Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

1 May 2019

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 1 MAY 2019

COMMENCING AT 9AM IN THE BOARD ROOM

EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v	
2	**Declarations of Interest** Chair	v	
3	**Chair's Business** Chair	v	
4	**Key Strategic Issues** Chair	v	
5	**Board of Directors**		
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	5.1.2 Board Action Log Board Secretary	d	Page 13
6	**Chief Executive's Report** Chief Executive	d	Page 14
7. Quality and Safety			
7.1	**Patient Story** Head of Patient Experience	v	
7.2	**Quality Strategy** Director of Quality & Governance	d	Page 17
8. Performance & Improvement			
8.1	**Integrated Performance Report**		
	8.1.1 Quality and Performance Dashboard and Exception Reports Chief Operating Officer, Medical Director, Chief Nurse, Director of Workforce, Director of Governance & Quality	d	Page 37
	8.1.2 Month 12 Finance Report Acting Director of Finance	d	Page 44
9. Workforce			
9.1	**Review of Freedom to Speak Up Guardian Report** Director of Workforce	d	Page 59

9.2	**Review of Healthcare Flu Vaccination Programme and Lessons Learnt** Director of Workforce	d	Page 64

10. Governance

10.1	**Report of Trust Management Board** Chief Executive	v	
10.2	**Report of Audit Committee** Chair of Audit Committee	v	
10.3	**Report of Programme Board** External Programme Assurance / Delivery Director	d	Page 69
10.4	**CQC Action Plan Progress Update** Director of Quality & Governance	d	Page 91
10.5	**Review of Board Assurance Framework** Director of Quality & Governance	d	Page 102

11. Standing Items

11.1	**Any Other Business** Chair	v	
11.2	**Date and Time of Next Meeting** Wednesday 5 June 2019	v	

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

3rd APRIL 2019

BOARDROOM EDUCATION CENTRE ARROWE PARK HOSPITAL

Present

Sir David Henshaw	Chair
Janelle Holmes	Chief Executive
Jayne Coulson	Non-Executive Director
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Chief Nurse
Helen Marks	Director of Workforce
Chris Clarkson	Non-Executive Director
Karen Edge	Acting Director of Finance
Paul Moore	Director of Quality and Governance (Non voting)
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Dr Ranjeev Mehra	Associate Medical Director, Surgery

In attendance

Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
John Fry	Public Governor
Steve Evans	Public Governor
Ann Taylor	Staff Governor
Jane Kearley*	Member of the Public
Matthew Burch	Member of the Public
Joe Gibson*	Project Transformation
Sally Robers*	Member of the Public / Patient Story
Marsha Parton-Murphy*	Patient Experience Team

Apologies

John Coakley	Non-Executive Director
Steve Igoe	Non-Executive Director
Paul Charnley	Director of IT and Information
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 19-20/001	**Apologies for Absence** Noted as above.	
BM 19-20/002	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/003	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair informed the Board of Directors that following recent discussions culminating in a very positive Board to Board meeting with the CCG. The positive step change in views from all parties will	

Reference	Minute	Action
	enable the Trust to build on and work through the changes required across the local health economy and therefore provide better outcomes for patients.	
BM 19-20/004	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Chief Nurse** – informed the Board that the 'Patient Information Bank' has been rebranded to 'Patient Experience Hub' following feedback from patients and carers. NHS Improvement has recently established a Matrons network with the first engagement event being held today and 2 matrons are representing the Trust. The Chief Nurse congratulated Radio Clatterbridge who won 'best promotion' at Hospital Broadcasting Association's annual conference for its special day commemorating the life and legacy of the Liverpool comic Ken Dodd who was patron of the charity with the judges deciding the CGH radio 'Doddy Day' trailer was the best of the year. In support and celebration of national Autism awareness day the Trust is hosting a Learning Disability and Autism awareness session on Tuesday 9th April, Board members are invited to attend. The Chief Nurse apprised the Board of a number of forthcoming charity events including an abseil of the hospital that the Chief Executive, Medical Director and herself are undertaking, suggestions for fancy dress were sought from the Board. **Director of Quality & Governance** – apprised the Board that following the recent unannounced CQC inspection the formal draft report has been received for review and factual accuracy. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board of the impact of winter pressures from a divisional perspective for 2018/19 and the development programme on the Clatterbridge site to maximise use and support winter pressures in future years. **Director of Workforce** – Mrs Marks advised the Board that two reviews have been commissioned, one in the HR business service and the other in medical staffing process and systems. In turn these reviews will strengthen vacancy and non contractual pay control processes including agency medical spend. The reviews will explore alternatives such as job plans for medics and specialist nurses so the Trust has a clearer picture of spend against activity and highlight any gaps. **Associate Medical Director, Women & Children's–** Mr Ellard apprised the Board that two consultants have been appointed to national posts and work was underway to support the cancer two week waits within the breast specialty. **Mrs Sue Lorimer – Non-Executive Director** – informed the Board that she had recently attended the Wirral Audit Chairs meeting to discuss 'Thinking	

Reference	Minute	Action
	differently about independent assurance in a system setting'. In conclusion it was agreed to hold another meeting later in the year to discuss a shared understanding and approach to assurance framework including risks regarding the Healthy Wirral Programme. **Chief Operating Officer** – Mr Middleton advised that a review of Soft FM services is underway and will consider the benefits of alternative models such as collaborative working. Following the recent tender process for the additional car parking facility, the unsuccessful bidder has raised a challenge and the Trust has sought legal advice regarding the matter. **Medical Director** – advised the Board of the retirement of Dr Mark Lipton, Deputy Medical Director at the end of March 2019. Recruitment for his replacement is underway. The Board thanked Dr Lipton for keeping the ship steady in period of instability. The rapid improvement project to improve patient flow has reset the model in relation to patient assessment, referrals to specialist wards and discharges earlier in the day. This also has positive impact on reduced length of stay, corridor care and ambulance waits. The project is to be extended to enable the processes to be embedded and will enable a review of the metrics to provide Board assurance. **Acting Director of Finance** – informed the Board that the procurement team was leading support regarding national policy in relation to new procurement models and security of supply following Brexit. ***The Board noted that although some members did not have detailed updates there were themes across a number of reports such as leadership, accountability and possible skills gap of middle managers.***	
BM 19-20/005	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 6th March 2019 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 19-20/006	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including: • Millennium Upgrade • EU Brexit Planning • Leadership structure of NHS England and NHS Improvement • Local elections – Purdah • NHS Improvement – new provider directory.	

Reference	Minute	Action
	CQC unannounced inspection – recently took place in AMU and A&E. The formal draft report has been received for review and factual accuracy. The final report, the Trust's response and appropriate actions will be formally reported to Board once completed. **Wirral A&E Delivery Board** – at the last meeting it was agreed that Wirral A&E Delivery Board would lead the Health Economy Urgent Care Improvement Work. It was suggested that the A&E Delivery Board change its name and report of progress, around the Transformation programme, to Healthy Wirral Partners Board. In recognising that the transformation programme requires support from all Health Economy Partners, the proposal for the Director of Commissioning and Transformation, as deputy Chair, was seen as advantageous in driving activity and performance. ***The Board noted the information provided in the March Chief Executive's Report.***	
BM 19-20/007	**Patient Story** The Board was joined by Mrs Sally Rodgers, daughter of Mrs Kay Gibbings who had been a patient. Sally stressed that this experience was not a formal complaint but an opportunity for the hospital to learn lessons from this. She provided the Board with a detailed overview of her families experience of poor patient care from attending A&E and then across Wards 19 and 23. There were however at times evidence of real care and compassion shown to Mrs Gibbings. Sally provided examples of numerous incidents and observations during Mrs Gibbings time as an inpatient; incorrect general administration, lack of staffing, general care and attentiveness. There were also incidents of misinformation around a fall whilst an inpatient and the family not being involved in the MDT meeting. Having intervened, the family spoke very highly of Julie Reid, Associate Director of Nursing, for stepping in, listening and implementing changes for Mrs Gibbings. These changes were also highlighted when Sally's mother-in-law was an inpatient, and noted improvements pertaining to treatment and care. In conclusion, Sally's view was that the poor practices were mainly due to inadequate leadership. In response the Chief Nurse apprised that Board that Ward 19 in winter 2017 was introduced as a temporary ward to address winter pressures and was most likely to have been staffed with some temporary staff. She assured the Board that the staff involved had been dealt with appropriately and explained the changes implemented since then to address concerns such as those raised. On behalf of the Board, the Chair expressed his thanks and appreciation to Sally for sharing her experience. ***The Board noted the feedback received from Mrs Rodgers and acknowledge the changes that had been implemented subsequent to this.***	
BM 19-20/008	**Lessons from Learning from Deaths** The Board were provided a report in line with national guidance which requires Trusts to review 100% of deaths in care to gather learning and improve patient experience.	

Reference	Minute	Action
	Dr Stevenson reported that subsequent to the introduction of a revised process reviews are more robust and there had been significant improvement and learning disseminated across the organisation. The Board were advised that when reviewing the performance data contained within the Quality & Performance Dashboard they should be mindful that mortality data is collected from 90 days post month of death (i.e. January data is closed in April). Consequently there is a three month lag after which the performance level will be locked and rated. ***The Board noted the learning from deaths report and the main learning points which are delivered by direct e-mail, safety bites bulletin, patient safety summit, druggles bulletin, local clinical governance meetings, safety huddles and audits by Governance Support Unit.***	
BM 19-20/009	**Productivity Efficiency Priorities** The Chief Executive presented a high level summary of the change programme outlining the priorities and highlighted the focus needs to be on fixing key issues with operational grip and delivery which is currently 80% of the job and will allow the organisation to, over time, grow from a 20% transformation focus. As previously agreed the areas of focus would be: • **patient flow** - redesign of acute take, redesign discharge, pathways and nurse led discharge • **outpatients and theatre** – job plans (nurses and doctor's), rotas, leave, theatre efficiency, activity and income, programmed investigations / daycase. It was acknowledged that as enablers IT and system improvement programmes are to be aligned to the three priority areas. Regarding the Healthy Wirral future models of care the Trust will lead on planned care to include outpatients and electives and urgent care encompassing health economy flow and the emergency village. From an IT perspective support will be provided for the patient portal, health economy EPR and service line reporting. A discussion took place regarding the leadership actions as described below: • The need for an 80% focus on creating solid foundations • Agreement that the 3 priority projects for improvement at pace are: Flow, Outpatients and Theatres • Providing SROs with the mix and level of capabilities they require to assure delivery • Sponsoring governing meetings (project boards) that make timely decisions and meet at the tempo needed to deliver • Absolute focus on delivering action plans that shift the dial • Engaging well and communicating our success effectively To ensure pace is implemented across all programmes both operationally and a transformation basis, there are a number of controls that have been introduced with Executive oversight to ensure delivery and timeframes are met.	

Reference	Minute	Action
	It was recognised that in order to achieve the changes outlined there may be areas of work that are no longer a priority and therefore may be stopped this would evolve over time and would be communicated to staff. ***The Board noted the presentation and endorsed the leadership actions identified.***	
BM 19-20/010	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Of the 56 indicators with established targets or thresholds 34 are currently off-target or failing to meet performance thresholds. The Director of Governance & Quality stated that although there is improvement from the January position, performance against many of the indicators is not where the Trust needs to be. The updated metrics and thresholds across a range of indicators were highlighted The lead Director for a range of indicators provided a brief synopsis of the issues and the actions being taken. Areas of focus for discussion were: • Infection Prevention Control (IPC) indicators - NHS Improvement site visit undertaken with recommendations to be incorporated into IPC action Plan. • Sickness – targeted review of departments with high instances to be implemented. • Nutrition and Hydration (MUST) – as at today performance was 94% and expectation is that from March onwards the threshold would be met. • Discharges – patient flow programme reviewing metrics to implement change. • Vacancy rate – focus on attrition rate being higher than recruitment rate. Alternative flexible working opportunities and improved career pathways to be considered. • Appraisal – roll out of revised process imminent including alignment with mandatory training compliance which will require a lead in time to ensure availability of training. • FFT response rate – additional volunteers recruited to support process. Whilst there was disappointment that a number of the indicators had seen a decline in performance there were some indicators that had improved, namely: VTE, CAS alerts, serious incidents and complaints. The Chief Nurse informed the Board that by way of support to address ongoing concerns relating to the IPC indicators staff resources have been moved from non clinical areas to clinical with a more focused oversight of performance. The Director of Workforce advised that to address departments with high instances of sickness absence a pilot of an external management attendance solution to be undertaken starting in Estates and Facilities. In addition a	

Reference	Minute	Action
	'deep dive' will be considered at the Workforce Assurance Committee and a review of the HR business partner role is underway. The Chief Operating Officer reported that with the exception of A&E 4 hour waits it was expected that all indicators would be 'green'. The Board recognised that whilst the revised dashboard has now been in place for a period of time and provides greater clarity, Board members were asked if they were confident it captures the right indicators and has the appropriate metrics. It was agreed that future discussion is required to determine areas for focus against the three priorities patient flow, outpatients and theatre ie leading indicators rather than emphasis on outputs. ***The Board noted the current performance against the indicators to the end of February 2019.***	**Exec's**
BM 19-20/011	**Month 11 Finance Report** The Acting Director of Finance apprised the Board of the summary financial position. At the end of month 11, the Trust reported an actual deficit of £30.6m versus planned deficit of £24.3m and includes non-current support of £2.4m which means the underlying position is £8.7m worse than plan. In month, the Trust reported a deficit of (£4.0m) against a planned deficit of (£2.7m) and a forecast of (£3.0m). This being (£1.0m) worse than the forecast position. The key driver of the variance is the under-performance in elective activity in both surgery and medicine, non elective both activity and case mix and outpatients worse than forecast. In addition, there were some pay pressures due to the cost of escalation capacity over the above winter plan and additional support to the Emergency Department The Acting Director of Finance reported that cash is better than plan at £7.7m as a result of capital slippage and working capital movements. There were no significant balance sheet variances – in line with cash management approach and capital slippage. Capital expenditure is £5.0m YTD against full year programme of £12.5m. Significant schemes in progress include MRI scanner, GDE, PACS, Estates backlog and medical equipment. Additional key aspects apprised to the Board included: • Elective income which continues to under-perform against plan although the run rate has improved from Q1. However, bed pressures in Jan/Feb have impacted on elective activity. • Non-pay pressures associated with out-sourcing both elective activity and diagnostics, noting that elective outsourcing has reduced significantly in Q4 as expected. • Pay pressures in medical pay and acute care nursing have been mitigated with vacancies in other area's, predominately corporate and non medical and acute nursing. • CIP is £0.8m below plan YTD with a delivery of £8.7m, as expected performance has deteriorated as a result of the high profile in Q4 and in	

Reference	Minute	Action
	addition a proportion of the delivery (£2.9m) is non-recurrent against vacancies/non-pay. The Trust committed to a forecast deficit position of (£27.3m) with NHSI at the meeting in January following the December meeting where delivery of the planned position of (£25.0m) was sought. The current forecast is (£31.4m) deficit and a view with regard to the exposure to a retrospective VAT claim of c£3.5m was highlighted. The Acting Director of Finance advised the Board that negotiations with the CCG regarding the 2019/20 contract are reaching conclusion with agreement to rebase non elective forecast to the most recent lower activity level and the CCG are to underwrite the gap in income. This approach would be in the best interests of the Wirral Health Economy. Assurance that the capital expenditure programme would not be rear year end loaded was sought which could risk value for money decision making. Significant work has been undertaken with the Divisions and Estates regarding a draft three year plan with an emphasis to approve the annual programme earlier than in previous years. 2019/20 has been approved and schemes are being mobilised. The three year plan will be reviewed again by Finance, Business, Performance & Assurance Committee and Trust Management Board following receipt of the 6 FACET survey. ***The Board noted the M11 finance performance.***	
BM 19-20/012	**Operational Plan 2019/20** The Acting Director of Finance provided a brief overview of the Operational Plan 2019/20 for submission to the regulator. The plan had been considered in detail by the Finance, Business, Performance & Assurance Committee (FBPAC) at its meeting on 26th March 2019 prior to the Board. The key points discussed were: • Most Pressures can be managed within Divisions, except £1.7m in Medicine & Diagnostics with some corporate control measures to be put in place as mitigation • CIP programme has been scoped with £12.3m of the £13.2m challenge being identified. Plans on Page for all schemes have been produced with profiles and RAG ratings. Additional oversight meetings are to be introduced. • Internal Audit on Budgetary control has been completed with Significant Assurance • Implementation plan for Bed closures received and approved. In addition, Mark Brearley of Unique Health Solutions had presented his report and verbal update to FBPAC that supported the internal assurance work and the acceptance of the Control Total with recommendations for contingent control measures which will be implemented. The finance elements of the Operational Plan has been updated which summarises a budget of £0.0m break-even with a 3.5 % (£13.2m) Cost Improvement Programme (CIP). Contract negotiations have progressed such that there is no misalignment of contract values and work in progressing of the finer points of a risk-share	

Reference	Minute	Action
	arrangement that mitigates against significant variation in income as a result of activity movements is underway. A potential risk was disclosed on depreciation charges (c£1.5m) which it was agreed was not material in comparison to the benefits of accepting the control total. ***The Board noted and approved the Operational Plan 2019/20 and accepted the NHSI notified control total.***	
BM 19-20/013	**Report of Finance, Business, Performance & Assurance Committee** Ms Sue Lorimer, Non-Executive Director provided a summary report of the FBPAC meeting on 26th March 2019 which covered: • 2019/20 Operational Plan • Critical Care Service Line Reporting (SLR) • Pharmacy Dispensing Robot business Case • Board Assurance Framework 2018/19 – Year end report • Quality Performance Dashboard • Bed Closure Option Appraisal The Committee approved: • Pharmacy Dispensing Robot business case The Committee recommendation to the Board the approval of the Operational Plan 2019/20. In relation to the SLR item, it was recognised that the layout of the Critical Care Unit was sub-optimal and consequently a review of cost drivers and the strict network standards in respect of staffing requirements indicates that the size of the unit is adversely impacting on cost. The Medical Director advised that there was more work to complete on delayed discharges, medical staffing and peer cost structures that would be presented to the committee at a future meeting. ***The Board noted the report of the Finance, Business, Performance & Assurance Committee and the items approved.***	
BM 19-20/014	**Report of the Quality Committee** Mr Chris Clarkson, Non-Executive Director, apprised the Board of the key aspects from the recent Quality Committee, held on 26th March 2019 which covered: • Serious Incidents and Duty of Candour • Nutrition & Hydration Report • Mortality Review and Learning from Deaths • Resuscitation Report • CNST • Medicines storage • Infection Prevention and Control Report • CQC Action Plan Report • Wirral Individualised Safe-Care Everytime (Ward Accreditation)	

Reference	Minute	Action
	In reviewing the Ward Accreditation report the Committee raised concern regarding leadership capability which would support the observations raised within the patient story discussed earlier in the meeting. It was noted that the Chief Nurse would review the questions behind this elements of the programme to establish if there is a sustainable issue. ***The Board noted the Quality Committee report and the opportunity to adapt the ward accreditation model for other sections of the Trust ie creating a departmental accreditation.***	
BM 19-20/015	**Report of Trust Management Board** The Chief Executive provided a summary report of the Trust Management Board (TMB) meeting on 28th March 2019 which covered: • Quality & Performance Dashboard • GDE Position • Clinical Review of NHS Access Standards • Outpatient Update • Health & Safety Management • 2019/20 Budget Update • Referral to treatment standard • CQC Inspection feedback ***The Board noted the report of the Trust Management Board.***	
BM 19-20/016	**Report of the Workforce Assurance Committee (WAC)** Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee, held on 27th March 2019 which covered: • Staff story • Medicine & Acute Workforce agenda • Workforce Planning update • Update on the Organisational Development Plan • 2018 NHS Staff Survey – next steps • Evaluating the current recruitment campaign • Gender Pay Gap Report 2018 • Workforce Disability Employment Standards (WDES) • Organisational Development Implications of the NHS Long Term Plan • Workforce KPI's dashboard The Director of Workforce advised that following the success of the new recruitment campaign the focus will now move to retention including flexible working and alternative career pathways such as introduction of junior sister role. The next WAC will focus on one of the Trust's Corporate Division's as the core competencies required are inevitably quite different from the clinically based competencies required in the other divisions of the Trust. A representative from Estates and Facilities is to be invited to discuss how they will develop their workforce performance going forward.	

Reference	Minute	Action
	The Board noted the report of the Workforce Assurance Committee.	
BM 19-20/017	**Report of Programme Board** Joe Gibson, External Assurance provided a summary of the Trust's change programme and the independent assurance ratings undertaken to assess delivery as discussed at the Programme Board on 20th March 2019. He advised that in response to the direction set at the March Trust Board, the Executive Team have agreed and initiated enhanced focus on three areas of the Programme; Patient Flow, Outpatients and Theatres Productivity. Each area has reviewed and reset plans to respond to this greater focus and these are being reviewed. The framework of the assurance report is to be triangulated with other report provided to assurance committees. For priority projects, plans and benefit/finance trajectories will be finalised, supporting and enhancing work already underway. Work to allocate corporate function, transformation team and operational resource to support work on the priority programmes is already underway. In order to improve assurance ratings for all programmes it was agreed that Senior Responsible Owners (SRO's) are to direct their projects to improve confidence in delivery by: • Ownership of standards • Monitor project plans on a regular basis (suggested weekly) to enable all members of the team to understand progress. ***The Board noted the Trust's Change Programme assurance report and confirmed the programme priorities as Patient Flow, Outpatients and Theatres productivity.***	
BM 19-20/018	**CQC Action Plan progress Update** The Director of Quality & Governance apprised the Board of the improvements pertaining to the CQC Action Plan. The Director of Quality & Governance emphasised the challenges in relation to the overdue actions which mainly concern patient flow management, ED assessment protocols and medicines storage. Updates for these actions were provide as follows: • Patient flow management - as socialised earlier in the meeting • Medicines storage - temperature control for room, clarification that this work has been actioned to be provided to the Chairman. • ED assessment protocols - triage only process is being launched with consultants. ***The Board noted the progress to date of the CQC Action Plan.***	
BM 19-20/019	**Annual Review of Declaration of Interest and Fit & Proper Person Declaration** The Trust Secretary provided a summary of the annual declarations of interest and provided assurance that all directors and director-equivalent posts are compliant with the requirements of the Fit & Proper Persons test.	

Reference	Minute	Action
	Two minor amendments of the declaration for Non Executive Director, Sue Lorimer and Chief Nurse, Gaynor Westray were provided for inclusion in the register. **The Board noted the declaration of interests and compliance for all directors against the Fit & Proper Persons requirements.**	
BM 19-20/020	**Any Other Business** There was no other business to report.	
BM 19-20/021	**Date of next Meeting** Wednesday 1st May 2019.	

……..……

Chair

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Date

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors Action Log
Updated – 3rd April 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 03.04.19						
1	BM 19-20/010	Consider further development of performance dashboard indicators to align with top three priorities – patient flow, outpatients and theatres.	**Exec's**	Indicators with yet to be established thresholds to be reviewed and agreed.	June '19	

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	1 May 2019
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

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

Serious Incidents

In April 2019 there was one incident that crossed the threshold for reporting as a serious incident. The incident declared relates to a patient who presented at ED on 3 occasions over a 24 hour period who subsequently died. Full investigation and duty of candor is underway.

Navajo Merseyside & Cheshire LGBT Charter Mark

The Trust has successfully passed the assessment process and will be awarded with a Navajo Merseyside and Cheshire LGBT Charter Mark.

The Charter Mark is an equality mark sponsored by In-Trust Merseyside & Sefton Embrace and supported by local LGBT Community networks – a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, and transgender (LGBT) people in Merseyside.

Assessors praised the Trust for the commitment shown in identifying and improving services and support for LGBT+ staff and patients. Navajo will continue to support the organisation on its improvement journey.

Anyone wanting to get involved in this exciting agenda can contact Sharon Landrum, Diversity & Inclusion Adviser on 0151 678 5111, ext 7475 – you can join a staff network or newly developing LGBT+ patient forum (to be led by patient experience).

The awards ceremony is to be held on Friday 17th May 1 – 4.30pm at John Moore's University.

Millennium Upgrade

Work continues on fixing the issues with viewing and reporting on images since the Millennium upgrade. A solution in radiology will be tested w/c 29th April and if successful will be live within a week. Daily interactions with Cerner's Senior Management continue to ensure it remains a high priority with them. Work is also progressing on the new Carestream PACS. In recognition of the issues, Cerner UK have agreed to provide the integration software needed for this free of charge and also compensate the Trust for any radiology reporting work we have had to outsource. A meeting with Cerner's Managing Director will take place on 20th May 2019.

It was agreed at Trust Management Board to publish weekly updates to the Organisation on progress. The lead for Business Continuity has also reviewed remaining issues to ensure that there is a clear Business Continuity plan in place. There are only a very small number of issues remaining but these are also receiving active attention by Cerner.

NHSI Bulletins – April 2019

NHS England and NHS Improvement

NHS England and NHS Improvement have now come together formally to act as a single organisation. Their aim is to better support the NHS and help improve care for patients. As local health systems work more closely together, the same needs to happen at a national level to achieve the vision of care set out in the NHS Long Term Plan.

2019/20 will be a transitional year as they implement their new ways of working.

Janelle Holmes
Chief Executive
May 2019

Board of Directors	
Agenda Item	7.2
Title of Report	Quality Strategy
Date of Meeting	1 May 2019
Author(s)	Janelle Holmes – Chief Executive Nikki Stevenson – Executive Medical Director Gaynor Westray – Chief Nurse Anthony Middleton – Chief Operating Officer Paul Moore – Director of Quality & Governance
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	This strategy, when implemented in full, will support a positive patient experience, enable safer care, support clinical effectiveness and improve CQC ratings. Implementation of this strategy will make a positive contribution to further strengthening the control framework for the following risk scenarios: • Demand that overwhelsm capacity to deliver care effectively • Catastrophic failure in standards of safety and care • Fundamental loss of stakeholder confidence
Level of Assurance • **Positive** • **Gap(s)**	Not applicable
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Yes

Wirral University Teaching Hospital
NHS Foundation Trust

Quality Strategy 2019-22: not just great care, but the best care that can be provided for the people of Cheshire & Merseyside

Contents

EXECUTIVE SUMMARY

It gives us great pleasure to outline our Quality Strategy for Wirral University Teaching Hospitals NHS Foundation Trust. We recognise that every day all our staff, no matter where or how they contribute within the organisation, demonstrate their commitment to patient-focussed care and strive for excellence in often very difficult circumstances. We are proud to be a part of this great organisation and also proud to be part of this journey with you as one talented team. Together we have the potential to transform the quality of healthcare for all service users and, in doing so, become an outstanding provider in the eyes of those who use our services, those who work in them and those who inspect them.

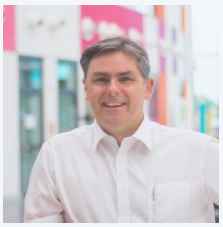
By 2022 we aspire to be rated outstanding for quality by the Care Quality Commission. We understand this represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks. This Quality Strategy reflects our ambition for sustainable, high value, high quality services delivered in partnership with other health and social care providers across Cheshire and Merseyside. As we move forward we will witness a much closer alignment between quality, activity and financial planning to boost our combined efforts to deliver safe, effective and financially sustainable services in the longer term. The challenges that lie ahead are demanding and will require creative adaptation within the Trust and across the wider health and social care system in order to meet them. By investing in improvement expertise to advance quality and developing our teams to lead, learn, and continuously improve we are positioning the Trust to act as system leader for quality. The driving force behind our new approach to quality is partnership: (i) united by shared quality goals - a partnership which brings about much closer integration across the health and social care system to deliver safer and more sustainable clinical services; (ii) a partnership with patients which seeks to put them more in control of their own care – promoting self-management and involving them in service developments and decisions about their care; and (iii) through our workforce strategy a partnership with staff that fosters an open, inquisitive, responsive and learning culture. This represents an opportunity to deliver care that is not just great, but the best care that can be provided across Cheshire and Merseyside.

We believe that we can demonstrate outstanding care and be one of the best providers of healthcare in the country. This Quality Strategy gives us the road map to get there.

Janelle Holmes
Chief Executive

Gaynor Westray
Chief Nurse

Nicola Stevenson
Medical Director



Paul Moore
Director of Quality & Governance

Anthony Middleton
Chief Operating Officer

Wirral University Teaching Hospital
NHS Foundation Trust

Quality Strategy 2019-22

1	A Positive Patient Experience	Changing behaviours and the way care is delivered to impact positively on how care is experienced by those who use the services we provide	• By 2022 or sooner, >95% of staff believe 'care is the organisation's top priority' • By 2022 consistently achieve at least 98% recommendation ratings for inpatient, outpatient and maternity care using friends and family test
2	Care is Progressively Safer	Focussing on frailty and learning disability we will adapt to meet the healthcare needs of an increasingly elderly patient population and, by delivering 'better basics', reduce exposure to harm	• By 2022 have the lowest number of serious incidents of any North West NHS acute care provider • By 2022, achieve at least 12 consecutive months without a Never Event • By 2022 reduce by at least 50% the MET call rate per 1000 bed days • By 2022 achieved RoSPA Gold for Safety Management
3	Care is Clinically Effective and Highly Reliable	Effective patient flows reduce length of stay, reduce unplanned readmissions, saves lives and support sustainable care.	• By 2022 remain below expected levels on all mortality indices • By 2022 benchmark in the top quartile for lowest Length of Stay • By 2022 benchmark in the top quartile for lowest number of readmissions within 28-days of discharge for the same HRG
4	We Stand Out	Being a system leader for care quality and striving for excellence on our journey to outstanding.	• By 2022 rated outstanding by the Care Quality Commission in the caring and well-led domains

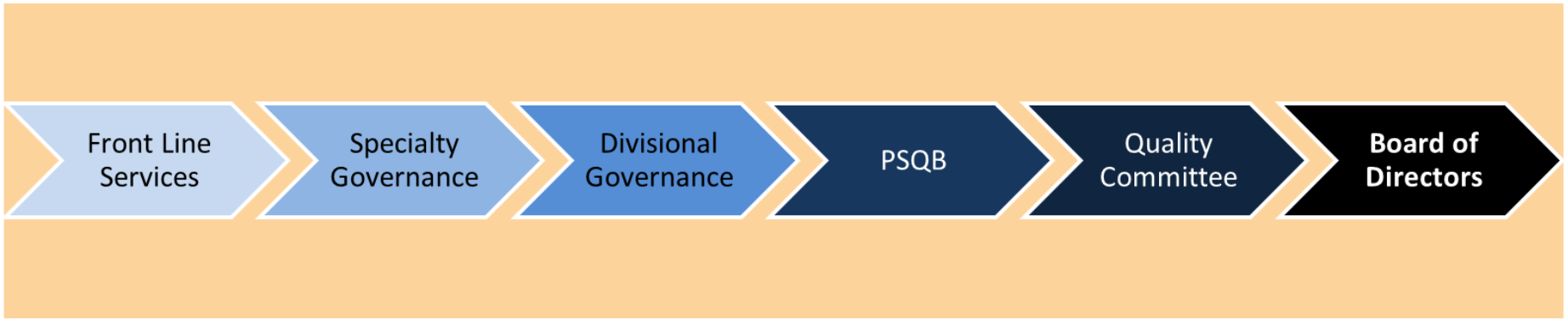
Not just great care, but the best care that can be provided for the people of Cheshire & Merseyside

Headline Measures

Campaign	KPI		BASIC 2019/20	BETTER 2020/21	BEST 2021/22
A positive patient experience	Staff satisfaction: percentage of staff who believe 'care is the Trust's top priority'		≥85%	≥90%	≥95%
	Patient satisfaction: care was explained in an understandable way		≥90%	≥95%	≥98%
	Patient satisfaction: involved in planning their care		≥85%	≥90%	≥95%
	Patient Recommendation Ratings (FFT)		95%	97	≤1/1000 bd
Care is progressively safer	Falls risk: assessment and implementation of care plans for people at risk		≥92%	≥95%	≥98%
	Reducing hospital acquired infections	Hospital Acquired Clostridium difficile	CDT on Trajectory	CDT 5% below trajectory	CDT 5% below trajectory
		Hospital Acquired MRSA Bacteraemia	≥365 consecutive days	≥700 consecutive days	≥1000 consecutive days
	Pressure sore risk: assessment and implementation of care plans for people at risk		≥92%	≥95%	≥98%
	VTE: high reliability in delivery of end-to-end thromboprophylaxis		≥80%	≥90%	≥95%
	Safer surgery: compliance with WHO checks and 'stop the line'		100%	100%	100%
	Fluid balance monitoring: completion and calculation of fluid balance daily		≥90%	≥95%	≥98%
	Delivering harm-free care		≥95%	≥97%	≥98.5%
	Safe staffing levels: fill rates		≥95%	≥95%	≥95%
	50% reduction in MET Calls		Baseline	25% Lower	25% Lower
	Review by senior doctor every day (ST3 or above)		≥80%	≥90%	≥95%
	RoSPA Accreditation for Safety Management System		BRONZE	SILVER	GOLD
Care is clinically effective and highly reliable	Reduce exposure to harm for those who are learning disabled		Baseline	5% Lower	5% lower
	Reducing emergency admissions in the last 90 days of life		Baseline	5% Lower	5% Lower
	Mortality Ratio: proximity to expected range		Below 5%	Below 5%	Below 5%
	Mortality Review: Avoidable factors associated with mortality		≤3%	≤2%	≤1%
	Patient satisfaction: involved in planning their discharge		≥85%	≥90%	≥95%
	Patient satisfaction: complaints concerning discharge quality		Baseline	5% Lower	5% Lower
	Reduce by 30% exposure to serious incidents		10% below 18/19	10% below 19/20	10% below 20/21
	Assessment of compliance with NICE guidelines: assessment at specialty level		≥75%	≥90%	≥95%
	Every patient is reviewed by a consultant within 14 hours of admission		≥95%	≥98%	≥100%
	Staff satisfaction: able to contribute to improvements at work		≥70%	≥75%	≥80%

Campaign	KPI	BASIC 2019/20	BETTER 2020/21	BEST 2021/22
We stand out	Staff satisfaction: recommendation as a place to work (KF1)	≥3.95	≥4.0	≥4.5
	Staff satisfaction: the quality of their work and care they can deliver (KF2)	≥4.15	≥4.20	≥4.25
	Rapid review of potentially serious incidents: scoping within 72 hours	≥75%	≥80%	≥90%
	Reduce harmful instances of high-risk medicines, falls and pressure sores	5% below 18/19	5% below 19/20	5 % below 20/21

Governance Arrangements

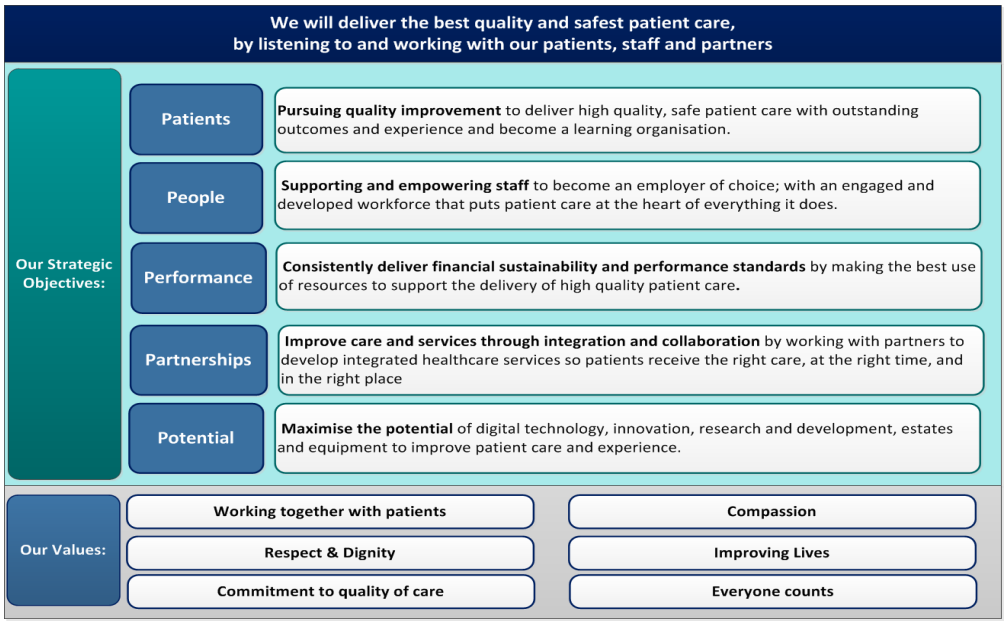


OUR QUALITY CAMPAIGNS

We are dedicated to delivering outstanding care at Wirral University Teaching Hospitals. Our four quality campaigns are:

- **Campaign One: Delivering a positive patient experience**: by 2022 we aim to: (i) have moved beyond a paternalistic approach to a model of care that is genuinely patient centred and making progress towards models of care developed in partnership with service users; and (ii) to consistently achieve and maintain service user recommendation ratings at or above 98%
- **Campaign Two: Care is progressively safer**: by 2022 we aim to: (i) have the lowest number of serious incidents of any North West NHS acute care provider; and (ii) achieve 12 consecutive months or more without a Never Event
- **Campaign Three: Care is clinically effective and highly reliable**: by 2022 we aim to: (i) benchmark in the top quartile for lowest Length of Stay; and (ii) benchmark in the top quartile for lowest rate of readmissions within 28-days of discharge for the same HRG
- **Campaign Four: We stand out:** by 2022 we aim to: (i) be rated outstanding by the Care Quality Commission; and (ii) at a system level, to keep patients with long term conditions well, as independent as possible and avoid foreseeable crisis points which often result in hospital admission.

The values below define the culture, beliefs and behaviours at Wirral University Teaching Hospitals. These values underpin how we work, how we interact with each other and provide a guiding compass for how we overcome problems and deal with uncertainty. Adopting these values every day in our working lives will support decision making, problem solving and support the delivery of the Quality Strategy.



Quality Campaign One:
A Positive Patient Experience

Changing behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide

Goals	• By 2022 or sooner, ≥95% of staff believe '***care is the Trust's top priority***' • By 2022 consistently achieve at least 98% recommendation ratings for inpatient, outpatient and maternity care using friends and family test
Lead(s)	**Chief Nurse** | Director of Quality & Governance | Medical Director | Head of Communications
Supporting Strategies	**Patient & Public Engagement Strategy** | **Workforce Strategy** | **Communications Strategy**
Co-ordinating / Oversight Committee	Patient Safety & Quality Board & Quality Committee

	Success Criteria		
Key Outcome	**BASIC 2019-20**	**BETTER 2020-21**	**BEST 2022-22**
• **Focus on explaining care in an understandable way**	At least 90% or more patients satisfied their care was explained in an understandable way	**≥95%**	**≥98%**
• **Engage and involve people in planning and delivering their care**	At least 85% or more patients reporting they were involved in planning their care	**≥90%**	**≥95%**
• **Educate and train staff to adopt the principle of co-design in care planning**	Service improvement leads trained in co-design and the use of co-design principle and piloted in selected areas	The use of co-design evaluated, adapted and rolled out across all divisions	All service improvement projects supported through co-design principle
• **Service users will be active participants of PSQB, Quality Committee and Divisional Governance Groups**	Patients/service users will attend and participate in proceedings of PSQB and Quality Committee	Patients/service users will attend and participate in proceedings of divisional governance meetings	Patients/service users will attend and participate in proceedings of directorate governance meetings
• **Patient stories and pathway diaries used to better understand patient experience and identify touch points and Always Events**	Always Events pilot completed and impact on patient experience evaluated Implement pathway diaries in services to better illustrate experience and different points in the journey	At least 1 Always Event a quality priority in each Division and providing a positive impact on patient experience Patient stories are integral to the process of sign off and learning from serious incidents	At least 5 Always Events identified as quality priorities in each Division and demonstrating a positive impact on patient experience

Quality Campaign Two:

Care is Progressively Safer

Focussing on frailty and learning disability we will adapt to meet the healthcare needs of an increasingly elderly patient population and, by delivering basic-better-best care, reduce exposure to harm

Goals	• By 2022 have the lowest number of serious incidents of any North West NHS acute care provider • By 2022, achieve 12 consecutive months or more without a Never Event By 2022 reduce by at least 50% the MET call rate per 1000 bed days • By 2022 achieved RoSPA Gold for Safety Management
Lead(s)	**Medical Director** | Director of Quality & Governance | Chief Nurse
Supporting Strategies	**Risk Management Strategy** | **Patient Safety Culture** | **Workforce Strategy**
Co-ordinating / Oversight Committee	Patient Safety & Quality Board & Quality Committee

	Success Criteria		
Key Outcome	**BASIC 2019-20**	**BETTER 2020-21**	**BEST 2021-22**
• **Reducing Hospital Acquired Infections**	On trajectory for hospital acquired Clostridium difficile	5% below trajectory	5% below trajectory
	≥365 consecutive days without MRSA bacteraemia	≥700 consecutive days without MRSA bacteraemia	≥1000 consecutive days without MRSA bacteraemia
• **Achieve high reliability of risk assessment and effective care planning for patients at risk of falls**	92% or more compliance with implementation of falls care plans for at risk patients	**≥95%**	**≥98%**
• **Achieve high reliability of risk assessment and effective care planning for patients at risk of hospital acquired pressure ulcers**	92% or more compliance with implementation of pressure sore prevention plans for at risk patients	**≥95%**	**≥98%**
• **Achieve high reliability of end-to-end care for patients at risk of venous thromboembolism (VTE)**	**≥80%**	**≥90%**	**≥95%**
• **Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken**	100% compliance with WHO Checks	**100%**	**100%**
	Every 'query' raised before or during procedure results in a 'stop moment'	**At least 6 consecutive months without surgical Never Event**	**At least 12 consecutive months without surgical Never Event**
• **Reliable daily completion of charts and calculation of +/- fluid balance**	**≥90%**	**≥95%**	**≥98%**
• **Delivering harm-free care**	**≥95%**	**≥97%**	**≥98.5%**

Key Outcome	BASIC 2019-20	BETTER 2020-21	BEST 2021-22
• **Safe staffing:**			
(i) Reduce the incidence of staffing levels as direct causal factor in harmful incident reports	Establish 2018/19 baseline of harmful incidents involving staffing levels as cause Reduce by 3% (based on 2018/19) number of harmful incidents involving staffing levels as a cause	**Reduce by 3%**	**Reduce by 3%**
(ii) Focus on maximising fill rates in rotas;	Overall fill rate for WUTH ≥95%	Every clinical area can demonstrate a fill rate ≥95%	Every clinical area can demonstrate a fill rate ≥95%
(iii) Sequentially reduce Band 5 vacancies	**≤10%**	**≤8%**	**≤5%**
• **Apply for RoSPA accreditation of safety management system**	Awarded **BRONZE**	Awarded **SILVER**	Awarded **GOLD**
• **Minimise and/or respond early and effectively to the signs of clinical deterioration**	**Establish MET Call Baseline for 2018/19**	**Reduce by ≥25%**	**Reduce by ≥25%**
• **Ensure every patient (not medically optimised) is reviewed by a senior doctor (ST3 or above) at least once daily**	**≥80%**	**≥90%**	**≥95%**

Quality Campaign Three:

Care is Clinically Effective and Highly Reliable

Patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Goals	• By 2021 remain at or below expected levels on all mortality indices • By 2021 we aim to benchmark in the top quartile for lowest Length of Stay • By 2021 we aim to benchmark in the top quartile for lowest number of readmissions within 28-days of discharge for the same HRG
Lead(s)	**Medical Director** | Chief Operating Officer | Director of Quality & Governance
Supporting Strategies	**Risk Management Strategy** | **Clinical Strategy** |**Clinical Effectiveness Strategy** | **Service Improvement Strategy** | **Workforce Strategy**
Co-ordinating / Oversight Committee	Patient Safety & Quality Board & Quality Committee

	Success Criteria		
Key Outcome	**BASIC 2019-20**	**BETTER 2020-21**	**BEST 2021-22**
• **Reducing harm for those using our services who have a learning disability**	Establish 2018/19 baseline of harms involving those who have a learning disability	Reduce by 10% (based on 2018/19) number of harmful incidents involving learning disabled patients	Reduce by 10% (based on 2019/20) number of harmful incidents involving learning disabled patients
• **Reducing the percentage of patients with ≥3 emergency admissions in the last 90 days of life**	Establish 2018/19 baseline numbers of patients with ≥3 emergency admissions in last 90 days of life	**Reduce by 5%**	**Reduce by 5%**
• **HSMR**	Below 5% of expected range	Below 5% of expected range	Below 5% of expected range
• **Mortality Reviews**	Avoidable factors associated with mortality ≤3%	**≤2%**	**≤1%**
• **Improve effectiveness of discharge planning and resilience of discharge venue**	Achieve at least 85% or more patients reporting they were involved in planning their discharge	**≥90%**	**≥95%**
	Reduce by 5% (based on 2016/17) number of incidents or complaints concerning unsatisfactory/unsafe discharge	**Reduce by 5%**	**Reduce by 5%**

Key Outcome	BASIC 2019-20	BETTER 2020-21	BEST 2021-22
• **Improving the timeliness of the clinical response to abnormal or unexpected (and clinically significant) radiology or pathology results**	10% fewer serious incidents (compared to 2018/19) involving failure to detect and act upon (clinically significant) abnormal pathology or radiology findings	10% fewer serious incidents (compared to 2019/20) involving failure to detect and act upon (clinically significant) abnormal pathology or radiology findings	10% fewer serious incidents (compared to 2020/21) involving failure to detect and act upon (clinically significant) abnormal pathology or radiology findings
• **Compliance with NICE**	**All specialities are reporting their position on uptake of NICE guidelines** **≥75% of Clinical Specialties completed baseline assessment against all applicable NICE guidelines**	**≥90%**	**≥95%**
• **Ensuring all patients have a review by a consultant within 14 hours of hospital admission**	**≥95%**	**≥98%**	**100%**
• **Implementation of CAS Alerts**	≥98% closure on or before deadline day	**≥99%**	**100%**
• **Culture of enquiry and continuous improvement**	**≥70% of staff report they are able to contribute to improvements at work (staff survey)**	**≥75%**	**≥80%**

Quality Campaign Four:
We Stand Out

Being a leader and striving for excellence on our journey to outstanding.

Goals	• By 2021 we aim to be rated outstanding by the Care Quality Commission • By 2021 we aim - at a system level – to keep patients with long term conditions well, as independent as possible and avoid foreseeable crisis points which often result in hospital admission
Lead(s)	**Director of Governance & Quality Improvement |** Medical Director **|** Director of Human Resources and Organisational Development | Chief Operating Officer | Director of Strategy
Supporting Strategies	**Risk Management Strategy** | **Clinical Effectiveness Strategy** | **Service Improvement Strategy** | **Workforce Strategy**
Co-ordinating / Oversight Committee	Patient Safety & Quality Board & Quality Committee

	Success Criteria		
Key Outcome	**BASIC 2019-20**	**BETTER 2020-21**	**BEST 2021-22**
• **Staff engagement / Satisfaction**	KF1: Staff recommendation of the organisation as a place to work is ≥3.95	**≥4.0**	**≥4.5**
	KF2: Staff satisfaction with the quality of their work and care they are able to deliver is ≥4.15	**≥4.20**	**≥4.25**
• **Getting to the learning faster: response to serious incidents**	≥75% of incidents scoped within 72 hours of incident occurring or sooner	**≥80%**	**≥90%**
• **Learning from high-risk events**	5% reduction (based on 2018/19) in number of reported instances of • *Errors involving high-risk medicines (Opiates, Insulin, Sedatives, Anticoagulants)* • *Falls involving moderate/severe harm* • *Hospital acquired pressure ulcers*	5% fewer incidents (compared to 2018/19)	5% fewer incidents (compared to 2019/20)

Key Outcome	BASIC 2019-20	BETTER 2020-21	BEST 2021-22
• **Create the perfect system-wide patient pathway for long term conditions such as diabetes, respiratory disease and hypertension**	Establish baseline admission rates for Diabetes, Respiratory and Hypertension conditions		
	Pathways for Diabetes, Respiratory diseases and Hypertension are 'process mapped' to isolate potential crisis points and act on the analysis	Reduce by 10% (based on 2018/19 baselines) in admissions to hospital for Diabetes, Respiratory diseases and Hypertension	Further reduction by 10% (based on 2019/20 baselines) in admissions to hospital for Diabetes, Respiratory diseases and Hypertension
	Scope and rapidly adopt technological innovations that could promote and support integrated whole-person care (such as home monitoring, smartphone apps etc)		
	Patient experience evaluated: service users positively report less fragmentation and a clear shift in emphasis towards self-care	Patient experience: service users report they are actively encouraged and more able to look after their own condition and know where and how to access help if needed	Patient experience: service users positively report self-care as 'mainstream'

WHAT COULD STOP US FROM ACHIEVEING OUR QUALITY GOALS?

We understand that success represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks. There are many risks that will need to be effectively managed order to remain resilient and promote success. At a high level the primary risks to quality that we expect to face, and are working to mitigate, include:

Potential Risk	How the risk might arise	How the risk is being mitigated
Catastrophic failures in standards of safety and care	*This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality within the governance of Wirral University Teaching Hospitals*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk
Demand for care overwhelms our capacity to deliver care safely and effectively	*This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease*	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward
A critical shortage of workforce capacity and capability	*Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges to be significant*	The Workforce Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce - we aim to make Wirral University Teaching Hospitals the employer of choice
A failure to achieve and maintain financial sustainability	*The delivery of high quality care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk may arise if the trust is not able secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals*	A local and system-wide Financial Improvement Plan is specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-even (no surplus or deficit at the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Executive Medical Director and Chief Nurse.

We recognise that the risk horizon evolves over time and can change. These and other principal risks are kept under review by the Board as part of the Board Assurance Framework.

BUILDING OUR TEAM OF IMPROVEMENT PIONEERS

We recognise that to transform our patient safety culture and consistently deliver excellence in clinical outcomes and patient experience, it will be necessary to build capacity and capability to learn and improve. Learning is demonstrated in our ability to reduce the frequency of the same defects within our system of work. When we learn, we still experience new and novel failures as we adapt to risk; but we also see a change in the pattern of defects which adversely impact on quality. The surprising truth about success is that it requires failure[1]. Failure presents us with an opportunity to understand how and why our system of work leads to harm, poor outcomes or a bad experience for service users. We use this intelligence to discover, innovate and adapt. To capitalise on and transform failure into learning and improvement requires expertise, insight and an unstinting determination to keep trying no matter how hard the challenges become.

To support the delivery of our Quality Strategy we are making a solid commitment to:

- actively recruit from amongst experts on the front line and build a team of improvement pioneers;
- join forces with an internationally recognised improvement partner to educate, train and develop the skills of our improvement pioneers so that they can make a difference;
- move towards an organisational culture where care is the primary concern, 'safe' is a managed outcome and where we exploit the tension between innovation and risk to initiate adaption and learning; and
- mobilise financial and other resources required to deliver at pace the goals set out in our Quality Strategy.

HOW WE IMPROVE QUALITY

Our approach to quality improvement is based on a well-defined tool for accelerating improvement[2] that has been widely adopted across the NHS. We use the following principles to guide how we improve the quality of care at Wirral University Teaching Hospitals. We start every improvement journey by asking a series of important questions:

1. What problem are we attempting to solve - what exactly are we trying to achieve?
2. What change can we make to bring about an improvement?
3. How will we know that making a change delivers an improvement?

Considering these questions will clarify the aims, measures, specific interventions and how changes will be tested in the clinical setting.

Setting Aims

Improvement requires setting aims. The aim will be easy to understand, time bound and measurable; it will also define the specific population that will be affected. Agreeing on the aim is crucial; so is clarifying roles and responsibilities and allocating the people and resources necessary to accomplish the aim.

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[1] Syed, M. (2016) *Black Box Thinking: Marginal Gains and the Secrets of High Performance*. London. John Murray Publishers.
[2] Based on Langley, G.L., Moen, R., Nolan, T.W., Norman, C.L. & Provost, L.P. (2009) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition)*. San Fransisco, Josey-Bass

Establishing Measures

Measurement is a critical part of testing and implementing sustainable improvement; measures tell a team whether the changes they are making actually lead to improvement or not. Our preference for evaluating improvement is to use quantitative measurement; outcome **measures** (such as impact on health, well-being, clinical results), **process measures** (such as system performance, timeliness and compliance) and **balancing measures** (such as triangulating different measures from different perspectives to evaluate impact). We will, if appropriate, also adopt a combination of quantitative and qualitative measures should it help to determine and demonstrate if a specific change actually leads to sustainable improvement.

Selecting Changes

All improvement requires making changes, but not all changes result in improvement. Changes that do not result in improvement are helpful as they can help us to learn and adapt. By implementing changes, succeeding and failing as we go forward, we will identify sustainable change that is most likely to lead to improvement.

Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the clinical setting – by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-orientated learning.

PDSA provides a structured experimental learning approach to testing changes. The purpose of the PDSA method lies in learning as quickly as possible whether or not an intervention works in a particular setting and making adjustments to increase the chances of delivering desired and sustainable improvement. Successful application of PDSA will help Wirral University Teaching Hospitals to achieve our quality improvement goals more efficiently or to address priorities we might otherwise not have achieved under a business as usual approach. But PDSA is also successful if it saves wasted effort by revealing improvement goals that cannot be achieved under realistic constraints or it identifies flaws in the intervention.

THE QUALITY IMPROVEMENT PLAN

Each year, the Trust will review and identify the quality priorities and establish a tactical plan to drive forward the Quality Strategy. This tactical plan shall be known as the Quality Improvement Plan and will be monitored closely, amended as required and updated throughout the year to support the delivery of the Quality Strategy.

The progress made towards implementation of the Quality Strategy shall be monitored and reviewed each month by the Patient Safety & Quality Board (PSQB). Any adjustments to the tactical plan shall be determined and agreed by the PSQB and progress reported to the Quality Committee routinely as part of the cycle of business.

Board of Directors	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	1 May 2019
Author(s)	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
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken • **Yes** • **No**	No adverse equality impact identified.

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of March 2019.

2. Background

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

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

3. Key Issues

Of the 51 indicators with established targets that are reported for March 2019:

- 20 are currently off-target or failing to meet performance thresholds
- 31 of the indicators are on-target

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

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

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

6. Recommendation

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

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

April 2019

	Indicator	Objective	Director	Threshold	Set by	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	Safe, high quality care	DoN	≤0.24 per 1000 Bed Days	WUTH		0.27	0.17	0.27	0.22	0.18	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.17	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (**)	Safe, high quality care	MD	≥95%	WUTH		76.3%	77.0%	83.3%	84.8%	80.1%	82.9%	81.6%	76.7%	80.3%	89.9%	95.0%	98.1%	96.6%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	Safe, high quality care	MD	≥95%	SOF	95.2%	95.3%	95.3%	94.7%	95.3%	95.0%	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	95.6%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.6%	95.9%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	6	6	14	13	3	2	1	3	2	4	2	4	2	5	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	0	1	0	0	0	0	0	0	0	0	1	
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	0	0	1	5	1	0	0	0	0	0	1	0	0	8	
	Clostridium Difficile (avoidable)	Safe, high quality care	DoN	≤28 for FY18-19, as per mthly trajectory	SOF	3	4	1	3	1	3	0	3	4	2	7	10	5	43	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	2	4	2	6	7	2	3	5	4	2	3	4	2	44	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	10	11	14	17	18	18	15	13	23	9	10	6	5	159	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	1	0	0	0	0	0	0	0	1	0	0	0	2	3	
	Hand Hygiene Compliance (*)	Safe, high quality care	DoN	≥95%	WUTH	99%	95.0%	97%	88%	89%	90%	81%	87.0%	85.0%	76.0%	83.0%	86.0%	83.0%	86.7%	
	Medicines Storage Trust wide audits - % of areas fully compliant (with standards and data submission)	Safe, high quality care	DoN	≥90%	WUTH												98%	99%	99%	
	Protecting Vulnerable People Training - % compliant (Level 1) (*)	Safe, high quality care	DoN	≥90%	WUTH	89.5%	89.2%	–	–	87.4%	–	85.6%	90.4%	91.5%	91.4%	91.6%	92.8%	93.9%	93.9%	
	Protecting Vulnerable People Training - % compliant (Level 2) (*)	Safe, high quality care	DoN	≥90%	WUTH	82.5%	84.8%	–	–	82.7%	–	82.2%	86.0%	87.2%	87.1%	87.6%	88.7%	90.7%	90.7%	
	Protecting Vulnerable People Training - % compliant (Level 3) (*)	Safe, high quality care	DoN	≥90%	WUTH	85.2%	85.6%	–	–	85.6%	–	86.5%	87.2%	91.7%	91.4%	93.6%	92.6%	93.5%	93.5%	
	Nursing Vacancy Rate	Safe, high quality care	DHR	≤6.5%	WUTH	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%	7.47%	8.97%	9.07%	9.16%	9.16%	
	Consultant Vacancy Rate %	Safe, high quality care	DHR	≤6.5%	WUTH	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	7.90%	6.48%	6.61%	6.43%	6.73%	6.73%	
	Sickness absence % (12-month rolling average)	Safe, high quality care	DHR	≤4%	SOF	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.93%	4.94%	4.95%	5.02%	5.10%	5.10%	
	Short-term sickness (in month rate)	Safe, high quality care	DHR	TBC	WUTH	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.19%	2.36%	2.93%	2.80%	2.54%	2.31%	
	Long-term sickness (in-month rate)	Safe, high quality care	DHR	TBC	WUTH	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.81%	3.09%	2.79%	2.82%	2.72%	2.70%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	TBC	WUTH	7.1	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	7	7.3	7.2		–	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

April 2019

	Indicator	Objective	Director	Threshold	Set by	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Trend
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	94.7	–	–	97.06	–	–	97.22	–	–	–	–	–	–	97.22	
	HSMR	Safe, high quality care	MD	≤100	SOF	88.0	88.7	93.0	93.0	95	95	92	92	97	97	–	–	–	97	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	–	–	–	–	–	–	83%	66%	39%	63%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH			44%	59%	71%	78%	67%	74%	84%	87%	83%	81%	94%	74.7%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	14.6%	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	14.5%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	436	418	405	409	386	387	411	409	408	397	437	457	438	414	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.0	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.8	3.0	4.4	8.8	4.5	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.2	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	814	886	923	873	913	961	888	936	925	917	903	788	914	902	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	9	13	12	13	13	6	18	12	17	14	10	16	14	11.4	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	86.9%	

Quality Performance Dashboard

April 2019

	Indicator	Objective	Director	Threshold	Set by	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	16	18	22	10	8	16	14	19	18	15	20	14	13	187	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	82%	85%	90%	91%	89%	89%	86%	87%	84%	92%	85%	87%	87%	88%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11.0%	10.0%	11.0%	11.0%	13.0%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	97%	98%	97%	98%	98%	98%	97%	98%	98%	98%	98%	97%	97%	98%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	18.0%	18.0%	19.0%	15.0%	13.0%	18%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	94%	95%	95%	94%	95%	94%	94%	94%	95%	94%	95%	94%	95%	94.5%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	100%	97%	97%	99%	96%	100%	100%	96%	100%	100%	99%	98%	96%	98%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	19.0%	37.0%	27.0%	36.0%	44.0%	32%	

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Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2018/19	SOF	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	78.9%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	2	0	0	2	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	623	414	327	291	213	326	474	371	440	393	379	323	273	352	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory for 2018/19 (80% by 31 March 2019)	SOF	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	80.00%	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory for 2018/19 (zero by 31 March 2019)	National		66	67	79	57	56	40	43	30	28	28	19	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	98.9%	
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	93.9%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	97.0%	96.7%	
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	86.2%	85.4%	86.4%	85.6%	86.2%	
	Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	Outstanding Patient Experience	DoN	TBC	WUTH	144	118	134	110	140	123	155	119	165	118	178	153	157	1670	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	Outstanding Patient Experience	DoN	TBC	WUTH	30	34	23	36	24	25	22	19	13	13	27	28	17	281	
	Complaint acknowledged within 3 working days (*)	Outstanding Patient Experience	DoN	≥90%	National	97%	32%	81%	95%	72%	75%	80%	100%	100%	100%	100%	100%	100%	86.2%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	1	2	2	7	5	0	4	2	3	2	2	1	3	33	

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	Indicator	Objective	Director	Threshold	Set by	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Trend
Well-led	Staff Friends and Family Test - overall engagement score	Safe, high quality care	DHR	≥3.88	National	-	3.60	-	-	3.72	-	3.63	-	-	-	-	6.7		3.65	
	Live employee relations cases	Safe, high quality care	DHR	≤30	WUTH	29	30	33	35	36	32	29	23	30	32	35	33	35	32	
	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	-	-	-	-	-	-	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of patients recruited to NIHR research studies (*)	Outstanding Patient Experience	MD	650 for FY18/19 (ave min 55 per month until year total achieved)	National	-	53	39	336	70	48	42	38	57	38	43	41	54	859	
	% of staff that completed all core MAST in the preceding 12 months	Safe, high quality care	DHR	≥95%	WUTH		73.0%		74.8%	75.1%	82.0%	81.4%	82.2%	82.8%	81.5%	81.8%	84.1%	85.3%	85.3%	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	83.3%	84.9%		81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.6%	85.7%	88.2%	88.2%	

	Indicator	Objective	Director	Threshold	Set by	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	6.485	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-36.077	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	0.162	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-10.796	
	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	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-13.0%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-1.4%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-20.9	
	Capital Programme		DoF	On Plan	WUTH	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	12.2%	

Board of Directors	
Agenda Item	8.1.2
Title of Report	Month 12 Finance Report
Date of Meeting	1 May 2019
Author	Shahida Mohammed – Acting Deputy Director of Finance Julie Clarke – Assistant Director of Finance Deborah Harman – Assistant Director of Finance
Accountable Executive	Karen Edge Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 12 Finance Report 2018/19

Contents

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

The following summary details the Trust's outturn position for FY19 against plan, and forecast.

Actual performance against the operational forecast deficit of (£31.4m) was slightly better. The Trust concluded the operational position for the year with a deficit of (£31.3m). The net Trust position for 2018/19 is a deficit of (£33.0m), including technical adjustments. This includes a historic VAT charge in relation to Brookson (+Us) of (c£1.5m) for the provision of medical locums. This has been included following external advice and discussions with NHSI. This is pending audit review, and reflects the risk of retrospective VAT being levied by HMRC via Brookson. The second relates to the Frontis building, and reflects the effects of under-occupancy. Including the technical adjustments, the variance against the initial plan of (£25.0m) is (c£8.0m).

The patient-related income position is £2.5m better than plan, this predominantly relates to contracted income. This is inclusive of c£6.4m relating to MSK and income CIP added in year, hence the underlying position is (£3.9m) worse than plan. The main areas driving this position are the under performance in elective and daycase activity, which is 2,742 spells (5.4%) behind plan, with a corresponding financial impact of (c£5.2m), and Outpatients attendances, follow up's and procedures which are showing an adverse variance of (3,131) (1.0%), and a financial consequence of (£0.8m). There is also an under-performance in neonatal cot days of (£0.7m). Non-elective activity underperformed during quarter 4, with a cumulative under performance of (1,542) spells year to date, however from a financial perspective although the complexity of case-mix has been remained strong the impact of the under performance is (£0.6m). Further mitigation of the below income plan position has been the benefit of the MSK block contract (£2.2m) and the release of the accrual related to the Sepsis dispute (£1.4m) which has been concluded with Wirral CCG.

The pay reform funding of £4.1m is showing as above plan in other income with the contra entry in pay costs. The overall financial position includes a pressure of (c£0.3m) in relation to actual costs of the AFC changes which were not funded centrally from NHSI.

The overall expenditure position is above the NHSI plan by (£15.1m). However, pay costs includes the Agenda for Change (AFC) pay reform as discussed above of (£4.1m) and is offset in other income. Non pay includes (£4.2m) associated with the MSK contracts which were not included within the original NHSI plan as the contract sign off happened in year; this again is offset in clinical income. Excluding these significant planning variances the underlying operational expenditure position is (c£6.8m) worse than plan.

The underlying pay position (adj for AFC reform) is overall on plan for the financial year. Although total pay is overall on plan there have been significant pay variances with pressures in medical staffing in acute care to manage winter demand in the Emergency Department and across acute medical beds. The opening of the Grove discharge unit in November last year has supported patient flow as we continue to work with our partners to transfer medically optimised patients to the right community setting. Medical budgets in some specialties are also overspent where there have been key senior medical gaps and have resulted in the use of agency due to constrained market factors. High levels of qualified nurse vacancies have continued throughout the year and have consequently resulted in a high use of bank nurses to maintain safe staffing levels across the wards. Non-clinical vacancies have supported non-recurrent CIP delivery.

The agency spend for the financial year was £7.8m and is £0.4m above the NHSI ceiling/target for the year. Agency spend is largely used to cover key critical medical gaps and is closely managed, however the position since February has seen an increase over the cap largely driven by the VAT pressure on the Brookson contract, this reflects the change in HMRC's view in relation to VAT. A further (c£1.5m) of historic VAT charge in relation to Brookson (+Us) has been included in the financial position as a technical accounting adjustment as discussed earlier.

The underlying non pay (adj for the MSK contracts) is a financial pressure overall of (c£6.8m). The key variance on this significant overspend is undelivered CIP of (c£3.7m) which has been partially mitigated non-recurrently in pay with non-clinical vacancies in-year. Outsourcing costs are in total (c£1.6m) above plan and (c£1.0m) is due to requirements to deliver the patient waiting times in a number of surgical specialties from transfers earlier in the year. A further (c£0.7m) pressure relates to the Grove discharge unit that was opened in late November for medically optimised patients that is a contracted service with an external partner. External management consultants is (c£0.7m) above plan this year and has supported transformation and governance structures in-year.

The overall I&E position includes £3.0m of non-recurrent balance sheet support (including Sepsis).

The Trust delivered cost improvements of £9.6m, which is in-line with the forecast position. Of the value delivered, c£2.3m is non-recurrent largely relating to non- clinical vacancies. The recurrent CIP for 2019/20 is c£7.2m; this has been reflected in the 19/20 Plan. There is a now a focus on developing and implementing the 19/20 CIP schemes, to ensure the control total can be delivered and the Trust can access the central funding.

As part of the Winter Capacity planning the Trust opened the "step down" facility (T2A) beds part way through November 2018. 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 has cost the Trust (c£1.2m) for 2018/19, Wirral CCG provided funding of c£0.6m.

Cash balances at the end of March were £6.5m, exceeding plan by £4.7m. This is primarily due to positive working capital movements, capital outflows below plan and above-plan PDC received, offset by EBITDA below plan.

3. Financial performance

2.1 Income and expenditure

Month 12 Financial performance	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
Income from patient care activity	307,162	26,203	27,204	1,001	307,162	309,755	2,594
DOH - Pay Reform Income	0	0	339	339	0	4,066	4,066
Income - PSF	0	0	0	0	0	0	0
Other income *	29,428	2,500	3,171	672	29,428	31,312	1,884
Total operating income before donated asset income *	336,589	28,702	30,714	2,012	336,589	345,133	8,544
Employee expenses	(247,732)	(20,419)	(20,478)	(58)	(247,732)	(251,792)	(4,060)
Operating expenses *	(101,875)	(7,925)	(10,034)	(2,109)	(101,875)	(112,934)	(11,059)
Total operating expenditure before depreciation *	(349,607)	(28,345)	(30,512)	(2,167)	(349,607)	(364,726)	(15,119)
EBITDA *	**(13,018)**	**357**	**202**	**(155)**	**(13,018)**	**(19,593)**	**(6,575)**
Depreciation	(8,160)	(693)	(689)	3	(8,160)	(8,187)	(27)
Capital donations / grants income	0	0	0	0	0	165	165
Operating surplus / (deficit) *	(21,178)	(335)	(487)	(152)	(21,178)	(27,615)	(6,437)
Net finance costs	(4,105)	(378)	(259)	118	(4,105)	(3,806)	299
Gains / (losses) on disposal	0	0	75	75	0	75	75
Actual surplus / (deficit) *	**(25,282)**	**(713)**	**(672)**	**41**	**(25,282)**	**(31,347)**	**(6,064)**
Reverse capital donations / grants I&E impact	243	20	22	2	243	80	(163)
DEL net impairments *(damage, not revaluation)*	0	0	(34)	(34)	0	(34)	(34)
Adjusted financial performance surplus/(deficit) [AFPD] *	**(25,039)**	**(693)**	**(683)**	**9**	**(25,039)**	**(31,300)**	**(6,261)**
Less technical accounting adjustments		0	(1,706)	(1,706)	0	(1,706)	(1,706)
Adjusted financial performance surplus/(deficit) [AFPD]	**(25,039)**	**(693)**	**(2,389)**	**(1,697)**	**(25,039)**	**(33,006)**	**(7,967)**

**** before year end technical adjustments and impairments***

- During Month 12 the plan was delivered, the year end operational position is a deficit of (c£31.3m), with the inclusion of "year end" technical adjustments, the net Trust position for 2018/19 is a deficit of (£33.0m). This includes a historic VAT charge in relation to Brookson (+Us) of (c£1.5m) for the provision of medical locums. This has been included following external legal advice and discussions with NHSI. This is pending audit review, and reflects the risk of retrospective VAT being levied by HMRC via Brookson. A further (c£0.2m) relates to the Frontis building, and reflects the effects of under-occupancy.
- The main driver of this position is the underperformance of the elective programme which is (c£5.2m) below plan. Excluding MSK sub-contract variations which are offset in expenditure and the benefit of the MSK "block" arrangement, the underlying contract income position is YTD (c£3.9m) worse than plan..
- The overall income position includes the AFC pay reform funding of c£4.1m YTD which offset in the pay overspend.
- Although total expenditure is (c£15.1m) worse than plan, the underlying expenditure position (adj for AFC pay reform and MSK) is (c£6.8m) overspent. The underlying pay is overall on plan and the underlying non pay is (c£6.8m) over plan and reflects earlier outsourcing pressure for elective capacity, the discharge unit outsourcing costs, consultancy costs and non-delivery of CIP.
- It has to be noted the overall year to date position also includes c£3.0m 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	689	639	(50)	(7.22%)	8,351	6,870	(1,481)	(17.74%)
Daycase	3,661	3,730	69	1.88%	42,846	41,585	(1,261)	(2.94%)
Elective excess bed days	321	683	362	112.86%	3,960	3,080	(880)	(22.22%)
Non-elective	4,150	3,862	(289)	(6.95%)	46,605	45,063	(1,542)	(3.31%)
Non-elective Non Emergency	538	428	(110)	(20.49%)	5,309	5,162	(147)	(2.77%)
Non-elective excess bed days	866	914	48	5.53%	9,750	9,828	78	0.80%
A&E	7,869	7,882	13	0.16%	92,658	90,981	(1,677)	(1.81%)
Outpatients	25,038	27,559	2,520	10.07%	299,363	296,232	(3,131)	(1.05%)
Diagnostic imaging	2,463	2,719	256	10.38%	29,282	30,884	1,601	5.47%
Maternity	538	501	(37)	(6.87%)	6,334	5,920	(414)	(6.54%)
Total NHS patient care income	46,135	48,917	2,782		544,460	535,606	(8,854)	

- The main specialities driving the under performances in elective and daycase activity were Colorectal, Ophthalmology, Urology and Trauma and Orthopaedic surgery. Clinical Haematology has over performed which is partially mitigating the position.
  Going forward into 2019/20 “Booked” activity is being monitored on a weekly basis by each Division and the Chief Operating Officer. This method of prospective management will enable the Divisions to enact remedial action plans to ensure the position does not deteriorate.
- In March demand for emergency care was below plan levels, this is consistent with demand seen in January and February, the overall position was an under performance to (1,542) spells; this is across a number of specialities. The only area over performing in emergency care is Upper GI, this has mitigated the overall position.
- Although Outpatient follow up attendances improved significantly during the month, mainly in Trauma and Orthopaedics this was undermined by a reduction in OP first attendances in both respiratory and T&O first appointments.
- Births were below plan by (c143).

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	2,131	2,140	9	0.41%	26,661	22,773	(3,888)	(14.58%)
Daycase	2,349	2,279	(69)	(2.95%)	27,660	26,354	(1,305)	(4.72%)
Elective excess bed days	78	159	81	104.44%	957	751	(206)	(21.52%)
Non-elective	7,987	7,421	(566)	(7.09%)	89,515	88,879	(636)	(0.71%)
Non-elective Non Emergency	1,296	970	(325)	(25.11%)	12,449	11,939	(510)	(4.10%)
Non-elective excess bed days	214	213	(1)	(0.64%)	2,401	2,402	1	0.05%
A&E	1,099	1,104	5	0.46%	12,944	13,134	190	1.47%
Outpatients	2,851	3,023	172	6.03%	33,985	33,229	(756)	(2.22%)
Diagnostic imaging	197	212	15	7.64%	2,338	2,358	20	0.87%
Maternity	483	457	(26)	(5.42%)	5,493	5,162	(331)	(6.03%)
Non PbR	5,502	5,900	398	7.24%	68,575	69,754	1,179	1.72%
HCD	1,284	1,282	(3)	(0.22%)	15,413	15,798	385	2.50%
CQUINs	563	484	(79)	(14.03%)	6,753	6,226	(527)	(7.80%)
MSK Sub Contracts	0	211	211	0.00%	0	4,229	4,229	0.00%
MSK back to Block	0	230	230	0.00%	0	2,198	2,198	0.00%
Other	0	950	950	0.00%	0	2,456	2,456	0.00%
Total income from patient care (SLAM)	26,033	27,035	1,001	3.85%	305,144	307,642	2,498	0.82%

- Within the overall year to date position the main area which under performed significantly was, elective and daycases, which is showing a deficit of (£5.2m), reflecting both activity and casemix reductions. Outpatient attendances are (c£0.8m) below plan, this is predominantly in first attendances and procedures. For 2019/20, activity plans have been set on actual demand and capacity modelling undertaken by the Division. This ensures there is closer alignment of activity and resource, performance is managed prospectively on a weekly basis.
- 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 c£6.4m, (some of this will be offset in expenditure due to payments to sub-contractors e.g. Wirral CT for Physio services). As this is a "block" contract, the position includes a cumulative benefit of c£2.2m.
- Despite non elective activity underperforming the casemix has remained strong, supporting the overall position.
- Performance in other PbR areas has remained static throughout the year from a financial perspective. The impact of Births being under plan was (c0.4m). Neonatal activity concluded the year with an underperformance of (£0.7m). Given the unpredictable nature of this activity and the reliance on the Neonatal network for a large proportion of this work, the Trust has successfully negotiated a "block" arrangement for 19/20, based on the 18/19 plan.
- 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£1.4m, and other balance sheet support of £0.9m, this is recorded in the "Other" category in the above table.

2. Financial performance

2.3 Expenditure

- The overall year end expenditure position is (c£15.1m) above plan. However excluding significant plan adjustments for MSK of c£4.2m YTD and AFC reform funding of c£4.1m YTD there is an under-lying overspend of (c£6.8m). Pay is overall on plan and non-pay is (c£6.8m). Further details 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	Adjusted for AFC Funding Year to date Plan £'000	Adjusted for AFC Funding Year to date Actual £'000	Adjusted for AFC Funding Year to date Variance £'000
Substantive	(225,643)	(18,552)	(17,780)	772	(225,643)	(226,131)	(488)	(229,709)	(226,131)	3,578
Bank	(6,662)	(551)	(1,072)	(521)	(6,662)	(9,488)	(2,826)	(6,662)	(9,488)	(2,826)
Medical Bank	(7,057)	(589)	(677)	(88)	(7,057)	(7,433)	(376)	(7,057)	(7,433)	(376)
Agency	(7,469)	(652)	(874)	(222)	(7,469)	(7,833)	(364)	(7,469)	(7,833)	(364)
Other - Apprenticeship levy	(900)	(75)	(75)	0	(900)	(907)	(7)	(900)	(907)	(7)
Total Pay	(247,732)	(20,419)	(20,478)	(58)	(247,732)	(251,792)	(4,060)	(251,798)	(251,792)	6
Other Technical Year End Adj	0	0	(1,523)	(1,523)	0	(1,523)	(1,523)	0	(1,523)	(1,523)
Adjusted NHSI Total Pay	(247,732)	(20,419)	(22,001)	(1,581)	(247,732)	(253,315)	(5,583)	(251,798)	(253,315)	(1,517)

- Performance against the 18/19 plan for pay costs (before technical adjustments) is (c£4.1m) worse than plan. However, the plan excluded the AFC pay reform funding of (c£4.1m) year to date which is offset in income. Hence the underlying pay position (i.e. adjusted for pay award funding) is overall on plan for the financial year. This is shown in the adjusted section of the table above.

- Although on plan overall throughout the year there have been significant pressures on the medical budgets with high use of non-core to cover key critical gaps and to staff acute medical areas. Nursing budgets have underspent particularly for qualified nurses and the Trust continues to progress substantive recruitment initiatives. Non- clinical vacancies were high in year and these underspends have non-recurrently supported the delivery of the CIP target as well as offsetting other financial pressures.
- The agency figure is c£0.9m for March and the year end spend on agency was c£7.8m, c£0.4m above the NHSI cap. The change on VAT treatment from February has impacted this and the technical accounting adjustment reflects the potential retrospective VAT charge on the Brookson contract.

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	Adjusted for MSK Funding Year to date Plan £'000	Adjusted for MSK Funding Year to date Actual £'000	Adjusted for MSK Funding Year to date Variance £'000
Purchase of Healthcare - Non NHS	(2,583)	(275)	(635)	(360)	(2,583)	(8,414)	(5,831)	(6,805)	(8,414)	(1,609)
Supplies and services - clinical	(35,475)	(2,918)	(3,106)	(189)	(35,475)	(35,349)	125	(35,475)	(35,349)	125
Drugs	(25,395)	(2,109)	(2,102)	7	(25,395)	(25,402)	(6)	(25,395)	(25,402)	(6)
Consultancy	0	0	(109)	(109)	0	(729)	(729)	0	(729)	(729)
Other	(38,422)	(2,624)	(4,082)	(1,458)	(38,422)	(43,040)	(4,618)	(38,422)	(43,040)	(4,618)
Total Operating Non Pay	(101,875)	(7,925)	(10,034)	(2,109)	(101,875)	(112,934)	(11,059)	(106,097)	(112,934)	(6,837)
Depreciation	(8,160)	(693)	(689)	3	(8,160)	(8,187)	(27)	(8,160)	(8,187)	(27)
Other Technical Year End Adj	0	0	(10,682)	(10,682)	0	(10,682)	(10,682)	0	(10,682)	(10,682)
Adjusted NHSI Total Operating Expenses	(110,035)	(8,618)	(21,405)	(12,787)	(110,035)	(131,803)	(21,768)	(114,257)	(131,803)	(17,546)

- Performance against the 18/19 plan for non pay is (c£11.0m) above plan however the plan excludes the MSK contract costs of c£4.2m YTD which are offset in income. Hence the underlying non-pay position (adjusted for MSK) is (c£6.8m) overspent. This is shown in the adjusted section in the table above.
- Purchase of Healthcare – Non NHS (Outsourcing) adjusted for MSK is (c£1.6m) above plan. Earlier outsourcing costs to Spire in relation to gaps in elective capacity at the beginning of the year for number surgical specialties (Orthopaedics, Pain and ENT) is (c£1.0m),whilst a further (c£0.7m) is the Grove Discharge Unit and radiology non NHS outsourcing pressures of (c£0.3m) to manage capacity gaps. The RTT outsourcing reserve has partially offset these pressures.
- Clinical supplies are marginally below plan and drug costs have delivered to plan.
- Consultancy/ external management consultant costs have continued in-mth largely to support transformation and governance and have partially been offset by vacancies. As substantive structures are embedded these costs will decrease.
- In other the variance largely reflects the under-delivery of CIP of (c£3.7m). The CIP plan was heavily weighted to non pay as the £4.0m unidentified gap at the time of submitting the plan was allocated to non pay and in year has been partially delivered non-recurrently in pay due to vacancies.

2. Financial performance

2.4 CIP by programme

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	Recurrent Savings NHSI Plan £k	Recurrent Savings Total £k	Recurrent Savings Variance £k
Transformation							
Improving Patient Flow	Anthony Middleton	1,000	1,337	**337**	1,000	1,337	**337**
Improving Productivity	Anthony Middleton	478	808	**330**	478	1,260	**782**
Collaboration	Janelle Holmes	952	812	**(140)**	952	86	**(866)**
Digital Wirral	Paul Charnley	1,000	1,260	**260**	1,000	1,000	**0**
Sub total - transformation		**3,430**	**4,217**	**787**	**3,430**	**3,683**	**253**
Cross cutting workstreams							
Workforce	Helen Marks/ Tracy Fennell	134	374	**239**	134	19	**(115)**
Estates & Site Strategy	Dave Sanderson	0	0	**0**	0	0	**0**
Pharmacy and Meds Management	Pippa Roberts	500	473	**(27)**	500	360	**(140)**
Procurement and Non Pay	Jane Christopher	1,150	419	**(731)**	1,150	201	**(949)**
Tactical and transactional		0	0		0		
Divisional and Departmental	Divisional Directors	1,936	4,075	**2,139**	1,936	2,961	**1,025**
Unidentified		3,850	0	**(3,850)**	3,850	0	**(3,850)**
Total		**11,000**	**9,558**	**(1,442)**	**11,000**	**7,223**	**(3,777)**

- Overall c£9.6m of cost improvements/efficiencies were delivered in 2018/19, this represents c88% of the initial target of £11.0m
- Of the £9.6m CIP achieved to, £7.2m is recurrent, the remaining difference of c£2.3m has been achieved non-recurrently largely due to in-year vacancies, which have hence supported the efficiency programme for the year. The vacancies are mainly in non-clinical areas.
- The recurrent CIP gap of (c£3.8m) has been accounted for as part of the 19/20 Draft plan.

3. Financial position

Wirral University Teaching Hospital NHS Foundation Trust

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 31.03.19 £'000	Actual as at 31.03.19 £'000	Variance (to plan) £'000	Plan 31.03.19 £'000
	Non-current assets					
159,754	Property, plant and equipment	⇧	160,148	161,213	1,065	160,148
12,763	Intangibles	⇧	12,369	14,225	1,856	12,369
903	Trade and other non-current receivables	⇩	903	820	(83)	903
173,420		⇧	**173,420**	**176,258**	**2,838**	**173,420**
	Current assets					
4,171	Inventories	⇩	4,171	3,973	(198)	4,171
18,423	Trade and other receivables	⇩	18,424	14,036	(4,388)	18,424
0	Assets held for sale	⇨	0	0	0	0
7,950	Cash and cash equivalents	⇩	1,773	6,515	4,742	1,773
30,544		⇩	**24,368**	**24,524**	**156**	**24,368**
203,964	**Total assets**	⇩	**197,788**	**200,782**	**2,994**	**197,788**
(32,538)	Trade and other payables	⇩	(27,752)	(34,815)	(7,063)	(27,752)
(1,074)	Borrowings	⇨	(1,076)	(1,077)	(1)	(1,076)
(37,384)		⇩	**(32,600)**	**(42,173)**	**(9,573)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	⇩	**(8,232)**	**(17,649)**	**(9,417)**	**(8,240)**
166,580	**Total assets less current liabilities**	⇩	**165,188**	**158,609**	**(6,579)**	**165,180**
	Non-current liabilities					
(8,812)	Other liabilities	⇧	(8,470)	(2,697)	5,773	(8,470)
(49,258)	Borrowings	⇧	(73,221)	(73,223)	(2)	(73,221)
(2,318)	Provisions	⇩	(2,131)	(7,787)	(5,656)	(2,131)
(60,388)		⇧	**(83,822)**	**(83,707)**	**115**	**(83,826)**
106,192	**Total assets employed**	⇩	**81,366**	**74,902**	**(6,464)**	**81,366**
	Financed by Taxpayers' equity					
77,575	Public dividend capital	⇧	78,031	79,587	1,556	78,031
(12,259)	Income and expenditure reserve	⇩	(37,541)	(49,803)	(12,262)	(37,541)
40,876	Revaluation reserve	⇧	40,876	45,118	4,242	40,876
106,192	**Total taxpayers' equity**	⇩	**81,366**	**74,902**	**(6,464)**	**81,366**

Capital asset variances	**£m**
Capex underspend	0.5
Donations above plan	0.2
18/19 additional funding balance	2.3
Total variance of capital assets to plan	**2.9**

Cash variances	**£m**
EBITDA and donation income below plan	-8.3
Working capital movements	10.3
Capital expenditure (cash basis) below plan	0.5
PDC received above plan	1.6
Other minor variances above plan	0.6
Total variance of cash to plan	**4.7**

3. Financial position

3.2 Capital expenditure

	2018/19 NHSI capital plan	Full year			Comparison to M11 Forecast		
		Budget [1]	Actual	Variance	Forecast	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Depreciation	8,160	8,160	8,187	(27)	8,193	8,187	6
Loan repayment	(1,015)	(1,015)	(1,015)	0	(1,015)	(1,015)	0
Finance lease	(60)	(60)	(59)	(1)	(60)	(59)	(1)
Additional funding per plan	3,250	3,250	3,250	0	3,250	3,250	0
Additional funding - equipment trade-in	0	108	108	0	0	108	(108)
Additional external (donations / grant) funding	0	185	165	20	176	165	11
Public Dividend Capital (PDC) - GDE	456	456	0	456	0	0	0
Public Dividend Capital (PDC) - Urgent and Emergency Care	0	2,000	2,000	0	2,000	2,000	0
Public Dividend Capital (PDC) - Pharmacy Infrastructure	0	12	12	0	12	12	0
Total funding	**10,791**	**13,096**	**12,648**	**448**	**12,556**	**12,648**	**(92)**
Expenditure - schemes							
Divisional priorities - *Medicine and Acute Care*		238	130	108	227	130	97
Divisional priorities - *Surgery*		372	556	(184)	602	556	46
Divisional priorities - *Women and Children's*		553	538	15	568	538	30
Divisional priorities - *Clinical Support and Diagnostics*		1,960	1,845	115	1,975	1,845	130
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,518	1,495	23	1,518	1,495	23
Divisional priorities - contingency [3]	500	0	0	0	0	0	0
Informatics - *Digital Wirral / Global Digital Exemplar*	2,811	2,801	2,647	154	3,029	2,647	382
Informatics	500	536	586	(50)	593	586	7
Switchboard		850	787	63	850	787	63
Estates - backlog maintenance	1,500	3,466	3,190	276	3,401	3,190	211
Car park		0	0	0	0	0	0
Cerner		(400)	(400)	0	(400)	(400)	0
Equipment trade-in		0	108	(108)	0	108	(108)
All other expenditures		(193)	(145)	(48)	(155)	(145)	(10)
Urgent and Emergency Care		0	0	0	0	0	0
Contingency [3]	1,180	1,210	0	1,210	0	0	0
Reallocated funding	3,250	0	0	0	0	0	0
NHSI plan subtotal	**10,791**						
Donated assets	0	185	165	20	176	165	11
Total expenditure (accruals basis)	**10,791**	**13,096**	**11,502**	**1,594**	**12,384**	**11,502**	**882**
Capital programme funding less expenditure	**0**	**0**	**1,146**	**(1,146)**	**172**	**1,146**	**(974)**

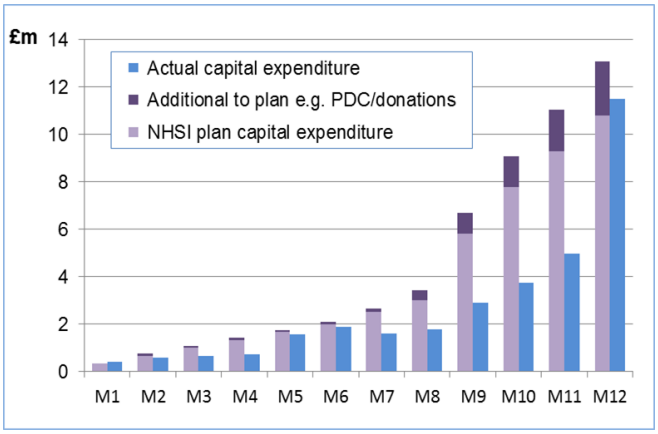
[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.

Capex summary

Capital spend for the year is £11.5m against full-year plan of £10.8m and budget of £13.1m.

PDC to be received in year (£0.5m), in respect of the Digital Wirral scheme, has been deferred to 2019/20.

2019/20 capital expenditure will continue to be monitored at FPG to ensure that outturn is in line with budget.



Capital funding

- Capital expenditure is forecast to be within external funding and internally generated limits for the year.
- Internally generated funding includes brought forward cash.

3. Financial position

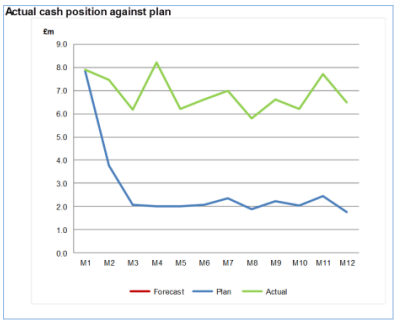
Wirral University Teaching Hospital NHS Foundation Trust

3.3 Statement of Cash Flows

	Month			Year to date			Full Year
	Actual	Plan	Variance	Actual	Plan	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening cash	**7,715**	**2,446**	**5,269**	**7,950**	**7,950**	**0**	**7,950**
Operating activities							
Surplus / (deficit)	(6,869)	(712)	(6,157)	(37,544)	(25,281)	(12,263)	(25,282)
Net interest accrued	167	183	(16)	1,606	1,778	(172)	1,806
PDC dividend expense	91	191	(100)	2,192	2,292	(100)	2,292
Unwinding of discount	1	3	(2)	7	36	(29)	6
(Gain) / loss on disposal	(75)	0	(75)	(75)	0	(75)	0
Operating surplus / (deficit)	(6,684)	(335)	(6,349)	(33,813)	(21,175)	(12,638)	(21,178)
Depreciation and amortisation	689	690	(1)	8,187	8,157	30	8,160
Impairments / (impairment reversals)	4,492	0	4,492	4,492	0	4,492	0
Donated asset income (cash and non-cash)	0	0	0	(165)	0	(165)	0
Changes in working capital	5,620	2,163	3,457	9,336	(982)	10,318	(996)
Investing activities							
Interest received	12	3	9	124	36	88	48
Purchase of non-current (capital) assets [1]	(3,241)	(508)	(2,733)	(11,898)	(12,444)	546	(12,444)
Sales of non-current (capital) assets	218	0	218	218	0	218	0
Receipt of cash donations to purchase capital assets	0	0	0	35	0	35	0
Financing activities							
Public dividend capital received	12	0	12	2,012	456	1,556	456
Net loan funding [2]	(508)	(508)	0	24,027	24,026	1	24,027
Interest paid	(658)	(1,026)	368	(1,583)	(1,844)	261	(1,845)
PDC dividend paid	(1,146)	(1,146)	0	(2,335)	(2,335)	0	(2,335)
Finance lease rental payments	(6)	(6)	0	(72)	(72)	0	(70)
Total net cash inflow / (outflow)	**(1,200)**	**(673)**	**(527)**	**(1,435)**	**(6,177)**	**4,742**	**(6,177)**
Closing cash	**6,515**	**1,773**	**4,742**	**6,515**	**1,773**	**4,742**	**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	-8.3
Working capital movements	10.3
Capital expenditure (cash basis) below plan	0.5
PDC received above plan	1.6
Other minor variances above plan	0.6
Total variance of cash to plan	**4.7**



Cash summary

- The Trust continues to borrow through a Board-approved facility administered by DHSC and NHSI, which supports the Trust's revenue requirements.
- The elevated cash position (£4.7m) includes additional cash to be used to finance the capital plan.
- The Financial Services team actively manages the net working capital position in tandem with treasury borrowings to maintain liquidity and minimise finance costs.

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%	-12.9	3	-20.9	4	-12.9	3
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-2.5	4	-4.2	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-7.4%	4	-9.4%	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	-2.0%	3	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	0.0%	1	4.8%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has overspent against the agency cap, increasing the risk rating to 2. The Trust needs to continue its focus to reduce 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 12 UoR rating is 3 overall, which matches the 2018/19 plan UoR rating of 3.

Conclusion

The Trust concluded the year operationally as forecast in month 11 despite continuing operational pressures.

The Trust has learned from the 2018/19 in-year challenges, and has set a more robust deliverable activity plan for 2019/20 which is based on demand and capacity modelling, which is aligned to the staffing resource.

Pay and non pay budgets have been set to support the operational delivery of the plan; this also includes additional pressures funding of c£4.0m.

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

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

In addition weekly monitoring arrangements have also been introduced, these meetings are chaired by the Chief Executive, the review includes, vacancy approval, non-core spend, and discretionary spend authorisation, which are subject to delivery of CIP milestones.

Although the Trust's closing cash position is above plan, the Trust's quarter 1 liquidity is dependent on revenue borrowing. This is due to the outturn position significantly exceeding the 18/19 plan. As the Trust has matched its borrowings to the initial plan deficit of (£25.0m) throughout 2018/19, the Trust will now be requesting additional borrowings in Q1 of 2019/20 which will be c£6.5m. Although this will be drawn in the subsequent financial year, this 'Q1 catch up' is an allowed feature of the Trust's borrowings arrangement, this was approved by the Board during the April meeting.

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

Karen Edge
Acting Director of Finance
April 2019

Board of Directors	
Agenda Item	9.1
Title of Report	A Review of Freedom to Speak Up Guardian Report
Date of Meeting	1 May 2019
Author	Ann Lucas, Deputy Director of Workforce Intelligence
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Bronze
FOI status	Yes
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

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

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

2. Background

2.1 Guidance issued by NHSI in May 2018 ("Guidance for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts") stated that reports should be presented to the Trust Board on a six monthly basis to enable a good oversight of FTSU matters and issues. Reports should be presented by the FTSU Guardian or a member of the Trust's local Guardian network in person. All data presented has to maintain the confidentiality of individuals who speak up. The FTSUG also provides information to the national guardian's office on a regular basis.

3. Key Issues

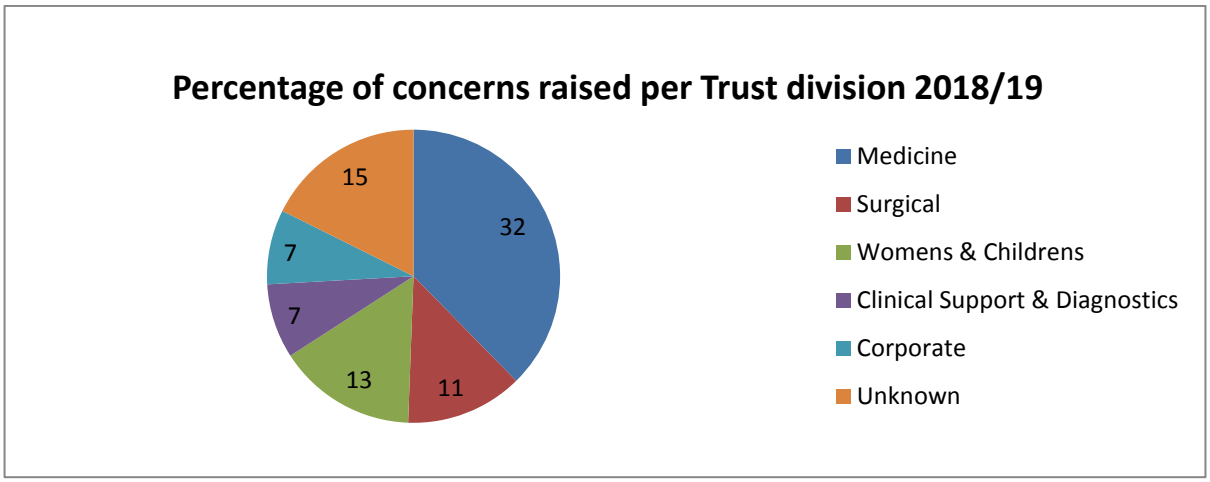
Year ended March 2019

3.1 In 2018/19 the FTSUGs received 47 cases, which is a reduction on the previous year; during 2017/18 there were 56 cases raised. It is proposed that an external independent review of the Guardian service be carried out. Included in the review will be to understand if there are any concerns about using the service that would have led to the reduction.

3.2 Data is submitted to the National Guardians Office on a quarterly basis and 2017/18 quarter 4 has not yet been formally published. Comparable figures for medium sized acute Trusts for the first three quarters is shown in the table below:

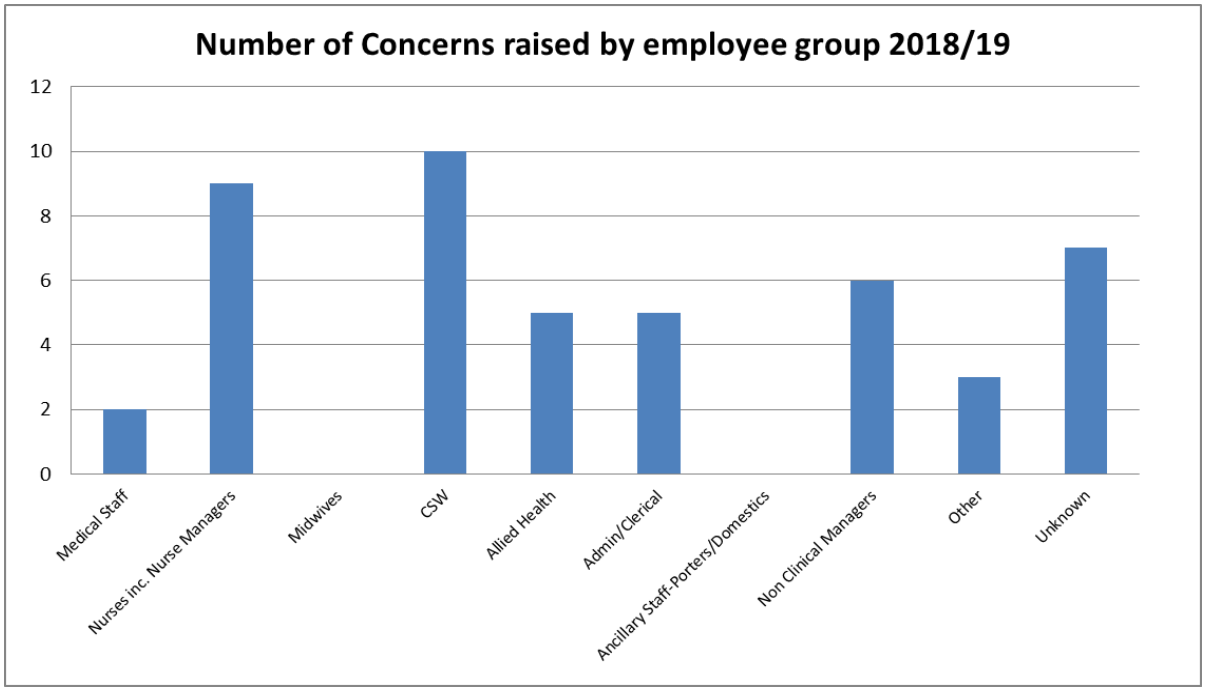
Number of WUTH cases compared both at a regional and national level					
As published by National Guardian Office	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Total 2018/19
Wirral UTH	25	4	7	10	46
Regional Average	11	13	14	Not yet published	
National Average	10	10	12		

3.3 The chart below shows the percentage of concerns raised during 2018/19 by division:



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

The chart below details the concerns raised in 2018/19 year by staff group:



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

The submission of anonymous complaints to the FTSGs continues to make it difficult to extract all of the required data and to personalise the support offered and to give feedback.

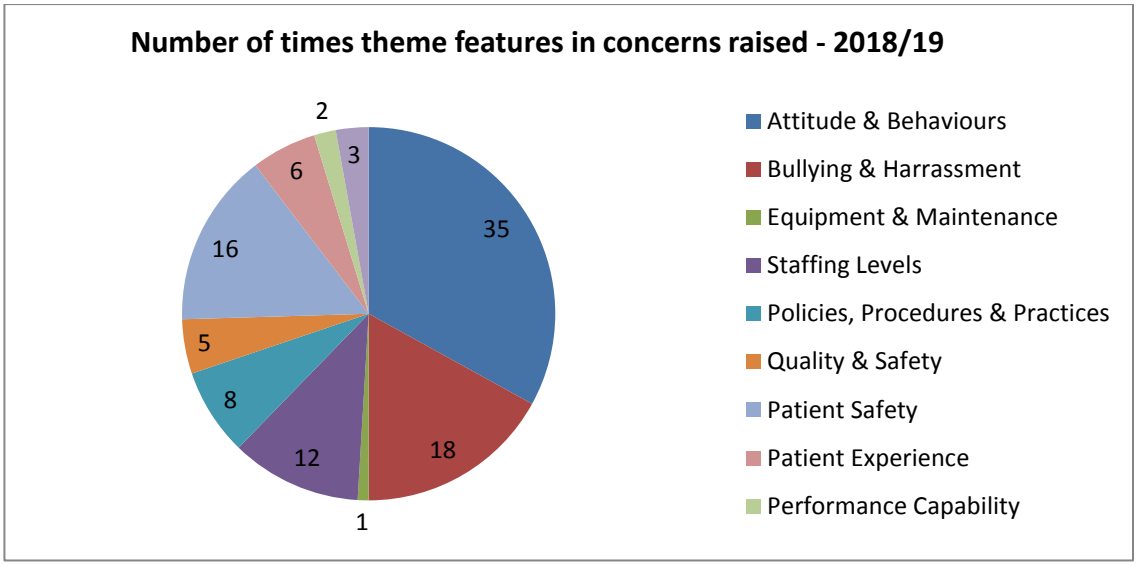
Feedback from our staff, who have attended the FTSU training, have highlighted the following barriers to speaking up:-

- Fear of disciplinary action
- Limiting career progression
- Fear of negative response from co-workers
- Nothing will change
- Lack of anonymity and confidentiality

Assessment of issues raised

3.4 Attitude and behaviour continues to be the most reported theme of those concerns raised. However, we have decided to separate out bullying as a category.

From the issues identified above the following themes have been identified in the chart below:



Specific details about the actions that have been taken to resolve issues have not been recorded against each individual case as well as the dates of when a case is closed. However, this is currently being rectified as a matter of urgency.

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

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

Raising the profile of the FTSUG within the Trust

3.5 The profile of the FTSUG in the Trust forms part of the staff induction process (including junior doctors) and FTSU training is available across the organisation. Leaflets and posters are available and have recently been refreshed. Work is ongoing to recruit a guardian from the medical body. A Non-Executive director has also been identified with responsibility for overseeing the FTSU agenda.

Update on lessons learned and improvement actions

3.6 **Training and development** - Given that one of the main themes raised over the last year was attitudes and behaviours, and in particular bullying, joint training with staff side colleagues is available. However, the compliance figures for the Bullying and Harassment training are disappointingly low and as at 31 March 2019 level 1 (for all staff) was 17.84% and level 2, which is for managers was 24.97%. If managers are undertaking level 2 they do not have to complete level 1. The executive have now taken the decision that this training has to be undertaken by **all**

staff across the Trust over the next 12 months. Compliance will be monitored by the executive team.

3.7 **FTSU training -** Whilst the quality of the FTSU training being provided for staff within the Trust has been acknowledged by both NHSI and the National Guardian's Office current numbers of people who have undertaken the training are again small and as at 31 March 2019 level 1 (for all staff) compliance was 7.2% and level 2 (for managers) 10.69%. The training is currently provided face-to-face as it is an interactive session. This also limits the number of people who can attend each session and the number of sessions available. In order to address this issue a number of actions have been agreed which include:

- E-Learning module training to be available for level 1 training
- To have in place additional trainers to be trained for level 2 face-to-face delivery
- The number of sessions and the availability on those sessions to be increased

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3.8 **FTSU Champions** - Expressions of interest have been sent out for FTSU champions and a number of responses have already been received ahead of the closing date of 26 April 2019. The role will be about promoting speaking up and signposting staff to training. A review of the numbers and the individuals to be enlisted as champions will take place at the end of April.

3.9 **A FTSUG from the medical profession** – discussions are currently being held with a senior medic who has agreed to take on the role. A date for when they can commence is to be agreed this week with the Lead Guardian. This would give a total of four guardian roles within the Trust.

3.10 **Greater granularity of record keeping** – the Guardian data base records need to be improved by adding in the dates that issues are resolved, together with actions taken and reason for any delays in resolving issues. This must be done against each individual case. Records must also be undated in real time so that they are always up-to-date.

4 Next Steps

4.2 In addition to the above it is also intended that an external independent review be carried out to assess the effectiveness of WUTHs FTSUG processes and how the Trust might further improve for the future. Steps are being taken to prepare a scope for this review together with aims and objectives. Progress and outcomes of this review will be monitored through the workforce governance arrangements.

5. Recommendations

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

Board of Directors	
Agenda Item	9.2
Title of Report	Review of Healthcare Flu Vaccination Programme and Lessons Learnt – 2018/19
Date of Meeting	1 May 2019
Author(s)	Ann Lucas, Deputy Director of Workforce Intelligence Carol Skillen, Occupational Health & Wellbeing Manager
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	
FOI status	Yes
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

1.1 The following report provides the Trust Board with details of the final position on the 2018/19 Flu Campaign at WUTH. It outlines the final Trust position compared to other Trusts within the region and compared to WUTH's own performance last year. The report also highlights the campaign successes and areas where lessons have been learned in order to further improve things for 2019/20.

1.2 The final trust position was 84.5% of frontline healthcare workers vaccinated compared with 81.3% last year and WUTH was fourth highest in the northwest region compared to seventh place last year. Many things went well in the 2018/19 campaign including robust planning and a comprehensive Trust wide communications plan, as well as an early start to the campaign. Newly introduced 'opt out' forms proved a challenge for the 2018/19 campaign with only 61 of the 812 people who were not vaccinated completing a form, and the forms were only partially completed. Actions will be built into the 2019/20 plan to improve this. The 2019/20 plan will also give a greater focus to high risk areas such as haematology, oncology, neonatal intensive care and the special care baby unit. Again, the plan will incorporate lessons learnt from this year's campaign. The relevant actions are included within this report.

2. Background

2.1 In February 2018, the Medical Directors of NHS England and NHS Improvement wrote to all NHS Trusts to request that the quadrivalent (QIV) flu vaccine was made available to all healthcare workers during winter 2018-19. It was believed that this particular vaccine offered the broadest protection. It was a major initiative, which formed part of a suite of interventions to reduce the impact of flu across the NHS.

2.2 The letter also advised that higher-risk departments such as haematology, oncology and neonatal intensive care and special care baby units should move to achieve 100% staff vaccination uptake.

2.3 NHS England wrote to NHS CEO's in September 2018 stating it was the ambition for 100% of healthcare workers with direct patient contact to be vaccinated. Where staff are offered the vaccine and decide, on the balance of evidence and personal circumstance, against having the vaccine, they should be asked to provide their reason for doing so by completing a form. The opt out forms would be collated and used to inform future vaccination programmes.

3. Key Issues

<u>Trust position</u>

3.1 In 2018/19, 4439 out of 5251(which equates to 84.5%) staff with direct patient contact were vaccinated against influenza. This was WUTH's highest ever total achieved and an increase on the 2017/18 flu campaign which delivered 81.3%. This meant that the Trust achieved its required CQUIN target of a 75% uptake of the flu vaccination.

3.2 In 2018/19 WUTH achieved the fourth highest rate of vaccination of Trusts in the North West Region compared to seventh highest in 2017/18. However, our ambition is to deliver similar rates of vaccination to the best performing Trusts.

NHS Hospital Trusts North West Region	Percentage uptake for flu vaccination
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	95.4%
EAST LANCASHIRE HOSPITALS NHS TRUST	93.6%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	89.6%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	84.5%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	81.9%
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	81.8%
THE WALTON CENTRE NHS FOUNDATION TRUST	80.2%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	80.2%
WIRRAL COMMUNITY NHS TRUST	77.5%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	77.1%
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	76.8%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	76.3%
EAST CHESHIRE NHS TRUST	76.3%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	75.4%
MERSEY CARE NHS TRUST	75.4%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	75.3%
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	67.9%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	60.0%

Campaign successes

3.3 There were a number of actions that worked well and contributed to the high level of vaccination.

These are described below:

- Having a robust plan in place that was monitored by the Occupation Health team on a daily basis
- Having adequate levels of vaccine stock assessed and ordered early to cover the full duration of the campaign
- Ensuring appropriate storage was agreed and in place with easy, but secure, access and clear communication about this to all relevant vaccinators
- Having robust vaccine stock control methods agreed and communicated to all relevant vaccinators

- Early recruitment and training of 35 peer vaccinators across the Trust to support the campaign.
- A robust and extensive Trust communications campaign
- A variety of interventions such as 'Dial a Jab' service, vaccinations available day, evenings and nights to fit with all shift patterns
- Early start to the campaign - 19 September 2018

3.4 Initially the campaign was serviced by the Occupational Health nurses and a bank staff nurse, as has been the case in previous years. From November 2018 there was a greater reliance on the use of the peer vaccinators to staff the all-day clinics. In December there was also the added benefit of an interim placement nurse provided by one of the divisions. This allowed for fulltime staffing of the all-day clinics.

4. Challenges from the 2018/19 campaign

4.1 The use of the 'opt out' form that was introduced in the 2018/19 campaign could have been better and is an area to be improved for 2019/20. Of the 812 people who chose not to be vaccinated only 61 forms were completed. There were several reasons for the low usage of the form which included:

- Staff being reluctant to fill out a form as they were unsure of how the data would be used
- Managers perceiving the form was the individuals' responsibility to complete and not always encouraging staff to do so
- Vaccinators did not consistently ask staff to complete the form if they chose not to be vaccinated.

4.2 The 61 staff who did complete the 'opt out' form did not all complete the form fully with some leaving out details such as role or place of work. Of the staff that did complete forms, the reasons given for opting out are shown in the table below (note more than one reason was frequently ticked).

Reason	Number
I don't like needles	18
I don't think I'll get flu	32
I don't believe the evidence that being vaccinated is beneficial	11
I'm concerned about possible side effects	41
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get the vaccine	0
The times when the vaccination is available are not convenient	0
Other reason	22

Despite the low response rate the messages from the forms that were completed were used to target messages in communications to staff.

5. Lessons Learnt from 2018/19 campaign

5.1 The following actions will be taken this year to ensure better completion of the 'opt out' forms which will include:

- Early engagement with managers and staff side representatives to co-brand 'opt out' forms
- More to be included within the communication meetings with managers about how the opt out form should be used and why it is important
- Targeting of 'opt out' form completion alongside targeting of low uptake areas
- 'Opt out' form completion to be included in flu plan and monitored at weekly flu team meetings
- Clearly communicating with staff the reasons for using the form and how their data will be used.
- Having a clearer focus and monitoring on the high risk, areas as described above, to achieve the 100% (Haematology / Oncology 76% and Neonatal Intensive Care / SCBU 83%)
- Increasing the number of peer vaccinators to enable maximum flexibility in delivering vaccinations.
- In addition to learning from our own experience we will be approaching the highest performing Trusts to learn from their experiences
- Having a greater granuality around the flu data.

6. Next Steps

6.1 The Trust is currently planning for next flu season 2019/20 which will include:

- Peer vaccinator in every clinical area e.g ward, department
- Even earlier communication plan actions and launch prior to campaign starting
- Use of all day clinic on both sites
- Communication and meeting with managers to support improved buy-in to ensuring their staff are fully informed and encouraged to have the vaccine or complete the opt out form
- Identification of and focused action on the high risk clinical areas
- Consideration of a prize draw to incentivise staff to get vaccinated early in the campaign
- Learning from other successful acute Trusts.

7. Recommendations

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

Board of Directors	
Agenda Item	10.3
Title of Report	Report of Programme Board
Date of Meeting	1 May 2019
Author	Part 1. Steve Sewell, Delivery Director Part 2. Joe Gibson, External Programme Assurance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Choose an item	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

PART ONE – PROGRAMME DELIVERY

1. Update

Priority areas in the Trust Programme are receiving increasing focus and have all recently reviewed and reset objectives, plans and defined benefits to reflect this increased priority, however delivery against benefits remains challenging.

Programme Board has initiated work to bring together a pool of people with change management capabilities across the organisation and develop a consistent change approach for the whole organisation. This approach would reduce the current fragmented approaches and provide a more cohesive method of supporting the resource and capability requirements of the priority projects. Programme Board agreed a definition of change management and supported the next steps.

Programme Board reviewed the plans and ambitions of the Patient Flow work.

The work of the 'Paperless Steering Group' was also reviewed, with agreement that the priority of the work needed to be higher and that governance needed to be linked to service change programmes. The work currently supports the establishment of a single safe digital record on the Cerner system through eliminating paper elements of this record in: In Patient areas, Outpatient clinics and ED.

2. Programme Delivery – Priority Areas

2.1. Patient Flow

A rapid improvement event over the past month has begun to impact on some aspects of hospital flow with:

- 30% reduction in ambulance waits over
- 33% reduction in medical outliers
- 40% more patients being admitted from ED into AMU & OPAU
- 52% reduction in Length of Stay on AMU
- 8% increase in daily medical discharges.

This good progress, however there are many areas where further progress needs to be made including sustaining the progress made to date.

The current plan for the patient flow work is focused on; strengthening Stranded Patient Reviews, redesigning element of the Integrated Discharge Team and the development of a Capacity and Demand model.

2.2 Perioperative

Plans have been revisited and a fall in cancelled theatre sessions within 28 days has been seen, but needs to be continued and sustained. Progress against milestones is good, however progress on key benefit metrics remains challenging.

2.3 Outpatients

Outpatient activity has been higher in the past two months although this was lower than hoped. Monitoring of activity has now transferred to the weekly performance meetings and the programme is now completely focused on improvement work that aims to improve efficiency and release capacity through; reducing Trust initiated appointment cancellations, increasing telephone clinics and reducing unnecessary follow ups. The programme plan is being reviewed following final agreement of the outpatient element of the 19/20 contract. A workshop is being held in late April to further develop an innovative clinically led approach to outpatients. Board will receive a more detailed update in the near future.

3. Next Steps

Ensure that priority projects have the right level of resource and that digital projects are aligned and supportive of the objectives of these priority projects.

4. Recommendations

The Board of Directors are asked to note this update.

PART TWO – PROGRAMME ASSURANCE

1. Summary

The assurance indicators have remained largely static since the last report. The trend of improvement in the governance domain has stalled and there has been a slight deterioration in the assurance ratings for delivery. Overall pace is not yet responding to deliver the ambition. The realisation of benefits is still falling short of the desired trends as highlighted by the ratings. The actions needed to improve the confidence levels are described in the assurance statements for each project and independent monitoring will continue to assess the assurance evidence.

2. Background

The attached assurance report has been undertaken by Joe Gibson, External Programme Assurance, and provides a detailed oversight of assurance ratings per project. The report provides a summary of the Assurance Report to the Trust's Programme Board; the independent assurance ratings have been undertaken to gauge the confidence of delivery. The supporting assurance evidence has been discussed at the Programme Board meeting (the membership of which includes two non-executive directors) held on Wednesday 17th April 2019.

3. Programme Assurance - Key Points

3.1. Governance Ratings

The trend graph shows a consistent improvement in project governance since August 2018; however, this has recently plateaued and a renewed focus and determination is required to ensure that the changes are being enacted in a safe and governed fashion.

3.2. Delivery Ratings

The trend graph shows a stubborn level of amber and red rated projects. The reasons for this are diverse across the projects within the change programme scope; however, definition of benefits and tracking of milestone plans will lead to improvements. In sum, the realisation of 'service benefits' at the levels aspired to remains elusive.

4. Assurance Focus

As requested at the Programme Board, and in line with current change strategy, the Trust Board report has now been reframed to provide an executive summary on the top 3 priority projects, namely: Flow, Theatres and Outpatients. It follows, in aggregate, that the assurance ratings for these projects should carry much greater weight than the other 12 projects. This weighting is true not only in terms of their significance to the Trust mission in the near term but also the size and degree of difficulty of the work involved.

The first page of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress. The second and third pages show the trends of assurance ratings for governance and delivery respectively.

5. Recommendations

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

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

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance		Delivery	

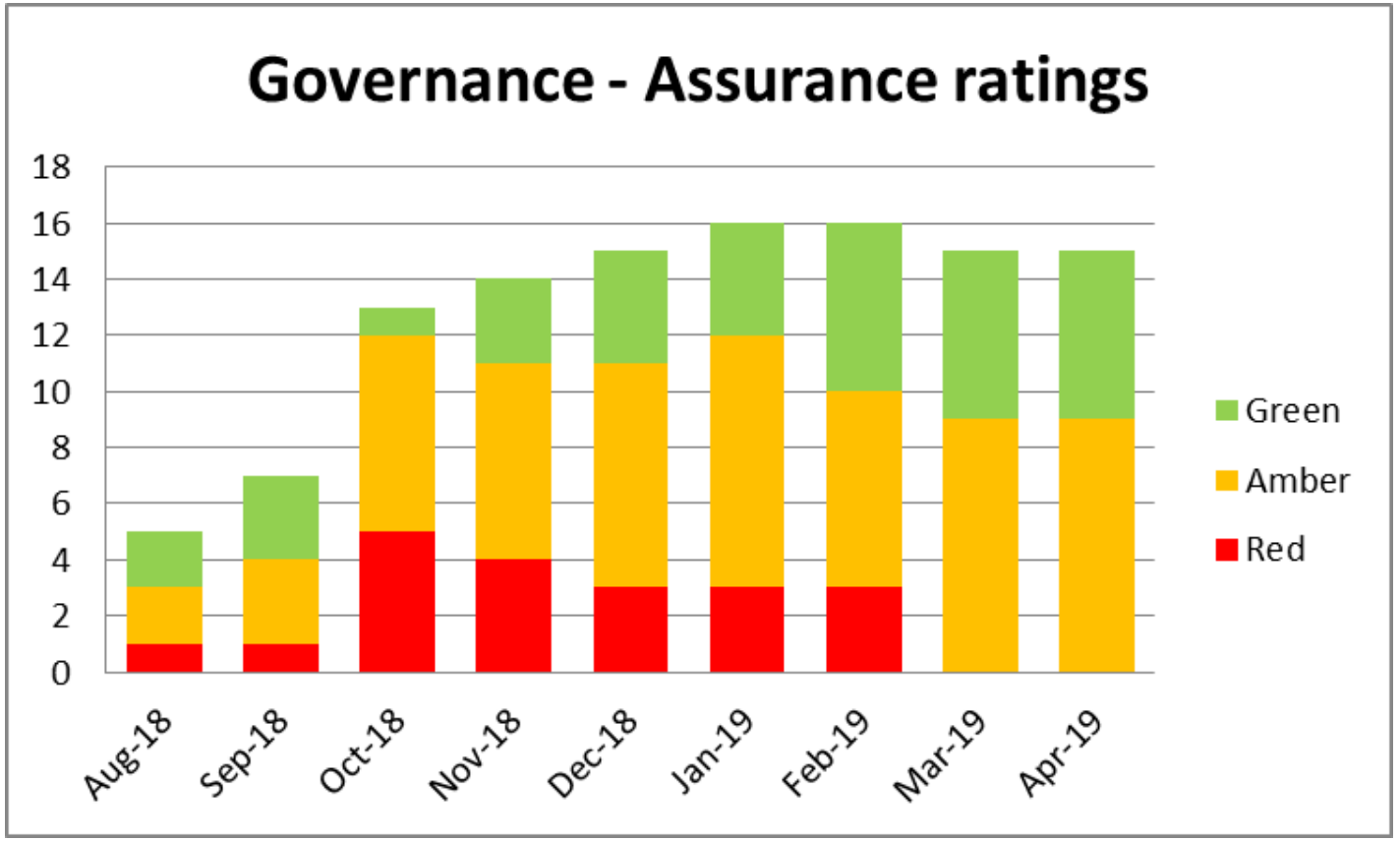
- **'Ward Based Care for Earlier Discharges'** has seen no change in assurance ratings. Outstanding concerns are delays of some elements shown now that the plan is being tracked (albeit the plan is overall green rated) and the need for all benefits to be subject to measurement, currently 4 of 8 defined benefits have no evidence of tracking.
- The **'Command Centre'** project plan - beyond the Millennium upgrade - shows a 'go live' date of June 2019; however, there is still no evidence available to show that this plan is being actively tracked. Moreover, there remains an absence of any metrics by which benefits might be measured.
- **'Transformation of Discharge Services'** has seen an improvement in ratings this month. The overall plan has been extended and is now being tracked. The evidence of measurement of one key KPI has been updated to March 2019; further tracking of supporting metrics is required.

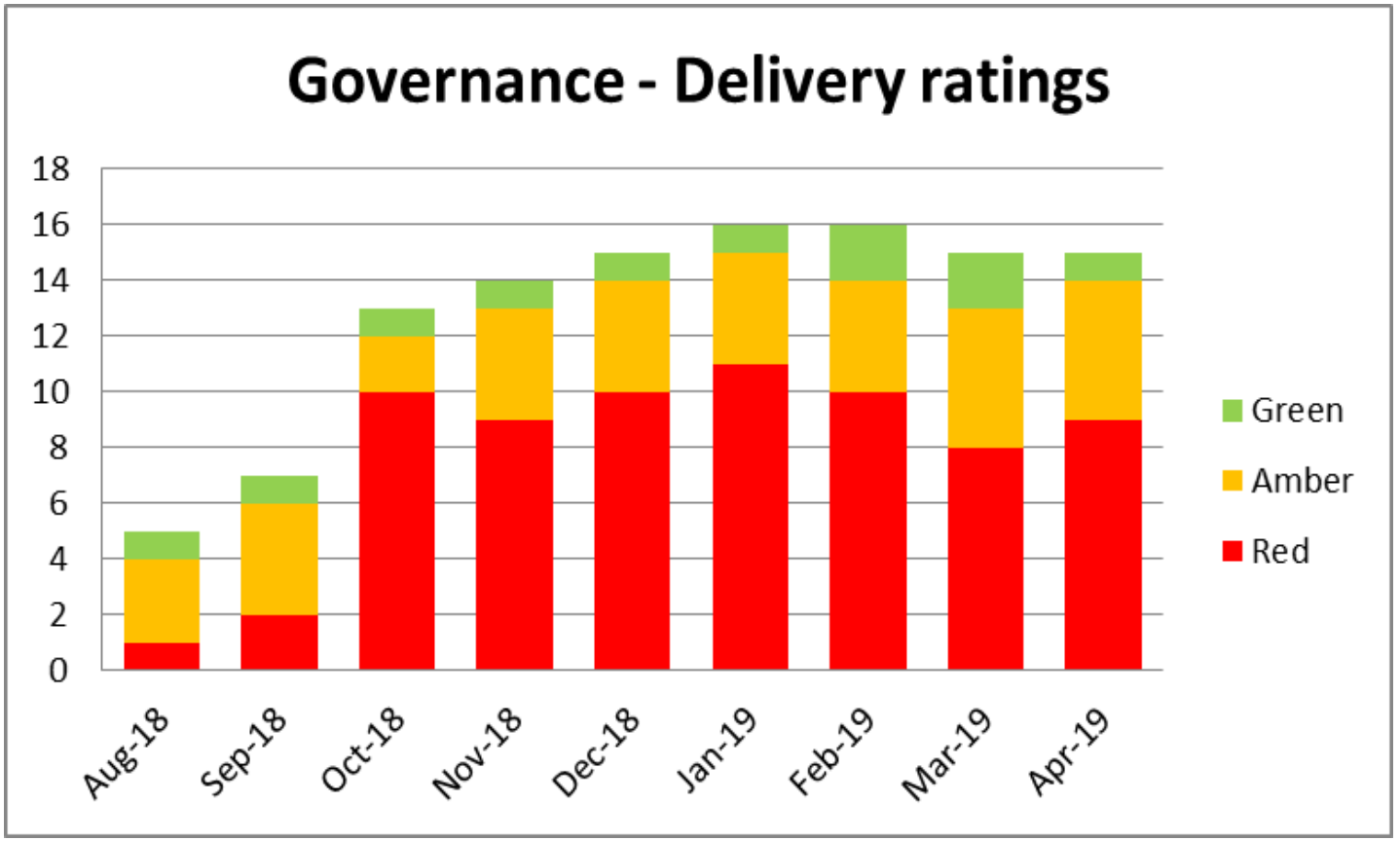
Perioperative Medicine Improvement	Governance		Delivery	

- The **'Perioperative Medicine Improvement'** project has revalidated the QIA and a comprehensive communications and engagement plan is now in place, this plan will need to be tracked.
- The revised milestone plan, dated 2 Apr 19, is a detailed and well tracked document; however, it shows significant delays in some key areas of the project in excess of 6 months.
- Of the four metrics being tracked, monthly, show an average of 'amber' performance (e.g. 'Core session utilisation – aim is to utilise 80% of 52 week capacity by April 1st 2019'; this is reported as 81% in March 2019 and has averaged 76.7% over the past 12 months. Evidence in place concerning risk and issue management but 'date of last review' information is now essential on the Risk Log.

Outpatients Improvement	Governance		Delivery	

- The **'Outpatients Improvement'** project now has an 'Outpatients Communications and Engagement Plan' draft v1.1 Jan 19 (this will need tracking) as well as action planning from stakeholder workshops. A 'Trello' Board is being used to create and track milestones; moreover, a high level summary plan has now been produced to cover 2019 but needs to be 'trackable'. KPIs are now in place with trajectories featured in the OPD Highlight Report for April 2019; this shows the benefits substantially off track at M12.


Governance - Assurance ratings
18
16
14
12
10
8
6
4
2
0
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
Green
Amber
Red


Governance - Delivery ratings
18
16
14
12
10
8
6
4
2
0
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
Green
Amber
Red

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Change Programme Scope - May 2019

WUTH Trust Board of Directors

Programme Board – CEO Chair

Workforce Planning (WRAPT) SRO - Helen Marks

Improving Patient Flow
SRO - Nikki Stevenson

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

Operational Transformation
SRO - Anthony Middleton

- Perioperative
  Lead: Jo Keogh
- Outpatients
  Lead: Steve Sewell
- Diagnostics Demand Management
  Lead: Alistair Leinster

Quality, Safety & Governance
SRO - Paul Moore

Pipeline

'Themes'

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

Digital
SRO - Nikki Stevenson

- GDE Meds Management
  Lead: Pippa Roberts
- GDE Device Integration
  Lead: Gaynor Westray
- GDE Image Management
  Lead: Mark Lipton
- GDE Patient Portal
  Lead: Mr David Rowlands

Partnerships (GDE Enabled)
SROs - per programme

- Women's & Children's **Collaboration**
  Lead: Gary Price
- **Healthy Wirral** Medicines Optimisation
  Lead: Pippa Roberts
- **Wirral West Cheshire Alliance** Pathology
  Lead: Alistair Leinster

Workforce Planning - Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a revised PID v0.2 dated 16 Mar 19 has been drafted with benefits described; however, there are no benefits start dates or metrics identified (that could lead to estimated financial benefits). **2. & 3.** Names of the project team on this dashboard are now complete and a high level description taken from the PID. WSG minutes of 21 March 2019 are in evidence; however, there should be reference to the project in the ToRs for this group and the discussion should cover the plan (incl. delays) and assurance status/actions. **4.** There is no evidence of a communications plan or stakeholder engagement. **5.** EA/QIA in draft are available and need to be signed off. **6.** High level planning dates are in the PID (delays from original dates are not explicit) but there needs to be a trackable plan that exists as a stand alone document. **7.** There are benefits outlined in the PID but no metrics or start dates attached; it is stated that these will be completed following the pilot stage. **8 & 9.** There is a risk register but no evidence of last review dates for those risks nor any issue management to date. **Most recent assurance evidence submitted 27 Mar 19.**

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

Ward Based Care for Earlier Discharges - Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. PID Version 1.3 dated 20 March 2019 describes the project; section 4.0 'Benefits & Measures' still shows 4 of 8 metrics to have the proposed improvement defined. **2. & 3.** Names of the project team on this dashboard are now completed. An agenda and minutes for the Ward Based Care for Earlier Discharges meetings up to 27 Mar 19 are in evidence. Trello Board is in use for this project. **4.** There is now extensive evidence of stakeholder engagement. **5.** EA/QIA are now completed. **6.** A 'Ward Based Care Milestone Plan' dated 29 Mar 19 is now available and shows actions broadly on track (a weekly granularity would add further precision); SHOP model now being embedded in Medicine & Acute with a view to consistent use by Oct 19. **7.** 'Benefits and Measures: Revised 20th March following PFIG' shows the benefits as defined in the PID; however, 4 of 8 need targets set and tracking should be available. **8 & 9.** There is now evidence of risk and issue management in the form of a RAID Log with risks reviewed up to 20 Mar 19. **Most recent assurance evidence submitted 8 Apr 19.**

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

Command Centre - Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. The PID, draft v0.4 dated 8 Apr 19, lacks metrics by which benefits will be measured. **2. & 3.** Evidence of documented project meetings is now out of date vis-a-vis the governance described in the PID. Updates to PFIG are only in evidence up to Dec 18. There is a DRAFT governance structure uploaded on 7 Mar 19. **4.** The PID outlines a comprehensive communications plan but this needs to be tracked. There is evidence of recent dialogue with staff side concerning the project. **5.** EA has been drafted and QIA signed-off. **6.** The new Command Centre Project Plan dated 9 Apr 19 shows good progress and needs a revised 'informatics/digital' section completing. **7.** As described above, there are no metrics for the benefits to be measured by. **8 & 9** There is now a RAID Log updated to 11 Apr 19. **Most recent assurance evidence submitted 11 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.2	**Command Centre**	To implement a new real time bed management system, including a re-design of all relevant processes and practices to enable accurate reflection of the bed state	Nikki Stevenson		●	●	●	●	●		●	●	●	●

Transformation of Discharge Services - Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. The scope document comprises a 'final draft' PID, TDSS v0.4 uploaded 8 Apr 19, for the 'Transformation of Discharge Services Sustainability Programme' which is in DRAFT until signed off by the Project Team. Benefit #4 still requires a target and start date. **2.** Project Team names are now complete on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v7 dated April 2019) and there is also an action log updated to 11 Mar 19. **4.** There is now a comprehensive communications plan TOD v3, 5 Mar 19, and this will need tracking to assure delivery. There is also notice for the demonstration of the new 'Social Care process...' on 9 Apr 19. **5.** EA/QIA have been completed for an 'Independent Provider Led Discharge Unit'. **6.** There is a 'TDS Internal Plan' dated April 2017 with detailed milestones out to Q3 2019 and is currently on track. **7.** The key KPIs - Long Stay Patient Improvement Trajectory (Target) of 282 by Oct 19 shows information to March 2019; further, supporting, metric measurement will be useful . **8 and 9.** Risks and issues are featured in a RAID Log and were reviewed on 4 Apr 19.
Most recent assurance evidence submitted 8 Apr 19.

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.3	**Transformation of Discharge Services**	To reduce patients length of stay in acute hospital beds by early identification of patients able to be discharged through transfer to assess home and bed based pathways.	Nikki Stevenson											

Perioperative Medicine Improvement – Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. The PID v4 dated 28 Mar 19 has a comprehensive set of objectives (with some precision still required) and measurable benefits defined with metrics. **2.** A Project Team is in place with a wide range of activity in evidence. **3.** The Perioperative Medicine Steering Group is governing with evidence of meetings to 2 Apr 19; brief minutes of these meetings would assist governance. **4.** There is evidence of wider stakeholder engagement and a communications plan is now available, this will need to be tracked. **5.** The QIA has now been revalidated. **6.** The revised milestone plan, dated 2 Apr 19, is a detailed and well tracked document; however, it shows significant delays in some key areas of the project in excess of 6 months. **7.** KPIs are developed in the PID. The four metrics being tracked, monthly, show an average of 'amber' performance (e.g. 'Core session utilisation – aim is to utilise 80% of 52 week capacity by April 1st 2019'; this is reported as 81% in March 2019 and has averaged 76.7% over the past 12 months). **8 and 9.** Evidence in place concerning risk and issue management but 'date of last review' information is now essential on the Risk Log. **Most recent assurance evidence submitted 10 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.1	**Perioperative**	The specific focus/brief of the Theatre Productivity Group, to achieve our objectives, was to: Reconfigure the Theatre Schedule; Enable the planning of theatre staff and anaesthetics; implement a system to track and monitor 45 week usage; reduce specialty level variation so that all lists are achieving 85% utilisation target; implement a weekly process to enable prospective and retrospective assessment of session utilisation.	Anthony Middleton		●	●	●	●	●		●	●	●	●

Outpatients Improvement - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. PID v0.5 dated 22 March 2019 defines the project. It was approved by the OP Transformation Group on 1 Apr 19 and will need review post the 'Incentivised Contract' decision of 8 Apr 19. **2.** A project team is in place. **3.** The 'Outpatients Transformation Group' is in place with ToR agreed at the meeting of 1 Nov 18 and documents to evidence the meetings up to 1 Apr 19; this is supplemented by evidence of how this reports into the 'Operational Transformation Steering Group' (agenda and actions in evidence) through to Apr 19. **4.** There is now a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan 19 (this will need tracking) as well as action planning from stakeholder workshops. **5.** The signed QIA has been submitted. **6.** The Trello' Board' is being used to create and track milestones; moreover, a high level summary plan has now been produced to cover 2019 but needs to be 'trackable'. **7.** KPIs are now in place with trajectories featured in the OPD Highlight Report for April 2019; this shows the benefits substantially off track at M12. **8 and 9.** There is a RAID Log in evidence with risks and issues last reviewed on 8 Apr 19. **Most recent assurance evidence submitted 8 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.2	**Outpatients Improvement**	To design and implement 21st century outpatient services to meet the needs of the Wirral population. Goals/Expected Benefits: to achieve the planned outpatient activity for 18/19 by March 2019; to design a Trust Wide Operational Structure for outpatients that is able to create and manage a consistent operational framework for outpatients right across the Trust; to design and implement 21st Century Outpatients and eliminate paper from outpatient processes; improve patient experience.	Anthony Middleton		●	●	●	●	●		●	●	●	●

Diagnostics Demand Management - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. The project PID, v0.6 as uploaded 28 Mar 19, appears to have the benefits work now completed. It is supplemented by a BOSCARD, 'Initiation Pack' and the paper 'Unwarranted Variation & Demand Management: Pathology Tests', A Bamber. **2.** A project team is defined. **3.** There is a comprehensive meetings log with agendas and action notes to 28 Mar 19. **4.** There is a stakeholder mapping assessment and draft Comms Plan (although the latter still requires an action plan) but lacks evidence of wider stakeholder engagement (beyond project meetings). **5.** A QIA/EA have been drafted and QIA has been signed off on 18 Mar 19. **6.** A comprehensive milestone Gantt chart plan has been developed, v1.5 dated 15 Mar 19, but the tracking is now out of date. **7.** There is now a comprehensive document describing baselines, targets and trajectories together with a full financial profile; although the first benefit start date is June 2019, a dashboard has been prepared in advance. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 28 Mar 19. **Most recent assurance evidence submitted 28 Mar 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.3	**Diagnostics Demand Management**	This programme aims: to reduce spend on diagnostic testing to acceptable levels as indicated by NHSI Model Hospital Data; to reduce demand for pathology tests (costs, patient experience); to reduce the number of units of blood transfused into patients (risk, cost); to create a template to reduce demand for diagnostic imaging (& other projects); and	Anthony Middleton		●	●	●	●	●		●	●	●	●

Digital: GDE Medicines Management – Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. OPD PID v2 dated 16 Jan 19 (no metrics). AMS PID v3, 25 Oct 18, 1 benefit of £187k CQUIN (no metrics). MAT NNU PID v2, 23 Oct 18, 1 benefit from EPMA for maternity / neonates; baseline but no target. MED Eye PID v4, 25 Oct 18, 1 benefit 'closed loop meds admin' (no metrics). Paper Charts PID v1, 23 Oct 18, 1 benefit to improve safety (no metrics). The ePMA in OPD PID added 4 Jan 19; metrics required for benefits.**2.** The 'Programme Core Team' now complete. **3.** ToR (undated) for Medicine GDE meeting available. Notes of meetings available to 27 Mar 19. PIDs yet to be approved by the 'Project Board'. **4.** Comms Plans outlined in the PIDs but only AMS has evidence of a 'live' (v3 12 Oct 18) list of actions; further evidence of meetings with stakeholders to Mar 19. **5.** No EA/QIA in evidence. **6.** Milestone Plans: AMS PP v2 20180119 (date?) complete but 2 overdue comms actions; Mat and NNU PP v4 dated 9 Sep 18, shows delays and has activities undated; MED Eye PP v1, 1 Nov 18, shows delays and has many activities undated. Paper Charts PP v 25 Jan 19, largely up to date**. 7.** Of the 20 benefits defined on the 'Meds Benefits Matrix' uploaded March 2019, none has an implementation date and there are only 3 with targets. **8 & 9.** Risks & Issues: RAID Log v16, 6 Mar 19, colour coding of risk scores as per the key would aid comprehension. **Most recent assurance evidence received 4 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.1	**Meds Management**	This meeting exists to monitor progress of the agreed and ratified GDE Medicine programme. To ensure that appropriate resources are available to meet the requirements of the programme and objectives and benefits are identified and realised. There is also an acknowledgement that it is essential that BAU work for the Pharmacy service is carried out in parallel. It is understood that BAU and GDE projects will impact on each other as essentially the same resources are required for both. This meeting will support prioritisation of work for both BAU and GDE projects.	Nikki Stevenson											

Digital: GDE Device Integration – Programme Assurance Update – 17th April 2019

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

Independent Assurance Statement

1. Infusion Pumps GDE PID v0.4, 23 Feb 19; benefits to save nurses time, prevent inaccurate data into EPR (no metrics). PCECG GDE PID v0.3, 01102018; benefits 'tbc'. Vitalslink GDE PID v0.8, 23 Feb 19; benefits: a. save nurses time @ 30,665 hours by Apr 2020 b. ensure all basic observations are recorded accurately - details provided for Mar - May 18 has shown a decrease "in error" rate to 0.1119% (baseline 0.2161%). SECA PID v0.6 dated 23 Feb 19 has objectives and 1 of 3 benefits defined. 2. 'Programme Core Team' names on dashboard completed. 3. Device Integration Project team minutes in evidence to 12 Feb 19. PIDs have now been approved (Feb 19) in a 'Project Board'. 4. 'Vitalslink Communication Plan', 30102018, is a schedule for Proj. Board and not evidence of engagement. 5. No EA/QIA in evidence. 6. SECA Project Plan, 6 Mar 19, shows some delays. Infusion Pumps project plan, 25 Jan 19, needs to show completion/progress of tasks. Device Integration Project Plan v0.10 4 Dec 2018 shows many elements completed but overdue 'Go Live' in Paediatrics since June 2018; plan now completes Feb 19. PCECG Project Plan v0.7 dated 22 Mar 19 appears to be on track. 7. No evidence of tracking of benefits. 8 & 9. Evidence of risk management on SharePoint to 12 Feb 19. **Most recent assurance evidence received 4 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.2	**Device Integration**	To connect and integrate Medical Devices with Wirral Millennium enabling the automation of results recording in the following areas: Observations, ECG's and Infusion Pumps	Nikki Stevenson		🟡	🟢	🟢	🔴	🔴		🟡	🔴	🟢	🟢

Digital: GDE Image Management - Programme Assurance Update - 17th April 2019

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

1. Scope comprises: PID Bronchoscopy PID v0.2 02112018, PID Colposcopy v0.1 02112018, Theatres Image Mgt PID 02112018, PID Medical Photography; 09112018; 1 benefit cited - for all 4 projects - is that all clinical images will be stored electronically in one central location (PAC's), therefore clinicians can access the images more efficiently. **2.** The 'Programme Core Team' names on dashboard have been completed. **3.** Evidence of project meetings: 're-start meeting' of 1 Feb 19 and Medical Photography to 18 Apr 19; all PIDs yet to be approved at a Project Board. **4.** There is a 'Colposcopy Comms Plan' v0.1 02112018 which is a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** Revised Project Plans, dated 6 Mar 19, received for Bronchoscopy, Med Photo and Theatre. Colposcopy PP 07112017 started and finished in Nov 17 has been submitted (but not clear why). **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** A consolidated 'Risk and Issue Log' is now in use, updated on 6 Mar 19, and needs a 'date of last review' column for risks. **Most recent assurance evidence received 4 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.3	**Image Management**	This project aims to deliver: Digital images and reports from Bronchoscopy examinations stored within the EMR via the PACS Network; Provide Excellent services to: our colleagues, quality services, clinician led changes to improve services, eliminating unwanted clinical variation; To maximise value: in the solutions and Wirral Millennium; Clinicians will have all images they need available to them electronically; Improved clinical safety; Opportunity to review clinical processes.	Nikki Stevenson											

Digital: GDE Patient Portal - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. PID v1.5, 25 Oct 18, approved by project board on 28 Jun 17. 3 benefits reducing follow-up O/P appts for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit baseline cited for Urology with £36.5k target). Patient Story defines patient benefit. 2. The 'Programme Core Team' names on this dashboard to be completed. 3. Minutes of the Project Board available to 26 Sep 18; however, the meeting of 21 Nov 18 was cancelled due lack of quoracy and the decision was taken, due to 'dwindling attendance' to cancel the meeting of 12 Dec 18 - the next meeting will be 23 Jan 19 although no evidence of this meeting received to date. There is an 'Action Log' now available dated 20 Feb 19. 4. There is a Comms Plan, v4 24 Oct 18, which has some activities recorded but lacks forward looking schedule; there is also a presentation to Project Board of 20 Mar 19. 5. No EA/QIA in evidence. 6. Milestone Plan, v1.6 of 5 Mar 19, is tracked but behind schedule in some areas. 7. 2 graphs show, prospectively, the level of benefits expected from 2020. 8 & 9, Risks and Issues: RAID Log, 5 Mar 19, captures risks and issues and these were - for the most part - last reviewed at the Project Board of 2 Feb 19. One risk appears to have been reviewed on 7 Feb 19. **Most recent assurance evidence received 4 Apr 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.4	**Patient Portal**	One of the pieces of functionality Cerner Millennium offers is a "patient portal". Through patient portal individuals can have real-time access to specific requests such appointment changes and clinical information that can be viewed in the Cerner Millennium electronic medical record (EMR). The patient portal is essential for remote surveillance and self - management of patients living beyond cancer. The portal, along with a robust tracking system will allow for patients to be managed remotely and therefore reduce the amount of follow ups required within a hospital setting.	Nikki Stevenson		●	●	●	●	●		●	●	●	●

Partnerships: Women & Children's - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. Scope is in: 'Appendix 1, Wirral and Western Cheshire Women and Children's Alliance objectives and KPIs: Summary. Revised Nov 18 Overview'; a PID has been uploaded but appears to be at least 12 months out of date. A Women's & Children's Alliance slide pack, Mar 19, also available. **2.** 'Programme Core Team' in place. Minutes of a W&C Alliance Leadership Group of Wednesday 20th March 2019 are available. **3.** ToR for the 'Women's & Children's Alliance – South of the Mersey Leadership Delivery Group' are in evidence. The W&C Alliance record of attendance / action log / minutes are available to 15 Nov 18. **4.** There is some evidence of strategic engagement and a recent start on an incomplete process map for the Paediatric Hub. **5.** QIA and EA drafted and due to be signed off w/c 10 Dec 18. **6.** There is no current milestone plan in evidence. **7.** There are 7 KPIs associated with the programme reported on SharePoint these are being rated: 3 Green, 3 Amber, 4 Red. **8 and 9.** Risks and Issues updated in RAID log of Nov 18 showing no live risks or issues (need to verify that the programme of 6 work streams has no current risks or issues). **Most recent assurance evidence received 4 Apr 18.**

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

Healthy Wirral: Medicines Management - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. 'Scope': 'Medicines Optimisation Programme Board is an enabling programme of work supporting Healthy Wirral' of 12 Dec 18 and there is a PID in draft, uploaded on 13 Dec 18. There is also a 'Wirral Formulary Transition Incorporating Pan Mersey Decision-Making' uploaded 12 Mar 19. **2.** Notes of Healthy Wirral OPAT Meeting, 6 March 2019, are available; no minutes seen of the 'Medicines Optimisation Programme Board'. **3.** Governance structure shows how the 'Medicines Optimisation Programme Board' relates to the 'Healthy Wirral Executive Delivery Group' and the 'Healthy Wirral Programme Board'; version 5 of the Programme Board ToR needs a date to show when the document was authorised. A General Practice Clinical Pharmacist (GPCP) Implementation Group meets, ToR Issue 3 signed off June 2018. Biosimilars has ToRs dated Apr 18, met in Sep 18. **4.** There is evidence of GPCP stakeholder engagement and comms. **5.** EA/QIA signed off 18 Mar 19. **6.** There is no milestone plan. **7.** Some KPIs are being tracked in terms of activity for GPCP but no sense of target thresholds for output / outcome. Biosimilar financial savings are shown in 'Adalimumab Biosimilar Implementation: January 2019 Update'. **8 and 9.** A Risk Register is in the process (at 6 Mar 19) of being drafted. **Most recent assurance evidence submitted 18 Mar 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
6. Programme Six - Partnerships (GDE Enabled)														
Collaboration - Healthy Wirral														
6.3	**Medicines Optimisation**	The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicines expenditure.	Mike Treharne, DOF CCG											

WWC Alliance: Pathology - Programme Assurance Update - 17th April 2019

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

Independent Assurance Statement

1. The scope document comprises the 'Strategic Pathology Collaboration Wirral and West Cheshire: Current Positon and Next Steps' dated October 2018 and submitted to the Trust Board on 1 November 2018. This has now been supplemented by a summary document. **2.** Project Team names need to be populated on this dashboard. **3.** The 'Wirral & West Cheshire Pathology Service Transitional Management Team' has Terms of Reference (undated) and minutes of the meetings are available to 28 Feb 19. **4.** There is evidence of stakeholder engagement by means of the notes of a 'Whole Lab Meeting' of 19 July 2018 but no evidence of a communications plan or wider/subsequent staff engagement. **5.** There is no EA/QIA. **6.** There is a 'WWC Pathology Timeline' Plan in evidence but appears to be subject to significant delays (5 Months) and the tracking of the plan is not clear. **7.** KPIs (...Next Steps paper - Oct 18) are potential savings from a joint COCH / WUTH Pathology service are estimated to be between £1.6m and £2.6m; these from procurement and staffing savings. **8 and 9.** The '...Next Steps paper refers to issues and risks as topics and there is a risk register in evidence; however, the risk register would benefit from having a 'date of last review' column. **Most recent assurance evidence submitted 13 Mar 19.**

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

Assurance ratings will be suspended from 17 Apr 19, as agreed at Programme Board, pending a Trust decision on the creation of a joint service with CoCH

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors	
Agenda Item	10.4
Title of Report	CQC Action Plan Progress Update
Date of Meeting	1 May 2019
Author(s)	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**
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken • **Yes** • **No**	No adverse equality impact identified

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 23RD APRIL, 2019

1. PURPOSE

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

2. BACKGROUND OR CONTEXT

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

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

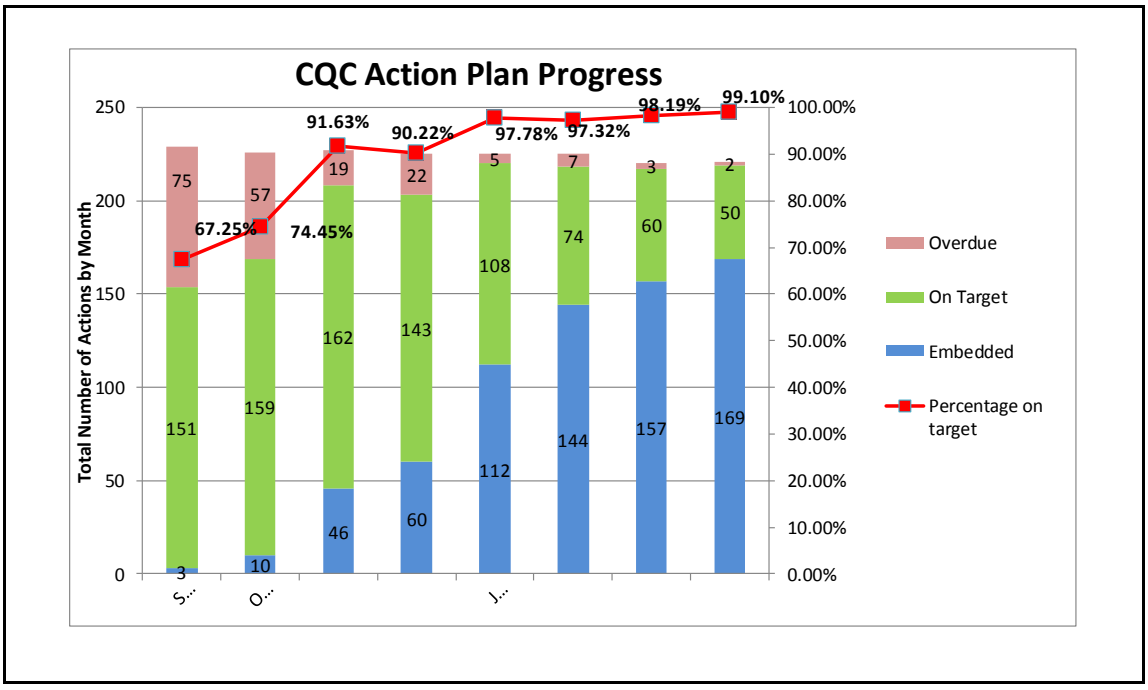
3.1 The CQC inspected the Trust in March and May 2018. The outcome of the inspection was as follows:

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 **221** 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 – 23R APRIL 2019



5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held week commencing 08th April 2019, there are 2 actions which have been 'red-rated' and one 'amber rated' action and are to be reported as exceptions for this reporting period

Overdue actions concern patient flow management, ED Assessment protocols, and medicines storage. For reference the detail of overdue actions is set out in **Annex A**.

In **Annex B** we draw the Board's attention to 'embedded' actions (i.e. those actions completed and sustained for 3 months or more). In line with expectations set out in the plan, the number of embedded actions has increased in this reporting period with **12** actions moving into the embedded category. This can be interpreted by the Board as positive evidence of implementation, and the progressive work that is happening across the Trust to address each element of the action plan.

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

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

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

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

7. RECOMMENDATION

The Board of Directors are invited to:

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

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
173	Should Do	Corporate / Trust-Wide Issues	**PATIENT FLOW** The trust must ensure that all information is monitored to improve the flow of patients through the hospital and all areas being used for additional beds are fit for purpose.	Deliver all components of work streams governed by the Patient Flow Improvement Group: Ward Based Care and Transformation of Discharges Bed Management Medical Assessment Unit Review - outline key elements of plan	Executive Director of Quality & Governance	Well Led	**Updated: 02/04/2019** A review of the governance arrangements and role of PFIG is underway. The Governance is in place and being led through Patient Flow Improvement Group and Programme Board. The improvement controls have not had the desired impact on the delivery of the Patient Flow Improvement Group do date. Future proposals are being considered.	31/11/2018	
208	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing SOPs (1/8/18)	Chief Operating Officer	Effective	**Updated 02.04.2019** Transposed reporting arrangements within our data capture systems have been identified. Trial of triage only process is has been undertaken with consultant colleagues and a change in practice will be implemented.	01/09/2018	
104	Should Do	12 – Safe Care and Treatment, 15 - Premises and Equipment	**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		**Updated 02.04.2019** Clarity is required on what decision has been reached in regard to the funding and implementation plans previously identified. *"risk assessment has been undertaken residual number of rooms that do not currently have air conditioning have been identified. Assessment has been undertaken and a work plan has been developed. We have prioritised a number of rooms, 10 priorities out of a number of circa 30 rooms. Implementation/delivery plan to be developed, long term"*	01/10/2019	

ANNEX B (Embedded actions in March 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
12	Must Do	Corporate / Trust-Wide Issues	**MAINTENANCE & CLEANLINESS** **Emergency Department: The** service must ensure that the environment and equipment are maintained and cleaned in line with trust policy and best practice guidance. **Medicine:** The service should ensure that equipment and premises are kept clean and daily checks take place. **Maternity:** The service should ensure up to date cleaning schedules are in place in all areas and that all areas are clean. **Surgery:** The service should ensure that all equipment is recorded, serviced and calibrated in line with the manufacturer's instructions.	Establish systems for monitoring and reporting the standard of ward and service area cleanliness	Executive Director of Nursing and Midwifery and Medical Director	Safe	**02.04.2019** - IPC audits are managed via perfect ward. Routine walkabouts take place in partnership with estates colleagues. Staffing issues have been identified for cleaning teams. Chief Nurse is confident that the systems have been established and they are flagging where there are issues in terms of capacity that need to be addressed.	01/11/2018	
45	Must Do	Medical Care (Acute & Medical Division)	**PREMISES** The service must ensure premises are suitable for the purpose for which they are used, especially in the discharge hospitality centre and day case unit.	Invite service users/Health Watch to visit the discharge hospitality centre and day case unit to give their feedback on the quality of the environment	Chief Operating Officer (executive lead for Estates)	Well Led	**02/04/2019 -** Health Watch Wirral attended the discharge unit on Wednesday 13th March, a feedback report has been received and an action plan will be devised.	01/04/2019	
90	Must Do	Corporate / Trust-Wide	**SAFEGUARDING** **Trust wide** :	Review the effectiveness and uptake of current training on	Executive Director of	Safe	**02/04/2019 –** Chief Nurse reported a significant improvement PVP training. A	01/10/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
		Issues	The trust must ensure that all application for deprivation of liberty safeguards are made in line with legislation; and The trust must ensure that safeguarding children training is in line with national guidance. **Medicine** : The service must ensure that safeguarding systems and processes are operated effectively and capacity assessments completed in a timely manner to ensure that patients are not deprived of their liberty without lawful authority. **Emergency Department** : The service should ensure that best interest decisions and mental capacity assessments are recorded in line with trust policy and legislation	safeguarding	Nursing and Midwifery		review of our current training provision has been undertaken against national Intercollegiate document - we await national opinion following review of that document of any mandated changes necessary to our training provision.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
98	Must Do	Corporate / Trust-Wide Issues	**TRANSFER OF PATIENTS** **Emergency Department :** The service should ensure that the transfer of care for all patients is completed appropriately, in line with trust policy. **Medicine :** The service must decrease the number of patients transferred between wards at night. The transfer of dementia patients at night must only take place in exceptional circumstances to ensure that care and treatment is appropriate, meets individual needs and reflects preferences.	Audit compliance with the Transfer Procedure	Executive Director of Nursing and Midwifery	Safe	**02/04/2019 -** SOP's have been developed. The intention is to simplify and rationalise transfer policy in line with review timeframes	30/04/2019	
101	Should Do	Corporate / Trust-Wide Issues		Introduce pharmacy induction for new matrons and ward managers to ensure aware of medicines management roles and responsibilities from outset	Executive Director of Nursing and Midwifery	Effective	**02/04/2019** Chief Nurse checklist developed and presented as evidence	01/11/2018	
113	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Audit compliance through use of perfect ward and rounding	Executive Director of Nursing and Midwifery	Effective	**02/04/2019 –** Compliance is routinely audited via perfect ward reporting tool	01/02/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
114	Should Do	Medical Care (Acute & Medical Division)	**RESUSCITATION TROLLEYS** The service should ensure that all resuscitation trolleys across the service are regularly checked and emergency equipment has the appropriate portable appliance tests carried out. **Surgery:** The service should ensure any emergency equipment in areas accessible to the public without a constant staff presence should be secure.	For those managers unable to provide that assurance, agree performance objectives with that individual	Executive Director of Nursing and Midwifery	Responsive	**02/04/2019** Compliance and audit meetings are in place. Action plan and monitoring tools are in place and managed via perfect ward app	07/12/2018	
124	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**ANTT** The service should monitor and audit nursing staff carrying out aseptic non touch technique when administering medication.	Undertake regular audit of ANTT practice	Executive Director of Nursing and Midwifery	Safe	**02/04/2019 -** Embedded process - audit tools are in place and evidence that regular audits are undertaken	30/04/2019	
176	Must Do	Corporate / Trust-Wide Issues	**STAFFING ISSUES** The trust should consider how there is a trust oversight of all staffing issues.	Improve recruitment to vacant posts	Executive Director of Workforce	Well Led	**09/04/2019** as reported to Trust Board we have seen an increase in recruitment figures, particularly in Medicine and Acute	31/03/2019	
191	Must Do	Corporate / Trust-Wide Issues	**MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards.	Provide assurance report of compliance to PSQB	Chief Nurse	Effective	**02/04/2019 -** embedded action compliance reports provided to PSQB	31/12/2019	
203	Must Do	Corporate / Trust-Wide Issues	**SAFE STAFFING** **Emergency Department :** The service must ensure that appropriate numbers of nursing and medical staff are available at all times. **Medicine :**	Ensure that the shift rotas are pre-planned (6 weeks in advance)	Chief Nurse	Safe	**02/04/2019 -** evidence provided confirming that shift rotas are now planned 6 weeks in advance. This is managed via E Roster project and Perfect Ward	01/12/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			The service must deploy sufficient staff with the appropriate skills on wards and on the acute medical unit, medical short stay ward and ambulatory care unit **Surgery :** The trust must ensure there are enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.						

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
204	Must Do	Corporate / Trust-Wide Issues	**SAFE STAFFING** **Emergency Department:** The service must ensure that appropriate numbers of nursing and medical staff are available at all times. **Medicine:** The service must deploy sufficient staff with the appropriate skills on wards and on the acute medical unit, medical short stay ward and ambulatory care unit **Surgery:** The trust must ensure there are enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.	Ensure effective use of NHS Professionals across 6 week rota	Chief Nurse	Safe	**02/04/2019 -** evidence provided confirming that shift rotas are now planned 6 weeks in advance, thus supporting the Trust to effectively manage its NHS professional usage. This is managed via E Roster project	01/12/2019	

Board of Directors	
Agenda Item	10.5
Title of Report	Board Assurance Framework 2019/20
Date of Meeting	1 May 2019
Author	Andrea Leather, Board Secretary
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The Board Assurance Framework (BAF) is a method of setting out the most important risks facing the organisation and providing assurance on the effectiveness of controls to mitigate them. It should outline the control framework used to manage the most important risks, any gaps in control and how the Board satisfies itself that the controls are working as intended.

The Board Assurance Framework contributes to the effectiveness of the system of internal control in the Annual Governance Statement.

The BAF contains the six primary risk scenario's. Each primary risk has an identified lead Executive Director and is aligned to a Board Committee to monitor progress on behalf of the Board.

The BAF identifies sources of assurance incorporate the three lines of defence:

- **Level 1** Management (those responsible for the area reported on);
- **Level 2** Corporate functions (internal but independent of the area reported on);
- **Level 3** Independent assurance (Internal audit and other external assurance providers)

2. Background

In November 2018 the Board of Directors identified and approved the primary risk scenarios which informed the development of the 2019/20 Board Assurance Framework.

3. Key Issues/Gaps in Assurance

As identified in the attached BAF.

4. Next Steps

The 2019/20 BAF will be monitored by the relevant Board Assurance Committee and subsequently provide progress reports to the Board on a regular basis.

5. Recommendations

The Board of Directors formally notes the 2019/20 Board Assurance Framework approved at the Board Development session held on 3rd April 2019.

This BAF includes the following primary risk scenario's that could, if not sufficiently mitigated, impact adversely on delivery of the Board's Strategic goals:

	Primary Risk Scenario's	Severity	Likelihood	Current Risk Exposure	Change	Tolerable Risk	Gaps in control	Gaps in assurance	Lead Assurance Committee	Page No.
PR1	Demand that overwhelms capacity to deliver care effectively	5. V.High	5. V.Likely	**25 Significant**	⟺	**12 High**	Yes	Yes	FBPAC	2
PR2	Critical shortage of workforce capacity & capability	5. V.High	4. Likely	20 **Significant**	⟺	**12 High**	Yes	None identified	WAC	4
PR3	Failure to achieve and maintain financial sustainability	5. V.High	5. V.Likely	**25 Significant**	⟺	**8 Medium**	Yes	Yes	FBPAC	6
PR4	Catastrophic failure in standards of safety and care	4. High	4. Likely	**16 Significant**	⟺	**9 Medium**	Yes	None identified	Quality	8
PR5	A major disruptive event leading to rapid operational instability	3. Medium	5. V.Likely	**15 Significant**	⟺	**5 Medium**	Yes	None identified	FBPAC	10
PR6	Fundamental loss of stakeholder confidence	3. Medium	5. V.Likely	**15 Significant**	⟺	**5 Medium**	Yes	None identified	Board	12

How to use the BAF

The key elements of the BAF to be considered are:

- A simplified description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a system, trust wide
- and service level)
- A simplified way of displaying the risk rating (current residual risk and tolerable level of risk)
- Clear identification of primary strategic threats and opportunities within a 5 year horizon, along with the anticipated proximity within which risks are expected to materialise and the degree of certainty that the level of risk will change (**Intensifying** = risk level is expected to increase; **Uncertain** = unable to predict change; **Moderating** = risk level if likely to reduce)
- A statement of risk appetite for each risk, to be determined by the lead committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low risk options; **Cautious** = preference for low risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- The over-arching risk treatment strategy for each principle risk is identified (**Seek**; **Modify**; **Avoid**; **Accept**; **Transfer**)
- Key elements of the risk treatment strategy identified for each risk, each assigned to an executive lead and individually rated by the Lead Committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: **Level 1** Management (those responsible for the area reported on); **Level 2** Corporate functions (internal but independent of the area reported on); and **Level 3** Independent assurance (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales
- Relevant Key Risk Indicators (KRIs) for each strategic risk, taken from the Trust performance management framework to provide evidential data that informs the regular evaluation of exposure.

Key to lead committee assurance ratings:

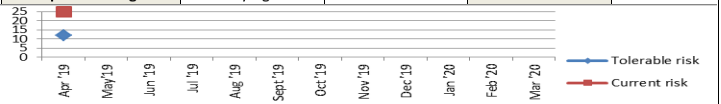

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the risk


Amber = Inconclusive assurance: the Committee is uncertain that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy


Red = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk is not being kept under prudent control

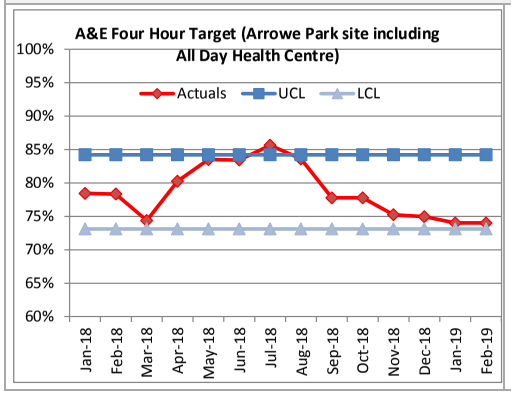
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

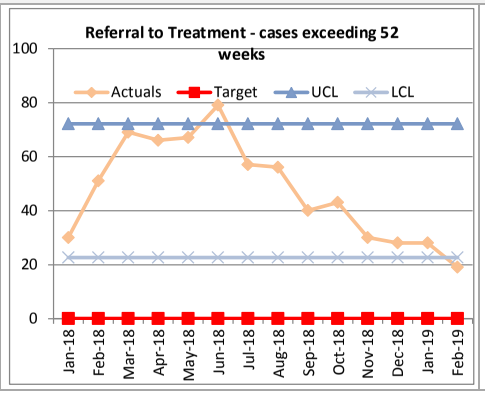
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:** Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that overwhelms capacity to deliver care effectively** A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards	**Executive lead**	COO	**Likelihood:**	5. V. Likely	3.Possible	**Risk appetite** Open
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	4. High	
		Last reviewed	01/04/2019	**Risk rating**	**25. Significant**	**12. High**	
		Last changed	01/04/2019	**Anticipated change**	Intensifying		
Details of change	Revised BAF for Board consideration						



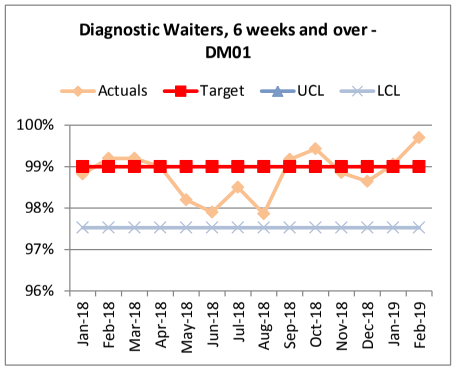
Risk Vector (what might cause this to happen)	Primary Risk Treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Level & Source of assurance (& date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Threat: Exponential **growth in demand for care** caused by an ageing population (forecast annual increase in emergency demand of 4-5% per annum); -2% reduced social care funding and increased acuity leading to more admissions & longer length of stay **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency demand & patient flow management arrangements ▪ Winter capacity plan ▪ Access Policy in place ▪ Detailed operational plans agreed annually ▪ Activity based contract and commissioners ▪ Workforce model adjusted for planned activity ▪ ED Streaming ▪ Defined escalation areas (act as flood plane) during periods of exceptional pressure ▪ Discharge procedures ▪ Use of admission avoidance schemes ▪ Use of SHOP model medical review ▪ Ambulatory & Day case care **Contingency controls** ▪ Emergency preparedness (Surge plan) ▪ Expansion into corridor / designated escalation area ▪ Staffing plan for escalation	▪ Higher than expected length of stay (LOS) ▪ Normalised reliance upon escalation areas during pressure ▪ Insufficient daily discharges to deliver net patient flow ▪ Standards of care in corridors or escalation areas during periods of very high demand and very high bed occupancy ▪ Capacity and demand modelling inc. theatre utilisation ▪ Reliability of SHOP implementation	Patient flow transformation programme **SLT Lead:** MD/Transformation Lead **Timescales:** As per programme Review of outpatient processes **SLT Lead:** COO/ Transformation Lead **Timescales:** As per programme Process whereby Quality matrons conduct patient safety checks for all patients in corridor/ escalation areas is fully implemented and embedded **SLT Lead:** Chief nurse **Timescales:** June 2019	**Level 1** ▪ Divisional performance reviews (monthly); ▪ Stranded patient reviews (2 per week) ▪ Overall bed occupancy rate (daily) ▪ 52 week wait & size of waiting list **Level 2** ▪ Q&P Dashboard (monthly); ▪ PFIG Report to Board (monthly); ▪ Transformation Board; ▪ Wirral A&E Delivery Board; **Level 3** ▪ CQC improvement oversight; ▪ System Improvement Board ▪ Limited scope external audit – Quality Account 2017/18 ▪ CQC unannounced inspection (March '18) ▪ Contract meetings	None identified	
Threat & Opportunity: Operational **failure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort' **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board(UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of GP practice collapse on Wirral there would likely be surges in demand for secondary care	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of general practice in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of General practice in Wirral **SLT Lead:** COO **Timescales:** May 2019	
Threat & Opportunity: Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board (UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of collapse, emergency procedures will govern the response	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing Review Contingency plans **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of neighbouring providers in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of neighbouring providers in the Wirral **SLT Lead:** COO **Timescales:** May 2019	

Key risk indicators (KRIs) – Data updated 21/03/19



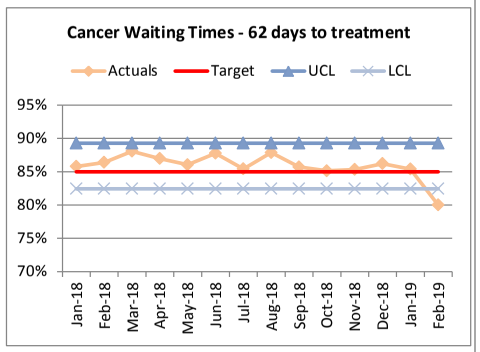


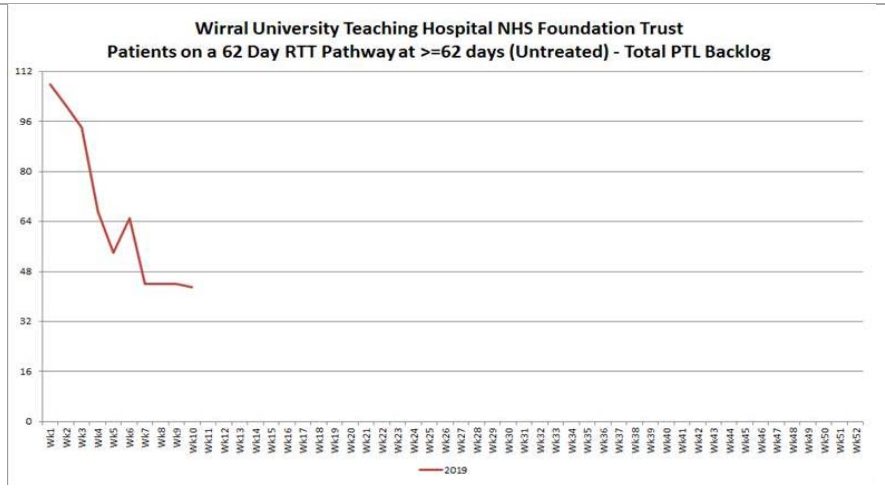
Total no.on waiting list



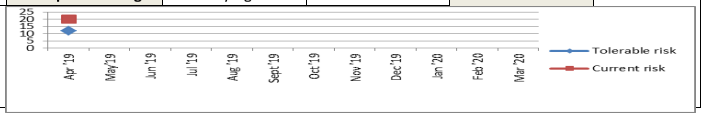
WUTH activity (Admitted, Discharges & Net flow)
To be developed

Bed occupancy on a week by week basis
To be developed





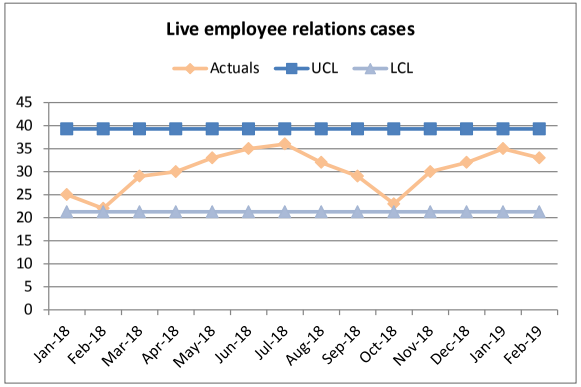
Strategic priority	I. PEOPLE: Supported empowered workforce II. PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	WAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:** Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 2: Critical shortage of workforce capacity & capability** A critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards	**Executive lead**	Dir. HR/Workforce	**Likelihood:**	5. V. likely	3.Possible	**Risk appetite** Open
		Initial date of assessment	01/04/2019	**Consequence**	4. High	4. High	
		Last reviewed	01/04/2019	**Risk rating**	**20. Significant**	**12.High**	
		Last changed	01/04/2019	**Anticipated change**	Intensifying		
Details of change	Revised BAF for Board consideration						

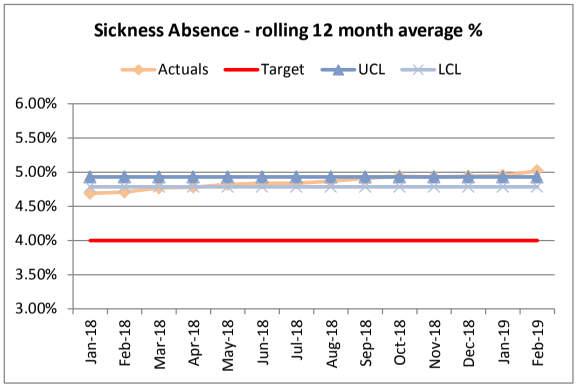


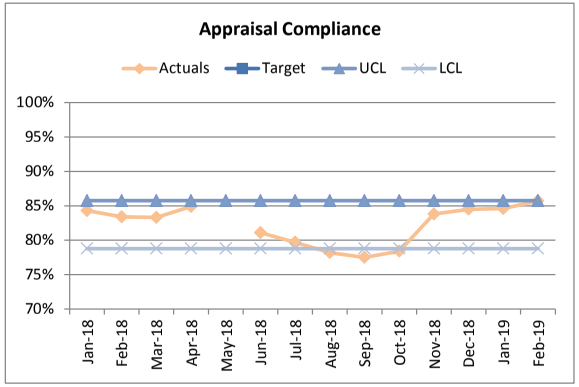
Risk Vector (what might cause this to happen)	Primary risk treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Level & Source of assurance (& date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap	Assurance rating
Threat: Demographic changes (including the impact of Brexit and an ageing workforce) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition) resulting in critical workforce gaps in some clinical services **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ E-rostering and job planning to support staff deployment ▪ Vacancy management and recruitment systems & processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards & departments/ Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels ▪ 'No deal' EU Exit Planning Team – incl workforce planning – action cards/ global comms/ EU exit page on intranet ▪ Medical staffing & HR Teams in place ▪ Nursing & Midwifery recruitment & retention strategy ▪ Volunteer strategy ▪ Recruitment campaign (Band 5; CSW; Volunteers) ▪ Ward establishment review	Divisional ownership and understanding of their workforce issues Lack of understanding re: the impact of age demographics on staff retention risk Vacancy rates / high locum use and hard to recruit medical posts Vacancy rates for nursing posts No workforce plan aligned to service strategy	Develop understanding & boost ownership through WF Steering group/ Divisional Performance reviews **SLT Lead:** Dir HR **Timescales:** Commence April '19 Bed modelling & specialty capacity/ demand review **SLT Lead:** COO **Timescales:** By end April '19 T&F group – recruitment B 5's **SLT Lead:** Ch. Nurse **Timescales:** July '20 Develop and approve workforce strategy and implementation plan by end of April '19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) **Level 2** ▪ Workforce strategy & plan ▪ Quality and Performance dashboard- W/force metrics (monthly); ▪ Report of Workforce Assurance Committee to Board (Monthly); ▪ FBPAC reports (Monthly) ▪ EU exit paper presented to TMB and Chairmans report to Board (Feb/ Mar '19)	None identified	
Threat: A failure to acquire or loss of of workforce productivity arising from a reduction in discretionary effort amongst substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint or workforce fatigue	▪ Staff Communication bulletin; Schwartz rounds ▪ Divisional action plans from staff survey ▪ Policies (Inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Leadership development programme / Duties of a doctor programme ▪ Executive & SLT visibility; Big debates; Ask the Exec Team ▪ Divisional staff support networks; Freedom to Speak up Guardians; Occupational Health Support (as required) ▪ Health & Wellbeing team in place ▪ Rewards & recognition i.e. annual staff celebration; cards ▪ Attendance Management procedures	Staff survey results identify areas for further improvements Unsustainable levels of sickness absence	Strengthen and boost oversight of OD delivery via Workforce Assurance Committee **SLT Lead:** Dir HR **Timescales:** From April'19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) **Level 2** ▪ Workforce/ OD strategy & plan ▪ Quality and Performance dashboard- Workforce metrics (mthly); ▪ Report of Workforce Assurance Committee to Board (Monthly); **Level 3** ▪ National Staff Survey (Mar 19); ▪ CQC Report (Mar '18); ▪ Medical engagement survey	None identified	
Proximity of threat 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) ▪ The LHRP co-ordinated response	Limits to the extent contingencies can provide the state required in emergency	Test EPRR arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by Q3 '19	**Level 2** ▪ Resilience Assurance report to RMC (Mar; Sept 19) **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs; ▪ LHRP Assurance Process	None identified	

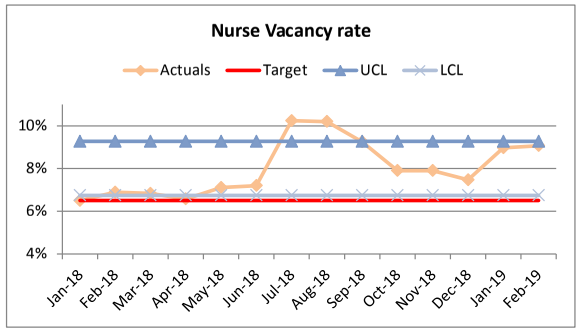
Threat: Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Induction; Mandatory & role specific training programmes; ▪ Corporate teams provide support and training as required ▪ Exercises to test business continuity and incident management plans including loss of technology ▪ ESR training record ▪ Protected budgets for training & development ▪ Practice educators	Difficulties in releasing staff from wards	Deliver 80% of mandatory training as an e-learning option for staff **SLT Lead:** HR Dir **Timescales:** By end Q1 '19	**Level 2** ▪ Q&P Dashboard- Mandatory training (monthly); ▪ Report of Workforce Assurance Committee to Board (monthly) **Level 3** Staff survey (Mar '19)	None identified	
		Effectiveness of mandatory training (knowledge & skill acquisition and transfer into practice)	Introduce knowledge acquisition tests for those – e-learning options available for practical skills-based training, **** BLS, test all staff at point of training. Review role of practice educators **SLT Lead:** HR Dir **Timescales:** By end Q1 '19			

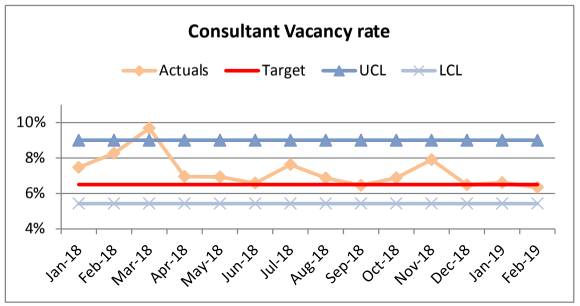
Key risk indicators (KRIs) Data updated 21/03/19



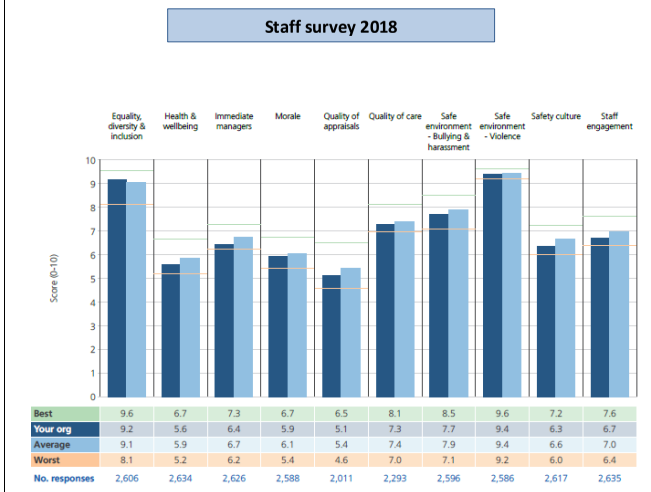




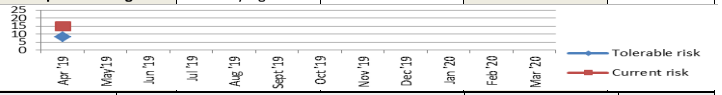




To be developed – established nursing posts vs staff in post



Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:** Modify / Transfer
Principal risk (what could prevent us achieving this strategic priority)	**PR 3: Failure to achieve and/or maintain financial sustainability** Inability to deliver the annual control total resulting in a failure to achieve and maintain financial sustainability.	**Executive lead**	Finance Dir.	**Likelihood:**	3. Possible	2. Unlikely	**Risk appetite** Open
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	4. High	
		Last reviewed	01/04/2019	**Risk rating**	**15. Significant**	**8. Medium**	
		Last changed	01/04/2019	**Anticipated change**	Intensifying		
Details of change	Revised BAF for Board consideration						

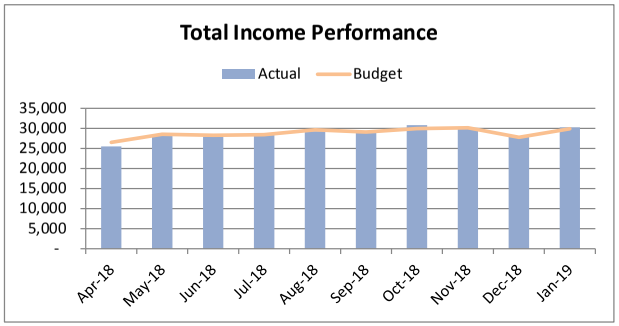


Risk Vector (what might cause this to happen)	Primary risk controls (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Plans to improve control	Source of assurance (& date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap	Assurance rating
Threat: Increased cost & income volatility as a result of tariff changes; deteriorating condition of clinical estate; dependency on temporary staffing; growth in competition from the private health sector; contract penalties/ fines leading to uneconomic services **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Annual plan, including control total consideration; reduction of underlying financial deficit ▪ SFI's authorisation limit (scheme of delegation) ▪ Core financial control Policies / Procedures ▪ Access to Working Capital support ▪ Budgetary controls/Budget at Ward & Dept level ▪ Training for budget holders ▪ Procurement processes and Team ▪ Risk based annual capital planning process	▪ Not all budget holders have completed training ▪ Lack of accuracy of ward/dept budgets ▪ Compliance with escalation as per SFI ▪ MTFM not yet agreed ▪ Effectiveness of budget management @Divisional/ Corporate/ Ward/ Dept ▪ Operational productivity impacting adversely on income and expenditure ▪ Robust capacity plan ▪ Job planning and e-roster	Embed S/L reporting & establish steering group **SLT Lead:** MD **Timescales:** End of September '19 Robust capacity plan/ job planning and e-roster- add on required - efficient deployment of staff across organisation (IT solution) **SLT Lead:** Ch. Nurse **Timescales:** End of September '19 Ensure all budget holders receive refresher training on budget mgmnt & SF1 compliance **SLT Lead:** FD **Timescales:** End of July '19 Develop & agree accurate pay & non-pay budgets **SLT Lead:** FD **Timescales:** End of April '19 Develop & agree MTFM **SLT Lead:** FD **Timescales:** End of July '19	**Level 1** ▪ Divisional risk reports to Risk Committee bi-annually; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Significant risk report to RMC (monthly); ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit; ▪ External audit;	None identified	
Threat: Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ CIP planning processes and coordination of delivery ▪ Agreed CIP plans at Divisional and Dept level ▪ Access to Working Capital support ▪ Programme Board ▪ SRO's identified for CIP programme ▪ CIP planning; scoping; approval and initiation process in place with QIA and clinical sign-off	▪ Unidentified CIP in year ▪ Effectiveness of oversight	Establishment of CIP delivery monitoring meetings **SLT Lead:** FD **Timescales:** End of April '19	**Level 1** ▪ Divisional reports to Programme Board; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit/ External audit;	None identified	
Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Treasury loan process/NHSI Capital approval process. ▪ Planned and preventative maintenance regime in place based on compliance ▪ Reactive maintenance regime to repair immediate issues as they arise with dedicated Budget for Backlog maintenance - circa £1.2 million ▪ Dedicated Capital Budget for improvement works on the Physical Environment- various.	The condition of the current estate and ageing medical devices presents a significant maintenance and affordability burden in a restrained operations environment	Establish a trust wide 6 facet survey and report on the physical environment to identify areas of concern and replacement costs **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ Divisional risk reports to RMC (monthly) ▪ Backlog report presented to RMC -March 19; ▪ Compliance Audit undertaken (every 6mths) **Level 2** ▪ Significant risk report to RMC (monthly) **Level 3** ▪ PLACE audits (annually) ▪ 6 Facet survey ▪ Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	

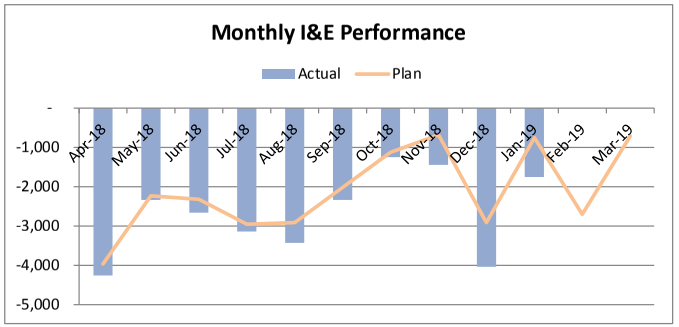
Threat: Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society **Proximity of threat** 19/20 ◄ 20/21 ▬ 21/22 ▬ 22/23 ▬ 23/24 ►	▪ Specialist H&S advisors & legal team employed ▪ Membership of CNST scheme ▪ H&S policies and procedures/ staff training ▪ Investigation processes; action planning and sharing lessons learnt to reduce likelihood of recurrence ▪ Clinical audit and effectiveness programme ▪ Other insurance policies	▪ Maturity of the safety management system is currently at 'emerging' level ▪ Limited monitoring of compliance with H&S requirements ▪ Restricted adaptive capacity ▪ Delayed responses to non-clinical incidents	Commission an independent safety management audit and develop a plan to take whatever steps are necessary to strengthen the Safety management systems **SLT Lead:** Dir Q&G **Timescales:** May 2019	**Level 2** ▪ H&S report to RMC (6 monthly) ▪ SIRG receives all claims/ RIDDOR incidents **Level 3** ▪ Authorised engineers reports; UKAS ▪ NHSR claims profile; MHRA inspection reports; HSE inspection/ Environmental Health inspections; CQC inspection reports		

Key risk indicators (KRIs) Data updated

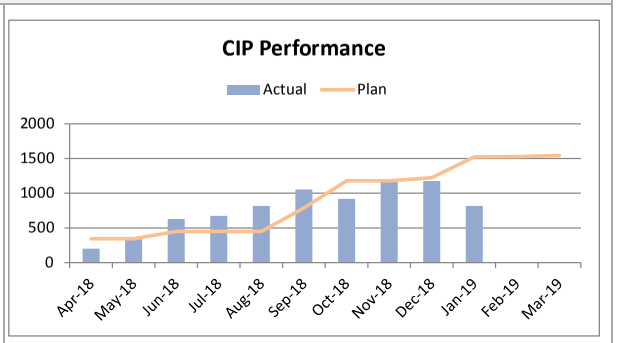
Total Income Performance



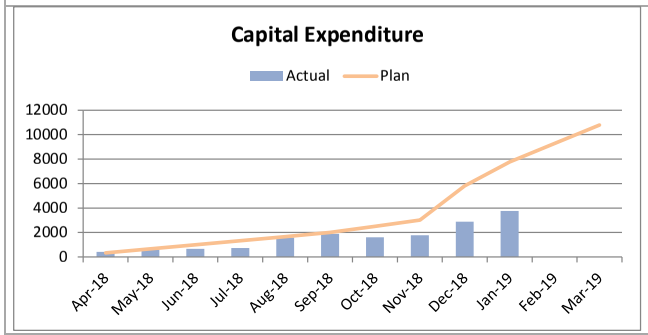
Monthly I&E Performance



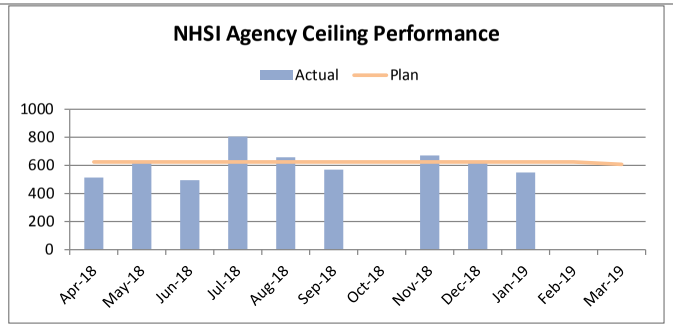
CIP Performance



Capital Expenditure



NHSI Agency Ceiling Performance



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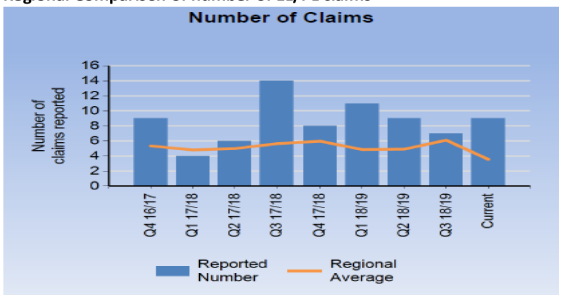
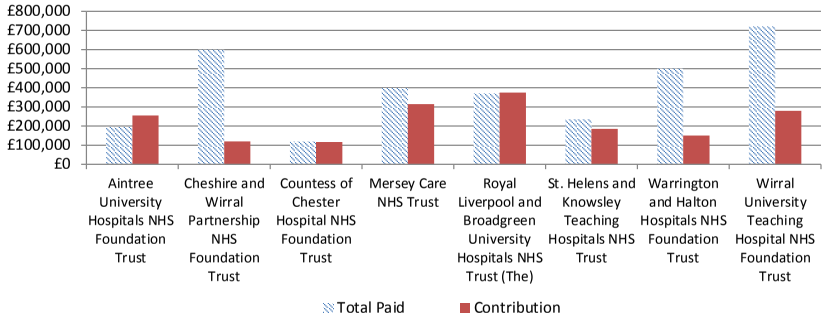
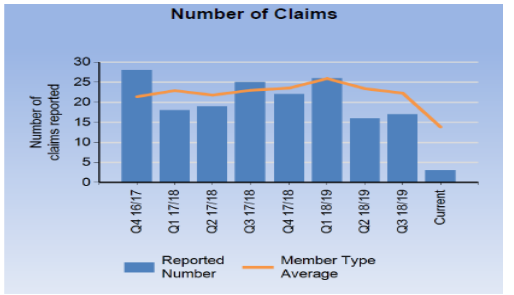
Regional Comparison of number of EL/PL claims



Regional comparison of RPST contribution and level of compensation paid



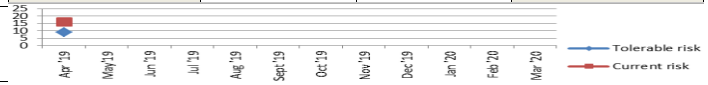
Regional Comparison of number of CNST claims



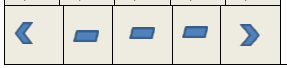
Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 01 April 2019)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Strategic priority	PATIENTS: Pursuing quality improvement	**Lead Committee**	Quality	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 4: Catastrophic failure in Standards of Care** A Catastrophic failure in standards of safety and quality of patient care across the Trust resulting in multiple incidents of severe, avoidable harm and poor clinical outcome	**Executive lead**	Medical Director	**Likelihood:**	4. Somewhat likely	3. Possible	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	4. High	3.Moderate		
		Last reviewed	01/04/2019	**Risk rating**	**16. High**	**9. Medium**		
		Last changed	01/04/2019	**Anticipated change**	Uncertain			
Details of change	Revised BAF for Board consideration							



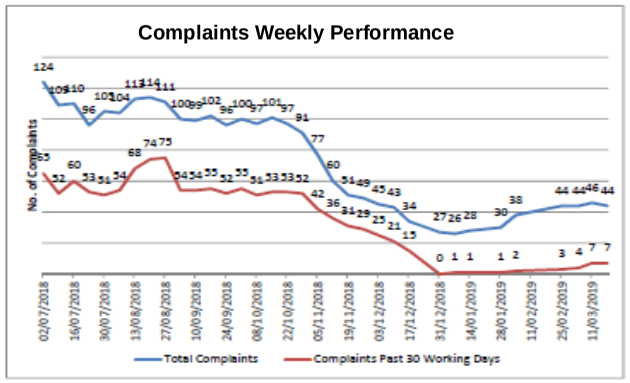
Risk Vector (what might cause this to happen)	Primary risk treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Source of assurance (& date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
An outbreak of infectious disease (such as pandemic influenza; norovirus; infections resistant to antibiotics) that forces closure to one or more areas of the hospital and/or causes avoidable serious harm or death to service users **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Chief Nurse identified as DIPC • IPC service provided Trust wide by the IPC Team incl. seven day out of hour's on-call service; IPC Programme of work • Infection Prevention & Control policies/ procedures • Staff training • Antibiotic stewardship • Environmental cleaning Procedures / Standards in all areas • Decontamination standards – CSSD; Flu vaccination prog • Strict adherence to single use items • Bed occupancy managed by leads that attempts to minimise risk of cross contamination • Mattress decontamination / disposal & replacement	Unsustainable levels of bed occupancy (sufficient to control infections) Inadequate hand hygiene compliance in clinical areas (wards) Mattress replacement/ decontamination/ disposal	Infection prevention control improvement plan to be fully implemented **SLT Lead:** Ch. N **Timescales:** August '19	**Level 1** ▪ Perfect ward/ ward accreditation audits; Divisional reports to IPORT **Level 2** ▪ Infection Prevention & Control Performance Report to Board; Infection Prevention and Control - Improvement Plan – PSQB/Quality; Quality ▪ Performance Dashboard; Weekly escalation report IPC specific; IPCG/ PSQB oversight **Level 3** IPC Improvement plan; MIAA Internal audit reports; PHE reports	Lack of assurance re standard of cleaning **Action:** A review of hotel services to be undertaken **SLT Lead:** COO **Timescales:** End of Aug 19	
A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including • Monthly Patient Safety & Quality Board (PSQB) with work programme aligned to CQC registration regs • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Clinical audit programme & monitoring arrangements • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe medical & nurse staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • CAS Implementation process • Mortality review policy & process	Current levels of mortality review and structured judgement review where these are indicated Timeliness of end to end VTE assessment through to treatment	Further develop & strengthen Learning from deaths process **SLT Lead:** MD **Timescales:** By end Q1 '19 Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission. **SLT Lead:** MD **Timescales:** By end Q1 '19	**Level 1** ▪ Perfect ward/ ward accreditation audits (ongoing) **Level 2** ▪ Quality Performance Dashboard (monthly); ▪ PSQB reports (monthly) ▪ Quality Account (annual); ▪ KLOE inspections local inspections; ▪ Weekly escalation areas report **Level 3** ▪ CCG oversight of SI's (monthly) ▪ CQC Insight tool(monthly); ▪ Dr Foster updates; ▪ Internal Audit SI's (monthly) ▪ Patient/ Staff surveys	None identified	

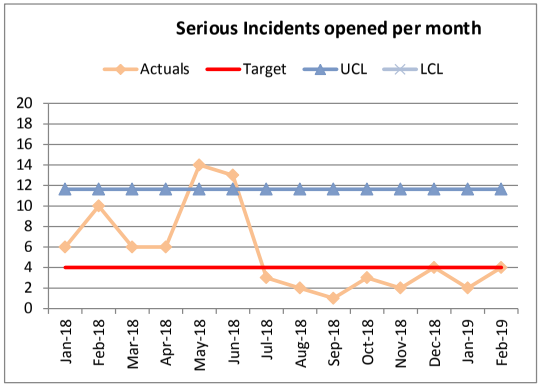
Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	**Key Measures** - We have the ability to measure metrics shown in the rest of the BAF eg VTE and MUST **Training** – end users are not provided access unless they are trained **Continuous improvement of the EPR** Response to divisions about usability and function	**Extended measures** There are other areas to monitor e.g fluid balance or IVs **Training** – adoption of a new way of training described in paper to WAC which includes regular updates **Innovation** – The way innovations are introduced into the Trusts needs more of a framework to manage priorities, costs and sustainability	**Cerner Optimisation** – address specific areas for improved usage **SLT Lead:** Dir IT & Info **Timescales:** 30/09/2019 **New Training** - adoption of a new way of training to be resourced and delivered **SLT Lead:** Dir IT & Info **Timescales:** 30 June 19 **End user Survey** and benchmark report on end user experience **SLT Lead:** Dir IT & Info **Timescales:** June 19 **In partnership with AHSN,** develop and approve model for innovation and adoption model **SLT Lead:** Dir IT & Info **Timescales:** By end Q1 '19	**Level 1** Digital Maturity assessments done as self-assessments with peer review Competency based assessment of training / knowledge/skills Perfect Ward assessments of compliance **Level 2** MIAA Audits on use of the system and accuracy of data **Level 3** GDE audits for milestone payments HIMSS assessment	Currently no mechanism to determine success of training **Action:** **Measure objective** feedback e.g. immediately after training and again later **Introduce tests of knowledge** to see how many people know what they should. **SLT Lead:** Dir IT & Info **Timescales:** Sept 19	

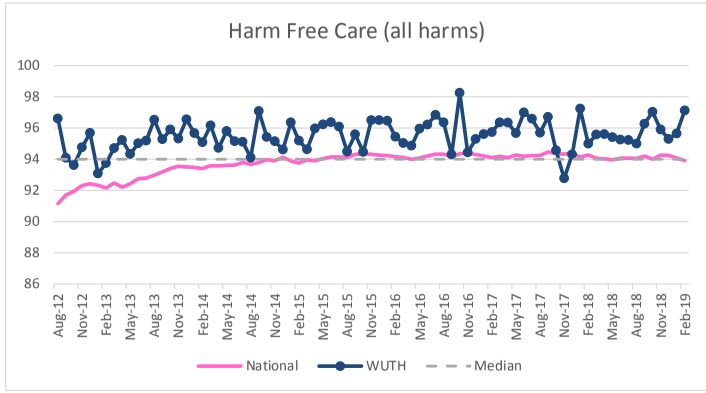
Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 01 April 2019)

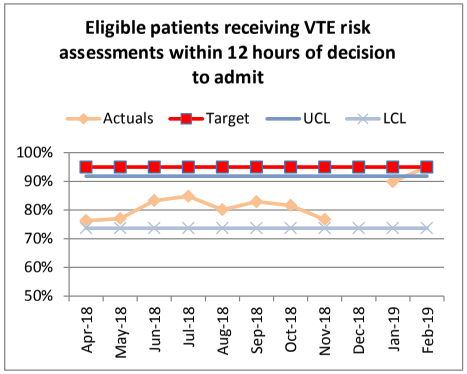
Wirral University Teaching Hospital NHS
NHS Foundation Trust

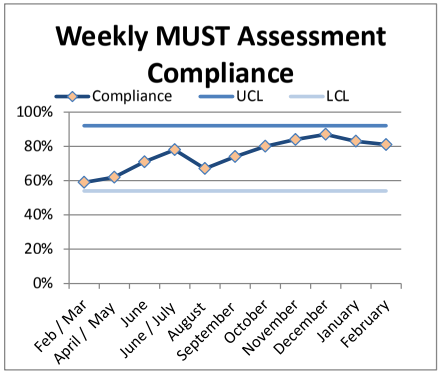
Key risk indicators (KRIs) - Data updated 21/03/19

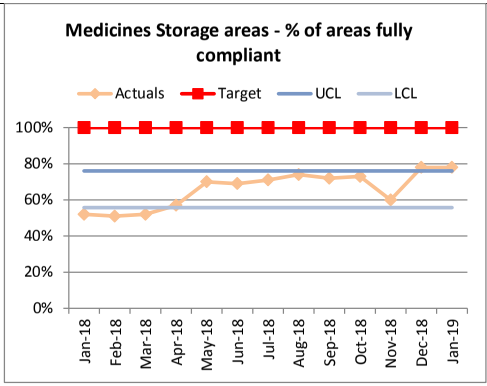


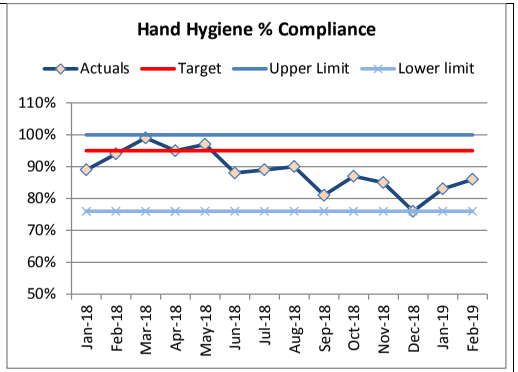


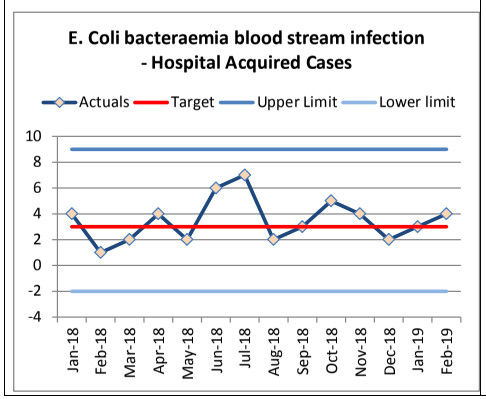


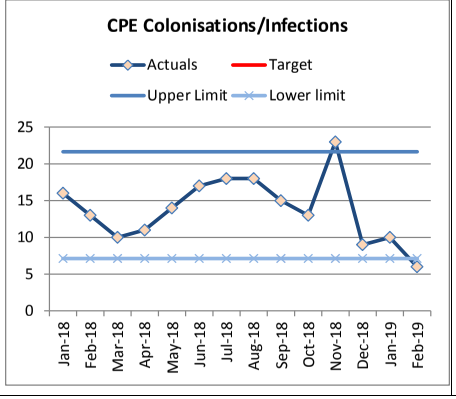


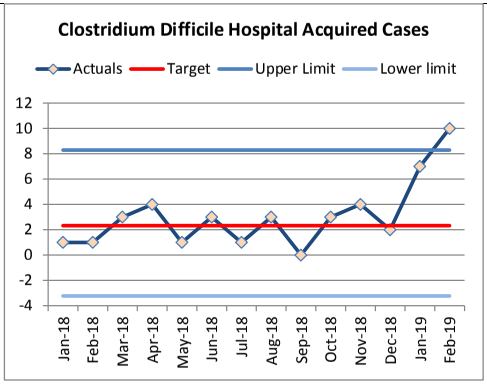


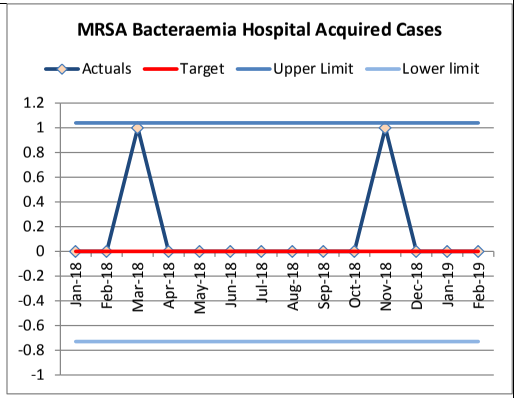








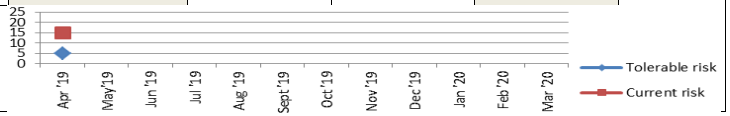




Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 01 April 2019)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Strategic priority	ALL STRATEGIC OBJECTIVES	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 5: Major disruptive incident (leading to rapid operational instability)** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community	**Executive lead**	COO	**Likelihood:**	3. Possible	1. V. Unlikely	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	5. V. High		
		Last reviewed	01/04/2019	**Risk rating**	**15. Significant**	**5. Med**		
		Last changed	01/04/2019	**Anticipated change**	Intensifying			
Details of change	Revised BAF for Board consideration							



Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Source of assurance (& date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gap in Assurance/ Action to address gap	Assurance rating
Threat: A large-scale **cyber-attack** that shuts down the IT network and severely limits the availability of essential information for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Data Security Assurance Framework (IGAF) • Fire wall controls • Access controls • VPN access • Anti virus and updates • Mandatory Data Security Training • Business Continuity plans & BIA – Divisional & IT specific • Pilot site unified cyber risk framework	Lack of co-ordination of incident response across region	Implement funded program to co-ordinate cyber security across the Mersey in liaison with NHS(E) **SLT Lead:** Dir IT & info **Timescales:** By end Q1 '19	**Level 1** ▪ IG & Clinical Coding Group **Level 2** ▪ Data Security and protection toolkit submission to Board; **Level 3** ▪ Business Continuity Confirm and Challenge NHSE; ▪ LHRP Assurance Process	None	
Threat: A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels • Operational strategies & plans for specific types of major incident (e.g. fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) • Strategic, Tactical, Operational command structure for major incidents • Business Continuity, Emergency Planning & security policies • Power failure action cards • Business Impact assessments • Major incident plan and action cards	Deterioration of plant equipment & Fabric of building due to age of estate and availability of funding & extent of work required.	6 Facet survey commissioned **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ EPRR Twice yearly report to RMC **Level 2** ▪ Monthly Significant Risk Report to Risk Committee ▪ EPRR annual report (Sept) ▪ Communication testing (every 6 months) **Level 3** ▪ EPRR Core standards compliance rating (+ve); ▪ Facet survey (May '19) ▪ MIAA Internal audit report – Emergency planning (May 19)	None	
Threat: A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	▪ CAS alert system – Disruption in supply alerts ▪ Procurement ▪ Account Management ▪ Supplier Assurance ▪ Contingencies – Stock control ▪ 'No deal' EU Exit Planning Team established ▪ SRO & EU Exit lead identified for Exit preparation ▪ Risk assessment and business continuity planning	EU Exit Operational Readiness Guidance identifies a number of actions Trusts must take in preparation for Brexit	EU Exit planning team to review Operational guidance and ensure all actions completed within timescales **SLT Lead:** COO **Timescales:** As determined by Parliament (Review end Q1 '19)	**Level 2** ▪ EU Exit paper to TMB (Feb 19) ▪ EU Exit preparation update to Board (Mar 19) ▪ EPRR Twice yearly report to RMC (Mar; Sept) ▪ EPRR Annual Report **Level 3** ▪ Letter of assurance, DoH		

Key risk indicators (KRIs) Data updated 17/03/19

EPRR
Confirm and Challenge by NHS England Regional team and CCGs
September 2018:

Full Compliance
Substantial Compliance
Partial Compliance
Not Compliant

NHS Information Governance Toolkit — Department of Health

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 14.1 (2017-2018)	Published	77%	Satisfactory	n/a	n/a

NHS Digital — Estates Returns Information Collection, England, 2017-18
Publication date October 2018

RIDDOR incidents	30
Estates and facilities related incidents	184
Clinical service incidents caused by estates and infrastructure failure	111
Overheating occurrences triggering a risk assessment (No.)	8
Fires recorded	0
False alarms - No call out	34
False alarms - Call out	25

Cyber Security measures

Patching overview	Quantity	Compliance levels (Target 100%)
Desktop patching	3906	91%
Server patching	273	82%

Anti-virus overview	Quantity	Compliance levels (Target 95%)
Desktop	3906	100%
Server	273	TBC

Inactive directory device accounts	Mar '19	Apr '19	May '19	YTD
60 days (notice issues)	48			48
90+ days to be disabled	79			79

Web filtering	Mar '19	Apr '19	May '19	YTD
Access requests authorised	20 (Av)			20 (Av)

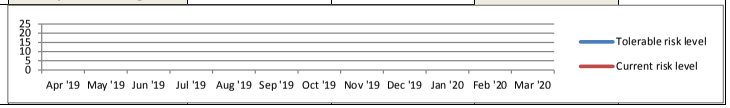
Removable media	Mar '19	Apr '19	May '19	YTD
Additions to the whitelist	0			0

Planned Preventative Maintenance performance measure – to be developed

Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 01 April 2019)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Strategic priority	PARTNERSHIPS: Improve services through closer integration	**Lead Committee**	Board	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Seek, Modify, Accept
Principal risk (what could prevent us achieving this strategic priority)	**PR 6: Fundamental loss of stakeholder confidence** Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public	**Executive lead**	CEO	**Likelihood:**	3. Possible	1. V. Unlikely	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	5. V. High		
		Last reviewed	01/04/2019	**Risk rating**	**15. Significant**	**5. Medium**		
		Last changed	01/04/2019	**Anticipated change**	Uncertain			
Details of change	Revised BAF for Board consideration							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Changing regulatory demands (including potential impact of Brexit) or reduced effectiveness of internal controls resulting in failure to make sufficient progress on agreed quality improvement actions; Or widespread instances of non-compliance with regulations and standards **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Quality & corporate governance & internal control arrangements ▪ Conflicts of interest & whistleblowing management arrangements ▪ Routine oversight of quality governance arrangements & maintenance of positive relationships with regulators ▪ Formal notification process of significant changes (Relationship manager, CQC; Chief Inspector of Hospitals) ▪ Internal KLOE inspections in clinical areas ▪ Exec visibility & visits ▪ Clinical & management audit ▪ Policies and procedures	Compliance:- ▪ Infection prevention ▪ Medicines storage ▪ Estate Condition ▪ ED Triage within 15 mins arrival	As per CQC Action plan – refer to Board report	**Level 1** ▪ Ward accreditation metrics **Level 2** ▪ CQC Action Plan Progress Report ▪ PSQB Report to Quality Committee ▪ Quality Performance Dashboard **Level 3** ▪ CQC Inspection report	None identified	
Threat: Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Communications department to handle media relations: ▪ Established relationships with regulators ▪ Trust website & social media presence ▪ Internal communications channels ▪ Continued public & stakeholder engagement utilising a wide range of consultation & communication channels; ▪ Involvement & Engagement Strategy Trust Board ▪ Surveys and Friends and Family Testing ▪ Consultation on proposed strategy and service changes	None identified	N/A	**Level 2** ▪ Communication / Press statements **Level 3** ▪ CQC National patient survey; ▪ FFT recommendation ratings ▪ Healthwatch commentary ▪ OSC commentary ▪ NHS Choices ratings	None identified	

Key risk indicators (KRIs) Data updated 07/03/19

Wirral University Teaching Hospital NHS Foundation Trust

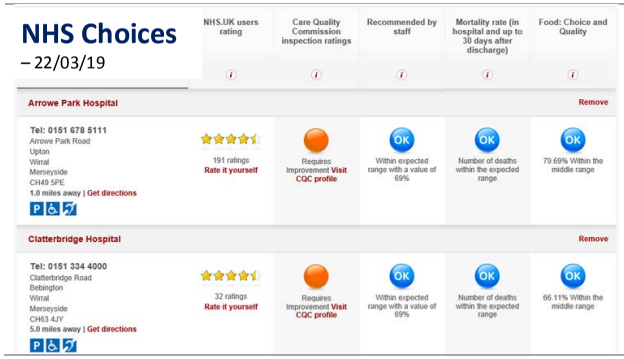
CQC overall rating

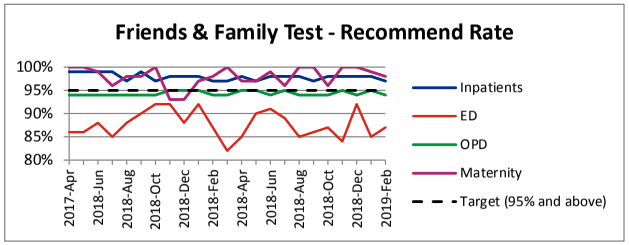
Requires improvement

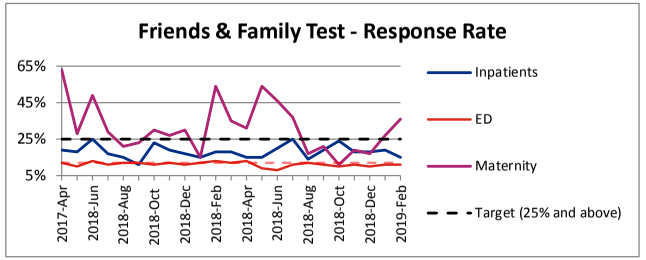
13 July 2018

Location level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Overall	RI 13/7/2018	RI 13/7/2018	G 13/7/2018	RI 13/7/2018	I 13/7/2018	RI 13/7/2018
Arrowe Park Hospital	RI 13/7/2018	RI 13/7/2018	G 13/7/2018	RI 13/7/2018	I 13/7/2018	RI 13/7/2018
Clatterbridge Hospital	RI 10/3/2016	G 10/3/2016	G 10/3/2016	RI 10/3/2016	RI 10/3/2016	RI 10/3/2016

NHS Choices
– 22/03/19







Inpatient Survey – to be added when released

Comms & Engagement KPI
To be developed

CQC Maternity Services patient survey – Published Feb 2019

Patient survey	Patient response	Compared with other trusts
Labour and birth	9.1/10	About the same
Staff	9.3/10	Better
Care in hospital after the birth	8.4/10	Better