Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

19th December 2018

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 19 DECEMBER

COMMENCING AT 9AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v	
2	**Declarations of Interest** Chair	v	
3	**Chair's Business** Chair	v	
4	**Key Strategic Issues** Chair	v	
5	**Board of Directors**		
	5.1 Minutes of the Previous Meeting – 28 November 2018	d	Page 3
	5.1.2 Board Action Log Board Secretary	d	Page 13
6	**Chief Executive's Report** Chief Executive	d	Page 15
7. Quality and Safety			
7.1	**Patient Story** Head of Patient Experience	v	
7.2	**Learning from Deaths** Medical Director	d	Page 18
8. Performance & Improvement			
8.1	**Integrated Performance Report**		
	8.1.1 Quality & Performance Dashboard and Exception Reports Chief Operating Officer, Medical Director, Director of Nursing & Midwifery, Director of Workforce, Director of Governance & Quality	d	Page 23
	8.1.2 Month 8 Finance Report Director of Finance	d	Page 30
9. Workforce			
9.1	**Trust Flu Immunisation Position** Director of Workforce	d	Page 47

9.2	**6th Monthly Nurse Staffing Report** Director of Nursing & Midwifery	d	Page 53

10. Governance

10.1	**Report of Finance Business Performance & Assurance Committee** Chair of Finance Business Performance & Assurance Committee	v	
10.2	**Report of Trust Management Board** Director of Governance & Quality	v	
10.3	**Report of Workforce Assurance Committee** Chair of Workforce Assurance Committee	d	Page 60
10.4	**CQC Action Plan Progress Update** Director of Governance & Quality	d	Page 63

11. Standing Items

11.1	**Items for BAF/Risk Register** Chair	v
11.2	**Any Other Business** Chair	v
11.3	**Date and Time of Next Meeting** Wednesday 30th January 2019.	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

28 NOVEMBER 2018

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
Chris Clarkson	Non-Executive Director
Jayne Coulson	Non-Executive Director
Graham Hollick	Non-Executive Director
David Jago	Director of Finance
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
John Coakley	Non-Executive Director
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director

In attendance

Paul Moore	Director of Quality and Governance
Natalia Armes	Director of Transformation & Partnerships
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
Ann Taylor	Staff Governor
Jane Kearley*	Member of the Public
Joe Gibson	External Programme Assurance
Ian Wilson*	Member of the Public / Patient Story
Tracy Fennell*	Deputy Director of Nursing

Apologies

Dr King Sun Leong	Associate Medical Director, Medical & Acute
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Paul Charnley	Director of IT and Information

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 18-19/134	**Apologies for Absence** Noted as above.	
BM 18-19/135	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/136	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair highlighted recent local health economy discussions and the establishment of a command centre, led by WUTH to support patient flow at the front door. Agreed that each of the strategic partners is to provide an appropriate lead representative to ensure continuity	

Reference	Minute	Action
	of service during periods of increased pressure such as during the winter. If support is not forthcoming the Trust will escalate the matter to NHS England / NHS Improvement. Discussion took place as to other measures that could be implemented to improve patient flow both in short and long term such as access to nursing care beds, audit of short length stays to provide evidence of poor access to community services and the lack of strategic vision across the health economy. It was acknowledged that 'status quo' was not an option and therefore Executive Directors were asked to consider topics to improve collaborative working with partners and prevent duplication, ideas to be forwarded to Chair via Chief Executive.	**Exec Directors**
BM 18-19/137	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Quality and Governance** – the Board were informed of the positive progress to date across all areas. The revised governance structure is now being embedded across the Trust with the first cycle complete. Mr Moore advised the Board that the CQC inspection notification was imminent and there had been significant progress against the CQC action plan which would be discussed in more detail within item BM 18-19/145. Risk management across the organisation was evolving at pace and the Board should be assured by the improvements. **Director of Nursing & Midwifery** – the Board learned that the response rate to acknowledge complaints was now 100% compliant and the improvement against the target for first written response of 46% compliance. With effect from January 2019 the Divisional Performance Review meetings are to monitor compliance with the agreed end to end process. Since the last Board meeting the Quality buses have visited the Breast Clinic and Outpatients at Clatterbridge and Orthopedics. Some of the topics covered were the importance of patient discharge, Wirral digital and staff survey. **Director of Finance** – Mr David Jago informed the Board that work was ongoing in relation to the strategic pathology collaboration. A review of the Trust activity / clinical coding is underway to ascertain accuracy of coding. **Medical Director** – Dr Stevenson apprised the Board that the Standard Operating Procedure (SOP) for ward rounds was to be revisited to support better patient flow and inform the overall site strategy. A meeting has recently been held with junior doctors to encourage better engagement and discuss any concerns they may have and the subsequent actions to be taken to address them. These meetings will be held on a regular basis to ensure continuity. **Chief Operating Officer** – the Board was apprised that the Urgent Care Clinical senate had taken place earlier in the week. Also at the recent Wirral	

Reference	Minute	Action
	Overview & Scrutiny Committee (OSC) the loss of walk-in centres across the peninsula and the impact for urgent care provided at WUTH were discussed and the Council will be escalating this matter to Parliament. The Board will be informed of any update as and when available. The OSC also highlighted the benefits of the new Musculoskeletal service provided by WUTH. **Mrs Sue Lorimer – Non-Executive Director** – expressed concern regarding the quality performance indicators that were not compliant, this would be discussed in detail under agenda item BM 18-19/141. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that discussions are on going in relation to a neonatal services across Merseyside, with the next meeting being held later today. The Division been nominated for a national award at the Royal College of Midwives. Representatives of the Division will attend the event due to take place in March 2019. **Director of Transformation and Partnerships** – Mrs Armes apprised the Board that the first cycle of Strategy development days has taken place with each of the Divisions. Planning guidance for 2019/20 is expected to be issued during December with Trusts likely to be requested to submit both a one year and a longer term plan. A more detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received. **Director of Workforce** – Mrs Marks advised the Board that the Trust was looking to establish a partnership with Edge Hill University as the university will be establishing a medical school from 2019 as well exploring how we can work in partnership around nursing opportunities. To date 77% of front line workers have received their flu vaccination and work is ongoing to encourage staff who have not yet been vaccinated. The national staff survey has been circulated to all staff with a response rate of 43%. Divisions have identified champions to urge staff to participate by the deadline, 30th November 2018. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board that activity has increased and improved plans were being implemented to address backlogs. Dr Mehra is currently in the cohort of senior managers undertaking the Trust's 'Top Leaders Programme' and suggested inviting the speaker to a future Board development session, the Board supported this suggestion. **Mr John Sullivan, Non-Executive Director** – to encourage a culture of openness consideration should be given to supporting staff at times of high emotional stress which inadvertently impacts the patient experience. This could be provided through senior leaders participation of the Schwartz rounds. The Board noted that Non Executive Directors, Steve Igoe, Chris Clarkson, Jayne Coulson and John Coackley had no items to report.	**HM**

Reference	Minute	Action
BM 18-19/138	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 1 November 2018 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 18-19/139	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Quality & Risk Profile Meeting –** the meeting took place at the end of October 2018 with NHS England Cheshire & Merseyside and discussed the Trust's draft Quality Risk Profile (QRP). Subsequently the Trust has received a revised copy of the Quality Risk Profile and this will form the basis of the improvement plan along with the CQC action plan and will be monitored as part by the System improvement Board. The inaugural meeting of the System Improvement Board was held on the 8th November 2018 where the tracking of the improvement plan as described above was agreed. **Serious Incidents** - in October 2018 the Trust declared three incidents that crossed the threshold for reporting as a serious incident. Duty of Candour was completed and staff have been supported as an investigation progresses. **Undergraduate Medical Education Quality Visit** – took place on 20th November 2018 and preliminary feedback from the visit was positive with recognition of the improvements since the last visit in 2016. Formal feedback and any required improvement will be agreed & monitored through the Workforce Assurance Committee. **Wirral A&E Delivery Board** - there are a number of system improvement actions being overseen by the Board in support of the winter plan, as detailed in the report. The regulators commended the Wirral winter plan and the additional actions to support resilience. In addition the regulators have requested that Wirral CCG share the financial risk of the additional 48 acute beds required for winter following the health economy demand and capacity work. The executive teams of both organisations are working through the financial impact of this. ***The Board noted the information provided in the November Chief Executive's Report.***	

Reference	Minute	Action
BM 18-19/140	**Patient Story** The Board was joined by Mr Wilson, who apprised the Board of his experience since his diagnosis and is intended to improve the experience of future patients. He did emphasise that his experience whilst an inpatient on ward 21 was very positive. He explained that at various points along his journey lack of information and poor internal communications had contributed his inadequate experience. Had it not been for his vigorous follow-ups when timeframes were not met or telephone calls unreturned. It was suggested that one way to support patients during this time would be the introduction of pre-operation course in conjunction with clinical professional which would allow patients to talk through the process, outlining expectations. Whilst Mr Wilson indicated the areas of concern regarding his experience at WUTH, he also highlighted the poor service of other areas such as the district nurse team. Mr Wilson stated that although his personal experience was difficult he understands that as a consequence of the concerns he has raised improvements have and are continuing within the Urology Department. He thanked Paul McNulty, Deputy Divisional Director – Surgery who had discussed his concerns in detail. On behalf of the Board, the Chair expressed his thanks and appreciation to Mr Wilson for sharing his experience and would welcome further insight and suggestions as to how the Trust can learn from this feedback. ***The Board noted the feedback received from Mr Wilson and acknowledged the lessons learned to improve the experience of future patients.***	
BM 18-19/141	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. The additional exception report provides a summary of the remedial action being undertaken where indicators are not meeting the established targets or thresholds for the standards. Of the 55 indicators with established targets or thresholds 32 are currently off-target or failing to meet performance thresholds. The lead Director for each of these indicators provided a brief synopsis of the issues and the actions being taken. A query was raised regarding percentage of discharges taking place before 12 noon and the impact on performance if there was a 2pm threshold. It was explain that in the two hour window approximately 15 patients could be moved and this could support patient flow from A&E. Other areas of focus for discussion were: • Referral to treatment (RTT) - the Trust is currently achieving trajectory • 52 weeks – slower progress which is being monitored closely with colorectal being an outlier.	

Reference	Minute	Action
	Both of the above indicators are impacted by patient choice eg of 44 patients, 26 exercised their right to delay. The Director of Nursing reported that following the relaunch of hand hygiene competencies Divisions are to audit compliance via the Perfect Ward app. Monitoring of the compliance with be through the Infection Control report to Patient Safety & Quality Board. Following discussion it was agreed that future reports should include clear trajectory targets for all indicators to achieve compliance and an improvement statement based on trajectory. Also identify which the assurance committee is responsible for monitoring which indicator and then the relevant committee to select exception reports to have deep dive topics to clarify the risks and mitigations in place to achieve targets. The Medical Director informed the Board that the VTE redesign process within Cerner which provides an automatic prompt to be trialled for a six week period from December 2018. If this does not achieve improvements then a plan B will be enacted. The Director of Workforce advised the Board that a review of long term sickness is underway which involves an individual plan to be developed for each case by end of November 2018. Plans will then to be monitored a monthly basis through the e divisional performance reviews. A review of the appraisal documentation is currently underway to streamline and focus on discussion, the review will also reflect the feedback provided earlier in the meeting regarding quality of process rather than percentage that have taken place. ***The Board acknowledged that the dashboard identifies the areas for focus where current performance requires improvement. The Board were satisfied for those indicators not yet under prudent control, that action is being taken to improve and future reports to monitor indicators against 'basic, better, best' elements and identify clear trajectories. This being overseen by the Trust Management Board.***	**AM,PM, GW,NS, HM**
BM 18-19/142	**Month 7 Finance Report** The Director of Finance apprised the Board of the summary financial position. At the end of month 7, the Trust reported an actual deficit of £19.4m versus planned deficit of £17.4m, an adverse to plan of £2.0m. The Board was apprised that the underlying deficit is closer to £21m given release of £1.9m of non-recurrent support. The underlying in-month is (£0.1m) worse than plan and delivered a deficit of £1.2m versus a plan of 1.1m. The key driver of the variance is the under-performance of income with elective (£0.6m) worse, non-elective (£0.5m) better and critical care/neonatal £0.1m better. The over-performance on non-elective was unexpected and reflected planned levels of activity and greater complexity in month. The Director of Finance outlined to the Board that the likely forecast outturn deficit at the end of month 7, at circa £28.4m including £1.25m for winter	

Reference	Minute	Action
	pressures. The known risks and opportunities during the remainder of the year which would mitigate/manage the current position to achieve a revised forecast outturn of £28.4m were discussed with further mitigations discussed with the potential to reduce the year end deficit forecast closer to £27.0m. Negotiations continue in relation to a risk share with WH&CCG in respect of both the step down ward and additional 18 beds at APH as part of the winter plan and system wide bed modelling work undertaken. Additional key aspects apprised to the Board included: • Non pay expenditure was above plan at £3.9m, essentially due to MSK outsourcing costs of £2.0m, therefore £1.9m above plan materially driven by outsourcing costs in relation to elective activity at £1.3m. • CIP was £0.6m above plan and had delivered £4.6m versus plan of £4.0m but noted risk re non recurrent savings at £1.9m and a more challenging profile to the latter end of the financial year. • Cash balances at the end of October were £7.0m, exceeding plan by £4.7m driven by robust working capital management and below plan capital expenditure. It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy. An additional Board development session to be arranged for early 2019 to focus on financial sustainability of the Trust and two of the Programme Board work streams – Improving Patient Flow and Operational Transformation. ***The Board noted the M7 finance performance and the proposed year end forecast be considered at the Board development session in early 2019.***	
BM 18-19/142	**Report of Quality & Safety Committee** Mr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the recent Quality & Safety Committee, held on 27th November 2018. The key areas of improvement were: • Control over serious incident handling – improved and now under control. • CAS Alert handling – received assurance that all overdue alerts have been actioned and control achieved over the process. • Falls – rate of falls/1000 bed days is much lower than England mean – falls are reviewed weekly with input from the specialist Matron for Falls and Dementia. • MCA/DOLs compliance shows very strong improvement in Q1 and Q2. • Quality Committee found the new dashboard helpful at making the performance and risk more visible. Improving accountability. • Complaints handling showing signs of improvement. Some of the areas that require improvement are: **Learning from deaths** - a review of concerns raised were discussed particularly in relation to escalation of investigations. The Trust providing external support to offer advice for clinical colleagues.	

Reference	Minute	Action
	CQC Insight Report - Executive leads have been identified to sign off all external reporting to ensure consistency of data. **Water safety management** - action plan now in place and to be monitored by Quality & Safety Committee. ***The Board noted the areas covered in the verbal report.***	
BM 18-19/143	**Report of Programme Management Board** Mr Joe Gibson, External Programme Assurance provided a brief overview of progress to date against each of the workstreams. He notified the Board that the workforce planning workstream would be on line from December 2018. The digital implementation plan for 'go live' to be monitored via the Digital Board and progress reported to Programme Management Board. The Board acknowledged that benefits realisation for each programme are to be clearly defined by the Executive leads and to encompass financial model interfaces with areas such as Divisional CIP's, themes of change programme. Each programme to identify timeframe for delivery eg 12 months, 2-3 years or 4-5 years. This will ensure overall confidence to deliver programme and monitor areas of risk of non delivery. The Board raised concern in relation to the pace of change and emphasised the need for great focus of programme. Communication for staff to be drafted to stress the importance of the change programme and the support available to divisions and corporate areas to achieve the plan. ***The Board noted the Programme Management Board report and progress to date.***	**HM,NS, AM,DJ, PM** **NA**
BM 18-19/144	**Report of Trust Management Board** The Director of Quality & Governance provided a summary report of the Trust Management Board (TMB) meeting on 5th November 2018. The reports outlined matters agreed by the TMB for escalation to the Board: **Outpatient Transformation** - the modernisation programme '*21st Century Outpatients*' will focus on three specific aims: (i) Increasing clinic capacity to return to or exceed planned activity levels before the financial year end; (ii) Review and redesign outpatient structures (iii) Develop and implement transformation which leads to the eradication of paper and drives innovation in delivery of outpatient transactions with service users. **Diversity & Inclusion Strategy** - TMB received and approved the Diversity & Inclusion Strategy 2018-22. **Strategy** – a presentation outlining the proposed strategic objectives and orientating Trust values as discussed at Trust Board was provided and endorsed.	

Reference	Minute	Action
	The next steps will include: (i) communicating and engaging with front line teams to build a strong commitment towards our goals; (ii) focussing more directly on delivery; and (iii) building a culture of continuous improvement supported by transparency, openness, innovation and learning. **Risk Management Committee** – recognised the revised risk management processes reflected recent changes introduced following the CQC's inspection. Its represents encouraging progress, but important to be aware that both the Committee and Policy are new and at an early stage of development/implementation in the organisation. A rolling programme to review all risks is currently underway and the output of those discussions will be presented to future Risk Management Committee meetings. An updated overview of the Trust risk profile will be provided to Board in January 2019. It was noted that Steve Igoe, Audit Committee Chair will be invited to attend the Risk Management Committee. To ensure triangulation of assurances the Trust Management Group received reports from the Patient Safety & Quality Board, Programme Board and the Quality and Performance Dashboard. ***The Board noted the report of the Trust Management Board.***	**PM**
BM 18-19/145	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the report provided progress pertaining to the CQC Action Plan. The paper provides the Board of Directors with an update on the progress of the CQC Action Plan, and highlights, by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation. The actions identified as 'blue' are those that have been completed and embedded. Evidence that underpins completion of these actions is available to Board members to provide reassurance. The actions identified as 'red' are mainly related to operational plans and estates. These have clear timescales identified to progress but some will be a challenge to achieve eg refurbishment – is it affordable and deliverable within the timeframe. ***The Board noted the progress to date of the CQC Action Plan and the corrective actions required to meet the March 2019 deadline.***	
BM 18-19/146	**Appraisal and Revalidation Report 2017-18** The Medical Director apprised the Board of the processes for both revalidation and appraisal for consultants. She highlighted that the Trust is compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England and is now monitored by providing a quarterly statement of compliance. The Trust has appointed a new Medical Appraisal Lead, Dr Catherine Hayle and a new structure for the department introduced with three Senior Appraisers to support the process appointed. Also the Senior Medical Staff Appraisal Policy has been reviewed and updated.	

Reference	Minute	Action
	The Board noted the report and agreed to receive the next report in a year for the period 2018/19.	
BM 18-19/147	**Items for BAF/Risk Register** Board Assurance Framework The Director of Quality and Governance confirmed that the current BAF had been reviewed and updated for presentation to the Audit Committee. Work is ongoing in relation to the development of the BAF for 2019/20. ***The Board noted the future development of the revised Board Assurance Framework.***	
BM 18-19/148	**Any Other Business** There was no other business to report.	
BM 18-19/149	**Date of next Meeting** Wednesday 19th December 2018.	

……..……

Chair

……..

Date

Board of Directors Action Log
Updated – 28 November 2018

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 28.11.18						
1	BM 18-19/136	To consider topics to improve collaborative working with partners and prevent duplication, ideas to be forwarded to Chair via Chief Executive.	**Exec Directors**		January '19	
2	BM 18-19/137	Invite 'Top Leaders Programme' speaker to a future Board development session.	**HM**		January '19	
3	BM 18-19/141	Quality & Performance Dashboard - future reports to monitor indicators against 'basic, better, best' elements and identify clear trajectories	**AM,PM, GW,NS, HM**		January '19	Report is work-in-progress and will be developed over time. See also item BM18-19/119
4	BM 18-19/141	Produce a longer term model utilising the NHSI financial modelling tool which maps business as usual versus in year pressures.	**DJ**	Secured LTFM model and reviewing finance team capacity to populate	March '19	
5	BM 18-19/143	Programme Management work streams to identify timeframes for delivery eg 12 months, 2-3 years or 4-5 years.	**HM,NS, AM,DJ, PM**		January '19	
6		Prepare communication for staff to stress the importance of the change programme and the support available to divisions and corporate areas to achieve the plan.	**NA**		January '19	
7	BM 18-19/144	Provide an updated overview of the Trust risk profile	**PM**		January '19	

Date of Meeting 1.11.18						
4	BM 18-19/119	IPC Improvement Plan to identify timeframes to monitor future progress	**GW**		January '19	
5		Q&P - future reports to include narrative as to how the failing indicators will achieve 'green' rating. Also consider if a target is currently unachievable would an interim target be appropriate	**AM,PM, GW,NS HM**		January '19	Report is work-in-progress and will be developed over time. See also item BM18-19/141
7	BM 18-19/123	Report outlining the local impact assessment of tariff proposals to be provided at the next meeting.	**DJ**	Verbal update to be provided pending full tariff details being released December 14th	December 2018	
8		detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received early in December 2018	**NA**		January 2019	
	BM 18-19/123	Future 'freedom to speak up reports' to include comparisons with Trusts who provide better engagement			January 2019	
Date of Meeting 27.9.18						
5	BM 18-19/104	Review of Information and Coding Assurance Report to FBPAC	**PC/DJ**	Discussed at Oct FBPAC the need for clarity on risks raised and mitigating action of GDPR non compliance.	February 2019	Revised report to Feb '19 FBPAC

BOARD OF DIRECTORS	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	19th December 2018
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**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides an overview of work undertaken and any important announcements in December 2018.

Serious Incidents

In November 2018 two serious incidents were declared by the Trust. They concern: (i) a failure to organise a follow up appointment for a patient with suspected cancer which led to a delayed diagnosis. Immediate action was taken by the Division of Surgery to review and strengthen control arrangements for booking and managing follow up appointments; and (ii) an potentially avoidable fall resulting in a broken hip. Immediate action taken included treatment for the injury sustained, a

review of the patient-level risk assessment and increased nursing observation. In both cases investigations are underway and Duty of Candour properly applied.

New NHS Executive Group: Regional Directors announced

NHS Improvement and NHS England have a number of appointments to the new senior leadership team, the NHS Executive Group to head up the seven regional teams. The NHS Executive Group will provide leadership across both organisations to enable them to do more for the NHS and patients.

The regional Directors will support the development and identity of sustainability and transformation partnerships and integrated care systems, and will be responsible for proactively sharing learning from local areas across the national health and care system.

The appointments are:

- Richard Barker – NHS North East and Yorkshire Regional Director
- Dale Bywater – NHS Midlands Regional Director
- Anne Eden – NHS South East Regional Director
- Bill McCarthy – NHS North West Regional Director
- Elizabeth O'Mahony – NHS South West Regional Director
- Ann Radmore – NHS East of England Regional Director
- Sir David Sloman – NHS London Regional Director

The new regional Directors are expected to formally lead their teams from April 2019.

Cheshire & Merseyside Health & Care Partnership

The Cheshire & Merseyside Health & Care Partnership sets out how the health and care system can remain fit for the future. The latest edition of the Partnership stakeholder bulletin contains an article on the 'Seacombe birthing suite' as part of the Trusts community midwifery service. A copy of the bulletin is available through the Cheshire & Merseyside Partnership website, link provided below.

https://www.cheshireandmerseysidepartnership.co.uk/

NHSI Provider bulletin

Changes to Seven Day Hospital Services measurement - the board assurance framework is the new approach to measuring progress in implementing seven day hospital services (7DS).

This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards. This self-assessment will then be formally assured by the trust board and the completed template submitted to regional and national 7DS leads to enable measurement against the national ambitions for 7DS.

A trial period of December – February '19 will enable the Board to discuss and provide assurance. Following this Trust's will be required to implement the Board assurance process full from March 2019 with supporting evidence from local audits to allow Trust Boards to give formal assurance of the self-assessment.

Wirral Community NHS Foundation Trust (WCT)

Earlier this year WCT consulted with stakeholders regarding a change of name. In recognition of the feedback received in relation to the importance of the word 'community' which highlights the value of community services and the important role they continue to play with their partners supporting both the health and care needs of the population they serve they have reconsidered the proposed option. They have notified stakeholders that WCT is to be renamed Wirral Community Health and Care NHS Foundation Trust. The change of name will be phased in over the coming months in the most cost effective way.

Janelle Holmes
Chief Executive
December 2018

Public Board	
Agenda Item	7.2
Title of Report	Learning from Deaths - Mortality Review & Dashboard
Date of Meeting	19.12.2018
Author	Dr M Lipton Deputy MD
Accountable Executive	Dr N Stevenson MD
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1
Level of Assurance **Positive** **Gap(s)**	N/A
Purpose of the Paper **Discussion** **Approval** **To Note**	To Note and Support
Reviewed by Executive Committee	N/A
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. Executive Summary

In March 2017, the National Quality Board, NQB, published 'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care'; this report is in response to the CQC document.

2. Background

- The Trust's fourth mortality dashboard is included being for the period of Q218/19 as well as an update to previous dashboards.

- There were 480 deaths, 60 completed primary mortality reviews (PMRs) and 70 in process.
- 14 deaths in Q2 at present need to have a second line review by SJR, RCA, LeDeR, or Women's and Children's review. These have been raised from primary mortality reviews, elective deaths, deaths in patients with severe learning disabilities and serious incident meetings. No secondary review has been raised from the bereavement service or junior doctors at death certification.
- 6 deaths from Q3 17/18 to Q2 18/19 at present have been judged as being partially avoidable being <=3 on the avoidable death score.
- Mersey Internal Audit Agency reviewed the service and gave "significant assurance" with 2 recommendations for improvement.
- An internal mortality outlier report into Myocardial Deaths Jan 17 – Dec 17 has been completed. 43 deaths were indicated from SHMI, 38 deaths have been identified from hospital electronic case records of which 1 patient was admitted twice leaving 4 unidentified cases. Preliminary review has found all care was appropriate, full report has been shared at PQSB and with the CCG.
- The 2016 Mothers and Babies Reducing Risk through Audit and Confidential Enquiry has been released. WUTH for stillbirths, neonatal deaths and extended perinatal mortality was within the normal range for units throughout the UK.

3. Key Issues/Gaps in Assurance

- CQC in their inspection report commented on the poor % of PMRs being completed within the Trust.
- To meet this requirement a decision has been made to utilise Ulysses, (WUTH's electronic governance system) to track primary mortality reviews and progress to SJRs. When the system is installed automatic reminders will be triggered which will increase completion rates.
- A speedier process will also be provided with the bereavement office registering deaths for PMR and thus avoiding a delay through coding.
- A backlog of SJRs which is being dealt with.
- Recurrent themes in the SJRs are 1) falls prevention; 2) medical early warning score escalation; 3) naso-gastric tube documentation; 4) identification of abdominal aortic aneurysms; 5) documentation of Do Not Resuscitate for CardioPulmonary Resuscitation.
- Dissemination of findings from learning from deaths.

4. Next Steps

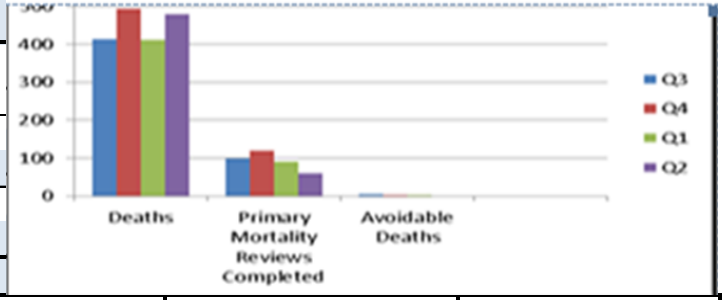
1. Communications to all consultants and SAS doctors regarding revamped PMR system - completed
2. Ulysses mortality module installed – completed
3. Monthly compliance report available on PMRs – Jan 19
4. Escalation process of incomplete PMRs – process completed
5. PMR improvement trajectory agreed –
   Q1 19/20 35%; Q2 19/20 60%; Q3 19/20 80%; Q4 19/20 100%
6. Backlog of SJRs eliminated – Dec 18
7. Increase number of SJR reviewers – training program Feb 19.
8. Combined report on PMRs, SJRs, SIs, RCAs and inquests – Q4 18/199.
9. Safety bites bulletin on learning from deaths to be disseminated trust wide quarterly

5. Recommendations

- To note and support report

Wirral University Teaching Hospital: Learning from Deaths Dashboard

Total Number of deaths		Primary Mortality reviews		SJRs, RCAs & formal Reviews		Total deaths considered potentially avoidable	
Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18
413	494	100, (24%)	120, (24%)	24	42	3	3
Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19
412	480	91, (22%)	61, (70)*	21	17	1	0
()*-in process,							



Avoidable Death Assessment Score	Score 1 Definitely avoidable		Score 2 Strong evidence avoidable		Score 3 Possibly avoidable >50:50		score 4 Probably avoidable but not very likely		Score 5 Slight evidence of avoidability		Score 6 Definitely not avoidable	
	Q3	0	Q3	1	Q3	3	Q3	0	Q3	3	Q3	16
	Q4	0	Q4	0	Q4	2	Q4	0	Q4	10	Q4	16
	18/19 Q1	0	18/19 Q1	0	18/19 Q1	0	18/19 Q1	1	18/19 Q1	5	18/19 Q1	12
	Q2	0	Q2	0	Q2	0	Q2	0	Q2	1	Q2	2

Summary	Total actvity Q2 2017/18	Deaths Q2 2018/19
elective surgical patients:	17,424	1
patients with severe learning disabilities	not available	2
patients with severe mental health needs	not available	0
Women's and Children's Hospital		
Neonatal patients:	950	5
Births:	805	3
Mothers:	790	0

	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Avoidable deaths	4	2	0	0
Still under investigation	1	14	3	14

Narrative for "Learning from Deaths dashboard"

Q2 18/19 Dashboard

- At WUTH there have been 480 deaths in quarter 2, (1st of July 2018 – 31st of July 2018). This compares to 343 deaths in the same period of 2017
- There are two national mortality indexes for the hospital: Firstly HSMR-hospital standardised mortality ratio - this measures 85% of in-patient deaths adjusted for palliative care, social deprivation and admission history. It is a more timely mortality index.
- HSMR for WUTH Apr 17 to Mar 18 is 95, (expected is 100, 2SD-90.8 to 98.7) which means we are significantly better than what is expected by statistical analysis.
- Secondly SHMI – Standardised Hospital Mortality Index – this measures all deaths in the hospital and those occurring within 30 days of discharge.
- SHMI for WUTH Aug 17 to Jul 18 is 95, (expected is 100, 2SD-90.3 to 99.8) which means we are significantly better than what is expected by statistical analysis.
- Of the Q2 deaths so far 61 have had a completed primary mortality review,(PMR), 71 are in process. It is likely that if all PMRs sent out are completed then the completion % for the quarter would be 66% by the end of November.
- There have been, so far, 4 deaths which now require a more detailed review. These reviews will take place using 1) Strategic Judgmental Review, – a specifically trained process to assess the death for any lapses in care, with an assessment as to whether the death was avoidable; 2) Root Cause Analysis for those deaths where a serious incident has been raised – eg: in-patient fall with harm; 3) Deaths in Women's and Children's hospital – specific national processes are followed for these deaths.
- At the present notification there have been 1 elective surgical death, 1 death undergoing RCA, 3 deaths undergoing SJRs and 8 deaths in Women's and Children's hospital.
- Compared to previous quarters there will be a greater number of SJR's compared to RCA's due to the application of the March 2015 NHSI serious incident framework.
- The 2017 preliminary audit review of all recorded myocardial infarction deaths attributed to WUTH has been completed and no cases have been found of inappropriate care. 43 cases were identified from the SHMI data but only 38 hospital cases found, (1 patient had 2 MI's within the year bringing the total to 39). 1 of the 39 episodes was not an MI. Of note was the high age, co-morbidity and deprivation score of the group as a whole. The majority of patients were treated on a cardiology ward, reviewed by a cardiologist and were transferred to Liverpool Heart and Chest Hospital if appropriate or had their cases discussed with them. A formal detailed report has been submitted .
- The MBRRACE, (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries), report for 2016 has been released. WUTH delivered 3,353 births, had an adjusted stillbirth rate of 4.18 per 1000 total births, (2SD 3.45 – 5.08) within expected limits, had an adjusted neonatal death rate of 2.07 per 1000 live births, (2SD 1.36 -3.07) within expected limits and had an adjusted extended perinatal death rate of 6.22 per 1000 total births, (2SD 5.34 – 8.21) within expected limits. It should be noted that WUTH's figures are 10% higher than the national average, this is similar to the previous year and many Trusts within Merseyside.
- The dashboard for Q1 will be updated at the time of the Q2 dashboard.

Q1 18/19 Dashboard

- Of the Q12018/19 deaths 91 had a completed primary mortality review. This was 22% of total deaths in the quarter.
- There have been 22 deaths which required a more detailed review. 9 are still in progress, all SJRs.
- From the second line review of Q1 deaths important learning points have been.
- 1) Delay in discharging frail and elderly patients often results in their deterioration.
  2) Again the need to follow the naso-gastric tube policy.
  3) Again the need to follow the MEWs policy.
  4) The need to perform Mental Capacity Assessment.
- The dashboard for Q1 will be updated at the time of the Q3 dashboard.

Q4 17/18 Dashboard

- Of the Q4 2017/18 deaths 120 had a completed primary mortality review. This was 24% of total deaths in the quarter.
- There have been 40 deaths which required a more detailed review. 9 are still in progress, all SJRs.
- From the second line review of Q4 deaths important learning points have been.
  1) Need to follow the Naso-gastric tube policy for all naso-gastric injections.
  2) Red flag signs for abdominal aortic aneurysm.
  3) Need to follow the MEWs policy in deteriorating patients.
  4) Failure of documented communication with patient and relatives in deteriorating patients.
- The Q4 17/18 dashboard will be updated at the time of the Q3 18/19 dashboard.

Q3 17/18 Dashboard

- Of the Q3 2017/18 deaths 100 had a completed primary mortality review. This was 24% of total deaths in the quarter
- There have been identified 22 deaths for more detailed review.
- From the second line review of Q3 deaths, important learning points are:
  1) to treat in-patient falls as if they present from outside the hospital to ED, thus national protocols are followed regarding CT head scans and the reversal of anti-coagulation.
  2) for all patients admitted to the hospital; they are assessed as to the likelihood of having a fall.
  3) for deteriorating patients without the prospect of recovery a discussion regarding not performing cardio-pulmonary resuscitation is undertaken with the patient and relatives, furthermore this decision is documented within the patient's electronic patient health record.
  4) The nMEWS escalation policy must be followed, further junior doctor resource has been found to respond promptly to nMEWS alerts.
  5) Patients admitted with abdominal pain, despite any medical treatment, with a surgical plan must be seen by the surgeons prior to discharge, investigations agreed must be completed and future investigations ordered.

BOARD OF DIRECTORS	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	19.12.2018
Author	WUTH Information Team and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This revised 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 November 2018.

2. Background

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

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

3. Key Issues

Of the 55 indicators in with established targets that are reported for November:

- 36 are currently off-target or failing to meet performance thresholds
- 19 of the indicators are on-target

Due to the earlier timing of this month's Board of Directors meeting, the full Issue, Decisions and remedial Action (IDA) exceptions reports were not available. They will be incorporated again for future months.

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

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

6. Recommendation

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

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2018

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	13 month Trend	In-year 2018/19 Trajectory
Safe	Falls per 1000 occupied bed days reported on Ulysses (excluding lowered to floor incident)	DoN	≤4.8 per 1000 Bed Days	WUTH	1.40	1.40	1.30	1.50	1.30	1.90	2.20	1.50	2.00	2.30	1.20	1.75		1.84		
	Eligible patients having VTE risk assessment within 6 hours of decision to admit.	MD	≥95%	WUTH	78.6%	64.3%	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	77.0%	68.9%	73.0%		
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	MD	≥95%	SOF	96.0%	95.4%	95.3%	95.6%	95.2%	95.3%	95.3%	94.7%	95.3%	95.0%	95.6%	95.6%		95.3%		
	Harm Free Care Score (Safety Thermometer)	DoN	≥95%	National	92.7%	94.3%	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.8%		
	Serious Incidents declared	DQ&G	≤48 pa (= 4 per month)	WUTH	16	11	6	10	6	6	14	13	3	2	1	3	2	44		
	Never Events	DQ&G	0	SOF	0	0	0	1	0	0	0	0	1	0	0	0	0	1		
	CAS Alerts not completed by deadline	DQ&G	0	SOF	0	1	1	3	0	0	1	5	1	0	0	0	0	7		
	Clostridium Difficile (avoidable)	DoN	≤28 for FY18-19, 2.42 per month	SOF	1	2	1	1	3	4	1	3	1	3	0	3	3	18		A M J J A S O N D J F M
	E.Coli infections	DoN	≤42 pa (No more than 3 per month)	WUTH	7	2	4	1	2	4	2	6	7	2	3	5	4	33		
	CPE Colonisations/Infections	DoN	TBC	WUTH	21	20	16	13	10	11	14	17	18	18	15	13	22	128		
	MRSA bacteraemia	DoN	0	National	0	0	0	0	1	0	0	0	0	0	0	0	1	1		
	IPC Audit of Practices and Procedures (random areas)	DoN	≥75% (gold)	WUTH	77%	77%	73%	73%	78%	83%	81%	78%	77%	78%	74%	75%	75%	78%		
	Hand Hygiene Compliance	DoN	100%	WUTH	93%	94%	89%	94%	99%	95%	97%	88%	89%	90%	81%	87.0%	85.0%	89.0%		
	Medicines Storage audits - % of areas fully compliant	DoN	100%	WUTH	74%	-	52%	51%	52%	57%	70%	69%	71%	74%	72%	73%	60%	68.3%		
	Surgical Site Infections (data once per year over 3 months)	DoN	TBC	WUTH	Indicator Under development															
	Surgical Safety Checklist Compliance	MD	100%	WUTH	Indicator Under development															
	Protecting Vulnerable People Training - % compliant (Level 1)	DoN	≥95%	WUTH	91.2%	90.9%	90.6%	89.9%	89.5%	89.2%	-	-	87.4%	-	85.6%	90.4%	91.5%	88.8%		
	Protecting Vulnerable People Training - % compliant (Level 2)	DoN	≥95%	WUTH	80.3%	81.1%	81.3%	80.7%	82.5%	84.8%	-	-	82.7%	-	82.2%	86.0%	87.2%	84.6%		
	Protecting Vulnerable People Training - % compliant (Level 3)	DoN	≥95%	WUTH	83.5%	84.6%	83.6%	83.8%	85.2%	85.6%	-	-	85.6%	-	86.5%	87.2%	91.7%	87.3%		
	Nursing Vacancy Rate	DHR	≤6.5%	WUTH	5.96%	6.09%	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%	7.90%		
	Consultant Vacancy Rate %	DHR	≤6.5%	WUTH	7.71%	7.75%	7.47%	8.26%	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	7.90%	7.90%		
	Sickness absence % (12-month rolling average)	DHR	≤4%	SOF	4.58%	4.61%	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.93%	4.79%		
	Short-term sickness (in month rate)	DHR	TBC	WUTH	2.43%	1.92%	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.19%	2.14%		
	Long-term sickness (in-month rate)	DHR	TBC	WUTH	2.32%	2.88%	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.81%	2.63%		
	Care hours per patient day (CHPPD)	DoN	TBC	WUTH	7.5	7.1	7.1	7.2	7.1	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	-		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2018

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Effective	SHMI	MD	≤100	SOF	-	94.04	-	-	99.49	-	-	-	-	-	-	-	-	99		
	HSMR	MD	≤100	SOF	73.0	89.0	88.0	88.0	88.0	88.7	93.0	93.0	95	95	-	-	-	91		
	Mortality Reviews Completed	MD		WUTH	Indicator Under Development															
	Nutrition and Hydration - MUST completed at 7 days	DoN	≥95%	WUTH	-	-	-	-	-	44%	59%	71%	78%	67%	74%	84%	87%	70.5%		
	SAFER BUNDLE: % of discharges taking place before noon	COO/ DoN	≥33%	National	14.0%	15.0%	14.3%	14.8%	14.6%	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.4%		
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	COO/ DoN	≤156	WUTH	369	369	412	417	422	418	405	341	386	387	411	383	408	392		
	SAFER BUNDLE: Expected date of discharge achieved	COO/ DoN	TBC	WUTH	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
	Length of stay - elective (actual in month)	COO	TBC	WUTH	4.4	5.0	3.9	7.4	4.0	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.2		
	Length of stay - non elective (actual in month)	COO	TBC	WUTH	5.0	5.2	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.1		
	Emergency readmissions within 28 days	COO	TBC	WUTH	884	891	849	840	814	886	923	873	913	961	888	936	925	913		
	Delayed Transfers of Care	COO	TBC	WUTH	15	14	11	12	9	13	12	13	13	6	18	12	17	11.4		
	NICE Guidance Compliance (Assessment & Gap Analysis)	DQ&G	100%	WUTH	-	-	-	71.0%	72.0%	72.0%	73.0%	73.0%	73.0%	73.0%	74.0%	74.0%	98.0%	98%		
	% of national clinical audits participation / % required	DQ&G	100%	National	-	-	-	-	-	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	95.0%	95.0%		
	% Theatre Utilisation	COO	≥85%	WUTH	89.3%	82.9%	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	88.2%		

Quality Performance Dashboard

December 2018

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Caring	Same sex accommodation breaches	DoN	0	SOF	9	16	12	18	16	18	22	10	8	16	14	19	18	125		
	FFT Recommend Rate: ED	DoN	≥95%	SOF	92%	88%	92%	87%	82%	85%	90%	91%	89%	89%	86%	87%	84%	88%		
	FFT Overall Response Rate: ED	DoN	≥25%	WUTH	12.0%	11.0%	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11.0%	11%		
	FFT Recommend Rate: Inpatients	DoN	≥95%	SOF	98%	98%	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%	98%	98%		
	FFT Overall response rate: Inpatients	DoN	≥25%	WUTH	19.0%	17.0%	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	18.0%	19%		
	FFT Recommend Rate: Outpatients	DoN	≥95%	SOF	95%	95%	95%	94%	94%	95%	95%	94%	95%	94%	94%	94%	95%	95%		
	FFT Recommend Rate: Maternity	DoN	≥95%	SOF	93%	93%	97%	98%	100%	97%	97%	99%	96%	100%	100%	96%	100%	98%		
	FFT Overall response rate: Maternity	DoN	≥25%	WUTH	27%	30%	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	19.0%	30%		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2018

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	COO	≥95%	SOF	85.7%	78.4%	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	80.9%		A A A A A S O N D J F M
	12 hour trolley waits	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Ambulance Handovers >30 minutes	COO	TBC	National	252	651	528	427	623	414	327	291	213	326	474	371	440	357		
	Patients leaving ED without being seen	COO	<=5%	WUTH	1.9%	3.9%	2.3%	3.0%	4.3%	2.8%	2.8%	1.4%	1.7%	1.5%	2.3%	2.2%	2.0%	2.1%		
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	COO	≥92%	SOF	80.9%	77.7%	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	76.8%		A M J J A S O N D J F M
	Referral to Treatment - cases exceeding 52 weeks	COO	0	National	9	11	30	51	69	66	67	79	57	56	40	43	30	55		A M J J A S O N D J F M
	Diagnostic Waiters, 6 weeks and over - DM01	COO	≥99%	SOF	99.5%	98.7%	98.8%	99.2%	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%		98.6%		
	Cancer Waiting Times - 2 week referrals	COO	≥93%	National	98.8%	97.4%	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	94.3%		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	COO	≥96%	National	96.6%	97.0%	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.3%	96.5%		
	Cancer Waiting Times - 62 days to treatment	COO	≥85%	SOF	85.5%	85.9%	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	92.3%	87.2%		
	Cancelled outpatient appointments	COO	TBC	WUTH	5937	5304	6437	5808	3451	6131	6035	6515	6862	6771	6183	7098	6641	52236		
	Cancelled elective admissions - TCIs	COO	TBC	WUTH	322	316	711	307	345	206	190	243	218	234	203	266	277	1837		
	Cancelled Operations (on the day of planned surgery)	COO	TBC	WUTH	24	30	12	27	20	9	26	15	8	2	7	7	17	91		
	Did Not Attend - Outpatient Appointments	COO	≤6.5%	WUTH	8.3%	9.1%	8.6%	8.0%	8.1%	8.3%	8.6%	8.2%	8.7%	8.9%	8.7%	8.3%	8.3%	8.5%		
	Appointment slot issues (Outpatient Utilisation)	COO	TBC	WUTH	2326	1730	1532	1703	1812	2325	2477	3646	3868	4076	4117	4383	5075	3746		
	Patient Experience: Number of concerns received in month - Level 1	DoN	TBC	WUTH	117	68	123	134	144	118	134	110	140	123	155	119	165	1064		
	Patient Experience: Number of complaints received in month - Levels 2 to 4	DoN	TBC	WUTH	22	21	43	31	30	34	23	36	24	25	22	19	13	196		
	Complaint acknowledged within 3 working days	DoN	100%	National	95%	100%	96%	100%	97%	32%	81%	95%	72%	75%	80%	100%	100%	79.4%		
	First written response within policy timescale	DoN	100%	WUTH	6%	50%	19%	35%	22%	14%	32%	23%	23%	11%	29%	48%	39%	27.5%		
	Number of re-opened complaints	DoN	≤5 pcm	WUTH	2	6	4	4	1	2	2	7	5	0	4	2	3	25		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2018

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Well-led	Staff Friends and Family Test - overall engagement score	DHR	≥3.88	National	-	-	3.75	-	-	3.60	-	-	3.72	-	3.63	-	-	3.65		
	Live employee relations cases	DHR	≤30	WUTH	-	-	25	22	29	30	33	35	36	32	29	23	30	33		
	Duty of Candour compliance (for all moderate and above incidents)	DQ&G	100%	National	-	-	-	-	-	-	-	-	-	-	100%	100%	100%	100.0%		
	Number of patients recruited to NIHR research studies	MD	650 for FY18/19 (= average 55 per month)	National	-	-	-	-	-	37	48	331	66	45	40			567		
	% Mandatory Training compliance	DHR	≥95%	WUTH	-	-	-	-	have	73.0%	-	74.8%	75.1%	82.0%	81.4%	82.2%	82.8%	82.8%		
	% Appraisal compliance	DHR	≥88%	WUTH	88.2%	85.5%	84.3%	83.4%	83.3%	84.9%	-	81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	83.8%		

	Indicator	Director	Threshold	Set by	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Use of Resources	I&E Performance	DoF	On Plan	WUTH	-1.402	-3.712	-2.315	-1.614	6.485	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-20.845		
	I&E Performance (Variance to Plan)	DoF	On Plan	WUTH	-1.639	-2.898	-2.624	-0.424	0.162	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-2.639		
	NHSI Risk Rating	DoF	On Plan	NHSI	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
	CIP Forecast	DoF	On Plan	WUTH	-38.1%	-38.4%	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-5.4%		
	NHSI Agency Ceiling Performance	DoF	NHSI cap	NHSI	14.8%	19.6%	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%		
	Cash - liquidity days	DoF	NHSI metric	WUTH	-22.3	-17.5	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-13.0		
	Capital Programme	DoF	On Plan	WUTH	65.5%	68.6%	53.1%	51.2%	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	41.4%		

Board of Directors	
Agenda Item	8.1.2
Title of Report	**Month 8 Finance Report**
Date of Meeting	19 December 2018
Authors	Shahida Mohammed – Assistant Director of Finance Julie Clarke – Assistant Director of Finance Deborah Harman – Assistant Director of Finance
Accountable Executive	David Jago Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 8 Finance Report 2018/19

Contents

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

The following summary details the Trust's financial performance during November (Month 8) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£20.8m) against a plan of (£18.0m), being (£2.8m) worse than plan. The underlying deficit given deployment of non-recurrent resources of some £2.1m at month 8 is c £23.0m.

The patient related income position is £0.4m better than plan, however this includes £3.6m relating to MSK and income CIP added in year. The underlying position therefore being (£3.2m) worse than plan. The main areas driving this position are the under performance in elective and daycase activity, which is 2,659 spells (7.5%) behind plan, with a corresponding financial impact of (c£4.3m), and Outpatients attendances and procedures which are showing an adverse variance of (4,277) (2.1%), and a financial consequence of (£0.8m). There is also under-performance in maternity (£0.3m) and neonatal (£0.7m).Non-elective activity has delivered plan, and from a financial perspective the complexity of case-mix has remained strong resulting in a year to date surplus of £0.4m supporting the overall position. Further mitigation of the below income plan position has been the benefit of the MSK block contract (£1.2m) and the release of the accrual related to the Sepsis dispute (£1.3m) which has now been concluded with Wirral CCG.

In addition the pay reform funding of £2.7m for Mths 1-8, is showing as above plan in income with the contra entry in pay costs. Other income is better than plan by £0.5m but these relate to specific projects which are offset in expenditure.

The overall expenditure position is higher than plan by (£6.4m). However, pay includes the AFC pay reform as discussed above (£2.7m) and is largely offset in income. Non pay includes (£2.5m) associated with the MSK contracts which were not included within the original plan given in year contract sign off and again is offset in income. The underlying expenditure position is therefore (£1.2m) worse than plan.

The underlying pay position is £1.2m better than plan and is largely due to non-clinical vacancies which are delivering non-recurrent CIP. High levels of qualified nurse vacancies continue and consequently result in a high use of bank nurses. The agency spend is largely to cover medical gaps and remains under scrutiny and is marginally above the NHSI cap. Non pay is showing a financial pressure overall of (£2.4m) partly a result of outsourcing costs to deliver the patient waiting times in a number of surgical specialties from transfers earlier in the year and also as part of planned MSK contractual arrangements.

The overall I&E position includes £2.1m of non-recurrent balance sheet support (including Sepsis).

In month, the position is a deficit of (£1.5m) against a planned deficit of (£0.7m), therefore some (£0.8m) worse than plan.

The underlying contract income position is (£0.4m) worse than plan, the main impacts being elective/daycase income which is (£0.6m) worse than plan and Outpatients (£0.2m) worse than plan. This being offset by MSK block contract of some £0.4m.

The underlying expenditure position is (£0.5m) worse than plan and relates to medical pay pressures from vacancies and job plan changes prior period adjustments; in addition to some non-recurrent non-pay pressures and costs supporting staffing gaps through outsourcing and professional fees.

It should be noted that whilst the in month position is £0.8m worse than plan, this was in line with the forecast position with the actual compared to forecast for November being £39k better than expected.

The delivery of cost improvements is £0.6m above plan as at the end of M8 and the forecast for the year is £10.4m(£1.2m red risk rated), an improvement of £0.6m since last month. There remains a (£0.6m) gap still unidentified but work is on-going to crystallise further opportunities to close this gap. Of the £5.8m delivered to date £2.3m is non-recurrent where vacancies have mitigated the delivery of recurrent CIP. The plan for the delivery of cost efficiencies has been largely profiled to be achieved during the latter part of the year with a challenging Q4. The recurrent CIP for 2019/20 is £9.3m at M8 but further opportunities including the outpatient productivity programme are progressing.

As part of the Winter Capacity planning the Trust opened the “step down” facility (T2A) beds part way through November. This Ward will manage the previously significantly high numbers of “medically optimised” patients within the acute bed base, reflecting a lack of alternative support within the health and social care system and consequent adverse impact on flow. The facility will cost the Trust (£1.2m) for 2018/19, Wirral CCG has agreed to fund £0.6m, the remaining cost will be a pressure for the Trust.

Cash balances at the end of November were £5.8m, exceeding plan by £3.9m. This is primarily due to positive working capital movements and capital outflows below plan, offset by EBITDA below plan.

The Trust’s most likely forecast is a deficit of (£27.8m) against the planned deficit of (£25.0m); this includes the current recovery plan in place to manage the elective programme and the additional winter funding (£0.6m). Further opportunities are currently being explored which would reduce the deficit by a further £1.0m including revenue to capital and further balance sheet review. Notwithstanding this as there will remain a shortfall against the original plan submitted to NHSI, the Trust will be required to gain formal agreement of the increased deficit in line with the NHSI protocol. This is outlined in detail in Section 5.

3. Financial performance

2.1 Income and expenditure

Month 8 Financial performance	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Month 8 Forecast £'000	Month 8 Actual £'000	Month 8 Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Income from patient care activity	307,162	26,746	26,887	141	26,646	26,887	241	205,516	205,874	358
DOH - Pay Reform Income	0	0	348	348	348	348	0	0	2,669	2,669
Income - PSF	0	0	0	0		0	0	0	0	0
Other income	29,428	2,475	2,583	109	2,781	2,583	(198)	19,539	20,036	497
Total operating income	336,589	29,221	29,819	598	29,775	29,819	44	225,055	228,580	3,524
Employee expenses	(247,732)	(20,674)	(21,070)	(396)	(21,022)	(21,070)	(48)	(165,792)	(167,288)	(1,496)
Operating expenses	(101,875)	(8,201)	(9,220)	(1,019)	(9,221)	(9,220)	1	(69,430)	(74,352)	(4,923)
Total operating expenditure	(349,607)	(28,875)	(30,290)	(1,415)	(30,243)	(30,290)	(47)	(235,221)	(241,640)	(6,419)
EBITDA	(13,018)	346	(471)	(817)	(468)	(471)	(3)	(10,166)	(13,061)	(2,895)
Depreciation and net impairment	(8,160)	(684)	(684)	0	(684)	(684)	0	(5,398)	(5,398)	(0)
Capital donations / grants income	0	0	40	40		40	40	0	130	130
Operating surplus / (deficit)	(21,178)	(338)	(1,115)	(777)	(1,152)	(1,115)	37	(15,564)	(18,329)	(2,765)
Net finance costs	(4,105)	(346)	(330)	15	(333)	(330)	2	(2,643)	(2,516)	126
Gains / (losses) on disposal	0	0	0	0		0	0	0	0	0
Actual surplus / (deficit)	(25,282)	(684)	(1,445)	(762)	(1,485)	(1,445)	39	(18,206)	(20,845)	(2,639)
Reverse capital donations / grants I&E impact	243	20	(19)	(39)	(19)	(19)	0	162	35	(126)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	(25,039)	(664)	(1,464)	(801)	(1,504)	(1,464)	39	(18,044)	(20,810)	(2,765)

- In Month 8 there has been a further (£0.8m) deterioration in the position with a year to date deficit of c(£2.8m) however the Month 8 was marginally better than the expected forecast for November.
- The main driver of this position is the continued underperformance of the elective programme which is (£0.6m) below plan in M8 and (£4.3m) ytd. This is behind the expected elective recovery trajectory. The underlying position for contract income is (£3.2m) worse YTD and (£0.2m) worse in month excluding contract variations such as MSK which are offset by expenditure.
- The overall income position includes the AFC pay reform funding of £2.7m. Other income is £0.5m above plan which partly offsets expenditure.
- Total expenditure is (£6.4m) worse than plan; (£2.7m) relates to the AFC pay award and a further (£2.5m) is the sub-contracting costs of the MSK contract hence the underlying expenditure position is (£1.2m) above plan. Pay underspends are due to non-clinical vacancies which are mitigating recurrent CIP delivery whilst outsourcing costs in Surgery have been high earlier in the year.
- It has to be noted the overall year to date position also includes £2.1m non-recurrent balance sheet support.

3. Financial performance

2.2 Income

Activity

	Activity							
	Current month				Year to date			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%
Income from patient care activity								
Elective	813	619	(194)	(23.90%)	5,855	4,704	(1,151)	(19.65%)
Daycase	3,794	3,776	(18)	(0.48%)	29,365	27,857	(1,508)	(5.14%)
Elective excess bed days	397	401	4	1.02%	2,814	1,844	(970)	(34.46%)
Non-elective	4,019	3,835	(184)	(4.57%)	30,249	30,205	(44)	(0.15%)
Non-elective Non Emergency	484	426	(58)	(12.07%)	3,525	3,461	(64)	(1.82%)
Non-elective excess bed days	849	1,004	155	18.24%	6,358	6,881	524	8.23%
A&E	7,616	7,381	(235)	(3.08%)	61,942	61,756	(186)	(0.30%)
Outpatients	27,767	25,999	(1,768)	(6.37%)	203,238	198,961	(4,277)	(2.10%)
Diagnostic imaging	2,707	3,244	538	19.87%	19,943	20,373	430	2.16%
Maternity	521	515	(6)	(1.08%)	4,234	3,977	(257)	(6.08%)
Total NHS patient care income	48,967	47,201	(1,766)		367,523	360,019	(7,504)	

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

3. Financial performance

Income

	Income							
	Current month				Year to date			
	Plan £'000	Actual £'000	Variance £'000	%	Plan £'000	Actual £'000	Variance £'000	%
Income from patient care activity								
Elective	2,641	2,133	(507)	(19.21%)	18,735	15,749	(2,986)	(15.94%)
Daycase	2,533	2,483	(49)	(1.95%)	19,150	17,791	(1,359)	(7.10%)
Elective excess bed days	95	97	2	2.01%	678	453	(225)	(33.17%)
Non-elective	7,496	7,523	27	0.36%	57,922	58,330	409	0.71%
Non-elective Non Emergency	1,069	950	(120)	(11.18%)	8,313	8,019	(294)	(3.54%)
Non-elective excess bed days	210	243	33	15.53%	1,567	1,686	119	7.63%
A&E	1,064	1,087	23	2.16%	8,653	8,916	263	3.04%
Outpatients	3,143	2,920	(222)	(7.07%)	23,074	22,297	(777)	(3.37%)
Diagnostic imaging	219	250	32	14.52%	1,591	1,540	(51)	(3.20%)
Maternity	443	437	(6)	(1.32%)	3,605	3,466	(139)	(3.85%)
Non PbR	5,815	5,849	34	0.58%	46,118	46,398	280	0.61%
HCD	1,284	1,306	22	1.70%	10,276	10,540	265	2.58%
CQUINs	563	521	(42)	(7.50%)	4,502	4,192	(309)	(6.87%)
MSK Sub Contracts	0	375	375	0.00%	0	2,410	2,410	0.00%
MSK back to Block	0	413	413	0.00%	0	1,247	1,247	0.00%
Other	0	126	126	0.00%	0	1,381	1,381	0.00%
Total income from patient care (SLAM)	26,575	26,715	140	0.53%	204,183	204,416	233	0.11%

- Within the overall year to date position there are certain key areas under performing significantly, elective and daycases, which is showing a deficit of (£4.3m), reflecting both activity and casemix reductions, outpatient attendances are (c£0.8m) below plan, this is predominantly in outpatient first attendances and procedures. The revised elective recovery plan is being closely managed, although it is not expected the under performance in the earlier part of the year will be recovered.
- The overall position is mitigated following the commencement of the MSK “prime provider” contract from July 2018, which was not included in the original plan submitted to NHSI.This is supporting the income position by £2.4m, (some of this will be offset in expenditure due to payments to sub-contractors e.g. Wirral CT for Physio services). In addition, as this is a “block” contract, there is an additional cumulative benefit of £1.2m.
- Other PbR areas are not significantly behind plan, with the exception of Births which are (£0.3m) behind plan equating to (96) births, and Neonatal activity is cumulatively underperforming by (£0.7m), given the unpredictable nature of this activity and the reliance on the Neonatal network for a large proportion of this work, it is difficult to predict the recovery of this. There is an expectation that the position to recover.
- Included in the position is the successful conclusion with Wirral CCG of the disputed coding of Sepsis activity, during 17/18. This supported the position by c£1.3m, and other balance sheet support of £0.1m, this is recorded in the “Other” category in the above table.

2. Financial performance

2.3 Expenditure

- The overall expenditure position as at the end of M8 is showing an YTD over-spend of (£6.4m) against plan but excluding MSK of £2.5m ytd and AFC reform funding of £2.7 m then is an overspend of (£1.2m).

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

2.3 .1 Pay

Pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(225,643)	(18,857)	(18,863)	(5)	(151,166)	(151,069)	98
Bank	(6,662)	(556)	(793)	(237)	(4,444)	(5,701)	(1,257)
Medical Bank	(7,057)	(588)	(670)	(82)	(4,704)	(4,894)	(190)
Agency	(7,469)	(598)	(670)	(72)	(4,877)	(5,020)	(143)
Other - Apprenticeship levy	(900)	(75)	(75)	(0)	(600)	(605)	(5)
Total	(247,732)	(20,674)	(21,070)	(396)	(165,792)	(167,288)	(1,496)

- The pay position in M8 is showing a net overspend of (£0.4m) and YTD is (£1.5m) worse than plan. However, the plan excluded the AFC pay reform funding of (c£2.7m) year to date which is offset in income. The underlying pay position (i.e. adjusted for pay award funding) is largely on plan in-mth and c£1.2m underspent YTD.
- The underlying pay position shows substantive vacancies offset with significant use of bank, agency and other non-core pay. The bank figure is above plan and is largely due to supporting the substantive nursing vacancies and acuity particularly in the Medicine division. There remains substantial nursing vacancies across the Trust that bank are being used to cover gaps however fill rate remains low. Workforce plans and recruitment initiatives are continually under review with a proposed strategy on trainee nurse associate roles
- The agency figure is £0.7m this month and YTD is £28k above the NHSI ceiling of £4,992k ytd.
- Vacancies in Clinical Support and Corporate continue and non-recurrently they are supporting delivery of the CIP target.
- Pay CIP delivery is £1.3m higher than the NHSI plan however to note £0.9m of this is non-recurrent. The CIP plan was heavily weighted to non-pay.

2. Financial performance

2.3.3 Non pay

Non pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Purchase of Healthcare	(3,184)	(248)	(738)	(491)	(2,432)	(6,034)	(3,603)
Supplies and services - clinical	(35,475)	(2,917)	(2,950)	(34)	(23,809)	(23,049)	761
Drugs	(25,395)	(2,109)	(2,180)	(72)	(16,960)	(17,107)	(147)
Other	(45,982)	(3,612)	(4,034)	(423)	(31,626)	(33,560)	(1,933)
Total	(110,035)	(8,885)	(9,903)	(1,019)	(74,827)	(79,750)	(4,923)

- Non pay expenditure is (£1.0m) overspent in M8 and YTD is (£4.9m) above plan but the plan excludes the MSK contract costs of £2.5m year to date which are offset in income. The underlying non-pay position (adjusted for MSK) is c(£2.4m) overspent YTD of which CIP is a major variance (£1.7m). Clinical supplies reflect the low levels of elective activity in earlier months and the associated prostheses/clinical supplies underspend.
- Drug costs are above plan in-month and YTD; the high cost drugs element is (£0.2m) and is offset as a variance in clinical income.
- The position includes outsourcing costs to Spire in relation to gaps in elective capacity earlier in the year of c£1.6m for a number surgical specialties (Orthopaedics, Pain and ENT) with further radiology spend of £1.1m and the MSK contract of £2.5m.
- In other CIP delivery against the original plan is (£1.7m) lower and is offset in pay. The original plan was heavily weighted to non pay as the £4m unidentified gap at the time of submitting the plan was allocated to non pay. Again similar to pay £0.4m of the £2.6m YTD non pay CIP position is non-recurrent.
- In Q1 £0.3m supported the non pay position non-recurrently and was allocated to the divisions.

2. Financial performance

2.4 CIP by programme and division

Programme	Director	YTD			In Year Forecast						Recurrent Savings					
		NHSI Plan £k	Actual £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	Pipeline £k	Total £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	Pipeline £k	Total £k	Variance £k
Transformation																
Improving Patient Flow	Anthony Middleton	0	897	**897**	1,000	1,337	**337**	0	1,337	**337**	1,000	1,337	**337**	0	1,337	**337**
Improving Productivity	Anthony Middleton	285	443	**158**	478	726	**248**	144	869	**391**	478	860	**382**	749	1,610	**1,132**
Collaboration	Janelle Holmes	389	456	**67**	952	812	**(140)**	125	937	**(15)**	952	998	**46**	300	1,298	**346**
Digital Wirral	Paul Charnley	667	790	**123**	1,000	1,143	**143**	117	1,260	**260**	1,000	1,000	**0**	0	1,000	**0**
Sub total - transformation		**1,341**	**2,586**	**1,245**	**3,430**	**4,018**	**588**	**385**	**4,403**	**973**	**3,430**	**4,195**	**766**	**1,049**	**5,245**	**1,815**
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	90	221	**131**	134	314	**180**	41	355	**221**	134	19	**(115)**	30	49	**(85)**
Estates & Site Strategy	Dave Sanderson	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Pharmacy and Meds Management	Pippa Roberts	304	303	**(1)**	500	454	**(46)**	46	500	**(0)**	500	360	**(140)**	35	395	**(105)**
Procurement and Non Pay	Jane Christopher	657	204	**(454)**	1,150	275	**(875)**	775	1,050	**(100)**	1,150	193	**(957)**	372	565	**(585)**
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	1,111	2,504	**1,393**	1,936	3,446	**1,510**	657	4,103	**2,168**	1,936	2,493	**557**	541	3,034	**1,098**
Unidentified		1,681	0	**(1,681)**	3,850	0	**(3,850)**	0	0	**(3,850)**	3,850	0	**(3,850)**	0	0	**(3,850)**
Total		**5,184**	**5,818**	**634**	**11,000**	**8,507**	**(2,493)**	**1,905**	**10,411**	**(589)**	**11,000**	**7,260**	**(3,740)**	**2,027**	**9,287**	**(1,713)**

- YTD CIP performance is £0.6m ahead of the NHSI plan as at the end of M8 but the profile significantly increases in Q4.
- For the full year the Trust is currently forecasting £8.5m of fully developed schemes with a further £1.9m of plans in progress (pipeline) and opportunities and £0.6m remains unidentified at this stage. However included in the pipeline is c£1.1m of schemes that have a red risk rating.
- There are further opportunities to improve as the outpatient productivity work stream is validated. However there are significant risks associated with the £1.2m still risk rated as red and progressing the amber schemes of £0.9m to delivery.

3. Financial position

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 30.11.18 £'000	Actual as at 30.11.18 £'000	Variance (to plan) £'000	Forecast 31.03.19 £'000	Plan 31.03.19 £'000
	Non-current assets						
159,754	Property, plant and equipment	↓	158,458	157,527	(931)	166,302	160,148
12,763	Intangibles	↓	11,676	11,358	(318)	11,020	12,369
903	Trade and other non-current receivables	↑	903	855	(48)	853	903
173,420		↓	**171,037**	**169,740**	**(1,297)**	**178,175**	**173,420**
	Current assets						
4,171	Inventories	↑	4,171	4,157	(14)	4,157	4,171
18,423	Trade and other receivables	↓	20,364	19,338	(1,026)	18,454	18,424
0	Assets held for sale	→	0	0	0	0	0
7,950	Cash and cash equivalents	↓	1,894	5,776	3,882	2,117	1,773
30,544		↓	**26,429**	**29,271**	**2,842**	**24,728**	**24,368**
203,964	**Total assets**	↓	**197,466**	**199,011**	**1,545**	**202,903**	**197,788**
	Current liabilities						
(32,538)	Trade and other payables	↑	(28,914)	(31,926)	(3,012)	(35,390)	(27,752)
(3,224)	Other liabilities	↓	(3,224)	(4,396)	(1,172)	(3,224)	(3,224)
(1,074)	Borrowings	→	(1,075)	(1,076)	(1)	(1,076)	(1,076)
(548)	Provisions	→	(548)	(548)	0	(548)	(548)
(37,384)		↑	**(33,761)**	**(37,946)**	**(4,185)**	**(40,238)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	↓	**(7,332)**	**(8,675)**	**(1,343)**	**(15,510)**	**(8,240)**
166,580	**Total assets less current liabilities**	↓	**163,705**	**161,065**	**(2,640)**	**162,665**	**165,180**
	Non-current liabilities						
(8,812)	Other liabilities	↑	(8,584)	(8,585)	(1)	(8,471)	(8,470)
(49,258)	Borrowings	↑	(64,944)	(64,945)	(1)	(73,224)	(73,221)
(2,318)	Provisions	↑	(2,193)	(2,188)	5	(2,124)	(2,131)
(60,388)		↑	**(75,721)**	**(75,718)**	**3**	**(83,819)**	**(83,826)**
106,192	**Total assets employed**	↓	**87,984**	**85,347**	**(2,637)**	**78,846**	**81,366**
	Financed by Taxpayers' equity						
77,575	Public dividend capital	→	77,575	77,575	0	80,031	78,031
(12,259)	Income and expenditure reserve	↓	(30,467)	(33,104)	(2,637)	(42,061)	(37,541)
40,876	Revaluation reserve	→	40,876	40,876	0	40,876	40,876
106,192	**Total taxpayers' equity**	↓	**87,984**	**85,347**	**(2,637)**	**78,846**	**81,366**

Capital asset variances	£m
Capex underspend	-1.4
Donations above plan	0.1
Total variance of capital assets to plan	**-1.2**

Cash variances	£m
EBITDA and donation income below plan	-2.9
Working capital movements	6.1
Capital expenditure (cash basis) below plan	0.5
Other minor variances above plan	0.2
Total variance of cash to plan	**3.9**

3. Financial position

3.2 Capital expenditure

	2018/19 NHSI capital plan £'000	Full year Budget [1] £'000	Full year Forecast [2] £'000	Variance £'000	Full year Forecast [2] £'000	Green light schemes [4] £'000	Variance £'000	YTD Actual £'000
Funding								
Depreciation	8,160	8,160	8,160	0				5,398
Loan repayment	(1,015)	(1,015)	(1,015)	0				(508)
Finance lease	(60)	(60)	(60)	0				(41)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	176	173	3				130
Public Dividend Capital (PDC) - GDE	456	456	456	0				0
Public Dividend Capital (PDC) - Urgent and Emergency Care	0	2,000	2,000	0				0
Total funding	**10,791**	**12,967**	**12,964**	**3**				**8,229**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		238	238	0	238	92	146	47
Divisional priorities - *Surgery*		412	487	(75)	487	371	116	220
Divisional priorities - *Women and Children's*		432	436	(4)	436	283	153	168
Divisional priorities - *Clinical Support and Diagnostics*		1,069	936	133	936	223	713	66
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,518	1,518	0	1,518	1,518	0	0
Divisional priorities - contingency [3]	500	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Informatics - *Digital Wirral / Global Digital Exemplar*	2,811	2,801	2,801	0	2,801	2,410	391	373
Informatics	500	536	545	(9)	545	525	20	300
Estates - backlog maintenance	1,500	3,429	3,552	(123)	3,552	1,226	2,326	1,017
Car park		2,700	2,700	0	2,700	0	2,700	0
Cerner		(400)	(400)	0	(400)	(400)	0	(400)
All other expenditures		(193)	(155)	(38)	(155)	(155)	0	(155)
Urgent and Emergency Care		0	0	0	0	0	0	n/a
Contingency [3]	1,180	249	133	116	133	0	133	n/a
Reallocated funding	3,250	n/a	n/a	n/a	n/a	n/a	n/a	n/a
NHSI plan subtotal	**10,791**							
Donated assets	0	176	173	3	173	132	41	130
Total expenditure (accruals basis)	**10,791**	**12,967**	**12,964**	**3**	**12,964**	**6,225**	**6,739**	**1,766**

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.
[2] Current forecast includes slippage from 2017/18.
[3] Funding is transferred as business cases are approved.
[4] Green light schemes are those for which a feasible capital bid form has been approved, the scheme is expected to deliver in year and order(s) have been raised.

3. Financial position

NHS Wirral University Teaching Hospital NHS Foundation Trust

3.3 Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening cash	**6,969**	**2,344**	**4,625**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(1,445)	(684)	(761)	(20,845)	(18,207)	(2,638)	(29,802)	(25,282)
Net interest accrued	138	152	(14)	986	1,094	(108)	1,614	1,806
PDC dividend expense	191	191	0	1,528	1,528	0	2,292	2,292
Unwinding of discount	0	3	(3)	2	24	(22)	3	6
Operating surplus / (deficit)	(1,116)	(338)	(778)	(18,330)	(15,561)	(2,769)	(25,893)	(21,178)
Depreciation and amortisation	684	684	0	5,398	5,397	1	8,161	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(40)	0	(40)	(130)	0	(130)	(130)	0
Changes in working capital	(352)	(285)	(67)	3,791	(2,288)	6,079	(562)	(996)
Investing activities								
Interest received	13	3	10	79	24	55	113	48
Purchase of non-current (capital) assets [1]	(338)	(508)	170	(6,782)	(7,301)	519	(10,104)	(12,444)
Financing activities								
Public dividend capital received	0	0	0	0	0	0	2,456	456
Net loan funding [2]	0	0	0	15,728	15,728	0	24,027	24,027
Interest paid	(38)	0	(38)	(727)	(818)	91	(1,586)	(1,845)
PDC dividend paid	0	0	0	(1,189)	(1,189)	0	(2,335)	(2,335)
Finance lease rental payments	(6)	(6)	0	(48)	(48)	0	(70)	(70)
Total net cash inflow / (outflow)	**(1,193)**	**(450)**	**(743)**	**(2,174)**	**(6,056)**	**3,882**	**(5,833)**	**(6,177)**
Closing cash	**5,776**	**1,894**	**3,882**	**5,776**	**1,894**	**3,882**	**2,117**	**1,773**

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

Cash variances	£m
EBITDA and donation income below plan	-2.9
Working capital movements	6.1
Capital expenditure (cash basis) below plan	0.5
Other minor variances above plan	0.2
Total variance of cash to plan	**3.9**

4. Use of Resources

4.1 Single oversight framework

UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-11.9	3	-13.0	3	-12.9	3
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-3.1	4	-4.1	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-8.0%	4	-9.1%	4	-7.4%	4
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-1.1%	3	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-2.3%	1	0.6%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has marginally overspent against the agency cap, increasing the risk rating to 2, The Trust needs to continue its focus to reduced the spend in this area to bring the *Agency spend* rating back down to 1.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 8 UoR rating is 3 overall, which matches the 2018/19 plan UoR rating of 3.
- Forecast UoR rating is 3.

5. Forecast

The forecast scenarios are detailed in the table below and reflect the range of deliverables from the "best case" (£25m) to a forecast deficit of (£27.8m) "most likely" and "worst case" of (£29.5m).

	RAG rating	Best FOT £,000	Likely FOT £,000	Worst FOT £,000	Exec Lead	Comments and key actions, milestones required by Trust to achieve the Likely FOT
Annual Plan (excluding PSF) full year		**(25,042)**	**(25,042)**	**(25,042)**		
YTD Actual (CT excluding PSF)		**(20,810)**	**(20,810)**	**(20,810)**		
YTD run rate extrapolated for 18/19 full year		**(32,313)**	**(32,313)**	**(32,313)**		
Gross Income Risks						
CQUIN	Red	(218)	(325)	(325)	DJ	Staff and Wellbeing/Antibiotics/Improving Ill Health etc.
Readmissions	Amber	(500)	(500)	(500)	NS	Under query with WCCG
A&E Streaming	Red	(62)	(62)	(62)	DJ/AM	Transfer of funding to WCT
Other Penalties	Amber		(100)	(400)	DJ/AM	PLCP, ECDS impact on A&E activity
Income Upsides / Recovery Actions						
Income recovery plan EL/DC	Red	558	558	558	AM	Surgery EL/DC Recovery Plan
NEL Winter Profiling Adjustment	Amber	4,884	4,440	3,996	AM	Winter Profiling Medicine & W&C
Winter Funding (External)	Red	600	600	600	JH	Addl winter beds recognised by System and funded
Sepsis	Green	100	100		DJ	Mediation expected outcome
Activity Profiling	Amber	(959)	(1,065)	(1,172)	AM	Profiling improvments
MSK Contract	Green	872	872	872	AM	Reflects adjustment to run-rate income commencing M4
AFC Funding	Green	55	55	55	DJ	Scale Factor
National Support Funding	Green	98	98	98	DJ	Collorectal/UGI and Robotic activity - improve 62 day targets
Challenged Provider Funding	Green	200	200	200	DJ	In run rate
CIP Delivery						
Green schemes & Blue Schemes	Green					*In Run Rate £8,727*
Amber schemes	Amber	935	273		DJ/AM	Most Likely is £9.0m
Red schemes	Red	749			DJ/AM	Best Case £10.4m
Unidentified - gap	Red				DJ/AM	Worst Case £8.7m
Expenditure Risks / Commitments						
Step Down Ward	Red	(750)	(750)	(750)	AM	M3 Ward Contract
Additional Winter Beds	Red	(150)	(150)	(150)	AM	M3 Ward associated costs
Activity increase - Clinical Supplies	Red	(100)	(100)	(100)	AM	Related to Surgery EL/DC Recovery Plan
Seasonal Spend e.g energy	Red	(500)	(650)	(650)	AM	
MSK Contract	Green	(670)	(910)	(910)	AM	Reflects adjustment to run-rate costs commencing M4
Expenditure Upsides						
Elective Outsourcing	Amber	400	400	400	AM	Improvement in run-rate costs (no new transfers)
Activity Reserve	Amber	545	545	546	DJ	Central Reserve no longer required
RTT Delivery Reserve	Amber	464	464	464	DJ	Central Reserve no longer required
Balance Sheet Support	Red	722	503	25	DJ	Review of provisions and deferred income
Overall FOT		**(25,040)**	**(27,818)**	**(29,518)**		

The forecast analysis above is based on the current actual run rate of the deficit which stands at Month 8 at (£32.3m) which is an improvement on last month of (£34.5m). This improvement on last month is due to the continued improvement in the actual run rate of income.

The run rate is then adjusted for known changes to the current average monthly income/spend to give a forecast outturn of best, likely and worst scenario's.

These key changes to the run rate fall into the following categories:

Income Risks – the key risks to income are non-delivery of Q3/Q4 CQUIN milestones, additional penalties associated with a higher than contract level of avoidable readmissions and other contractual movements.

Income Upsides/Recovery Actions – Upsides include the benefit of winter on non-elective casemix and adjustments to the run rate for all income areas associated with lower activity planned in December and February as the current run rate has now recognised the improvements in maternity, neonatal and outpatient performance (profile adjustments). In addition, a number of smaller non-recurrent allocations have been consolidated. The recent

agreement on winter funding allocated to the Trust by the Health Economy has been recognised.

CIP Delivery – improvements in the run rate to achieve £9.0m in the 'Most Likely' case have been made. This is deterioration from the previous month as a detailed review of schemes has been completed. The assumption here is that all Amber and a small amount of Red rated schemes will be delivered. The total value of identified schemes is £10.4m and this is the assumption in the 'Best' case scenario. CIP is under constant review month by month.

Expenditure Risks / Commitments – the key items here are the costs associated with winter plans and increases in the run rate of seasonal spend such as energy. The MSK costs are the changes required to the run rate due to the commencement of the contract mid-year and reflect the expected costs of sub-contracting arrangements. The 'Best' case scenario includes an assumption that these costs will reduce as a result of the new pathway but this has not as yet been evidenced in the charges received, however the contract is only in month 4 of commencement.

Expenditure Upsides – This includes a slowing down of outsourcing costs reflecting no new transfers being made since Q2 and in addition the release of central reserves. The 'Best' case scenario assumes Balance sheet reserves associated with Research accounts and deferred incomes are enacted although this is likely to be controversial.

The Finance team have prepared a month by month forecast for the Finance, Business & Performance Assurance Committee recognising that the run rate methodology whilst useful initially can be replaced by an improved approach.

In line with guidance issued by NHSI the Trust will need to follow a set protocol in order to vary any financial outturn position and the variations can only be completed at the end of Q2 and Q3 reporting. As part of the process the Trust will be required to:

- Explain and analyse the key drivers of the deterioration.
- Formally evidence the actions that have been undertaken to recover the financial position.
- Confirm that the Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.
- Confirm that the senior clinical decision making body with the Trust has been engaged with and are party to the identification and delivery of the recovery actions.

This recovery plan described must explicitly reference:

- Detail the additional measures which will immediately be implemented to improve financial control and working capital/cash management, including capital programme review. This will need to include all discretionary spend, agency/locum spend, supplies and consumable spend and delegated commitment range and levels.

  Details of how the Trust is reviewing:

- The affordability of planned investments to improve service quality and performance;
- The acceleration of the delivery of productivity opportunities identified by the Carter Review;

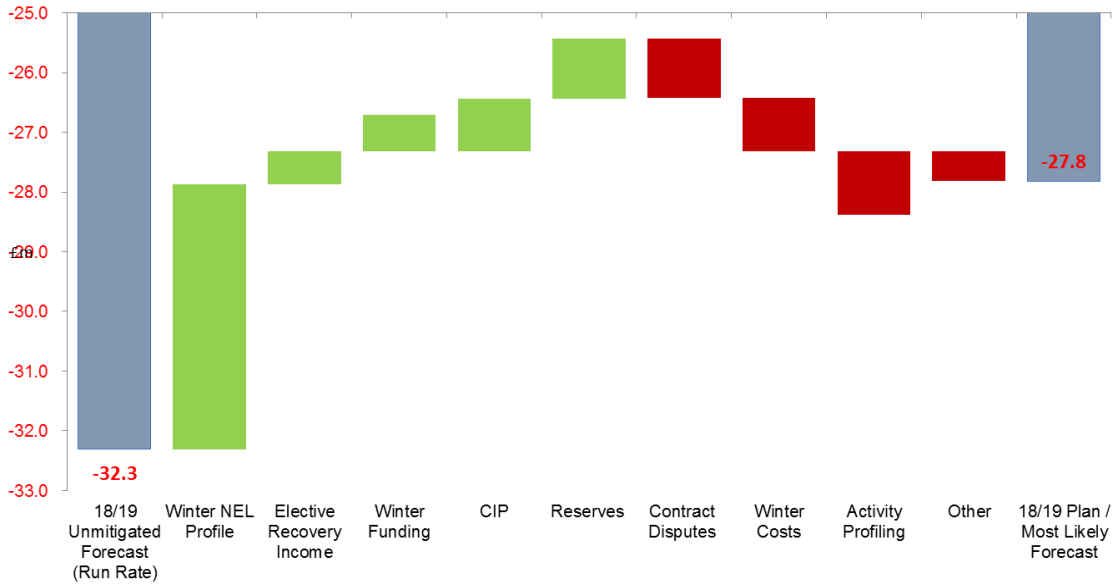
5. Forecast

- The acceleration of proposals for sub-scale service consolidation or closure;
- The impact on patient safety and experience of recovery actions;
- Demonstration of quarter on quarter improvement in I&E run-rate from the point the revision is submitted and how CIP delivery is being maximised.

"Most Likely" Forecast outturn (£27.8m)

The table below details by theme, the "known" risks and opportunities during the remainder of the year which would mitigate/manage the current position to achieve a revised deficit of (£27.8m).

- Elective recovery plan (including a benefit from the MSK block contract),
- Increase in non-elective activity as part of Winter profiling
- Income profiling impact on run rate
- Improvement in CIP delivery
- Potential contract penalties, CQUINs and PLCPs
- Release of RTT reserve.
- Offsetting these are the anticipated winter costs (step down ward) as part of the winter plan.



Board of Directors	
Agenda Item	9.1
Title of Report	Trust Flu Immunisation Position
Date of Meeting	19th December 2018
Author	Carol Skillen, Health & Wellbeing Manager
Accountable Executive	Helen Marks, 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 Impact Assessment Undertaken • **Yes** • **No**	No

1. **Executive Summary**

The following report provides the Trust board with an update on the take up rate of the flu vaccine in front line employees.

2. Background

Public Health England estimated that an average of 8,000 people die from flu in England each year. Some years that figure reaches 14,000. The National Institute for Health and Care Excellence (NICE) guidelines recently highlighted a correlation between lower rates of staff vaccination and increased patient deaths.

Flu-related staff sickness affects service delivery, and impacts on patients and other colleagues. Recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence.

This all describes a compelling case for ensuring that as many of our frontline workers are vaccinated. The NHS ambition is for 100% of healthcare workers with direct patient contact to be vaccinated and is seeking the leadership support of all Trusts

3. Key Issues/Gaps in Assurance

The trust activated its flu plan on 19th September 2018 which included the following actions:

- Ensuring that there are adequate levels of vaccine for the duration of the flu campaign in addition to having appropriate storage and access arrangements in place
- The recruitment of 35 peer vaccinators across the Trust to support the campaign
- Ensuring communications were involved in delivering key messages from the executive team to encourage staff to be vaccinated
- That 'opt out' forms were available for staff to complete if they refused the vaccination
- That structures for collecting and reporting data were in place

As of the 10th December 2018 the Trust has vaccinated 82.3% of healthcare workers with direct patient contact, which means we are in the top 8 of Trusts across the North West (top 4 of acute Trusts in the region). In fact, in all four of our divisions there are areas that have achieved 100%, for example the Emergency Department. However, this means that 922 of our frontline workers with direct patient contact remain unvaccinated. Currently only 36 members of staff have completed 'opt out forms' with some of our staff refusing to complete the forms. We are proactively using the 'opt out' forms to address some of the issues that staff have identified as concerns, such as:

"The vaccine will make me unwell"
"I don't know what's in it"
"I don't like needles"
"I am concerned about possible side effects"
"The vaccine will give me the flu"

4. Next Steps

By February 2019 there is an expectation that every Trust will report their Organisation's performance through their public board papers. In order to ensure that Trusts are doing everything possible to protect patients and staff from flu the Trust is required to complete a self-assessment checklist, which is **appendix 1** of this report.

Work is underway to address the areas that need improving and to look at what actions can be taken to continuously improve our figures through the winter period. The self-assessment framework will also be used as a blueprint to plan for next year's flu campaign.

5. Recommendations

The board is asked to:

- Note the Trust's current position in relation to the number of healthcare workers with direct patient contact being vaccinated
- Confirm the Trust Board's support to work towards achieving 100% of healthcare workers with direct patient contact being vaccinated
- Receive a position statement on Flu at the February 2019 board meeting

Appendix 1 - Healthcare worker flu vaccination best practice management checklist –for public assurance via trust boards by December 2018

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**	RAG RATED
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	An update on the flu uptake was given at November Trust Board. A Position statement to be presented at December Trust board confirms the Trust commitment to achieving the ambitious 100% target. Opt out forms are available for staff to complete and information is collected and is being used proactively to address issues and concerns	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	The Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	The board did not receive an evaluation of the flu programme 2017-18. However, the board will be receiving a board report, as described, in April 2019 for the 2018/19 flu season.	
A4	Agree on a board champion for flu campaign (3,6)	The executive Director of workforce is the board champion for the flu campaign	
A5	Agree how data on uptake and opt-out will be collected and reported	There are clear processes in place to capture the uptake data which is reported to the Executive Director of Workforce on a weekly basis. However, as this is the first year where staff refusing the vaccination needed to complete an opt out form the process for collecting this data has not been so robust. Managers have not always insisted on the form being completed and some staff have refused to complete the form. Data collection processes will be improved for the 2019/20 flu season	

A6	All board members receive flu vaccination and publicise this (4,6)	As at week commencing 10th December 2018 only two of our board members have not had the flu vaccination. There was a communication piece on the DOF receiving his vaccination last week but this has was has not be communicated across the Trust.	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	The Flu team was established in August 2018. However not all the groups identified were involved.	
A8	Flu team to meet regularly from August 2018 (4)	Flu team have met regularly since August 2018	
B	**Communications plan**		
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Letter from the Chief Executive as part of the opt out form encouraging staff not to opt out. Regular items in In Touch, Staff Magazine. Use of opt out forms to address employees concerns in In Touch. However, there has not been any clinical leadership or trade Union involvement.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	Accessible drop in clinic established which was advertised across the Trust using social media.	
B3	Board and senior managers having their vaccinations to be publicised (4)	Communication opportunity missed to publicise members of the Trust board and senior managers having the flu vaccination.	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Arrangements have been and remain in place for flu vaccination to be available at Induction.	

B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	There has been systematic flu promotion across the Trust using social media, screensavers posters.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Weekly feedback figures on uptake are provided to the Triumvirate leadership and the appropriate Executive Directors	
C	**Flexible accessibility**		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	35 Peer vaccinators have been identified and trained across all the divisions, who have supported their release to assist in the campaign	
C2	Schedule for easy access drop in clinics agreed (3)	Accessible drop in flu clinics are in place	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Mobile vaccinations which are available 24 hours are in place	
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this (3,6)	To date the Trust Board have not considered incentives	
D2	Success to be celebrated weekly (3,6)	Updates have been provided on date flu vaccination uptake but this has not been publicised or celebrated on a weekly basis.	

Board Of Directors	
Agenda Item	9.2
Title of Report	Six Monthly Nurse Staffing Report
Date of Meeting	19 December 2018
Author	Gaynor Westray Director of Nursing & Midwifery Tracy Fennell Deputy Director Of Nursing
Accountable Executive	Gaynor Westray Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1,3,5
Level of Assurance **Positive** **Gap(s)**	Positives • A full establishment review has been undertaken following a Safer Care Nursing Tool (SCNT) acuity and dependency review as per National requirements • The Trust has the ability to demonstrate effective processes to meet the National Quality Board requirements. • A detailed report reviewing all key areas of safer staffing was presented to and noted by Patient Safety and Quality Board (PSQB) in November 2018. • An updated safe staffing action plan will be presented to WAC in January 2019 detailing regional work to address staffing gaps. Gaps • Mandatory Training in below target raising a risk the Trust is unable to ensure it has the staff who are suitably qualified and competent to meet patients' needs safety and effectively . • The Trust continues to have large numbers of nursing vacancies affecting the ability to provide optimum levels of care / patient experience to patients.
Purpose of the Paper **Discussion** **Approval** **To Note**	Discussion and Approval
Reviewed by Executive Committee	
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not required

Executive Summary

Following the investigation into Mid Staffordshire NHS Trust, The Francis Report (2013), NHS England (NHSE) and NHS Improvement (NHSI) requested that all NHS Providers Boards receive monthly reports on planned and actual nursing and care support staffing levels. This report provides an update to the Board of Directors on staffing levels during June - September 2018 and reports the Trusts ability to meet the National Quality Board Requirements set out below.

Background

The Carter report and the NHS Five Year Forward View planning guidance make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute Trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and E-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, Care Hours per Patient Day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments. CHPPD data is now being collected as mandated by NHS England (2016) and will be routinely compared to all other regional Trusts when the data is available through the Carter review and NHSI model hospital portal.

The National Quality Board (NQB) published "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe, sustainable and productive staffing" (2013, updated in 2016). In line with the NQB requirements, a six monthly safe staffing establishment review of inpatient areas has been completed, and the results of which will be reported to Board of Directors in December 2018. The NQB (2016) describes three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework that will support effective, caring, responsive and well led care.

The table below identifies the three updated NQB expectations that form a 'triangulated' approach 'Right Staff, Right Skills, Right Place and Time' to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which are monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

The Trust has reviewed position against the requirements noting compliance with mandatory and essential training remains a risk for the Trust. Trajectories have been set within the Divisions for Mandatory Training to achieve the Trust target of 95% by 31 March 2019. This performance is monitored via the Workforce Assurance Committee, Divisional Performance Reviews. Essential Training standards are currently being mapped against core competencies for each nurse role; this will be presented to WAC in February 2019.

Trust Position

Available evidence from NHSI / NHSE suggests there are six critical issues for safe staffing and quality patient care and experience are as follows:

1. Expert clinical leadership at Sister / Charge Nurse and Matron Level
2. Appropriate skill mix for the acuity and dependency of the patient group
3. Appropriate establishment for the size / complexity of the unit
4. Ability to recruit the numbers required to fill the establishment
5. Good retention rates to ensure staff that are experienced in the clinical speciality and context / environment
6. Ability to flex at short notice to fill with temporary staff when there are unplanned vacancies / or to use staff from other areas

Clinical leadership

Across all the wards and units at Arrowe Park and Clatterbridge Hospitals there are very few vacancies at ward manager / matron level, Currently the Trust has one ward manager vacancy (advertised) and two matron vacancies, one in medicine and one in theatres. However it must be recognised that a number of key roles, such as the Matrons, Associate Directors of Nursing and the Divisional Directors of Nursing posts in both divisions are or will be new appointments. Whilst this brings new ideas and energy to Wirral University Hospitals Trust, it is essential these leaders have the right development / support opportunities. These leaders are being developed via the Top Leaders Programme, and the WUTH Leadership at every level framework. A Training Needs Analysis is currently being undertaken to fully understand training and development needs of the ward managers. Agreement has be sought to include ward managers in a bespoke 'Top Leaders' programme.

Skill mix Registered Nurse (RN) : Clinical support Worker (CSW)

Every ward and unit will have different acuity and dependency scores and, therefore, require a specific skill mix. Nationally it is recognised that a skill mix for general wards of 60:40 ratio of RN:CSW is significant in achieving improved outcomes and good patient experience. The evidence based acuity tool currently used within the Trust is The Safer Nursing Care Tool (SNCT), often referred to as the Shelford model. The latest acuity and dependency review was conducted in Quarter 2 2018/19, in conjunction with skill mix review and professional judgement. All staffing models were checked and confirmed on the basis of 60:40 ratio, increasing CSW in some areas to support therapeutic supervision of vulnerable patient. Outcomes of this review was presented to Trust Management Board and Board of Directors in December 2018. It is recommended by the National Quality Board (NQB) that such a review is performed using a recognised validated tool every six months. The next review at WUTH will be commenced in January 2019 again using the SCNT tool for general wards and the recognised model Baseline Emergency Staffing Tool (BEST) for the Emergency Department. The Trust will continue to use this methodology until Cerner is able to launch Clairvia (real time acuity and dependency based on clinical entries to each individual patient), an options appraisal will be presented to Wirral Digital Board January 2019.

Establishment

Numbers of registered nurses (RN) and clinical support workers (CSW) for each ward is also essential. The review cited above concluded in November 2018 ensuring all areas were working to minimum safe staffing levels as set out by the Director of Nursing and Midwifery:

General wards: 1 RN to 8 Patients on a dayshift and 1 RN to 10 Patients on a night shift
Assessment Areas: 1 RN to 6 patients
Critical Care Level 2: 1 RN to 2 patients

As part of the staffing standard it was agreed ward manager will work clinically two days and protected leadership days for three days.
The role of a ward based housekeeper for each area was identified to assist with the vision for a safe clean environment and releasing the nursing staff time to care.

The establishment paper was presented to Executive Management Team (EMT) and Trust Management Board (TMB) in December 2018 where recommendations were agreed.

Retention

Consistent retention rates are important to ensure staff are experienced and expert in the specialty, and working as a coherent part of the multidisciplinary team. Overall Midwifery and Nursing turnover is 9.20% against a Target of 10%. However it is be noted that the turnover within Medicine and Acute is currently 12.87%, Surgery at 11.9% and Women and Children's at 7.9%. The Trust has an Organisational Development Workforce plan that is monitored via Workforce Assurance Committee. All actions relating to retention remain on track. The Trust is also actively involved in regional work led by NHS England to address this issue as part of a national drive to improve workforce and retention across the NHS. The Trust is also introducing internal transfer of substantive staff to support individual development and requests to support the retention of staff.

Recruitment

Recruitment of band 5 nurses remains a challenge nationally. WUTH currently holds 136 band 5 Registered Nurse vacancies with 100 being in the Medicine and Acute Division. WUTH has pursued a variety of recruitment initiatives including oversea recruitment and regional events. However speciality recruitment open days appear to be proving effective, particularly in areas such as theatres and Emergency Department (ED). Rotational contracts have been particularly popular recently recruiting 16 WTE to rotational contracts covering ED, Older Peoples Assessment Unit (OPAU) and Acute Care Unit (ACU). The Trust has a plan to ensure from January 2019 recruitment initiatives will be taking place every month including Divisional, Corporate and regional events. There are particular drives to engage with Academic Institutions and Schools to increase the awareness of nursing and healthcare roles.

Temporary staff

The overall fill rate for N&M for October 2018 is 56.10% The Trust has challenges in achieving fill rates with temporary staff, this is reported to be due to the low base rate of pay; a review paper will be presented at Workforce Assurance Committee (WAC) in January 2019 to explore options to address this issue. Nurse agency use remains low compared to other Trusts; fewer than 3% of the temporary staff fill rates. The Trust has a safe staffing oversight tracker (SSOT) in place to ensure staffing remains safe on a daily basis. Staffing is reviewed divisionally daily and plans are made for any forthcoming gaps ensuring any "red areas" have a mitigation plan. This is presented on a heat map overseeing the whole organisation visible to the Director of Nursing and Midwifery, and escalated as per the Trust safer staffing policy. As of December 2018 compliance with the SSOT will be reported monthly to Executive Management Team. December noting 100% compliance in use of tool across Medical and Surgical Divisions but also raising the need for a technology solution to monitor fluid and responsive staffing models based on activity and acuity.

OD Work Plan

Nursing and Midwifery is a key component of the OD work plan which also includes the collaborative working now being undertaken by the Trust as part of Cheshire and Merseyside Nursing and Midwifery Workforce Programme. This programme has five key work streams.

- Nursing and Midwifery workforce data
- High quality clinical placement management and capacity
- Recruitment and retention: zero vacancies
- Continuous Professional development framework and core CPD offer
- Shared services

The updated plan will next be presented to Workforce Assurance Committee in January 2019. The safe staffing work plan is divided into the following areas:

Strategic

To continue to implement the published guidance from NHSI including the publishing of safe staffing levels, taking into consideration the recent ward acuity and dependency reviews. The escalation procedures to support actions when staffing levels are below the safe staffing levels. A review of IT options including use of TrendCare, SafeCare and Clarvia acuity monitoring tools with an options appraisal being presented to Wirral Digital Board January 2019

Operational

Effective use of E-rostering systems including the monitoring of KPIs, E-roster compliance meetings, Escalation SOP, Safer Staffing Oversight Trackers

Quality Assurance

Monthly dashboard including CHPPD presented to Workforce Assurance Committee and Quality and Safety Committee. A six monthly review of nurse staffing levels, with a declaration made to Patient Safety Quality Board (PSQB) and Board of Directors.

Harm Reviews

The Trust has a robust process in place following revision of the Serious Incident Reporting Group (SIRG) to ensure that for any patients who have come to moderate or severe harm, that staffing levels are reviewed to ensure this was not an influencing factor. The reviews completed for this time period confirms that staffing levels was not a factor in any of the harm reviews.

Safe Staffing

The number of staff required per shift is calculated via the establishment reviews using an evidence based tool, based on the level of acuity of the patients. This is further informed by professional judgement, taking into consideration issues such as ward size and layout, patient dependency, staff experience, incidence of harm and patient satisfaction which is in line with NICE guidance. This provides the optimum planned number of staff per shift. Trusts are now required to report staffing data by using the consistent measure of Care Hours per Patient Day (CHPPD) rather than the traditionally reported fill rates. CHPPD is calculated daily by the cumulative hours of RN and CSW divided by the total number of patients. This data has been recorded on Unify since May 2016. The table below is the latest data available from within the portal which is for July 2018. Currently this CHPPD data when compared to other Trusts within the region is demonstrating that WUTH is below the national average. However as indicated in the latest guidance (August 2018) there has been a call to include AHP staffing data into CHPPD and this has been actioned in other organisations. Work has commenced with colleagues in AHP to enable the Trust to include this data from January 2019. An initial review has indicated that this will bring our CHPPD in line with the national average figures. This is reported monthly in the Quality Dashboard and data was presented by ward level to PQSB.

	WUTH	National Average	Peers based on Trust size and spend
Total CHPPD	7.6	8.1	8
Registered Nurse	4.2	4.8	4.8
CSW	3.5	3.2	3.2

Conclusion

- The Trust continues to work towards compliance with the requirements of NHS England, the CQC and the NQB Guidance in relation to the Hard Truths response to the Francis Inquiry. With a focus on mandatory training compliance to be at 95% by 31 March 2019 and incorporating AHP into CHPPD data by January 2019
- The Trust is engaged with national and regional programmes which are aimed at supporting the Trust to build a safe and sustainable workforce.
- Within the reporting period, the Divisions have been actively managing their staffing levels and actively attempting to increase the number of care hours available.
- The Divisions have been developing a number of innovative and diverse roles that enhance patient care and experience as well as building a competent sustainable work force through the use of clinical educators, therapy assistant roles, pharmacy technicians and discharge trackers.
- There are a number of initiatives that the Trust has planned over the next 12 month period, such as the introduction of Nursing Associates to further build on sustainable staffing development. The Nursing Associate role will provide new routes into pre-registration nurse training.

Safe Staffing Declaration

Through analysis and triangulation of the available data, reported via the monthly nurse staffing report, and local monitoring by divisions and corporate nursing team aligned with the review of all moderate and severe harms via the serious incident panel there are no correlations between staffing levels and patient safety issues. Hence no patient safety, serious incidents occurred during the time period as a result of staffing issues.

Recommendations

The Board of Directors is asked to note six monthly nurse staffing report and the safe staffing declaration presented by the Director of Nursing and Midwifery

Appendix 1

NQB Expectation	RAG	WUTH position
Expectation 1 Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers		• Establishment reviews completed using Safer Nursing Care Tool (SNCT) and Baseline Emergency staffing Tool (BEST). Triangulated with clinical outcomes and professional judgement • Safe staffing levels set by Director of Nursing & Midwifery • Monthly reporting of CHPPD to NHSI • CHPPD benchmarked using Model hospital
Expectation 2 Right Skills 2.1 mandatory training, development and education 2.2 working as a multi-disciplinary team 2.3 recruitment and retention		• Mandatory training compliance below target. No centralised records held for clinical training. Trajectories monitored divisionally at Divisional Management Boards, Divisional Performance Reviews. • AHP – to be included in CHPPD, use of therapy assistants, pharmacy technicians, ANP to fill medical and nursing gaps. Role of Nurse Associate in future work force planning
Expectation 3 Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency		• Safe staffing levels set by Director of Nursing & Midwifery • Escalation procedure in place , recruitment drives, use of safe staffing oversight tracker (SSOT) - compliance report monthly to EMT from December 2019 • Ward staffing information boards including all required information available outside all ward areas. Currently scoping for a IT version as part of IT solution • Planned review of non-ward based nursing staff

BOARD OF DIRECTORS	
Agenda Item	10.3
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	19 December 2018
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The fifth meeting took place on Thursday 6 December 2018. The committee has been reformed and aligned with revised terms of reference which were approved at the meeting.

2. Key Agenda Discussions

2.1 Chair's Business

The Chair described some of the wide range of improvements and initiatives put in place in 2018 by the Trust's Workforce directorate. Whilst it is appropriate to focus on workforce risks and associated assurance, it was also important to recognise successful workforce interventions and thank the staff responsible.

2.2 **Staff Story**

The committee received a staff story from a junior doctor at the Trust. The story highlighted the potential damage caused by inappropriate staff behaviours and the patient safety risk that can accompany internal conflicts. The committee agreed it was a powerful reminder of how far the culture needs to change as this was just one department. The committee were assured that the incident had been followed up and corrective and preventative actions taken.

The committee noted that Freedom to Speak Up is to be re-launched with new communication materials.

.

2.3 **5 Key Workforce Goals**

The Executive Director of Workforce reminded the committee of the Trust's 5 Key Workforce goals

- To develop leadership and culture that supports and enables the workforce to deliver high quality care and positive staff experience
- To engage our workforce, communities and stakeholders in our improvement journey
- To recruit, retain and develop a sustainable workforce
- To strengthen and focus action that supports the health and wellbeing needs of the workforce
- To promote inclusion and diversity

These five goals will inform the Workforce Assurance Committee priorities going forward.

2.4 Workforce Planning

The Workforce Repository and Planning Tool (WRaPT) project will be progressed through the Transformational Programme Board with the scope to be agreed at the December meeting. A pilot of the tool is planned for the Women & Children Division. The goal is for a Trust wide workforce plan to be in place by end June 2019.

2.5 Recruitment Update

The committee received a report on the work being undertaken in relation to recruitment.
It was agreed that a 'deeper dive' on band 5 nurse recruitment, retention and demographics to be presented on a Divisional basis at the next Workforce Assurance Committee.

The committee also noted the breadth of planned actions for a future recruitment strategy, including greater use of social media, links to the volunteer initiatives and greater collaboration with local universities on a wider basis.

2.6 Workforce Dashboard

The committee noted the continued risks of deteriorating sickness absence levels and increasing nurse vacancy rates. The committee was advised that the HR Business Partners are now meeting with divisional managers weekly to review all the HR KPIs and performing audits of key workforce processes (e.g. appraisals).

The committee received and approved a suggestion to invite one Division per meeting to give assurance on the Workforce agenda and its 5 key goals in their area of staff responsibility.

2.7 2018 Staff Survey

The committee were pleased to hear the response rate had reached 45% (all staff were surveyed this year) and were reminded of the much lower return rate from only 10% of the population in the 2017 staff survey. The committee thanked Mike Baker, Head of Communication & Engagement for his considerable efforts with this year's staff survey.

3. Next Meeting

Tuesday 22 January 2019 2pm to 4pm

4. Recommendations to the Board of Directors

- To note the contents of this report

BOARD OF DIRECTORS (Public)	
Agenda Item	10.4
Title of Report	CQC Action Plan Progress Update
Date of Meeting	19th December 2018
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	To be confirmed.
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for **assurance** to the Board **The Board is invited to receive and consider this report as provisional assurance. Under normal conditions teams would have at least an extra 7 days to provide evidence of assurance which demonstrates progress against the plan. As the Board's meeting in December occurs earlier in the month, there are some actions that have been 'red-rated' following confirm and challenge meetings on the basis that assurance was not yet available at the time of report. We are continuing to source and review evidence of progress, and will do so up to and including 31st December 2018. We therefore anticipate an improvement on the overall position against the plan for December which will be confirmed and reported to the Board in January 2019.**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

CQC ACTION PLAN UPDATE REPORT
PROVISIONAL REPORT - POSITION AS AT 19TH DECEMBER, 2018

1. PURPOSE

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

2. BACKGROUND OR CONTEXT

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

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

3. ANALYSIS

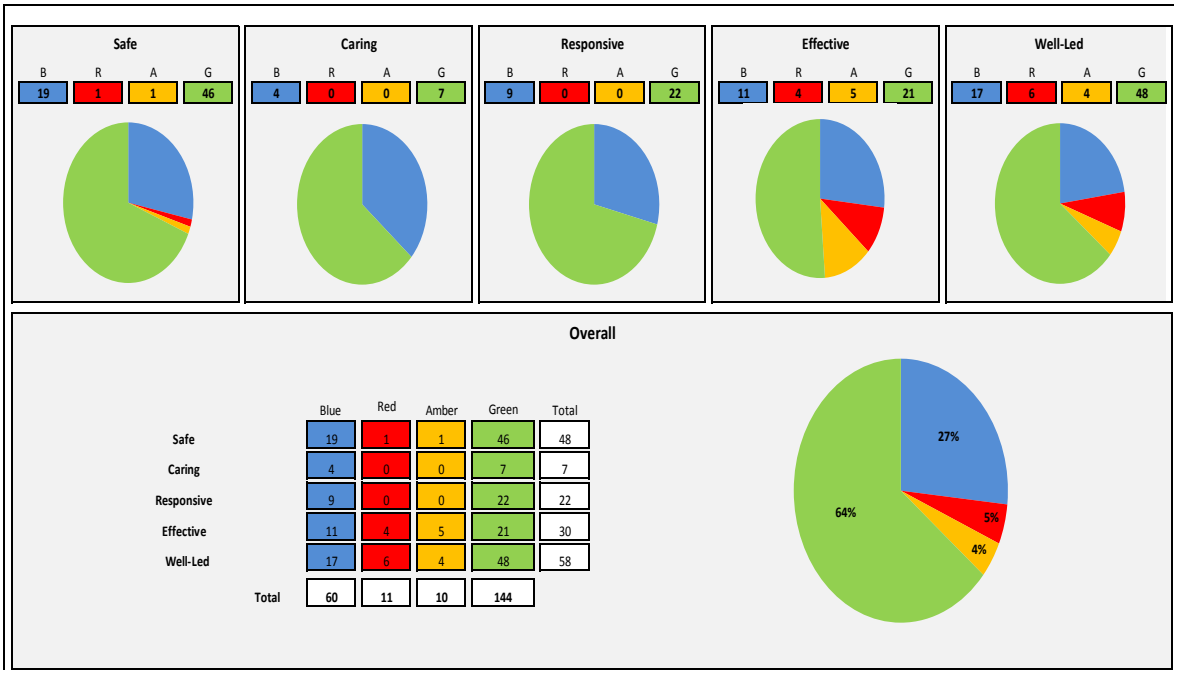
3.1 The CQC inspected the Trust in March and May 2018. The outcome of the inspection was as follows:

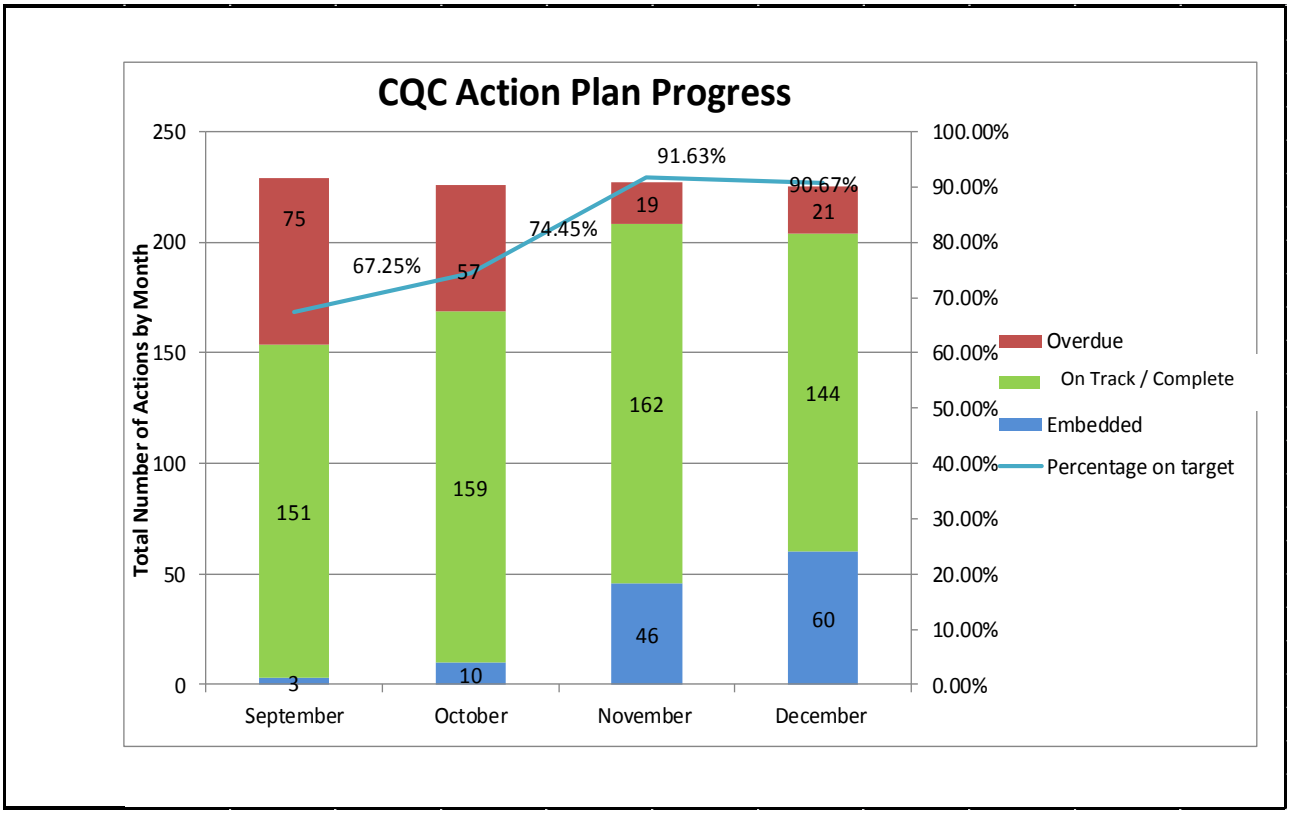
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

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

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

4. CQC Action Plan Progress –December 2018





5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held on 11th December 18, there are 11 actions which have been [provisionally] 'red-rated' and are to be reported as exceptions for this reporting period. The assurance at the time of report indicates a slight increase in overdue actions this month. Directors are actively managing these matters and have until 31st December 2018 to conclude the December cycle. An improvement on the overall position against the plan for December is therefore anticipated. This will be confirmed and reported to the Board in January 2019.

Overdue actions concern operational matters and refer to medicines management, risk reporting tools, Health & Safety, Estates, Clinical and IT. For reference the detail of overdue actions is set out in **Annex A**.

In **Annex B** we draw the Board's attention to 'embedded' actions (i.e. those actions completed and sustained for 3 months or more). The number of embedded actions is growing steadily and can be interpreted by the Board as satisfactory evidence of implementation.

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

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

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

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

7. RECOMMENDATION

The Board of Directors are invited to:

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

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
30	Must Do	Corporate / Trust-Wide Issues	**HEALTH & SAFETY** Surgery : The Trust must ensure systems and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Emergency Department: The service should ensure that health and safety risk assessments are kept up to date.	Carry out a site survey at APH and CBH to ensure that extension **leads are compliant with all safety requirements and only PAT-tested leads are in use**. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	**UPDATED: 11/12/18** Initial report presented to RMC in November 2018. This was discussed but not accepted by the Committee because it [the report] lacked detail of a specific remedy to address the matters identified in the site survey. The Committee requested an action plan to be made available for the December meeting. Head of Estates has agreed to review and PAT test all extension leads that are in use. Update to be provided at Risk Management Committee 17th December 18.	01/10/2018	
57	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery:** The service should ensure all medical records are stored securely. **Maternity:** The service must ensure that women's care records are kept securely in locked cabinets at all times.	Identify and resolve any faulty or defective records cabinets or trolleys and obtain assurance from all ward managers / departmental heads that records cabinets / trolleys are fit for purpose	Director of IT and Information	Well Led	**Updated: 11/12/2018** 'Red-rated' as due date has lapsed. Director of IT is confident that there is a Standard Operating Procedure available, and thus action has been completed, but evidence of completion could not be produced at the time of Confirm & Challenge meeting. The Director of IT has agreed to source and provide the assurance that demonstrates completion of this action. RAG can be updated next month once evidence has been submitted.	01/09/2018	

58	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery :** The service should ensure all medical records are stored securely. **Maternity :** The service must ensure that women's care records are kept securely in locked cabinets at all times.	Review and assure the security of records during transit	Director of IT and Information	Well Led	**UPDATED 11/12/2018** Audit has taken place and security arrangements have been reconfirmed. Director of IT is taking steps to address ongoing issues with Ward Managers. Action is Red-rated until confirmation of completion received from Director of IT. Delivery date has lapsed.	01/10/2018	
104	Should Do	Corporate / Trust-Wide Issues	**MEDICINES TEMPERATURES** The service should ensure that staff monitor the drugs room temperature and take action to address the temperature if it is outside of an appropriate range. **SLUICES AND MEDICINES ROOMS** The service should ensure all sluice areas and medication rooms in the unit are secure and that refrigerators in the medical room and packed appropriately. **Maternity :** The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations.	Conclude discussions on case for change to introduce air conditioning in selected/all medicines storage areas due to temperature excursions >25 degrees	Executive Director of Nursing and Midwifery	Effective	**Updated: 11.12.2018** Information to confirm completion of action was not available to the Executive at the time of the December Confirm & Challenge meeting. Action provisionally 'Red-rated' due to slippage on due date and evidence available to demonstrate compliance. An additional Confirm & Challenge meeting is being arranged with the Director of Pharmacy to secure the assurances needed to demonstrate progress against this action.	01/10/2018	

167	Must Do	Corporate / Trust-Wide Issues	**"RISK REGISTER** This issue affects all divisions but the report highlighted the Critical Care, Medicine and End of Life Care core services Critical Care : The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service. Medicine : The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way. End of Life Care : The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers. "	Review and refresh the divisional risk profile	Executive Director of Quality & Governance	Well Led	**Updated: 11/12/2018** In November 2018, the Risk Management Committee advised all divisional teams of the need to produce updated risk registers for review of reportable risks (i.e. ≥10). The Risk Management Committee is on track to review risk registers in readiness for submission to CQC as part of the 'Provider Information Request' anticipated early in the new year. However, there is some uncertainty at the time of report that the Division of Surgery will be ready to submit their risk register for review. This matter has been escalated internally.	30/11/2018	
190	Should Do	Medical Care (Acute & Medical Division)	**"MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards. "	Rectify defects identified through the existing quarterly audits in all wards and departments	Executive Medical Director	Effective	**Updated: 11/12/2018** The Medical Director is content that this is being monitored and non-compliance followed up. Reporting metrics are to be reviewed and streamlined [simplified]. Ongoing monitoring will be included in Perfect Ward app. The Executive was lacking information at the time of the December Confirm & Challenge meeting. Action provisionally 'Red-rated' due	01/11/2018	

							to apparent slippage on due date. An additional Confirm & Challenge meeting is being arranged with the Director of Pharmacy to secure the assurances needed to demonstrate progress against this action.		
216	Must Do	Corporate / Trust-Wide Issues	**"MORTALITY REVIEWS** The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning."	Review and provide assurance regarding the fitness for purpose of the existing Learning from Deaths policy making changes as necessary	Executive Medical Director, Executive Director of Quality & Governance	Well Led	**November Position** A review of the mortality review process has been undertaken; established a need for further development of the process. Mortality review group data to be better utilised. Ulysses system planned to be operational from December to facilitate timely reviews. Some discussion and agreement required with Bereavement services. **UPDATE: 11.12.2018** - Ulysses system procured and communications have been issued. Policy to be developed and approved. Ulysses mortality module has been switch on. The rate of reviews requires improvement.	01/09/2018	
111	Should do	Urgent And Emergency Care (Acute & Medical Division)	**Pain Management** The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.	Review and provide assurance on the adequacy of pain management training and completion to PSQB	Executive Director of Nursing and Midwifery	Effective	**Updated: 11/12/2018** This item has been delayed due to staff sickness. Reallocation of the action is being considered and will be picked up as part of 'role specific essential training programme'		

178	Must Do	Corporate / Trust-Wide Issues	**COMPETENCY ASSESSMENTS AND MANDATORY TRAINING** **Emergency Department :** The service must ensure that all staff complete full competency assessments to undertake their roles and that this is recorded in line with trust policy. The service should ensure that mandatory training is completed by all staff in a timely way. **Medicine :** The service should ensure a record is maintained when role specific competencies are achieved. The service should improve mandatory and safeguarding training compliance across all staff groups. **Critical Care :** The service should ensure that the unit meets the trust target of 95% for completion of mandatory training and for protecting vulnerable people training. **Maternity :** The service should ensure that mandatory training, safeguarding training and appraisal compliance is increased.	Establish online training and courses, where appropriate, to meet staff training needs	Executive Director of Workforce	Well Led	**Updated: 11/12/2018** Substantial progress has been made to establish a virtual learning environment using on-line learning materials for the 'core-10' mandatory training subjects. There is only one subject that has yet to conclude the review and migrate to e-learning platform. This is core Health & Safety mandatory training: the Health & Safety Advisor is not satisfied that the content of the national e-learning module for Health & Safety is sufficient to meet the needs of WUTH because it does not sufficiently highlight hazards such as needle stick injury, violence & aggression, falls from height and other elements that would appear on the Trust's Duty Holder's Matrix for Health & Safety. This action is 'Red-rated' due to slippage on due date, but it is anticipated sufficient progress will be made to conclude.	30/09/2018	

208	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing Standard Operating Procedures (1/8/18)	Chief Operating Officer	Effective	**Updated: 11/12/2018** The Trust can demonstrate that it is documenting and reporting against standard; however, it is not yet able to demonstrate compliance with national standards. Investment has been made to increase nursing capacity. Performance is reported daily via ED dashboard and monitored through Patient Flow Improvement Group (PFIG).	01/09/2018	
210	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**mews SCORES** The service should ensure that patients who have an increased modified early warning score are monitored and escalated for further review, in line with trust policy.	Review and develop the policy for recognising and responding to the signs of clinical deterioration (to incorporate the requirement to implement NEWS2)	Executive Medical Director, Executive Director of Nursing and Midwifery	Safe	**Updated: 11/12/2018** The Trust has made a commitment to implement NEWS2. There is some concern clinically that the criteria in NEWS2 is not as robust as the modified NEWS which it replaces at WUTH. These concerns have been made known to NHSI. It has been agreed locally that the Trust will implement NEWS2, as it is required to do, but compare its effectiveness with MNEWS. If NEWS2 is shown to be less effective, the Medical Director will initiate the mechanism for reconsidering the criteria used by WUTH for early warning scoring. Implementation of NEWS2 has commenced but an unanticipated technical issue with the Trust's Wirral Millennium (Cerner) system will require addressing before any further progress can be made. Subject to the response from Cerner, implementation of NEWS2 may be delayed. This matter has been escalated internally and with the system vendor.	01/11/2018	

ANNEX B (Embedded actions in December 2018)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
17	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**MAJOR INCIDENT EQUIPMENT** The service should ensure that staff are able to access major incident equipment in a timely manner and that major Incident equipment is checked and maintained in line with trust policy.	Report assurance to the Risk Management Committee	Chief Operating Officer	Safe	**04/12/18**. Confirmation received that this was presented to PSQB committee	01/10/2010	
39	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**HAND HYGIENE - SIGNS** The service should consider ensuring there are adequate signs on entry to the unit instructing visitors to wash their hands.	Restate the Trust's standards for hand hygiene and environmental cleanliness to frontline staff	Executive Director of Nursing & Midwifery	Safe	**UPDATED: 11.12.2018** Relaunched standards section in Perfect ward app to check competency of staff	01/10/2018	
68	Must Do	Corporate / Trust-Wide Issues	**COMPLAINTS** **Trust wide :** The trust must ensure that complaints are managed effectively in line with trust policy. The service should ensure that they provide information to patients and relatives so that they are aware of how to raise a concern or complaint. **Emergency Department :** The service should consider ways to make sure that complaints are dealt with in	Clarify role and responsibilities for complaints handling at divisional and corporate levels	Executive Director of Nursing & Midwifery	Caring	**UPDATED: 11.12.2018 - embedded process**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			both a timely manner and in line with trust policy. **Maternity :** The Service should ensure responses to all complaints are in line with trust policy.						
70	Must Do	Corporate / Trust-Wide Issues	As at 68	To embed ownership and control at the right level, introduce a mechanism whereby Divisional Director signs off prior to consideration by CEO	Executive Director of Nursing & Midwifery	Caring	**UPDATED: 11.12.2018 - embedded process**	01/10/2018	
71	Must Do	Corporate / Trust-Wide Issues	As at 68	Introduce a mechanism to evaluate the need for incident reporting upon receipt of the complaint details. If an incident has occurred, to ensure the correct procedures for investigation and reporting are followed	Executive Director of Nursing & Midwifery	Caring	**UPDATED: 11.12.2018 - embedded process** SOP in place	01/10/2018	
153	Must Do	Corporate / Trust-Wide Issues	As at 149	Introduce a mechanism to capture and performance manage the delivery of serious incident actions (this is promoting and embedding learning within front line teams).	Executive Director of Quality & Governance	Well Lead	**UPDATED: 11.12.2018 - embedded process** Satisfied PSQB are tracking the actions. Actions to be included in DPR standard suite of documentation	31/10/2018	
91	Must Do	Corporate / Trust-Wide Issues	As at 89	Develop a trajectory to ensure gaps in safeguarding mandatory training are closed within 6-9 months (by 01/10/18, then achieve trajectory by 31/03/19)	Executive Director of Nursing and Midwifery	Safe	**11.12.2018** – trajectory and improvement evidence provided	01/01/2019	

138	Should Do	Corporate / Trust-Wide Issues	**RECORD KEEPING** These issues arose within the Emergency Department only but require Trust-wide action. The service should ensure that records for children are completed consistently, including using the mandatory safeguarding questions for children at all times and correctly using the paediatric early warning score. The service should consider ways to make sure that patient pathways for different conditions are included in all patient records and completed fully when appropriate.	Communicate to their frontline staff the mandatory safeguarding questions required to be asked and recorded	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 12.12.2018** – embedded process	01/08/2018	
139	Should Do	Corporate / Trust-Wide Issues	As at 138	Establish systems within ED / Paediatric ED whereby all Safeguarding questions relating to children are asked and recorded (this may be a template, or can form part of the Electronic Patient Record)	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 12.12.2018** – embedded process	01/11/2018	
209	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Establish a clinical audit of 15 minute assessment standards within ED	Chief Operating Officer	Effective	**Updated: 11.12.2018** Monitored through ED dashboard and daily reporting tools	01/08/2018	

222	Should Do	Maternity Services (Women's & Children's Division)	**OBSTETRIC COVER** The service should review obstetric cover for the triage area to prevent access and flow and delays in treatment issues.	Provide assurance that there is sufficient obstetric cover in the triage area to maintain the effective flow of patients through the unit at all times	Executive Medical Director	Effective	**Updated: 11.12.2018** Assurance statements received, action completed	01/10/2018	
223	Should Do	Maternity Services (Women's & Children's Division)	**OBSTETRIC COVER** The service should review obstetric cover for the triage area to prevent access and flow and delays in treatment issues.	Develop a contingency plan to be used in the event that obstetric cover is insufficient	Executive Medical Director	Effective	**Updated: 11.12.2018** SOP has been developed to follow if short of staff in the following; Escalation Divert of unit	01/10/2018	