were key in supporting to achieve this measure

Patient stories and pathway diaries used to better understand patient experience and identify touch points and Always Events	Following a successful always 'event pilot' which focused on ensuring that every mealtime is a positive experience. It is proposed that the principles are now rolled out across the Trust. Protected Meal Times Optimum patient position, sitting out of bed where possible Hand hygiene pre meal Declutter environment pre meal Whole team focus on providing meals hot and assistance to so Patient safety huddles to highlight those requiring assistance and the red tray to be used.
	The Trust utilise Patient diaries in the Colorectal unit. Utilising these to drive ward improvements Such as improving Pre admission information including meeting a specialist nurse prior to admission have been initiatives Telephone contact is made post discharge with patients.

Key Outcome	Progress Update
Reducing Hospital Acquired Infections	The trajectory target was narrowly missed by one case of Clostridium Difficile. An IPC Strategy is in development and a comprehensive action plan to deliver it. The trust successfully contained a clostridium Difficile outbreak during 2019
	One incidence of a MRSA bacteremia was thoroughly investigated and was contamination during collection found to be the root cause. The patient had no symptoms of bacteremia.
Achieve high reliability of risk assessment and effective care bundle for patients at risk of falls	The Trust focus on falls prevention led to a combined achievement for over and under 65y. Compliance with lying and standing BP remains high. The Trusts harm panel identified fast learning which resulted in a significant reduction in avoidable falls The Trust has identified that medication review is a key
Achieve an effective pressure ulcer prevention plan for those patients at risk of hospital acquired pressure ulcer	The Trust has completed a full review of our pressure ulcer prevention and management across the Trust. This was following learning from our harms panel and we now have a strengthened improvement plan to reduce occurrence A full review has been completed of the audit tool with the questions revised in line with the pressure ulcer improvement plan and modifications within the pressure ulcer prevention bundle which have been implemented as a result of learning form the combined Harms panel.
Achieve high reliability of end-to-end care for patients at risk of venous thromboembolism	The Trust has had focused improvement work, utilising our business intelligence portal. We have developed on from on our 95 % compliance of risk of VTE assessment. Our ambition is to have high reliability of end to end care, improving compliance in accurate prescribing and administrate of appropriate medication. We narrowly missed our end of year target for year 1 but have shown a 20% improvement through the year.

Key Outcome	Progress Update
Reliable daily completion of charts and calculation of +/- fluid balance	We narrowly missed our end of year target. The Collection of automated of data extracted from our electronic patient record continues to be a challenge for the Trust. This has been adopted as a QI project to support focused progression. Initial stages have been completed with identification of hard coded data to provide condition specific compliance in line with policy guidance. As an interim fluid balance compliance is audited manually within the Perfect Ward system for high risk patients
	Our target was missed for this group but we have focused on Sepsis training which includes the importance of fluid balance management. Approx. 300 staff have now been trained and we have Champions on each ward.
Delivering harm-free care	The Trust consistently met the threshold throughout the year.
Safe staffing: Reduce the incidence of staffing levels as direct causal factor in harmful incident reports	We successfully reduced our staffing Incidents. We are strengthening our incidence management system by looking at causal factor analysis
Safe staffing: Focus on maximising staffing rates in rotas	Care hours per patient day has not gone below threshold
Safe staffing: Sequentially reduce Band 5 vacancies	We were over our target of ≤10% by 1% The trust undertook a review of band 5 vacancies A new tool has been developed which identifies clearly all recruited posts, mitigation actions / temporary posts, the tool is in the pilot phase. The trust introduced daily safe staffing oversight meeting and tracker improving organisational oversight of staffing daily
Apply for RoSPA accreditation of safety management system	Achieved GOLD which was the target for 2021/2022
Minimise and/or respond early and effectively to the signs of clinical deterioration	We have established our baseline of MET and The Trust is now focused on Quality improvement which targets assessment of the deteriorating patient
Ensure every patient (not medically optimised) is reviewed by a senior doctor (ST3 or above) at least once daily	There is difficultly obtaining an accurate data set to measure this. However our 7 day service audit which monitors consultant review has shown a steady improvement throughout the year

Campaign 3 – Care is Clinically Effective and Highly Reliable

Key Outcome	Progress Update
Reducing harm for those using our services who have a learning disability	Our safeguarding team reviews all clinical incidents on a weekly basis. During 19/20 The team established the baseline of harm. From April 2020, learning disability awareness training will be incorporated to safeguarding training.
Reducing % of patients with ≥3 emergency admissions in the last 90 days of life	After a full service review the Trust has a reconfigured Palliative and Supportive care team. They are currently reviewing the best measure of quality for patients receiving palliative or supportive care
HSMR	Remained within expected level
Mortality Reviews	Achieved less than 012%. See further detail earlier in report on learning from deaths
Improve effectiveness of discharge planning and resilience of discharge venue	The trust did not reach its target for this. We launched a patient experience strategy during 2019/2020 which has a focused action plan
	The Trust has an 'Improving Patient Flow' programme in place which is overseen by PFIG and the Programme Board. We have successfully reduced our incidents due to unsafe / unsatisfactory by over 30 %
	Although The Trusts Level 1 complaints for quarter 4 regarding unsatisfactory discharge has increased, Level 1 is out lowest level of complaint, and our volume of higher level complaints has reduced significantly. This indicates quicker more effective local resolution. Suitable support packages / and availability of transfer 2 assess beds features frequently. We have shared this information with our on a regular basis to the Commissioners to inform decisions on their commissioning intentions
Improving the timeliness of the clinical response to abnormal or unexpected (and clinically significant) radiology or pathology results	The Trust reduced the number of incidents by over 50% Radiology developed and implemented a follow-up process for all diagnostics tests where a 'Serious Unexpected Findings' has been identified.
Compliance with NICE	Baseline assessment has been completed in 99% of NICE guidelines
Ensuring all patients have a review by a Consultant within 14 hours of hospital admission	We didn't achieve this target but have shown good improvements and greater detail is given earlier on in this report. Further information is detailed with the seven day section of this report
Implementation of CAS Alerts	The trust has been fully compliant with the CAS alert process.

Campaign 4 – We Stand Out

Key Outcome	Progress Update
Staff engagement / satisfaction	The Trust benchmarked against other similar Trusts nationally and our staff survey results were improved generally across the board.
Getting to the learning faster: response to serious incidents	We have strengthened our serious review process throughout 2019/2020 but the initial review still requires improvement in terms of timeliness, and unfortunately didn't achieve this
Learning from high risk events	Considerable work has been undertaken to ensure that harm categorisation is correct as historically there was some 'over scoring'. Model hospital data suggests median harm rate is 10.7%. Progress monitored via The Trust's medicine safety group. The trust has reviewed themes and utilised various method to share learning and drive improvements. We introduced 'druggles' to share learning at ward level immediately, and preventation of frequently themed incidents. The trust developed a safe medication film which was viewed successfully by our staff The Trust recognizes that incident reporting does not always indication the extent of the potential risk. Interface medication incident reporting system re-launched end 2019 so increase in reported incidents expected. Audit planned for January 2020 to review information included on discharge summaries. Nursing leadership team to define improvement plan.
	Falls with moderate or above harm, remain below the agreed target
	Trust participation in the national stop the pressure day. Commenced training end of Feb with the appointment of the new TVN lead. Increase in assessments carried out in the emergency department and increase in number of incident forms identifying pressure ulcer damage on admission to the Trust. Improved assurance process regarding pressure ulcers.

Create the perfect system-wide patient pathway for long term conditions such as: Respiratory Cardiovascular Liver disease Frailty	COPD patients who have been admitted but not gone home with the COPD early supported discharge team within 72 hrs to try to anticipate any problems and to get them into the excellent chronic nurse led COPD and PR service to try to reduce re admissions. Initiation of project to utilise smart technology. Working with developers to Modify an app to trial within the COPD population. Long term project to be personalised dependant on self -management and awareness of condition. Project commencing looking at Patient activation measures (PAM scores) in our COPD patients who attend clinic and pulmonary rehab. Plan to personalise care by self-management / awareness of respiratory condition. . <u>Frailty</u> Community Geriatricians involved with tele triage and care homes re: admission avoidance. Home first modelling / pilot demonstrated success

Appendices

Appendix One – Healthwatch Commentary

Quality Account Commentary
for Wirral University Teaching Hospital NHS Foundation Trust
provided by Healthwatch Wirral CIC
November 2020

Healthwatch Wirral (HW) would like to thank the Trust for the opportunity to comment on the Quality Accounts for 2019/20. This review was undertaken by associate members of the HW Working Group.

Over the last year Wirral University Teaching Hospital NHS Foundation Trust has welcomed Healthwatch Wirral's input on improving patient experience and has included Healthwatch at a strategic decision-making level.

It was reassuring to read that the Trust have made progress on quality, governance, risk and leadership and have developed a 3-year Quality Strategy.

Review of Priorities for Improvement for 2019/20

Priority 1: Patient flow through the Trust

Effective patient flow remains challenging and the average bed occupancy for the year is higher than the agreed target. However, there is concerted effort to address the overall length of stay for long stay patients.

HW would welcome details of the involvement of families / carers in the discharge process during the 48-hour period prior to discharge and how well informed patients are in relation to their Estimated Date of Discharge, and after care. We would also welcome progress updates on how the Trust works with the care sector and social services to improve patient flow and whether any new patient care pathways which have been developed during the pandemic to reduce hospital admissions and length of stay.

Priority 2: Improve patients nutrition and hydration

Following implementation plans to improve, it was reassuring to read that significant improvements have been achieved within nutrition and hydration. MUST compliance has increased from 67% to over 95% and menu changes have resulted in improved patient satisfaction. However, HW would like reassurance that patients have fluids within easy reach meaning that they are able to drink the fluid, or are actively monitored to see if they need help.

Priority 3. Reduce pressure ulcers in patients who are cared for in the Trust

The Trust reported an end of year position of two category 3 and two category 4 hospital acquired pressure ulcers.
HW noted the measures that are being taken to improve performance and pleased that this remains an active target; and that a full review of pressure ulcer prevention and management across the Trust has been completed. This was following learning from the Harms Panel, which resulted in a strengthened improvement plan to reduce occurrence.
HW look forward to receiving regular updates on improvements and what the impact of the employment of a Tissue Viability Specialist Nurse has been to the Trust.

Priorities for 20/21

The Trusts priorities and quality targets for 20/21 were noted and HW look forward to receiving progress updates.
The Trust should be encouraged to include mental health quality targets as they appear to be omitted from the report. A review of work/targets both before and since COVID 19 pandemic would be a welcome inclusion.

Statements of Assurance - National Audits and Local Clinical Audits:

The account included a large amount of detail including sections on Clinical Coding; Hospital Episode Stats; Learning from Deaths; and Seven-day Service.
HW look forward to hearing about the progress of any action required for improvement in audits to help Healthwatch understand the role and impact of audit on 20/21 priorities.
HW would recommend a summary of audit outcomes, actions and any changes in clinical practice as a result of the actions taken. This would help the reader to fit them into the Quality agenda and improved care targets.

CQC Rating

The report included a succinct and clear summary of the substantial progress the Trust has made to ensure compliance with regulations since the previous CQC inspection in 2018. Whilst the overall rating remained as 'Requires Improvement' the Trust appears to be on course to improve ratings further going forward.

External Reviews Accreditation:
HW would like to congratulate the services that received recognition in 2019/20.

Core Indicators:

The indicators and the action taken for improvement were noted and HW would welcome regular updates and outcomes on these.

Actions to improve patient experience has been made a priority and Friends and Family Tests continue to be promoted by various methods, including face to face and by using innovative technology. It was positive, and encouraging, to note that the Trust was grateful for HW's support as being key in supporting them to achieve this measure.

It was reassuring to read that work is ongoing around discharge from hospital and the effectiveness of discharge planning, particularly since the target was not met during the year.

Although it was disappointing to read that staff attitudes and behaviours continue to be the most reported theme, it was positive to note that the Trust is engaging with staff to develop a Vision and Values set and that Speak Up Champions have been made available for staff to access.

Overview of the Quality of care and performance:
This section was easy to read and provided a clear link to the core indicators and Quality Strategy campaigns.

To conclude, Healthwatch believes, based on its knowledge of the Trust, that the report is a fair reflection of the health care services provided. We appreciate the opportunity to support the Trust in providing a positive patient experience, to comment as a critical friend and look forward to receiving regular quarterly updates of the Quality Accounts.

A suggestion from HW Wirral would be that the Foundations of Quality Statement (below), written by HW Wirral, Age UK, NHSE and ECIST could be included in policies and procedures which encourages the staff to remember that patients are at the heart of everything we do. This is continuing to be adopted by NHS organisations by including within Terms of Reference.

Foundations of Quality Improvement should always have what patients tell us about their treatment and care at the heart of everything, as a system, that we plan and do. We must be able to evidence that all actions and decisions made come back to this, making certain that everyone feels respected, involved and valued at each and every part of the journey. We should all feel confident that we are either giving or receiving quality care.'
Healthwatch Wirral, Age UK Wirral, NHS England and ECIST, Wirral System

Karen Prior

Karen Prior - Chief Officer
On behalf of Healthwatch Wirral

Appendix Two – Statement from CCG

Statement from NHS Wirral Clinical Commissioning Group
Quality Account 2019/20

NHS Wirral Clinical Commissioning Group (CCG) is committed to commissioning high quality services from Wirral University Teaching Hospital NHS Foundation Trust. We take seriously our responsibility to ensure that patients' needs are met by the provision of safe, high quality services and the views and expectations of patients and the public are listened and acted upon.

We welcome the opportunity to comment on this account and believe it reflects accurately quality performance in 2019/20 and sets out forthcoming priorities for 2020/21.

We acknowledge that the trust has continued progression against quality priorities and achieved some of the targets set out in the 2018/19 quality accounts.

Patient flow through the trust has been a priority during 2019/20 and builds upon previous priorities in relation to SAFER described in previous quality accounts. As with previous priorities around patient flow some improvements have been seen but not consistently maintained and it is acknowledged that this remains a challenge within the trust. The quality account does highlight the support accessed during the year through the Emergency Care Intensive Support Team (ECIST) and actions implemented towards the end of the year based on this work. Due to the COVID-19 pandemic some of the indicators in relation to this priority were skewed during Quarter 4. Further scrutiny will be needed throughout 2020/21.

Similarly, nutrition and hydration has been a previous quality priority and whilst the improvements seen during 2018/19 were positive but did not meet the target, during 2019/20 the Trust has been able to achieve target compliance with the application of Malnutrition Universal Screening Tool (MUST) for all of quarters 3 and 4 and even stretched the ambition to completion of the screening tool within 24 hours of admission.

The reduction of pressure ulcers for patients cared for by the Trust has been a significant priority during 2019/20. The outcomes aligned to this priority have not been fully evaluated due to the inability to draw direct comparisons from previous year's data. Whilst this is a barrier to clarifying the reduction in pressure ulcers to date, this does represent an improved and more robust data capture process for future target setting. The CCG has received sight of the Trust's plans to drive further improvement in pressure ulcer prevention and will monitor this closely.

The CCG feels it is important for the Trust to note that there were two Never Events during the year, which is an increase from one Never Event during 2018/19. Both of the Never Events were fully investigated by the trust and learning has been discussed through the appropriate routes with the CCG. Further detail about the learning from these Never Events and other Serious Incident investigations is discussed regularly with the CCG to support a learning culture.

It is pleasing to see the intended improvements for 2020/21 and the CCG is in agreement that these areas are of priority. The CCG would suggest consideration of the wider sources of patient experience feedback the trust collates to gain assurance of positive experience outcomes.

The Trust's continued participation in external reviews and audits is noted and supports a good understanding of the Trust's position in each of these areas.

NHS Wirral CCG will continue to work in partnership with the Trust to assure the quality of services commissioned for the population over the forthcoming year.

Dr Paula Cowan, Chair NHS Wirral CCG

Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital

Monthly Board of Directors Safe Staffing Report

Board of Directors	
Agenda Item	20-21/197
Title of Report	Monthly Safe Staffing Report.
Date of Meeting	2nd December 2020.
Author	Tracy Fennell - Deputy Chief Nurse. Johanna Ashworth-Jones- Senior Analyst, Corporate Nursing Team.
Accountable Executive	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC).
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6.
Level of Assurance • **Positive** • **Gap(s)**	Positives. • The Trust has robust systems and processes in place to monitor and flex staffing to meet the changing demands of the organisation and patient requirements. • The Trust has launched a time limited staff incentive scheme commencing November 2020 to assist in filling gaps in rotas due to nurse vacancies. • The Trust has seen no serious incidents or complaints in relation to safe staffing. • The Trust has seen a reduction in the number of staff moves in October 2020. Gaps. • The Trust has seen a small increase in the number of episodes where care standards fall below expected requirements.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No	No

1. Executive Summary.

The purpose of this paper is to provide the Board of Directors with a review of the safety of nurse staffing during October 2020 (M7). The paper includes the newly developed Safe Staffing Oversight Dashboard providing oversight of a variety of metrics. These metrics allow triangulation of information from a variety of sources to enable the Board of Directors to assess the safety and suitability of nurse staffing in Wirral University Trust Hospitals (WUTH) inpatient wards.

This report identifies some areas of improvement including a reduction in vacancies to 17.11% (ward based band 5 nurses) mainly attributed to an improvement in the registered nurse (RN) vacancy position in the Medical Division. The report also notes the positive reduction in staff moves and an increase in RN fill rates.

Despite improvements the Trust still reports a number of shifts where the quality of care fell below the expected standard, as a direct result of staffing levels. To minimise this risk we have implemented a staff incentive scheme commencing from November 2020 to improve fill rates.

2. Background.

In October 2020 it was agreed by the Board of Directors this report would continue to be reviewed monthly with the inclusion of a Safe Staffing Oversight Dashboard. Following this agreement a number of metrics have been brought together to produce the dashboard (Appendix 1). This comprehensive dashboard provides a month by month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD), 'Red Flags' (risks) and patient experience metrics. Any known risk is highlighted within the report along with mitigations.

3. Current Position.

3.1 Data validation.

Throughout October 2020 Human Resources (HR) have been undertaking an extensive validation exercise to ensure Electronic Staff Record data is accurate and validated. Due to this data validation there is some slight variation from previous Safe Staffing Reports. The validated position will continue to be reported monthly in the Safe Staffing Oversight Dashboard.

3.2 Fill rates / CHPPD.

During October 2020 the Trust started to report improved fill rates; increasing RN fill rates to 83% (days) and 79% fill rate (nights). Lower RN fill rates on nights were supplemented with grade changes providing a care support worker fill rate of 104%. However lower occupancy rates of 79% Arrowe Park and 46% Clatterbridge means CHPPD still remains at 8.5 (within the approved range of 6-10 CHPPD).

3.3 Vacancies / Pipeline / Attrition Rates / Sickness.

The Trust's ward based band 5 vacancy rate has improved from 18.7% in September 2020 to 17.11% (October 2020). This is mainly due to the improving position in the Medicine Division with a vacancy rate of 17.43% (77 WTE) an improvement from September 2020 at 21.27% (94 WTE).

Critical Care has had an increase of 1 vacancy in October, meaning a 15.88% vacancy factor; this area is seen as an emerging risk due to the impact of the second wave of COVID-19. The Critical Care Unit is starting to see increased pressures and is preparing to have to staff escalation areas. Plans are agreed for this deployment if required. Approval has been given to temporarily over recruit to this area and recruitment processes are now underway.

The Trust has 48 WTE band 5 RNs and Midwives in the pipeline; 10 WTE are expected to commence before December 2020. Actions continue to expedite recruitment processes to provide new recruits with an earlier start date.

In October 2020 the Trust saw a rising monthly nursing and midwifery sickness figure to 6.8% which has further compounded the existing pressure from vacancies. This is partially due to the impact of the National Test and Trace requirement to self-isolate.

3.4 Safe Staffing Oversight Tracker Review.

During October 2020 the SSOT recorded 454 shifts that were considered to fall below minimum safe staffing levels for RNs, slightly increasing from September 2020 figure of 445. Senior Nurses are required to make a professional judgement on whether wards are safely staffed and apply a RAG rating of "red" if wards are at high risk of care standards falling below agreed standards; "amber" signifying medium/low risk or "green" no risk. Of the 454 shifts identified, there were no shifts with a professional judgment rating of red.

3.5 Staff moves.

The actions taken to reduce staff moves through more effective rostering for night shifts have led to a significant reduction of staff moves during October 2020 where 140 staff moves were recorded compared with 329 in September 2020. Acuity, dependency and sickness also affect staff moves on a day to day basis.

5. NHSP / Agency Use Month 7.

60.2% of 28,432 requested RN hours were filled by NHSP during M7; this was an increase in the number of requested hours from last month and a decrease in the percentage of filled shifts. A further 32,505 CSW hours were also requested during M7 with 71.1 % of these filled by NHSP.

6. Quality Impact Analysis of Staffing Levels in Month 7 (October 2020).

It is worthy of note that the SSOT reporting portal has been enhanced during October 2020 to include improved oversight of the number of patients that have care standards affected when staffing levels fall below the agreed minimum levels . Previous reports had the ability to identify the number of shifts where care standards were affected however could not account for the number of patients affected. This improved oversight has led to a significant increase in the reported numbers of patients that have had care standards affected, for example the number of patients who have experienced delayed medications has increased from 20 (episodes) in M6 to 127 (patients) in M7.

During October 2020, 62 shifts were recorded within the SSOT were the quality of care provided was below the expected standard and staffing levels were also deemed to be below the agreed minimum staffing levels. As described above, the highest reported area related to delayed medications, affecting standards of care for 127 patients across 12 shifts (detail featured in Appendix 1). Additional detail of wards with more episodes when care standards fell below the agreed standard can be seen in Appendix 2.

AMU has had high numbers of shifts where care standards are not as expected. This area is currently carrying a 39 % vacancy rate (8 RNs and 1 CSW) that have now been recruited to. To mitigate gaps until the new staff commence, staff are undertaking additional shifts and supporting from other areas.

There were 17 no-harm falls and 1 low harm fall noted to have occurred on shifts with less than agreed minimum safe staffing levels; however a Root Cause Analysis undertaken following the falls has provided assurance staffing was not an influencing factor for these patients.

In October 2020, 20 formal complaints were reported and 178 informal concerns were raised with the Patient Experience Team. Low staffing featured as a factor in one of the informal concerns during this period. This was in Urgent Medical Assessment Centre (UMAC).

7. Safe Staffing Incidents – month 7

In October 2020, 75 incidents were reported for nursing and midwifery staffing, with all these incidents recorded as low or no harm.

The areas with the highest frequency of staffing incidents reported during M7 were Ward 30 relating to staff moves, AMU highlighting the care issues as reflected in the SSOT (Table 1) and Delivery Suite where escalation processes were used appropriately for short staffing.

8. Actions to improve staffing

WAC received a nursing recruitment and retention update in November 2020 on initiatives such as the Wirral Nurse Programme, international recruitment, and Apprenticeship Programmes. The Workforce Strategy for the Trust is being developed, but work is continuing at pace to reduce vacancies.

9. Conclusion

Daily monitoring of nurse staffing continues, with a good system of internal control being applied consistently to ensure gaps are filled and manged effectively in line with the Safe Staffing Escalation Policy. Quality indicators are also monitored through the use of Business Intelligence, Perfect Ward applications, patient feedback and ward accreditation; any areas of concern escalate to enhanced monitoring and scrutiny by the Deputy Chief Nurse in scheduled Corporate Reviews until sustainable improvement is evident.

10. Recommendations

The Board of Directors are requested to note the contents of report.

Appendix 1 Safe Staffing Assurance Dashboard

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

Appendix 2:

Date	Area	Shift	Number of falls	Falls with harm	Meds Errors/Misses	Patient/ Relative Complaints	Staffing Incidents	Failure To Provide 1:1	Missed staff Breaks	Delayed Obs	Delayed NEWS2	Delayed Pressure Area Care	Delayed Meds
01/10/2020	AMU	Night	0	0	1	0	0	0	0	0	0	0	0
04/10/2020	AMU	Night	0	0	0	0	1	0	3	0	0	1	0
05/10/2020	AMU	Night	0	0	0	0	1	0	0	1	1	1	1
06/10/2020	AMU	Night	0	0	0	0	0	0	0	0	0	1	0
10/10/2020	AMU	Night	0	0	0	0	1	0	1	0	0	0	0
11/10/2020	AMU	Night	1	0	0	0	0	0	0	0	0	0	0
14/10/2020	AMU	Night	1	0	0	0	0	2	3	27	0	5	27
15/10/2020	AMU	Night	1	0	0	0	0	0	0	0	0	0	0
16/10/2020	AMU	Night	0	0	0	0	0	0	0	0	0	0	1
17/10/2020	AMU	Night	1	0	0	0	0	0	0	0	0	0	0
19/10/2020	AMU	Night	0	0	0	0	0	1	0	0	0	0	0
20/10/2020	AMU	Night	0	0	0	0	1	0	0	0	0	1	0
21/10/2020	AMU	Night	0	0	0	0	0	2	7	27	0	10	27
22/10/2020	AMU	Night	0	0	1	0	0	0	0	0	0	0	0
23/10/2020	AMU	Night	1	0	0	0	0	0	0	0	0	0	0
24/10/2020	AMU	Night	1	0	0	0	1	1	0	0	0	0	0
25/10/2020	AMU	Night	0	0	0	0	0	0	0	0	0	1	0
26/10/2020	AMU	Night	0	0	0	0	1	0	0	0	0	0	0
30/10/2020	AMU	Night	0	0	0	0	0	0	0	0	0	1	0
07/10/2020	ED	Late	2	0	0	1	0	0	0	0	0	0	0
14/10/2020	ED	Late	0	0	0	0	1	0	0	0	0	0	0
27/10/2020	ED	Late	1	0	0	0	0	0	0	0	0	0	0
19/10/2020	MSSW	Night	0	0	0	0	0	0	1	0	0	0	0
03/10/2020	UMAC	Early	0	0	1	0	1	0	0	0	0	0	1
08/10/2020	UMAC	Early	0	0	1	0	0	0	0	0	0	0	0
03/10/2020	Ward 21	Early	0	0	0	0	1	0	0	0	0	0	0
08/10/2020	Ward 22	Late	0	0	1	0	0	0	0	0	0	0	0
10/10/2020	Ward 22	Early	0	0	0	0	1	0	0	0	0	0	0
14/10/2020	Ward 22	Night	0	0	1	0	0	0	0	0	0	0	0
23/10/2020	Ward 22	Night	1	0	0	0	0	0	0	0	0	0	0
15/10/2020	Ward 23	Early	1	0	0	0	0	0	0	0	0	0	0
21/10/2020	Ward 23	Late	1	0	0	0	0	0	0	0	0	0	0
25/10/2020	Ward 23	Night	1	0	0	0	0	0	0	0	0	0	0
10/10/2020	Ward 24	Late	0	0	0	0	1	0	0	0	0	0	0
24/10/2020	Ward 27	Early	0	0	0	0	0	0	0	0	0	1	0
02/10/2020	Ward 30	Night	0	0	0	0	1	0	0	0	0	0	0
05/10/2020	Ward 30	Night	0	0	0	0	0	0	2	22	0	0	22
07/10/2020	Ward 30	Night	0	0	0	0	1	0	0	0	0	0	0
13/10/2020	Ward 30	Night	0	0	0	0	1	0	0	0	0	0	0
19/10/2020	Ward 30	Night	0	0	0	0	0	0	2	0	0	0	10
22/10/2020	Ward 30	Night	1	0	0	0	0	0	0	0	0	0	0
23/10/2020	Ward 30	Night	0	0	0	0	0	0	0	22	0	0	22
01/10/2020	Ward 32	Late	0	0	0	2	1	0	2	0	5	0	6
05/10/2020	Ward 32	Late	0	0	0	0	1	0	0	0	0	0	0
24/10/2020	Ward 32	Night	1	0	0	0	0	0	0	0	0	0	0
25/10/2020	Ward 32	Night	1	0	0	0	0	0	0	0	0	0	0
28/10/2020	Ward 32	Late	0	0	0	0	0	0	0	0	0	1	0
01/10/2020	Ward 33	Night	0	0	0	0	0	0	1	1	1	1	1
08/10/2020	Ward 33	Early	0	0	1	0	0	0	0	0	0	0	0
19/10/2020	Ward 33	Late	0	0	0	0	0	0	0	5	0	0	0
20/10/2020	Ward 33	Late	0	0	0	0	0	0	0	0	5	0	0
22/10/2020	Ward 33	Night	0	0	0	0	0	0	2	10	0	0	0
27/10/2020	Ward 33	Night	0	0	0	0	0	0	0	0	0	0	8
29/10/2020	Ward 33	Night	0	0	0	0	0	1	2	7	0	0	0
30/10/2020	Ward 33	Night	1	1	0	0	0	0	0	0	0	0	0
14/10/2020	Ward 36	Night	0	0	0	0	1	0	0	0	0	0	0
16/10/2020	Ward 36	Night	1	0	0	0	0	0	0	0	0	0	0
05/10/2020	Ward 38	Late	0	0	0	0	1	0	0	0	0	0	0
05/10/2020	Ward 38	Night	0	0	0	0	0	1	0	0	0	0	0
07/10/2020	Ward 38	Late	0	0	1	0	0	0	0	0	0	0	1
16/10/2020	Ward 38	Late	1	0	0	0	0	0	0	0	0	0	0
25/10/2020	Ward 38	Night	0	0	0	0	0	1	0	0	0	0	0
Totals			19	1	8	3	18	9	26	122	12	24	127

Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital

6 Monthly Chief Nurse Acuity and Dependency Nurse Staffing Report

Board of Directors	
Agenda Item	20-21/198
Title of Report	6 Monthly Chief Nurse Acuity and Dependency Nurse Staffing Report
Date of Meeting	3 December 2020
Author	Tracy Fennell - Deputy Chief Nurse Johanna Ashworth-Jones - Senior Analyst, Corporate Nursing Team
Accountable Executive	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6.
Level of Assurance • **Positive** • **Gap(s)**	Positives. • The Trust has a number of processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risks. • The Trust continually fulfils its duty to undertake 6 monthly establishment reviews in line with National Quality Board / NHSI guidance • The Trust uses the licensed Safer Nursing Care Tool (SNCT) to undertake acuity and dependency reviews as recommended by National Quality Board / NHSI. • The Trust has effective safe staffing governance arrangements ensuring visibility of nurse staffing from floor to board. Gaps • The Trust was required to close the Neonatal Unit to admissions for one day in August 2020 due to low staffing numbers.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Gold - externally validate
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No	No

1. Executive Summary

The purpose of this paper is to provide the Board of Directors assurance that the Trust has met its regulatory requirements in accordance with guidance set out in NHS Improvements, 'Developing Workforce Safeguards' document (2018). The NHSI document sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time.

The report provides oversight how the Trust has met effective governance requirements set out in the guidance to ensure boards can be assured workforce decisions promote patient safety and so comply with the Care Quality Commission (CQC) fundamental standards.

The report also outlines the outcomes of the mandatory acuity, dependency and establishment review undertaken in Q2. There is a recommendation that no changes should currently be made to nursing establishments due to the need to continually flex nurse staffing requirements as a consequence of the COVID- 19 pandemic.

This assurance report was presented to Workforce Assurance Committee for scrutiny and challenge in November 2020.

2. Background

Trusts have a duty to comply with both National Quality Board (NQB 2016) guidance and the recommendations set out in the 'Developing Workforce Safeguards' document. The document is explicit in the need to for Trusts to work differently to deploy a "triangulated approach" when reviewing staffing requirements. This approach must combine evidence based tools, professional judgement and outcomes to ensure staff are skilled and placed based on patient's needs, dependency and risks. Trusts must demonstrate they are robustly monitoring this from ward to board with effective escalation protocols in place.

To provide oversight of nurse staffing processes WAC received a Safe Staffing Assurances Report in July 2020. The report outlined current processes and procedures the Trust has in place to ensure registered nurses (RNs) and care support workers (CSWs) are deployed effectively to wards, and gave oversight how the Trust can provide daily assurance that wards are appropriately staffed. The report also detailed the current escalation processes the Trust has in place should staffing levels fall below the agreed levels. Through the report WAC were able to conclude the Trust has substantial assurance around staffing processes with a good system of internal control that is being applied consistently.

The challenge for the Board of Directors is to ensure that staffing deployment does not have an adverse impact on the quality of care for patients, staff experience and staff recruitment and retention (NHS Improvement 2018). To enable the Board of Directors to have oversight of the visibility of safe staffing assurances including any known consequence on patient care, safety or experience a monthly report is received at the Public Board of Directors for scrutiny and challenge. This report includes a comprehensive dashboard providing a month by month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD) data, 'Red Flags' and patient experience metrics. Any known risk is highlighted along with mitigations and future plans to enhance staffing assurances moving forward.

The Trust is developing a new Workforce Strategy and part of that is the discreet approach to nursing recruitment and retention. WAC is receiving an update of this, this month (November 2020).

3. Establishment Reviews / Acuity and Dependency studies

In line with requirements the Trust undertakes a formal establishment review of each adult inpatient ward area every six months. The establishment reviews comprise of a systematic

approach that allows for enhanced triangulation and scrutiny led by the Deputy Chief Nurse reviewing 72 multifactorial indictors including, nurse sensitive indicators, workforce sensitive indicators, financial and budgetary indicators, professional judgement and the outcome results of acuity and dependency studies.

Acuity and dependency studies are undertaken over a 21-day period using the licensed Shelford, Safer Nursing Care Tool. Acuity and dependency assessments are undertaken daily by Ward Managers followed by daily validation by Quality Matrons and secondary validation by Associate Directors of Nursing. For this period the Trust took the decision to omit acuity and dependency reviews in some areas where wards had significantly low occupancy or wards were closed due to COVID-19 (Appendix 1).

It is acknowledged the past six months has been highlighted as of one of the most challenging times in the history of the NHS due to COVID – 19 pandemic. The impact of this has significantly compromised the validity of traditional metrics used to support establishment reviews. Despite low occupancy it is recognised the Trust has still had to temporarily enhance staffing in some areas during COVID-19 to support increased acuity and donning and doffing practices. Due to rapid daily change across the hospital professional judgement has had to remain the overarching influencing factor in identifying and flexing safe staffing levels on a daily basis.

In line with requirements the Trust completed acuity and dependency studies in Q2. Due to the changes in ward operational models, patient presentation and the need to work differently during the pandemic the Trust should be cautious about forming judgements or making any decisions based on the outcomes of the Q2 acuity and dependency review.

The Q2 results are included in appendix 1 for information however due to the requirement to continually flex ward models to meet the rapidly changing demands no permanent changes are currently recommended to the ward establishments. The next acuity and dependency study will commence post pandemic 2021.

4. Women and Children staffing assurance

W and C operate a flexible model across all areas in midwifery, Ward 53, Delivery Suite and Midwifery Led Units (MLU). In times of escalation additional staffing is currently sourced through the on call Community Midwifery Team. The Cheshire & Merseyside Escalation and Divert Policy that also supports collaborative working across the region in times of high acuity/demand.

The Community Midwifery Service provides Midwifery staffing for the whole of Wirral and is currently going through a process of change given the introduction of Continuity of Carer Teams. Midwives provide care both antenatally and postnatally to the women in the community as well as in hospital, this includes a Home Birth Service (including on call), Seacombe pop up MLU and staffing to support the Midwifery Led Unit (Eden Suite).

Safe staffing of the maternity service is a priority to any organisation and is determined using the nationally recognised acuity tool Birthrate Plus. A full Birthrate Plus review is being undertaken in December 2020 to meet the requirements of the CNST Maternity Incentive Scheme. This review will also inform the new model of care Continuity of Carer.

Further assurance is provided through the submission of monthly midwifery staffing ratios looking at the number of midwives to the number of births. This is reported monthly on the Maternity Dashboard, and has been a consistent rate of between 1:26 to 1:28 signifying staffing was safe as reported in Table 1.

Table 1. Monthly midwifery staffing ratios showing the number of midwives compared to the number of births April 2020 to September 2020.

MONTH	April	May	June	July	August	September
RATIO	1:27	1:26	1:27	1:26	1:27	1:28

Midwife to birth ratio		
1:25 - 1:30	<1:25 or >1:30	<=1:20 or >=1:35

The Maternity Service reported no closures or diverts between April and September 2020. There was however a temporary suspension of the Homebirth Service at the start of the COVID-19 pandemic agreed regionally based on a risk assessment undertaken with North West Ambulance Service (NWAS). This was reviewed after a couple of weeks and the service reinstated across the whole of the Local Maternity System.

4.1 Children services

Both neonatal and paediatric staffing are reviewed every 6 months to identify whether there are increasing demands. Staffing is calculated daily within Children Services using a modified recognised acuity tool – SCAMPS (Scottish Children's Acuity Measurement in Paediatric Settings). Overall activity has remained low on the Children's ward during the last 6 months from April – September 2020 and safe staffing ratios have been maintained at safe levels.

There is currently an increasing need to staff Children's ED with two Registered Nurses for Children however a separate proposal is being developed to establish options to staff this area safely and will incorporate national recommendations including those outlined in the CQC Patient First document and the RCPCH "Facing the Future: Standards for Children in emergency care settings".

4.2 Neonatal services

Staffing requirements of the Neonatal Unit vary depending on the acuity, number and level of care required for cots available. Current staffing is provided to meet British Association of Perinatal Medicine (BAPM) safe staffing ratios (Appendix 2). Neonatal planned staffing is rostered to 80% of the establishment at any one time as capacity and demand varies month on month. Between April - September 2020 there has been a reduction in neonatal activity. When demand and acuity is high additional staffing is sought through a combination of additional hours and NHSP staff covering vacant shifts. Should acuity exceed staffing available there is a process for escalation, if staffing cannot be sought the Neonatal Unit closes to admissions. The Neonatal Unit has closed on one occasion between April 2020 and September 2020 due to low staffing. Overall BAPM compliance has been >100% over the last 6 months, the average being 106%.The Trust is developing a W and C specific staffing dashboard to mirror the Trusts SSOT processes utilised in adult areas so the Trust can monitor the impact on care when staffing falls below the required levels this will be implemented during Q4, 20/21.

5. Critical Care staffing

Pre Covid-19, Critical Care at WUTH had seen a reduction in the need for level 3 ventilator supported patients and an increase in high dependency level 2 patients. Establishment reviews had taken place proposing a plan to reduce the band 5 workforce. Since COVID-19 further guidance from the Cheshire and Mersey Critical Care Network has stated that Critical Care Units must now increase their existing bed capacity by 150% to support the management of COVID and non-COVID patients and a potential second surge.

In response the Trust are undertaking a recruitment drive to increase the nursing establishment back to the required staffing levels for 8 level 3 beds and 12 level 2 beds but also to explore

options for over recruiting to allow enough staff to care for the predicted increase when absence levels may be high or Critical Care footprint extends to additional areas.

The Critical Care Unit has been significantly impacted during the COVID-19 pandemic seeing 13 staff leave the unit during the period and an average 10 WTE absent from work due to sickness at any one time. Staffing mitigation is sought through a combination of additional hours and NHSP staff covering vacant shifts, in addition a small number of previous critical care staff have returned to the unit to offer aid during this difficult time.

On occasion during the first wave staffing pressures meant reduced patient ratios were prevalent particularly in the High Dependency Area reducing patient / staff ratios from 1 registered nurse to 2 patients to 1 registered nurse to 3 patients. Staffing incidents and untoward incidents are closely monitored during this period. Between April and September 2020 there have been no serious untoward incidents attributed to unsafe staffing and patient and family feedback is consistently extremely positive for care provided in this area.

6. **Conclusion**

The Trust has applied effective governance processes to ensure visibility and scrutiny of nurse safe staffing from ward to board. Through these processes WAC is able to conclude daily staffing monitoring processes continue, with a good system of internal control being applied constantly to ensure gaps are filled and manged effectively in line with the Safe Staffing Escalation Policy.

The Trust has met its requirements to undertake the mandatory acuity, dependency and establishment review for adult wards recommending that no changes should currently be made to nursing establishments due to the need to continually flex nurse staffing requirements as a consequence of the COVID- 19 pandemic.

The Trust is also able to assure the Board of Directors the Trust has systems and processes in place to assure safe staffing requirements are met in Women and Children areas (including neonates) and Critical Care areas in line with national recommendations and induvial specific specialty guidance.

7. Recommendations

The Board of Directors is requested to note the contents of paper accepting assurance the Trust has met its requirement to complete a 6 monthly acuity and dependency audit using a recognised tool.
The Board of Directors is also requested to approve the recommendation that no changes should currently be made to nursing establishments.

Appendix 1 Acuity and Dependency results reflecting the impact of COVID- 19 pandemic on patient acuity July 2020 compared to July 2019 / February 2020.

Division	Ward	Establishment excluding house keeper and ward clerk	**Jul 2019** Shelford Acuity Results	**Feb 2020** Shelford Acuity Results	**July 2020** Shelford Acuity Results
Surgical	10	28.03	31.48	21.8	12.79
Surgical	11	38.96	33.5	37.4	29.27
Surgical	12	20.63	17.57	9.28	No audit undertaken
Surgical	WAFFU	18.67	11.57	11.82	7.14
Surgical	M2Ortho	22.21	No data	15.54	Ward closed at time of audit
Surgical	14 colorectal	43.44	39.67	42.92	No audit undertaken
Surgical	SEU / 17	43.86	38.18	38.94	24.58
Surgical	18	40.8	37	38.58	35.59
Surgical	20	39.37	32.49	34.83	30.48
Medical	24	32.1	41.2	35.4	22.1
Medical	25	40.15	32.5	29.9	21.27
Medical	26	39.05	42.68	49.5	39.01
Medical	30	36.24	32.11	33.31	No audit undertaken
Medical	32 & CCU	64.35	57.32	60.78	56.66
Medical	33	36.18	41.9	41.5	No audit undertaken
Medical	36	48.36	51.95	49.63	48.15
Medical	37 & 38	68.12	68.32	69.48	63.63
Medical	21	40.48	42.68	43.75	37.05
Medical	22	39.26	42.45	50.47	34.6
Medical	23	41.26	36.49	39.93	34.1
Medical	27	38.89	No data	38.24	39.9
Medical	CRC	38.71	50.4	48.27	29.23
Medical	M1 rehab	40.84	No Data	51.09	Ward closed at time of audit
Medical	EDRU	15.76	No Data	12.58	Ward closed at time of audit
Medical	AMU	42.25	No Data	26.62	23.5
Medical	MSSW	32.69	No Data	23.49	4.89

Appendix 2. British Association of Perinatal Medicine (BAPM) guidelines for staffing on Neonatal Units

BAPM recommends that a supernumerary Team Leader should be present on all shifts; other staffing is based on the following:

- **Special Care** includes those neonates requiring additional care for jaundice, tube feeding, and hypoglycemia care. The national recommendation is a ratio of 1:4 x1 registered nurse to 4 infants
- **High Dependency Care** includes those neonates requiring nasal continuous positive airway pressure (CPAP) the national recommendation is a ratio of 1:2 x1 registered nurse to 2 infants
- **Intensive Care** includes those neonates requiring respiratory and other system support. The national recommendation is a ratio of 1:1 x1 registered nurse to 1 infant.

Board of Directors	
Agenda Item	20-21/199
Title of Report	Infection Prevention and Control COVID update
Date of Meeting	2 December 2020
Author(s)	Jay Turner-Gardner. Deputy Director of Infection Prevention and Control Hazel Richards
Accountable Executive	Hazel Richards. Chief Nurse Executive Director for Midwifery and Allied Health Professionals Director of Infection Prevention & Control
BAF References • **Principal Risk**	PR 4, 5, 6
Level of Assurance • **Positive** • **Gap(s)**	Positive • WUTH has responded quickly and robustly to ensure emerging evidence and good practice is implemented at pace. • WUTH has reviewed IPC control measures and mitigations as outlined in the IPC Board Assurance framework (v 1.2 Oct) and has many areas of good practice and systems in place. Gaps • Audits of compliance to initiatives introduced need to continue and results to improve and sustain.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion and Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The paper provides the Board of Directors with an update and assurance about the reliability of Infection Prevention and Control measures introduced as part of Wirral University Teaching Hospitals FT (WUTH) response to COVID-19 pandemic. It confirms that there is increased risk of COVID 19 outbreaks and nosocomial infections consequent to the prevalence rate of COVID19 in the Wirral population. Mitigation of the risk is full compliance with IPC policies and procedures. Challenges in achieving such compliance are outlined within the paper and descriptions of the most commonly found deficiencies across organisations in the North West as identified by NHSE/I.

2. Background

On 21st September 2020 , the joint Biosecurity Centre and the Chief Medical officers recommended that the COVID-19 alert level for the UK should move from level 3 to level 4 (COVID-19 epidemic is in general circulation, transmission is high or rising exponentially).

Wirral has been experiencing high numbers of COVID-19 infections since September 2020. This is of particular importance due to the risks associated with COVID-19 being a highly transmissible respiratory virus.

MANAGEMENT OF COVID-19 INFECTION PREVENTION CONTROL MEASURES

Management of the virus relies upon a range of IPC measures: standard and transmission based precautions, early identification of possible cases, management of suspected/confirmed patients, patient placement, bio-security measures, the use of standard infection control precautions such as hand hygiene, correct use of PPE, maintaining social distancing of 2 metres, environmental and equipment decontamination, timely reporting of nosocomial infections and the management and prevention of outbreaks.

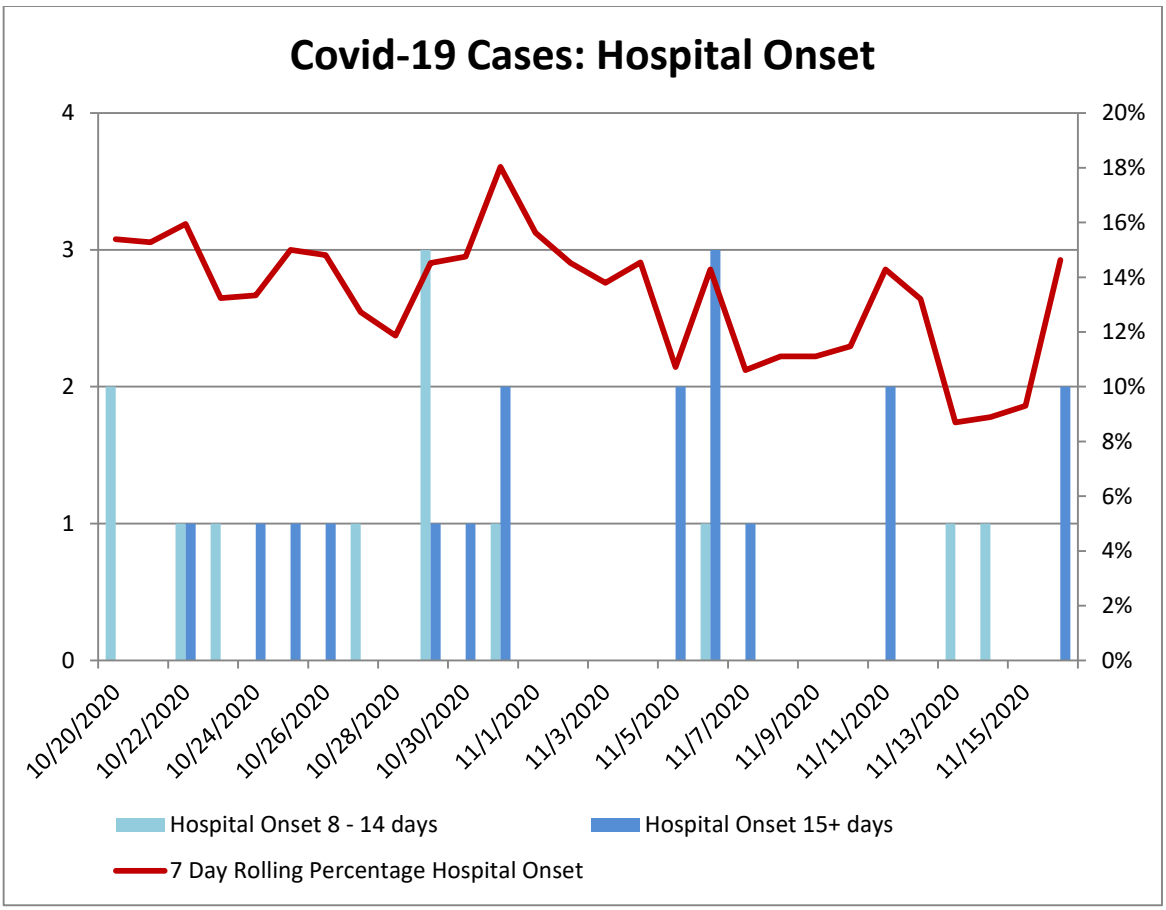
It must be noted that no single measure will be effective, COVID-19 reduction and management is multifactorial, one measure will not negate the need for another.

As the emerging evidence base on COVID-19 evolves, effecting change at pace to share learning and implement additional measures to limit transmission and improve patient and staff safety is crucial and at the same time challenging. This is also of paramount importance in understanding the current challenges faced with compliance to the IPC measures already in place to manage COVID-19.

1. Outbreaks of COVID-19

Nosocomial infection of COVID-19 is an important indicator on reliability of IPC measures.
To determine the likelihood of nosocomial infection COVID-19 is classed as:

- **Community-Onset (CO)** - positive specimen date <=2 days after hospital admission or hospital attendance;
- **Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA)** - positive specimen date 3-7 days after hospital admission;
- **Hospital-Onset Probable Healthcare-Associated (HO-pHA)** - positive specimen date 8-14 days after hospital admission;
- **Hospital-Onset Definite Healthcare-Associated (HO-dHA)** - positive specimen date 15 or more days after hospital admission.



The NW average has been running at 20% in October and 15% nationally.

Each patient diagnosed with COVID falling within the 2 categories of HO.pHA and HO.dHA undergoes a Root Cause Analysis to establish how the infection occurred, identify potential contacts, identify whether there are any other linked cases that might indicate ongoing transmission, and to establish and share rapid learning.

An outbreak of COVID-19 is defined as two or more of HO-pHA and/or HO-dHA cases occurring within the same ward/ environment at the same time (for COVID this is within 14 days of each other).

WUTH COVID outbreak control policy directly aligns with national recommendations for identification and management of outbreaks. COVID outbreaks are declared to NW NHSE/I via EPRRNW by an initial IIMARCH report with daily sit reps until 14 days has elapsed since the last case, this then triggers a local outbreak closure and no more sit reps are required to be sent, the outbreak is not officially considered closed by EPPRNW until a 28 day period has elapsed with no further positive cases identified.

2. Challenges in IPC compliance

There is increased risk of COVID 19 outbreaks and nosocomial infections consequent to the prevalence rate of COVID 19 in the community. Mitigation of the risk is full compliance with IPC policies and procedures by all staff each time, every time. However, the built environment and subsequent constraints can also contribute to the risk of nosocomial transmission.

There is recognition that there are challenges in achieving such compliance and to assist organisations in focusing their attention on possible deficiencies in practice NHSE/I NW in October 2020 published the shared learning they had collated from outbreaks declared across the NW since reporting began in June 2020.

Following the release of the document and associated dialogue with NW Regional IPC leaders to share the learning to reduce outbreaks and nosocomial infections, WUTH has concentrated on some local themes and also the areas NHSE/I have most commonly found to be deficient in other organisations across the NW.

These are detailed below-

- Lack of robust adherence to admission and 5 day post admission testing (swabbing)
- Staff compliance with PPE, especially in non-ward areas where staff are not considered to be clinical.
- Staff breaches in PPE especially around break times.
- Staff changing areas have been seen to have low compliance to wearing masks.
- Staff compliance with social distancing.
- Testing turn-around times. This needs to be consistently below a 24 hour mean.
- Bed spacing challenges.
- Visiting- ensuring that this is as per guidance/ NW Good Practice Guidelines.
- Staff following protocols when travelling to work in a car with other passengers and walking to cars whilst talking to each other, without masks.

As a result, weekly walk rounds and point prevalence audits take place which are presented at the Clinical Advisory Group (CAG), which meets three times a week. Signs have been placed on all office doors to stipulate how many are allowed in the room and signs are on rooms where staff take breaks re-iterating the guidance during meal times. Areas have been reviewed and risk assessed for rigid Perspex screens and there is ongoing installation of these in staff work areas throughout the trust.

The effectiveness of these measures is monitored weekly and the improvement has been noticeable in recent weeks.
Staff who are not adhering to these guidelines and are identified as a high risk contact during contact tracing following a COVID positive staff member will be managed locally following HR guidance.

3. Local themes from outbreaks amongst patients

- No social distancing or Perspex curtains in assessment areas
- Patient testing (swabbing) not taking place as per screening policy (day zero and day five)
- Frequent movement of patients around the trust
- Patients not wearing masks
- Misconceptions of patients regarding the need to take COVID precautions themselves at all times
- Lack of single rooms

As a result a patient questionnaire was devised to ascertain patient perceptions of the safety measures needed to keep them and others safe whilst in hospital. Many patients said that they thought masks were important, yet they didn't have one on, some said they could not reach the alcohol based hand gel, some felt they had no immediate access to a sink to wash their hands, and there were some patients who said that they had been told that once they got to the ward they could take their mask off. To address these concerns a patient COVID awareness pack has been introduced that is given to all patients who are admitted in ED and the assessment areas containing: a leaflet explaining what they should do whilst in hospital to help keep them safe, surgical masks, hand gel, hand wipes, a pack of tissues and a small rubbish bag. Following its introduction patients and staff were asked what they thought about the bag and feedback was very positive from staff and patients alike.

4. Compliance with post admission testing

In May 2020 the NHS published an 'Operating framework for urgent and planned services in hospital settings during COVID-19'. This advised screening for all elective and non-elective admissions on day of admission and on day 5 of admission if the initial swab was negative, which is the optimum time for detecting those that are positive.
In addition to this a discharge screen was also introduced for all patients being discharged to a nursing/residential facility 48 hrs before discharge to reduce community transmission amongst the most vulnerable.
This screening guidance was introduced throughout WUTH. Details are available real time on the Mpage and ward managers check these on a daily basis. Point prevalence audits are now completed every 2 weeks by all the divisions to determine the compliance against admission and 5 day screening policy.

Currently there are discussions nationally regarding what day is classed as day of admission, is it day 0 or day 1. For completion for sit rep purposes it is day 1, for calculation of determining Healthcare associated infections it is day 0. WUTH classify day of admission as day 0 for determining screening compliance. I.e. Patients admitted on a Monday is day 0 and day 5 will be on the Saturday. There are anomalies in the screening as each patients journey is unique, clinical assessment may determine swabbing outside of these guidelines and this is taken into account when calculating compliance.

Compliance to admission and day 5 screening for COVID

SURGERY	W/B 02/11/20	W/B 16/11/20
Patients are swabbed for COVID- 19 on admission	10%	90%
In patients are re-swabbed at day 5 (If admission swab was negative)	73%	76%

DIAGNOSTICS	W/B 02/11/20	W/B 16/11/20
Patients are swabbed for COVID- 19 on admission	100%	90%
In patients are re-swabbed at day 5 (If admission swab was negative)	0%	75%

WOMEN & CHILDRENS	W/B 02/11/20	W/B 16/11/20
Patients are swabbed for COVID- 19 on admission	100%	88%
In patients are re-swabbed at day 5 (If admission swab was negative)	20%	25%

MEDICINE	W/B 02/11/20	W/B 16/11/20
Patients are swabbed for COVID- 19 on admission	94%	96%
In patients are re-swabbed at day 5 (If admission swab was negative)	34%	84%

The introduction of a dedicated team, 'COVID patient flow nurses' and sharing of the compliance data at divisional meetings has raised awareness and improvements have been noted. Going forward, auditing compliance to discharge screening will commence.

5. **PPE – staff** The level of PPE required for contact with known/suspected COVID-19 patients is dictated by national guidance and although the guidance has changed several times as new information became available about the virus, this has remained relatively stable for the past 3 months. The key principles are :
   - The level of PPE is determined by patient risk pathways.
   - A fluid repellent surgical face mask (FRSM) is required when entering the hospital and must remain in situ throughout the working day unless in a room alone, even in a COVID secure environment with social distancing.
   - Additional PPE (gloves and apron) is required when coming within 2m of the patient. Eye protection is also worn as needed to prevent transmission from body fluids.
   - In areas where aerosol generating procedures (AGP's) are performed a filtering face piece (FFP3) mask and full length gown is also required.
   - The wearing of masks for all staff at all times regardless if they were in a COVID secure environment, this includes all non-clinical office based staff (September 20. NHSEI NW instruction).

PPE – Patients and visitors

In early June 2020 following further guidance from PHE WUTH introduced:

- The wearing of a surgical face mask for all staff/visitors within our healthcare buildings.

In September 2020 we also introduced/reinforced as an additional measure:

- The wearing of a surgical face mask for all inpatients who can tolerate it.

6. Visitor restrictions /compliance

WUTH has developed a visitor guide which is reviewed in line with the changes published by NHSEI. Volunteers are based at the designated patient and visitor entrances. All visitors are asked the purpose of their visit, they must then gel their hands and put on a surgical face mask.

Visiting restrictions have remained in place throughout as recommended by the national guidance. The Family Support Team was introduced in March 2020, to support alternatives to physically visiting loved ones.

WUTH has introduced ward log books for any visitors who have been allowed to visit by special permission from the ward manager; these are used to record the names of any visitors and the person they are visiting in case a patient is identified with COVID and they need to be contacted by the contact tracing team.

7. Bed spacing guidance

Due to the available science, subsequently endorsed by national guidance the distance to be maintained between persons is based upon the transmission potential of respiratory droplets, with most falling <2m from the infection source.
To support this every inpatient bed space was measured by the Environmental Safety Matron and Estates team to gather assurance on compliance with the minimum requirement of 2m between all bed spaces (centre to centre).
Many areas were not compliant to the 2 m distance. In order to address this, beds were removed out of bays in the amber wards and in addition several differing designs of screens and curtains were reviewed and each ward was assessed for suitability of each type, the fire officer and health and safety officer were consulted during the reviews.

- **Pop up room**

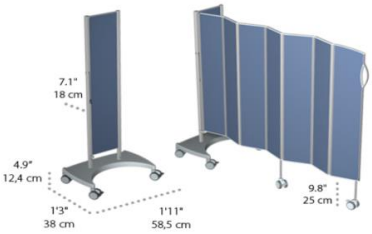
Within critical care a redi-room was trialed, which opened up from a small oblong box on wheels to a large open isolation room, due to the amount of specialist equipment patients in critical care require this was determined unsuitable due to space constraints.

Before

After opened

- **Curtains/Screens**

Screens- The Trust has now been assessed for the installation of PVC curtains and/or screens to assist in creating a barrier between patients and promote social distancing. Many of the screens were thought to be too clumsy and could potentially be a trip hazard; they also would not allow visibility of the patient when in use.



Curtains - PVC curtains have been the obvious option in many areas which create a barrier between bed spaces but still allow vision between the bed spaces to ensure that patient's safety can be maintained. When privacy and dignity is required the disposable /cloth curtains can be pulled across. The new rail and curtain installation has now begun across both sites and patients are handed information leaflets explaining what the curtains are for and the initiative we have introduced to help keep them safe.

8. Enhanced cleaning

Clinical areas -Increased cleaning using chlorine based detergent commenced across all Red and Amber areas and Outbreak wards in April 2020; this was in addition to the enhanced cleans that were already taking place for any patients bed space who has another infection identified. Yellow aprons have been introduced for the domestics to wear when completing the extra clean so that staff are aware of the enhanced cleaning taking place.

Non patient areas - have also been addressed and flyers have been sent out on two occasions to keep the staff updated and give advice on keeping their non-clinical areas clean and COVID safe, the first flyer (1) 'CLEAN BETWEEN' was part of the IPC campaign and was delivered to all offices in a bag with samples of the cleaning products for hard surfaces i.e. Desks and electronic equipment and details of where to order them with order codes.
(2) 'HANDS.FACE.SPACE' was to raise awareness that all staff needed to wear a face mask at all times regardless of where they worked unless they were in a room on their own.

Ongoing compliance is assessed weekly and reported to CAG.

1. 

2. 

9. Demand/capacity- Minimising Unnecessary Patient Moves

Increased patient moves maximises exposure to infection. The admission screening and management guidance for WUTH for both elective and non-elective admissions focuses on patient risk pathways – high (Red), medium (Amber), low (Green) planned surgery (Silver). Separation between patients with respiratory and non-respiratory symptoms at the front door and prompt patient placement and testing is key in reducing transmission of infection. Regular audits of admission appropriateness to amber areas, as well as findings from RCAs help to inform improvements.

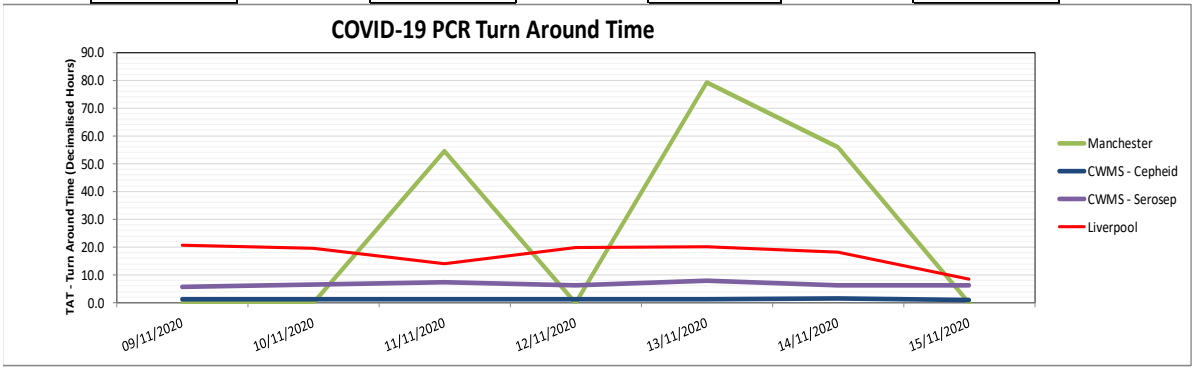
There are now two COVID safety patient flow nurses, whose raison d'etre is to safely step patients down from red wards within the agreed criteria and to manage the flow through the COVID bed base; and to ensure compliance with day zero and day five swabbing (see section 4).

10. Testing turnaround times

Early identification of positive cases is critical in helping to reduce the potential for cross transmission and therefore to reduce the potential for outbreaks. Turnaround test times (TAT) for COVID-19 are required to be consistently below 24 hours. The tables below show the TAT for WUTH . It must be remembered that testing during outbreaks (all inpatients and staff within the area) places an additional resource pressure on the laboratory.

Mean Hours expressed as decimal (0.5 = 30mins)

	Manchester PHE		Chester and Wirral Microbiology Service (CWMS)				Liverpool Clinical Labs	
			Cepheid		Serosep			
Date	CWMS Receipt to Manchester Report	Number of tests	CWMS Receipt to CWMS Report	Number of tests	CWMS Receipt to CWMS Report	Number of tests	CWMS Receipt to Liverpool Report	Number of tests
09/11/2020	0.0	0.0	1.2	48.0	5.7	161.0	20.8	488.0
10/11/2020	0.0	0.0	1.3	54.0	6.7	151.0	19.6	308.0
11/11/2020	54.4	2.0	1.3	51.0	7.5	180.0	14.0	129.0
12/11/2020	0.0	0.0	1.3	55.0	6.4	322.0	19.9	88.0
13/11/2020	79.3	4.0	1.2	53.0	8.1	360.0	20.2	126.0
14/11/2020	55.9	5.0	1.6	33.0	6.4	228.0	18.1	143.0
15/11/2020	0.0	0.0	1.0	31.0	6.3	263.0	8.5	202.0
Mean Hours:	27.00		1.26		6.71		17.30	

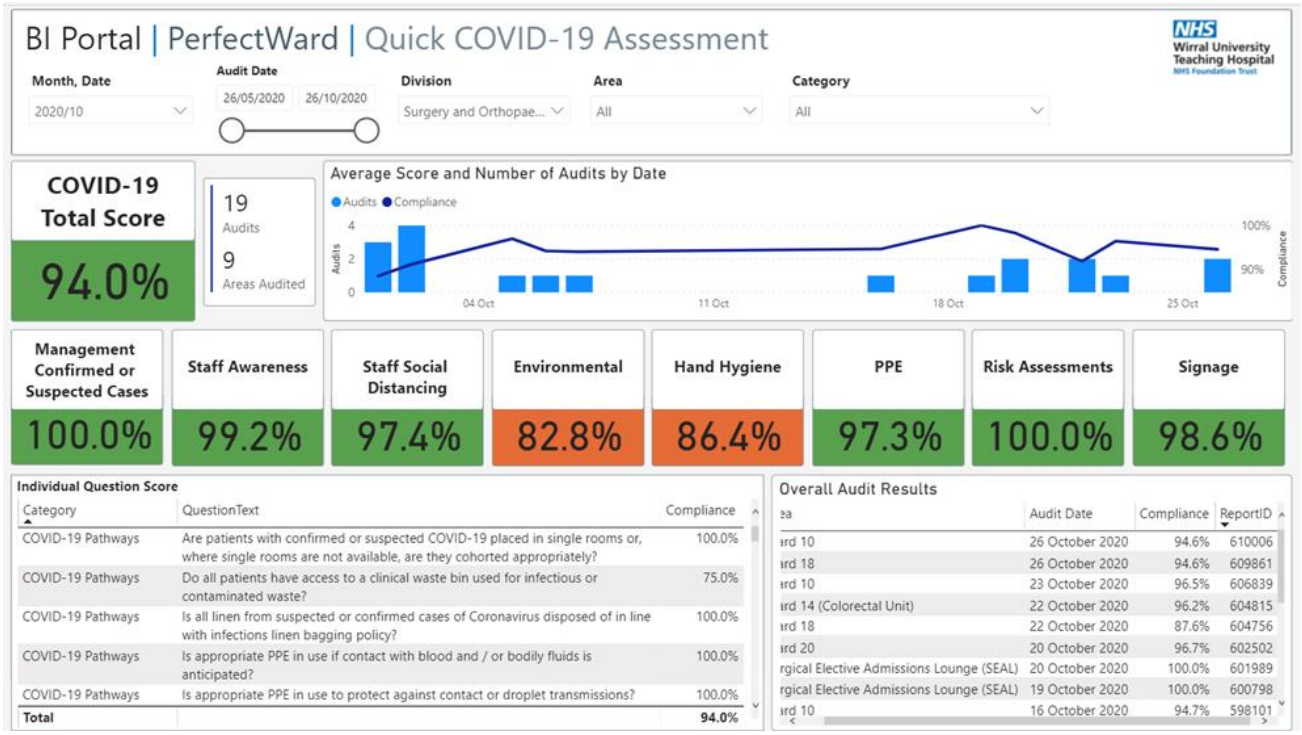


11. Quick COVID audit and example

As a result of the increased COVID activity the perfect ward audits have been increased to give assurance on compliance to the standards and to give teams a focus on their challenges.

Audit	Brief description of questions	Clinical areas	Current inspection frequency	Escalation frequency based on ward status	Audit timing	Responsible for audit	Who will conduct the audit
Hand Hygiene (IP&C)	Visual audit of 10 staff members	All inpatient areas	Daily	RED- Daily Amber- Daily Green- Weekly Outbreak Wards - Daily	Various times across the day and week	Ward Manager	Ward Manager
Ward managers inspections	Sisters self-check audit to ensure basics are established	All inpatient areas	Weekly	Monthly	Various times across the day and week	Ward Manager	Ward Manager
Quick COVID	COVID practice	All areas	Weekly	Weekly	Various times across the day and week	Ward Manager	Ward Manager
PPE	PPE processes	Red and Amber areas and Outbreaks	Weekly	Weekly	Various times across the day and week	Ward Manager	Ward Manager

A quick COVID audit has also been developed that gives a snap shot assessment so that you can see at a glance how performance and practice is in real time and gives a road map to help improvement.



12. Training - Don/Doff

Donning and doffing is the practice of staff putting on and removing work-related personal protective equipment (PPE) and in the case of COVID this relates to anything from gloves, apron and fluid repellant surgical mask to FFP3 masks, visor, gown, gloves. Donning refers to putting on the equipment while doffing means removing them. Correct donning and doffing of PPE is a crucial step in preventing and controlling infections in healthcare settings. In acknowledgement of this, practical training is delivered to all staff by either face to face training or via video presentations on the intranet. Following the visual training there is also a competency assessment that is completed for each member of staff, this is to ensure that it is put on correctly and very importantly removed correctly to avoid self-contamination with potential harmful pathogens that could be on the outside of the PPE.

13. Fit Testing

There are two fit testing methods, these are known as: Qualitative (hood) and Quantitative (porta count). Both quantitative and qualitative face fit testing methods are widely used however the type of test that is chosen depends on the equipment available and also the environment that you will be fit testing in.

Qualitative (Hood)

Quantitative (Porta count)

Qualitative testing is subjective, meaning that it relies on the senses and judgement of the individual. This can make it much harder to determine the quality of the seal and whether adequate levels of protection are being provided.

Two Porta count machines had been purchased when the guests from Wuhan arrived; these machines were then used to Fit Test staff in the Clinical Skills Department. Over the coming months a further 4 machines were purchased and a total of 56 staff across the Trust have now been trained on how to deliver the testing on the machines.

A fit testing hub was set up at the beginning of the pandemic which has evolved over time and is now a managed service with fit testing booked by appointment. The purpose of fit testing is to keep clinical staff safe whilst delivering care in specific areas or undertaking an Aerosol Generating Procedure. To date we have fit tested over 3,600 staff with 13 different varieties of masks.

14. Environmental risk assessments

The Environmental Safety Group was set up during the first wave of the pandemic. This group reports into the Health & Safety Committee. Their remit is to oversee all operational aspects that deliver a safe COVID environment. In October 2020, the divisions were asked to review all their COVID environmental risk assessments and an aggregate summary of results is below.

Table 1

Rating	Descriptor
Red	Areas with no mitigation in place or no timeframe for delivery of mitigation
Amber	Areas with timeframe to deliver mitigation
Green	Areas with no risk or full mitigation in place and being monitored

Trust wide review

Area Reported	Total Areas Assessed	Red	Amber	Green
Trust	212	3	37	172

The audit was a snap shot at the time , red rating relates to offices and their inability to follow the 2m social distancing guideline, this is being addressed by requests for alternative office space, staff working from home, Perspex screens and alternative ways of working. The amber areas received advice on how to meet the guidelines and once implemented will move to green.

The Environmental Safety Group have a weekly agenda item to review the current Trust compliance status and progress made against the defined timeframe for control measures i.e. updates on signage, best practices, installation of screens and the review of auditing that has taken place , results of which trigger further mitigations.

Compliance audits are carried out by the Environmental Safety Matron on a weekly basis and reports generated for discussion at Clinical Advisory Group (CAG) and further action if required at the Environmental Safety Group meetings. A summary of the findings is also reported to the Health & Safety Committee as part of the Environmental Safety Group chairs report.

15. Asymptomatic testing of patient-facing staff

On 14th October there was a national request to carry out asymptomatic testing of all patient facing staff in the North West, the rationale for this testing was the level of community transmission as well as nosocomial infection rates. Regular asymptomatic testing of all NHS staff was planned however the NW was prioritised because of the high rates. The trust had a window of 10-14 days to capture all patient facing staff and a high level plan was submitted to EPRRNW within 24 hours of the notification. The results can be seen below.

	Tested	Positive	Void	Positivity Rate
Asymptomatic Pillar 2	3276	45	25	1.4%

The testing did not involve the local laboratory or Occupational Health (OH), staff were advised of their results via personal text message or e-mail direct from a NHS source. Requests went out via communications asking staff to contact OH if they received a positive result to enable contact tracing to take place.

16. Lateral flow testing

In November 2020 mass testing was rolled out in Liverpool involving lateral flow antigen tests. Lateral flow antigen tests are a new kind of technology that can be used to test a higher proportion of asymptomatic people; this will enable early identification and isolation of more people who are at high likelihood of spreading the virus, and help break the chain of transmission.

Lateral flow devices do not require a laboratory to process the test. The devices are designed to be intuitive and require minimal training to operate; results are ready within the hour. It is proposed that twice weekly lateral flow antigen testing will commence imminently at WUTH as it will for all NHS patient facing staff. Implementation plans are in development including training on their use. Staff instructions will be provided. Staff with positive results will be tested again using the PCR method, results of which will then be captured by OH to facilitate contact tracing.

17. COVID-19 vaccination programme

The NHS has reported that the COVID vaccination service will be operationally ready for launch across England by 1st December. The operational expectation for planning purposes of vaccination uptake is 75%, 2 doses are required for each staff member 28 days apart. WUTH is currently preparing a local strategy to meet this requirement in a safe and regulated manner.

18. Conclusion

The approach taken by WUTH to achieve reliability around IPC measures is robust and consistent with national and regional best practice and evidence. Ongoing progress in each of the areas is reviewed weekly and where necessary actions are taken. Reliable implementation is being supported by leadership teams, subject matter experts, CAG, IPCG, Environmental Safety Group and onward reporting.

Board of Directors	
Agenda Item	20-21/200
Title of Report	Short Term Sickness Absence Update
Date of Meeting	December 2020
Author	Amy Park, Interim HR Business Partner Garry Sweeney, Head of HR
Accountable Executive	Jacqui Grice, Executive Director of Workforce
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	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 purpose of this information paper is to provide the Board of Directors with an update in relation to current and existing measures to address Short Term Sickness absence at Wirral University Teaching Hospital (WUTH).

The Board is asked to note the content of this report.

2. Background & Current Work

2.1 Sickness absence levels continue to be above the Trust's 5% target for 2020/21 – the latest performance being over 6% (October 2020). The split between long term – over 28 days and short term – under 28 days is roughly even at just over 3% for both. It is therefore

imperative that interventions are in place to address both and that the Board is appropriately sighted.

2.2 This paper sets out some of the current work and initiatives in place to improve performance by addressing Short Term Sickness absence. It also features broader interventions which are intended to improve Short Term Sickness. It is not intended to be an exhaustive list but to present key highlights, and provide reassurance to the Board.

2.3 Current work includes:

- The Attendance Management Policy & Procedure
- HR Business Partner (HRBP) Interventions
- Working with specific Staff Groups – Hotel Services
- Knowledge Transfer and upskilling
- Improved access to the Employee Assistance Programme
- Promotion of Health and Wellbeing
- Increased psychological support

2.4 Overview of Current Work

2.4.1 WUTH Attendance Management Procedure

Under the current Attendance Policy, using the Bradford Factor, triggers are fairly broad and formal action is not always invoked. Therefore, the current WUTH Attendance Management Policy and Procedure is being re-written based on the framework of the previous policy. The return to sickness absence triggers is intended to bring short term and short term persistent absence back within the Trust tolerance levels. The procedure will trigger at 4%, ahead of the 95% attendance rate. When this previous policy was in operation, the Trust achieved and maintained sickness absence at 4% for the organisation. As part of the re-write, the policy is also being modernised to clarify Trust expectations, outline support to staff, and to enable unsatisfactory absence to be appropriately managed. This change is supported by Management and Staff Side colleagues as it provides greater clarity and transparency in addressing attendance issues. The rewrite will bring together both short term and long term absence.

2.4.2 HR Business Partner Interventions

The HRBPs are continuing with monthly Workforce Meetings with management teams. Attendance Management forms an important aspect of these meetings and discussions take place on a case by case basis. This includes a focus on Short Term Sickness cases within Divisions every month.

Regular sickness review meetings and hearings have been re-enacted as part of re-set and recovery.

A three month pilot commenced last month. HRBPs can now fast track appropriate referrals for Occupational Health Support. This includes expedited referrals for stress, anxiety & depression cases, which will support staff, and help prevent cases going long term.

2.4.3 High Sickness Levels in Hotel Services

There has been significant focus on high sickness levels within Hotel Services with close partnership working between Hotel Services Management, HR and Organisational Development

Analysis has identified a hypothesis whereby some of the Short Term Sickness levels in Hotel Services relate to staff not feeling valued. To explore this further Welfare sessions have been held with staff working in Hotel Services (Band 2), and also with both Admin & Clerical, and Clinical Support Workers within the function. Separate sessions have been held for Managers and the last one is due to take place this week (w/c 23.11.20). A further session is scheduled to be held at Clatterbridge.

The feedback from the listening sessions is in the process of being written up by the facilitators of the Welfare sessions. Early indicators suggest Hotel Services staff perceive they are treated less well than other staff groups. For example, being asked to cover additional duties without any more time to complete the supplementary tasks, with an expectation these extra duties would be completed to the same standard; a perception of lack of respect from ward staff/ senior staff; lack of praise and appreciation.

In addition, two Staff Side representatives have been engaged to provide further context based on feedback/ contact from their members, which has highlighted concerns regarding staff shortages and changing of duties. Louise Kiely (Soft FM Lead) is working with Jill O'Callaghan (HRBP) to address concerns, improve engagement and improve morale.

2.4.4 Knowledge Transfer

The Attendance Module was delivered on the 19th October 2020 as part of the Effective Management Training. This is a fairly new Programme aimed at enhancing managerial skills across the organisation. It includes supporting and guiding line managers so that they feel equipped to have sensitive and supportive discussions whilst managing staff attendance.

2.4.5 Employee Assistance Programme

A new online referral process has been introduced for the Employee Assistance Programme (EAP), which is easy to use, secure and accessible from any web browser.

2.4.6 Promotion of Health & Wellbeing

A staff support poster has been produced as an easy guide for staff to identify what support is readily available. This signposts both emotional and practical support for staff.

2.4.7 Psychological Support

The primary reason for absence continues to be anxiety, stress and mental health. We do not yet know exactly what the mental health impacts of COVID-19 will be. Access to the Red Poppy Company is a new and additional service offer for staff suffering from PTSD type symptoms, work related stress and/ or personal stress. Red Poppy is effective in improving staff wellbeing and is intended to help employees maintain their attendance in work.

3. Key Issues/ Gaps in Assurance

There is no doubt that these are unprecedented times as we continue to deal with the enormous challenge of fighting the COVID-19 pandemic, alongside impending winter pressures. COVID sickness currently accounts for over 1% of total WUTH sickness. The current sickness levels remain a serious organisational threat and the Trust is focused on and stepping up efforts to reduce sickness levels to a minimum. Encouragingly, sickness is continuing to track downwards from 2019/20 into 2020/21.

4. Next Steps

WUTH remains an outlier with regards to current sickness levels and wider work is in progress aimed at achieving an improved trajectory, at an accelerated pace.

5. Conclusion

WUTH has been working hard to best protect its workforce and place employee's health and wellbeing at the heart of its response to the crisis.

6. Recommendations

The Board is asked to note:

- Note the contents of this report and next steps.

Board of Directors	
Agenda Item	20-21/201
Title of Report:	Diversity and Inclusion Annual Report
Date of Meeting:	02 December 2020
Author:	Sharon Landrum, Diversity and Inclusion Lead / FTSU Guardian
Accountable Executive:	Jacqui Grice, Executive Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1A, 1B, 4A, 7D
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	Previously completed

1. Executive Summary

This report seeks to provide assurances on the progress made in not only complying with statutory requirements under the Equality Act 2010 and associated public sector duties, but also work to meet requirements contained within the Trusts standard contract with local commissioners.

2. Background

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations:

- To eliminate unlawful harassment and victimisation and other conduct prohibited by the Act
- To foster good relations between people who share a protected characteristic and those who do not
- To advance equality of opportunity between people who share a protected characteristic and those who do not

In addition to the previously referred to **general duty**, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED.

The Equality Act also defined a number of groups that have protected characteristics, as follows:

- Sex / Gender
- Age
- Disability
- Race
- Sexual Orientation
- Religion or belief
- Pregnancy and Maternity
- Marriage and Civil Partnership
- Gender reassignment

The Trust is required to fulfil a number of obligations that are outlined within the Equality Act (2010) and within the Public Sector Equality Duty, along with requirements built in to the standard NHS contract monitored by commissioners and forms part of the Care Quality Commission's well led inspection.

The Trust is required to submit annual data for:

1) Annual workforce demographics
2) Workforce Race Equality Standards (WRES)
3) Workforce Disability Equality Standards (WDES), (introduced from April 2019)
4) Gender Pay Gap Analysis

Along with producing and displaying reports for all of the above we are required to produce:

5) Annual and 6 month update reports
6) Review of progress towards achievement of equality and diversity by using the Equality Delivery System (EDS2) framework

A Diversity and Inclusion Steering Group was established to support achievement of the overarching diversity and inclusion agenda and an additional "Inclusivity" theme was added to the Workforce and OD Plan to ensure key priorities are embedded across the Trust.

The Trust is required to have key objectives in place, along with monitoring additional areas such as:

7) The introduction and ongoing monitoring of the Accessible Information Standard
8) Consideration of equality related impacts on redesign of services and evidence that findings have been considered by decision makers prior to making a decision to change.
9) Interpretation and translation services

The Trust's diversity and inclusion strategy 2018-22 and last annual report are available for review on the public section of the Trust's Diversity and Inclusion webpages. Appendix 1 is the updated action plan that supports the achievement of the strategy.

The strategy identifies the Trust's vision of creating an environment for patients and staff where the principles of equality legislation are fully embraced and where people feel respected, valued and treated with dignity. The strategy also highlights the aim of ensuring that our services are accessible to all members of our community, that they are delivered equally regardless of any differences and that our staffing reflects the communities we serve.

This report seeks to provide assurance that we are complying with the requirements outlined above and identifying any key areas for concern and consideration.

3. Progress Report

3.1 Reporting Requirements

3.1.1 Workforce Demographics
Appendix 2 provides the breakdown of workforce demographics as at 31 March 20, compared with community demographics where available.

3.1.2 WDES and WRES Reporting
The Trust is currently compliant with the reporting requirements outlined above, with recent data submissions now completed for both WDES and WRES. WRES and WDES reports were reviewed and approved via the workforce governance structure and Trust Board in October.

3.1.3 Gender Pay Gap Reporting
Gender pay gap reporting has not as yet commenced, however is not required to be completed until 30 March 2021 and will therefore be presented for review at a future date.

3.1.4 Annual and six month update reports
This report seeks to provide the annual update for workforce information and includes detailed workforce demographic information at appendix 4. A six month update was provided to Workforce Steering Group in February 2020.

3.1.5 Equality Delivery System (EDS2)
Trusts are required to conduct a review of services against the criteria contained within the nationally developed equality delivery system (EDS2). WUTH conducted a full review of all areas in 2018/19 and actions identified where included within the action plan attached at appendix 1. A further review has not been completed this year due to COVID-19 implications and capacity, however the Trust has linked with Merseyside D&I Leads and clinical commissioning colleagues to ensure best practice is considered and ideas shared.

A national review has also been conducted on EDS2 itself and a new EDS3 framework has been developed to ensure greater effectiveness. This has been piloted and final information and launch dates are awaited. More details will follow as soon as they are confirmed.

3.1.6 Accessible Information Standard (AIS)
This is a national standard that supports those with disabilities, impairments and sensory loss and requires organisations to ensure they have access to information and communication in a format suitable for them. The Trust launched a pilot within Outpatient and Pre-Operative Assessment in Jan 2019, however requires further review in order to continue roll out.

Continued implementation of AIS has been identified as an area of concern and entered on to the Trust's risk register. A steering group has been reconvened to ensure further progress is made and actions are in place to ensure further progress is made.

3.1.7 Equality Analysis / Impact Assessments
As identified in section 2, reporting area no.8 highlights that consideration must be given to equality related impacts on redesign of services and evidence that findings have been considered by decision makers prior to making a decision to change. Equality impact assessments must also be conducted on new and revised policies.

The Trust launched an equality analysis policy in 2018 and equality analysis is now embedded within the policy approval process. All policies are therefore required to have this completed and support is offered via the D&I Lead. There has therefore been a significant increase in the number of equality analysis impact assessments being completed however the quality of those now needs to be reviewed, as when audited, a number of those completed only contain minimal information. New development sessions have been offered as part of the Trust's learning and development prospectus and 1:1 support is also available.

Equality analysis impact assessments are required to be published therefore as this is now integrated within the policy approval process, the Trust is compliant with this aspect.

With regards to service improvement however, whilst Board papers require confirmation that equality analysis has been completed, these are not always attached to papers for open review. Board paper cover sheets have therefore been updated to reflect this and therefore continued monitoring is required.

Initial plans were to ensure a heightened focus and improvement in this area, however due to COVID-19, this has unfortunately been delayed. Focused efforts on equality analysis will therefore be considered as soon as practicable and updates provided within future reports.

Standardised equality analysis templates have also now been developed to support new Divisional strategy and service planning, taking into consideration potential community and workforce implications. The Trust has worked in partnership with local Cheshire & Merseyside D&I Lead Collaborative forum, and considerations templates are based on Merseyside CCG recommendations and engagement work conducted internally.

3.1.7 Interpretation and Translation Services

The Trust has been reviewing it's current provision for interpretation and translation services throughout 2019/20 with review meetings and action plans in place. The Trust commenced a new contract with DA Languages on 5th October 2020 and hopes that this will ensure further improvements moving forwards.

Browsealoud software is also installed on the Trust's website which allows enhanced accessibility of information including the translation of information on our webpages in to 99+ languages, including approximately half of those in audio format too.

3.1.8 People Plan 2020/21

NHSE/I have called organisations to develop local people plans in response to the national plan that was published on 6th August 2020. A section is dedicated to D&I and key areas are:

i) Ensuring recruitment and promotion practices reflect the community, regional and national labour markets
ii) D&I considerations to be linked with wellbeing conversations
iii) Published progress against the model employer goals to ensure the workforce leadership is representative of the overall BAME workforce
iv) 51% organisations to eliminate the ethnicity gap when entering formal disciplinary processes

3.2 Raising Awareness of Diversity and Inclusion

3.2.1 Mandatory Training

The Trust introduced mandatory diversity and inclusion training for all staff and has delivered a variety of e-learning and face to face sessions. As well as delivering face to face sessions for hard to reach staff, the Trust has also rolled out a mandatory training handbook for those staff and diversity and inclusion has been contained within it. As at 30 September 2020, the Trust achieved 96.15% compliance for this component and is therefore above the compliance level required.

3.2.2 Promotional / Engagement / Developmental Opportunities

The Diversity and Inclusion Steering Group and staff networks review key dates throughout the year and support a calendar of events to offer engagement, promotion and information opportunities. Events supported over the last twelve months included:

i) **Transgender, Intersex and Non-Binary Awareness** – the Trust has offered smaller sessions as well as a larger scale conference that was identified as being the first of its kind, linked with local community organisations and service users. Opportunities were designed to heighten awareness and opportunity for questions around how best to support and improve health inequalities for our trans and non-binary community and for those who have an intersex condition.
ii) **NHS Rainbow pin badge launch** – 2000+ staff have pledged support to the initiative launched at WUTH in September 2019. The Trust developed a series of promotional leaflets and pledge cards and facilitated a communications campaign to capture team photos of those who pledged their support, integrating the new Trust values of Together We Will. Staff network members visited

numerous wards and departments, held stalls across the Trust to talk to staff about the initiative, the research behind it and the support available.

iii) **Chinese New Year** –Special Chinese menu in Bowmans and Firtrees restaurants with decorations provided by Wirral Multicultural Organisation

iv) **LGBT+ History month** – linked with Year of the Nurse – staff network members held stalls at Firtrees Restaurant and APH main entrance

v) **"E"Quality Bus** – members of the staff network have been out and about to wards and departments promoting key messages surrounding the Diversity and Inclusion Agenda

vi) **Health and Wellbeing** – supported HWB Lead with promotion of support available for mental health e.g. Employee Assistance Programme and new Mental Health First Aiders

vii) **Springboard** Womens Personal Development Programme – The Trust supported a number of women in completing the Springboard programme. This was the first programme delivered at the Trust for a considerable period of time and all participants found it beneficial.

viii) **Navigator** Mens Personal Development Programme – the first programme of its kind delivered within WUTH designed specifically for male staff and incorporating mens health. The programme was unfortunately postponed due to COVID-19, however will resume as soon as possible

ix) **Dementia Conference –** The Trust successfully hosted a Dementia Conference on site, October 2019

x) **Treating Me Well Campaign –** The Trust continues to link with Mencap and their treating me well campaign to ensure improvements are made for our patients and service users with a learning disability. The Campaign will be relaunched at APH in December.

xi) **LGBT+ Pride parade** – The Trust again participated in Liverpool and Chester parades. The Trust also had a recruitment stall at Chester.

xii) **Reverse Mentoring** – Pilot commenced to enable staff within Trust staff networks to reverse mentor colleagues, to learn more about the protected characteristics they share. Paper approved at WSG and to be rolled out with immediate effect.

xiii) **Disabilities and long-term health conditions wellbeing event** – event was scheduled and promoted for 17th March, with a variety of external organisations and internal services involved. Guest speaker arranged along with Schwartz round, featuring staff sharing personal experiences. A variety of new developments scheduled to launch at the event however due to COVID-19, the event was cancelled and launch of key items postponed.

xiv) **Staff Networks** – various Trust promotions regarding staff networks and opportunities to get involved:

   a. **Rainbow Alliance** – Staff network for those who identify as lesbian, gay, bisexual and/or transgender, or those who identify in any other way (LGBT+)
   b. **WUTH Sunflowers** – for staff with disabilities and long-term health conditions
   c. **BAME Staff Network** – for staff who identify as black, Asian or an ethnic minority

xv) **Browsealoud** – Trust promotion of new software on website allowing increased accessibility of website information including translation of information in 99+ languages and audio options.

3.3 Current Key Work Streams

Previous reports have highlighted that a heightened focus would take place on a phased basis with focused on LGBT+ staff first, due to the interest and support within the staff network group. This would be followed by a focus on those with disabilities and long-term health conditions and then our BAME staff. Due to COVID-19 and the delays in work streams to support our staff with disabilities and long-term health conditions and the urgent need to ensure BAME staff voices are heard, the Trust is currently striving to focus on both areas and working through a number of actions to move forwards.

3.3.1 Work undertaken to support staff with disabilities and long-term health conditions

The Trust has developed the following, in conjunction with staff network members:

i) Jacqui Grice identified as new **Executive Partner** for the disability staff network

ii) **New Disability and Long-term health condition policy** (previously the disability leave policy). This has just been ratified and therefore will be launched with immediate effect.

iii) **New reasonable adjustment planning documentation** including form to be completed by the staff member, new personal emergency egress plan form (in cases of emergency evacuation) and a sample letter for management to complete to confirm the outcome of any discussions and review dates agreed. New processes seek to further support staff and managers of new and existing staff and include a revised monitoring opportunity.

iv) The Trust has signed up to the **Hidden Disabilities Sunflower Lanyard Initiative** and Trustwide launch took place In November to recognize identification of those wearing sunflower lanyards or pin badges and additional support they may require. The Trust has purchased a number of pin badges for distribution to those colleagues who may also wish to wear one. A press release is being prepared to highlight this commitment across our community.

v) **New support leaflet** drafted and under final review, to enable easier promotion of key support information and contacts when needed

vi) **Disability self-reporting questionnaire** developed. It is anticipated that this will be used following discussions with staff at training sessions events or engagement opportunities and will be an alternative way to capture consent from staff to centrally update their disability status, thus increasing the self-reporting rate

vii) Planning and delivery of a **dedicated health and wellbeing event** specifically focused on supporting staff with disabilities and long-term health conditions. An event was planned **for Tuesday 17th March** across the Education Centre with a **variety of stalls from** internal and external partners providing information, advice and guidance on a range of different subjects, including benefits advice, access to work support, disability advocacy support, hearing tests etc. Unfortunately however the event had to be postponed due to the changing circumstances of COVID-19 and will therefore be rearranged as soon as practicable.

viii) The Trust has renewed its sign-up to the **Government's Disability Confident Scheme** and remains at the first "Committed" level. The Trust is preparing an application to progress to the next stage of being a "Disability Confident Employer"

ix) **New read and write software** has been purchased to support greater accessibility across all Trust computers. It is hoped that this software will aid staff accessing and understanding information across all of our systems and will allow a variety of different levels of functionality including information in audio format, translation of information, screen masking etc. The software will support a variety of differing staff needs and in particular, those with Dyslexia and other Neurodiversity conditions. Champions will be trained and a Trust wide launch planned as soon as practicable.

x) Increased numbers of new **disabled parking** spaces made available in new parking plans.

xi) **Disability mentors** in place with a growing list of staff happy to share their lived experiences with others in order to offer support advice and guidance

xii) **Reverse mentoring** programme has been piloted, with member of the disability staff network mentoring the former Director of Workforce and a member of the LGBT+ staff network mentoring a HR colleague. Feedback has been well received and a paper outlining roll out of the initiative was approved at WSG in March. Roll out will be under planning shortly.

xiii) The Trust signed up to the TUC **Dying to work campaign**, which seeks to recognise terminal illness as a protected characteristic under the Equalities Act (2010) and as such, offer additional support to staff.

xiv) A variety of **engagement opportunities** have been held as detailed in 3.2.2

xv) The Trust is currently reviewing potential locations for a **new Adult Changing Space**. Funding has been identified via NHS England for the implementation of new adult changing spaces within Trusts. The Trust is currently struggling to identify an area close to the main entrance. Whilst this is not currently mandatory, complaints have been received that our current provision isn't suitable and is expected to become a mandatory requirement in the future.

xvi) The Trust has a designated **Learning Disability Liaison Nurse** for expert advice and support

3.3.4 Work undertaken to support our BAME staff

i) **Staff network re-established**, June 2020 and monthly meetings scheduled. Membership growing steadily and email distribution list developed and terms of reference under discussion. Network members getting to know each other and key local and national items raised for review and discussion, although network still in its infancy.

ii) Hazel Richards identified as new **Executive Partner** for the BAME staff network

iii) Trust was one of the first to include BAME colleagues within the **health risk assessments**

iv) Innovative support developed to offer all BAME staff free one months' supply of **Vitamin D**, with referral process for blood test, Occupational Health and GP built-in. Additional bone-screening testing included for research opportunity too. Recognised as excellent practice nationally.

v) Staff encouraged to **share experiences** and link in with national events e.g. National Inclusion Week and Black History month.

vi) BAME Freedom to Speak Up (FTSU) Guardian Identified and **FTSU Champions** promoted as additional support and contact points
vii) BAME specific **development opportunities** promoted

3.3.5 LGBT+ Staff Network "Rainbow Alliance"

The Trust identified a new Chair and Deputy for its Rainbow Alliance and meetings continued to take place until COVID-19. A variety of actions, events and engagement opportunities have been held within 2019/20 and work is now taking place to re-establish the network post COVID-19 and identify key priorities.

Nikki Stevenson identified as new Executive Partner for the Rainbow Alliance.

3.3.6 Chaplaincy and Spiritual Care

The Chaplaincy team continue to support our staff and patients spiritual needs. Key religious festivals continue to be observed despite COVID-19, with additional advice and support was promoted during COVID-19, particularly with regards to those staff observing Ramadan and wanting to fast. Additional prayer spaces made available within the library wellbeing hub and prayer mats made available across sites, including Microbiology.

3.3.7 National Inclusive Leadership Project

The NHS England and Improvement (NHSEI) Leadership and Lifelong learning team are conducting a review to understand the needs (taking particular note of COVID) of our Leadership and Lifelong Learning (LLL) and Talent functions. In order to do that well, they are collecting information and data from lots of different sources and people and have asked Deeds and Words to work with NHS leaders from a range of backgrounds to articulate what it is like to be a leader in the NHS, what barriers exist to inclusion, and what leadership interventions might help change the picture.

WUTH were successful in a place on the project and as such, the D&I Lead has contributed to the findings. Outcomes and recommendations are expected soon.

4. Key Issues/Gaps in Assurance

i) **AIS implementation** –implementation of the standard have been delayed, however meetings have now taken place to review actions required and an action plan has been developed. It is hoped that further progress will soon be seen in this area
ii) A **review of D&I provision against EDS2** has not been completed this year due to COVID-19 implications and therefore this will take place within 2020/21
iii) **Equality analysis impact assessments** are not currently robust enough for all policies or completed for service improvement options. Further promotion of the importance of these and support to conduct will take place within the remainder of 2020/21.
iv) Whilst a number of positives can be seen from the recent **WDES report**, key issues identified are:
    a. Experiences for disabled staff are still lower than non-disabled colleagues
    b. A reduction in the number of disabled staff reporting bullying, harassment and abuse
    c. Incomplete data regarding the recruitment process, with particular reference to those who have been appointed. A backlog exists within the recruitment team therefore numbers are not fully accurate with regards to the number ad percentage of staff appointed
    d. Continued low self-reporting rates within ESR. Only 1.9% of staff have identified within ESR that they have a disability which impacts on the credibility of the data and ultimately, the identification of key areas of concern.
    e. Non-diverse board representation

v) Whilst a number of positives can also be seen from the recent **WRES report**, key issues identified are:
    a. Experiences for BAME staff are still lower than non-BAME colleagues
    b. BAME representation significantly higher within clinical staff than non-clinical and significantly higher within certain staff groups e.g. medical and dental staff
    c. Incomplete data regarding the recruitment process, with particular reference to those who have been appointed. A backlog exists within the recruitment team therefore numbers are not fully accurate with regards to the number and percentage of staff appointed

d. Non-diverse board representation

vi) Capacity to deliver the D&I agenda is already stretched and the implications of COVID-19, Black, Lives Matter, NHSE/I Inclusive Leadership Projects and the NHS People Plan 20/21 will require additional actions to be taken and therefore capacity to deliver, will need to be reviewed and prioritised.

vii) **Dedicated support for staff with disabilities –** more support is required to support staff with access to work applications and reasonable adjustments for example and therefore a Disability Adviser role has been included within the actions for consideration in our local People Plan. A funding application was submitted to a new WDES innovation fund to provide for short-term temporary support in this capacity, outcome is expected 27/11/2020.

viii) **Usage of services disaggregated against local population** – whilst workforce data has been included, this has not as yet been completed for service users. This will therefore be included within future reports.

5. Feedback Received / Recent Recognition

5.1 Staff Survey Data

As highlighted within previous update reports, the 2019 NHS Staff Survey results have seen positive feedback received across a number of themes. Diversity and Inclusion has remained the same score this year, remaining at 9.2, which is currently above the national average of 9.0 and just below the highest scoring Trust of 9.4.

The data identifies improvements in a number of areas including an overall reduction in levels of discrimination at work, an overall increase in staff feeling that the organisation acts fairly with regards to career progression / promotion regardless of protected characteristics and a significant increase in staff feeling that the employer has made adequate adjustment(s) to enable them to carry out their work. The overall result for this question (Q28b) shows an increase from 67.1% last year, to 73.9% this year and is now above the national average. This was an area of concern last year therefore progress made should be noted. There has been a significant decrease in discrimination due to age from 22.8% to 18.8% and is now in line with the national average.

Key improvement actions have been identified and included within the overarching diversity and inclusion action plan.

5.2 Navajo Merseyside & Cheshire LGBTIQA Chartermark Accreditation

Following a detailed application and ratification process, the Trust was awarded this prestigious chartermark for the first time. Assessors were impressed with the journey the Trust has been on, the efforts made to try and support LGBT+ staff and patients and the commitment shown. The Trust were presented with a certificate at their annual awards ceremony in May 2019.

Achievement of the Navajo Chartermark is due for review in 2021 and achievement of this is now expected from all Trusts within the Cheshire and Merseyside region.

5.3 Unsung Heroes Award

The Diversity and Inclusion Steering Group were delighted to win the national Unsung Heroes Award recently! The Trust was recognised for achieving a range of different initiatives and had inspired the judges with the progress so far.

Thanks are extended to all members for their support and contributions during and outside of meetings.

5.4 NHS England WDES Recognition

The Trust has been identified as a good practice employer with regards to the action planning undertaken for the first Workforce Disability Employment Standard (WDES) report. The Trust's action plan will be held up as an example of good practice within the region and featured in their first WDES national report.

6 Next Steps

1) D&I key priorities identified and KPI's developed
2) Progression of actions related to supporting staff with disabilities and long-term health conditions and BAME staff. Particular focus to be paid to
    a. Increasing the number of staff who self-report that they have a disability
    b. Ensuring stability within the newly established BAME staff network
3) Extended roll out of AIS
4) Review of D&I performance against the national Equality Delivery System
5) Promotion of equality analysis and impact assessments and additional support and review mechanisms considered.
6) Review of service usage disaggregated by protected characteristics and compared to the local population

7 Conclusion

The Trust has been working hard to ensure it shows due regard to eliminating bullying, harassment and victimisation however has been wanting to advance the agenda by working proactively to foster good relations and advance opportunities for all, with a specific focus on those who share a protected characteristic.

This report provides an overview on the variety of work undertaken within 2019/2020 to work towards improvements in these areas, whilst also providing assurance to the Trust on progress with reporting areas.

In summary, all required data uploads have been completed. Plans are in place to ensure continued compliance and development of key priorities.

8 Recommendations

1) Members to note the progress made to date
2) Members to note the Diversity and Inclusion Strategy Action Plan and identify and additional actions required to ensure progress in these areas
3) Trust to review D&I priorities and resource allocation to support the agenda and new action plan to be developed for 2021/2022
4) Members to consider opportunity for reverse mentoring

Wirral University Teaching Hospital NHS Foundation Trust

Diversity & Inclusion (D&I) Implementation Plan 2018-2022 – October 2020

This action plan has been developed on the back of legal, commissioning and Public Sector Equality Duty (PSED) requirements and will be monitored by the Trust's Workforce Steering Group and reviewed annually.

Objectives outlined in the action plan are aligned to the four Equality Delivery System (EDS2) Goals:

Goal 1 = Better Health Outcomes for All **Goal 2 = Improved Patient Access and Experience**
Goal 3 = A Representative and Supported Workforce **Goal 4 = Inclusive Leadership**

No.	Objective	Action	Lead	Deadline	RAG	Progress
1	Increase links with stakeholders and community organisations, holding engagement opportunities to share learning and gain further understanding of their needs.	i) WUTH to establish and host stakeholder engagement opportunities to annually review EDS2 goals ii) Identify new community organisations that the Trust is not yet linked to and ensure all are involved in corporate events and promotional opportunities e.g. WUTH to host a Living Library iii) Calendar of events to be drafted which supports national and international awareness days and ensure stakeholders are involved as appropriate iv) Promote all networking opportunities and events as and when they arise across a range of Trust wide communication mechanisms	D&I Lead D&I Lead D&I Lead All as necessary	i) 31 Dec 19 ii) 31 July 18 & ongoing iii) 31 July 18 iv) In place and Ongoing	Green	Member of the Wirral Community Advisory Group from and linked with Healthwatch Wirral, WIRED, Older Peoples Parliament, Mencap and various other community organisations. Feedback received from community to support EDS2 ratings. Calendar of events in place. Staff networking groups promoted across Trust. Attendance and recruitment stall at Pride parades in 2018 & 19. Variety of events held including Living library and Transgender, Intersex and non-binary conference with a variety of staff and community members involved. Patient and family Experience Group re-established Nov 18 and meeting regularly since. Attended various events and opportunities with Merseyside Fire and Rescue and Police. International Womens and Mens Day promoted with staff stories shared and mens health stand offered at CGH and APH. Various engagement opportunities held and shared via social media. Specific engagement undertaken to review Trust signage, with feedback sought from a range of service users inc visually / hearing impaired and those with a learning disability. Trust members asked for their involvement. Mencap Treat Me Well service user group meetings held with a number of actions identified and variety of events held in partnership with WUTH. Celebrated Chinese new year with local multicultural organisation and special menu's created for hospital restaurants. D&I webpages

						with community support links added. Regular Trust wide communications in place. Attendance at Merseyside Trans Advisory Group and contacts made to support the Trust moving forwards. New patient forums established, with the first one held to review OPD services and plans for a New LGBT+ patient forum moving forwards. Visits being undertaken to local community stakeholders e.g. linked to spiritual care, LGBT+, BAME Disability and mental health HWB events scheduled with community stakeholders and although postponed for 20 will be reconvened
2	Review the Trust's Equality Analysis (EA) process and ensure that all new and revised policies and service transformation plans fully consider equality issues	i) Launch EA Policy ii) Ensure EA Assessments are attached to Board and Committee papers as necessary **iii)** Annual audit of EA assessments and findings reported to WAC with any actions and progress made towards them iv) Equality Analysis Training to be offered to support staff understanding on requirements v) Six monthly review of Equality Analysis	D&I Lead	i) 31 May 18 ii) 31 May 18 iii) 30 Apr 19 and then annually iv) 31 May 20 v) 30 Sep 20	Amber	New EA Policy launched and processes streamlined with EA's now embedded with policy approval process and considered as part of the Trust wide consultation process. All Board and Committee papers include reference to completion of EA's however further recommendation submitted to ensure attachment of those completed. Presentation held at TMB Nov 18 and importance of completing EA stressed and form circulated to all members and asked to attach with future papers. Equality Analysis form now added to organisational change pro-forma and sent by HR colleagues to complete as part of the organisational change process. D&I Lead sought for advice and support as necessary. EA complete to consider workforce COVID-19 implications. New template developed to support divisional strategy planning, based on CCG and internal engagement. EA Training included within new Education Directory for 2020. Detailed review to be conducted within 20/21.
3	Implementation of the Accessible Information Standard (AIS)	i) Task and finish group established to ensure implementation ii) Accessible Information Policy ratified and launched iii) System functionality to be piloted and rolled out across the organisation iv) Communications plan to be developed and implemented to ensure education and development of staff v) Governance arrangements established to ensure robust and effective monitoring vi) Annual review of implementation	Head of Patient Experience	i) 31 July 18 ii) 30 Nov 18 iii) 30 Nov 18 iv) 31 Oct 18 v) 31 Mar 19 vi) 31 Mar 20 and then annually	Amber	Pop-up developed within Millennium and launched, however withdrawn due to service issues. New lead identified and group reconvened and regular meetings being undertaken. Phase 1 rolled out in OPD and Elective surgery and currently under review and further actions before extended roll out. New policy in draft and comms launched with training to staff within the initial areas affected. Ongoing steering group meetings in place to review actions still required. Video prepared for use with elearning programme. Browsealoud software added to Trust website for enhanced accessibility for staff and patients. Added to the risk register. Steering group meeting reconvened for October 2020 to ensure actions are in place to move forwards.

4	Review the effectiveness of the Trusts interpretation and translation services	i) Review and audit of the Interpretation and translation services to be undertaken and action plan developed to improve	Head of Patient Experience	i) 30 Nov 18 and then annually	Green	Review completed and contract with previous provider ceased and new contract agreed with DA languages with effect from 5 October 2020. Ongoing reviews will continue.
5	Review patient feedback processes so as to ensure greater levels of consistency and effective monitoring	i) Task and finish group to be established to review actions required ii) New process identified and ratified iii) Communication plan to ensure awareness for all staff iv) Monitor and review effectiveness of new process v) Ensure demographical data is captured for complaints, disaggregated by protected characteristic	Head of Patient Experience	i) 30 Nov 18 ii) 31 Dec 18 iii) 31 Dec 18 iv) 30 Jun 19 and then annually v) 30 Sep 20	Amber	Patient complaints process reviewed and improvements seen. Demographical data reports not currently produced however IT support being sought to ensure completion. Data being prepared on complaints received should be disaggregated by protected characteristics and will be included within future annual reports. New complaints and compliments leaflet produced and Patient and family experience re-established. New feedback kiosks introduced. Fabio Frog feedback mechanism developed for childrens services
6	Ensure all staff are trained at the level appropriate to their role	i) Ensure 90% completion rate of Level 1 equality and diversity / diversity and inclusion training ii) Develop equality analysis support session for staff in policy development / review or management of organisational change / service improvement within their work area	D&I Lead	i) 31 Aug 20 and then annually ii) 31 Mar 20	Green	Compliance level for mandatory level 1 achieved. Compliance at 96% as at 30 Sep 20. E-learning programme and face to face sessions delivered for hard to reach staff and new workbook also developed Transgender, intersex and non-binary conference and awareness sessions held with publicity received in the local press and excellent feedback gained. Diversity session included on recruitment and selection masterclass and integrated within new Effective Manager programme. Leadership Masterclass held on Inclusive Leadership and plans in place to ensure Inclusive leadership is embedded as a golden thread within all leadership programmes. Equality analysis support session developed and promoted via new education directory.
7	Link in with local and national initiatives to enhance further development and support for staff	i) Secure places on and promote NHS Leadership “Stepping Up” and “Ready Now” development programmes for BME staff ii) Promotion of Trust sign up to Disability Confident Scheme and identify actions required to advance the agenda and progress to the next level iii) Review feasibility of Royal College of Nursing (RCN) Cultural Ambassador training to support protected characteristic groups	D&I Lead / OD Team	i) 31 Mar 19 ii) 31 Oct 18 iii) 31 Aug 18 iv) Ongoing	Green	1 Colleague completed the “Ready Now” NHS leadership academy programme with 1 colleague completing the Florence Nightingale Windrush Programme for bands 5-7 BAME nurses. “Stepping Up” and “Ready Now” programmes advertised with some interest shown and further dates circulated July 19. North West Stepping UP programme developed and promoted across the Trust. Cultural Ambassador programme discussed internally and agreement to pursue, however has been placed on hold by the RCN until 2020. New BAME staff network group launched Dec for NHS Wirral and extended to West Cheshire. Following review, agreement to separate and proceed with individual Trust network groups and host an

		iv) Identify and promote any other development opportunities that support development of WUTH staff v) Work towards achievement of Navajo Chartermark Accreditation highlighting a positive way forward for LGBT+ staff				annual event with the wider localities. Springboard Leadership Programme for Women commenced September 2019 and Navigator mens programme to commence in Mar 20. LGBT+ and disability mentoring programme launched Feb 19. Local CPD opportunities explored and offered to staff. Navajo LGBT+ Chartermark accreditation achieved on 17 May 19. Trust signed up to the Disability Confident scheme and currently at level 1 – committed employer. Disability Confident Manager Guide promoted across the Trust to support staff with a disability or long-term health condition. Action on Disability Task and Finish group commenced October 2019 to ensure key priorities were progressed. Disability wellbeing event scheduled for 17 March 2020, although postponed will be reconvened in 2021 NHS rainbow pin badge scheme launched in Sep 2019 and approx. 1600 staff pledged support so far. WUTH now a member of the new NHS North West Dyslexia network and development of screening tool for staff. Signed up for the Hidden Disabilities Sunflower Initiative, that seeks to identify and offer additional support to those with invisible/hidden disabilities. Roll out plan underway.
8	Review recruitment processes to ensure adhering to equality legislation and principles of Disability Confident Employer Scheme	i) Identify recruitment data for 2018/19 by protected characteristic and identify any actions needed to improve ii) Implement new recruitment system so as to further improve reporting processes and data provision by protected characteristic iii) Review link with recruitment processes to ensure those with disabilities or long-term health conditions are appropriately identified and supported with reasonable adjustments if necessary	Head of HR & Wellbeing Service	i) 31 Jul 19 and then annually ii) 31 Jul 19 iii) 30 Apr 20	Green	New TRAC system introduced on 1 Sep 18 and first report received and data review underway. Initial focus on data to support WRES and WDES but further data to be included within the next annual report. Vacancy information discussed with recruitment and content reviewed with a reference to D&I. New recruitment Co-ordinator in place to monitor recruitment events and opportunities and processes. D&I slot being undertaken on Recruitment training and within effective managers programme. New Trust wide recruitment campaign launched with an initial focus on Band 5 nurses and includes representation from those who share a protected characteristic. Diversity and Inclusion statement sent to recruitment co-ordinator to include within adverts, along with access to work information. New Action on Disability Steering Group established to focus attention on key priorities and new disability pack for staff to be developed. Review of recruitment processes and documentation to ensure effective links are made and any reasonable

						adjustments identified. Meeting held with recruitment lead and new promotional statements to be included within adverts and process to be introduced to ensure more effective identification of reasonable adjustment requirements.
9	Improve D&I monitoring processes so as to provide a clearer picture as to the demographics of our workforce and service users so as to more effectively monitor any trends or issues	i) Implementation of communication plan for ESR Self Service roll out to support staff in registering with ESR and promoting the updating of personal information ii) Trust-wide messages to emphasise importance of updating personal information iii) Consider additional options to directly target staff not yet registered or updated personal information iv) Ensure monitoring processes are in place for key HROD activities such as grievance and disciplinary processes to capture numbers of staff affected by protected characteristics v) Review usage of services, benchmarked against local population and disaggregated by protected characteristic vi) Ensure completion of Equality Delivery System (EDS2) annually including public grading	ESR team D&I Lead / ESR team Head of HR / D&I Lead Head of Patient Experience / D&I Lead	i) With immediate effect ii) As i) iii) 30 Sep 18 iv) 30 Sep 18 v) 31 Jul 18 vi) 31 Mar 19 and annually	Green	Trust wide messages cascaded and drop in sessions to support staff are in place. Data collated for staff and patients and disaggregated by protected characteristic and compared to local community data via NHS Measuring Up Report. Included in annual report for 2017/18 and 2018/19 report. Further improvements and analysis can be made to further understand ways to improve. Monitoring data for disciplinary and grievance cases disaggregated by protected characteristic included on workforce dashboard from Sep 18. Trust comms undertaken to highlight importance of updating personal information. EDS2 internal grading completed and reviewed at TMB March 2019 - External review with feedback received at Wirral CAG and in discussion with healthwatch. Healthwatch user group to be used for future assessments Questionnaire developed to offer support to staff in centrally updating disability status
10	Develop staff network groups to offer additional opportunities for staff within certain protected characteristics to share their views	i) Establish D&I Steering Group ii) Undertake BME focus group prior to establishing NHS Wirral shared staff network group iii) Establish an LGBT+ staff network group iv) Establish a Disability staff network group v) Consider options available for network groups / discussion forums for religion or belief	D&I Lead / Head of Chaplaincy and Spiritual Care	i) 30 Jun 18 ii) 31 Jul 18 iii) 31 Jul 18 iv) 31 Jul 18 v) 30 Nov 18	Green	LGBT+ staff network group launched. Disability staff network group launched. NHS Wirral BAME focus group held and posters dispatched and new staff network launched in Dec. Staff network met monthly however work undertaken with new local D&I Leads to rotate meetings, unsuccessfully. Agreement reached to have Trust specific networks and work to be undertaken to establish WUTH's own. WUTH BAME staff network re-established June 2020. D&I Steering Group established and linked in to WAC and links made with Chaplaincy and spiritual care team. Attendance from their team at induction. MacMillan staff forum and cancer café in place. Chaplaincy and spiritual care focus group promoted and discussions held with individuals to progress. Multi-faith staff forum advertised and conversations held

						with interested individuals Photography project completed for celebration within National Inclusion week (28 Sep) and the sharing of staff experiences.
11	Ensure internal and external links are made with D&I leads, lead specialists and community organisations so as to keep updated, share practice and support key initiatives	i) Regular attendance at appropriate regional and national meetings ii) Regular contacts / meetings with NHS Wirral D&I colleagues and shared approaches taken where appropriate iii) Ensure links made with staffside colleagues for all areas iv) Ensure links made with Chaplaincy and Spiritual Care team to ensure provision and support accessible for staff and patients	D&I Lead	All) In place and ongoing	Green	In place and ongoing. Part of regional meetings, NHS Employers Diversity Partner for 2018/19 and again for 2019/20. Feedback received from NHS Employers highlighted WUTH as one of the most improved Trusts in the year – externally verified. Member of local Wirral community advisory group. Attended Staff side meeting and in regular contact with Staff side leads for D&I. Sharing opportunities from staff side as they arise. Wirral Diversity Collaboration commenced and will continue on a regular basis. Trusts planning to link up for local LGBT+ events and BAME staff network. Member of the NHS North West Dyslexia Forum and now a member of the Merseyside CCG EDS2 working group. Member of Merseyside CCG D&I Collaborative group to review and discuss best practice. D&I Lead part of a national Inclusive Leadership project to support NHS Trusts in the future identification and support of Inclusive Leaders.
12	Ensure key data submission requirements are completed on time, with supporting reports and action plans completed with areas identified for improvement	i) Annual gender pay gap data submission, report and action plan ii) Annual workforce race equality standard (WRES) submission, report and action plan iii) Preparations made for workforce disability equality standard (WDES) launching in 2019 with annual submissions, reports and actions plans thereafter iv) Annual report of Diversity and Inclusion activities	D&I Lead	i) 6 April 2019 ii)28 Sep 18 iii)Ongoing iv)Completed for 2018	Green	Annual reports completed for all, with the exception of the 2020 Gender Pay Gap report which is now scheduled to be reported by 30/03/21 at the latest. All reports are accessible via the public section of the D&I Trust webpages.
13	Support access to services for vulnerable groups	i) Ensure engagement takes place with community organisations and patient representatives so as to better understand patient needs ii) Ensure reasonable adjustments are made to support access to services and improve patient outcomes and experience iii) Work towards achievement of Navajo Chartermark Accreditation and support for LGBT+ community	D&I Lead to collate and review current processes	i)In place and ongoing ii)In place and ongoing	Green	Engagement with community to improve catering menus, hospital access and treatment for those with Learning disabilities and in reviewing Trust signage. Wirral Community Advisory Group held on site with CCG and local community Trusts to be present as with local community and public sector organisations. Navajo LGBT+ Chartermark Accreditation achieved (May 19). 4 further work placements undertaken by participants on the Princes Trust programme and awards ceremony supported by WUTH. 2 Traineeships offered to young persons with autism and working well. Support

						provided to new partially sighted student nurse commencing placement and access to work promoted for those commencing work. Disability Confident line managers guide promoted and support to managers. Attendance Management Policies reviewed. New patient food menu launched Jan 19 with a variety of food and cutlery options available. Browsealoud software added to Trust website to enable enhanced access to Trust webpages for low literacy, visual and auditory impairments and for those where English is not their first language. Cultural celebrations recognised e.g. Chinese New Year and canteen food offered in support. Transgender awareness sessions being rolled out across the Trust along with Landmark Transgender awareness raising conference held on site on 12 July and local press publicised. Deaf Awareness sessions held. PFEG group re-established Nov 18 and includes reps from various community organisations. Reps identified for a new Merseyside Polish speaking Forum and first meeting attended (Oct 19). Links made with Wirral Change and meeting to be held with DoW, DoN and Medical Director as to how best to support our BAME community.

Appendix 2 – Workforce Demographic Information as at 31 March 2020

Workforce Composition (data as at 31 March 2020)

Understanding the workforce composition by equality and diversity demographics is important in order to ensure that we are a fair and open organisation and to monitor the effectiveness of our policies and procedures.

There has been an increase in the workforce numbers from 6187 staff last year to 6258 this year.

Sex / Gender

79.8% of the WUTH workforce is female and 20.2% is male. The numbers therefore reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts.

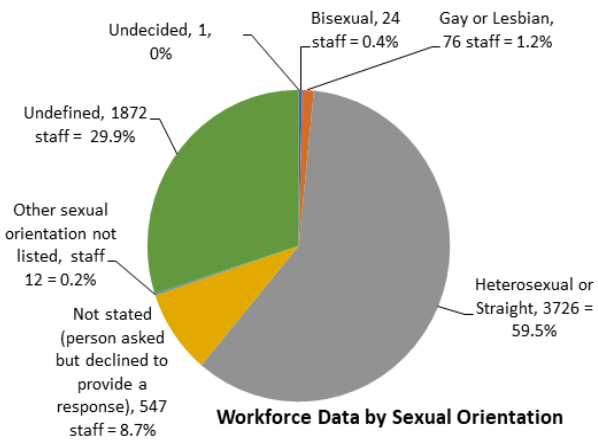
Gender Reassignment

ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed. A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area. The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

Sexual Orientation

Workforce data highlighting the sexual orientation of staff as at 31 March 2020 is:

Sexual Orientation	
	No. of staff
Bisexual	24
Gay or lesbian	76
Heterosexual	3726
I do not wish to disclose my sexual orientation	547
Other	12
blank (unspecified)	1872
Undecided	1
Grand Total	6258



Sexual Orientation Data Comparison with Community Demographics		
	Workforce	**Region:North West**
Gay / Lesbian / Bisexual	1.44%	1.66%
Heterosexual / straight	59.54%	94.89%
Unknown	29.91%	3.45%

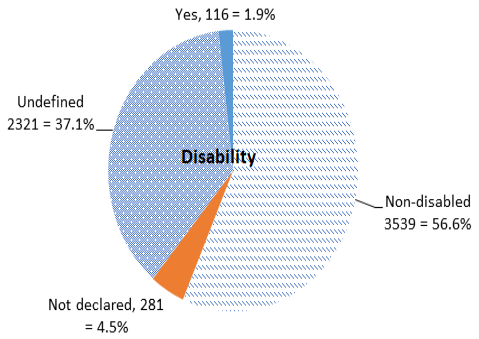
Appendix 2 – Workforce Demographic Information as at 31 March 2020

Disability

As at the 31st March 2020, the self-reporting rate for those staff with a disability within WUTH is 1.9%.

A total of 116 staff have identified they have a disability, with 77 staff in a clinical role and 39 staff in a non-clinical role.

Breakdown of workforce data by disability status

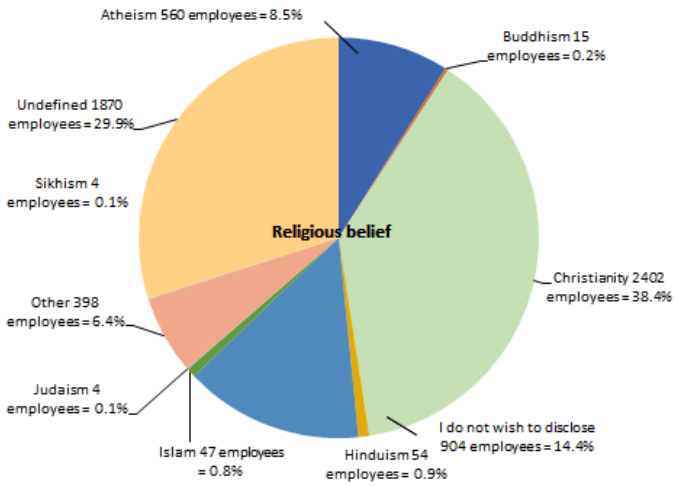


	Total Clinical Staff	% of Clinical	Total Non-Clinical Staff	% of non-clinical	Combined	% overall
Disabled	77	1.8	39	1.9	116	1.9
Non-disabled	2543	60.5	996	48.4	3539	56.6
Not declared	172	4.1	109	5.3	281	4.5
Prefer not to answer	1	0.0	0	0.0	1	0.0
Unspecified	1409	33.5	912	44.4	2321	37.1
TOTAL	4202	100.0	2056	100.0	6258	100.0

Religious Belief

Workforce data highlighting the religious beliefs of staff as at 31 March 2020 is:

Religious belief	
	No. of staff
Atheism	560
Buddhism	15
Christianity	2402
Hinduism	54
I do not wish to disclose my religion/belief	904
Islam	47
Judaism	4
Other	398
Sikhism	4
Undefined	1870
Grand Total	6258



Appendix 2 – Workforce Demographic Information as at 31 March 2020

Breakdown of workforce by religious belief, compared to community demographics:

Religious belief				
	Workforce	LA: Wirral	STP: Cheshire & Merseyside	Region:North West
Atheism / Not religious	8.95%	21.33%	19.08%	19.82%
Buddhism	0.24%	0.28%	0.26%	0.29%
Christianity	38.38%	70.41%	72.54%	67.25%
Hinduism	0.86%	0.23%	0.32%	0.54%
Islam	0.75%	0.57%	1.07%	5.05%
Judaism	0.06%	0.08%	0.17%	0.43%
Other	6.34%	0.26%	0.24%	0.27%
Sikhism	0.06%	0.07%	0.08%	0.13%
Unknown	29.88%	6.77%	6.24%	6.20%

Race / Ethnicity

Breakdown of workforce by ethnicity, compared to community demographics:

Ethnicity				
	Workforce	LA: Wirral	STP: Cheshire & Merseyside	Region:North West
White - British (inc English, Scottish & Cornish)	88.88%	94.97%	92.81%	87.08%
White - Irish	0.69%	0.83%	0.83%	0.92%
White Traveller / Gypsy / Irish Traveller	0.02%	0.02%	0.05%	0.06%
White - other	1.64%	1.17%	1.85%	2.15%
Mixed - White & Black Caribbean	0.11%	0.30%	0.40%	0.56%
Mixed - White & Black African	0.16%	0.17%	0.26%	0.26%
Mixed - White & Asian	0.13%	0.30%	0.33%	0.43%
Mixed - Any other mixed background	0.25%	0.25%	0.30%	0.32%
Asian or Asian British - Indian	3.17%	0.42%	0.56%	1.52%
Asian or Asian British - Pakistani	0.38%	0.07%	0.21%	2.69%
Asian or Asian British - Bangladeshi	0.06%	0.27%	0.15%	0.65%
Asian / Asian British: Chinese	0.29%	0.52%	0.61%	0.68%
Asian or Asian British - Any other Asian background	1.16%	0.33%	0.40%	0.66%
Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean	0.54%	0.18%	0.61%	1.17%
Any other Black African / Caribbean	0.08%	0.04%	0.13%	0.22%
Arab	0.00%	0.07%	0.30%	0.35%
Any Other	0.85%	0.10%	0.20%	0.28%

Appendix 2 – Workforce Demographic Information as at 31 March 2020

The full workforce breakdown for ethnicity is:

Row Labels	Count of Employee Number
A White - British	5562
B White - Irish	43
C White - Any other White background	80
C3 White Unspecified	3
CA White English	2
CD White Cornish	1
CK White Italian	2
CL White Irish Traveller	1
CP White Polish	6
CU White Croatian	2
CV White Serbian	1
CX White Mixed	2
CY White Other European	7
D Mixed - White & Black Caribbean	7
E Mixed - White & Black African	10
F Mixed - White & Asian	8
G Mixed - Any other mixed background	12
GA Mixed - Black & Asian	1
GD Mixed - Chinese & White	1
GE Mixed - Asian & Chinese	1
GF Mixed - Other/Unspecified	1
H Asian or Asian British - Indian	199
J Asian or Asian British - Pakistani	24
K Asian or Asian British - Bangladeshi	4
L Asian or Asian British - Any other Asian background	41
LA Asian Mixed	6
LE Asian Sri Lankan	2
LG Asian Sinhalese	1
LH Asian British	2
LK Asian Unspecified	10
M Black or Black British - Caribbean	2
N Black or Black British - African	32
P Black or Black British - Any other Black background	2
PC Black Nigerian	3
R Chinese	18
S Any Other Ethnic Group	34
SC Filipino	11
SE Other Specified	20
Z Not Stated	92
(blank)	2
Grand Total	**6258**

Age

Breakdown of workforce by Age

Age Band	No. of staff	% of workforce
<=20 Years	36	0.58
21-25	428	6.84
26-30	673	10.75
31-35	703	11.23
36-40	755	12.06
41-45	701	11.20
46-50	770	12.30
51-55	785	12.54
56-60	811	12.96
61-65	459	7.33
66-70	108	1.73
>=71 Years	29	0.46
Total	6258	100

Community demographic breakdown by age		
	LA: Wirral	Region:North West
Under 25	12.99%	14.99%
25-29	6.89%	8.15%
30-34	6.57%	7.50%
35-39	7.36%	7.86%
40-44	8.72%	8.99%
45-49	9.35%	9.12%
50-54	8.60%	8.12%
55-59	7.78%	7.15%
60-64	8.35%	7.68%
65-69	6.54%	5.98%
70+	16.86%	14.47%

Appendix 3 – Workforce Disability Equality Standards (WDES) Report

Appendix 4 – Workforce Race Equality Standards (WRES) Report

Board of Directors	
Agenda Item	20-21/203
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	2nd December 2020
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

PROGRAMME SUMMARY

1. Overview

At the Programme Board of 18th November 2020 the members received a presentation on the report into the 'Review of Bed Bureau' and an item on the progress of the 'Planned Care Control Centre'. Members again received full update presentations on the priority programmes of Outpatients, Flow and Theatres. The Programme Board also received the assurance evidence and that evidence (coupled with attendance at most programme meetings) forms the basis of this assurance report to the Board of Directors. The scope of the programme **(slide 2)** is shown as the version that will apply from January 2021 and includes a broader scope including: 'Productivity & Efficiency' (CIP) and 'Quality Improvement' initiatives.

PROGRAMME STATUS

In terms of the overall ratings assessments **(see slides 3 and 4)**, there has been slight improvement, compared to October, in the governance evidence relating to the portfolio and further progress is required. The delivery ratings have also seen a modest improvement. Further action should be taken to continue this trend to improve upon delivery of the planned changes.

Given the handover - this month - of the assurance role from external to internal action, a prospective picture of the December ratings position is also appended **(to slides 3 and 4)** to show the effect of the Programme Board closing the 'Workforce' programme; the notes also indicate those actions most likely to have a positive effect on the assurance position for December 2020.

1.1. Governance Ratings

For November, six of the ten 'live' programmes were green rated for governance, with three attracting an amber rating, and one was red rated; this is 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.

Provisional (indicative) ratings for December, showing the 'Workforce' programme closed, improve the position. The three amber ratings should turn green dependent upon: 1. 'Outpatients' QIA being signed off; 2. 'Electronic Booking Form' PID being agreed; and 3. 'Flow' targets and trajectories being set (what is the work aiming to improve, how much, by when).

1.2. Delivery Ratings

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

Provisional (indicative) ratings for December, showing the 'Workforce' programme closed, improve the position. The two remaining red ratings should turn (at least) amber dependent upon: 1. 'Flow' seeing evidence of positive movement against defined targets and trajectories; 2. The 'Electronic Booking Form' project improving adherence to delivery milestones.

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 Outpatients. The metrics for the Outpatients project are shown at **slides 6 and 7**.
2.2 Flow. The metrics for the Flow project are shown at **slides 8 to 11**.
2.3 Perioperative. The metrics for the Perioperative project are shown at **slides 12 to 15.**

At the Programme Board of 18th November 2020, it was agreed that programme teams would continue to provide a brief statement (on the slides) to give context and commentary on these metrics for the priority programmes.

ASSURANCE

3. Programme Assurance - Ratings

The attached assurance report has been undertaken by External Programme Assurance and provides a detailed oversight of assurance ratings per programme / 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 was presented at the Programme Board meeting - the membership of which includes a non-executive director - held on Wednesday 18th November 2020.

4. Assurance Focus

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

The first two pages (slides 17 and 18) of the Change Programme Assurance Report provide a summary of each of the three Priority Projects and highlights key issues and progress.

5. Recommendations

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

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

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Change Programme Summary

External Programme Assurance
November 2020

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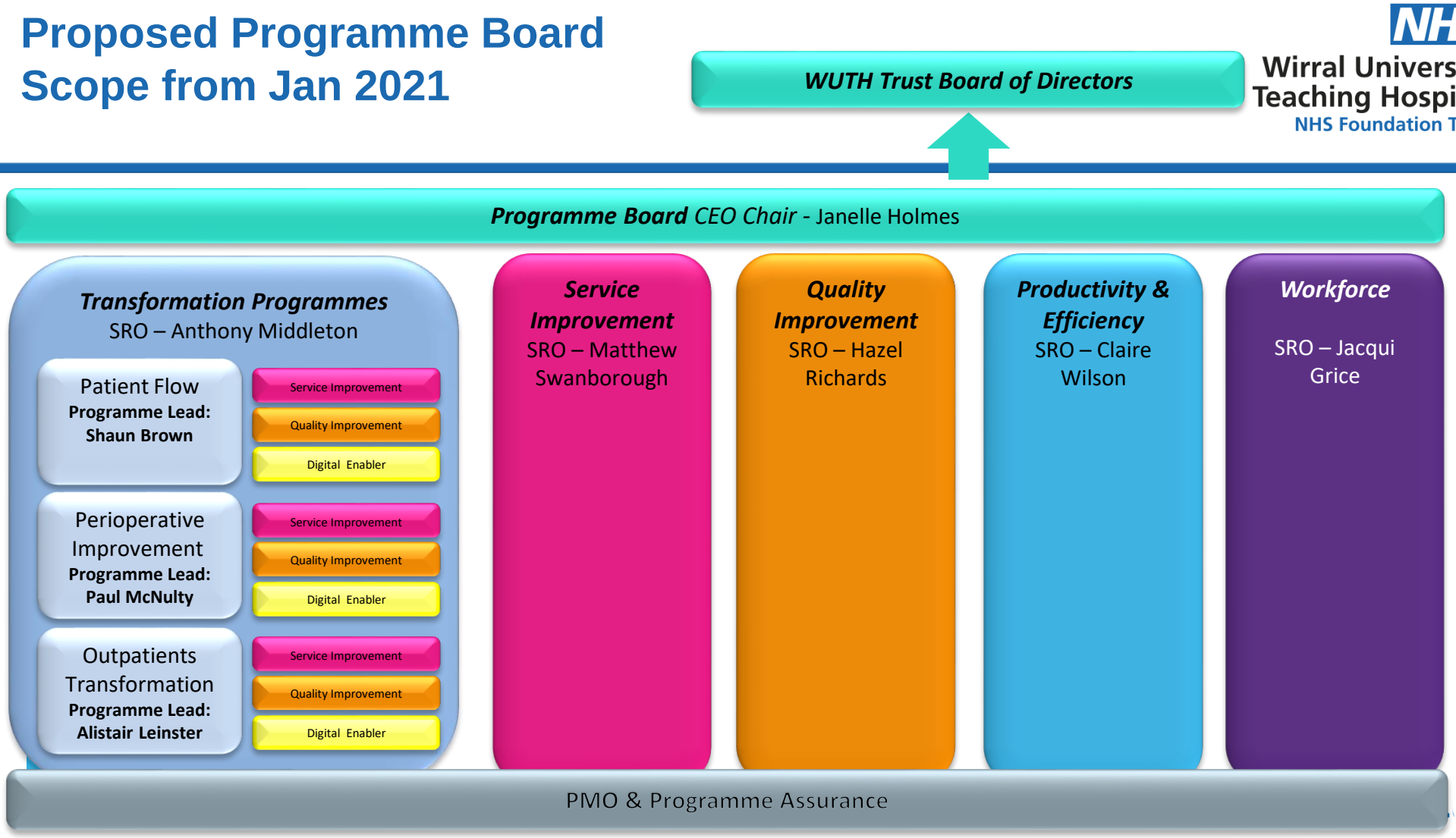
Proposed Programme Board Scope from Jan 2021



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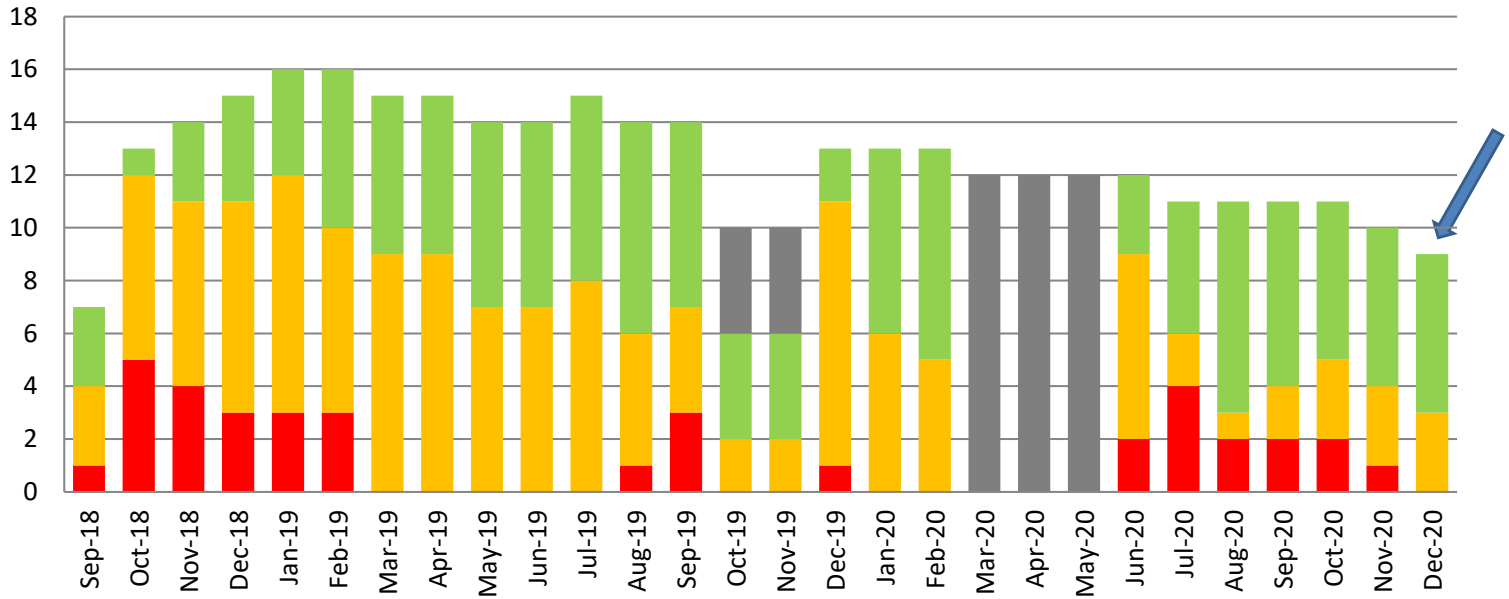
Change Programme Assurance Report - Trust Board Report - November 2020

J Gibson – External Assurance

Wirral University Teaching Hospital
NHS Foundation Trust

Assurance - Governance ratings



Note: provisional ratings for **December 2020** showing 'Workforce' prog. closed. The three amber ratings should turn green **dependent upon: 1.** 'Outpatients' QIA being signed off . **2.** 'EBF' PID being agreed. **3.** 'Flow' targets and trajectories being set.

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Change Programme Assurance Report - Trust Board Report - November 2020

J Gibson – External Assurance

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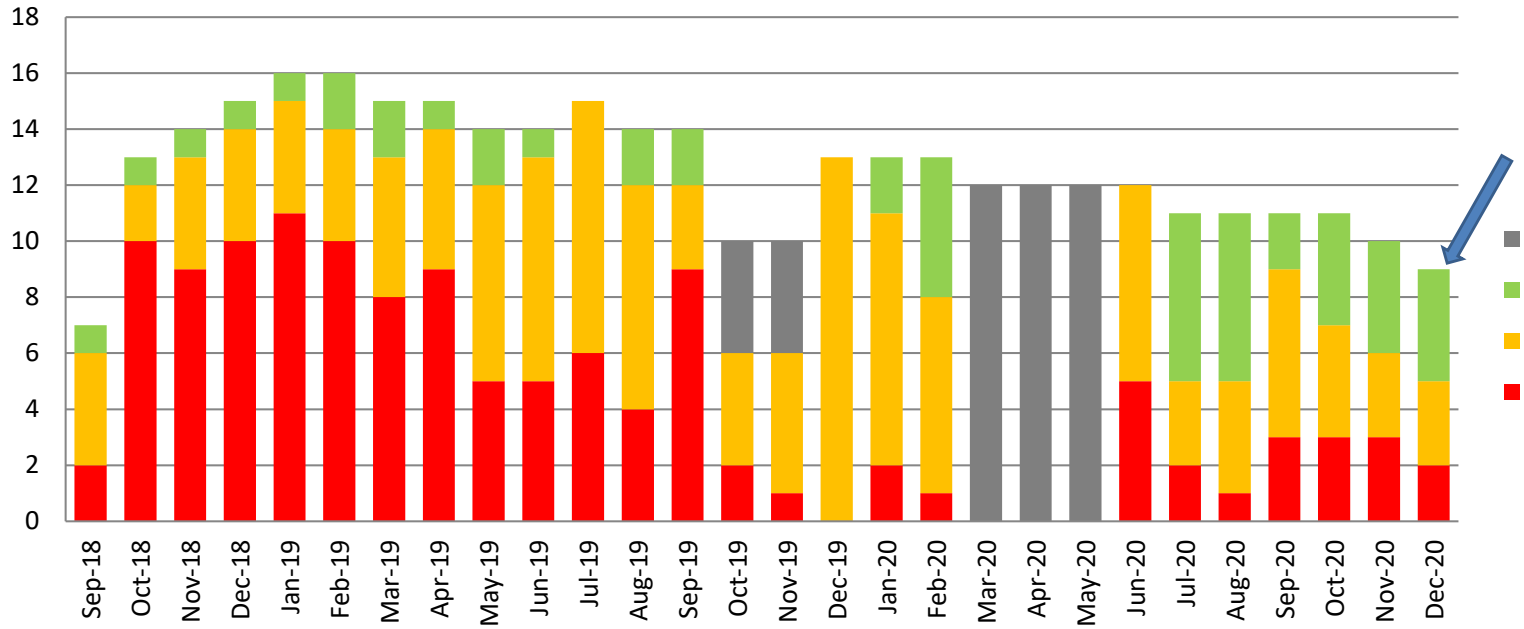
Assurance - Delivery ratings



Note: provisional ratings for **December 2020** showing 'Workforce' prog. closed. The two red ratings should turn amber **dependent upon: 1.** 'Flow' defining improvement trajectories and seeing +ve movement. **2.** The 'EBF' project improving adherence to delivery milestones.

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Priority Projects Metrics

Programme Board 18 Nov 20

Senior Responsible Owners

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Outpatient Consultations at WUTH

All Divisions

Wirral University Teaching Hospital
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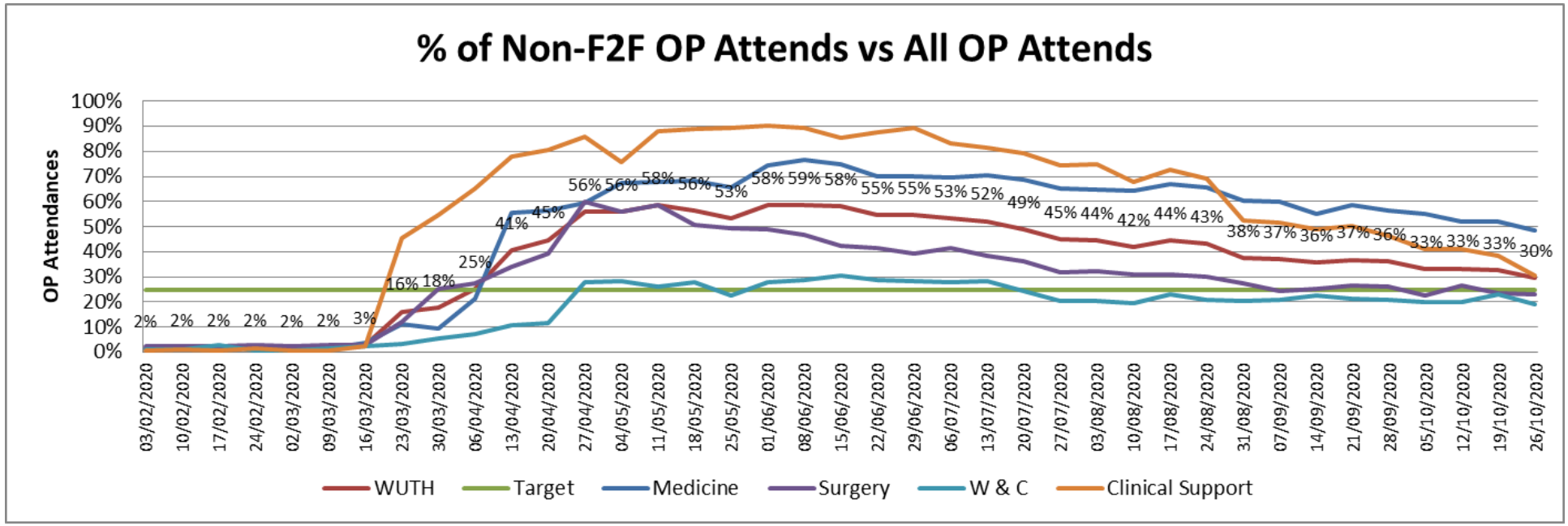

Data labels show overall WUTH % performance

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Non-F2F % by Division – October 2020

Wirral University Teaching Hospital NHS Foundation Trust

October	Total (New & Follow-up) Appointments Non-F2F		
Division	NHSE Target	C & M	Actual Activity Levels
Medicine & Acute	25%	28%	52%
Surgery			28%
Women & Children's			20%
Clinical Support			40%
Trust Total			**33%**

October	Follow Up Appointments Non-F2F		
Division	NHSE Target	C & M	Actual Activity Levels
Medicine & Acute	60%	30%	55%
Surgery			19%
Women & Children's			19%
Clinical Support			40%
Trust Total			**31%**

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Narrative

- Overall performance has reduced to 33% - however this is still tracking above the NHSE target of 25% and the C&M Regional Benchmark of 28%
- Non F2F Follow-up activity has reduced to 31% - this is not delivering against the NHSE target of 60%. This is tracking above the C&M Regional Benchmark of 30%
- Volumes of Non-F2F peaked in June & July at an average of approximately 15,800 and have reduced August – October to an average of 13,000

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Flow KPIs

Wirral University Teaching Hospital
NHS Foundation Trust

	ID	Description	Reporting Period	Period Target	Oct-20	Sep-20	Aug-20		YTD Target	YTD Performance	YTD Variance
		Flow Steering Group Reporting Meeting - Nov -2020									
	Patient Flow										
	1	Bed Occupancy	Oct-20	93%	85.4%	86.4%	85.2%		93%	81.8%	-11.2%
	2	Time spent in A&E (Minutes)	Oct-20	240	246	221	189		192	182	-10
	3	Average current in-patient LOS (Closed Spells)	Oct-20	7.1	5.32	4.48	4.13		7.1	4.93	-2.2
			Weekly Snapshot	Target	27/10/20	20/10/20	13/10/20		06/10/20	29/09/20	22/09/20
	4	Total Number of Long Stay Patients - >=21 days	27/10/2020	52	95	103	95		95	92	86

Narrative

1. Bed Occupancy stable at 85%.

2. Time spent in A&E increased by 25 mins compared to Sept. position. Partially attributable to covid related admission delays.

3. LOS within target at 5.32.

4. Long stay patients decreased from previous month to 95 although above target of 52. 95 long stay patients includes neuro, rehab & sub acute beds at CBH. (Target set during covid when 20 sub acute beds at CBH were closed and elective services were not operating).

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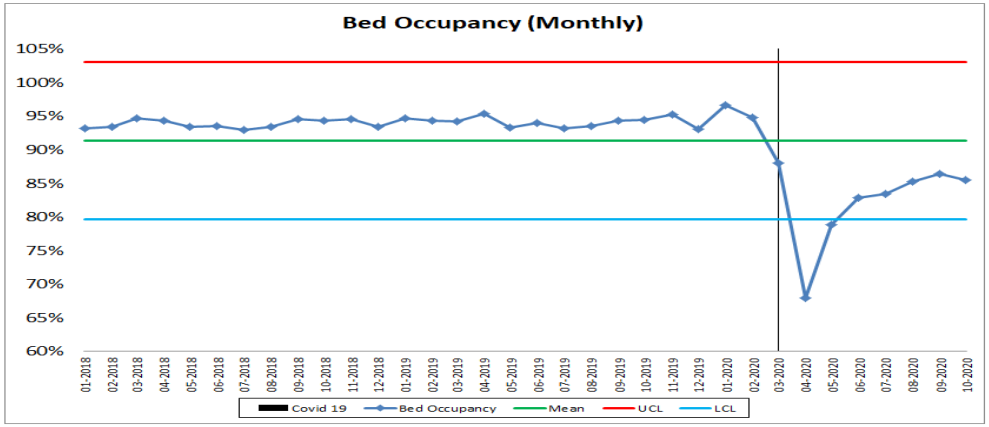
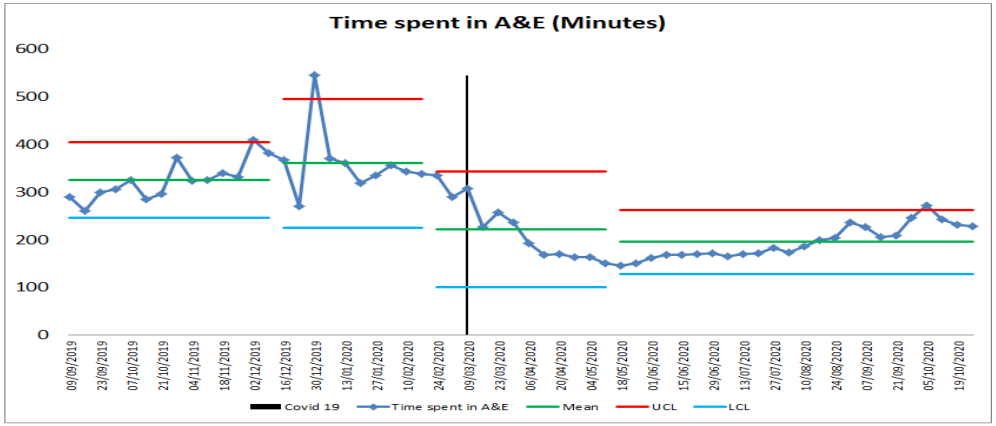
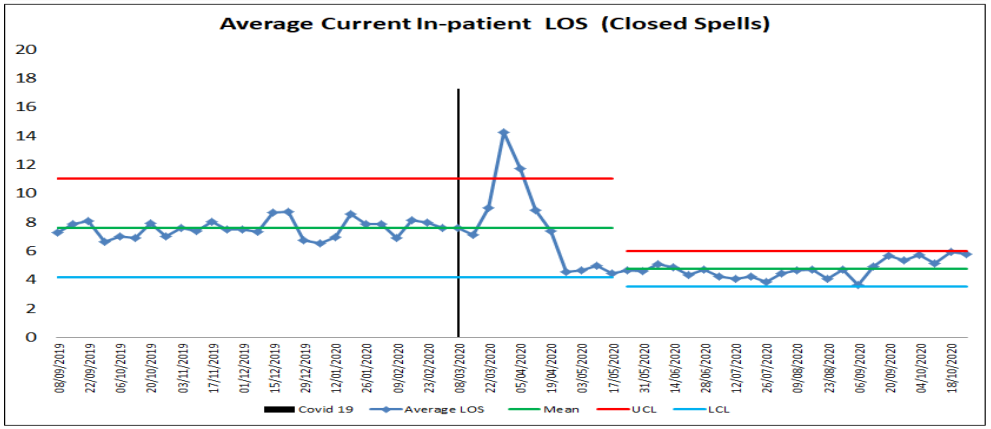
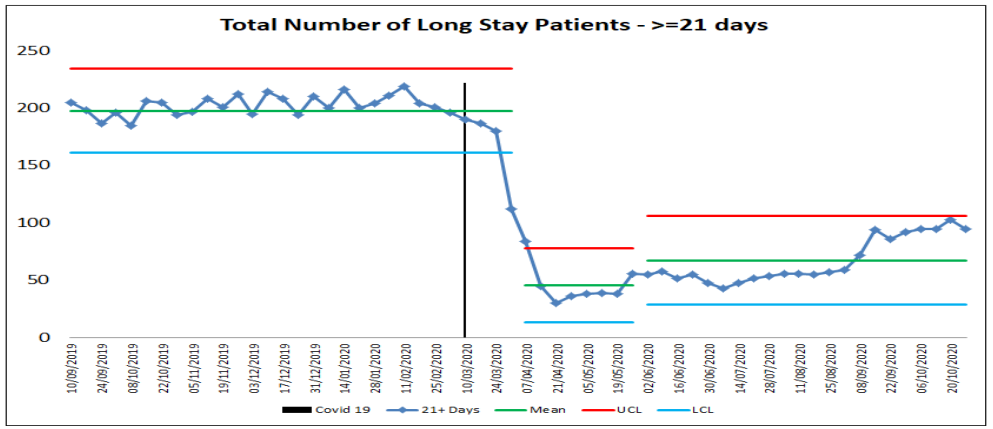
Flow KPIs

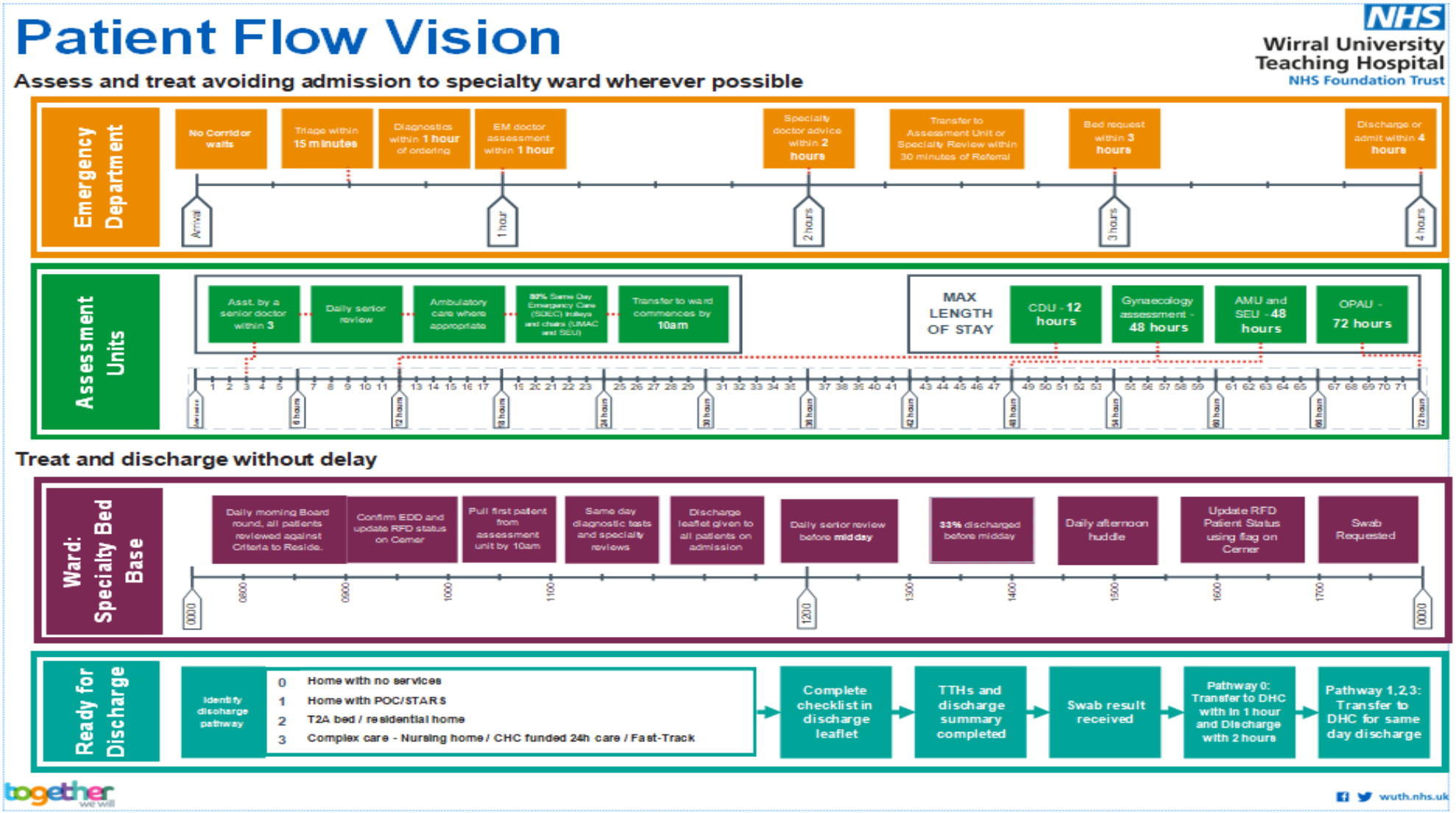
Wirral University Teaching Hospital
NHS Foundation Trust










Patient Flow Vision
Assess and treat avoiding admission to specialty ward wherever possible
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NHS Foundation Trust
Emergency Department
No Corridor waits
Triage within 15 minutes
Diagnostics within 1 hour of ordering
EM doctor assessment within 1 hour
Specialty doctor advice within 2 hours
Transfer to Assessment Unit or Specialty Review within 30 minutes of Referral
Bed request within 3 hours
Discharge or admit within 4 hours
Arrival
1 hour
2 hours
3 hours
4 hours
Assessment Units
Asst. by a senior doctor within 3
Daily senior review
Ambulatory care where appropriate
80% Same Day Emergency Care (SDEC) trolleys and chairs (UMAC and SEU)
Transfer to ward commences by 10am
MAX LENGTH OF STAY
CDU - 12 hours
Gynaecology assessment - 48 hours
AMU and SEU - 48 hours
OPAU - 72 hours
Treat and discharge without delay
Ward: Specialty Bed Base
Daily morning Board round, all patients reviewed against Criteria to Reside.
Confirm EDD and update RFD status on Cerner
Pull first patient from assessment unit by 10am
Same day diagnostic tests and specialty reviews
Discharge leaflet given to all patients on admission
Daily senior review before midday
33% discharged before midday
Daily afternoon huddle
Update RFD Patient Status using flag on Cerner
Swab Requested
0000
0800
0900
1000
1100
1200
1300
1400
1500
1600
1700
0000
Ready for Discharge
Identify discharge pathway
0 Home with no services
1 Home with POC/STARS
2 T2A bed / residential home
3 Complex care - Nursing home / CHC funded 24h care / Fast-Track
Complete checklist in discharge leaflet
TTHs and discharge summary completed
Swab result received
Pathway 0: Transfer to DHC with in 1 hour and Discharge with 2 hours
Pathway 1,2,3: Transfer to DHC for same day discharge
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Patient Flow Dashboard October 2020

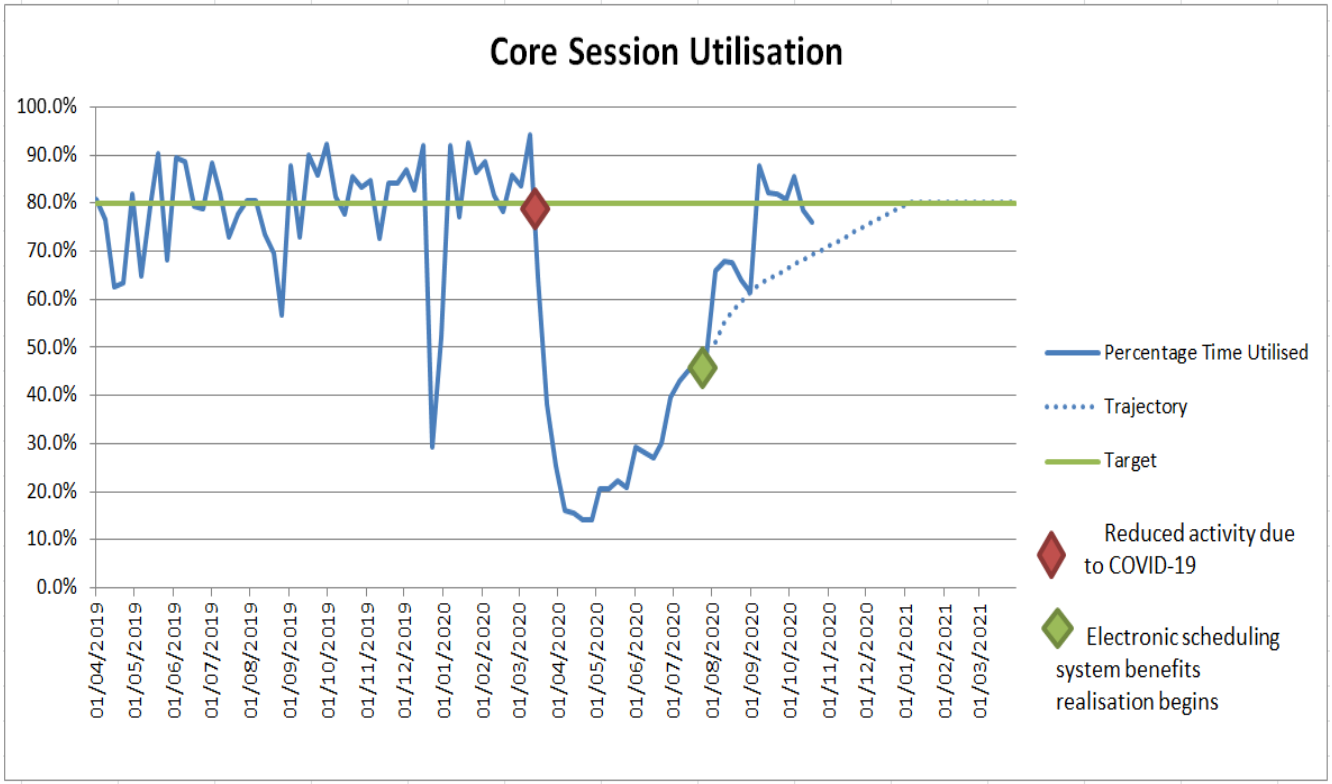
Output: Performance measure will show Compliance / number achieved (Numerator) / Cohort applicable to measure (Denominator)

Category	KPI ID	Key Performance Indicators	Target	Trend Rating	Month RAG	Compliance Trend	Measurement	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Programme KPI's	1	**Bed occupancy %**	93%	H			Occupancy %	67.9%	78.8%	82.8%	83.4%	85.2%	86.4%	86.4%
	2	**Average time spent in ED (arrival to admission or discharge)**	240 mins	H			Attendances	4329	5899	6441	7222	7726	7108	6743
							Average Mins In ED	184	153	167	172	189	221	246
	3	**Average inpatient length of stay (Mean average - discharged spells)** **Patient flow wards only*	7.1 days	H			Completed Spells	2027	2621	2812	3172	3323	3132	3208
							Mean Average	6.9	4.7	4.7	4.1	4.5	5.3	5.7
	4	**Number of long stay patients 21 day+** *(Latest validated snapshot in the month)*	52	H			Number of Patients	36	56	48	54	57	92	95
Emergency Department	5	**Number of ambulance patients waiting on a corridor**	0	H			Number of Patients	21	28	20	42	140	323	484
	6	**30-60 minute ambulance handover delays**	tbc				30-60 mins Handovers	125	75	75	68	77	126	159
							All handovers	1676	2117	2176	2346	2227	1945	1851
							% between 30-60 mins	7%	4%	3%	3%	3%	6%	9%
	7	**60+ minute ambulance handover delays**	tbc				60+ mins Handovers	6	6	1	8	16	36	96
							All handovers	1676	2117	2176	2346	2227	1945	1851
							% between over 60 mins	0.4%	0.3%	0.0%	0.3%	0.7%	2%	5%
	8	**Patients receiving ED triage within 15 mins**	95%	L			Within 15 Mins	3127	4566	4665	5147	5044	4567	4336
							Patients triaged	4171	5693	6064	6592	7052	7041	6682
							Target Compliance %	75%	80%	77%	78%	72%	65%	65%
	9	**Patients seen by an ED doctor within 60 mins**	95%	L			Within 60 mins	3488	4331	4262	4122	3911	3271	3566
							Patients seen by Dr	4117	5584	6049	6759	6750	6622	6308
							Target Compliance %	85%	78%	70%	61%	58%	49%	57%
	10	**Diagnostic orders completed within 60 mins (Bloods, CT, X-ray, MRI)**	95%				Completed within 60 mins	5917	6458	6772	7148	7107	6815	7015
							Diagnostics completed	7033	7638	7891	8543	8613	8456	8679
							Target Compliance %	84%	85%	86%	84%	83%	81%	81%
	11	**ED bed requests made within 180 mins**	95%	L			Within 180 mins	1193	1662	1609	1471	1405	1206	1264
							Beds requested	1781	2274	2455	2615	2802	2594	2586
							Target Compliance %	67%	73%	66%	56%	50%	46%	49%
	13	**Patients leaving ED within 4hrs (National Standard)**	95%	L			Completed Within 4hrs	3652	5477	5705	6429	5810	5244	4537
							Total Attendances	4350	5934	6477	7268	7197	7142	6773
							Target compliance %	84%	92%	88%	88%	81%	73%	67%
Assessment Units	14	**Patients assessed by senior doctor in assessment unit within 3 hours**	95%				Senior revew within 3 Hours	460	609	599	856	1047	895	698
							Total senior reviews	505	710	826	1226	1340	1119	927
							Target Compliance %	91%	86%	73%	70%	78%	80%	75%
	15	**Same day discharges in an ambulatory setting (trolleys and chairs only)**	80%				Same day discharges	211	327	311	402	403	394	403
							Total discharges	481	699	691	834	845	827	870
							Target Compliance %	44%	47%	45%	48%	48%	48%	46%
	16	**Patient length of stay within assessment unit target (AMU, SEU, GAU = 48hrs OPAU = 72hrs CDU = 12hrs)**	95%				Target LoS Achieved	827	1335	1624	2153	2293	1864	1578
							Total transfers/discharges	959	1492	1803	2372	2533	2113	1924
							Target compliance %	86%	89%	90%	91%	91%	88%	82%
Ward	17	**Patients receiving speciality triage in assessment Unit transferred to base ward within 60 minutes**	tbc	L			Base ward by 10am	42	70	72	53	66	39	23
							Total base ward transfers	474	684	803	1014	1176	1009	840
							Target Compliance %	9%	10%	9%	5%	6%	4%	3%
	20	**Time of the day achieving 33% discharges**	12 noon				Time of Day	14:15	14:47	14:53	14:32	14:25	14:26	14:42
	21	**Number of long stay patients 7-13 days** *(Latest validated snapshot in the month)*	140	L			Number of Patients	97	120	110	122	145	139	134
	22	**Number of long stay patients 14-21 days** *(Latest validated snapshot in the month)*	55	H			Number of Patients	39	48	38	42	52	67	67
Discharge	23	**Number of patients not meeting criteria to reside** *(Latest validated Wednesday snapshot in the month) *Criteria change Oct 2020*	0	H			Numer of patients ready for Discharge (RFD)	5	2	6	5	4	9	60
	24	**Pathway 0; time between RFD to discharge**	60 minutes (Tolerance % tbc)				Within 60 mins							
							Total pathway discharges							
							Target Compliance %							
	25	**Pathway 1,2,3; time between RFD to discharge**	24 hours (Tolerance % tbc)				Within 24 Hours							
							Total pathway discharges							
							Target compliance %							
Enablers	26	**CAPMAN: Patients leaving ED (admitted) within 30 mins of ED bed request**	30 mins - tbc	L			Leaving within 30 mins	534	1011	1030	1095	1033	754	685
							All bed requests	1642	2148	2323	2453	2619	2376	2361
							Compliance %	33%	47%	44%	45%	39%	32%	29%
	27	**CAPMAN: Bed reservations occupied within 25 mins of becoming available (Assessment wards only)**	25 mins - tbc				Occupied within 25 mins	68	369	414	503	534	432	380
							All bed reservations	130	662	810	1123	1290	1117	931
							Compliance %	52%	56%	51%	45%	41%	39%	41%
	28	**CAPMAN: Number of beds turned around from dirty to clean within 30 minutes**	30 mins - tbc				Turnaround within 30 minutes	3653	4834	5094	6160	6141	6058	5708
							All Dirty to Clean turnarounds	9397	10610	10136	11480	11377	11836	11721
							Compliance %	39%	46%	50%	54%	54%	51%	49%

KPIs/Benefits
Core Session Utilisation

Wirral University Teaching Hospital
NHS Foundation Trust

- The service aims to run a minimum of 80% of all available scheduled theatre sessions.
- Despite the negative impact of COVID on core session utilisation, the chart shows a significant improvement in performance highlighting continuous improvement week on week.
- With the interventions of locking down sessions at 6 weeks (supported by the electronic scheduling system), and the Theatres Resource group, the service can offer a quicker recovery.
- Despite a slight drop towards the end of October due to half term, performance is still ahead of trajectory and the focus continues to be on sustaining this performance ahead of the forecasted trajectory.



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KPIs/Benefits
In-session Utilisation

Wirral University Teaching Hospital
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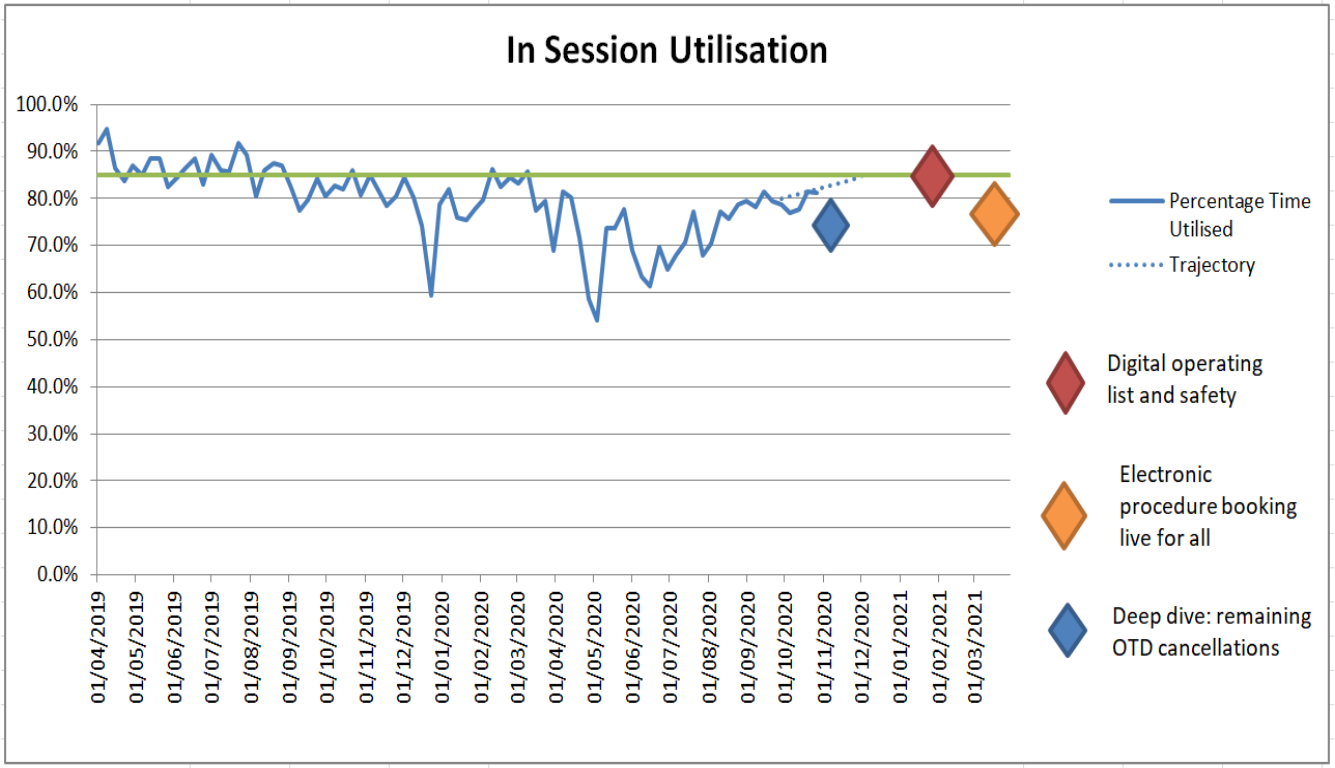
- The service aims to use a minimum of 85% of available time within all sessions.
- This chart shows the impact of the restart and recovery work to date in bringing levels back up to normal levels and then which of the improvement projects will improve and sustain utilisation levels over the coming year.
- The chart shows utilisation is on target against the trajectory.



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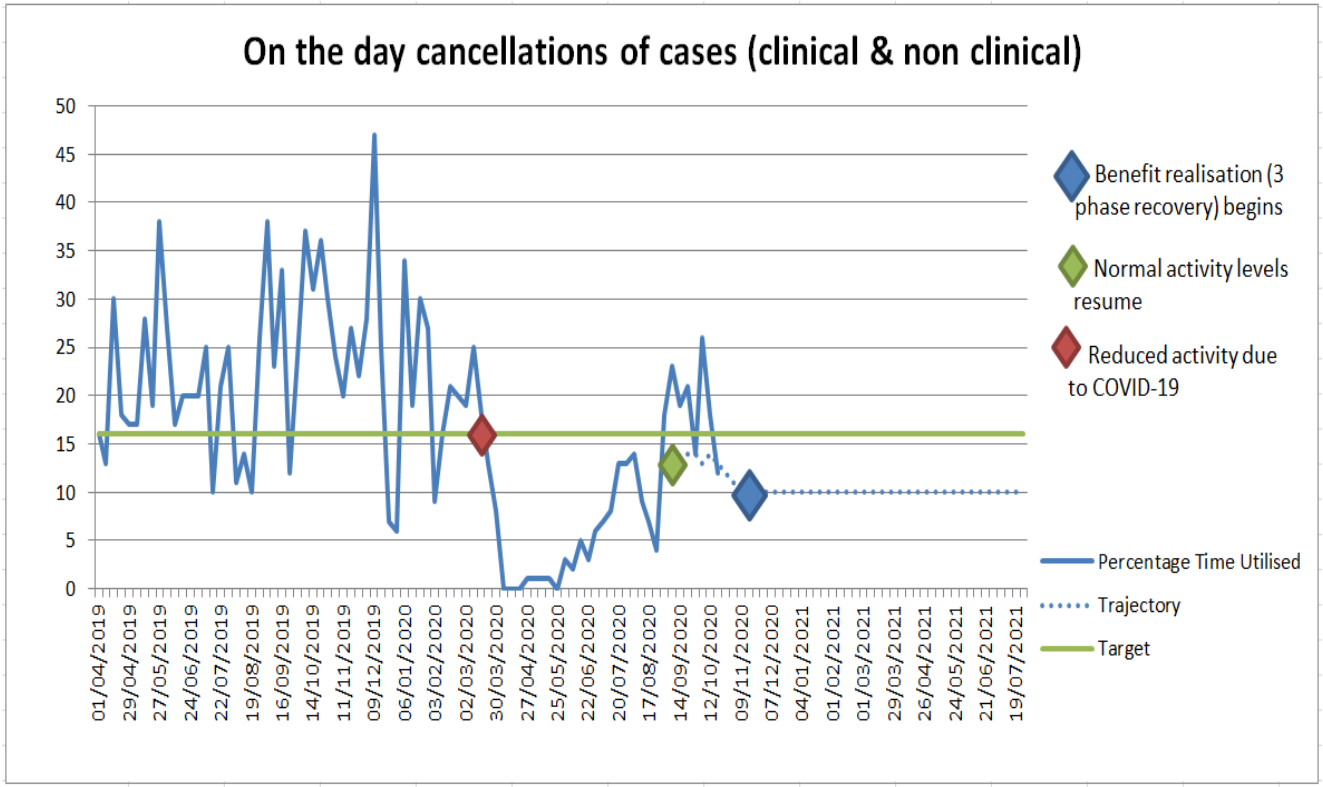
KPIs/Benefits
On the day Cancellations of cases

Wirral University Teaching Hospital
NHS Foundation Trust

- The reduction in planned activity due to COVID brought cancellations down, but as activity levels increase, we are seeing a corresponding or proportionate increase in cancellations.
- This chart shows some variation in performance last month, with 2 out of the 4 weeks performance being above the trajectory. Overall there has been a 12% reduction in OTDC compared with September.
- OTDC rapid improvement project aims to improve the quality of data recording for on the day cancellations and support real-time reporting.
- The more sustainable impact on cancellations will come from the three phase recovery unit being fully operational, in December 2020.



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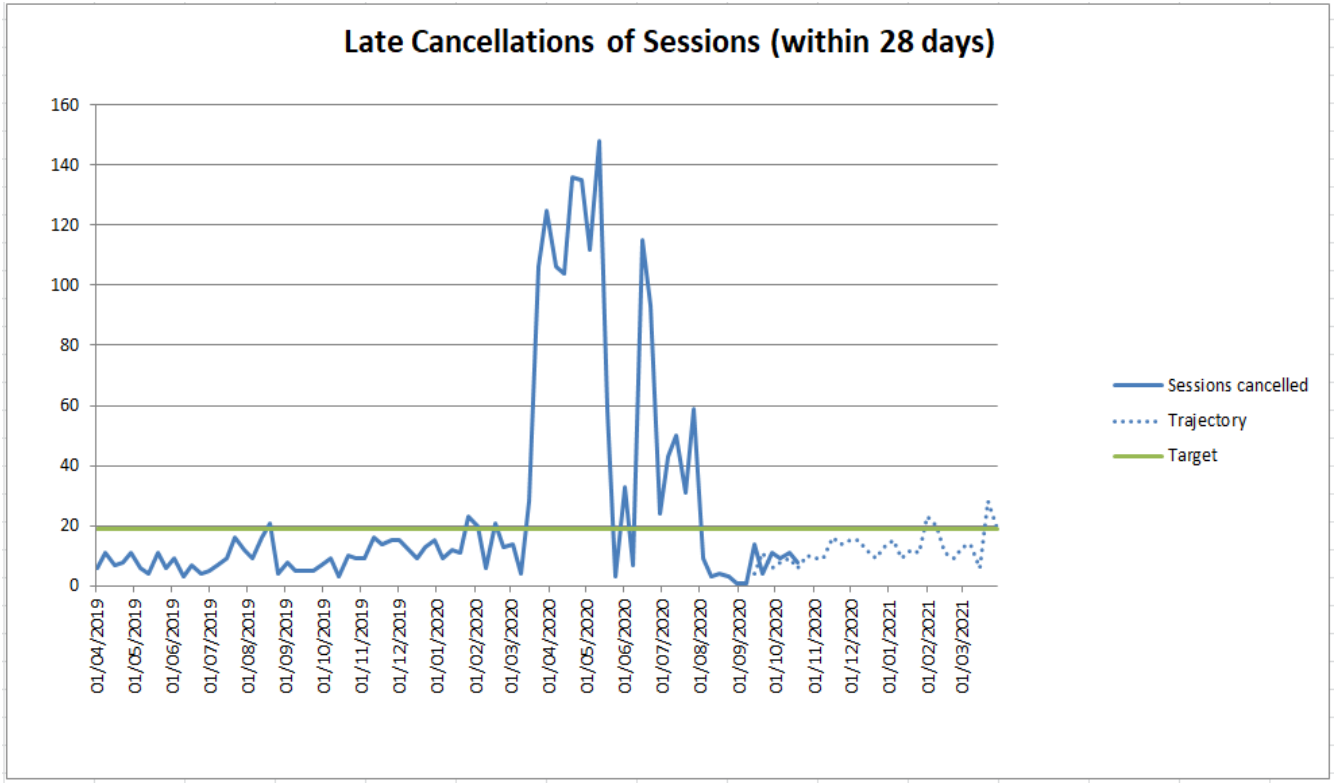
KPIs/Benefits
Late Notice Cancellations (within 28 days)

Wirral University Teaching Hospital
NHS Foundation Trust

- The reduction in planned activity due to COVID has increased cancellations but, as activity levels increase, we are seeing a corresponding or proportionate increase of late cancellations, which will be levelled off as improvements are introduced.
- As the theatre sessions are confirmed at a six week lock down (greater than 28 days), this is driving down the number of cancelations within 28 days.



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Programme Assurance Ratings

Joe Gibson
18 November 2020

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Change Programme Assurance Report -
Trust Board Report - November 2020 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Amber	Delivery	Red

- The key '21day + LoS' metric for the Flow Programme was reported at the end of October as 95 Long Stay Patients against the target of 52. A revised 'Flow Dashboard' was presented to Programme Board in November 2020.
- The programme is now in a position to consider what its aims are in terms of measurable improvement in the objectives (targets) on the dashboard within a specified period of time. The accuracy of the 'Capacity Management' system, launched 9 March 2020 - last reported as delivering a 93%-94% accurate picture of the Trust position in July/August - should form part of these goals.
- **A plan should be prepared to demonstrate how the defined improvements in flow - for the benefit of staff and patients - will be attained, and sustained, over a defined time period. Progress against this plan – what will improve, how much, by when - can then be tracked by those accountable for both delivery and assurance.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Green

- The revised PID v0.5 dated 4 Mar 20, as approved by the Programme Board - including an extensive schedule of benefits and measures - remains extant. The programme has devised revised trajectories and these are now being monitored for evidence of the planned improvements.
- **The KPIs declared by the programme, as agreed by the Programme Board, continue to show the positive impact of the changes the programme is driving.**

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Change Programme Assurance Report -
Trust Board Report - November 2020 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Amber	Delivery	Amber

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

- **Overall Progress:** The overall % use of non-F2F options has continued to move down to 33% in October (39%-35% during September). Setting this in context, as the programme reports: the Trust has attained the national 'overall' **25%** Non-F2F target in October at **33%;** the **60%** 'follow-up' non-F2F target was not achieved, reported at **31%. A QIA/EA has been prepared, and awaits signature, to underpin quality assurance.**

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

- **Targets resolved: As agreed at the Programme Board, 18 November 2020, the programme targets for overall delivery by remote means have been confirmed using a comprehensive bottom-up approach of analysis and validation of exceptions with Divisions. The programme lead states:**
  - The Trust (33%) is comfortably achieving the NHSE target (25%) for total appointments Non-F2F%, i.e. New + FU attendances. No intervention is needed and this figure will continue to be monitored for assurance.
  - The Trust (31%) is not achieving the NHSE target (60%) for total Follow Up Appointments Non-F2F%. To address this, an action plan and trajectory will be put in place to achieve: 45% by Mid-February 2021 (what the predicted level was based on Divisional Submissions June 2020) and 60% by end of May 2021 (NHSE target for follow up appointments Non F2F).

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

together we will

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Workforce Planning - Programme Assurance Update – 12 November 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Ann Lucas	Joe Roberts	Design	Red	Red

Independent Assurance Statement

1. Project Mandate and PID (v1.0 dated 17 Oct 19) uploaded 6 Nov 19 with benefits described; however, the metrics for measurement of benefits are yet to be defined. **2. & 3.** There are revised ToRs of the 'Workforce Planning Group' with minutes of a meeting to 28 Feb 20 and an update to the WAC on 21 Jan 20. **4.** There is some evidence of continuing stakeholder engagement (including e-mail exchanges on divisional priorities during Feb 20), a 'Communications Plan' and engagement with other Trusts - the plan will need to be tracked. **5.** EA/QIA were last signed off in May 2019 and are now considered beyond their normal annual review date. **6.** A 'draft' project plan has been tracked to w/c 16 Mar 20 and this shows that several important tasks from Nov 19 - Jul 20 are not completed. **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; however, the benefits profile in the PID has been revised (with metrics to be finalised). **8 & 9.** There is a revised risk register which shows evidence of updates to Dec 19; however, the 'date of last review' column needs to be completed. **Most recent assurance evidence submitted 16 Mar 20.**

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

Improving Flow - Programme Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The 'Vision for Patient Flow' v1 is uploaded to PM3. 'Scope' is the 'Project Initiation Document for Patient Flow' (undated) CPO Ref: 1048 that was presented at the Prog. Steering Group 9 Nov 20 and contains 22 objectives to be achieved. Further work is still needed to define the programme, particularly what change will be delivered in what timescales. **2. & 3.** A revised ToR is needed for the 'Flow Steering Group'. Action Tracker available up to meeting of 3 Nov 20. **4.** Evidence is required of stakeholder engagement as well as a comms plan. **5.** It is not clear whether there will be a single QIA for the 'combined' Flow programme (or the status of previous QIAs). **6. P**roject plan(s) now hosted on PM3. Two projects closed: 'ED One Patient Record' and 'PDSA SEU Pull from ED'. Three projects are open: 'Discharge' due to complete 30 Oct (now 27 Nov); '111 First' on 18 Dec and 'Ward Improvement II' due 16 Nov 20. The programme PID, once complete, should allow these plans to be evaluated against programme objectives and timescales. **7.** The Flow dashboard (9 of 22 objectives rated: 7 red, 1 amber, 1 green) was presented to FSG and PSG (Nov 20) and will be presented to Prog. Board; achievement of objectives is rated as red. **8. & 9.** There are no programme risks (last updated 22 Oct 20) and 5 issues (last updated between 23 Oct and 5 Nov). **Most recent assurance evidence submitted 9 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Service Improvement Programmes - Improving Patient Flow														
2.1	**Patient Flow**	Improving the flow of Urgent Care patients by providing the right care, first time, by referring the patient to the right place, first time. 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. Reduce patients length of stay in acute hospital beds by early identification of patients able to be discharged through transfer to assess home and bed based pathways. 'Better Sooner, Home Faster' - Board Rounds & Huddles; Discharge Pathways; Electronic Fastrack; Therapy Led Discharge; Optimising Discharge.	Anthony Middleton											

RAPID IMPROVEMENT PROJECT: 111 First- Project Assurance Update – 12 November 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	John Foley	Jane Hayes-Green	Design	Green	Green

Independent Assurance Statement

1. A 'Lean Canvas' slide defines the 'Rapid Improvement Project Implementation of NHS 111 First' (version number, date and author are needed on the slide). **2.** The project team is clearly defined and comprehensive record of meetings, to 3 Nov 20, and action log are in evidence. **6.** The PM3 milestone tracker shows nine actions completed, one amber rated and the remaining three actions green rated for delivery. **7.** There are National '111 Sitrep' metrics and 'ED Sitrep' metrics. The '111 First Local Metrics' are in draft form (uploaded 2 Nov 20) and include 6 benefits and 4 control measures. **8&9.** There are four open risks and these were last updated 4-5 Nov 20. There are four open issues and these were last updated 4-5 Nov 20. **Most recent assurance evidence submitted 9 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Service Improvement Programmes - Improving Patient Flow														
2.1a	**111 First (Rapid Improvement Project)**	There is a national mandate to implement 11 First by 24th Nov 2020. Implement bookable slots in ED. Identify one in hospital alternative service suitable for direct booking. Set up services and create operational pathways.	Anthony Middleton											

Perioperative Medicine Improvement – Programme Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The revised PID v0.5 dated 4 Mar 20 was signed-off by the Proj. Steering Group (and is updated by the Oct 20 'Scope' slide). The Exception Report and Re-start Plan (post-COVID Wave 1) was approved by the Prog. Board in June 2020. **2.** As well as the Steering Group, there is also a 'Patient Safety and Experience Project Group' and an 'Operational Excellence Project Group'. **3.** The Perioperative Steering Group has ToRs revised in Jan 20 and there is evidence of meetings up to 10 Nov 20. **4.** There is a Comms Plan, 19 Feb 20, supplemented by a Comms tracker updated to 9 Nov 20; evidence of Comms deliverables was also uploaded as supporting evidence. **5.** The renewed QIA has been prepared and awaits sign off. **6.** The PM3 programme plan is broadly on track, the exception being a 2 week delay in the 'On the Day Cancellations' project (delays in the EBF project are assurance RAG rated separately for that project line). **7.** The 'Benefits Tracking Tool' shows 10 metrics with 9 currently on track (albeit 'actual' data entry starts in Dec 20 for most of these) while other metrics are in development for delivery in: Mar 21 (4 metrics), May 21 (1 metric) and Sep 21 (4 metrics). Revised KPI trajectories were agreed at the Programme Board on 16 Sep 20. **8 & 9.** PM3 is showing 3 open risks, last reviewed 4-5 Nov 20, and 4 open issues, last reviewed on 4-5 Nov 20. **Most recent assurance evidence submitted 10 Nov 20.**

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

DIGITAL ENABLEMENT: Theatre Scheduling - Project Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The Theatre Scheduling PID v1.0 Final (v3 dated 27 Feb 20) approved by the Perioperative Steering Group on 28 Jul 20. **2.** There is evidence of a 'Theatre Scheduling System' Action Log last updated to 16 Oct 20. **6.** The Theatre Scheduling project plan has now been uploaded to PM3; it shows that 'post-implementation enhancements' will be completed by 30 Nov 20 and project closure is planned for 31 Dec 20. **8 & 9.** The PM3 risk register for the project shows 1 risk that was last reviewed on 4 Nov 20 and 2 issues last reviewed on 4 Nov 20. **Most recent assurance evidence submitted 4 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Service Improvement Programmes - Perioperative														
3.1a	**Theatre Scheduling** (Digital Enablement - Perioperative Care)	The objective of this project is to implement informatics developments to support operational changes and help streamline and improve theatre processes from pre-op through to recovery and discharge.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Booking Form- Project Assurance Update – 12 November 2020

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Lynn Tarpey	Implementation	Amber	Red

Independent Assurance Statement

1. The DRAFT PID, CPO 1091, (undated but) uploaded 10 Nov 20, defines the project and will be considered for approval at the next Steering Group. **2.** The PID has details of the project team membership. There is a record of team meetings with an action tracker up to 21 Oct 20. **6.** The milestone plan on PM3 states that the 'T&O Catalogue' went live on 14 Aug 20 (6 weeks over original milestone). Looking ahead, the 'Breast Service Catalogue' is now due to go live on 28 Nov 20 (12 weeks past the original milestone), the 'EBF Solution' is due to go live on 4 Dec 20 (9 weeks beyond the original milestone) and the Urology solution is due on 30 Jan 21 (12 weeks past original milestone); the governance page has red rated the 'Breast Services' due to delays. The closure date for the Project on PM3 is now 30 Jun 21. **8&9.** There is 1 risk raised on PM3 last updated on 4 Nov 20. There are 3 issues logged and they were last updated on 4 Nov 20. **Most recent assurance evidence submitted 10 Nov 20.**

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

Outpatients Improvement - Programme Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The PID v3.0 was agreed by Outpatients (3 Aug 20) and Programme Steering Groups (10 Aug 20). The key benefit, defined therein as '50% of Outpatient Consultations to be converted to Non-face to face (Telephone or Video)', needs re-visiting. **2.&3.** Project Team ToR v2.0, authorised 10 Jun 20, with evidence of meetings to 3 Nov 20 and an Action Log (2 of the 9 open actions are overdue). **4.** The 'Outpatients Comms Plan', last updated 10 Jun 20, is being replaced by each work-stream/rapid improvement project delivering a comms plan. **5.** The revised Draft QIA/EA, now uploaded to PM3, is prepared but still awaits sign-off at clinical executive level. **6.** The project programme milestones are now uploaded to PM3 and attract an amber rating due to some element of delay across the projects. **7.** The KPI data for October (reported at PSG 9 Nov 20) shows the Trust exceeding, at 33%, the national 25% Non-F2F target for Total appts but not achieving, at 31%, the national 60% Non-F2F target for Follow-Up appts. Both KPI results have been trending lower from mid-June 2020. **8 and 9.** On PM3, at programme level, there are 13 risks, all have been updated in the period 3-6 Nov 20. There is 1 live issue updated on 4 Nov 20. **Most recent assurance evidence submitted 9 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Service Improvement Programmes - Outpatients														
3.2	**Outpatients Improvement**	1. Data quality for planned procedures would be improved as new booking forms have additional procedures and information resulting in better quality of patient information in the EPR	Anthony Middleton											

RAPID IMPROVEMENT PROJECT: Electronic Referral Triage - Project Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The project is defined by the proposal, using a lean canvas, that has been uploaded to PM3; it was approved on 2 Sep 20. The scope stated that: At the end of this Rapid Improvement Project the Trust will have an implemented Electronic Referral Triage System with a sustainability plan in place. **2.** A 'core team' is listed on PM3 and there is an Action Log and Attendance Tracker for project meetings to 16 Oct 20. **6.** The milestone plan showed that the 'Options Appraisal' phase has overrun. **7.** There is no explicit statement concerning benefits and metrics beyond the reference to 'USPs' in the project description and the 'Picture': 'at the end of this Rapid Improvement Project the Trust will have an implemented Electronic Referral Triage System with a sustainability plan in place'. It is anticipated that 'benefits' will become clearer once the Options Appraisal phase (the options have benefits defined but not metrics) has completed and decision(s) made. **8&9.** There are 3 risks logged on PM3 and these were last reviewed on 6 Nov 20. No issues have been raised to date. **Most recent assurance evidence submitted 6 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Service Improvement Programmes - Outpatients														
3.2a	**Electronic Referral Triage (Rapid Improvement Project)**	Adoption of standardised Electronic Referral Triage system within the Trust. All referrals will be electronically triaged by Clinicians to maximise the benefit from the first consultation and direct patients accurately along the most appropriate Clinical Pathway. This will reduce unnecessary new and follow-up visits and thereby improve patient experience.	Anthony Middleton		●	●					●	●	●	●

DIGITAL ENABLEMENT: Outpatients One Patient Record - Project Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. A PID v2.0 dated 3 Jul 20 is in evidence (now uploaded to PM3) for 'Outpatient One Patient Record' and is reported as signed off by the Project Lead; 'high level benefits' are identified in the PID. There is also a 'Decisions and Actions' presentation dated 3 Jan 20. **2.** There is a project team ToRv2.0 as approved on 31 Jul 20. There is an Action Tracker and Attendance Log for project meetings up to 5 Nov 20. **6.** The PM3 milestone plan shows the plan broadly on track with a final closure date of 2 Apr 21. **8&9.** There are 8 risks logged on PM3, these were last updated on 3 Nov 20. There are 5 issues open and these were last reviewed on 3 Nov 20. **Most recent assurance evidence submitted 5 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Service Improvement Programmes - Outpatients														
3.2b	**Outpatients One Patient Record** (Digital Enablement - Outpatients Improvement)	The key deliverables from this project are: - Removing Case Notes from Outpatients - Reducing the amount of paper produced within the Outpatient environment - Solutions to make unavoidable paper available electronically.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Attend Anywhere - Project Assurance Update – 12 November 2020

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

Independent Assurance Statement

1. The project is defined in the PID v0.6 dated 8 Apr 20 which is uploaded to PM3 along with a project mandate. **2.** There is a ToR for the NF2F Project Team dated 1 July 2020. There is a Project Group Action Log updated to 28 Oct 20. **6.** While key elements of the project are broadly on track, the delivery summary (governance page on PM3) states there are: 'still concerns with specialties not submitting their video clinic requirements to the ESM team'. The data presented to PSG on 9 Nov 20 showed 25 specialties had responded for either 'full go live' or 'fast track' options; however, 17 specialties (some 40%) have yet to respond. **8&9.** There are 5 risks logged on PM3 and these were last updated on 4 Nov 20. There are 8 live issues on PM3 and these were updated on 4 Nov 20. **Most recent assurance evidence submitted 9 Nov 20.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Service Improvement Programmes - Outpatients														
3.2c	**Attend Anywhere** (Digital Enablement - Outpatients Improvement)	Attend Anywhere is a video consultation platform. It is a web based product which enables clinicians to conduct video consultations with outpatients. The objective is to make Attend Anywhere available as a third option for outpatient consultations, alongside telephone and face to face. It is envisaged that this platform would be used in both scheduled clinic settings and also in unscheduled settings such as 'Hospital at Home'.	Anthony Middleton		●	●					●		●	●

BOARD OF DIRECTORS	
Agenda Item	20-21/203
Title of Report	Report of the Audit Committee
Date of Meeting	24 November 2020
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Audit Committee

This report provides a summary of business conducted during a meeting of the Audit Committee held on 24 November 2020.

1. Internal Audit

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

- Medical staffing (Limited Assurance)
- Follow up of previous recommendations

Whilst MIAA provided positive assurance on the continued resolution of previous issues raised, the feedback on the Limited assurance report and the management responses undoubtedly exercised the Committee. This was further exacerbated by the subsequent report on overtime as an anti-fraud detection review, more of which later.

The review of Medical staffing highlighted a number significant control issues which were not being operated appropriately. The Committee expressed its disappointment in this given the basic and fundamental nature of the controls and the fact that there were controls in place that were just not being adhered to. This was further exacerbated by the management responses which fundamentally failed to address the issue instead choosing to refer to a subsequent review in April at which the failings would be considered and a resolution identified.

The Committee felt this was not acceptable given the serious nature of the issues, the basic nature of the controls and the fact that they could easily be rectified by following the accepted policies and procedures already in place. The management responses were rejected, and an updated report requested with amended responses to come to the next meeting in January.

A number of changes to the current year plan were agreed by the Committee.

b) Anti-Fraud Proactive detection exercise (Overtime review)

This review was requested in January 2020 and remained on the action log until this meeting when the report was presented.

Whilst there was no evidence of fraud, the report identified a significant number of control weaknesses and inappropriate practices highlighting the weaknesses in the control environment and the lack of basic policies and practices.

As a result of this and the issues raised in the previous report the Committee has decided that for all future limited assurance reports it would wish those reports to be responded to directly to the Committee by the appropriate and responsible Director.

2. External Audit

The Committee discussed the ongoing External Audit Tender and noted that whilst the process continues the market conditions to procure this service are challenging with a number of International firms withdrawing from the work.

The tender process completes on the 2nd December and the Audit Chair and Executive colleagues will meet to discuss the outcome of that process and options for the future after that date.

3. Governance -other assurance

a) Positive assurance was received in relation to debt control and management. Discussion took place on pharmacy stock losses and the interaction with equipment failure. It was agreed that there is a balance to be struck between expending monies planned and preventative maintenance /rolling equipment replacement and the impacts of failure. This was subject to ongoing review.
b) The annual accounts timetable was discussed noting there is still some uncertainty given the current COVID situation
c) Positive assurance was received on the tracing and resolution of Audit recommendations made

4. Risk Register

No items were raised for the risk register

5. Any other business

Given the earlier discussions, the point was made that in a regulated environment which is policy heavy this creates substantial compliance challenges. It was recommended that as policies are reviewed the opportunity is taken to consider if they really need to be there and if there is any capacity to reduce the number of said policies to aid compliance.

S J Igoe
Chair of Audit Committee
27th November 2020

Board of Directors

Subject:	Proceedings of the Quality Committee	**Date:** 25.11. 2020	
Prepared By:	Dr J Coakley, Non-Executive Director		
Approved By:	Dr J Coakley, Non-Executive Director		
Presented By:	Dr J Coakley, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**
Risks/Issues			
Indicate the risks or issues created or mitigated through the report			
Financial	**None identified**		
Patient Impact	**Potential risk to quality or safety of care:** • **Governance oversight** • **Quality Account approval** • **Learning from deaths**		
Staff Impact	**None identified**		
Services	**None identified**		
Reputational/ Regulatory	**CQC Action Plan**		
Committees/groups where this item has been presented before			
N/A			
Executive Summary			

The Quality Committee met on 25th November 2020. This paper summarises the proceedings.

Governance Oversight

Three SIs have been declared for the previous month. This is in line with recent performance. Assurance about the discharge of the Duty of Candour was given. Some 47 policies have now breached their review date, but all these are under review by the Policy Review Group, as are policies that are about to expire within the next six months. No other issues were noted (except SHMI – see below). CAS alerts are up to date, as is NICE guidance.

Draft Quality Account approved

The Board will have sight of this at today's meeting. The Quality Account has been reviewed twice by the Quality Committee, which approved it at the November meeting.

Learning from Deaths

The rising SHMI was noted. There is to be a presentation on SHMI to today's Board meeting.
Medical Examiner recruitment is complete. All deaths are now being reviewed

CQC Action Plan

Satisfactory progress is being made, although two 'must do' and 'seven 'should do' actions are overdue. Of the 107 requirements, 60 have all actions completed. Given the Covid situation, this is to be commended. The quarterly update will be presented to board at today's meeting.

Summarised and drafted by the Quality Committee Chair John Coakley 26th November 2020

BOARD OF DIRECTORS	
Agenda Item	20-21/206
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	25 November 2020
Author	Sue Lorimer, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee (FBPAC)

This report provides a summary of the work of the FBPAC which met on the 25th November 2020. Key focus areas are those which address the gaps in assurance in the Board Assurance Framework.

1. Finance Report for the period ending 31st October 2020

The Committee received the month 7 finance report and noted the overall position of a £0.8m surplus, representing a favorable variance of £0.4m from the plan submitted to NHSI for the second half of the year. Slippage on winter plans and an underperformance against the reset and recovery trajectory are the key contributory factors to this variance.

Delivery of the capital programme in 2020/21 remains a key risk which has been subject to detailed discussion at the Capital Assurance Group. The committee received assurance that whilst expenditure in the year to date is still significantly behind plan, a number of large value schemes are now underway and this will filter through to an acceleration of spend levels in the next few months.

2. Financial planning approach for 2021/22

The Chief Finance Officer shared a series of slides which updated the Committee on the approach to financial planning for 2021/22. This included a high level view on the emerging financial landscape for next year following the spending review announcements on the 25th of November, together with details on how the Trust would be progressing with the development of its CIP programme.

It is expected that the NHS will be required to deliver on efficiency requirements again in 2021/22 after a suspension of this requirement this year. The Committee agreed that Cost Improvement Planning (CIP) will need to be an important focus for the Trust over the next 4 months.

3. Urgent Emergency Care (UEC) Centre Options

The committee received a presentation from the Director of Strategy on the current status of the UEC Outline Business Case and the different options which have been developed through the UEC programme. The estimated capital cost of each option was presented and the preferred option was noted as being approximately £28m, a £10m increase on the funding available. As the case is progressed it was noted that to be successful, alternative funding options would need to be explored and that the case would need to demonstrate value for money and a strong financial case. The CFO provided feedback from NHS Improvement on the expected pressures on capital funding in 2021/22.

4. Quality Performance Dashboard report

The Quality Performance Dashboard report was reviewed. Key risks on cancer, A&E and RTT were discussed together with the performance against recovery phase 3 targets. It was noted that good progress had been made on the Trust 52 week waiting times. The Chief Operating Officer undertook to incorporate a report he presented on elective recovery into the regular report.

5. Clatterbridge Elective Programme

An update on the work being done to transfer elective activity to the Clatterbridge site was provided by the lead for the project. It was noted that this work is aligned to the Trusts agreed strategy and that engagement with clinical colleagues was very good. Further updates will be provided at future meetings before the final business case is considered by the committee in the new calendar year.

6. Risk Register

The committee asked Executive colleagues to review the future availability of capital resource as a risk for inclusion in the Trusts risk register.

7. Recommendations to the Board

The Committee recommends that Board of Directors note the contents of this report

Board of Directors	
Agenda Item	20-21/206
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	2 December 2020
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	Claire Wilson, Chief Finance Officer
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 7 August 2020

This report provides a summary of the progress of the Charitable Funds Committee which met on 10th November 2020.

1. Head of Fundraising Report

The Committee received a report on the recent activities of the Charity team. This included the fundraising activities since the last meeting and also the coordination and support provided in relation to public donations over the COVID-19 period.

It was noted that the last five months have been unprecedented as the Trust and wider community have responded to the COVID-19 pandemic. Inevitably, this has meant postponement of a number of fundraising activities which had been planned over the period, however, the team have quickly adapted and have provided a wide range of alternative support to the Trust and its staff.

Key activities are as follows:

- 'Rainbow Flower' appeal and installations in the hospital grounds
- Engagement with local celebrities to provide messages of support to staff
- Virtual London marathon
- Sponsored Lands' End to John O'Groats by staff
- Preparations for Christmas activities

For regular updates please visit wuthcharity.org or via social media - @wuthcharity. To lend your support to the Tiny Stars campaign please 'like' and 'share' the planned events as much as possible.

2. Draft Annual Report and Accounts 2019/20

The committee approved the Annual report and accounts for the year ending 31st March 2020 and will be recommending them for approval at the Trustees meeting in January 2021.

3. Draft Fundraising Plan 2020/21

The Committee reviewed and approved the fundraising plan for 2021/22 which sets out an ambitious target of £500k for the year. It was recognised that planning for charitable events and estimating likely levels of fundraising income was difficult in the current climate, however, setting out an initial plan was important and it will be continuously reviewed as more is known about which events can be carried out safely.

4. Finance report for Month 6

The committee reviewed the month 6 financial report and noted that the necessary pausing of traditional fundraising activities has had an impact on income. Total income recognised to date is £369k, of this, £166k related to the COVID-19 fund, £83k related to a legacy notified to the Trust in July 2020, the remainder was other donations. The executive team is in the process of generating proposals to use the COVID-19 fund balance to support staff.

5. Governance issues

The committee reviewed a number of Charitable Fund policies and approved minor changes and updates where required. Two main changes were:

i) A change the distribution of required reserves across the funds so that now smaller departmental funds only need to maintain a £2,000 balance, rather than the £15,000 set previously.

ii) Updates to the recharges of staff costs to the charitable funds committee which now reflect changes to management responsibilities

In reviewing the reserve policy, the Committee also asked the Chief Finance Officer to investigate options for ethical investments of our charitable cash balances and report back to a future meeting.

6. Recommendations to the Board of Directors

The Committee asks the Board to note the following:

- The annual report and accounts for 2019/20 have been reviewed and approved by the committee and will be presented to the Trustees for formal approval in January 2021.
- The charitable funds plan for 2021/22 has been reviewed by the Committee and will be presented to Trustees in January 2021 for approval

BOARD OF DIRECTORS	
Agenda Item	20-21/207
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	2 December 2020
Author	John Sullivan, Non-Executive Director
Accountable Executive Director	Jacqui Grice, Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Chair's Business

The meeting took place on Tuesday 24 November 2020 via Microsoft Teams. The meeting duration was reduced from 2 hours to 1 hour so as to release time for the HR attendees to plan and co-ordinate the emerging work on asymptomatic testing of staff and staff Covid vaccinations. Presenters of papers were requested to concentrate on 3 or 4 key points from their paper and thereby leave some time for Committee scrutiny. The Committee welcomed Roger Neilson, Head of HR, Barbara Cummings, Workforce Consultant, and Victoria Robinson-Collins, Deputy Director of Workforce.

2. Staff Story

The Committee welcomed Adele Davies, Ward Manager Ward 25, to describe the Covid journey on Ward 25. It was inspiring to hear that the Ward 25 team had done so well under such demanding pandemic conditions. Adele was asked to pass on our thanks and appreciation to all members of the Ward 25 team.

3. Workforce Performance Report

The Committee was surprised to hear that the Trust has been measuring ESR data accuracy for 2 years (WOVEN Data Quality Report) but not received the information until now.

The new performance report was well received for its structure, data content and transparency. It is a welcome addition to workforce assurance.

Divisional accountability for workforce performance and in particular compliance with workforce procedures and policies (eg return to work discussions) was discussed. Similar themes of line accountability and insufficient compliance with basic controls were also discussed at the Audit Committee meeting held on 24 November 2020.

4. Sickness Absence Report

Positive improvements were noted in Covid and non Covid absence rates.

The Committee noted and welcomed the transparent and competent actions being taken to improve absence rates.

5. Flu Plan 2020/21

The plan was reviewed. Vaccination clinics have continued. Staff vaccinations will exceed previous year rates.

6. Covid Vaccine Update

Detailed planning is underway with a target start of 350 / day from the second week in December 2020. Training of staff and regulatory approval of the vaccine are critical path items. Infection prevention and control modifications to the Education Centre at APH are required.

7. Asymptomatic Testing of Staff

This national programme rolls out this week to test all patient facing staff with weekly progress reports required. The target is for staff to self-test twice per week for 12 weeks. The coincident timing with staff vaccinations has increased the logistical challenges of the Covid response at WUTH.

8. Recruitment and Retention Strategy

The Committee reviewed the Recruitment and Retention Strategy 2020-2022 document. The document was supported and the implementation actions will be reported quarterly to the WAC.

9. Nursing Workforce -- Recruitment and Retention update

International recruitment has commenced successfully with the first cohort (11 nurses) due to arrive in January 2021. The Trust also now has access to an apprenticeship programme to support career development from CSW to RN.

Areas of focus are the band 5 vacancy rate of 17-20% and the CSW vacancy rate of 8-10%. NHSE/I predict that following the Covid-19 pandemic nursing vacancies in the region could rise to 30% in the coming years; therefore it is imperative that individual trusts work together to manage the risk across the region.

It is imperative that the WUTH increases its nursing and CSW recruitment and retention activities using a variety of methods and that we are able to grow our own nursing and CSW workforce for our future requirements.

10. Six monthly Chief Nurse Acuity and Dependency Nurse Staffing Report

The report provided oversight on how the Trust has met effective governance requirements set out in the guidance to ensure boards can be assured workforce decisions promote patient safety and so comply with the Care Quality Commission (CQC) fundamental standards.

The report also outlined the outcomes of the mandatory acuity, dependency and establishment review undertaken in Q2.

The following recommendation was accepted --- that no changes should currently be made to nursing establishments due to the need to continually flex nurse staffing requirements as a consequence of the COVID- 19 pandemic.

The Committee noted that midwifery staffing levels were very satisfactory with continuity of care rated best in region.

11. Management of Learners during the Initial Phase of the Covid 19 Pandemic

The Trust successfully facilitated a total of 134 student placements during the initial phase of the Covid-19 Pandemic. This has enabled students to remain on their current programme of study thereby ensuring students are able to take up their planned registered nurse posts, and avoid delays. The Chief Nurse recognised that key staff needed to be identified to manage this process successfully. The staff involved facilitated the process smoothly and adapted to the constant changes as each new guidance was published. Recognition is due to the staff and students who fully embraced and supported this process.

12. Health Education England (HEE) – Self-Assessment 2020

The purpose of this report was to present to the Workforce Assurance Committee an overview of the Health Education England (HEE) annual Self-Assessment for 2019-2020 (related to The Education Quality and the Learning and Development Agreement). This self-assessment was presented to and agreed with the accountable Executive Directors and was submitted to Health Education England on 30 September 2020. The self-assessments were also presented to the Education Governance Group prior to submission in September 2020.

The Trust Board is required by HEE to oversee education and training and assurance is provided via this Chair's report of the Workforce Assurance Committee.

13. Top Leader Programme Evaluation Plan

An overview was presented of the evaluation plan in relation to the Top Leaders Programme at Wirral University Teaching Hospital. The programme is a significant investment for the Trust and it is therefore important that the evaluation measures not only initial participant responses to the programme, but also the impact and application of learning in quantifiable ways. It has been proposed that the Kirkpatrick model of evaluation is used to measure the programme's impacts.

14. Communications and Engagement Monthly Report

The Committee noted this report on activity since its last meeting. It covered the areas of staff engagement and communications, media and social media, charitable fundraising and stakeholder relations.

15. Report of the Workforce Steering Board

The following risks were highlighted:

- Data quality of systems, TRAC, ESR and E Roster systems
- Staff fatigue across clinical and non-clinical
- Sickness levels given asymptomatic testing, Covid-19 and fatigue

16. NHS People Plan

The NHS People Plan Gap Analysis actions have been temporarily overtaken by the Covid vaccination programme. Focus is, however, being maintained on staff mental health and increased staff recognition during the Christmas period.

Date and time of next meeting

Tuesday 19 January 2021, 2.00 - 3.00 pm, via Microsoft Teams.

BOARD OF DIRECTORS	
Agenda Item	20/21 208
Title of Report	Report of the Trust Management Board [TMB]
Date of Meeting	2 December 2020
Author	Andrea Leather, Board Secretary
Accountable Executive Director	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	
Data Quality Rating	
FOI status	Chairs report may be disclosed in full
Equality Impact Assessment Undertaken	

The TMB met on 26th November 2020 via Microsoft Teams. A summary of the topics covered is provided below:

1. Quality and Performance Dashboard

The Quality Performance Dashboard was presented and acknowledged that it had been reviewed in detail at the Operations & Performance Committee (OPC) and likewise at Quality Committee earlier in the week. Discussion focused on a number of key performance metrics namely A&E, the elective programme and cancer waits along with some underlying supporting issues, such as harm reviews, the status of waiting lists with emphasis on the two week waits in particular breast services.

The proposal going forward would be areas of escalation are to be identified in a monthly OPC Key Issues Report to compliment the dashboard. Similarly, this approach is to be

adopted by the Quality Committee. TMB supported this approach and an OPC report is to be included in the cycle of business.

One outstanding performance issue related to cancer two week waits. The planned care control centre approach presents an opportunity to receive daily feeds re potential 2 week breaches within the quarter.

It was noted that the areas of priority for the Quality Performance Dashboard are the metrics that require a threshold to be identified and those that are continuing to underperform.

2. Finance Update

The TMB received the month 7 finance report and noted that the organisation continued to break even in line with NHSI's expectation.

The Chief Finance Office provided an overview the approach to 2021/22 financial planning highlighting the national finance regime and the key emerging themes and expectation nationally is that the capital programme will be significantly constrained. A recap of the 2020/21 pre-COVID-19 and the temporary finance regimes was provided. She went on to explain the principles of the 2021/22 planning processes and the development of the Cost Improvement Programme (CIP) for 2021/22. As part of this, a review of the work undertaken earlier in the year by PA Consulting has been completed. Work is underway to consider each of the opportunities previously proposed and identify those that require PIDs. In addition, the roll-out of the PM3 project planning tool to Divisional teams is underway to support the teams to monitor progress of CIPs. This work will be supported by a newly formed Cost Improvement Team as part of the Service Improvement Team.

To enable the Trust to deliver cost improvement plans there will need to be a requirement to focus on productivity, efficiency and waste. Therefore work has started with the Divisions and will be a focus for the coming months to understand the run rate and capacity and demand for each specialty.

3. Winter Plan 20-21

The report outlined the operational / surge plans providing clarity in regard to governance arrangements, bed configurations and how services are provided across the Divisions. Highlighting additional schemes to address both COVID and winter pressures along with contingency arrangements. It identifies surge planning arrangements to reconfigure wards, services, beds and staffing. This will be underpinned by the Bronze, Silver and gold command structure and when certain triggers are met around deliverables enabling step-up/step-down approach both internally and the wider system. The document is to be disseminated to all frontline staff as point of reference if the operational situation should change what escalation measures are in place to support.

The second element of the report detailed all escalation schemes including the financial analysis, these include COVID, those specific to winter and quality elements. An extensive Executive led check and challenge process was undertaken focusing on the impact and deliverability of each scheme with clearly identified benefits.

TMB approved the Winter Plan including the identified schemes as part of the wider financial plan.

4. Patient Safety & Quality Board – Key Issues

The meeting reviewed the report of the PSQB meeting held on 12 November summarising the key quality initiatives. TMB noted the 82% reduction in Hospital Acquired pressure ulcers in ED and that in Children's ED a gap analysis against standards established for required staffing and skill levels for children attending ED is being conducted.

The Chief Nurse advised that following the suspension of the CQC confirm and challenge process due to organisational pressures, a review is being completed to evaluate alternative ways to maintain momentum.

5. Operations & Performance Terms of Reference

TMB reviewed and approved the draft terms of reference for the Operations & Performance Committee, and nursing would be represented by the Deputy Director of Nursing.

6. Planned Care Control Centre

TMB were provided with a report that identified the process that has been undertaken to address the reduction of activity levels for Outpatients, Elective and Diagnostic procedures during quarter one of 2020/21. This work brings together a number of factors such as single SOPs, reconfiguration of the Service Improvement team, visibility of information and some minor changes within the estates team.

Further work is underway to bring together other teams within the centralised control structure. The will support the Trust to understand the capacity and demand across the organisation identifying the true demand and how the activity is delivered. Initial meetings are in place with the Divisions prior to cascading detail to the wider teams. This will enable testing of the modelling assumptions and inform the workforce planning.

7. Divisional Updates

The TMB noted the key issues in the previously circulated updates from each Division including:

Surgery

- Prostate cancer surgery waits all now been diarised and new patients planned within 4 weeks.
- Development of Operational Manager training programme which will cover Junior Managers to Senior Managers. TMB agreed that this should be included as part of the Trust wide training package which is to be discussed at a future meeting.
- Continuation of focus on Reset & Recovery, with enhanced Divisional A&P meetings and Theatre Scheduling meetings. All PODs forecast to deliver above trajectory at Divisional level. Within specialities there are pockets of under delivery due to COVID sickness staff and patients. Use of and expansion of the IS continues with Ophthalmology and ENT.

Medicine

- Virtual outpatient clinic started in respiratory (OP new waits reduced from 30 weeks to 12 weeks in month).
- Implemented weekly firebreak sessions commenced which will continue throughout Winter – touch point to allow a point prevalence review of why a patient is in a bed against the national guidance and consequently an in day action plan is agreed.
- The priorities of the Flow Steering Group are: roll-out live entry of Ready For Discharge/Criteria to Reside status on Board Rounds, implementation of Bed Bureau review recommendations.
- Action plan to address obstacles regarding the Endoscopy access target to be presented to Operations & Performance Committee (OPC). All access targets to be monitored via OPC identifying those on track and where actions plans are in place to achieve trajectory, these will then be reported within the OPC Key Issues report to TMB.

Acute

- Capital estates work has commenced in ED
    - Phase 1 (main works) completion date is 15/01/21
    - Phase 2 (ventilation works to existing red COVID cubicles) completion is expected to be late Jan/ early Feb 21
- 111 First 'go live' from 24th November with activity higher than expected. Phase 2 will look at signposting to other hospital services away from ED.
- Work ongoing with NWAS to reduce ambulance delays & corridor care.
- Two trials will start from the second week of December: live 'flow' dashboard and decision to admit from ED.
- TMB requested visibility of ED performance is monitored via OPC to understand the action plan to improve delays.

Women's and Children's

- Continued performance improvements in community paediatrics, is reducing the waiting list. The appointment of business manager to support service co-ordination across complex pathways and looked after children (as identified in CQC inspection)
- Neonatal Partnership with LWH and Alder Hey – initial meeting of clinical and operational leads held to mitigate current recruitment and retention risks. Need for shared strategic mandate for partnership working to manage services in this interim period.
- WUTH have achieved the 35% continuity of carer rate for the second month running and have secured funding for further equipment from LMS funding to support the roll out of further teams.
- National introduction of maternity dataset, WUTH on target to meet the targets identified.

Diagnostics and Clinical Support

- Reduction of waiting times for MSK line with contract and DMO1 6 week target now met with no patients waiting over 6 weeks.
- COVID - recognising the fast pace of developments leading to the increasing workload of the Micro biology team and acknowledging the inventiveness of the team to take platforms for testing implemented.
- Recognition of the work of the pathology team through the Roche incident and the support provided across the network meaning front line teams not impacted.

Estates and Facilities

- Car parking barriers across both sites to be reactivated with effect from 2nd December 2020.
- External legionella report expected imminently – action plan to be provided to TMB.
- A review of the financial package required to provide soft FM services for the utilisation of wards located within Clatterbridge Cancer Centre.

IT & Information

- ICE remote ordering system now live and is currently being rolled out to initial tranche of GP practices.
- Excellent progress made with regards to governance structure for informatics. Good engagement from all divisions / departments. Work underway to incorporate trial requests through the correct channels.

Andrea Leather
Board Secretary
December 2020

Agenda Item	20-21/209
Title of Report	Communications and Engagement Monthly Report
Date of Meeting	2 December 2020
Author	Sally Sykes, Director of Communications and Engagement
Accountable Executive	Jacqui Grice, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Staff Survey assurance Reputation and stakeholder risks
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

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

2. Background

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

3. Key Issues/Gaps in Assurance

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

Staff engagement is measured in the annual NHS Staff Survey and does provide a robust benchmark for both year on year changes and comparisons with other acute Trusts. This year's survey fieldwork requiring employees to return their questionnaires ends on 27th November with results expected in February 2021.

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

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

4. Conclusion

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

5. Recommendations

None

Report of the Director of Communications and Engagement

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

Campaigns

- We concluded the 'Keep it SIMPLE campaign' for Infection Prevention and Control with a focus on our Hotel Services team keeping the environment clean and we covered the work of the Trust's new Environmental Matron.

- Our seasonal flu campaign is well underway with vaccination clinics ongoing and messages being shared with staff. We have used the Public Health England campaign materials and supplemented these with localised messaging showing, for example, that Execs have had their jabs. WUTH staff take up has been really positive so far and one of the highest in the region, and with new supplies of the vaccine arriving, we should continue with this positive trajectory.

- We supported national stroke awareness campaigns and in Diversity and Inclusion (D&I) we highlighted the launch in the Trust of the sunflower lanyard scheme for people with hidden disabilities. We also supported Black History Month and the work of our staff networks.

- We continued to roll out the new NHS 111 First service for accident and emergencies. WUTH is in the phase 3 implementation roll out, which started on 24th November. The media release was covered in The Wirral Globe We have a section on our public website for NHS 111 First, which also has the pathway and a video with Dr. Denise Langhor (111 First Video). The information and video has been shared on Facebook and Twitter. The video on Facebook has now had over 23,000 views.

- We communicated cyber security awareness month and supported IT colleagues to get messaging across about the range of cyber security threats and scams.

- We promoted Volunteer Recruitment for the second wave of COVID-19 as a number of existing volunteers returned to work at the end of the first furlough scheme.

- We supported the vital contribution nursing support workers make in caring for the health of our nation on the UK's first Nursing Support Workers' Day. The term 'nursing support worker' encompasses hundreds of different job titles and roles, including health care support workers, assistant practitioners, nursing associates and health care assistants. Nursing support workers can work independently, alongside nurses and as part of wider multidisciplinary teams in all health and social care settings. They have a critical role to play in delivering high quality care and excellent outcomes for patients. We shared video messages from colleagues here at WUTH, showing great passion and care in their work and about this special role (video **HERE**.)

- We also promoted World Antimicrobial Awareness Week, which is an annual event that raises awareness about the serious health issue of antibiotic resistance and encourages people across the globe to handle antibiotics with care.

  This year, the COVID-19 pandemic has presented numerous additional challenges for health professionals managing patients with infections. Now, more than ever we needed to continue to work together to prevent serious infections – including COVID-19 - whilst reducing inappropriate antibiotic use.

Our organisation has pledged to be an Antibiotic Guardian to protect antibiotics.

WUTH Medical Director Nikki Stevenson recorded a video message supporting the week's activities **here.**

Media

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

- Our Rainbow Flower initiative has attracted lots of media coverage as we have installed flower displays at Clatterbridge Hospital and other local locations. We also received a boost when 'Hollyoaks' and 'Emmerdale' TV actor Joe Sutton produced a support video for WUTH Charity. Sales are going well and we are hoping that more will follow in the run up to Christmas.
- There was coverage of our Governor elections and the team supported the production of booklets and promotional literature for the elections and our Annual Members' Meeting.
- A member of staff in our Emergency Department, Consultant Dr. Denise Langhor has been appointed as a national spokesperson on Emergency Medicine for the British Medical Association (BMA) and was interviewed live on Sky News about the increases in COVID-19 cases from a BMA perspective.
- One of our Critical Care and Anaesthesia Consultants, Dr. Girendra Sadera has been featured in specialist journals for two projects, one a research study funded by Health Educations England (HEE) about the role of the clinical librarian, entitled 'The Gift of Time' and another concerning research, co-authored with academics from Edge Hill University and The University of Liverpool, into information sharing with patients, published in the Journal of Patient Experience.

Media Statements

- We provided data for an FOI media request about levels of BAME representation at leadership levels and the Board.

Internal Communications and staff engagement

- We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, clinical guidance, staff wellbeing and support; and charity updates. We regularly signposted staff wellbeing and support resources as the second wave began to take hold and hospital admissions grew.

- We continued to push for improvements in response rates to the NHS Staff Survey, which closes on 27th November. Of particular note is a very good performance at 55% response rates in Hotel Services, Estates and Facilities.

- We built on our new ways of working to communicate with Trust leaders and enhance executive visibility (a CQC action plan item) via MS Teams and November's topics included an overview of the patient flow work, briefing on plans to test all asymptomatic patient-facing staff and preparing to vaccinate our staff against COVID-19.

- The national lockdown measures prompted a need to communicate new requirements for Clinically Extremely Vulnerable staff and returns to home working, where possible, plus sustained vigilance in infection prevention and control.

Charity

- We have now exceeded £120,000 in donations for the local COVID-19 support appeal. The Head of Fundraising has secured an additional £50,000 from NHS Charities Together to provide staff with small gestures, virtual events and well-being items leading up to Christmas. We are focussed on supporting morale boosting activities for staff as the second wave, sustaining our elective programme, the busy winter period and lockdown are significant pressures on our staff.

- An additional £143,000 has been applied for the staff rest area plans and is hoped to be finalised before Christmas. A site visit from charity 'Design Havens for Heroes', who are assisting with the development of the staff rest areas is taking place Wednesday 25th November and visual proposals will follow shortly after.

- With the BTR Liverpool road race charity partnership, the Charity is now one of 8 official partners for all the Merseyside region road races planned to take place in 2021, also including this year's very popular virtual Santa Dash. We join local charities including Alder Hey, Clatterbridge Cancer Charity, Claire House amongst others to benefit from the partnership. This means when anyone enters a BTR Liverpool event, they are given an option to select WUTH charity from 8 charity partners.

- WUTH's Critical Care Team completed a1090 miles 'Land's End to John O'Groats' running challenge and have so far raised over £8,000 for the Critical Care Fund.

Stakeholders

- We supported the Trust's Annual Members' Meeting and prepared a video looking back at the Trust's exceptionally busy and challenging year, also featuring the many messages of thanks and support, which have sustained us during difficult times.

Sally Sykes
Director of Communications and Engagement

Board of Directors	
Agenda Item	
Title of Report	Calendar of Meetings 2021/22
Date of Meeting	2 December 2020
Author	J Hall, Interim Director of Corporate Affairs
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**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The 2020 calendar of meetings at appendix 1 sets out the meetings of the Board of Directors, the Boards sub-committees and the management meetings that report into Trust Management Board (TMB). The dates for 2021/22 follow a similar pattern to previous years in that the Board of Directors meets on the first Wednesday of each month with the exception of January and February and in May an extra-ordinary meeting is scheduled to sign off the Annual Report and Accounts:

January 2021 –scheduled on the last Wednesday of the month, 27 January 2021.

February 2021 – there will be no Board meeting this month due to the timing of the January meeting.

May 2021 – extra-ordinary meeting to sign off the Annual Report & Accounts on Wednesday 26 May as single agenda item.

In November, due to the current Covid-19 situation, the Board agreed to reinstate interim governance arrangements, that had been in place from May to July this year, until 31 March 2021. The calendar reflects this approach.

In line with Government guidance on large gatherings all meetings will continue to be held virtually via MS Teams.

2. Recommendations

The Board of Directors is asked to note the calendar of meetings for 2021/22

Schedule of Meetings 2021/22

	AM / PM	January '21	February '21	March '21	April '21	May '21	June '21	July '21	August '21	September '21	October '21	November '21	December '21	January '22	February '22	March '22
Board of Directors	tba	Wed 27th		Wed 3rd	Wed 7th	Wed 5th Wed 26th* (Annual Rept)	Wed 2nd	Wed 7th	Wed 4th	Wed 1st	Wed 6th	Wed 3rd	Wed 1st	Wed 26th		
Audit Committee	am	Fri 15th			Thurs 22nd	Mon 24th* (Annual Report)				Wed 22nd		Fri 19th		Fri 14th		
Quality Committee	am	Wed 20th		Wed 31st		Thurs 20th		Wed 28th		Thurs 23rd		Wed 24th		Wed 19th		Wed 30th
Finance, Business, Performance & Assurance Committee	pm	Wed 20th		Wed 31st	Wed 28th	Thurs 20th	Thurs 24th	Wed 28th	Thurs 19th	Thurs 23rd	Thurs 27th	Wed 24th	Wed 22nd	Wed 19th	Wed 23rd	Wed 30th
Workforce Assurance Committee	pm	Tues 19th		Tues 24th (pm)		Tues 18th		Fri 23rd		Wed 22nd		Fri 19th		Wed 12th		Tues 29th
Safety Management & Assurance Committee	am		Thurs 18th		Tues 20th		Wed 23rd		Wed 25th		Thurs 27th		Wed 22nd		Wed 23rd	
Charitable Funds Committee	am/pm				Wed 28th (am)			Fri 23rd (pm)			Thurs 21st (am)			Wed 12th (pm)		
Capital Committee	am		Wed 3rd			Wed 5th			Wed 4th			Wed 3rd				Tues 29th
Trust Management Board	am	**Exec Team Meeting**														
	pm (after 2pm)	Tues 19th	Tues 16th	Tues 23rd	Thurs 22nd	Thurs 13th	Tues 22nd	Tues 27th(am)	Tues 17th	Tues 21st	Tues 19th	Tues 23rd	Thurs 16th	Tues 18th	Tues 15th	Tues 22nd
Risk Management Committee	am	**Exec Team Meeting**														
	pm (after 2pm)			Tues 9th	Tues 6th	Tues 4th	Tues 1st	Tues 6th	Tues 3rd	Tues 7th	Tues 5th	Tues 2nd	Tues 7th	Tues 4th	Tues 1st	Tues 8th
Operations & Performance Committee	pm	Thurs 14th	Thurs 11th	Thurs 11th	Thurs 15th	Thurs 20th	Thurs 10th	Thurs 15th	Thurs 12th	Thurs 16th	Thurs 14th	Thurs 18th	Thurs 16th (am)	Thurs 20th	Thurs 17th	Thurs 17th
Patient Safety & Quality Committee	am	Thurs 7th	Thurs 4th	Thurs 11th	Thurs 8th	Thurs 6th	Thurs 3rd	Thurs 8th	Thurs 5th	Thurs 2nd	Thurs 7th	Thurs 4th	Thurs 2nd	Thurs 6th	Thurs 3rd	Thurs 10th
Divisional Performance Review (4th wk of the month)	am	Mon 25th	Mon 22nd	Wed 24	Mon 26th	Wed 26th (pm)	Wed 23rd (pm)	Mon 19th		Mon 27th	Mon 25th	Mon 22nd		Mon 24th	Mon 21st	Mon 21st
	pm (after 2pm)	Tues 26th	Tues 23rd	Tues 23rd	Tues 27th	Tues 25th	Tues 29th	Tues 20th		Tues 28th	Tues 26th	Tues 23rd		Tues 25th	Tues 22nd	Tues 22nd
	am	Thurs 28th	Thurs 25th	Thurs 25th	Thurs 29th	Thurs 27th	Thurs 24th	Thurs 22nd		Thurs 30th	Thurs 28th	Thurs 25th		Thurs 27th	Thurs 24th	Thurs 24th
	pm	Thurs 28th	Thurs 25th	Thurs 25th	Thurs 29th	Thurs 27th	Thurs 24th	Thurs 22nd		Thurs 30th	Thurs 28th	Thurs 25th		Thurs 27th	Thurs 24th	Thurs 24th
Urgent & Emergency Care Upgrade	pm (after 2pm)	Mon 12th		Mon 15th		Mon 10th		Mon 12th		Mon 13th		Mon 8th		Mon 10th		Mon 14th
Programme Board	am	Wed 20th	Wed 17th	Wed 17th	Wed 21st	Wed 19th	Wed 16th	Wed 21st	Wed 18th	Wed 15th	Wed 20th	Wed 17th	Wed 15th	Wed 5th	Wed 16th	Wed 16th
Council of Governors	pm	*11 January TBC*			*Mon 19th TBC*			*Mon 19th TBC*			*Mon 18th TBC Fri 22nd *(with Board)*				*Mon 10th TBC*	
Annual Members Meetings	pm									TBC						
Execs	am	Tues 5th, 12th, 19th, 26th	Tues 2nd, 9th, 16th, 23rd	Tues 2nd, 9th, 16th, 23rd, 30th	Tues 6th, 13th 20th, 27th	Tues 4th, 11th, 18th, 25th	Tues 1st, 8th, 15th, 22nd, 29th	Tues 6th, 13th, 20th Mon 26th	Tues 3rd, 10th, 17th, 24th, 31st	Tues 7th, 14th, 21st, 28th	Tues 5th, 12th, 19th, 26th	Tues 2nd, 9th, 16th 23rd, 30th	Tues 7th, 14th, 21st, 28th	Tues 4th, 11th, 18th, 25th	Tues 1st, 8th, 15th 22nd	Tues 1st, 8th, 15th, 22nd, 30th
A&E Board	pm 3.30-4.30	Tues 26th	Tues 23rd	Tues 30th	Tues 27th	Tues 25th	Tues 29th	Tues 27th	Tues 31st	Tues 28th	Tues 26th	Tues 30th	Tues 21st	Tues 25th	Tues 22nd	Tues 30th
System Improvement Board	pm (1 - 2.0pm)	*Thurs 28th*	*Thurs 25th*	*Thurs 25th*	*Thurs 22th*	*Thurs 27th*	*Thurs 24th*	*Thurs 22nd*	*Thurs 26th*	*Thurs 23rd*	*Thurs 28th*	*Thurs 25th*	*Thurs 23rd*	*Thurs 27th*	*Thurs 24th*	*Thurs 24th*
Healthy Wirral Partners	pm (3 - 5pm)	Thurs 7th & 21st	Thurs 4th & 18th	Thurs 4th & 18th	Thurs 8th & 22nd	Thurs 6th & 20th	Thurs 3rd & 17th	Thurs 1st & 15th or 15th & 29th	Thurs 5th & 19th	Thurs 9th & 23rd	Thurs 7th & 21st	Thurs 4th & 18th	Thurs 2nd & 16th	Thurs 6th & 20th	Thurs 3rd & 17th	Thurs 3rd & 17th