Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

5th June 2019

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 5 JUNE 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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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	**Six Monthly Nurse Staffing Report** Chief Nurse	d	Page 17
8. Performance & Improvement			
8.1	**Integrated Performance Report**		
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9. Governance			
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9.5	**Report of Audit Committee** Chair of Audit Committee	v	
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10. Standing Items

10.1	**Any Other Business** Chair	v
10.2	**Date and Time of Next Meeting** Wednesday 3rd July 2019	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

1st MAY 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
John Coakley	Non-Executive Director
Paul Moore	Director of Quality and Governance (Non voting)
Dr Ranjeev Mehra	Associate Medical Director, Surgery

In attendance

Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
John Fry	Public Governor
Jane Kearley*	Member of the Public
Joe Gibson*	Project Transformation
Steve Sewell*	Delivery Director

Apologies

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
Mr Mike Ellard	Associate Medical Director, Women & Childrens

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 19-20/022	**Apologies for Absence** Noted as above.	
BM 19-20/023	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/024	**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 the positive step change in engagement with the Clinical Commissioning Group (CCG) continues. This culminated in stakeholders participating in the site visit of NHS Improvement Emergency Care Intensive Support Team (ECIST)	

Reference	Minute	Action
	to review care provided through a number of sources emergency department, ambulance handover and streaming. Feedback from the visit highlighted a range of issues to be addressed and therefore would require input and support of local stakeholders to provide a more effective service. Immediately following the visit a further meeting was held to address the concerns raised and the implementation of change with effect from 1st June 2019. The CCG requested WUTH to describe the model of care to drive change across the health economy starting with care provided in ED and Walk-in centre which will comprise a single IT system and combined rota's. It was acknowledged that this would require the CCG to change the contracts with GP's and the Community Trust.	
BM 19-20/025	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Workforce** – Mrs Marks advised the Board that the Trust was working with Public Health England to improve the health and wellbeing of the local population. In addition the Trust is support the CCG employee scheme for young people in care to gain work experience. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board that opportunities for the Clatterbridge site are being explored and implementation of plans are to be discussed at the Divisional strategy session. **Director of Quality & Governance** – informed the Board that the independent Health & Safety audit has now been commissioned and interim support to address capacity within the Health & Safety team had now been secured. **Chief Nurse** – informed the Board that improvements had been maintained regarding complaint management with a 30% reduction in formal complaints during the past six months compared with the same period last year. There are currently sixteen active complaints and an overall response time of all complaints acknowledged within three working days compared with significantly higher response times in 2018/19. In December 2018 the Trust introduced touch screen kiosks and hand held devices to capture patient feedback. To date responses show that 79% of patients rated their experience as excellent or good. In addition the hand held devices have been utilised to monitor patient satisfaction before and after menu changes, the outcomes are pre-menu change 53% of patients rated meals and Excellent or Good and after menu change 89%. This will support the actions from the national inpatient survey. The Chief Nurse advised that the Royal College of Nursing (RCN) president is due to visit the hospital on 21st May to review digital technology supporting patient care. **Acting Director of Finance** – informed the Board the Healthy Wirral System are developing a five year Recovery & Sustainability plan and an overview of this will be presented at the next Board meeting. A solution to address the arrangements for the engaging of medical locums will be implemented from May 2019.	

Reference	Minute	Action
	Medical Director – reported that since March 2019 the Trust has appointed seven consultant including hard to recruit specialties. During the last twelve months the Trust has recruited 24 consultants with 10 pending start dates. The interviews for the Deputy Medical Director position are due to take place in early May, with three candidates. The Board will be notified of the outcome. With effect from 1st May 2019 the Trust will be moving to the NEWS2 early warning score system for patients. **Chief Operating Officer** – advised the Board that reverse cohort plans had been implemented to improve patient flow and address the hampering of ambulance hand over and volume of corridor care. Since implementation ambulance handover is the best in the North West and no patient has been treated in the corridor. The feedback received from staff has been very positive as it helps eliminate risk to patients. Mr Middleton reported that the Trust has received assurances from NHS England and directly from the company regarding recent concerns regarding the financial viability of Four Seasons Healthcare. It is the holding company that has been placed in administration. As one of the largest providers of elderly care, Four Seasons manage the Grove Discharge unit on the Clatterbridge site and are working with NHS England to ensure there should be no impact to patient care. Consideration of the long term plan and any contingency measures that may be required should be contemplated as a backup should the contract not run to the full two years. ***The Board noted that although some members did not have detailed updates there were a number of themes in relation to workforce. Board members reflected on the recent Board development facilitated by NHS Providers and reported that it been helpful and had provided good challenge.***	
BM 19-20/026	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 3rd April 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 19-20/027	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including: • Serious Incidents • Millennium Upgrade • Navajo Merseyside & Cheshire LGBT Charter Mark **NHS Improvement Licence Undertakings** – discussions are underway with NHSI to review the Trusts Licence Undertakings. The Board will be informed	**KE/AM/ AL**

Reference	Minute	Action
	of the formal outcome once completed. ***The Board noted the information provided in the April Chief Executive's Report.***	
BM 19-20/028	**Patient Story** The Patient experience team are collating a library of stories and will established availability of patients, in addition some stories are to be videoed. They will be shared at future Board and committee meetings as the 'Patient story of the month' if a patient unable to attend in person. Unfortunately a patient story was unable to be sourced for today's meeting. Therefore the Chief Nurse shared a message received from an acute medical consultant who previously worked at the Trust whose mother had been admitted to ward 38 during April 2019. During her cancer journey she was consistently grateful for the amazing people who helped her, from Arrowe Park, Aintree and Clatterbridge Cancer Centre. There are no words to describe the individualised amazing care given to her as a hospital and contributed to by far too many people to mention. I would not have chosen her care to be anywhere else. In the end to have her home, be cuddled up to by Abercrombie, (her loving dog) and die peacefully in our home was beyond amazing. In my mums final care I witnessed acts of kindness, care and true compassion that will live with me forever. Moreover they were universal, from those who knew us and those who met her at her most weak. Some very very special, beyond anything which I would ever have imagined. She always wanted to tangibly make a difference, and when this dust settles I will do this in her memory. The Chief Nurse explained that a Patient Experience Strategy was under development and the Board requested the option to include staff stories as part of future developments. ***The Board noted the revised process going forward. The Board acknowledged the feedback reported and requested the message of thanks be shared with the relevant teams.***	**GW**
BM 19-20/029	**Quality Strategy** The Director of Quality & Governance presented to the Board the Quality Strategy 2019 2022 for approval. The draft strategy has been circulated to a wide range of staff for consideration and comment. This enabled staff to contribute and influence the ambition and shape quality improvement activities. It was explained that when implemented in full, the Quality Strategy will support a positive patient experience, enable safer care, support clinical effectiveness and improve overall CQC ratings. Implementation of the Strategy will make a positive contribution to further strengthening the control framework for the following risk scenario's:	

Reference	Minute	Action
	• Demand that overwhelms capacity to deliver care effectively • Catastrophic failure in standards of safety and care • Fundamental loss of stakeholder confidence. A summary of the four quality campaigns with an outline the key performance indicators and milestones for each campaign were provided. The campaigns are: **i.** A positive patient experience **ii.** Care is progressively safer **iii.** Care is clinically effective and highly reliable **iv.** We stand out The Board acknowledged that whilst the strategy was challenging it clearly reflects the ambitions of the organisation to aspire to achieve an 'outstanding' rating by 2022. Whilst the potential risks to achieving stated quality goals are identified, discussion focussed on implementation and mitigation. The Board recognised the Quality Strategy is rightly ambitious and key to future success is the Board's ability to balance and adapt to the challenges that lie ahead. The Board recognised that the nature of the challenges that lie ahead pose some risk to ambitions outlined. However, the Board accepted that progress and success require ambition and a willingness amongst leaders to embrace failure and learn from it. ***The Board approved the Quality Strategy 2019 – 22 and noted that an implementation plan aligned to the organisations priorities would be provided to the Quality Committee.***	
BM 19-20/030	**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 51 indicators with established targets or thresholds 20 are currently off-target or not currently meeting performance thresholds. 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: • RTT (52 weeks) – year end target achieved and expected to be maintained going forward. Access policy had enabled patients to repeatedly cancel, this has now been addressed with a revised process and referral back to GP to escalate. • RTT (18 week) – internal processes improved leading to maintaining achievement of this indicator. • Infection Prevention Control (IPC) indicators – at year end there were 43 cases of avoidable cases against a threshold of 28. Although there was a reduction in March the focus remains on post infection review to ensure no lapse in care to determine avoidable or unavoidable. A number of measures introduced to address to the non compliance of IPC indicators should drive improvements.	

Reference	Minute	Action
	• MRSA – 2 cases were reported in March 2019. Both cases have undergone a 72 hour review and both identified an outcome of unavoidable but with lessons learnt. • Consultancy vacancy rate – metric to be reviewed to reflect impact of retire and return data. • Sickness – targeted review of departments with high instances to be implemented. A pilot of an external management attendance solution to be undertaken starting in Estates and Facilities. A business case to be presented to FBPAC for roll-out across the organisation. • Appraisal – revised process implemented to include evaluation of quality of appraisal. A number of the indicators have seen an improvement and/or continue to remain compliant, namely: Harm Free Care, VTE, CAS alerts, serious incidents and complaints. The Board took account of the current difficulties in respect of infection prevention and control. The main difficulties concern a particularly intractable strain of Clostridium difficile alongside environmental cleaning, compliance with dress code and high levels of bed occupancy. Whilst further mitigations regarding IPC have been introduced and were duly noted, the Board's concern as to the continued non compliance of a number of indicators was noted. Chief Nurse requested to review processes to ensure the basics are correct. The Chief Nurse informed the Board of the new criteria to measure Cdifficile cases and consequently the threshold for this indicator for 2019/20 has been set at 88. The Medical Director reported that whilst the Trust did not achieve compliance of the SAFER BUNDLE: percentage of discharges taking place before noon, this was also a national issue. This continues to be a focus as part of the patient flow programme. The Director of Workforce advised that the metrics of workforce indicators are to be reviewed particularly in relation to reporting of vacancy rate as described earlier in the meeting by the Medical Director. The Board recognised the progress to date and the Trust is closing the end of year in a stronger position. ***The Board noted the current performance against the indicators to the end of March 2019.***	**HM** **GW**
BM 19-20/031	**Month 12 Finance Report** The Acting Director of Finance apprised the Board of the summary financial position. At the end of month 12, the Trust reported an actual deficit of £33m versus planned deficit of £25m and includes non-recurrent support of £2.4m which means the underlying position is £8.0m worse than plan and includes a provision of £1.5m for a retrospective VAT charge in relation to medical locums and year end technical adjustments. NHSI are aware of our year end position and the provision.	

Reference	Minute	Action
	In month, the Trust reported a deficit of (£0.7m) against a planned deficit of (£0.7m) and a month 11 forecast of (£0.8m). This being (£0.1m) better than the forecast position. The key driver of the variance is the under-performance in elective activity. In addition, there were some pay pressures in medical pay and acute care nursing which have been mitigated with vacancies in other area's, predominately corporate and non medical and acute nursing. The Acting Director of Finance reported that cash is better than plan at £6.5m as a result of capital slippage and working capital movements. There were no significant balance sheet variances. CIP delivered (£1.4m) below plan with £9.6m achievement against the £11.0m target. A proportion of the delivery (£3.8m) is non-recurrent against vacancies/non-pay. This pressure has been recognised in the 2019/20 plan. Capital expenditure for the year was £11.5m against full year programme of £13.1m. It was agreed £0.5m would be rolled over to 2019/20 in respect of GDE spend matched against PDC. Underspends resulting from slippage in Estates and IT are areas responsible for the variance. Additional key aspects apprised to the Board included: • Other income was higher than expected due to Mth 12 receipts and year-end Stock levels also gave a benefit • Pay costs and Non-pay costs were in line with forecast • Elective activity was in line with the forecast, casemix adverse • Non-Elective activity was in line with forecast, casemix adverse • Outpatients better than forecast and an improvement on run rate In recognising the previous year's deficit the Board was clear that focus to maintain grip on capacity and demand was pivotal to achieving the 2019/20 break-even position. Close monitoring of any future investments would be required with oversight by Executive's and/or Finance Business Performance Assurance Committee (FBPAC). The Director of Finance assured the Board that the capital expenditure programme would not be rear year end loaded which could risk value for money decision making. ***The Board noted the M12 finance performance.***	
BM 19-20/032	**Review of Freedom to Speak Up Guardian Report** The Director of Workforce provided a review of Freedom to Speak Up matters and associated issues across the Trust. It was reported that 2018/19 had seen a reduction in cases received compared with 2017/18 and this does not reflect the volume of allegations of alleged bullying. Therefore an external independent review of the Guardian service is to be undertaken. The review will take into account if there are any concerns about using the service that would have led to the reduction. The outcome of the review will be reported to the Workforce Assurance Committee.	

Reference	Minute	Action
	Greater emphasis to raise the profile of the service to support staff across Trust has been introduced along with various training opportunities to reflect the lessons learned. ***The Board noted the review of Freedom to Speak up Guardian Report and the external review to be completed.***	
BM 19-20/033	**Review of Healthcare Flu Vaccination Programme and Lesson Learnt** The Director of Workforce presented the final position for the 2018/19 review of the Healthcare Flu Programme and the lessons learnt. The Trust achieved 84.5% and the report outlined the Trust's final position in comparison with other Trusts in the region as well as against last years performance. Feedback received through the 'opt out' forms were then used to dispel some of the myths as part of targeted communications to staff to encourage take up. The planning process for the 2019/20 programme is underway with a number of actions to be implemented. ***The Board noted the review of the Healthcare flu vaccination programme and the lessons learnt.***	
BM 19-20/034	**Report of Trust Management Board** The Chief Executive provided a verbal report of the Trust Management Board (TMB) meeting on 24th April 2019 which covered: • Divisional Strategy Development updates • Quality & Performance Dashboard • NHSI – Infection Prevention & Control support visit • Month 12 finance report • Emergency department non-core spend update • Medical staff review • Medical Locum provision • Business case for Nephrology – Renal Dialysis, to be considered at Finance, Business, Performance & Assurance Committee. ***The Board noted the verbal report of the Trust Management Board.***	
BM 19-20/035	**Audit Committee** Non-Executive Director representatives provided a brief overview of items covered at the Audit Committee on 17th April 2019 as follows: • Head of Internal Audit opinion • Anti- Fraud Annual Report 2018/19 and work plan 2019/20 • Review of single tender waivers • License Compliance review • Going concern update ***The Board noted the verbal report of the Audit Committee.***	

Reference	Minute	Action
BM 19-20/036	**Report of Programme Board** Steve Sewell, Delivery Director apprised the Board of that Programme Board objectives have been reviewed and reset in line with the priorities for the Trust ie Patient Flow, Outpatients and Perioperative medicine improvement. The Board requested Mr Sewell to provide a detailed update regarding the Outpatients work stream following the recent workshop held to further develop and innovate clinically led approach to outpatients. 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. 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 17th April 2019. He explained that the report has been reframed to focus on the three priority projects whilst providing an overview of the other twelve projects. A summary of each of the 3 priority projects was provided and highlighted key issues and progress, this was followed by the trends of assurance ratings for governance and delivery. ***The Board noted the Programme Delivery and Change Programme assurance reports.***	
BM 19-20/037	**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 confirmed that following the 'confirm and challenge' meetings held in early April there are two actions which have been 'red rated' and one 'amber rated' which concern patient flow management, ED assessment protocols and medicines storage. Updates for these actions were provide as follows: • Patient flow management - as the improvement controls has not had the desired impact alternative proposals are being considered by the Patient Flow Improvement Group. • Medicines storage – following implementation of plans identified this action is expected to be 'green' at the next cycle of meetings. • ED assessment protocols – trial of separation of process for triage and assessment launched. ***The Board noted the progress to date of the CQC Action Plan.***	
BM 19-20/038	**Board Assurance Framework 2019/20** The Director of Quality & Governance provided the Board Assurance Framework 2019/20. 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.	

Reference	Minute	Action
	The Board formally noted the 2019/20 Board Assurance Framework approved by the Board of Directors at a development session held on 3rd April 2019.	
BM 19-20/039	**Any Other Business** The Chair provided a summary of the actions identified during the meeting.	
BM 19-20/040	**Date of next Meeting** Wednesday 5th June 2019.	

……..……

Chair

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Date

Board of Directors Action Log
Updated – 1st May 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 01.05.19						
1	BM 19-20/027	Outcome of review of NHS Improvement Licence Undertakings to be reported to Board	**KE/AM/ AL**	Discussions ongoing, draft response being prepared	July '19	Timeframe to be determined by NHSI
2	BM 19-20/028	Patient Experience Strategy under development	**GW**	Draft for discussion at Patient Family Experience Group	July '19	
3	BM 19-20/030	Business case for external management attendance solution to be presented to FBPAC	**HM**		June '19	Approved at FBPAC 24.5.19 – see agenda item 9.2
		Review of Infection Prevention Control basic's to be undertaken	**GW**	Detailed Executive review based on basics, better, best criteria to agree Trust wide approach	July '19	
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**		June '19	See agenda item 8.1.1

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	5 June 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 May 2019.

Serious Incidents

In May 2019 there was one incident that crossed the threshold for reporting as a serious incident. The incident concerns a problem with a Patient follow-up. Duty of candour has been completed and a full investigation is underway.

ECIST / Front Door Redesign

The Health economy has now had four separate reports, the most recent being from Emergency Care Intensive Support Team (ECIST), it concerns over the confusing service around the "front door" of the Emergency Department, particularly the streaming to the adjacent walk in facility. This is a contributing factor of ED overcrowding, poor ambulance handover times and the routine use of corridor care. The economy led by the Trust is moving towards a more streamlined process at the front door which will align triage, pathways and increase volumes by a move to more major illness and minor injury service.

Whilst this redesign is underway the Trust from the 29th April has extended the footprint of the ED by an additional 12 spaces, whose use is deployed flexibly based on demand, and for patients who have been stabilised and are awaiting transfer to an assessment area or ward. This additional capacity has been highly effective and has improved ambulance handover times to some of the best in the North West, improved A&E 4 hour standard during the month of May and almost eliminated the use of corridors for care when pressures are extreme. These measured improvement are highly beneficial for patients and the staff in ED are reporting much higher levels of morale and improved working arrangements.

Carter at Scale

Cheshire & Mersey Health & Care Partnership are undertaking a review of Corporate Services under the banner of 'Carter@Scale'. An independent review has identified c£30m opportunities across the region over the next 5 years. Areas of opportunity include Procurement, Finance, Payroll, HR, Legal and IM&T. The work plan has been agreed and Outline and Full Business Cases will be developed where required, these will be presented for approval by the Carter@Scale Board and the Chief Executive Group this year. The Trust is now fully engaged in the oversight of the work streams and whilst no financial benefit has been assumed in 2019/20, any benefit would support the Trust financial position.

RCN Visit

On 22nd May, we gave a warm welcome to the Chair of Royal College of Midwives, Gill Walton. She joined in celebrations at the Seacombe Birth Centre for its first year anniversary. Helen Marks attended this event on behalf of the hospital Trust Board. Gill was also given a tour of Women and Children's at the Trust.

At the same time the Chief Nurse also welcomed Anne-Marie Rafferty, the Royal College of Nursing President to promote how digital technology has supported safe patient care within the Trust.

Annual Report & Accounts 'sign off'

Following approval by the Board of Directors at its meeting on 28th May 2019, the Annual Report and Accounts have been submitted to NHS Improvement in line with guidance. The report will be made available on the Trust website following review by Parliament.

A&E Board

Having previously agreed the Wirral A&E Delivery Board would lead the Health Economy Urgent Care Improvement Work, the Board reviewed the latest performance summary reflecting on an improving trajectory for both ambulance arrival to hand over and ambulance to clear standard. The current four hour performance standard had also improved since April.

Main focus and prioritization remains aligned to Admission Avoidance, from both an Acute setting and Community perspective, along with improving length of stay and a redesign of the Integrated Discharge Team. Early indications are that trials across two the Acute Wards are growing momentum with evidential improvements.

From a wider System perspective, Partners provided the Board with a number of updates including Primary Care colleagues who outlined the introduction Primary Care Networks, maximizing expertise and specialisation across groups of GP Practices.

From a Better Care fund perspective, and subject to formal sign off and ratification, the provision of additional funding to support Same Day Emergency Care, and acute frailty service development within the acute Setting, had been recommended.

Janelle Holmes
Chief Executive
June 2019

Wirral University Teaching Hospital
NHS Foundation Trust

Six Monthly Chief Nurse

Safe Staffing Report

Board of Directors	
Agenda Item	7.2
Title of Report	Chief Nurse six monthly safe staffing report
Date of Meeting	5 June 2019
Author	Gaynor Westray- Chief Nurse Tracy Fennell, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst
Accountable Executive	Gaynor Westray, Chief Nurse
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,3,5
Level of Assurance • **Positive** • **Gap(s)**	Positive • The Trust has had an external review of processes and assurances relating to safe staffing. The initial draft report that will be presented to Audit committee reports WUTH has having 'substantial assurance' with safe staffing requirements (MIAA April 2019). • The Trust has met the requirements for safe staffing set out by National Quality Board. • The Trusts Safe Staffing / Workforce / OD action plan remains on plan, no areas are highlighted as red. Gaps • The Trust currently does not have technology solutions to support live time deployment of staff to patient need
Purpose of the Paper	For Noting
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

1. Executive Summary

The purpose of this report is to update the Board of Directors on the output of the six month safe staffing review for period Q3 and Q4 2018/2019.

The report adheres to the recommendations set out by the National Quality Board paper in 2016 *How to ensure the right people, with the right skills, are in the right place at the right time*. The report also complies with the Trusts need to meet the requirements outlined by NHS Improvements '*Developing Workforce Safeguards'* guidance published in October 2018. This includes the triangulation of Care Hours per Patient Day (CHPPD) with quality metrics to identify any risks where staffing levels may have impacted on care.

The report also provides an update to the Board of Directors on the recently concluded review undertaken by Mersey internal Audit agency (MIAA) relating to safe staffing systems, processes and assurances with Wirral University Hospitals (WUTH). The final report is due to be presented to audit committee but the preliminary outcome has been rated by MIAA as having 'substantial assurance'.

2. Background

The Board of Directors should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Safe staffing is a fundamental part of good quality care and the CQC will, therefore, always include a focus on staffing in the inspection frameworks for NHS provider organisations. It is critical that Boards review workforce metrics, indicators of quality, outcomes and measures of productivity as a whole and not in isolation from each other and that there is evidence of continuous improvements across all of these areas. A full ward establishment review was undertaken in October 2018. The Board approved the recommendations of that review to ensure the provision of a safe staffing standard across all in patient wards.

3. Reporting

A comprehensive workforce report is presented quarterly to the Workforce Assurance Committee. In addition a gap analysis and associated action plan against NHSI '*Developing Workforce Safeguards'* (October 2018) was presented to Patient Safety Quality Board (PSQB) in December 2018. The gap analysis actions are now included in the overall workforce action plan which is monitored quarterly via Workforce Assurance Committee. The current workforce action plan remains on plan with no actions reported as red. A quarterly PSQB 'Open and Honest' report provides quality assurance in relation to the planned versus actual nurse and midwifery staffing, triangulated with patient experience and safety indicators. This report provides the opportunity to identify any areas of concern and articulate improvements to ensure patient safety and experience is maintained with escalation to Quality and Safety Committee as required.

4. Care Hours per Patient Day (CHPPD)

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review described a new nursing workforce metric to be used Care Hours per Patient Day (CHPPD) along with a model hospital dashboard. Recommendations indicate that CHPPD should between 6-10 and be paramount within staffing reports to provide a consistent measure for monitoring and benchmarking. The latest available CHPPD data in the Model Hospital Portal is December 2018.

WUTH Total (Dec 2018)	Peers	National
7	8	8

A monthly review of CHPPD is undertaken of the 38 reportable inpatient wards. This review includes wards highlighted where the threshold of Registered Nurse to Clinical Support Worker ratio is below 60:40

Number of wards identified with RN:CSW ratio below 60:40		
Jan 2019	Feb 2019	Mar 2019
11 wards	8 wards	13 wards

The Trust is required to report actual staffing levels in the CHPPD safe staffing report to NHSI/NHSE. The monthly individual ward reviews with the Divisional Directors of Nursing and Corporate Nursing team includes the assessment of the bed occupancy, acuity and dependency including any risk factors e.g. safeguarding concerns, clinical incidents including falls and pressure ulcers. The skill mix and competencies of available staff are also taken into consideration. Of the wards reporting a reduced ratio this has been confirmed as a result of either the intentional increase in CSW to support therapeutic observation of vulnerable patients and intentional grade change to utilise the nursing associate workforce. All actions taken are recorded on the daily safe staffing operational tool reflecting professional judgement decisions taken by the Divisional senior nursing teams.

5. Vacancies

The NHS as a whole is struggling to recruit and retain Nursing and Midwifery staff, NHSI most recently published figures showed a National (England) vacancy rate of 11.80% for all Nursing and Midwifery staff. WUTH currently is performing better than the national average and it has an overall Nursing and Midwifery vacancy rate of 9.07%. Whilst this is better than the national average it still represents a considerable pressure for the Trust, particularly with band 5 registered nurses.

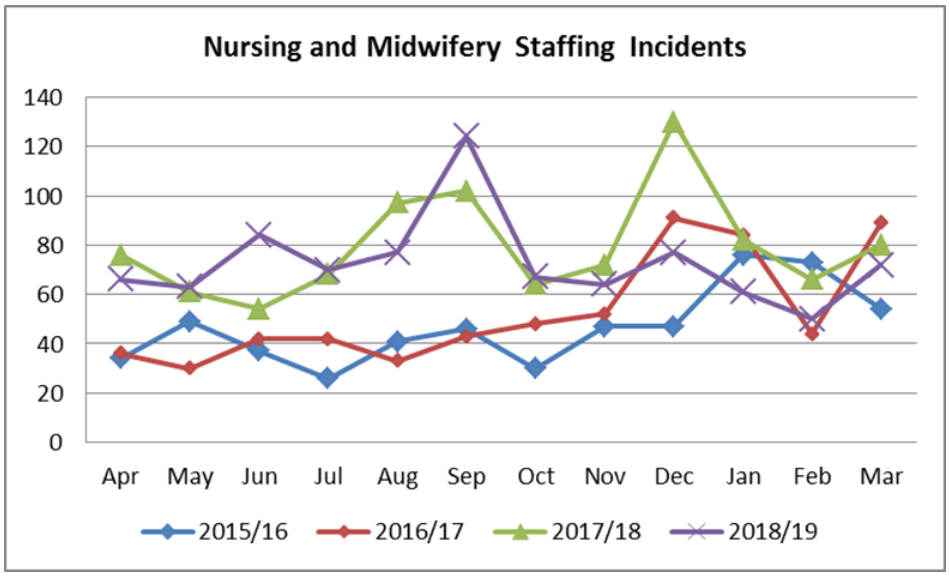
Nursing and Midwifery is the largest staff group in the Trust with the majority being band 5 registered nurses. WUTH is currently established for 913 WTE Band 5 Nursing and Midwifery Staff. As at 1 April 2019 the Trust has 149 WTE (16.06%) vacancies for Band 5 nurses. As highlighted in the table below the high number of vacancies 97.15 WTE is within the Medical and Acute division and specifically within the in-patient wards. Safe staffing levels are supported at ward level with the use of temporary workforce via NHSP to cover gaps in the rota.

Division	WTE Budgeted	WTE Actual	Vacancy WTE	Vacancy %
408 Clinical Support Div	73.54	55.69	17.85	24.27%
408 Corporate Support Div	2.00	0.91	1.09	54.67%
408 Medical and Acute Specialities Div	474.12	376.97	97.15	20.49%
408 Surgery Div	285.11	259.50	25.61	8.98%
408 Women and Children's Div	79.21	74.12	5.09	6.43%
Grand Total	913.98	767.19	146.79	16.06%

A continued recruitment and retention plan is supported by divisional colleagues supported by HROD.

6. Staffing Incidents

From November 2018 there has been a month on month reduction compared to same time period 2018/19 for reported incidents where staffing shortages has been escalated by employees at WUTH. Of the incidents reported there has been a thorough review by the Divisional Directors of Nursing and Deputy Director of Nursing confirming the wards remained safe within these periods. This is further demonstrated within the transparency tables in section 8 of this report. The two main reasons for reporting staffing incidents was the movement of staff from their base ward and the inability to take a break. Both issues are being reviewed by the divisions to ensure health and wellbeing of staff remains a Trust priority.



7. Technology

Since 2010, the Trust has utilised the Shelford Safe Staffing Acuity Tool to provide evidence based insight into staffing levels to help inform professional judgement. This paper based acuity audit is undertaken bi-annually over a 21 day period and results presented at Trust Board six monthly. The dependency tool also incorporates both ward specialty and ward layout factors within the review. These reviews are vital to inform the bi-annual establishment reviews however only provide a snap shot and are not able to support live time deployment of staff across the organisation based on patient need.

An options appraisal was presented to Wirral Digital Board in March 2019 that considered potential solutions to move the paper based Acuity and Dependency Tool to a live time technology solution. It was agreed an option will be presented at Trust Management Board May 2019 for further discussion and approval for funding from an existing budget within corporate nursing to purchase SafeCare. This technology is an addition to the current E-roster system. SafeCare will enable live time deployment of staff based on patient need and support live time validated metrics to inform forthcoming establishment reviews. KPI assurance reports have now been developed to ensure compliance with E-rostering policy and are being used to improve rostering practices and utilisation of resources.

8. Triangulation

NHSI 'Developing Workforce Safeguards' identifies the need to triangulate CHPPD with quality metrics to identify any risks where staffing levels may have impacted on care. As demonstrated below only two areas are noted as red (harms), these are relating to patients acquiring MRSA Bacteremia whilst in hospital. Review of these cases at the Executive Infection Control Panel noted staffing levels were not a factor in these cases. Women and Children's Division have flagged above trajectory due to four patient falls on ward 54 reported in October 2018. Each incident has been reviewed at the weekly harms review panel, and where required at the serious incident panel. The outcome of the reviews confirmed that staffing was not an influencing factor and appropriate mitigation including the use of temporary workforce, organisation of clinical care e.g. bay tagging was in place.

Trust Level Data	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care hours per patient day (CHPPD)	≥6.1	6.9	7.1	7	7.3	7.2	7.2
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	≤0.24 per 1000 Bed Days	0.13	0.04	0.13	0.17	0.14	0.13
Harm Free Care Score (Safety Thermometer)	≥95%	97.0%	95.9%	95.3%	95.5%	97.1%	96.6%
Serious Incidents declared	≤4 per month	3	2	4	2	4	2
Never Events	0	0	0	0	0	0	0
MRSA bacteraemia - hospital acquired	0	0	1	0	0	0	2
FFT Recommend Rate: Inpatients	≥95%	98%	98%	98%	98%	97%	97%
Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	TBC	119	165	118	178	153	157
Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	TBC	19	13	13	27	28	17

Medical Division	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care hours per patient day (CHPPD)	≥6.1				6.6	6.7	6.7
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	≤0.24 per 1000 Bed Days	0.06	0.07	0.20	0.19	0.21	0.20
Serious Incidents declared	≤4 per month	No data	2	1	2	2	1
Never Events	0	0	0	0	0	0	0
MRSA bacteraemia - hospital acquired	0	0	1	0	0	0	1
FFT Recommend Rate: Inpatients	≥95%	98%	98%	98%	98%	97%	97%
Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	TBC	40	62	35	78	59	62
Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	TBC	12	8	7	18	11	11

Surgical Division	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care hours per patient day (CHPPD)	≥6.1				7.4	7.5	7.3
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	≤0.24 per 1000 Bed Days	0.19	0.00	0.00	0.18	0.00	0.00
Serious Incidents declared	≤4 per month	No data	0	0	0	1	0
Never Events	0	0	0	0	0	0	0
MRSA bacteraemia - hospital acquired	0	0	0	0	0	0	1
FFT Recommend Rate: Inpatients	≥95%	98%	97%	97%	98%	97%	96%
Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	TBC	39	64	38	57	36	51
Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	TBC	4	3	4	4	7	6

Women's and childrens	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care hours per patient day (CHPPD)	≥6.1				11.9	11.2	12.7
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses (*)	≤0.24 per 1000 Bed Days	0.49	0.00	0.00	0.00	0.00	0.00
Serious Incidents declared	≤4 per month	No data	0	2	0	1	0
Never Events	0	0	0	0	0	0	0
MRSA bacteraemia - hospital acquired	0	0	0	0	0	0	0
FFT Recommend Rate: Inpatients	≥95%	93%	100%	99%	98%	97%	98%
Patient Experience: Number of concerns received in month - Level 1 (informal) (**)	TBC	17	15	19	20	20	20
Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) (**)	TBC	1	1	3	2	7	1

9. Safe Staffing Review March 2019

The staffing reviews have continued with the systematic approach that allows a greater level of triangulation and scrutiny. This review remains in line with NHSI guidance incorporating the following metrics.

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

The minimum safe staffing standards set out by the Chief Nurse in relation to staffing requirements across the organisation reported to Trust Board December 2018 remain unchanged. A small number of minor changes have been agreed and signed off by the Chief Nurse these changes remain cost neutral from previous establishments.

The latest review does not include areas such as Operating Theatres, Day Case areas and Endoscopy. A non-ward based review is planned for Q1 and Q2 2019/20.

The Emergency Department also had not undertaken a recent establishment review due to the unavailability of the Baseline Emergency Staffing Tool (BEST) as a result of a national review of the Acuity and Dependency tool. This has now been concluded and the assessment tool has been made available. A review has now been planned to commence in Q1 2019.

10. Mersey Internal Audit Agency external review

A review was concluded by MIAA in accordance with the requirements of the 2018/19 Internal Audit Plan, as approved by the Audit Committee 2018. The final report is due to be presented to Audit Committee but the preliminary outcome has been rated by MIAA as having 'substantial assurance'. The review undertook a deep dive in to the following areas:

Expectation 1: Right Staff

- A transparent governance structure including ward to board reporting of staffing requirements should be in place for determining staffing numbers and skill mix.
- Expected/actual staffing levels are reported monthly and compared with ward and organisational quality metrics.

Expectation 2: Right Skills

- Clinical leaders and managers should be supported to provide high quality, efficient services and staffing should reflect a multi-disciplinary approach. Recruitment and Retention strategies and plans are in place and effectively utilised.

Expectation 3: Right Place and Time

- Effective reporting, collating, monitoring and escalation tools should be utilised to inform decisions on safe staffing.

11. Conclusion

The Trust recognises it has experienced high level of operational pressure over the previous six months. Despite this the Trust has maintained safe staffing throughout and has continued to monitor a series of metrics to ensure patient safety is not compromised.

Where risk factors have been identified mitigations and safe staffing escalation protocols have been followed to ensure patient areas remain safe. The paper concludes the Trust has met its safe staffing requirements for this period.

12. Recommendations

The Board of Directors to receive the Care Hours Per Patient Day (CHPPD) data, and assurance related to nurse staffing for in-patient wards, as per national directives, noting actions being taken to ensure patient safety and quality of care are maintained. Also to receive assurance that the Trust has effective measures in place to effectively report, monitor and escalate staffing levels and uses effective escalation tools to inform decisions on safe staffing.

Board of Directors	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	5th June 2019
Author	WUTH Information Team and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

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

- 26 are currently off-target or failing to meet performance thresholds
- 25 of the indicators are on-target

As this is reporting the first month of the new financial year, some metrics and thresholds have been updated, and the YTD values recalibrated. Details of specific changes to metrics are listed at the foot of the dashboard.

The Trust does not yet have confirmation of a new target / threshold for this year for e coli cases and NIHR recruitment, so currently April is shown as Red against the 2018/19 monthly threshold.

For the Hand Hygiene metric, data from the Perfect Ward application is now being used for February 2019 figures onwards.

Appendix 2 provides the quarterly report detailing the indicators that have been 'Red' for the preceding six months requiring a brief description of the **I**ssue, the **D**ecision and remedial **A**ction (IDA).

4. Next Steps

WUTH remains committed to attaining standards through 2019-20.

5. Conclusion

Performance against many of the indicators is not where the Trust needs to be. The 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 performance against the indicators to the end of April 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

May 2019

	Indicator	Objective	Director	Threshold	Set by	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019/20	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	DoN	≤0.24 per 1000 Bed Days	WUTH	0.27	0.17	0.27	0.22	0.18	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.18	0.18	
	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%	96.2%	96.2%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital	Safe, high quality care	MD	≥95%	SOF	95.3%	95.3%	94.7%	95.3%	95.0%	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	96.4%	96.4%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.4%	96.5%	96.5%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	6	14	13	3	2	1	3	2	4	2	4	2	1	1	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	0	1	5	1	0	0	0	0	0	1	0	0	0	0	
	Clostridium Difficile (healthcare associated) (*)	Safe, high quality care	DoN	≤88 for FY19-20, as per mthly trajectory	SOF	4	1	3	1	3	0	3	4	2	7	10	5	19	19	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	4	2	6	7	2	3	5	4	2	3	4	2	5	5	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	11	14	17	18	18	15	13	23	9	10	6	5	12	12	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	0	0	0	0	1	0	0	0	2	0	0	
	Hand Hygiene Compliance (*)	Safe, high quality care	DoN	≥95%	WUTH	95.0%	97%	88%	89%	90%	81%	87.0%	85.0%	76.0%	83.0%	99.0%	99.0%	98.0%	98.0%	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	DoN	≥90%	WUTH											98%	99%	99%	99%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥90%	WUTH	89.2%	–	–	87.4%	–	85.6%	90.4%	91.5%	91.4%	91.6%	92.8%	93.9%	93.6%	93.6%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥90%	WUTH	84.8%	–	–	82.7%	–	82.2%	86.0%	87.2%	87.1%	87.6%	88.7%	90.7%	90.9%	90.9%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥90%	WUTH	85.6%	–	–	85.6%	–	86.5%	87.2%	91.7%	91.4%	93.6%	92.6%	93.5%	91.4%	91.4%	
	Attendance % (12-month rolling average) (*)	Safe, high quality care	DHR	≥95%	SOF	95.22%	95.18%	95.16%	95.13%	95.13%	95.09%	95.06%	95.07%	95.06%	95.05%	94.98%	94.90%	94.81%	94.81%	
	Staff turnover (*)	Safe, high quality care	DHR	≤10%	WUTH	9.8%	10.1%	9.7%	10.4%	9.9%	9.9%	10.0%	9.7%	9.6%	9.7%	9.7%	9.8%	10.0%	10.0%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	Between 6 and 10	WUTH	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	7.0	7.3	7.2	7.2	7.2	7.20	

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Quality Performance Dashboard

May 2019

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Effective	SHMI	Safe, high quality care	MD	≤100	SOF	–	–	97.06	–	–	97.22	–	–	–	–	–	–	–	97.22	
	HSMR	Safe, high quality care	MD	≤100	SOF	88.7	93.0	93.0	95	95	92	92	97	97	98	–	–	–	97	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	–	–	–	–	–	86%	71%	52%	33%	33%	
	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%	92.0%	92.0%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	17.1%	17.1%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	418	405	409	386	387	411	409	408	397	437	457	438	421	421	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.8	3.0	4.4	4.4	4.9	4.9	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.8	5.8	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	886	923	873	913	961	888	936	925	917	903	788	914	871	871	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	13	12	13	13	6	18	12	17	14	10	16	14	11	11	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	89.5%	89.5%	

Quality Performance Dashboard

May 2019

	Indicator	Objective	Director	Threshold	Set by	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	18	22	10	8	16	14	19	18	15	20	14	13	13	13	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	85%	90%	91%	89%	89%	86%	87%	84%	92%	85%	87%	87%	87%	87%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	13%	9%	8%	11%	12%	11%	10%	11%	10%	11%	11%	13%	9%	9%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	97%	98%	98%	98%	97%	98%	98%	98%	98%	97%	97%	98%	98%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	15%	15%	20%	25%	14%	22%	24%	18%	18%	19%	15%	13%	19%	19%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	95%	95%	94%	95%	94%	94%	94%	95%	94%	95%	94%	95%	94%	94%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	97%	97%	99%	96%	100%	100%	96%	100%	100%	99%	98%	96%	94%	94%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	31%	54%	46%	37%	17%	28%	11%	19%	37%	27%	36%	44%	25%	25%	

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Quality Performance Dashboard

May 2019

	Indicator	Objective	Director	Threshold	Set by	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019/20	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2019/20	SOF	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	73.6%	73.6%	
	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	2	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	414	327	291	213	326	474	371	440	393	379	323	273	437	437	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% through 2019/20	SOF	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	79.04%	79.04%	
	Referral to Treatment - total open pathway waiting list (*)	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	25,454	26,648	26,957	26,836	27,308	26,556	26,862	27,367	26,157	27,506	28,367	27,309	26,223	26,223	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019/20	National	66	67	79	57	56	40	43	30	28	28	19	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	99.5%	99.5%	
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	91.9%	91.9%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	96.8%	96.5%	96.5%	
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	86.2%	85.4%	86.5%	85.8%	85.5%	85.5%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	DoN	TBC	WUTH	118	134	110	140	123	155	119	165	118	178	153	157	162	162	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	DoN	TBC	WUTH	34	23	36	24	25	22	19	13	13	27	28	17	17	17	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	≥90%	National	32%	81%	95%	72%	75%	80%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	2	2	7	5	0	4	2	3	2	2	1	3	4	4	

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Quality Performance Dashboard

May 2019

	Indicator	Objective	Director	Threshold	Set by	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019/20	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	-	-	-	-	-	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of patients recruited to NIHR research studies	Outstanding Patient Experience	MD	500 for FY19/20 (ave min 42 per month until year total achieved)	National	53	39	336	70	48	42	38	57	38	43	41	59	30	30	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	84.9%		81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.6%	85.7%	88.2%	77.6%	77.6%	

	Indicator	Objective	Director	Threshold	Set by	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2019/20	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-3.340	-3.340	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-0.237	-0.237	
	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	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-6.0%	-6.0%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-19.5%	-19.5%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-14.0	-14.0	
	Capital Programme		DoF	On Plan	WUTH	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	52.1%	52.1%	

(*) Updated Metrics

Safe : Clostridium Difficile

Safe : Hand Hygiene Compliance

Safe : Workforce metrics

Safe : Sickness Absence

Safe : Staff turnover

Responsive : Referral to Treatment - total open pathway waiting list

All : Year aggregation

(**) Updated Thresholds

Well-led : Number of patients recruited to NIHR research studies

Metric Change

National change of definition and new threshold : maximum 88 cases for full year 2019-20

The date source used has changed to the Perfect Ward with effect from February 2019

A number of metrics have been removed as they are monitored at the Workforce Assurance Committee

Now reported as attendance, with a minimum threshold of 95%

New metric - staff turnover, with a maximum threshold of 10%

New metric - NHSI objective to reduce below March 2018 position (24,736) by March 2020

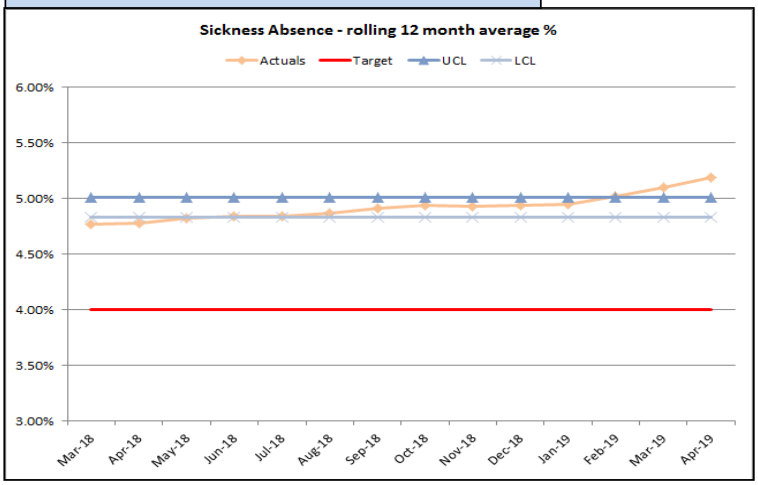
YTD performance now showing 2019-20 average or the most recent monthly position, as appropriate

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

Threshold Change

New threshold for 2019-20 set at a minimum 500 full year, or 42 per month until the total is achieved

Attendance % (12-month rolling average)



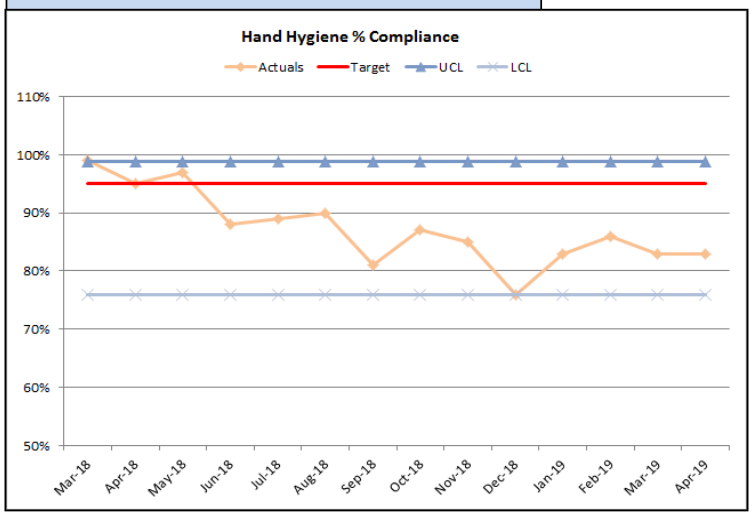
Executive Lead: Director of Workforce

Issue: The Trust has set an internal target of a minimum of 95%. The rate has been below this over the past 3 months with April 2019 being 94.8%

Decision: Current performance Inadequate. Strengthen controls.

Action: The First Care pilot to commence in August 2019 within Estates and Facilities (8% sickness absence). The new Attendance policy which, includes the introduction of the Bradford factor is being rolled out from 1st July 2019. A 12 month health and wellbeing plan has been developed and is being implemented to promote and support health and wellbeing.

Hand Hygiene Compliance



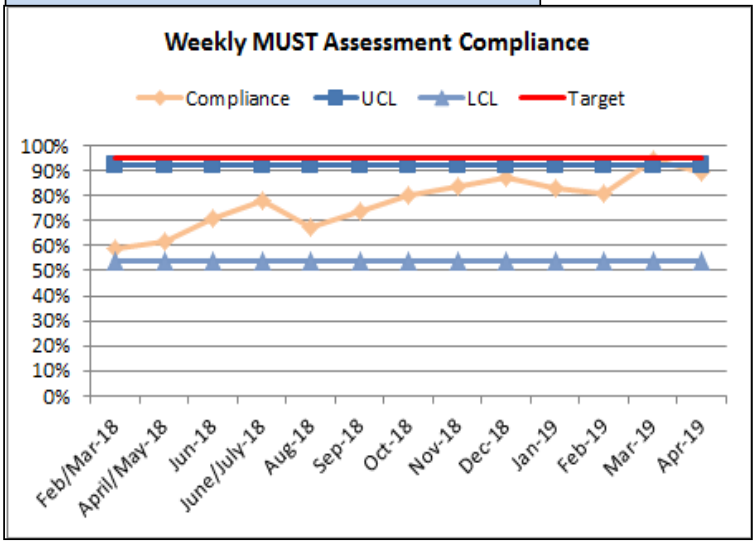
Executive Lead: Chief Nurse

Issue: The Trust hand hygiene compliance is set at a minimum of 95%. Performance has been below this in each of the last six months, with April 2019 performance at 83.0%

Decision: Current performance Inadequate. Strengthen controls.

Action: Hand Survey distributed to all staff. Hand hygiene and 'bare below elbow' standard shared across organisation. Compliance monitored via Perfect Ward App and observational audit

Nutrition and Hydration - MUST completed at 7 days



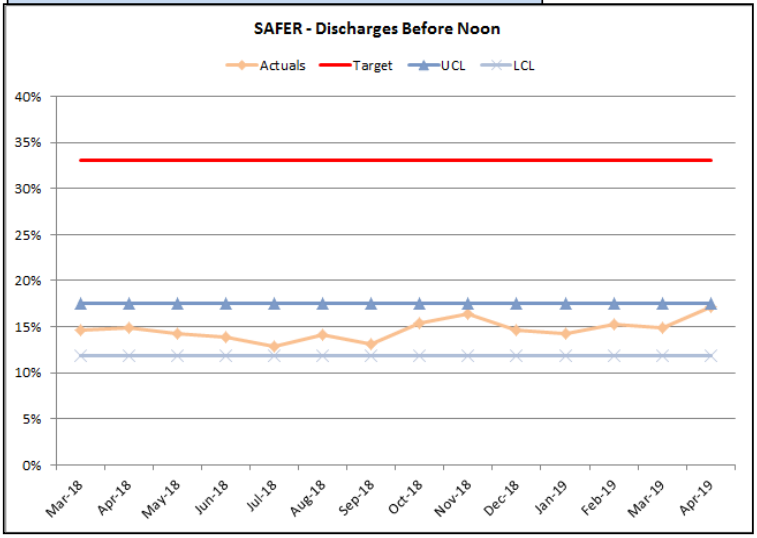
Executive Lead: Chief Nurse

Issue: The Trust has a target of a minimum 95.0%. The rate has been below this in each of the last six months, with April 2019 performance at 92%.

Decision: Current performance Inadequate. Strengthen controls.

Action: Quality Matron / ADN to review compliance on daily basis (Ward M page review).

SAFER BUNDLE: % of discharges taking place before noon



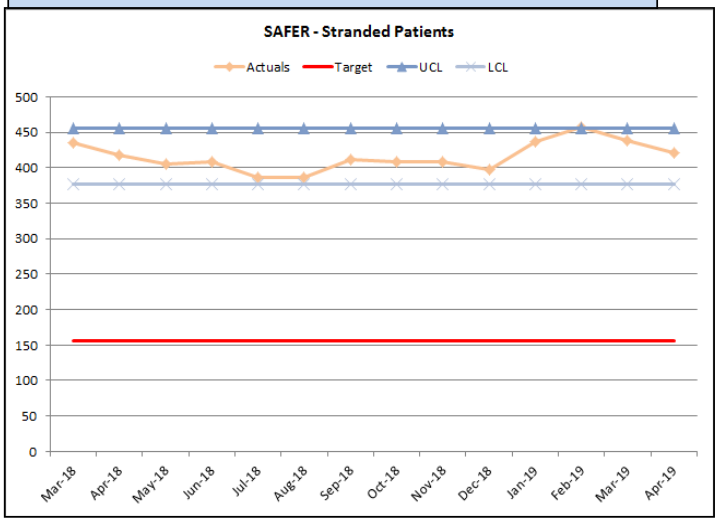
Executive Lead: Medical Director **/** Chief Operating Officer

Issue: The Trust has a target of a minimum 33%. The rate has been below this for each of the last 6 months, which impacts negatively on patient flow.

Decision: Current performance Inadequate. Strengthen controls.

Action: Matrons and Associate directors of nursing have maintained March trial to increase morning discharges.

SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual



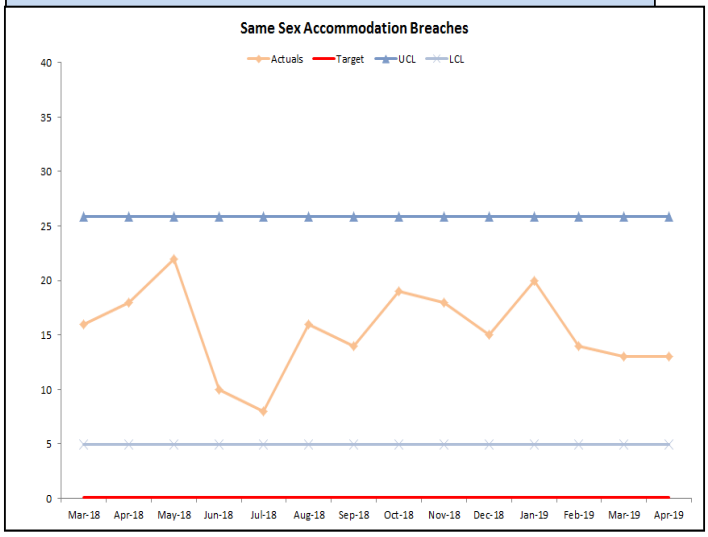
Executive Lead: Medical Director / Chief Operating Officer

Issue: The Trust has a target of a maximum 156 patients. The number has been significantly above this in each of the last 6 months, with April 2019 performance at 421.

Decision: Current performance Inadequate. Strengthen controls.

Action: Twice weekly system stranded reviews expanded to include escalation or outlier areas.

Same sex accommodation breaches



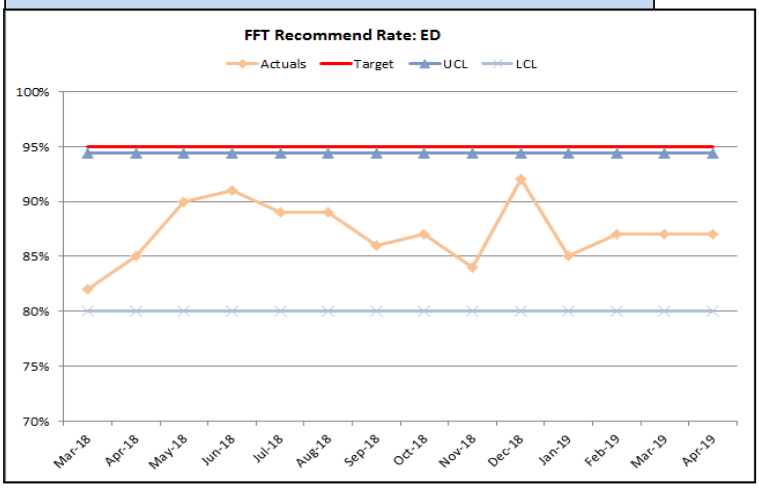
Executive Lead: Chief Nurse

Issue: The trust has a zero tolerance threshold for same sex accommodation breaches. The number has been above this in each of the last 6 months, with April 2019 performance at 13.

Decision: Current performance Inadequate. Strengthen controls.

Action: All breaches associated with critical care unit. Reviewed at all operational management / bed management meetings.

FFT Recommend Rate: ED



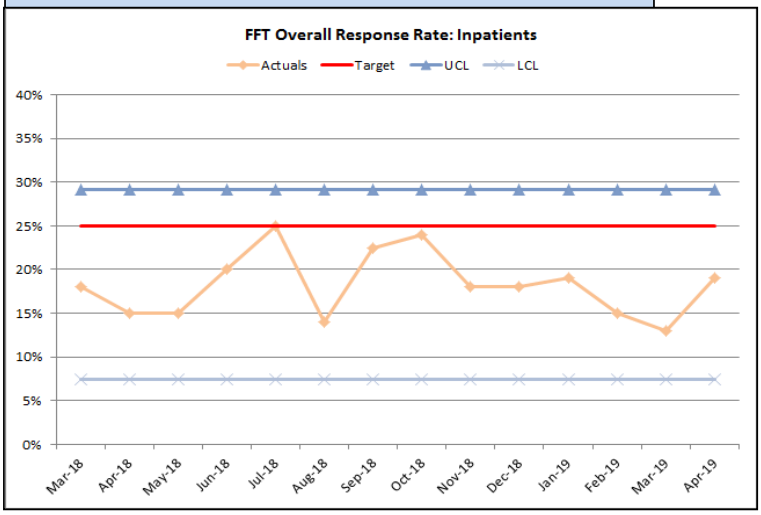
Executive Lead: Chief Nurse

Issue: The trust has a target rate of a minimum 95% recommend rate for FFT in ED. The rate has been below this in each of the last six months, with April 2019 performance at 87%.

Decision: Current performance Inadequate. Strengthen controls.

Action: Individual ward targets set to improve response rates and focus support from patient experience team.

FFT Overall Response Rate: Inpatients



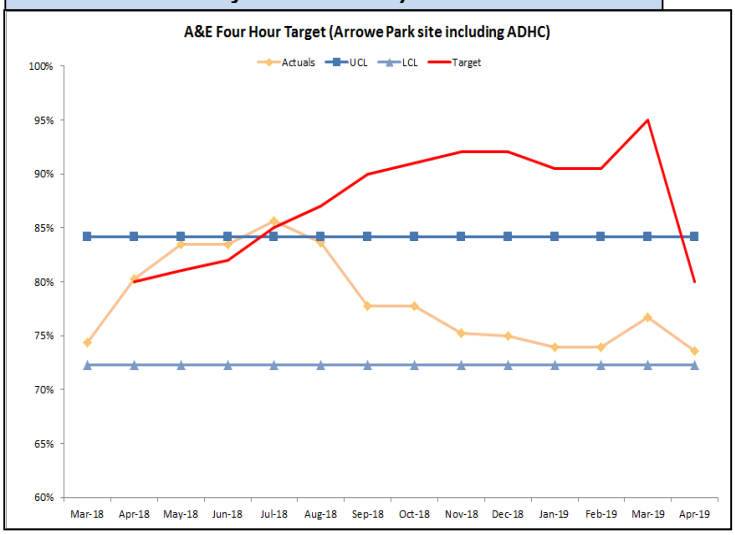
Executive Lead: Chief Nurse

Issue: The Trust has a target rate of a minimum 25% for overall FFT patient response in inpatients. The rate has been below this in each of the last six months, with April 2019 performance at 19%.

Decision: Current performance Inadequate. Strengthen controls.

Action: Individual ward targets set to improve response rate to 25%

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



Executive Lead: Chief Operating Officer

Issue: The Trust has a recovery trajectory agreed with NHSI for 2018-19 and for 2019-20 for the 4-hour Accident and Emergency target. Performance has been below this trajectory in each of the last six months, with April 2019 being at 73.6% against a trajectory target of 80%.

Decision: Current performance Inadequate - Strengthen controls

Action: Reverse cohort area established within ED footprint from the 29th April 2019.

Board of Directors	
Agenda Item	8.1.2
Title of Report	**Month 1 Finance Report**
Date of Meeting	5 June 2019
Author	Shahida Mohammed – Acting Deputy 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 1 Finance Report 2019/20

Contents

1. Executive summary

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

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

The following summary details the Trust's financial performance during April (Month 1).

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

On that basis for Mth 1 the Trust had planned a deficit of (£3.1m), actual performance was a deficit of (c£3.3m), an under delivery of (c£0.2m).

1.1 Key Headlines:

- Patient-related income is in line with plan. This reflects the application of local contract terms that support the Trust to deliver the control total. The overall Trust income position exceeds plan by c£0.2m.
- Pay costs exceeded plan by (£0.2m) mainly due to agency spend on Consultants and cover for Junior Medical vacancies. Non pay costs were higher than plan by (c£0.1m) this is largely driven by Clinical Supplies costs.
- Cash balances at the end of April were £5.5m which was £3.1m above plan. This is primarily due to controlled variances in the working capital cycle.
- The delivery of cost improvements is c£0.5m against a plan of £0.6m, being (£0.1m) under expectations.
- Capital spend during April was slightly behind plan (c£0.2m).
- The Trust delivered a UoR rating of 3 as planned.

2. Financial performance

2.1 Income and expenditure

Month 1 Financial performance	Annual Budget £'000	Current Period Budget £'000	Current Period Actual £'000	Current Period Variance £'000
NHS income from patient care activity	326,109	25,729	25,772	43
Non NHS income from patient care	3,382	265	313	48
Income - PSF/FRF	18,804	1,151	1,150	(1)
Other income	27,912	2,418	2,483	65
Total operating income before donated asset income	376,206	29,563	29,719	156
Employee expenses	(254,604)	(22,482)	(22,692)	(210)
Operating expenses	(108,399)	(9,100)	(9,224)	(124)
Total operating expenditure before depreciation and impairments	(363,003)	(31,582)	(31,916)	(334)
EBITDA	**13,203**	**(2,020)**	**(2,197)**	**(178)**
Depreciation and net impairment	(9,219)	(743)	(804)	(61)
Capital donations / grants income	0	0	0	0
Operating surplus / (deficit)	**3,984**	**(2,763)**	**(3,002)**	**(239)**
Net finance costs	(4,232)	(341)	(338)	3
Gains/(losses) on disposal	0	0	0	0
Actual surplus / (deficit)	**(249)**	**(3,104)**	**(3,340)**	**(236)**
Reverse capital donations / grants I&E impact	249	21	21	(0)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	**1**	**(3,083)**	**(3,319)**	**(236)**

- Although the overall position is marginally worse than plan, overall cost control and activity delivery across a number of Divisions has been demonstrated. This is supported by the weekly "scrutiny panels" lead by the HR & Finance Executive Directors, which are reviewing non-clinical vacancies, non-core spend, discretionary non pay spend, agency 'hotlist' and tracking CIP deliverables.
- The utilisation of agency medical staff and non-core WLI capacity to cover vacancies and gaps in junior medical rotas continues to present challenges, and is largely reflected in the pay overspend.
- High levels of qualified nurse vacancies continue which has resulted in use of bank nurses to maintain safe staffing levels across the wards, however, changes to the pay structure for bank nurses has reduced absolute cost compared to Q4. Vacancies remain in non-clinical areas and have supported non-recurrently the delivery of CIP.
- Non pay costs have broadly remained within budget with the exception of clinical supplies. This is currently being reviewed.

2. Financial performance

Items not included in the original Plan

- **Locum pay VAT**

The M1 pay position includes the continuing impact (c£0.1m) of the HMRC ruling (31 January 2019), in relation to the removal of VAT exemption for the supply of medical locums.
The Trust's HR team is currently engaging with the supplier to adopt an alternative model, which has been confirmed by HMRC as 'outside scope' for VAT, whereby locums pass through an outsourced payroll as employees. To mitigate the financial impact on the Trust, this transition must be implemented as soon as possible; this is estimated to be July 2019.

- **Depreciation**

There is a M1 pressure of (c£0.1m) in operating expenditure from additional depreciation charges which relate to changes in estimates of asset lives provided by the Trust's external valuer. These changes were mandated by amendments to valuation instructions issued by the Royal Institute of Chartered Surveyors (RICS) in February 2019.
Although this is a national issue, NHSI has maintained the view that this is a matter for individual trusts to manage and mitigate locally.

As discussed at March Committee, the additional costs (c£1.3m) are not included in plan.

2. Financial performance

2.2 Income

	Activity Current month			Income Current month		
	Plan	Actual	Variance	Plan £'000	Actual £'000	Variance £'000
Income from patient care activity						
Elective & Daycase	3,893	3,862	(31)	4,204	4,151	(53)
Elective excess bed days	257	246	(11)	70	61	(9)
Non-elective	3,708	3,751	43	8,616	8,614	(2)
Non-elective Non Emergency	375	415	40	818	922	104
Non-elective excess bed days	1,020	1,120	100	276	292	17
A&E	6,844	7,634	790	1,178	1,212	34
Outpatients	23,209	23,333	124	2,748	2,713	(35)
Diagnostic imaging	2,210	2,428	218	164	169	4
Maternity	448	504	56	421	435	14
Non PbR				6,163	6,128	(35)
HCD				1,228	1,227	(0)
CQUINs				186	186	0
Other				899	950	51
Total NHS patient care income	41,962	43,293	1,331	26,970	27,060	90
Other patient care income				56	72	16
Non-NHS: private patients & overseas				30	38	8
Injury cost recovery scheme				89	66	(23)
Total income from patient care activities				27,145	27,236	91
PSF/FRF				0	0	0
Other operating income				2,418	2,483	65
Total income				29,563	29,719	156

- The overall income position for month 1 is exceeding plan by c£0.2m, within this patient related income is balanced.
- Although Non-elective activity slightly exceeded plan from an activity perspective, the casemix was less complex. The elective performance is driven by an under performance in Colorectal and Upper GI. Although Urology delivered plan the casemix was less complex.
- In total Outpatients marginally exceeded plan, in-line with the contract agreement this has been balanced back to plan for WHCC.
- Births exceeded plan by 43, benefiting the position by c£0.1m
- Neonatal activity is based on a “block” for 2019/20, this has benefitted the position by c£0.1m.

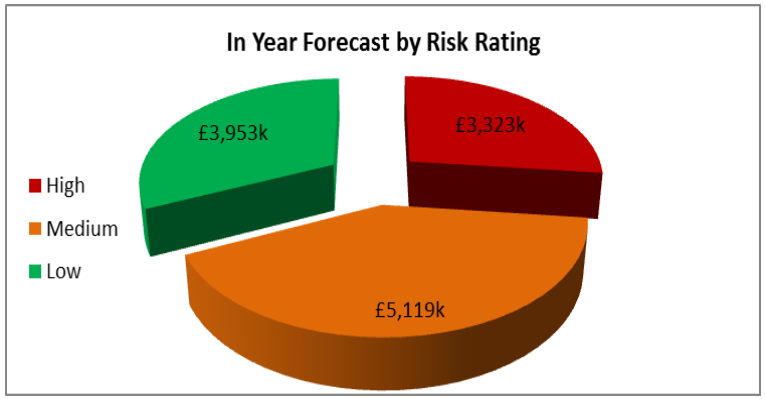
2. Financial performance

2.3 CIP Performance

April 2019	YTD		
Division	NHSI Plan £k	Actual £k	Variance £k
Medical And Acute	183	189	**6**
Surgery	187	112	**(75)**
Womens & Children	31	20	**(11)**
Clinical Support	45	49	**4**
Corporate Services	153	169	**15**
Total	**599**	**539**	**(60)**

- In Month 1 the CIP delivery is marginally below plan as detailed in the table above.
- The key variances reflect productivity gains expected from the perioperative / theatre productivity programme and identification of digitally enabled savings. Improvements in the theatre programme are expected in May and scoping is underway on the digital programme.
- The business as usual (BAU) schemes from the divisions are well under way and any gaps have been largely mitigated.

The chart below shows the current status of the risk rating of the delivery of the CIP target



- The weekly scrutiny panel is tracking progress of the delivery of the plans and assessing any risks.
- Compared to 2018/19, significant progress has been made in 2019/20, as only £0.8m is unidentified at Month 1, this was £4.0m in the previous year.
- Although delivering the 3.5% target is a challenge, there is active engagement across the Divisions

3. Use of resources

3.1 Single oversight framework

UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-23.0	4	-23.0	4	-30.4	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-5.7	4	-1.1	4	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-10.4%	4	-11.2%	4	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-0.8%	2	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	0.0%	1	19.5%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has overspent against the agency cap, this reflects the VAT implication of the HMRC ruling (31 January 2019), in relation to the removal of VAT exemption for the supply of medical locums. The Trust is working with the supply to adopt an alternative model to mitigate this.
- The *Distance from financial plan* metric is currently below plan as a result of the year to date EBITDA position
- The month 1 UoR rating is 3 overall, which matches the 2019/20 plan UoR rating of 3.

4. Risk & Mitigations

Risk 1 - Operational Management of the position to deliver a "break-even" position

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

Risk 2 – CIP Performance

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

Risk 3 – Cash

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

Risk 4 – Capital Expenditure

- Delays to the delivery of detailed capital plans present risks of potential capital underspend at year end. The capital position is actively managed through monthly divisional performance meetings and via the Finance and Performance Group.
- NHSI has recently indicated that planned capital spend at a national level is too high. They have asked Trusts to review plans and reduce if possible. The Trust has not altered its plan on the basis of necessity.

Conclusion

Although the Trust did not deliver the financial plan for April, the Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan.

Exceptional items such as the impact of VAT on medical locums have impacted the position; however plans are in place to mitigate this from July 2019.

The Trust continues to face operational challenges, mainly in relation to the recruitment of key medical posts and resourcing capacity to maintain flow. The 19/20 plan is also supported by positive contractual agreements reached with both Wirral CCG and NHS England – Specialised Commissioning. The agreements reflect overall "system support" to ensure the Trust is able to deliver the control total and access the central funding.

The cost improvement plan for 19/20 is £13.2m, although this is challenging, the Trust has set up weekly internal monitoring to maintain focus and pace in delivery, the month 1 position was broadly delivered and plans are progressing through the various CIP milestones. These meetings are chaired by the Chief Executive.

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

Karen Edge
Acting Director of Finance
May 2019

Board of Directors

Subject:	Item 9.1 Proceedings of the Quality Committee	**Date:** 5.6.2019	
Prepared By:	Dr J Coakley, Non-Executive Director		
Approved By:	Dr J Coakley, Non-Executive Director		
Presented By:	Dr J Coakley, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues				
Indicate the risks or issues created or mitigated through the report				

Financial	**None identified**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care:** • **Exposure to infection and infection control indicators including hand hygiene (beyond trajectory level for C.diff)** • **Nursing vacancy rates (remain high)** • **Quality dashboard improving but not yet completely reassuring** • **CQC plan on track** • **Resuscitation and other mandatory training**
Staff Impact	**Staff vacancy, attendance management and completion of mandatory training requirements represent a risk to workforce effectiveness**
Services	**None identified**
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.** **CQC Insight Tool improved – still some gaps**

Committees/groups where this item has been presented before

N/A

Executive Summary

Executive Summary

- The Quality Committee met on 24/05/2019. This paper summarises the proceedings.

Serious Incidents & Duty of Candour

- The Committee reviewed two recent investigations.
- One was a patient who acquired C. difficile infection. Contributing factors included antibiotic usage, high bed occupancy, the lack of a 'decant' ward, staff shortages and inadequate cleaning. It is not clear to what extent failure fully to discuss antibiotic regimens with microbiology contributed.
- The second was a patient who presented with an intracranial bleed who was inadvertently prescribed anticoagulants. The anticoagulant was prescribed before the result of the CT scan was known with an instruction to review the need for the anticoagulant after the CT scan result. This message was not acted upon after handover from physicians to surgeons. Unfortunately the nurse administering the drug failed to appreciate the significance of the bleed.
- A tracker has been introduced which demonstrates underlying themes of serious incidents (eg falls, complications, HAI and so on).

Update on CNST Maternity Incentive Scheme

- This was discussed and progress noted against the requirement to participate in the National Perinatal Mortality Review Tool.

Nutrition & Hydration Report

- After deterioration in performance of MUST assessments earlier this year, performance has improved. The figure for March was 94%, just below 95% target.

Draft Quality Account

- This was reviewed, discussed and approved**.**

Mandatory training

- The Committee noted that compliance with life support training had improved, although was not yet at required levels. This led to a discussion about mandatory training (eg for blood transfusion) in general, and how we measure the outcome of the training as well as compliance.

Infection Prevention and Control Report

- We continue to experience challenges with another outbreak of a particularly refractory strain of Clostridium *difficile*.
- The Committee noted the Trust is in receipt of support from Public Health England and NHSI in addressing the specific infection prevention challenges. The Committee remains concerned at the current trajectory, well above that expected.
- Regulatory bodies will doubtless be aware of these challenges and may seek answers and assurance.

CQC Action Plan Report

- The Committee took account of the progress report and are satisfied. The two areas of concern relate to patient flow throughout the hospital and initial assessment within 15 minutes of arrival in the ED. The CQC report was discussed.

Overall Quality Performance

- The Committee reviewed performance for those KPIs in the safe, effective and caring domains. It was acknowledged that further progress is needed to achieve the standards required by the Board of Directors. The Trust is moving steadily in the right direction.

Wirral Individualised Safe-Care Everytime (WISE, Ward Accreditation)

- The Committee were updated on the roll out of the Perfect Ward application to additional ward areas. Consideration is being given to extending monitoring to other non-ward areas such as out-patients and operating theatres. This will require some modification of the app.

Summarised and drafted by the Quality Committee Chair by:
John Coakley
29th May 2019

BOARD OF DIRECTORS	
Agenda Item	9.2
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	5 June 2019
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee 24th May 2019

This report provides a summary of the work of the FBPAC which met on the 24th May 2019. Key focus areas are those which address the gaps in assurance in the Board Assurance Framework and areas of development work to bring to the attention of the Board of Directors.

1. BAF

The Committee reviewed the primary risk scenarios of the BAF for which it has delegated responsibility from the Board. It noted the changes to risks, assurances and controls proposed by the Acting Director or Finance and Chief Operating Officer and these were agreed.

The assurance ratings based on the identified risks were considered by the Chair following the discussion in the meeting to be:

- PR 1 Consistently deliver financial sustainability and performance standards - Green following review of the controls and sources of assurance
- PR 3 Financial sustainability: Amber as a result of being slightly off plan at Month 1 with some CIP as yet unidentified and some emerging pressures in relation to health and safety, ward 1 and ED staffing, consultancy costs, VAT on locums and depreciation. Mitigation identified included review of ED staffing, review of junior medical rotas, new arrangements for procuring locums and savings from sickness costs arising from the Firstcare pilot although these needed to be worked through in more detail.
- PR 5 Major disruptive incident: Green following review of the controls and sources of assurance

2. Month 1 Finance Report

The committee received the Month 1 Finance report. The key points noted were the year to date deficit of (£3.3m), this being (£0.2m) worse than plan. The adverse performance against plan has been driven primarily by the costs of covering higher than expected consultant and junior doctor vacancies and the VAT impact of the medical locum supply. Of note, there has been a significant improvement in the run rate of nursing pay costs and Divisional cost control and budget performance. Income performance is balanced to plan and some under-performance in elective activity has been offset by higher birth income. In addition, higher than planned depreciation charges are being incurred following the change in the RICS guidance which was not included in the Trust submitted plan but the risk of which was noted at the previous committee.

The Trust delivered £0.5m against a plan of £0.6m CIP for Month 1. Significant progress was noted against the Trust target of £13.2m with £12.4m of schemes identified.

Cash at £5.5m was favourable to plan. The capital spend year to date totalled £0.2m with a forecast of £9.5m against a resource available of £10.5m; the submitted plan to NHSI, prior to the revaluation of the Trust estate and resultant impact on depreciation being £9.1m. The central capital team are imposing controls on capital expenditure such that the current view is the Trust will not be able to increase its capital plan for 2019-20 despite resource being available.

3. Service Line Reporting Q4 2018-19

The Acting Deputy Director of Finance presented the committee with the 2018-19 SLR position noting the relative contribution and surplus/deficit position by POD, Division and specialty. It was recognised that the change in the financial architecture in 2019-20 would impact on the overall Trust position and would potentially present a different view of the risk areas. However, the benefits of SLR reviews were noted with the recent Critical Care review presenting new insights and a comprehensive workplan is underway with improved clinical engagement. The Acting Deputy Director of Finance also gave an update on the Corporate benchmarking that the Trust has contributed to at a HCP level and that once analysis was completed further updates would be provided on opportunities identified on cost reduction locally and regionally.

4. Reference Cost Approval Process 2018-19

The Committee received a report on the changes to the Reference cost submission for 2019-20, being based on new guidance and requiring patient level costing for core PODs. The Committee were assured of the Trusts processes and capability and capacity to meet the new requirements and particularly drew on the previous audit report in this area which had delivered a Substantial Assurance opinion. The Committee gave approval for delegated authority to be given to the Acting Director of Finance (DoF) to authorise the Trust National Cost Collection documents for submission in August 2019.

5. First Care Business Case

The Director of Workforce presented a business case for a 6 month pilot of absence management services by First Care, an experienced NHS and public sector provider in this field. The pilot is to take place in Hotel Services and Estates with the aim of reducing the incidence of sickness absence and delivery of associated cost savings. The Committee supported the pilot and the initial investment of £27k with a review of progress to take place at Month 4.

6. Renal Business Case

The Divisional Director of Medicine & Acute presented a business case for approval of the contractual arrangements for the management and running of dialysis services at Trust sites and consideration of future arrangements at the satellite unit at Countess of Chester Hospital. The options for service provision were reviewed and the preferred option of a fully managed service at the Clatterbridge site and a partially managed service at the Arrowe Park site were outlined. The preferred option does not present the most economic financial case, although savings to the current arrangements accrue. Due to the clinical governance risks that pertain to the high acuity of patients on the Arrowe Park site, this was the option recommended by the Renal team and was supported by the Trust Management Board. The Committee supported the recommendation of the preferred option to the Board of Directors, see attached.

7. Quality Performance Dashboard

The Divisional Director for Womens & Childrens services, deputising for the Chief Operating Officer presented the 'responsive' element of the Quality performance dashboard. Discussion took place in regard to the deterioration over recent months in the A&E performance and the recent actions taken to improve the position by the opening of a new area to support ED capacity which was showing encouraging results. The financial consequences of the change were yet to be evaluated but would be presented to the Committee on completion or should a more permanent solution be proposed at the next meeting. The RTT position was noted to have dipped below the 80% local target in month but recovery actions are in place to return to target.

8. Capital Bid Form – Fire Protection Measures

The Acting Director of Finance presented to the Committee the Capital Bid Form for approval due to the level of spend (>£250k) for Fire Protection Measures which are included within the current agreed capital programme for 2019-19. The Committee gave its approval.

9. Reports from other committees

The committee received and noted the report from:

- Finance and Performance Group

10. Recommendations to the Board

- Approval of the Renal Business Case

Board of Directors	
Agenda Item	Renal Dialysis Business Case
Title of Report	**Executive Summary: Renal Dialysis Business Case**
Date of Meeting	5th June 2019
Author	Dr Noshaba Naz, Clinical Lead Mike Gibbs, Directorate Manager Lian Cheyne, Finance Business Partner
Division Sponsor	Shaun Brown, Divisional Director
Accountable Executive	Karen Edge, Acting DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Work programme 2: Quality services Work programme 3: Clinician led changes to improve our services Work programme 8: Providing best value
Level of Assurance **Positive** **Gap(s)**	Note for Report Writers – Ensure the mitigating action is included where gaps in assurance have been identified or alternatively where the gaps will be monitored.
Purpose of the Paper	Approval
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Entire document is exempt under FOI
Equality Impact Assessment Undertaken	No, the outcome of the tender will inform the requirement for an EIA which will be included in the recommendation award board paper, if applicable.

1. Overview

A business case setting out the Medicine & Acute Specialties (M&A) Division's plans for revising the contractual relationship between Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and a private provider (currently Fresenius) in the management and running of dialysis services at Arrowe Park Hospital (APH) and Clatterbridge General Hospital (CGH) sites was approved at Trust Management Board (TMB) and Finance Business Performance Assurance Committee (FBPAC) on 24th April 2019 and 24th May 2019 respectively. Approval for the recommended option is now sought from Trust Board via this overview paper.

WUTH delivers a haemodialysis service through a main clinical dialysis unit at APH and two satellite units, one at CGH (via a contract with Fresenius) and one at the Countess of Chester (CoCH) via a SLA. The dialysis unit site at CoCH is not considered in detail as part of this proposal due to the current contractual arrangements CoCH have in place with Fresenius.

The APH site is run solely by WUTH employed nursing staff. WUTH contract Fresenius to provide a fully managed service contract at the CGH site. Accordingly, Fresenius employ their own nursing staff (albeit WUTH provide consultant nephrologist cover to all three sites). The current contract expires on 31st March 2020. A new contract with private provider will go through the OJEU tender process and will be for a minimum 3 year duration.

2. Option Appraisal

The following options detailing what WUTH's future relationship with a private provider in the running of the APH and CGH dialysis units have been explored:

1. Managed Service Contract for equipment, consumables and associated services (but not staff) with an external supplier at both APH and CGH sites. WUTH provide staffing at both APH and CGH sites.
2. Managed Service Contract for equipment, consumables and associated services **and staff** with an external supplier on both site APH and CGH site. A private provider provides all equipment and nurse staffing at both APH and CGH sites.
3. Managed Service Contract for equipment, consumables and associated services with an external supplier for both sites and to include staff for **the CGH site only.** This would mean APH site continues to be run by WUTH employed staff.

The indicative financial impact of each option has been assessed, along with the operational and clinical model. Two key issues have determined what the preferred option for the contractual relationship in the management and running of dialysis services at APH and CGH sites between WUTH and a private provider:

1. Opportunity to transact a financially effective contractual relationship with a private provider that supports the agreed clinical model for dialysis care at APH and CGH sites.
2. Maintaining strong clinical governance assurance in the provision of safe care for complex and inpatient dialysis at APH site.

2.1 Financial review

The following section explores the financial impact upon the dialysis service and the current contribution. This section shows the contribution each of the options when compared to the current cost of delivery across the 2 sites. Each of the options would deliver an increased contribution in Year 1 as outlined in Table 1 below:

Table 1 – Summary of Financial Impact of Options in Year 1

	Current Position - 2018/19	Option 1	Option 2	Option 3
		Managed Contract Excluding Staff	Managed Contract Including Staff	Managed Contract Clatter Inc Staff / Arrowe Exc Staff
	Forecast	Arrowe and Clatterbridge	Arrowe and Clatterbridge	Arrowe and Clatterbridge
Income	£k	£k	£k	£k
Arrowe	1,972	1,972	1,972	1,972
Clatterbridge	1,020	957	1,020	1,020
Other	1,263	1,263	1,263	1,263
Total Income	4,255	4,192	4,255	4,255
Expenditure	£k	£k	£k	£k
Arrowe	2,667	2,644	2,446	2,644
Clatterbridge	1,041	899	884	884
Other	-	-	-	-
Total Expenditure	**3,708**	**3,543**	**3,330**	**3,528**
Contribution	**547**	**649**	**925**	**727**
INCREASE / (DECREASE) IN CONTRIBUTION		**102**	**378**	**180**

To demonstrate the full financial impact of each option, the financial analysis has been modelled over a ten year period in Table 2 below. The cumulative contribution during that period has been adjusted to indicate present values. In line with the Year 1 analysis above, the fully managed service presents the highest contribution of £11,847k. Options 1 and 3 provide a £7,220k and £8,350k contribution respectively.

Table 2 – Contribution for all Options Year 1 to Year 10

	Option 1	Option 2	Option 3
	Managed Contract Excluding Staff	Managed Contract Including Staff	Managed Contract Clatter Inc Staff / Arrowe Exc Staff
	Arrowe and Clatterbridge	Arrowe and Clatterbridge	Arrowe and Clatterbridge
Income	£k	£k	£k
Arrowe	26,562	26,562	26,562
Clatterbridge	12,906	13,604	13,604
Other	17,035	17,035	17,035
Total Income	**56,503**	**57,200**	**57,200**
Expenditure	£k	£k	£k
Arrowe	36,561	32,883	36,561
Clatterbridge	12,320	11,821	11,821
Capital / Lease Costs	-	-	-
Total Expenditure	**48,881**	**44,704**	**48,382**
Contribution	**7,622**	**12,496**	**8,818**
NET PRESENT VALUE OF CONTRIBUTION	**7,220**	**11,847**	**8,350**

The average increase in contribution for each option is detailed in Table 3, presenting the fully managed service as the largest increase in contribution of £589k. The partially managed service presents an increase of contribution of £146k. Option 3 would present a £255k benefit.

The financial analysis is based upon indicative prices and would be subject to potentially different prices submitted as part of the tender process. The financial modelling has been completed using current prices with the assumption that any pay or non-pay inflation would be funded by tariff increases or efficiencies. Activity has been assumed to grow by 4% per annum in line with the Renal Association recommendations.

Table 4 – Average Annual Increase in Contribution per Option

	Option 1	Option 2	Option 3
	Managed Contract Excluding Staff	Managed Contract Including Staff	Managed Contract Clatter Inc Staff / Arrowe Exc Staff
	Arrowe and Clatterbridge	Arrowe and Clatterbridge	Arrowe and Clatterbridge
Average Increase in Contribution per annum (over 10 Years)	£k	£k	£k
	146	589	255

2.2 Model of Care

The APH dialysis unit provides care for Wirral's most complex dialysis patients and acutely unwell patients that require dialysis. To provide a safe service for these patients, WUTH needs to ensure it has nursing staff with the correct knowledge base, experience and skill-set and the requisite nursing resource to deliver the required capacity. It currently has all of this with the WUTH employed dialysis nursing staff.

The M&A Division believe that WUTH should retain management and employment of its dialysis nursing staff at APH in order to maintain its existing staffing skill mix and establishment and ownership of the clinical governance arrangements within which these staff members operate. There is strong recent regional

precedent of NHS organisations moving away from a fully managed service contract for dialysis services i.e. Royal Liverpool University Teaching Hospital and Aintree University Hospital, due to the private provider's inability to maintain nurse staffing levels of the required establishment and skill mix. A replication of this risk at the APH site would represent a significant clinical governance concern given the acuity of the patients being dialysed on the Unit. In addition, a large share of the staffing establishment provided by Fresenius at WUTH's CGH site has sporadically been sourced from agencies. Whilst this is acceptable for the provision of more routine dialysis care, the M&A Division would not want this staffing model for its APH unit.

The M&A Division does believe however that there is an opportunity to enter in a contractual relationship with a private provider to run a managed service contract for all other elements of service provision i.e. equipment and consumables.

The CGH site primarily deals with more routine dialysis patients and therefore the governance risk associated with gaps in dialysis nurse staffing establishment are not as great. In addition, WUTH has had a longstanding contractual relationship with Fresenius to provide dialysis services on CGH site. Generally speaking, Fresenius have been complaint contractually for the duration of its contractual relationship with WUTH. As a result the M&A Division would support continuing with the fully managed service contract model currently in place at CGH.

2.3 Recommended Option

This paper recommends a procurement process for option 3: Managed Service Contract for equipment, consumables and associated services with an external supplier for both sites and to include staff for **the CGH site only.** This option allows for the current service model to be replicated, with staff at the Arrowe Park site remaining WUTH employed**.** The benefit of this option would be deliverable in 2020/21 following a 12 month lead in time required to tender, award and implement a managed service contract. This option would deliver an average FYE benefit of £255k.

3. OJEU Tender process

If Board approve to progress the Tender of the service, the time to delivery will be a likely to be 12.5 months. The tender process will conclude with the contracts being signed and the lead in time is essential for TUPE of staff and probable remodelling and installation of new equipment.

4. Next Steps

Should the Board approve progression to tender the project team will finalise the service specification for each option, along with the pricing schedule, KPIs and Award Criteria. These documents are crucial for a successful and smooth tender as any errors at this stage could delay the start date or open the tender up to legal challenge upon a contract award.

Once finalised the project team will publish the tender notice. Upon completion of the tender process the project team will write to the Board to seek approval for the highest scoring option to be awarded the contract.

BOARD OF DIRECTORS	
Agenda Item	9.3
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	5.6.2019
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	PR2
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The eighth meeting took place on Wednesday 22 May 2019.

2. Key Agenda Discussions

2(a) Chair's Business

The Chair welcomed 3 colleagues from ED with their staff story and the Estates and Facilities Leadership representative.

The Chair commented on a recent constructive 'time out' meeting with the HR Business Partners (to discuss their contributions to Division KPI improvements).

2(b) Staff Story

The committee received a staff story Adam, Nicky and Nick from ED. They described the progress made in ED since the Cultural Review in 2018. Improvements in training, values and behaviours, health and wellbeing and communications were discussed.

The committee warmly thanked the WUTH colleague for their contributions and insights and encouraged them to continue to sustain the improvements made to date.

2(c) Estates & Facilities Workforce Agenda

Glen Adams (ADO Estates & Facilities) attended the committee and presented the Division's workforce successes and challenges. Demographics of the groups were presented as challenging for management. Attendance was ~ 93% with different factors cited for the 2 areas. Mandatory Training gaps were hindered by lack of IT skills leading to poor access to E learning packages.

The committee was not assured that a robust performance improvement plan was in place. However, it was agreed that further work would be undertaken to develop a robust workforce plan which will be presented back to the committee in September 2019.

2(d) Organisational Development Implications of the NHS Long Term Plan

Cathy McKeown presented the recommended priorities for WUTH opposite the NHS Long Term Plan. Nationally the 8 areas in the NHS Long Term Plan do not include support functions such as Facilities & Estates or Finance, HR, Procurement, Quality, Admin etc. The committee agreed that the WUTH Organisation Development plan will sponsor detail work to develop the support functions.

It was also highlighted that there needs to be a robust workforce planning and change management plan in relation to the implementation of new roles. The example of the introduction of Advanced Nurse Practitioners was described as important learning for the Trust in this regard.

2(e) Mandatory and Role Specific Training Update

A report was presented in relation to mandatory and role specific training. Over the past 12 months a considerable amount of work has been undertaken in relation to mandatory training which has resulted in the organisation aligning itself with other NHS providers. This means the Trust now follows the Core Skills framework which means that the Trust has 10 pieces of mandatory training nearly all of which are e-learning packages.

The Trust has now ensured that every member of staff has a training record that includes both mandatory and role specific training. Previously the Trust has not tracked compliance in relation to role specific training. In addition there is an exemptions process in place whereby a manager can exclude an individual from a particular training programme if it is not relevant to their role.

It was explained that the ESR system does not have the functionality for individuals/managers or groups to opt out of role specific training modules directly and requires manual manipulation through the central team (which represents some data quality risk). The work to address was described and a 6 month trial period was approved.

There was a discussion regarding the value and effectiveness of some of the core training modules and concerns were raised about the level of complexity in the design of the controls and variable delivery thereof. Therefore, the committee remained concerned that we were yet on a path of sustained higher compliance with our defined training standards.

The committee agreed to escalate the risk of low assurance (on the Trust's role specific training) to the Trust Board.

2(f) Workforce KPIs

The Workforce KPIs to be presented at Trust Board were agreed as

- Attendance
- Turnover
- Appraisal completion compliance

The remaining Workforce KPIs will continue to be reviewed at Workforce Assurance Committee.

2 (g) Health and Wellbeing Plan

The Committee noted the Trusts Health and Wellbeing Plan, which will be implemented over the next 12 months.

3 Workforce Assurance Committee meeting management effectiveness

For the second time over the past 12 months the committee was unable to complete the meeting's agenda. In particular the following items were carried over

- Deep Dive -- Corporate Appraisals
- Bullying & Harassment
- New Induction Programme
- Update on Volunteer Implementation Plan
- Safe Staffing Report
- Communications & Engagement -- Pulse Testing Survey
- Update from Workforce Steering Group

The Chair agreed that he will reiterate the meeting's ground rules for presenting papers. E.g. present the executive summary only, assume the paper has been read, make no more than 3 key points for the Committee to consider, discuss and agree if required. It was also agreed to extend the time of the Committee.

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4. Next Meeting

30 July 2019

5. Recommendations to the Board of Directors

To note the contents of this report and to receive the escalation of the continued risk of low assurance on the Trust's role specific training effectiveness.

Board of Directors	
Agenda Item	9.6
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	5 June 2019
Author	Joe Gibson, External Programme Assurance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Choose an item	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

SUMMARY

1. Overview

The scope (see slide **2**) of the Change Programme has remained stable during the past month with the Executive Team continuing to direct enhanced focus on the three large **priority** projects within the Change Programme; Patient Flow, Outpatients and Theatres Productivity.

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

1.1. Governance Ratings
The picture demonstrates a continuing improvement in project governance since August 2018; renewed focus has brought a further increase in green ratings underpinned by assurance evidence. This provides a solid foundation for change to be transacted in a transparent and safe framework.

1.2. Delivery Ratings
This month has seen a renewed and welcome improvement in delivery ratings with fewer red ratings; however, it must be remembered that an amber rating remains indicative of substantive issues albeit considered within the competency of the project team to resolve. Continued focus on defining/realising benefits and tracking of milestone plans will pay dividends in terms of improved ratings.

That said, there is still a need for pace and a more significant 'shifting of the dials' in terms of the improvements aspired to by the teams.

DELIVERY

2. Programme Delivery – Priority Areas

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

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

2.2 Perioperative. The metrics for the Perioperative Medicine project are shown at slides **7-9**.

2.3 Outpatients. The metrics for the Flow project are shown at slide **10**.

ASSURANCE

3. Programme Assurance - Ratings

The attached assurance report has been undertaken by External Programme Assurance and provides a detailed oversight of assurance ratings per project. The report provides a summary of the assurance provided to the Trust's Programme Board as a gauge of the confidence in eventual delivery. The actions needed to improve those confidence levels are described in the

assurance statements for each project and this independent monitoring will continue to assess the assurance evidence. The supporting assurance evidence has been discussed at the Programme Board meeting (the membership of which includes a non-executive director) held on Wednesday 15th May 2019.

4. Assurance Focus

In aggregate, the assurance ratings for the top 3 priority projects - namely Flow, Theatres and Outpatients - carry much greater weight than the other 8 projects. This weighting is true not only in terms of their significance to the Trust mission in the near term but also the size and degree of difficulty of the work involved.

The first page (slide **12**) of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress.

5. Recommendations

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

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

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

External Programme Assurance

P Priority Project

WUTH Trust Board of Directors

Programme Board – CEO Chair

Workforce Planning (WRAPT) SRO - Helen Marks

Improving Patient Flow
SRO - Nikki Stevenson

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

Operational Transformation
SRO - Anthony Middleton

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

Quality, Safety & Governance
SRO - Paul Moore

Pipeline

'Themes'

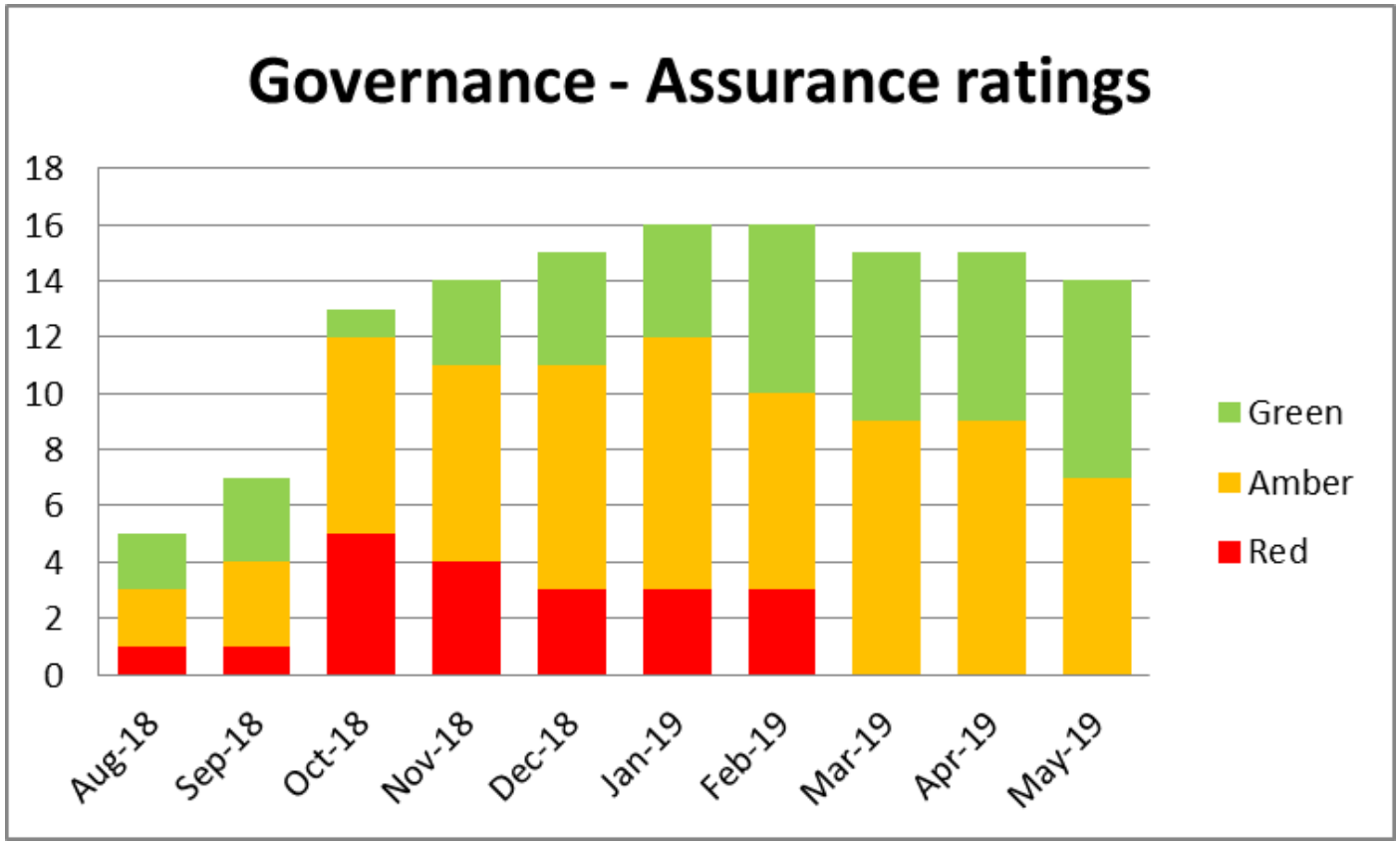
- A Positive Patient Experience
- Care is Progressively Safer
- Care is Clinically Effective and Highly Reliable
- We Stand Out

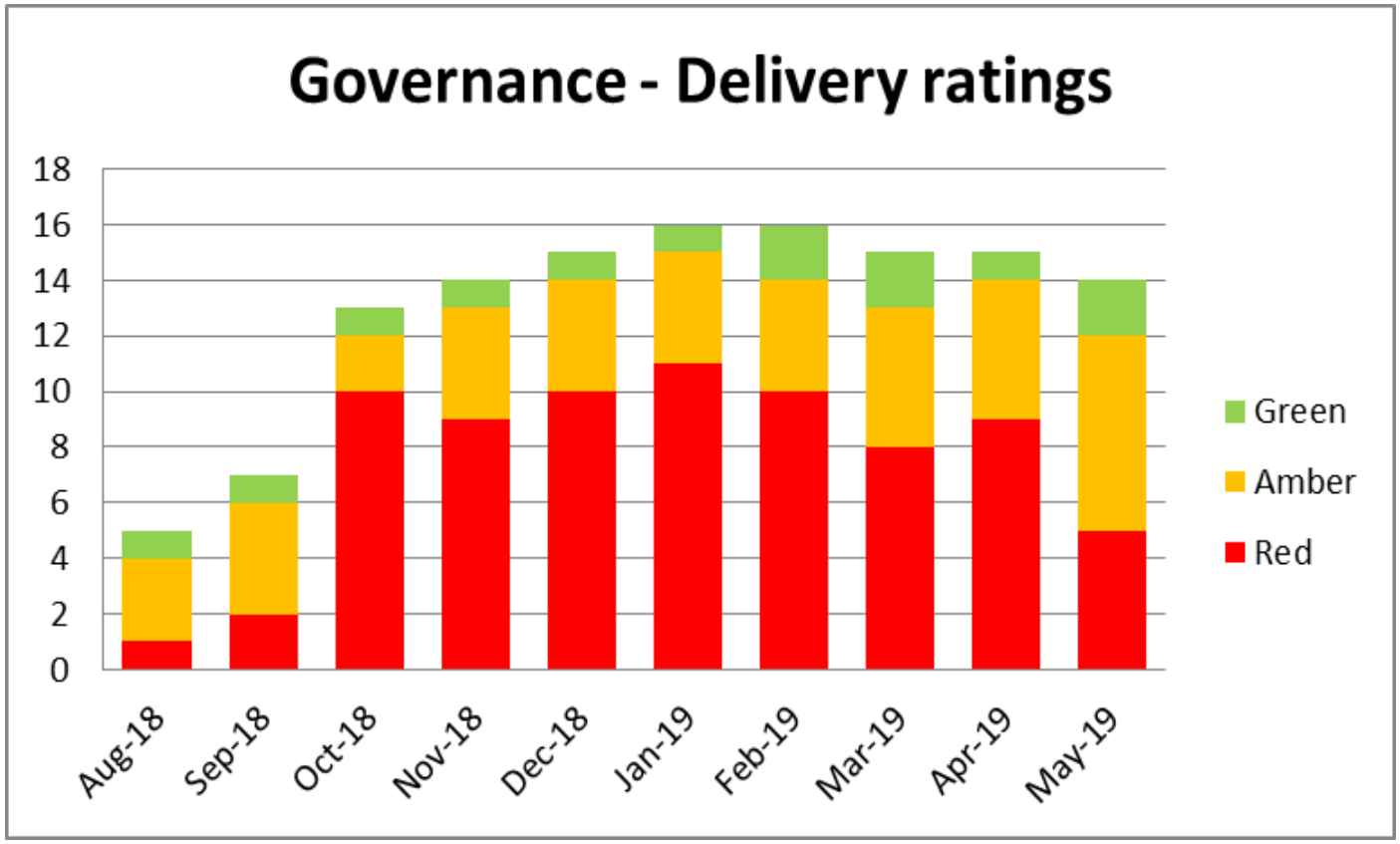
Digital
SRO - Nikki Stevenson

- GDE Meds Management **Lead: Pippa Roberts**
- GDE Device Integration **Lead: Gaynor Westray**
- GDE Image Management **Lead: TBD**
- 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**


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
May-19
Green
Amber
Red


Governance - Delivery ratings
18
16
14
12
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Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Green
Amber
Red

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Priority Projects
Highlight Report - Metrics

Senior Responsible Owners

Highlight Report – Patient Flow Improvement
Reporting Period – May 2019
Programme Lead – Shaun Brown

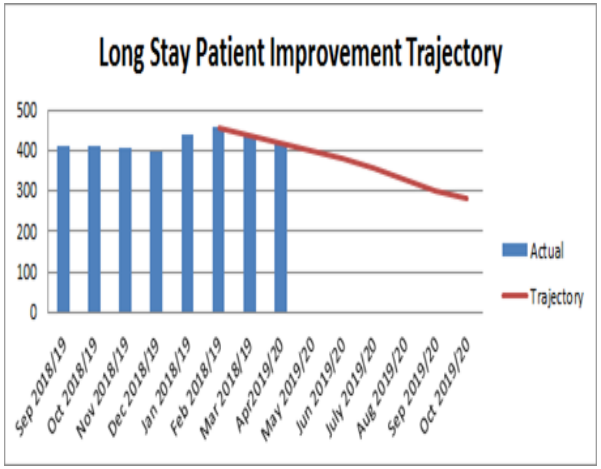
Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	Ward Based Care and Transformation of Discharges – PIDs will be signed off once LOS trajectories are agreed
Green	Red	Command Centre: Capacity Manager – Some metrics still to be defined and baselined

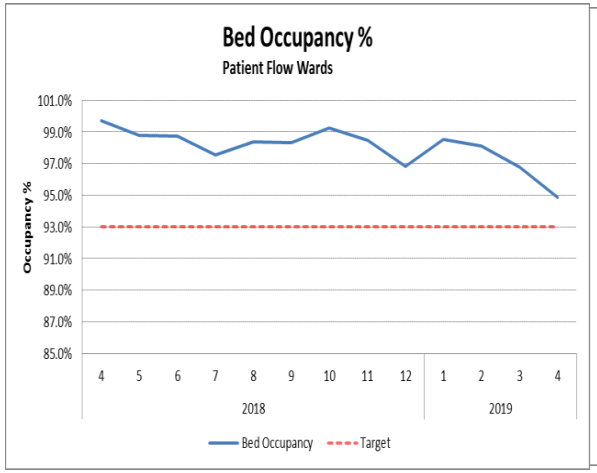
3 things you need to know

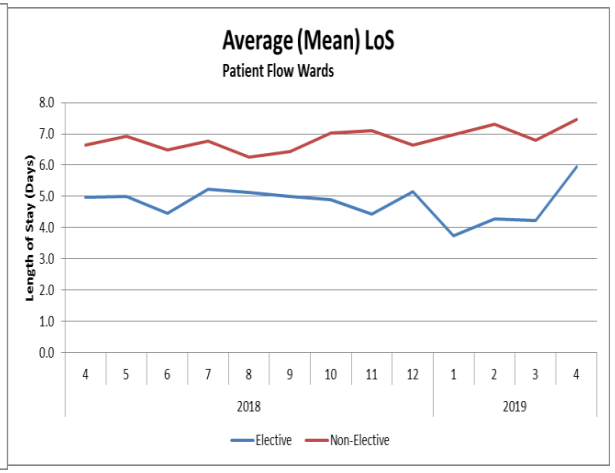
Completed Flow trial- improved flow from ED to Assessment Units to Base wards. Reduced Assessment Unit LOS.

Capacity Management System is available and a demo has been provided to the team – costs associated to hardware and cleaning capacity are being worked through. Wider engagement across Trust is taking place to shape go live plans.

MDT staff engagement sessions being set up in May to focus on team working and the cultural and behavioural changes required to adopt and embed patient flow improvements.







Escalation

High number of patients awaiting or undergoing social work assessment and lack of social worker capacity to support board rounds. This has been escalated to WCT.

There will be additional costs required to enable full implementation of capacity management system – these include purchase and support of hand held devices for porters and additional domestic staff to enable vacation cleans. Costs are being worked through & will be provided when more detail is known

STT & IT resource will be reduced on Capacity Manager due staff leaving. This may impact on pace of delivery.

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

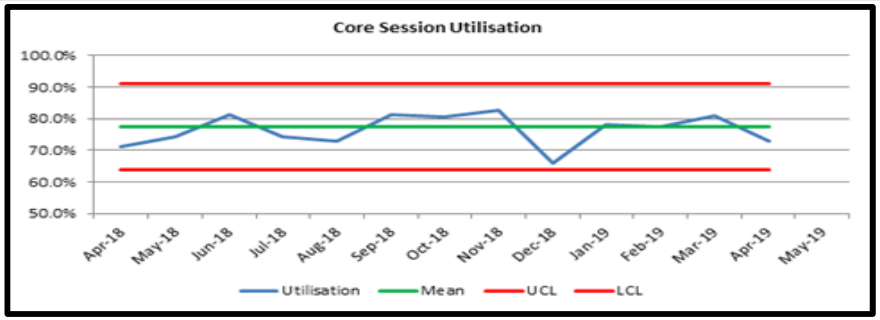
Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	Reset milestone plan in line with exception report and deliver against revised milestone plan

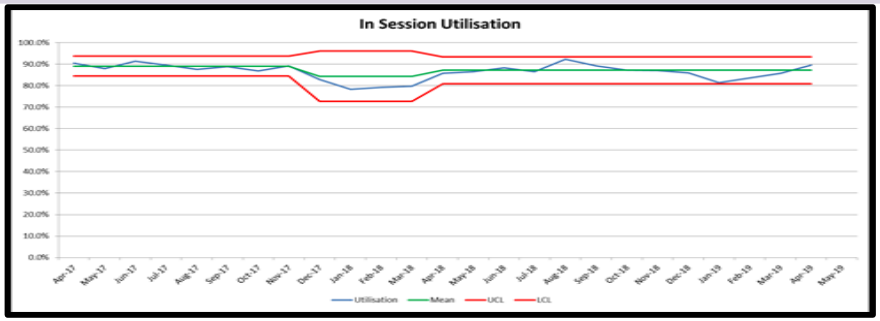
3 things you need to know

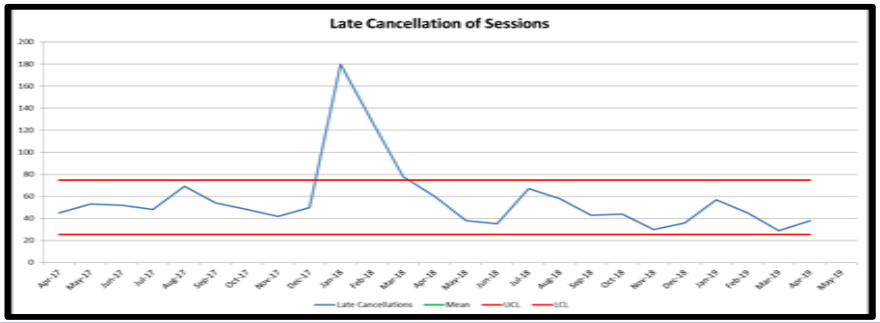
Main focus: Revised theatre schedule has been designed to maximize the use of CGH and has been presented to Divisional teams for review

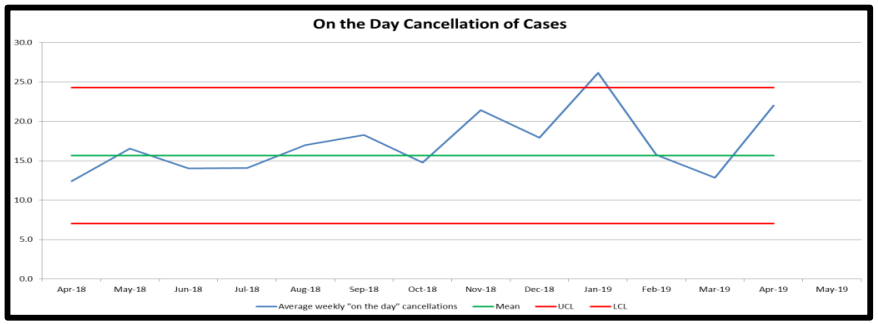
Agreement has been reached and space identified to move pre-op teams from SEAL area to Outpatient footprint, to improve patient flow and support roll out of fit and well questionnaire from June 19

Electronic booking form proposals are 'on track' for 80% consultant roll out by June 19 with the remaining specialties fully operational by sept 19. .









Escalation

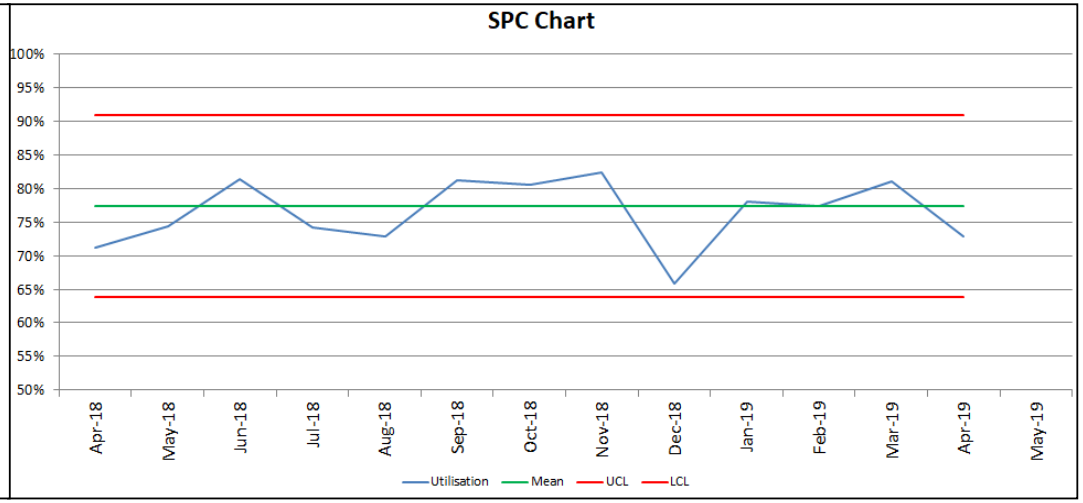
The roll out of technological initiatives has been delayed this month due to sickness, but will regain momentum mid May. A review of roll out proposals has been escalated to IT senior management and additional resource has been identified.

Theatre scheduling system design specification has been produced by Perioperative Team and provided to IT. IT liaising with external providers and procurement colleagues to arrange a tendering process.

Core Session Utilisation

Key		
<70%	70% - 80%	>=80%

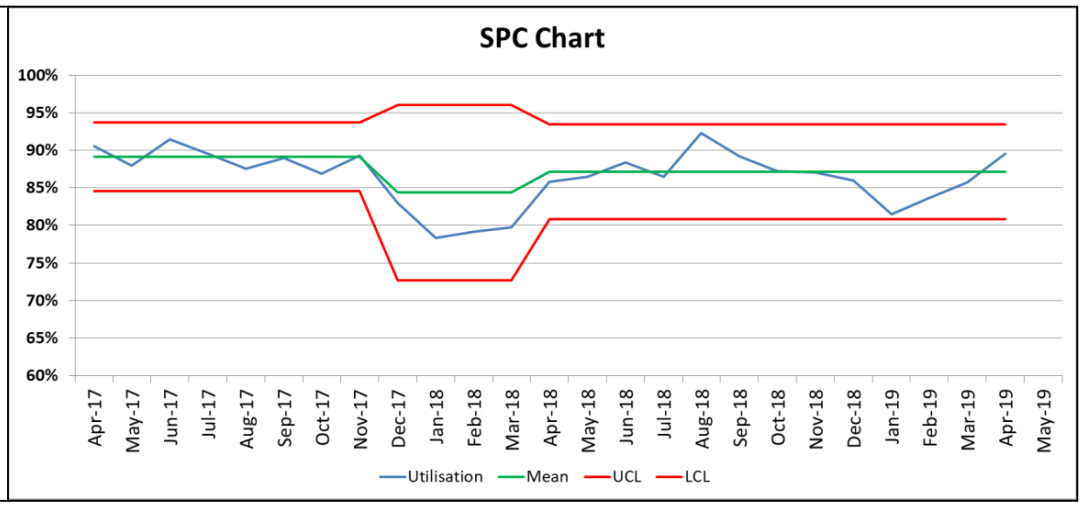
Core session utilisation – Target 80% of 52 week capacity	Mar	Apr
Total	81.0%	72.8%



In-Session Utilisation

Key		
<80%	80% - 85%	>=85%

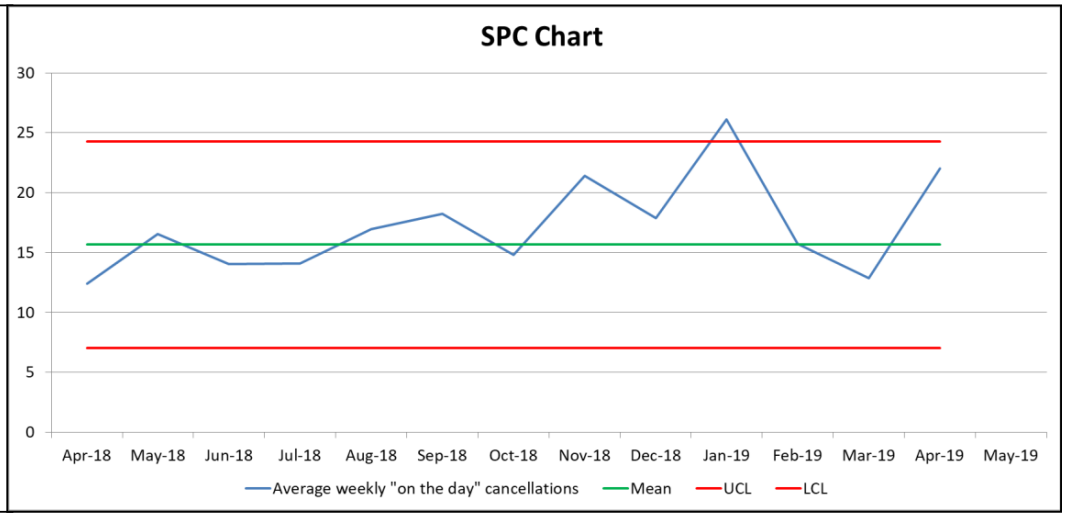
In Session Utilisation (Monthly Average - %)	Mar	Apr
Total	85.7%	89.5%



Avg On the Day Cancellation of Cases

Key	
<=11	>11

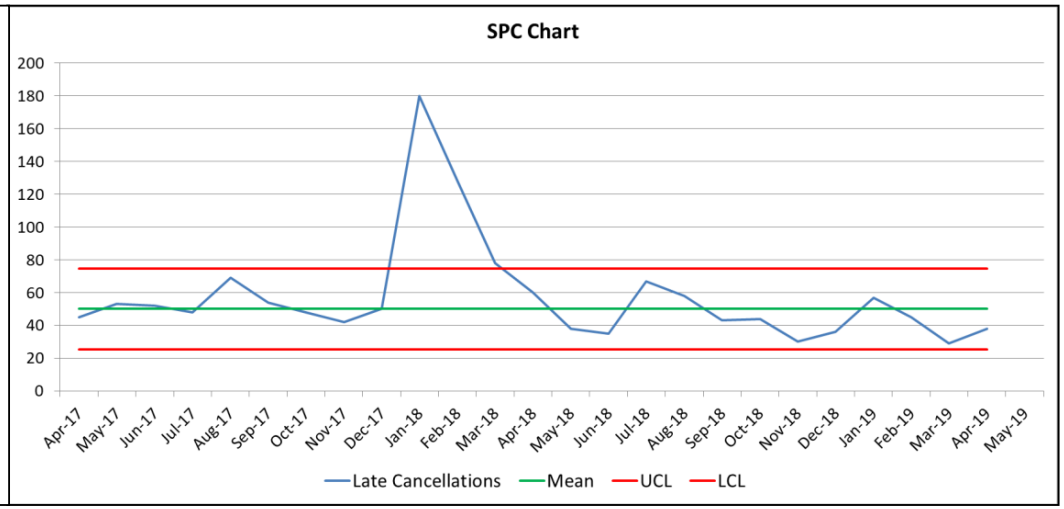
Case Cancellations on the Day – Reduce to a Daily Avg of 11	Mar	Apr
Total	12.9	22.0



Late Cancellation of Sessions

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

2019	Jan	57
	Feb	45
	Mar	29
	Apr	38



Highlight Report – Outpatients
Reporting Period – May 19
Programme Lead – Anthony Middleton

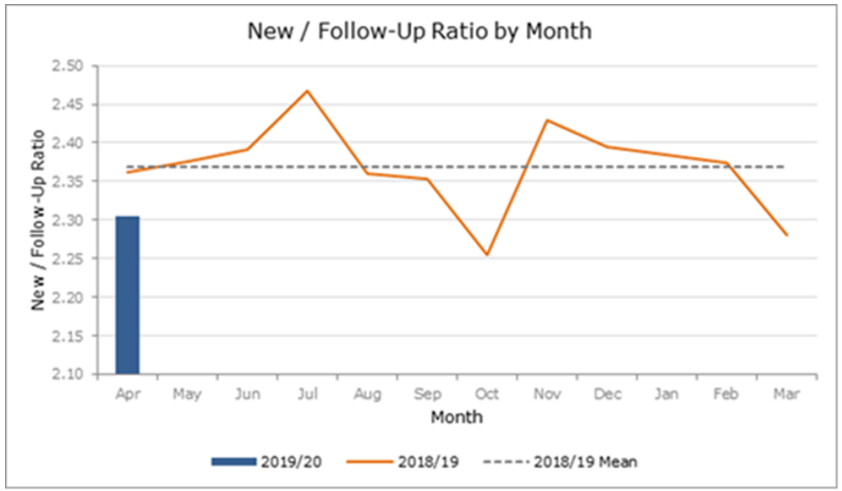
Overall Governance	Overall Delivery	Plan to turn green
Green	Amber	Approval of Project Initiation Document at Operational Transformation Steering Group on 10 June

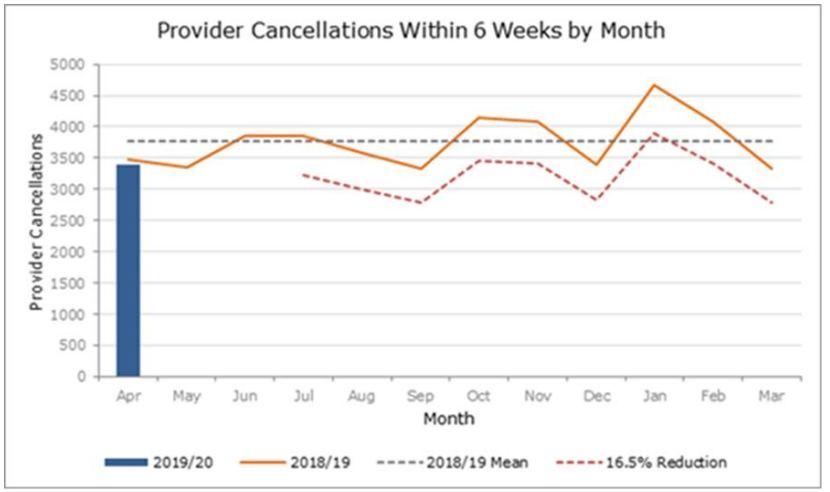
3 things you need to know

Programme benefits and objectives being reviewed. PID to be approved at Operational Transformation Steering Group on 10 June.

The Trust met the outpatients activity plan in month 1 (April)

Outpatients portal is now live and is being used by service teams





Trajectory to be developed

Escalation

There is currently no Programme Lead for the Outpatients Programme. New lead to be identified asap.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Programme Assurance Ratings

External Programme Assurance

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'** 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.
- The **'Command Centre'** PID, draft v0.4 dated 23 Apr 19, lacks metrics by which benefits will be measured and these are in the process of being developed. The new Command Centre Project Plan has been updated to 10 May 19 shows good progress (only 4 milestones revised to date) and the 'informatics/digital' section has now been completed.
- For **'Transformation of Discharge Services',** the key KPI - Long Stay Patient Improvement Trajectory (Target) to reach 282 by Oct 19 shows information to March 2019; further, supporting, metric measurement has now been developed is being further refined (as evidenced on slide **6** of the assurance report).

Perioperative Medicine Improvement	Governance		Delivery	

- The **'Perioperative Medicine Improvement'** has produced a revised milestone plan, dated 2 Apr 19, which is a detailed and well tracked document; however, it shows significant delays in some key areas of the project in excess of 6 months; this issue was covered by an 'Exception Report 'to the May Programme Board (to re-baseline the Plan) which was accepted and endorsed.
- The four metrics being tracked, monthly – Core Session Utilisation; In-session Utilisation; Avg On the Day Cancellation of Cases; and Late Cancellation of Sessions - show an average of 'amber' performance. The detail of these metrics is included in this report at slides **7-9.**
- The lack of evidence in place concerning risk and issue management - 'date of last review' information - has now been resolved.

Outpatients Improvement	Governance		Delivery	

- The **'Outpatients Improvement'** project has a project team is in place; however, the 'Programme Director' position is now vacant and will need filling as a matter of urgency.
- The Trello' Board' is being used to create and track milestones; moreover, a high level summary plan will be produced to cover 2019/20 following approval of the revised PID.
- KPIs are now in being finalised and trajectories set in the OPD Highlight Reporting for 2019/20; the benefits are rated 'amber' until the 3-month trend emerges (slide **10** of this report refers).

Workforce Planning - Programme Assurance Update – 15th May 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a revised PID v0.2 dated 16 Mar 19 has been drafted with benefits described; however, there are no benefits start dates or metrics identified (that could lead to estimated financial benefits). **2. & 3.** 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) and there is now a trackable Gantt chart plan that exists as a stand alone document (with dates for some work streams to be completed). **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 10 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 – 15th May 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 9 May 19 is in evidence; however, activity lines in progress need to be RAG rated (the new weekly granularity has added 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 10 May 19; however, only some of the risk show date of last review - this needs to be completed for all risks. **Most recent assurance evidence submitted 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 – 15th May 2019

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

Independent Assurance Statement

1. The PID, draft v0.4 dated 23 Apr 19, lacks metrics by which benefits will be measured and these are in the process of being developed. **2. & 3.** Evidence of documented project meetings is available up to the minutes of the meeting of 12 Apr 19 and ToRs are also in evidence. **4.** There is a comprehensive communications plan and this has started to be tracked (RAG rating would help transparency). There is now extensive evidence of stakeholder engagement. **5.** EA has been drafted and QIA signed-off. **6.** The new Command Centre Project Plan has been updated to 10 May 19 shows good progress (only 4 milestones revised to date) and the 'informatics/digital' section has now been completed. **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 10 May 19. **Most recent assurance evidence submitted 10 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 – 15th May 2019

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

Independent Assurance Statement

1. The scope document comprises the 'Final Approved' PID, TDSS v0.4 uploaded 8 Apr 19, for the 'Transformation of Discharge Services Sustainability' project. **2.** Project Team names are now complete on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v7 dated April 2019) and there is also a comprehensive action log updated to 7 May 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' updated to 8 May 19, with delays to some 6 of the milestones but largely on track. **7.** The key KPI - Long Stay Patient Improvement Trajectory (Target) to reach 282 by Oct 19 shows information to March 2019; further, supporting, metric measurement has now been developed is being further refined. **8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed on 7 May 19. **Most recent assurance evidence submitted 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 – 15th May 2019

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

Independent Assurance Statement

1. The PID v4 dated 28 Mar 19 has a comprehensive set of objectives and measurable benefits defined with metrics; it was signed off by the Project Board in April. **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 7 May 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; this will be covered by an Exception Report to the May Programme Board (to re-baseline the Plan). **7.** KPIs are developed in the PID. The four metrics being tracked, monthly, show an average of 'amber' performance. **8 and 9.** Evidence in place concerning risk and issue management and 'date of last review' information now added to 7 May 19. **Most recent assurance evidence submitted 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 - 15th May 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	TBC	Sarah Thompson	Implementation	Green	Amber

Independent Assurance Statement

1. An updated version of PID v0.2 dated 30 April 2019 will be presented for approval on 13 May 19. **2.** A project team is in place; however, the 'Programme Director' position is now vacant and will need filling as a matter of urgency. **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 7 May 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 will be produced to cover 2019/20 following approval of the revised PID. **7.** KPIs are now in being finalised and trajectories set in the OPD Highlight Reporting for 2019/20; the benefits are rated 'amber' until the 3-month trend emerges. **8 and 9.** There is a RAID Log in evidence with risks and issues last reviewed on 8 May 19. **Most recent assurance evidence submitted 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 - 15th May 2019

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

Independent Assurance Statement

1. The project PID, v0.8 as uploaded 9 May 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 24 Apr 19. **4.** There is a stakeholder mapping assessment and the Comms Plan has been incorporated into the Project Milestone Plan where it is tracked. **5.** A QIA/EA has been drafted and QIA has been signed off on 18 Mar 19. **6.** A comprehensive milestone Gantt chart plan has been developed, v1.8 dated 3 May 19 which is tracked up to 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 8 May 19. **Most recent assurance evidence submitted 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 – 15th May 2019

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

Independent Assurance Statement

1. All PID metrics cross-referred to SoPB: OPD PID v3 dated 24 Apr 19; AMS PID v6, 24 Apr 19; MAT NNU PID v4, 24 Apr 18; MED Eye PID v5, 24 Apr 19; Paper Charts PID v2, 24 Apr 19; EPMA in OPD PID added 4 Jan 19; metrics required for benefits. **2.** The 'Programme Core Team' now complete. **3.** ToR Issue 2 dated March 2019 'Pharmacy Medicines Optimisation and Informatics Group' in evidence. Notes of meetings available to 27 Mar 19. PIDs now approved by the 'Project Board'. **4.** Some limited evidence available of wider stakeholder engagement. **5.** No EA/QIA in evidence. **6.** AMS PP v3 1 Mar 19 appears to be complete, not clear if sustain & review phase is planned; Analytics PP 6 Sep 18 shows sustain & review gate required; Mat and NNU PP v4 dated 9 Sep 18, shows significant delays; MED Eye PP v2, 5 Apr 19, shows significant delays. Paper Charts PP v 25 Jan 19, now largely out of date and no sustain and review period planned**. 7.** Of the 20 benefits defined on the 'Meds Benefits Matrix' uploaded March 2019, none has an implementation date and there are only 3 with targets; however, all PIDs now refer to the SoPB. **8 & 9.** Risks & Issues: RAID Log v19, 3 May 19; risks reviewed 27 Mar 19. **Most recent assurance evidence received 9 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.1	**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 – 15th May 2019

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

Independent Assurance Statement

1. Infusion Pumps GDE PID v0.4, 23 Feb 19; benefits to save nurses time, prevent inaccurate data into EPR (no metrics). PCECG GDE PID v0.3, 01102018; benefits 'tbc'. 'Vitalslink' GDE PID v0.8, 23 Feb 19; benefits: a. save nurses time @ 30,665 hours by Apr 2020 b. ensure all basic observations are recorded accurately - details provided for Mar - May 18 has shown a decrease "in error" rate to 0.1119% (baseline 0.2161%). SECA PID v0.6 dated 23 Feb 19 has objectives and 1 of 3 benefits defined. 2. 'Core Team' names on dashboard completed. 3. Device Integration Project team minutes in evidence to 12 Feb 19. PIDs have now been approved (Feb 19) in a 'Project Board'. 4. 'Vitalslink Communication Plan', 30102018, is a schedule for Project 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 Plan v0.10 4 Dec 18 has many elements complete but overdue 'Go Live' in Paediatrics from Jun 18; plan now completes Feb 19. PCECG Project Plan v0.8 dated 3 May 19, largely on track. 7. No evidence of tracking of benefits. 8 & 9. Evidence of risk management on SharePoint to 4 Apr 19 (needs date of last review). **Most recent assurance evidence received 7 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.2	**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 - 15th May 2019

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

1. Scope comprises: PID Bronchoscopy PID v0.2 02112018, PID Colposcopy v0.1 02112018, Theatres Image Mgt PID 02112018, PID Medical Photography; 09112018; 1 benefit cited - for all 4 projects - is that all clinical images will be stored electronically in one central location (PAC's), therefore clinicians can access the images more efficiently. **2.** The 'Programme Core Team' names on dashboard have been completed. **3.** Evidence of project meetings: Medical Photography to 18 Apr 19 and 'Carestream' to 25 Apr 19. **4.** There is a 'Colposcopy Comms Plan' v0.1 02112018 which is a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** Revised Project Plan, dated 3 May 19, received for Med Photo which shows delays and status unclear. Bronchoscopy and Theatre Plans previously updated to March 2019 and now significantly out of date. Colposcopy PP 07112017 started and finished in Nov 17 has been submitted (but not clear why). **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** A consolidated 'Risk and Issue Log' is now in use, updated to 3 May 19, and needs a 'date of last review' column for risks. **Most recent assurance evidence received 7 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.3	**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 - 15th May 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 appointments for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit baseline cited for Urology with £36.5k target). Patient Story defines patient benefit. 2. The 'Programme Core Team' names on this dashboard to be completed. 3. Minutes of the Project Meeting available to 12 April 2019. 4. There is a Comms Plan, v4 24 Oct 18, which has some activities recorded but lacks forward looking schedule; there is also a presentation to Project Board of 20 Mar 19. 5. No EA/QIA in evidence. 6. Milestone Plan, v1.6 of 5 Mar 19, is tracked but behind schedule in some areas. 7. 2 graphs show, prospectively, the level of benefits expected from 2020. 8 & 9, Risks and Issues: RAID Log, 1 Apr 19, captures risks and issues and these were - for the most part - last reviewed at the Project Board of 23 Mar 19. **Most recent assurance evidence received 7 May 19.**

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

Partnerships: Women & Children's - Programme Assurance Update - 15th May 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 - 15th May 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' now fits as part of the revised 'Healthy Wirral' programme structures. The ToR were approved on 30 Apr 19. **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 7 May 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
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 - 15th May 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		●	●	●	●	●		●	●	●	●

BOARD OF DIRECTORS	
Agenda Item	9.7
Title of Report	CQC Action Plan Progress Update
Date of Meeting	5th June 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	To be confirmed.
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for **assurance** to the Board **The Board is invited to receive and consider this report**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 25TH MAY, 2019

1. PURPOSE

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

2. BACKGROUND OR CONTEXT

2.1 The CQC Action Plan brings together the actions required to address the CQC compliance concerns identified following inspection in March 2018. The plan takes account of: (i) all the 'must do' and should do' recommendations contained within the inspection reports; and (ii) some improvement interventions identified locally as immediate quality priorities by the Trust. After sufficient progress has been made the plan will evolve to incorporate matters highlighted as high risk within the Quality & Risk Profile for WUTH, and develop into the tactical plan to drive and deliver the Trust's Quality Strategy approved by the Board of Directors in May 2019.

2.2 We expanded the actions in the CQC Action Plan in May 2019 to incorporate improvement required following the unannounced inspection of urgent care facilities.

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

3. ANALYSIS

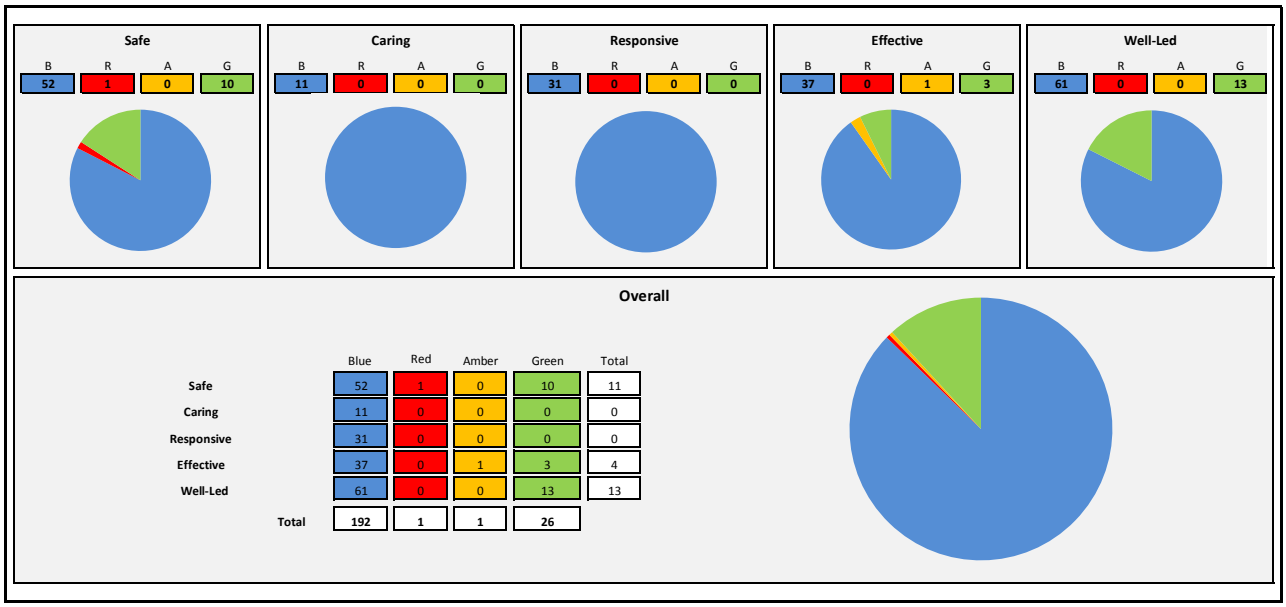
3.1 The CQC inspected the Trust during March and May 2018, and again in May 2019 (outcome not rated). The outcome of the inspection in 2018 was as follows:

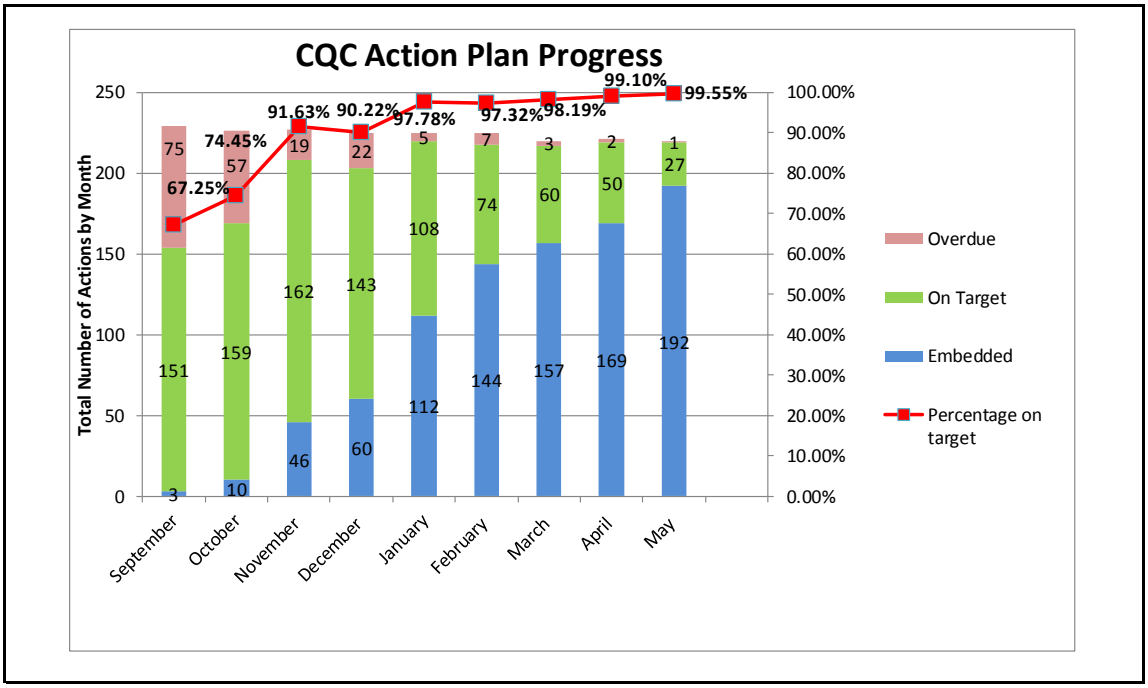
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

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

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

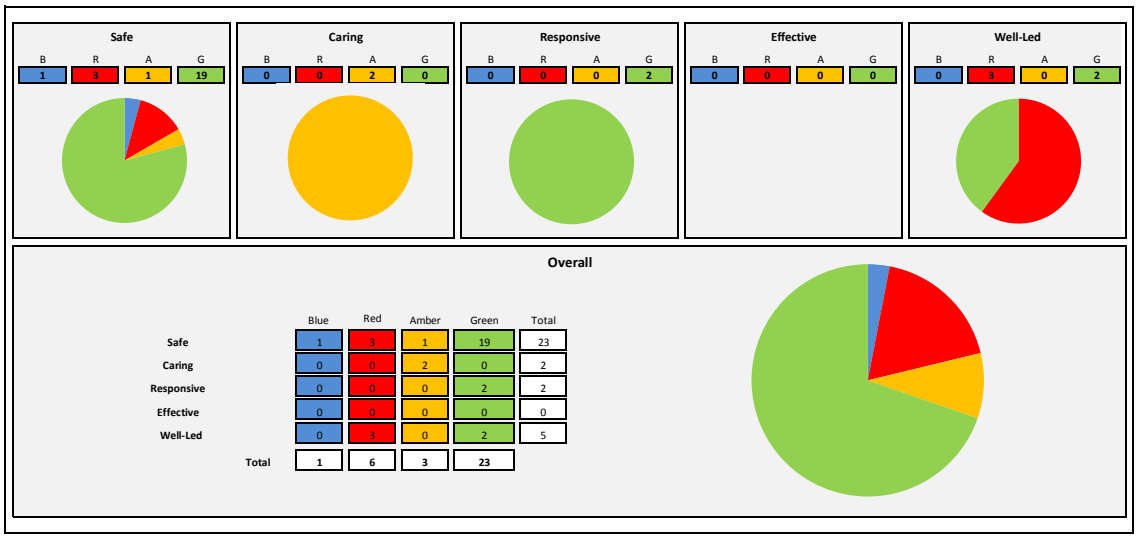
4.0 CQC Action Plan Progress – 24th May 2019

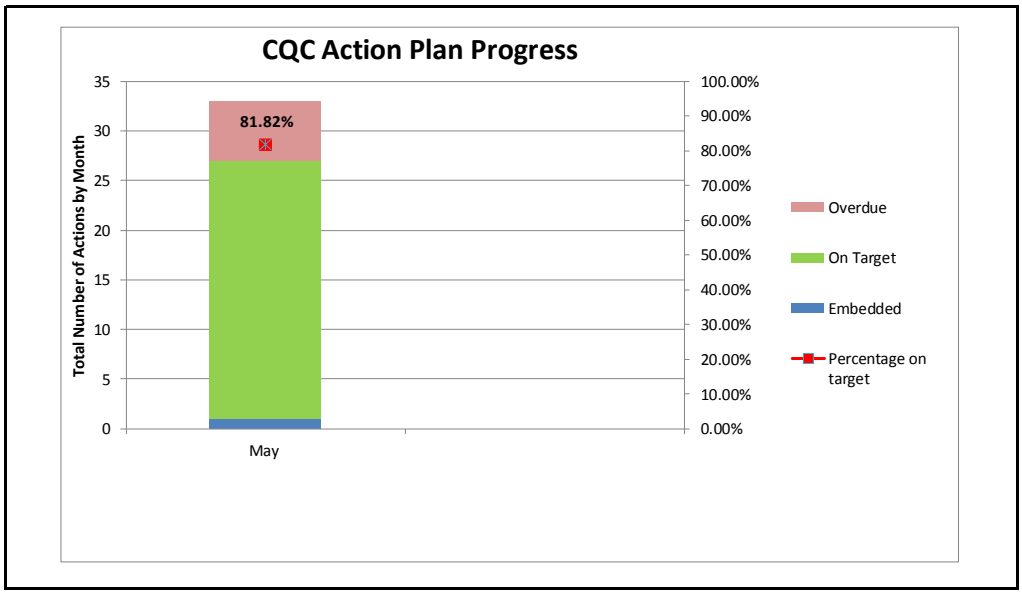




4.1 CQC Urgent Care Actions

The graphs below summarise the current position following the inaugural meeting of the Emergency Department group. Confirm and challenge meetings will form part of the monthly suite of meetings, that take place to assure delivery of the CQC action plan, and the respective leads will be invited to provide updates on this section of the plan. Recommended actions will be incorporated into the overarching plan.





5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held during May 2019, there is 1'red-rated' action and one 'amber rated' actions within the original plan and are to be reported as exceptions for this reporting period.

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

In addition, the Urgent Care overdue actions are detailed in **Annex A(ii).**

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 **23** 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.

During this reporting period the CQC Confirm and Challenge team introduced a further meeting to oversee delivery of improvement actions recommended by CQC, following their recent visit to the Trusts Emergency Department.

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

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

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

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

7. RECOMMENDATION

The Board of Directors are invited to:

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

ANNEX A(i) - 2018 CQC PLAN

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	Medical Director	Well Led	**Updated: 04/05/2019** 03.05.2019 - A 4 week flow trial was undertaken 11th March to 7th April 19. This showed demonstrable improvement in ambulance visits, a reduction in medical outliers and improved length of stay (LOS) on MAU and OPAU. A positive 8% increase in daily medical discharges has been reported Ward Based discharges work on track to deliver by October 19 for Elective and non elective A reduction in the number of stranded patients - Stranded patients are reviewed on a weekly basis. MDT approach applied. This is supported by IDT colleagues/WCT/IDT/therapists/ Medics and Ward Sisters. Decreased trajectories are in place to measure improvement. Governance is tracked through PFIG.	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 04.05.2019** Transposed reporting arrangements within our data capture systems have been identified. Trial of triage only process has been successfully undertaken with consultant colleagues and a sustained change in practice will be implemented.	01/09/2018	

ANNEX A(ii) - 2019 URGENT CARE ACTION PLAN

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
236	Must Do	Urgent & Emergency Care (Acute & Medical Division)	Deliver improvements in triage responsiveness	All GP referrals to go to go directly to speciality assessment facilities not ED	Executive Medical Director/ Chief Operating Officer	Safe	**Update 21.05.2019** Arrangements agreed for Medicine & Acute assessment areas. Conclusion required for Surgery and Women's & Children's. AMD meeting to be arranged take place to discuss way forward. To be escalated to Executive Medical Director.	30/04/2019	
237	Must Do	Urgent And Emergency Care (Acute & Medical Division)	Streaming	Take over streaming process from community trust	Executive Medical Director/ Chief Operating Officer	Well Led	**Update 21.05.2019** Chair and CEO are participating in local health economy process review with the intention that this will come under the jurisdiction of WUTH and ED governance going forward. Exact timing of transfer of responsibilities uncertain and therefore potential risk of slippage.	30/05/2019	
240	Must Do	Urgent And Emergency Care (Acute & Medical Division)	Improve timeliness of specialty review	Implement and embed existing internal professional standards for patients who need a speciality review - all speciality SOP's operational	Executive Medical Director/ Chief Operating Officer	Safe	**Update 21.05.2019** Arrangements agreed for Medicine & Acute assessment areas. Conclusion required for Surgery and Women's & Children's. AMD meeting to take place to discuss way forward. No confirmation that discussion has taken place and SOPs agreed and insitu for all assessment areas.	30/04/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
241	Must do	Urgent And Emergency Care (Acute & Medical Division)	Improve timeliness of specialty review	Ensure delays are escalated by consultant to consultant discussion	Executive Medical Director/ Chief Operating Officer	Well Led	**Update 21.05.2019** Assurance required of protocols for Consultant to Consultant referral in the event of an actual or anticipated long delay specialty review post referral by ED.	30/04/2019	
242	Must do	Urgent And Emergency Care (Acute & Medical Division)	Improve timeliness of specialty review	Each speciality to audit response/ review times and address delays	Executive Medical Director/ Chief Operating Officer	Safe	**Update 21.05.2019** Assurance required, not yet provided, regarding audit results for specialty response times following referral via ED. Action to be escalated to Medical Director.	30/04/2019	
264	Must Do	Urgent And Emergency Care (Acute & Medical Division)	EDRU Actions	Provide and deliver customer care training to colleagues assigned to work in EDRU in order to ensure staff have the competencies and ability to communicate appropriately with relatives of patients	Executive Medical Director	Well Led	**Update 21.05.2019** Not assured.	30/04.2019	

ANNEX B (Embedded actions in May 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
32	Must Do	Corporate / Trust-Wide Issues	**PREMISES & EQUIPMENT** **Surgery :** The trust must ensure all premises are maintained and fit for purpose. The service should ensure the paediatric theatre recovery area is suitably decorated for children **Critical Care :** The service must ensure that the unit provides a suitable environment for patients, staff and visitors. The trust must ensure plans are developed to indicate when facilities will comply with national standards The service should review the reception and entry system arrangements for visitors to the unit.	Develop a refurbishment plan for Critical Care	Chief Operating Officer	Effective	**02.05.2019 Embedded Process** Fit for purpose report submitted	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
33	Must Do	Corporate / Trust-Wide Issues	**PREMISES & EQUIPMENT** **Surgery :** The trust must ensure all premises are maintained and fit for purpose. The service should ensure the paediatric theatre recovery area is suitably decorated for children **Critical Care :** The service must ensure that the unit provides a suitable environment for patients, staff and visitors. The trust must ensure plans are developed to indicate when facilities will comply with national standards The service should review the reception and entry system arrangements for visitors to the unit.	Agree a trajectory for completion of the remedial works	Chief Operating Officer	Effective	**09.05.2019 – Embedded Process** Remedial works completed	01/10/2018	
34	Must Do	Corporate / Trust-Wide Issues	**PREMISES & EQUIPMENT** **Surgery :** The trust must ensure all premises are maintained and fit for purpose. The service should ensure the paediatric theatre recovery area is suitably decorated for children **Critical Care :**	Provide assurance to PSQB that Critical Care, Ward 17 and Theatre Recovery are fit for purpose	Chief Operating Officer	Effective	**02.05.2019 – Embedded process.** Report submitted	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			The service must ensure that the unit provides a suitable environment for patients, staff and visitors. The trust must ensure plans are developed to indicate when facilities will comply with national standards The service should review the reception and entry system arrangements for visitors to the unit.						
54	Must Do	Corporate / Trust-Wide Issues	**PERFORMANCE INFORMATION** The trust must ensure that all information that is used for managing performance is accurate and up to date. **NATIONAL GUIDANCE** The trust should ensure that compliance with national guidance is monitored.	Establish EBME systems for mandatory tracking, e.g. theatre instrument sets, and make improvements if necessary	Director of IT and Information	Well Led	**04.05.2019 - Embedded Process**	05.03.2019	
55	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery :** The service should ensure all medical records are stored securely.	Identify and resolve any faulty or defective records cabinets or trolleys and obtain assurance from all ward managers / departmental heads that records cabinets / trolleys are fit for purpose	Director of IT and Information	Well Led	**24.05.2019** - **Embedded Process** all defected trolleys have been replaced.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			Maternity : The service must ensure that women's care records are kept securely in locked cabinets at all times.						
104	Should Do	Corporate / Trust-Wide Issues	**MEDICINES TEMPERATURES** The service should ensure that staff monitor the drugs room temperature and take action to address the temperature if it is outside of an appropriate range. **SLUICES AND MEDICINES ROOMS** The service should ensure all sluice areas and medication rooms in the unit are secure and that refrigerators in the medical room and packed appropriately. **Maternity :** The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations.	Conclude discussions on case for change to introduce air conditioning in selected/all medicines storage areas due to temperature excursions >25 degrees	Executive Director of Nursing and Midwifery	Effective	**14.05.2019 – Embedded process** Discussions have been concluded and a decision has been taken that air conditioning is not required and will be replaced with heat reflecting materials on windows, with the exception of 7 south facing windows. Proposals will be presented to Chief Nurse for sign off. Finance Committee have approved 7 key areas at FBPAC.	05/03/2019	
107	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**MEDICINES MANAGEMENT** The service must ensure that all medicines, including controlled drugs and patient group directions are managed in line with trust policy and legislation.	**Controlled Drugs :** Implement formal action plan developed from Q1 2018/19 audit results (30/9/18). Impact is not expected to be fully evident until Q3 audit. Q2 audit is being planned for August/September 2018. Strengthen corporate and	Executive Director of Nursing and Midwifery	Safe	**14.05.2019 – Embedded Process.** CD perfect ward compliance shows 94% compliance as at May 19.	31/01/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
				divisional accountability					
108	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**MEDICINES MANAGEMENT** The service must ensure that all medicines, including controlled drugs and patient group directions are managed in line with trust policy and legislation.	**PGDs :** - Implement action required as a result of March 2018 audit (especially staff and clinical manager signatures and ensuring staff signed checked against establishment). Pharmacy will re-audit December 2018. - Expand monthly matron spot checks to include PGDs - Strengthen corporate and divisional accountability (1/10/18)	Executive Director of Nursing and Midwifery	Safe	**14.05.2019 – Embedded process** PGD's perfect ward compliance shows 92% compliance as at May 19. This was further supported by Director of Pharmacy independent audits		
172	Should Do	Maternity Services (Women's & Children's Division)	**PERFORMANCE MONITORING** The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles.	Design and implement a consistent divisional dashboard (aligned to the Trust Quality Dashboard)	Head of IT	Well Led	**24.05.2019 – Embedded process** Effective dashboards are in place and are regularly reported. Divisional dashboard continue to evolve and are regularly reviewed	01/12/2018	
175	Should Do	Corporate / Trust-Wide Issues	**PERFORMANCE MONITORING** The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles.	Implement divisional quality reporting on a monthly basis	Executive Director of Quality and Governance	Well Led	**24.05.2019 – Embedded process**	11/12/2018	
190	Should Do	Medical Care (Acute & Medical Division)	**MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards.	Rectify defects identified through the existing quarterly audits in all wards and departments	Chief Nurse	Effective	**21.05.2019 – Embedded Process** 99% compliance with Meds Storage, further supported by Director of Pharmacy Independent report. Confident BAU process	01/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
42	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.	Make recommendations for improvement	Chief Operating Officer (executive lead for Estates)	Well Led	**02.05.2019 –Embedded process** Independent review received and action plan developed April 19	31/03/2019	
43	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.	Implement identified improvement	Chief Operating Officer (executive lead for Estates)	Well Led	**02.05.2019 –Embedded process** Independent review received and action plan developed April 19	31/03/2019	
44	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.	Provide assurance to PSQB on completion of improvement work	Chief Operating Officer (executive lead for Estates)	Well Led	**02.05.2019 –Embedded process** Independent review received and action plan developed April 19	31/03/2019	
132	Should Do	Corporate / Trust-Wide Issues	**PATIENT LEAFLETS** *This issue was identified in Critical Care but is Trust wide in scope* The service should ensure that patient leaflets are up to date, relevant and accessible for patients and visitors to the unit.	Clarify the leadership and accountability arrangements for the management of patient information	Executive Director of Nursing and Midwifery Director of IT and Information	Responsive	**14.05.2019 – Embedded Process** Reading Group established.	28/02/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
133	Should Do	Corporate / Trust-Wide Issues	**PATIENT LEAFLETS** *This issue was identified in Critical Care but is Trust wide in scope* The service should ensure that patient leaflets are up to date, relevant and accessible for patients and visitors to the unit.	Review the process for managing patient information leaflets and link with work being undertaken to comply with the Accessible Information Standard	Executive Director of Nursing and Midwifery Director of IT and Information	Responsive	**14.05.2019 – Embedded Process** Reading Group established.	28/02/2019	
134	Should Do	Corporate / Trust-Wide Issues	**PATIENT LEAFLETS** *This issue was identified in Critical Care but is Trust wide in scope* The service should ensure that patient leaflets are up to date, relevant and accessible for patients and visitors to the unit.	Make patient information leaflets available online via the Trust's web portal and explore other means of sharing leaflets through the Wirral Digital Project, e.g. mobile apps	Executive Director of Nursing and Midwifery Director of IT and Information	Responsive	**14.05.2019 –Embedded Process** Browsealoud software implemented on trust website, making patient information easily accessible. Embedded process.	05/03/2019	
132	Should Do	Corporate / Trust-Wide Issues	**PATIENT LEAFLETS** *This issue was identified in Critical Care but is Trust wide in scope* The service should ensure that patient leaflets are up to date, relevant and accessible for patients and visitors to the unit.	Establish a translation mechanism for online material (see Sheffield Teaching Hospitals NHSFT website)	Executive Director of Nursing and Midwifery Director of IT and Information	Responsive	**14.05.2019 – Embedded Process** Browsealoud software implemented on trust website, making patient information easily accessible. Embedded process.	28/02/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
192	Should Do	Medical Care (Acute & Medical Division)	**VTE** The service should ensure that venous thromboembolism (VTE) assessments are carried out within 24 hours of admission in line with national institute of clinical excellence guidance.	Undertake review of clinical process for assessment of VTE and strengthen where required	Executive Medical Director	Safe	**03.05.2019 - Embedded Process -** dashboard submitted as evidence	01/03/2019	
205	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**PAEDIATRIC LIFE SUPPORT** The service must ensure that there is a member of staff trained in paediatric advanced life support available at all times.	Train clinical staff in PLS	Executive Medical Director, Executive Director of Nursing and Midwifery	Responsive	**03.05.2019 –Embedded Process.** Rotas received as evidence	31/03/2019	
219	Must Do	Corporate / Trust-Wide Issues	**MORTALITY REVIEWS** The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning.	Develop the Learning from Deaths report to enhance visibility of avoidable factors and clarify action taken to address them	Executive Medical Director, Executive Director of Quality & Governance	Well Led	**04.05.2019 - Completed embedded process**	05/03/2019	
220	Must Do	Corporate / Trust-Wide Issues	**MORTALITY REVIEWS** The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning.	Incorporate compliance with primary mortality reviews within the Quality Dashboard	Executive Medical Director, Executive Director of Quality & Governance	Well Led	**04.05.2019** - **Embedded Process.** Included in DPR process	05.03.2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
221	Must Do	Corporate / Trust-Wide Issues	**MORTALITY REVIEWS** The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning.	Incorporate the analysis of learning into the CLIPI Report	Executive Medical Director, Executive Director of Quality & Governance	Well Led	**04.05.2019** – Embedded Process Included in PSQB cycle of business	05.03.2019	

Board of Directors

Agenda Item	9.8
Title of Report	Board Assurance Framework
Date of Meeting	5.6.2019
Author	Andrea Leather, Board Secretary
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	There are gaps with mitigating action.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The attached report includes the following:

- A summary of the risks and their associated risk scores in the Board Assurance Framework (BAF)

- A detailed analysis of each risk and the associated actions to mitigate these.

NOTE: All updates have been highlighted in red text.

2. Next steps

The Board of Directors is asked to review and consider:

a) the updated assurances and mitigating actions
b) the assurance rating for each of the risk vectors as provided by the relevant Committee for (as defined in the guidance notes provided). In additional the provisional assurance ratings within PR6.
c) the overall risk rating, with a particular focus on those risks where 'negative' assurance ratings have been provided.

3. Recommendations

The Board of Directors is asked to:

- approve or amend the risk rating
- approve assurance rating and updates as detailed in the report.

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:

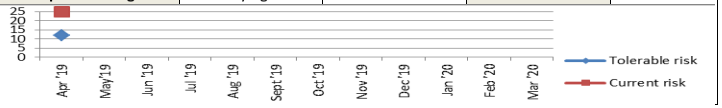

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the risk


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

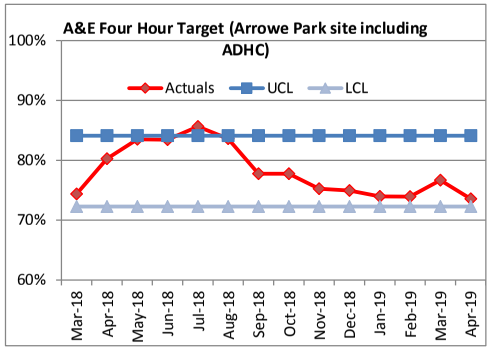
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify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

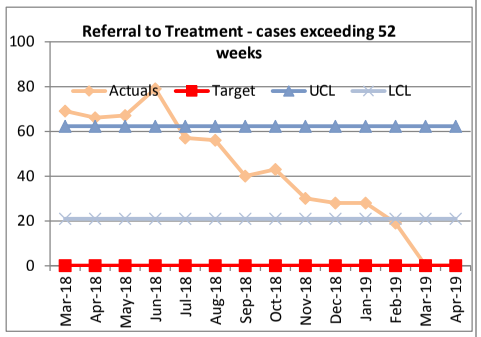
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:** Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that 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						

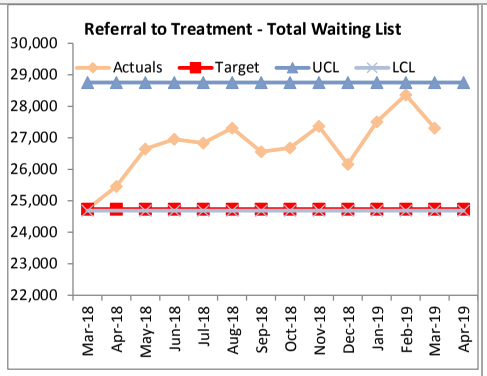


Risk Vector (what might cause this to happen)	Primary Risk Treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage 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 Reverse cohort area expansion within A&E footprint **SLT Lead**: COO **Timescale:** May 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 ▪ Ambulance Handover times (daily) **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	Positive
Threat & Opportunity: Operational **failure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort' **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Emergency preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board(UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of GP practice collapse on Wirral there would likely be surges in demand for secondary care	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of general practice in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of General practice in Wirral **SLT Lead:** COO **Timescales:** May 2019	Positive
Threat & Opportunity: Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL ▪ Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse ▪ Reliance on Walk-in-Centres / Urgent Care Centre ▪ A&E delivery Board (UCOG & UCEXG) ▪ System partners escalation process	Not within the Trusts sphere of control. In the event of collapse, emergency procedures will govern the response	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing Review Contingency plans **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** ▪ Reports to TMB **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); ▪ LHRP Assurance Process	Uncertainty re: fragility of neighbouring providers in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of neighbouring providers in the Wirral **SLT Lead:** COO **Timescales:** May 2019	Positive

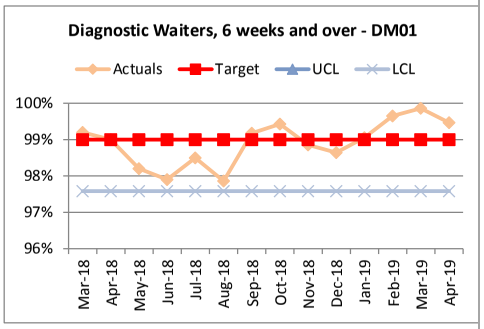
Key risk indicators (KRIs) – Data updated 17/05/19



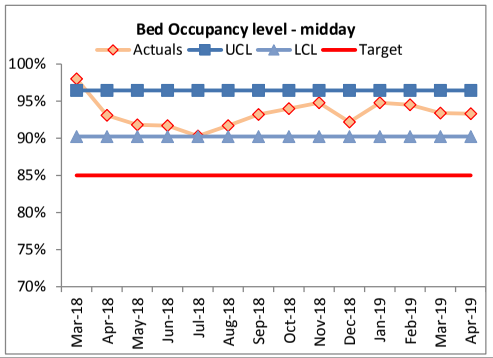


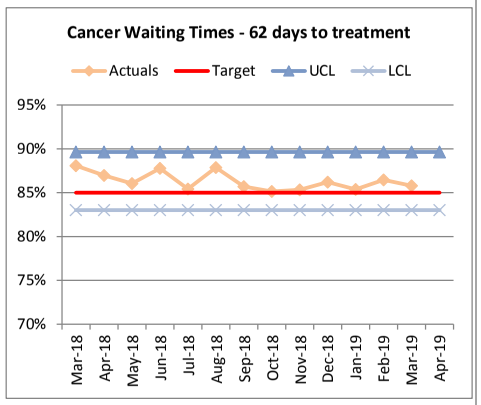


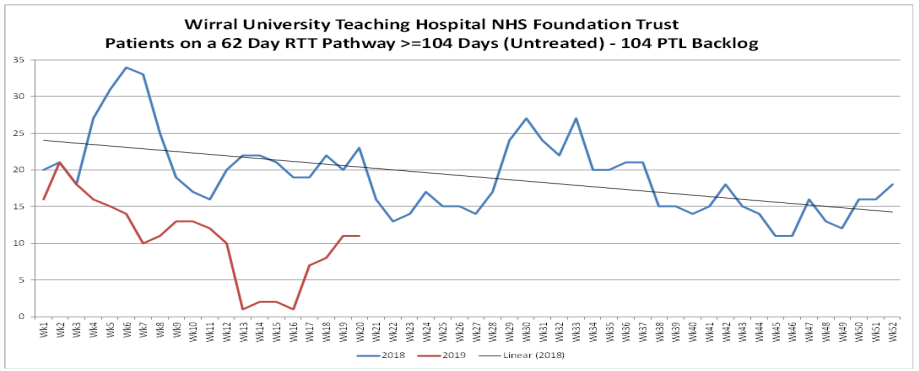
Total no.on waiting list



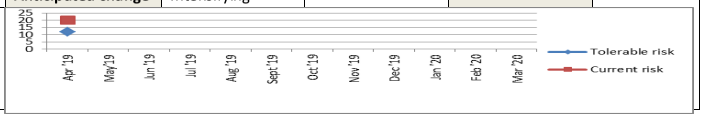
WUTH activity (Admitted, Discharges & Net flow)
To be developed







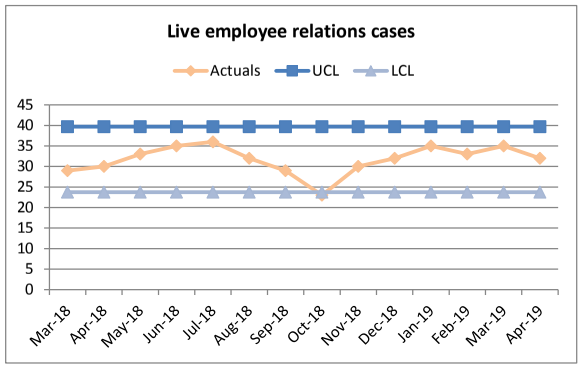
Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 17 May 2019)

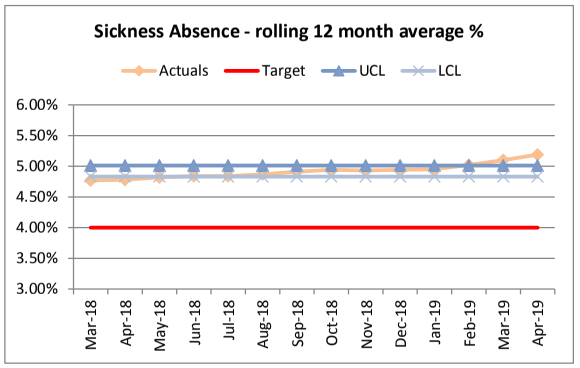
Strategic priority	I. PEOPLE: Supported empowered workforce II. PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	WAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving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

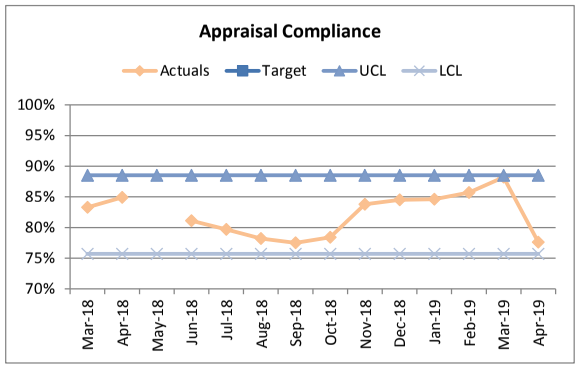
Risk Vector (what might cause this to happen)	Primary risk treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage 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 inc hard to recruit groups Lack of understanding re: the impact of age demographics on staff retention risk Vacancy rates / high locum use and hard to recruit medical posts Vacancy rates for nursing posts No workforce plan aligned to service strategy	Develop understanding & boost ownership through WF Steering group/ Divisional Performance reviews **SLT Lead:** Dir HR **Timescales:** Commence April '19 Bed modelling & specialty capacity/ demand review **SLT Lead:** COO **Timescales:** By end April '19 Medical Staffing Review **STL Lead:** Dir HR **Timescale:** June '19 T&F group – recruitment B 5's **SLT Lead:** Ch. Nurse **Timescales:** July '20 Develop and approve workforce strategy and implementation plan by end of April '19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) ▪ Safe Staffing Report – recruitment (quarterly) ▪ Finance & Workforce Scrutiny meeting.(weekly) **Level 2** ▪ Workforce strategy & plan ▪ Quality and Performance dashboard- W/force metrics (monthly); ▪ Report of Workforce Assurance Committee to Board (Monthly); ▪ FBPAC reports (Monthly) ▪ EU exit paper presented to TMB and Chairmans report to Board (Feb/ Mar '19)	None identified	Negative
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 External Sickness Management Solution Business Case to FBPAC **SLT Lead:** Dir HR **Timescales:** From May'19 Health & Well-being Programme inc. Employee Assistance business case being developed – June '19	**Level 1** ▪ Divisional performance reviews – workforce metrics (monthly) ▪ Workforce steering group – all KPI's (monthly) ▪ Regular pulse checks starting June '19 **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	Inconclusive
Proximity of threat 19/20 | 20/21 | 21/22 | 22/23 | 23/24 < | – | – | – | >	▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) ▪ The LHRP co-ordinated response	Limits to the extent contingencies can provide the state required in emergency	Test EPRR arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by Q3 '19	**Level 2** ▪ Resilience Assurance report to RMC (Mar; Sept 19) **Level 3** ▪ Confirm and Challenge by NHS England Regional team and CCGs; ▪ LHRP Assurance Process	None identified	

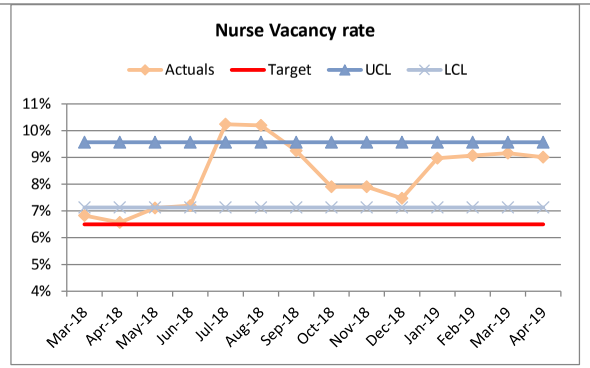
Threat: Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	▪ Induction; Mandatory & role specific training programmes; ▪ Corporate teams provide support and training as required ▪ Exercises to test business continuity and incident management plans including loss of technology ▪ ESR training record ▪ Protected budgets for training & development ▪ Practice educators	Difficulties in releasing staff from wards	Deliver 80% of mandatory training as an e-learning option for staff **SLT Lead:** HR Dir **Timescales:** By end Q1 '19 Individual responsibility – exploring personal ownership to complete mandatory training – 1st draft plan **SLT Lead:** HR Dir **Timescale:** June '19	**Level 2** ▪ Q&P Dashboard- Mandatory training (monthly); ▪ Report of Workforce Assurance Committee to Board (monthly) **Level 3** Staff survey (Mar '19)	None identified	Negative
		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			

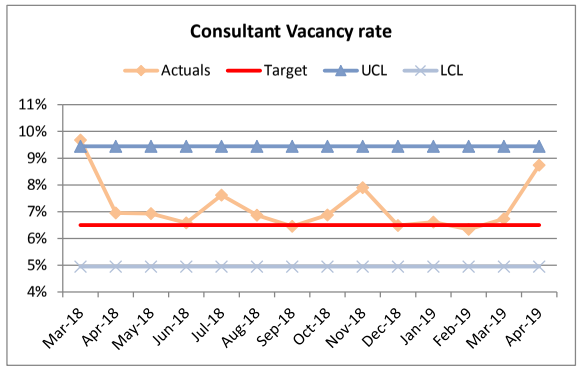
Key risk indicators (KRIs) Data updated 17/05/19





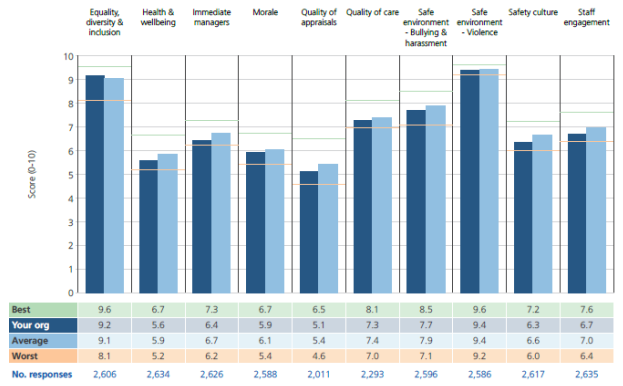






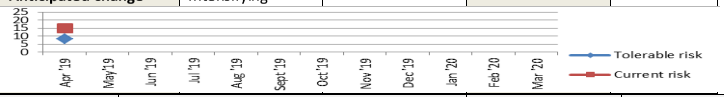
To be developed – established nursing posts vs staff in post

Staff survey 2018

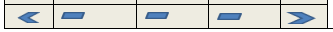


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.2	5.6	6.4	5.9	5.1	7.3	7.7	9.4	6.3	6.7
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	2,606	2,634	2,626	2,588	2,011	2,293	2,596	2,586	2,617	2,635

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						

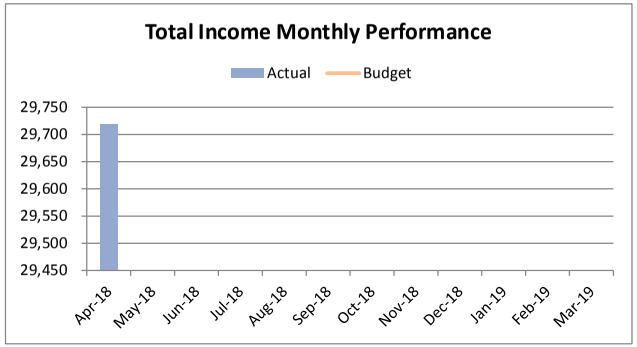


Risk Vector (what might cause this to happen)	Primary risk controls (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	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 ▪ Contract terms reduce risk of income volatility as a result of block payment basis for Outpatients and support to underwrite Non-elective variation ▪ SFI's authorisation limit (scheme of delegation) ▪ Core financial control Policies / Procedures ▪ Access to Working Capital support ▪ Budgetary controls/Budget at Ward & Dept level ▪ Training for budget holders ▪ Procurement processes and Team ▪ Risk based annual capital planning process	▪ Not all budget holders have completed training ▪ Compliance with escalation as per SFI ▪ MTFM not yet agreed ▪ Effectiveness of budget management @Divisional/ Corporate/ Ward/ Dept ▪ Operational productivity impacting adversely on income and expenditure ▪ Robust capacity plan ▪ Job planning and e-roster ▪ Estates Strategy in development ▪ Unbudgeted expenditure, including that related to meet regulatory requirements arising in year without mitigating savings	Embed S/L reporting & establish steering group **SLT Lead:** MD **Timescales:** End of September '19 Robust capacity plan/ job planning and e-roster- add on required - efficient deployment of staff across organisation (IT solution) **SLT Lead:** Ch. Nurse **Timescales:** End of September '19 Ensure all budget holders receive refresher training on budget management & SF1 compliance **SLT Lead:** FD **Timescales:** End of July '19 Develop & agree MTFM **SLT Lead:** FD **Timescales:** End of July '19	**Level 1** ▪ Divisional risk reports to Risk Committee bi-annually; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Significant risk report to RMC (monthly); ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit; ▪ External audit; ▪ Signed contract with WHCC/NHSE	None identified	Inconclusive
Threat: Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ CIP planning processes and coordination of delivery ▪ Agreed CIP plans at Divisional and Dept level ▪ Access to Working Capital support ▪ Programme Board ▪ SRO's identified for CIP programme ▪ CIP planning; scoping; approval and initiation process in place with QIA and clinical sign-off ▪ CIP delivery oversight meeting	▪ Unidentified CIP in year ▪ Effectiveness of oversight ▪ CIP planning only relates to current financial year	Develop & agree MTFM **SLT Lead**: FD **Timescales:** End of July '19 Healthy Wirral System 5yr Recovery & Sustainability plan in development **Timescale:** End of June '19	**Level 1** ▪ Divisional reports to Programme Board; **Level 2** ▪ Finance report presented to Board (monthly) ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit/ External audit;	None identified	Inconclusive
Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Treasury loan process/NHSI Capital approval process. ▪ Planned and preventative maintenance regime in place based on compliance ▪ Reactive maintenance regime to repair immediate issues as they arise with dedicated Budget for Backlog maintenance - circa £1.2 million ▪ Dedicated Capital Budget for improvement works on the Physical Environment- various.	▪ The condition of the current estate and ageing medical devices presents a significant maintenance and affordability burden in a restrained operations environment ▪ Restrictions on availability of central capital funding	Establish a trust wide 6 facet survey and report on the physical environment to identify areas of concern and replacement costs **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ Divisional risk reports to RMC (monthly) ▪ Backlog report presented to RMC -March 19; ▪ Compliance Audit undertaken (every 6mths) **Level 2** ▪ Significant risk report to RMC (monthly) **Level 3** ▪ PLACE audits (annually) ▪ 6 Facet survey ▪ Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	Inconclusive

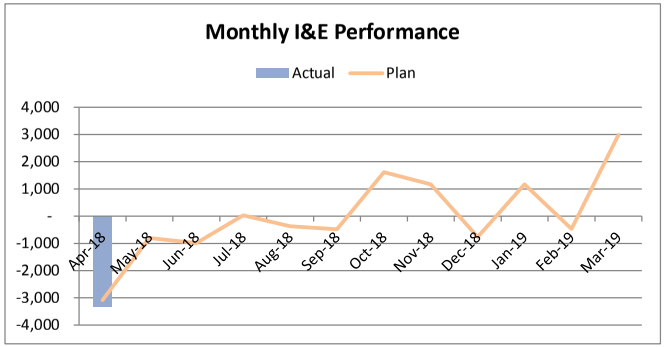
Threat: Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society **Proximity of threat** 19/20 20/21 21/22 22/23 23/24 	▪ Specialist H&S advisors & legal team employed ▪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

Key risk indicators (KRIs) Data updated 17/05/19

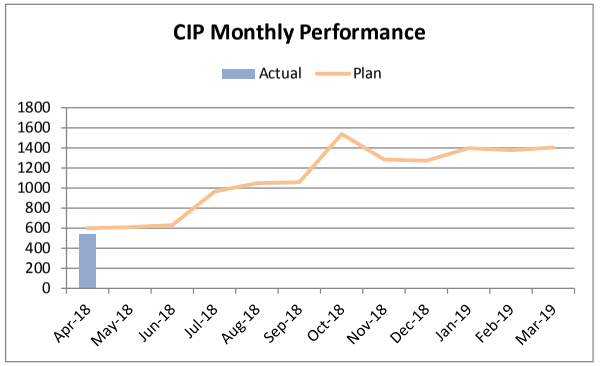
Total Income Monthly Performance



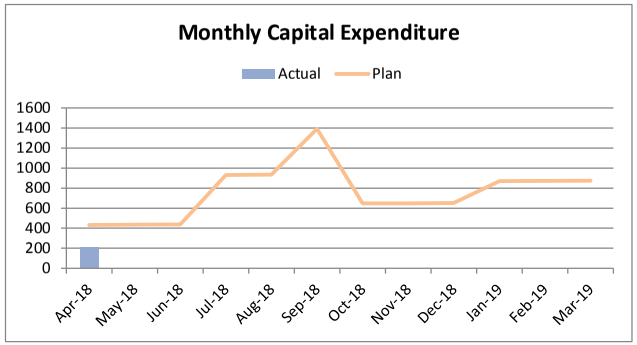
Monthly I&E Performance



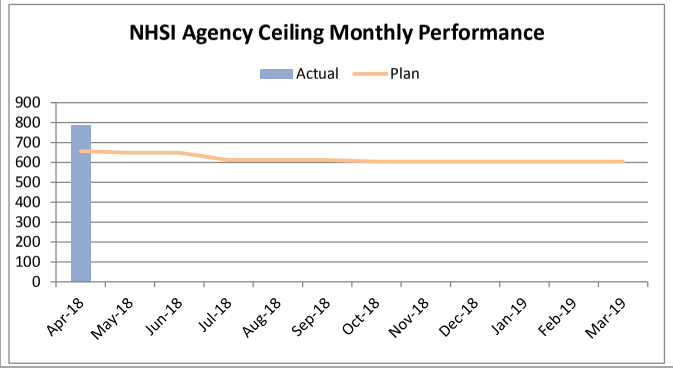
CIP Monthly Performance



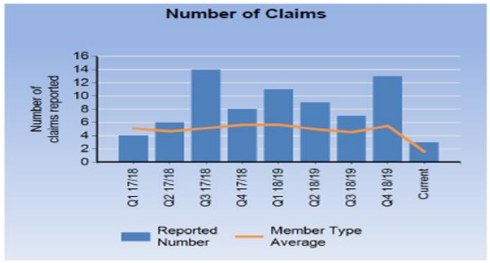
Monthly Capital Expenditure



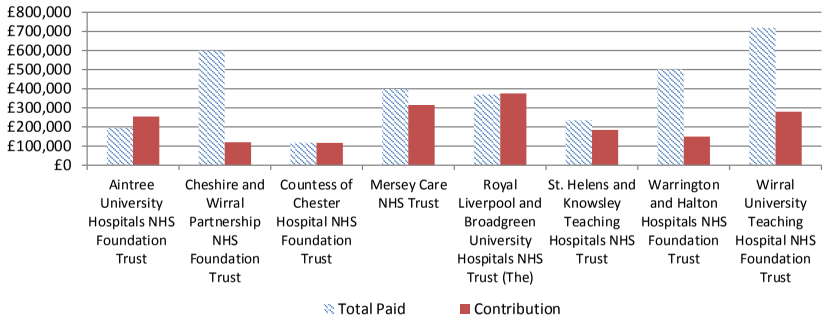
NHSI Agency Ceiling Monthly Performance



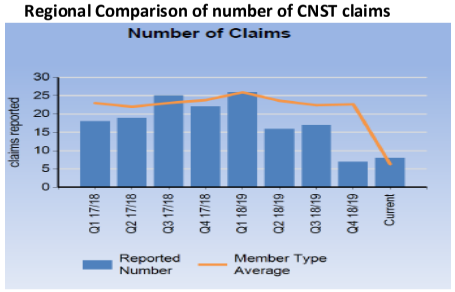
Regional Comparison of number of EL/PL claims



Regional comparison of RPST contribution and level of compensation paid



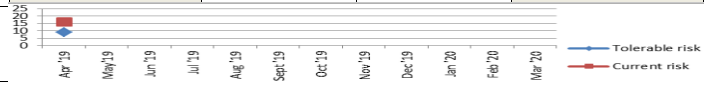
Regional Comparison of number of CNST claims



Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 17 May 2019)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

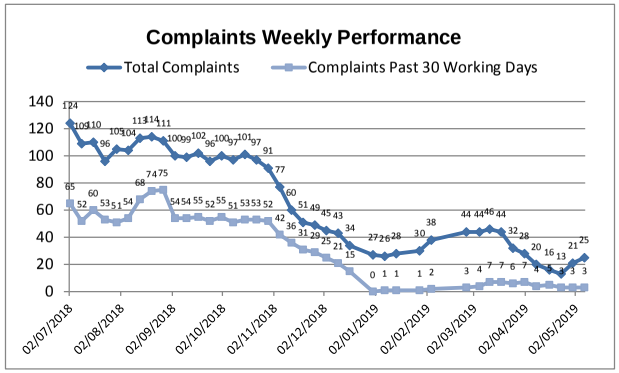
Strategic priority	PATIENTS: Pursuing quality improvement	**Lead Committee**	Quality	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 4: Catastrophic failure in Standards of Care** A Catastrophic 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							

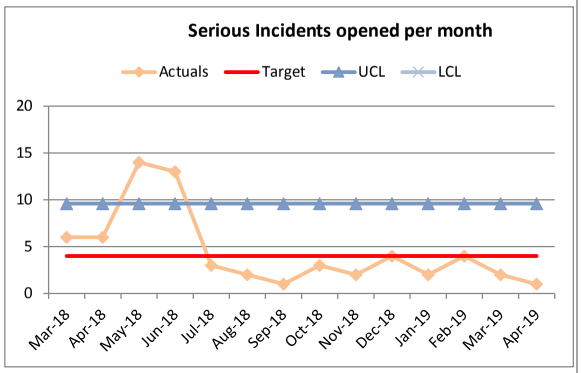


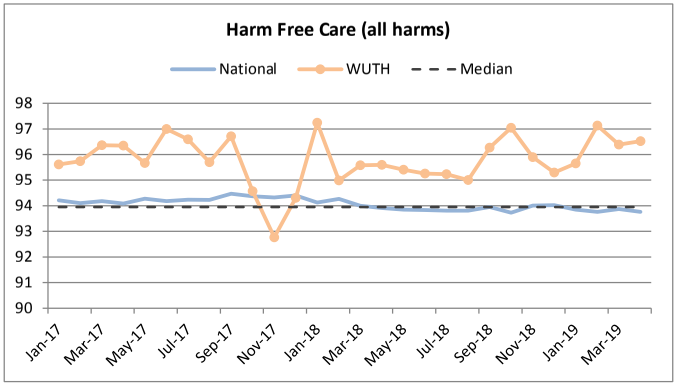
Risk Vector (what might cause this to happen)	Primary risk treatment (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage 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	Negative
A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including • Monthly Patient Safety & Quality Board (PSQB) with work programme aligned to CQC registration regs • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Clinical audit programme & monitoring arrangements • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe medical & nurse staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • CAS Implementation process • Mortality review policy & process • Real time review of incident reports and complaints handling	Current levels of mortality review and structured judgement review where these are indicated Timeliness of end to end VTE assessment through to treatment	Further develop & strengthen Learning from deaths process **SLT Lead:** MD **Timescales:** By end Q1 '19 Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission. **SLT Lead:** MD **Timescales:** By end Q1 '19	**Level 1** ▪ Perfect ward/ ward accreditation audits (ongoing) ▪ FTT and electronic patient/relative feedback kiosks ▪ Primary Mortality Reviews **Level 2** ▪ Quality Performance Dashboard (monthly); ▪ PSQB reports (monthly) ▪ Quality Account (annual); ▪ KLOE inspections local inspections; ▪ Serious Incident Review Group (weekly) ▪ Safety Summits (monthly) **Level 3** ▪ CCG oversight of SI's (monthly) ▪ CQC Insight tool(monthly); ▪ Dr Foster updates; ▪ Internal Audit SI- significant assurance ▪ MIAA audit re safe staffing: Significant assurance ▪ Patient/ Staff surveys	None identified	Positive

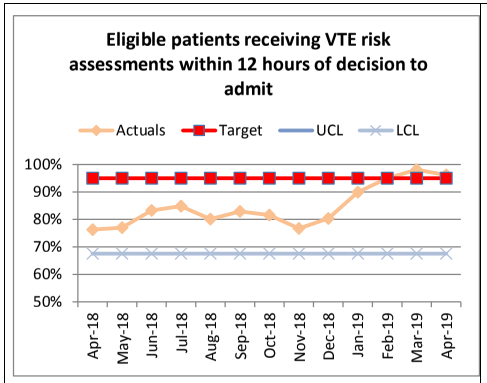
Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	**Key Measures** - We have the ability to measure metrics shown in the rest of the BAF eg VTE and MUST **Training** – end users are not provided access unless they are trained **Continuous improvement of the EPR** Response to divisions about usability and function	**Extended measures** There are other areas to monitor e.g fluid balance or IVs **Training** – adoption of a new way of training described in paper to WAC which includes regular updates **Innovation** – The way innovations are introduced into the Trusts needs more of a framework to manage priorities, costs and sustainability	**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	Inconclusive

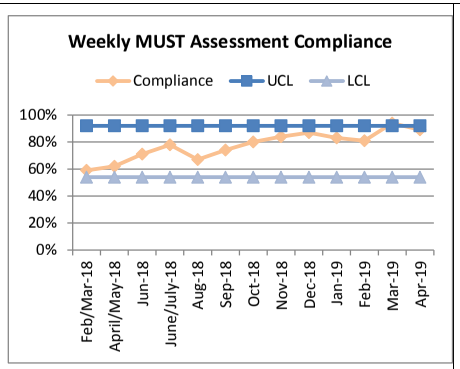
Key risk indicators (KRIs) - Data updated 17/05/19

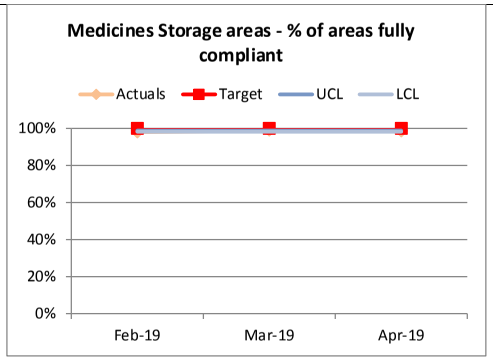


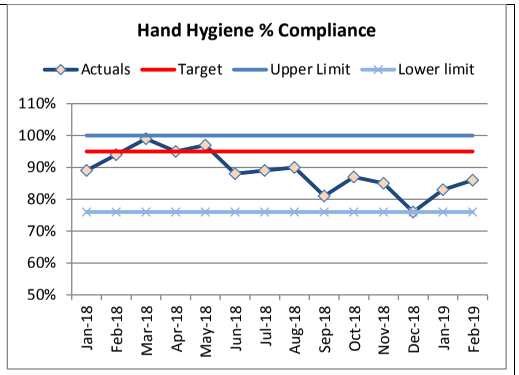


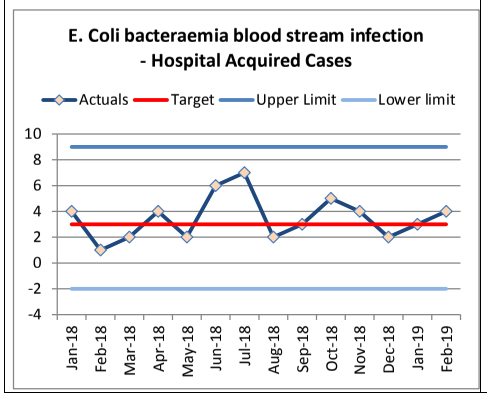


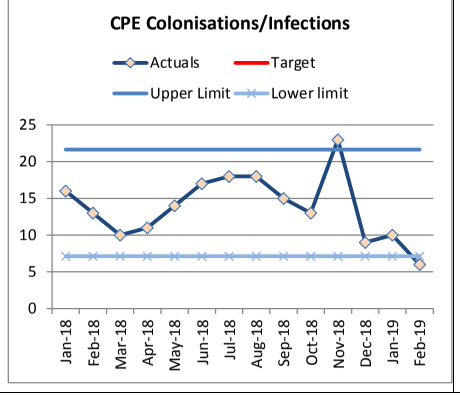


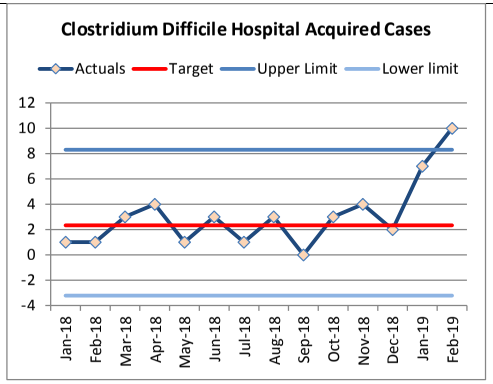


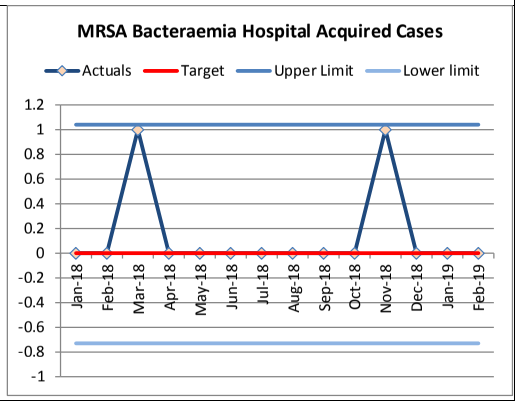








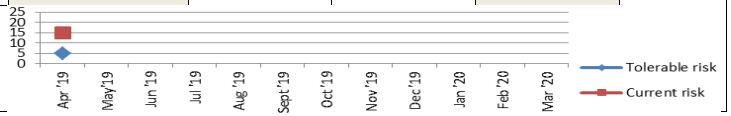




Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 17 May 2019)

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	Positive
Threat: A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels • Operational strategies & plans for specific types of major incident (e.g. fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) • Strategic, Tactical, Operational command structure for major incidents • Business Continuity, Emergency Planning & security policies • Power failure action cards • Business Impact assessments • Major incident plan and action cards	Deterioration of plant equipment & Fabric of building due to age of estate and availability of funding & extent of work required.	6 Facet survey commissioned **SLT Lead:** COO **Timescales:** May '19	**Level 1** ▪ EPRR Twice yearly report to RMC **Level 2** ▪ Monthly Significant Risk Report to Risk Committee ▪ EPRR annual report (Sept) ▪ Communication testing (every 6 months) **Level 3** ▪ EPRR Core standards compliance rating (+ve); ▪ Facet survey (May '19) ▪ MIAA Internal audit report – Emergency planning (May 19) ▪ April 2019 notification of NHSE review of EPRR core standards – Rating of "Substantial" assurance received for 2018/19	None	Positive
Threat: A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	▪ CAS alert system – Disruption in supply alerts ▪ Procurement ▪ Account Management ▪ Supplier Assurance ▪ Contingencies – Stock control ▪ 'No deal' EU Exit Planning Team established ▪ SRO & EU Exit lead identified for Exit preparation ▪ Risk assessment and business continuity planning	EU Exit Operational Readiness Guidance identifies a number of actions Trusts must take in preparation for Brexit	EU Exit planning team to review Operational guidance and ensure all actions completed within timescales **SLT Lead:** COO **Timescales:** As determined by Parliament (Review end Q1 '19)	**Level 2** ▪ EU Exit paper to TMB (Feb 19) ▪ EU Exit preparation update to Board (Mar 19) ▪ EPRR Twice yearly report to RMC (Mar; Sept) ▪ EPRR Annual Report **Level 3** ▪ Letter of assurance, DoH		Positive

Key risk indicators (KRIs) Data updated 17/05/19

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	Quality	Compliance levels (Target 100%)
Desktop patching	4462	100%
Server patching	273	94%

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

Inactive directory device accounts	Mar '19	Apr '19	May '19	YTD
60 days (notice issues)	48	396*		444
90+ days to be disabled	79	296*		375

Web filtering	Mar '19	Apr '19	May '19	YTD
Access requests authorised	20 (Av)	25		45

Removable media	Mar '19	Apr '19	May '19	YTD
Addition to whitelist	0	0		0

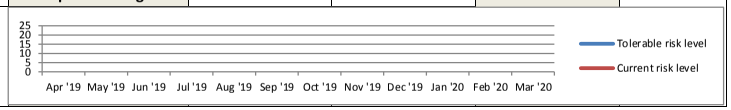
* Note: The large change is figures is due to the update of a large number of devices from windows 7 to windows 1. Old device account will be purged out by 20/5/19.

Planned Preventative Maintenance performance measure – to be developed

Board Assurance Framework (BAF): 2019/20 (Draft – valid as of 17 May 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		
		Initial date of assessment	01/04/2019	Consequence	5.V. High	5. V. High	Risk appetite	Open
		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	Positive
Threat: Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	▪ Communications department to handle media relations: ▪ Established relationships with regulators ▪ Trust website & social media presence ▪ Internal communications channels ▪ Continued public & stakeholder engagement utilising a wide range of consultation & communication channels; ▪ Involvement & Engagement Strategy Trust Board ▪ Surveys and Friends and Family Testing ▪ Consultation on proposed strategy and service changes	▪ No agreed Comms / PR Strategy	External support to develop Comms / PR Strategy	**Level 2** ▪ Communication / Press statements **Level 3** ▪ CQC National patient survey; ▪ FFT recommendation ratings ▪ Healthwatch commentary ▪ OSC commentary ▪ NHS Choices ratings	None identified	Inconclusive

Key risk indicators (KRIs) Data updated 17/05/19

Care Quality Commission

Wirral University Teaching Hospital NHS Foundation Trust

CQC overall rating

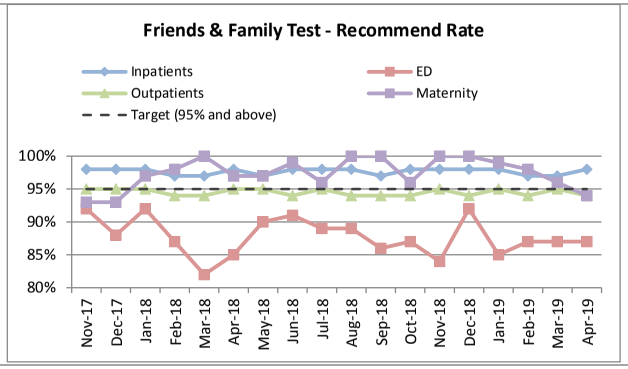
Requires improvement

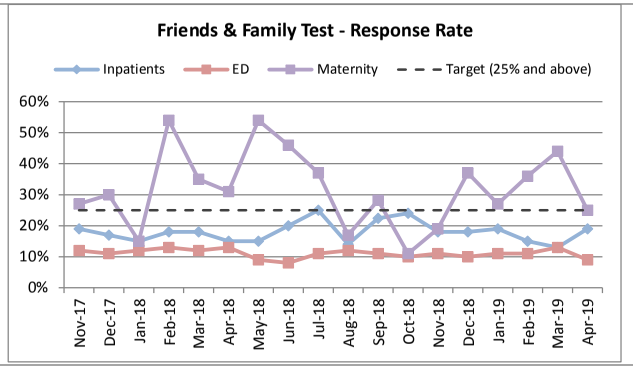
13 July 2018

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

NHS Choices – 17/05/19

	NHS.UK users rating	Care Quality Commission inspection ratings	Recommended by staff	Mortality rate (in hospital and up to 30 days after discharge)	Food: Choice and Quality
Arrowe Park Hospital (Remove)	180 ratings, Rate it yourself	Requires improvement, Visit CQC profile	OK – Within expected range with a value of 69%	OK – Number of deaths within the expected range	OK – 79.69% Within the middle range
Tel: 0151 678 5111, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE, 1.0 miles away | Get directions					
Clatterbridge Hospital (Remove)	36 ratings, Rate it yourself	Requires improvement, Visit CQC profile	OK – Within expected range with a value of 69%	OK – Number of deaths within the expected range	OK – 66.11% Within the middle range
Tel: 0151 334 4000, Clatterbridge Road, Bebington, Wirral, Merseyside, CH63 4JY, 5.0 miles away | Get directions					





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