Wirral University Teaching Hospital
NHS Foundation Trust

# Public Board of Directors

# 3rd July 2019

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 3 JULY 2019**

**COMMENCING AT 9AM IN THE BOARD ROOM**

**EDUCATION CENTRE, ARROWE PARK HOSPITAL**

# AGENDA

| | | | |
|---|---|---|---|
| **1** | **Apologies for Absence**<br>Chair | v | |
| **2** | **Declarations of Interest**<br>Chair | v | |
| **3** | **Chair's Business**<br>Chair | v | |
| **4** | **Key Strategic Issues**<br>Chair | v | |
| **5** | **Board of Directors** | | |
| | **5.1 Minutes of the Previous Meeting – 5 June 2019** | d | Page 3 |
| | **5.1.2 Board Action Log**<br>Board Secretary | d | Page 13 |
| **6** | **Chief Executive's Report**<br>Chief Executive | d | Page 14 |

## 7. Quality and Safety

| | | | |
|---|---|---|---|
| **7.1** | **Patient Story**<br>Head of Patient Experience | v | |
| **7.2** | **Learning from Deaths**<br>Medical Director | d | Page 17 |
| **7.3** | **Review of the Outbreak of *Clostridium difficile***<br>Chief Nurse & Medical Director | d | Page 23 |
| **7.4** | **Health & Safety Quarterly Update**<br>Director of Quality & Governance | d | Page 28 |

## 8. Performance & Improvement

**8.1 Integrated Performance Report**

**8.1.1 Quality and Performance Dashboard and Exception Reports** — d — Page 40
Chief Operating Officer, Medical Director, Chief Nurse, Director of Workforce, Director of Governance & Quality

**8.1.2 Month 2 Finance Report** — d — Page 47
Acting Director of Finance

## 9. Workforce

**9.1 Interim NHS People Plan** — d — Page 61
Director of Workforce

## 10. Governance

**10.1 Report of Programme Board** — d — Page 66
**Followed by presentation re Perioperative Medical Pathway**
Joe Gibson

**10.2 Report of Trust Management Board** — d — Page 99
Director of Quality & Governance

**10.3 CQC Action Plan Progress Update** — d — Page 103
Director of Quality & Governance

## 11. Standing Items

**11.1 Any Other Business** — v
Chair

**11.2 Date and Time of Next Meeting** — v
Wednesday 7 August 2019

**BOARD OF DIRECTORS**

**UNAPPROVED MINUTES OF PUBLIC MEETING**

**5th JUNE 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 |
| Steve Igoe | Non-Executive Director |
| 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**

| | |
|---|---|
| Paul Charnley | Director of IT and Information |
| Andrea Leather | Board Secretary [Minutes] |
| Mike Baker | Communications & Marketing Officer |
| Ann Taylor | Staff Governor |
| Richard Latten | Staff Governor |
| Jane Kearley* | Member of the Public |
| Joe Gibson* | Project Transformation |
| Stephanie Gray* | Member of the Public / Patient Story |
| Sue Milling-Kelly* | Patient Experience Team |

**Apologies**

| | |
|---|---|
| Helen Marks | Director of Workforce |
| 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 |

| Reference | Minute | Action |
|---|---|---|
| **BM 19-20/049** | **Apologies for Absence**<br><br>Noted as above. | |
| **BM 19-20/050** | **Declarations of Interest**<br><br>There were no Declarations of Interest. | |
| **BM 19-20/060** | **Chair's Business**<br><br>The Chair welcomed all those present to the monthly Board of Directors meeting.<br><br>In opening the meeting, the Chair informed the Board of Directors that it was volunteer week and took the opportunity to thank all individuals who support the Trust in this role with a particular thanks to Jayne Kearley who was in attendance at the meeting. | |

| Reference | Minute | Action |
|---|---|---|
| | He then apprised the Board of a range of items including correspondence and meetings with local MP's, the Trusts approach to recent adverse publicity and feedback from staff. The Wirral System Chair's meeting was scheduled for later that day and the Board of Directors would be updated at the next meeting. | |
| **BM 19-20/061** | **Key Strategic Issues**<br><br>Board members apprised the Board of key strategic issues and matters worthy of note.<br><br>**Chief Operating Officer** – apprised the Board of Directors in relation to continued performance improvements subsequent to the introduction of the reverse cohort plans. Mr Middleton reported that whilst the Trust has received independent reports identifying concerns regarding the front door/streaming and is continuing to work with partner organisations to progress patient flow changes, some resistance remains. Discussions are ongoing to seek alternative solutions.<br><br>**Medical Director** – requested the Board of Directors to delegate authority regarding two matters:<br><br>1. 7 day services self assessment submission – assessment will be reviewed at Patient Safety Quality Board.<br>2. CNST Board assurance sign off against 10 standards – assessment will be reviewed at Quality & Safety Committee.<br><br>The Board approved delegated authority to the Medical Director for the submissions detailed above.<br><br>**Acting Director of Finance** – informed the Board that the Trust has received notification from NHS Improvement to resubmit capital plans and advising of restrictions in relation to capital controls that that would prohibit the Trust sourcing alternative funds to be utilised within 2019/20.<br><br>**Chief Nurse** – informed the Board of two invitations to forthcoming events:<br><br>• 12th July - Transgender, Intersex and non-binary awareness raising conference, guest speakers include Tony Griffin, Chair of Navajo, Neil Perris, Diversity lead for Community Trust, Wirral LGBT+ Network, and Young Peoples Advisory Service (YPAS)<br>• 19th July - 'Treat me well' campaign as part of the Learning & Disability awareness week. It is expected that approximately 20 members of the public with a learning disability are to attend and the Trust will complete co-ordinated walks around the perimeter of the hospital. Staff will be encouraged to join the walk to demonstrate commitment to ensuring positive patient experience. Also the opportunity to show interested parties parts of the hospital they may come into contact with e.g. ED, SEAL, OPD again to meet staff and share concerns and or experiences<br><br>**Mr John Sullivan – Non-Executive Director –** reported that along with Chris Clarkson they had met with staff to review the process for those injured at work, the lessons to be learned from past incidents. It was agreed that in | |

| Reference | Minute | Action |
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| | establishing a task and finish Committee of the Board - Health & Safety Assurance Committee membership would require Non-Executive Director representation one of whom would be Chair – John Sullivan, Chris Clarkson and Steve Igoe. In addition, future Chief Executive reports to include a standing item for 'RIDDOR' incidents.<br><br>***The Board noted that although some members did not have detailed updates there were a number of topics already covered within agenda items.*** | |
| **BM 19-20/062** | **Board of Directors**<br><br>**Minutes**<br>The Minutes of the Board of Directors meetings held 1st May and 28th May 2019 were approved as an accurate record.<br><br>**Action Log**<br>In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required. | |
| **BM 19-20/063** | **Chief Executives' Report**<br><br>The Chief Executive apprised the Board of the key headlines contained within the written report including:<br><br>• Serious Incidents<br>• RCN visit<br>• A&E Board<br><br>**ECIST / Front Door redesign** – outcomes of meeting later today to be provided at next Board meeting.<br><br>**Carter at Scale** – Board to be advised of opportunities for consideration in conjunction with appropriate due diligence.<br><br>***The Board noted the information provided in the May Chief Executive's Report.*** | |
| **BM 19-20/064** | **Patient Story**<br><br>The Board was joined by Stephanie Gray who outlined her journey as a transgender patient, from personal turmoil through to the current day as an advocate and serving the community via various peer to peer support groups and advisory groups.<br><br>Through the recommendation of the Trans Support Service in Liverpool, Stephanie was referred to Dr Leong here at the hospital's endocrinology department to start her hormone treatment. Stephanie stated that<br><br>*"it's fair to say that your hospital holds a very special place within the transgender community on Merseyside because of the work Dr Leong does for my community. I know of no-one within it who does not hold Dr Leong in the highest regard. He always conveys empathy and kindness; he is so caring and makes you feel at ease at all times. You certainly feel you are in good hands, which is so important for a community which at times can feel* | |

| Reference | Minute | Action |
|---|---|---|
| | *isolated in the world. We are treated with dignity and respect and the department staff are always friendly"*<br><br>In concluding, Stephanie conveyed her gratitude for the opportunity to share her story and bring awareness of her community to the skilled people who are involved with their treatment and any medical conditions they may suffer, resulting in them being in-patients.<br><br>On behalf of the Board, the Chair expressed his thanks and appreciation to Stephanie for sharing her experience.<br><br>***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.*** | |
| **BM 19-20/065** | **Six monthly Nurse Staffing Report**<br><br>The Chief Nurse presented to the Board the planned and actual nursing and care support staffing levels during quarter 3 and 4 2018/19.<br><br>The report is line with national guidance and 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 Chief Nurse explained that this data is monitored on a daily, weekly and monthly basis.<br><br>The report also provided an update on the recently concluded review undertaken by Mersey Internal Audit Agency (MIAA) relating to safe staffing systems, processes and assurances provided by the Trust. The final report is due to be presented to the next Audit Committee but the preliminary outcome has been rated by MIAA as having 'substantial assurance'.<br><br>The Trust is looking to source a digital solution for reporting of acuity and dependency and efficient rostering, options to be considered at Trust Management Board.<br><br>Whilst appreciating nursing recruitment is both a national and local concern, the Board discussed different opportunities for flexible working to encourage people to come and work at the Trust eg new models of working. At the same time greater emphasis should be on retention. It was acknowledged that recruitment through the Workforce Strategy would be an element of the overall Trust Strategy discussion later in the year.<br><br>***The Board noted the six monthly nurse staffing report and the safe staffing declaration.*** | **GW/HM** |
| **BM 19-20/066** | **Quality & Performance Dashboard and Exception Reports**<br><br>The report provides a summary of the Trust's performance against agreed key quality and performance indicators.<br><br>Of the 51 indicators with established targets or thresholds 26 are currently off-target or not currently meeting performance thresholds.<br><br>The updated metrics and thresholds across a range of indicators were highlighted. The Director of Quality & Governance highlighted progress to date across a range of indicators that is now being sustained particularly in | |

| Reference | Minute | Action |
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| | the 'Safe, Caring and Responsive' domains. The lead Director for a range of indicators provided a brief synopsis of the issues and the actions being taken.<br><br>Areas of focus for discussion were:<br><br>• Infection Prevention Control (IPC) indicators – A number of measures introduced to address the non compliance of IPC indicators – details provided below.<br>• Attendance (previously sickness) – the metric has been changed to now report as attendance, with a minimum threshold of 95% based on a 12 month rolling average.<br>• Nutrition and hydration – discussion at daily safety huddle to continue until processes are embedded, reported performance for May of 95%<br>• Stranded patients – the weekly review considers treatment/ diagnostics from point of admittance to discharge. As a primary objective to address lack of improved performance the introduction of an estimated date of discharge to be identified. The interdependency of this indicator with the impact on IPC indicators were acknowledged.<br>• RTT – revised metric, now total open pathway waiting list. National focus. NHS Improvement objective to reduce below March 2018 position (24,736) by March 2020<br>• RTT (52 week) – high degree of confidence to maintain compliance.<br>• RTT (18 week) – backlog of clinical outcome forms – monitoring as part of weekly review.<br>• Appraisal – revised metric to reflect 12 month period.<br><br>Following concerns raised at the last Board regarding IPC and the impact on increasing numbers of Cdiff cases, the Chief Nurse reported that a review of processes and procedures had been undertaken. As a consequence a number of steps are to be implemented to address the current situation:<br><br>• Safe clean environment including standard of cleaning and estate issues<br>• De-clutter of all clinical areas to ensure effective cleaning can be actioned<br>• Individual staff responsibility hand hygiene, uniform policy.<br><br>There will be a focus on doing the basics brilliantly, with an agreed communication strategy circulated with a weekly topic of focus and use of screen savers to support information sharing.<br><br>The Trust will continue with weekly Executive led outbreak meeting (supported now by Medical Director and Director of Quality Governance) and includes internal support from Divisions, Estates & Facilities, IPC team and external support from NHS England/Improvement and Public Health England.<br><br>The Board took account of the current difficulties in respect of IPC and consideration was given to placing the Trust on an emergency footing. It was agreed that both a tactical (short term) versus strategic (long term sustainable) plan including an emergency SITREP position is to be developed.<br><br>**NOTE:** Following discussion later in the meeting agreement to contact Dr Richard Cook, Microbiologist to seek an external perspective of the possible unknowns. | **GW**<br><br>**NS** |

| Reference | Minute | Action |
|---|---|---|
| | ***The Board noted the current performance against the indicators to the end of April 2019.*** | |
| **BM 19-20/067** | **Month 1 Finance Report**<br><br>The Acting Director of Finance reminded Board members that the Control Total issued by NHS Improvement 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.<br><br>The Acting Director of finance apprised the Board of the summary financial position and at the end of month 1, the Trust reported an actual deficit of £3.3m versus planned deficit of £3.1m. This includes exceptional costs not included in the original plan in relation to VAT on locum spend and depreciation which have contributed a pressure of £0.2m to the position. The VAT issue should be resolved by 8th July with the new model coming into place.<br><br>The key headlines for month 1 include:<br><br>• 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.<br>• 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.<br>• 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.<br>• The delivery of cost improvements is c£0.5m against a plan of £0.6m, being (£0.1m) under expectations.<br>• Capital spend during April was slightly behind plan (c£0.2m).<br>• The Trust delivered a UoR rating of 3 as planned.<br><br>It was noted that the Divisions showed good budget management in the main with medical cost pressures being an issue in the Surgery division. Improvement in nursing costs within the Medicine division has resulted from better e-roster control measures.<br><br>Chair of Finance, Business, Performance Assurance Committee stressed concern regarding greater financial control and the need for more robust plans of mitigation. 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.<br><br>***The Board noted the M1 finance performance.*** | **KE** |

| Reference | Minute | Action |
|---|---|---|
| **BM 19-20/068** | **Report of the Quality Committee**<br>Mr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the recent Quality & Safety Committee, held on 24th May 2019 which covered:<br><br>• Serious Incidents and Duty of Candour<br>• Update on CNST Maternity Incentive Scheme<br>• Nutrition and Hydration<br>• Draft Quality Account<br>• Mandatory training<br>• Infection Prevention and Control<br>• CQC Action Plan<br>• Overall Quality Performance<br>• Wirral Individualised Safe-Care Everytime (WISE, Ward Accreditation)<br>• Board Assurance Framework<br><br>The Board noted the Committee's discussion about mandatory training (eg for blood transfusion) in general, and how we measure the outcome of the training as well as compliance.<br><br>***The Board noted the Quality Committee report.*** | |
| **BM 19-20/069** | **Report of the Finance, Business, Performance Assurance Committee**<br><br>Ms Sue Lorimer, Non-Executive Director apprised the Board of the key aspects from the recent Finance, Business, Performance Assurance Committee held on 24th May which covered:<br><br>• Month 1 Finance Report<br>• Board Assurance Framework<br>• Service Line Reporting – Quarter 4 2018-19<br>• Reference Cost Approval Process 2018-19<br>• First Care Business Case<br>• Renal Business Case<br>• Quality Performance Dashboard<br>• Capital Bid Form – Fire Protection Measures<br>• Reports from other committees<br><br>The Acting Director of Finance summarised the renal business case as reviewed by Trust Management Board and FBPAC prior to consideration by the Board.<br><br>The preferred option is for a Managed Service Contract for equipment, consumables and associated services with an external supplier for both sites and to include staff for the Clatterbridge GH site only.<br><br>***The Board noted the Finance, Business, Performance Assurance Committee report and approved progression to tender for the renal service.*** | |
| **BM 19-20/070** | **Report of Workforce Assurance Committee**<br><br>Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee, held on 22nd May | |

| Reference | Minute | Action |
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| | 2019 which covered:<br><br>• Staff story<br>• Estates & Facilities Workforce agenda<br>• Organisational Development Implications of the NHS Long Term Plan<br>• Workforce KPI's dashboard<br>• Health & Wellbeing Plan<br>• Workforce Assurance Committee<br><br>In reviewing the Estates & Facilities workforce agenda it was acknowledged that further work would be undertaken as part of the wider workforce plan and would be an element of the overall Trust Strategy discussion later in the year in conjunction with other strategies such as estates.<br><br>***The Board noted the report of the Workforce Assurance Committee.*** | |
| **BM 19-20/071** | **Report of Trust Management Board**<br><br>The Chief Executive provided a verbal report of the Trust Management Board (TMB) meeting on 30th May 2019 which covered:<br><br>• Quality & Performance Dashboard<br>• Acute Children's Nursing<br>• Acuity and Dependency Proposal<br>• Proposal for relocatable MR scanner<br>• Use of Resources<br>• Revised Business Case Process<br>• Corporate Induction Programme Review<br>• Chair reports from other meetings<br><br>***The Board noted the verbal report of the Trust Management Board.*** | |
| **BM 19-20/072** | **Audit Committee**<br><br>Mr Steve Igoe, Non-Executive Director provided a brief overview of items covered at the Audit Committee on 22nd May 2019 and subsequently approved by the Board on 28th May 2019 as follows:<br><br>• External Audit Findings (ISA 260)<br>• Annual Accounts 2018/19<br>• Quality Report (Account) 2018/19<br>• Annual report 2018/19 (including the Annual Governance Statement)<br>• Letters of Representation (for financial statements and for the Quality Report)<br>• Review of Corporate Governance Statements – Board Declarations<br>• Proceedings of the Risk Management Committee<br><br>***The Board noted the verbal report of the Audit Committee.*** | |
| **BM 19-20/073** | **Report of Programme Board**<br><br>Joe Gibson, External Assurance apprised the Board of the Change Programme progress which has remained stable during the past month with the Executive Team continuing to direct enhanced focus on the three large | |

| Reference | Minute | Action |
|---|---|---|
| | priority projects within the Change Programme; Patient Flow, Outpatients and Theatres Productivity.<br><br>He reported the improvement in the governance rating and explained that the 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.<br><br>The delivery rating is on an improvement trend and it was there are some challenges but with renewed focus there is an ability to change.<br><br>The Board were advised that 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.<br><br>The Board requested a presentation by the team at the next meeting summarising the three priority projects.<br><br>***The Board noted the Change Programme summary, delivery and assurance report.*** | **AM** |
| **BM 19-20/074** | **CQC Action Plan progress Update**<br><br>The Director of Quality & Governance apprised the Board of the improvements pertaining to the CQC Action Plan. He explained that the report has been expanded to include the actions following the unannounced inspection of urgent care facilities.<br><br>The Director of Quality & Governance confirmed that following the 'confirm and challenge' meetings held in May there is one actions which has been 'red rated' and one 'amber rated' within the original plan which concern patient flow management and ED assessment protocols.<br><br>While there are 6 overdue actions within the Urgent Care plan, this is the first time of reporting and there work is underway with partners to address these actions. Expectation is to see progress by the next time of reporting.<br><br>The Board acknowledged the value in the separation of actions from the two inspections so as not to obscure progress or areas for escalation to the Board.<br><br>***The Board noted the progress to date of the CQC Action Plan.*** | |
| **BM 19-20/075** | **Board Assurance Framework 2019/20**<br><br>The Director of Quality & Governance provided the update of Board Assurance Framework 2019/20. Relevant Assurance Committees have reviewed the updates identified in the report along with providing an assurance rating for each of the risk vectors.<br><br>**The Board of Directors approved the assurance rating and updates detailed in the report.** | |

| Reference | Minute | Action |
|---|---|---|
| **BM 19-20/039** | **Any Other Business**<br><br>In concluding the meeting, Board members discussed the prospect to refocus research along with exploring innovation opportunities within a centralised provision. A meeting convened by the Medical Director with the Associate Medical Directors is to consider the opportunities in conjunction with the establishment of a Research Committee.<br><br>The concerns of the Board regarding Infection Prevention Control (IPC) were reaffirmed and the Trust would seek the support of Dr Richard Cook as detailed earlier in the minutes. | |
| **BM 19-20/040** | **Date of next Meeting**<br><br>Wednesday 3rd July 2019. | |

……..……
**Chair**

……..
**Date**

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

# Board of Directors Action Log
## Updated – 5th June 2019

**Completed Actions moved to a Completed Action Log**

| No. | Minute Ref | Action | By Whom | Progress | BoD Review | Note |
|---|---|---|---|---|---|---|
| **Date of Meeting 05.06.19** | | | | | | |
| 1 | BM 19-20/065 | Provide a strategic view (innovative) on recruitment to nursing vacancies | **GW/HM** | | Sept '19 | |
| 2 | BM 19-20/066 | Infection Prevention Control (IPC) tactical (short term) versus strategic (long term) plan to be developed | **GW** | Complete | July '19 | See agenda item 7.3 |
| | | Contact Dr Richard Cook, Microbiologist to seek an external perspective of the possible unknowns | **NS** | Complete | July '19 | Meeting took place on 11.6.19 |
| 3 | BM 19-20/067 | Provide plan for greater financial control and robust mitigations for unplanned costs | **KE** | Complete | July '19 | Included on FBPAC agenda for July '19 |
| 4 | BM 19-20/073 | Provide presentation summarising the three priority projects within the change programme | **AM** | Complete | July '19 | See Programme Board agenda item |
| **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 | Review of Infection Prevention Control basic's to be undertaken | **GW** | Complete | July '19 | Detailed Executive review based on basics, better, best criteria to agree Trust wide approach, see also action BM 19-20/066 |

| Board of Directors | |
|---|---|
| **Agenda Item** | 6 |
| **Title of Report** | Chief Executive's Report |
| **Date of Meeting** | 3rd July 2019 |
| **Author** | Janelle Holmes, Chief Executive |
| **Accountable Executive** | Janelle Holmes, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | All |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | For Noting |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

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

**CQC**

The Trust received a request from the CQC on the 20th June to submit information under what is called the 'Provider Information Request'. This commences the process and lead into the next comprehensive and well-led inspection. As Board members will appreciate, the CQC do not give details of exact dates.

**Serious Incidents**

The Trust declared 1 serious Incident in May 2019. This case involves a delay in follow up of a patient with cancer. Full investigation is underway and will be monitored and reported via the Quality Committee.

**RIDDOR Update**

Incidents that are reportable to the HSE are now reviewed in the SI panel. There have been 3 RIDDOR reportable incidents since the 1st April - 2 were in relation to moving and handling the 3rd was a slip/trip/fall. All are being appropriately investigated and reported and monitored via the Quality Committee.

**Vision and Values**

The new WUTH Vision and Values were officially launched on Monday 1st July.

This huge piece of engagement work has involved over 2500 staff and members of the public telling us what's important to them and from this feedback we have shaped both our Vision and Organisational Values.

The new Vision is:


Underpinning the delivery of the Vision is a set of four Values:


These Values were described as important to the way care was delivered and people were treated. We also asked our teams and patients to describe how they would know that the Values were being 'lived' in the organisation and they described a number of behaviours against each Value they would want to see.

Over the weekend, the new Vision and Values were made visible in the public areas of the hospitals. The engagement the organisation has had with this project has made it very clear that working together and valuing each other is really important if we're to be the best. This includes working with our neighbouring health partners, our patients, our staff and of course the public.

This first phase launch is only the beginning of embedding the Vision and Values throughout the organisation. It will become a key part of how we recruit and attract new people to WUTH. It will also represent the way in which we appraise staff as part of their yearly contribution review.

On behalf of the WUTH Board, I would like to say a personal thank you to the thousands of staff and public for engaging with this project as it is their feedback that has helped develop, create, shape and launch them.

**NHS England / NHS Improvement Bulletin**

**Appointment of NHS' Chief Operating Officer and Chief Executive**
NHS England and NHS Improvement have announced the appointment of Amanda Pritchard to the position of NHS' Chief Operating Officer and Chief Executive. Amanda will take up the post full time on 31st July 2019.

The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens, and serves as a member of the combined NHS England/NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is also accountable to the NHSI Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

**Our NHS People Plan – A different way of working**
NHS Improvement has published 'Our interim People Plan for the NHS' which sets out a collective vision for how people working in the NHS will be supported to deliver the *NHS Long Term Plan* and identifies the immediate actions we will take in 2019/20 to help them.

Speaking at the launch of the interim People Plan, the Secretary of State spoke of how the NHS would welcome the expertise of nurses and doctors recruited from overseas. He also emphasised the need to make the NHS an attractive proposition for young people considering their career options and he announced plans for Government proposals to make pensions more flexible for senior clinicians.

The plan can be found at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

**A&E Board**
The Board continued to focus on aspects of both Urgent and Unplanned care, with specific updates around Admission Avoidance, Discharge from within the acute setting and then support from the Community. With the support of ECIST, the Board unanimously agreed that immediate focus would be aligned to Patient Streaming, to ensure Patients have access to the most appropriate service, and also to improve overall length of stay to enable Patients to return to their homes or an alternative community setting. Without exception, all Partner Orgianisations agreed to then support the findings and recommendations from the ECIST review.

**Janelle Holmes**
**Chief Executive**
**July 2019**

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.2 |
| **Title of Report** | Learning From Deaths |
| **Date of Meeting** | 3 July 2019 |
| **Author** | Mr M Ellard Deputy MD (interim) |
| **Accountable Executive** | Dr N Stevenson MD |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 1 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | N/A |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | To Note and Support |
| **Data Quality Rating** | N/A |
| **FOI status** | Bronze – qualitative data |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | Document may be disclosed in full |
| | N/A |

## 1. Executive Summary

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

- Trust Quality Dashboard
- Dr Foster Data
- Primary Mortality reviews
- Structured Judgmental Reviews

## 2. Background

Mortality reports to date have focused on learning from review of individual cases alone and the improvement in rates of conducting Primary Mortality Reviews (PMRs). The PMR document has a number of automatic triggers for a Structured Judgement Review (SJR) but this does not include where concerns have been raised by relatives, as happened in other trusts. In addition the findings of additional mortality reviews within Trauma and Orthopaedics, General Surgery and Urology for NCEPOD have not been included as these reports have not been forwarded to the mortality review team.

Trust and Dr Foster data have not been used in conjunction with the current process to enable focused learning on known susceptible groups or where there is deterioration in trends.

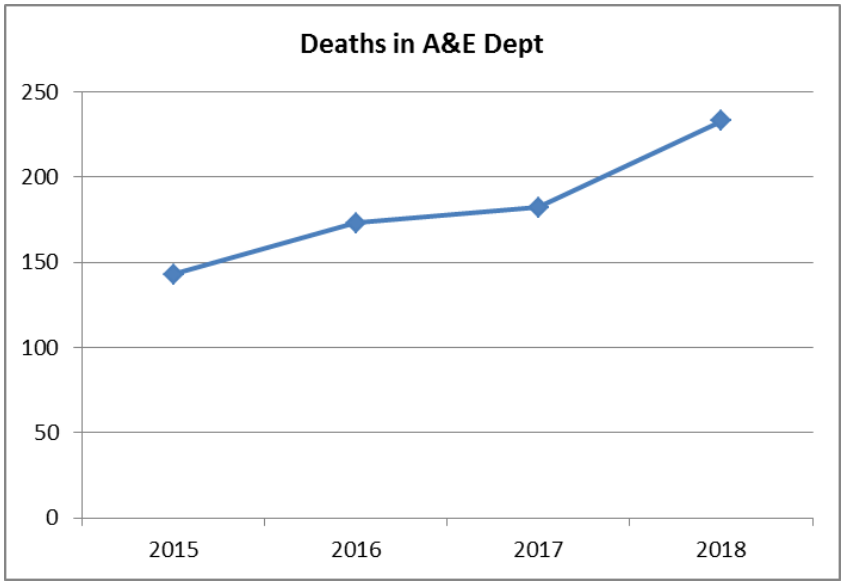
## 3. Key Issues/Gaps in Assurance

The quality dashboard has shown, that whilst the HMSR remains green (<100) there has been a trend increase over the last year, Table 1.

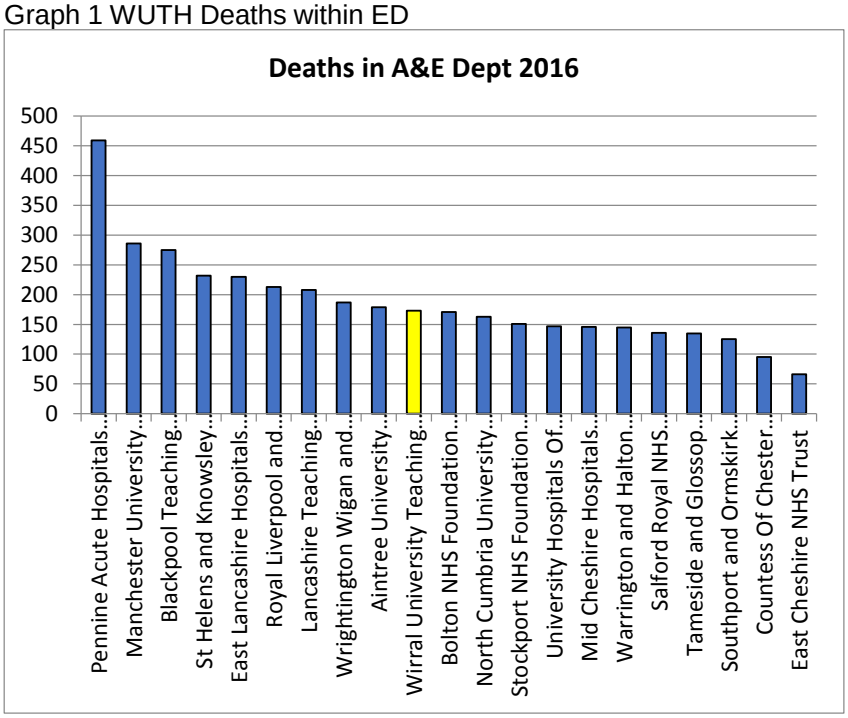
| Month 2018 | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan 19 |
|---|---|---|---|---|---|---|---|---|---|---|
| HMSR | 88.7 | 93 | 93 | 95 | 95 | 92 | 92 | 97 | 97 | 98 |

Dr Foster data

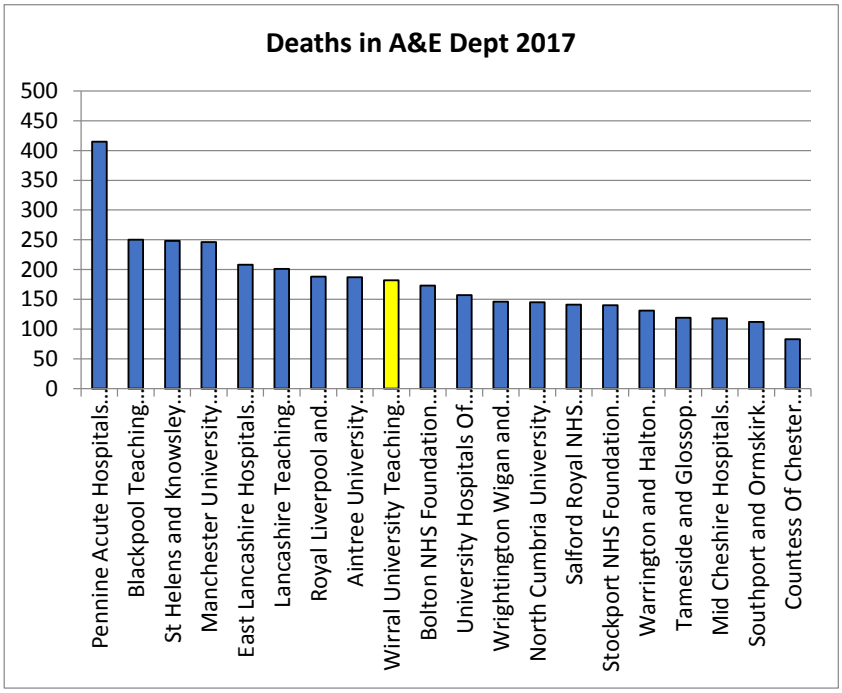
Whilst the number of acute admissions increases year on year, the number of deaths within ED has risen significantly in 2018, Graphs 1-5. Graphs 2-4 show annual data and Graph 5 shows the trend for each acute unit. Deaths within ED are excluded from the PMR process as PMR is only done on patients who have been admitted to the trust.




Graph 1 WUTH Deaths within ED




Graph 2 2016 NW acute trust data



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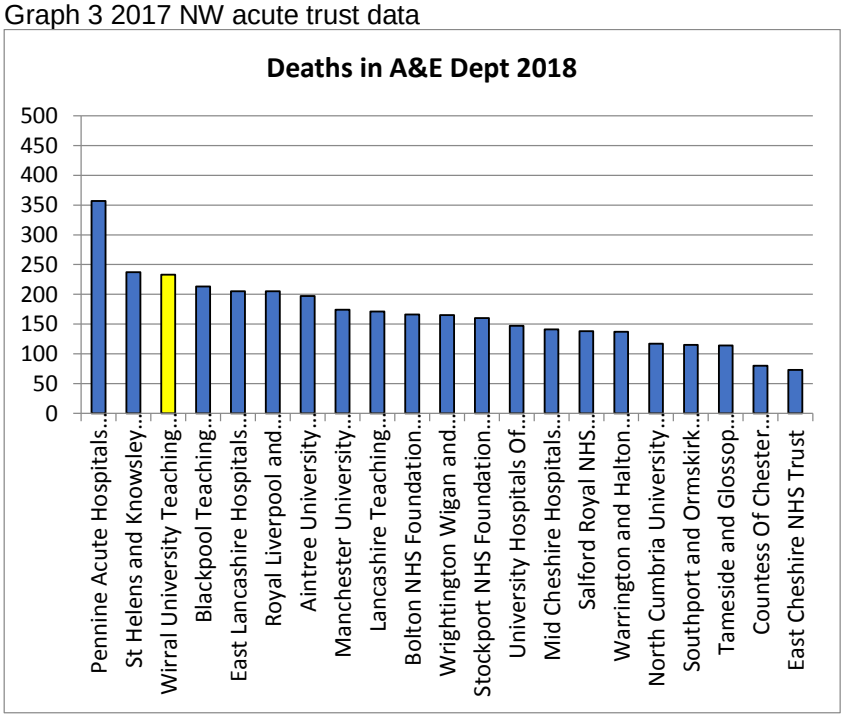
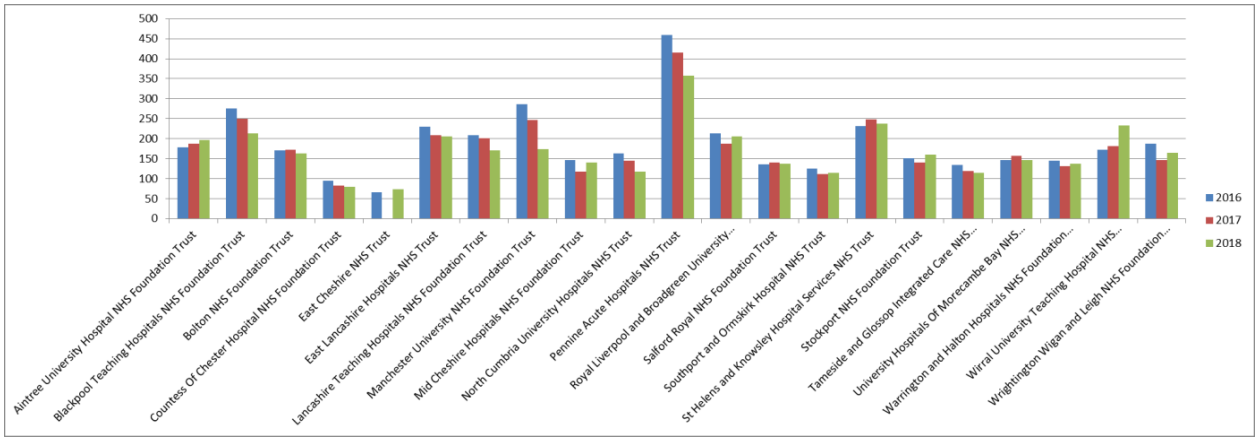
Graph 3 2017 NW acute trust data




Graph 4 NW acute trust data




Graph 5. Summary graph to demonstrate trends 2016-18 within NW acute trusts deaths within A&E

Whilst on average 3 deaths per week occurred in A&E in 2016 this has increased to about 5. The crude rate per 100 cases has risen from 4.4 to 6.6.

A retrospective review of Q3 mortality ratio between weekday and weekends shows no change across the week; 292 deaths from 8690 admissions on weekday vs 95 deaths form 2793 admissions at weekends (1:1)

Primary Mortality and Structured Judgmental Reviews

- The PMR review must be completed within 90 day standard. For this report data to End February is complete
- In the quarter there have been 528 deaths
- There have been 262 completed primary mortality reviews (PMRs) and 165 remain in process (ie March onwards). 101 cases did not have a PMR within the 90 day time frame. The monthly PMR data is shown in table 2.

| Month | Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|
| Deaths | 100 | 266 | 162 | 104 | 189 |
| PMR complete | 86 | 190 | 87 | 46 | 61 |

- 40 deaths, having had a PMR, in Q4 at present have requested a second line review by SJR. 19 of these were triggered by elective admission, LeDeR or Mental Health section 2/3. On further assessment a total of 19 cases required SJR
- The reasons for not requiring SJR were;
  Duplication in process (Coroner n=3, SI panel review procedure n=1), LeDeR/ Mental health n= 3, PMR report incorrectly completed n= 11, duplicate forms = 2
- The PMR showed that End of life phase was identified in all cases and all elevated NEWS scores had been escalated appropriately.
- In 3 cases documentation on CERNER on cause(s) of death were not documented

The backlog in SJRs has increased due to several changes in duties within the team. No SJRs have been received since the last report. The mortality lead has recently reviewed all requests now have identified leads.

Cases referred to Coroner

Since the last report there have been 6 inquests concluded. 3 were concluded ultimately as being due to a natural cause of death, 2 due to suicide and all of these had no criticism of care provided. In the remaining case the Coroner concluded there had been a missed opportunity to deliver treatment which may have prevented the death (48 hour delay in assessing a cardiac 5 day monitor).

As the patient needed transfer to LHCH for an implanted defibrillator, and it was deemed unlikely to have been possible to be carried out before his cardiac event, on balance the outcome would have been the same.

## 4. Conclusion

- In the quarter there have been 528 deaths
- There have been 262 completed primary mortality reviews (PMRs) and 165 remain in process. 101 cases did not have a PMR within the 90 day time frame.
- 40 deaths, having had a PMR, in Q4 at present have requested a second line review by SJR. 19 of these were triggered by elective admission, LeDeR or Mental Health section 2/3. On further assessment a total of 19 cases required SJR
- The HMSR has shown a gradual rise over 10 months
- A retrospective review of Q3 mortality ratio between weekday and weekends shows no change across the week
- Dr Foster data shows an increasing trend of deaths within ED with a deterioration against peer groups
- All elevated NEWS scores were acted upon appropriately

## 5. Recommendations

- Future reports to include a focussed review, starting with deaths within ED followed in by a review of deaths within 24 hours of admission
- Link Concern from bereavement carers feedback to SJR process
- Review PMR triggers to reduce duplication
- Integrate NCEPOD reviews into trust quarterly reports
- Review learning from deaths dashboard to enable trend analysis
- Presentation of draft report at quarterly operational review group to ensure divisional input prior to final report
- Liaison with clinical end of life care lead to facilitate shared learning form mortality reviews and SJRs from bereavement carers feedback
- To note and disseminate the report

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.3 |
| **Title of Report** | Review of the Outbreak of *Clostridium difficile* |
| **Date of Meeting** | 3 July 2019 |
| **Author** | Jay Turner-Gardner- Associate Director of Nursing – Infection Prevention and Control |
| **Accountable Executive** | Gaynor Westray |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Gaps |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | For Discussion |
| **Data Quality Rating** | Bronze - qualitative data |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

## 1. Executive Summary

The purpose of this paper is to inform the Board of the present situation regarding the outbreak of *Clostridium difficile* (CDI) at Arrowe Park site of Wirral University Hospitals Trust (WUTH) and to review the resulting recommendations.

In January 2019, two patients died of *Clostridium difficile* infection (named on part 1a of their death certificates) during a declared period of increased incidence of CDI infection at WUTH. The two deaths were investigated as serious incidents and were reported under StEIS.

The Trust declared an outbreak of CDI in February 2019 and as cases continued to be identified following closure of the outbreak in April 2019 the outbreak was extended and re-declared in May 2019. A further *Clostridium difficile* related death was reported in May 2019 which is at present under investigation as a serious incident and has been reported to StEIS.

## 2. Background

*Clostridium difficile* infection (CDI) remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment.

Great strides in reducing the number of CDIs have been made in the NHS but the rate of improvement has slowed over recent years. Some infections are a consequence of factors outside the control of the NHS organisation that detected the infection. Further improvement on the current position requires greater understanding of individual causes across the healthcare system to ensure all potential learning is identified and to avoid a culture of apportioning blame through the lapses in care process ( avoidable /unavoidable).

Following identification of a sample which tests positive for *C. difficile,* providers and commissioners assess the care provided to identify any areas for learning. Any learning must then support the development of an action plan and subsequent improvements in care to avoid further cases.

Processes must be in place to assess each infection as this allows clinical teams working across health and social care to focus their efforts where problems have been identified, ensuring that remedial actions are implemented and lessons learned to prevent future infections. This approach supports continual learning and improvement of patient safety. It is critical that implementation of appropriate action plans are monitored following identification of cases.

In 2018/19 the Trust did not meet its objectives for *Clostridium difficile* Infection (CDI) of having no more than 29 avoidable infections. 78 cases were reported in total, of which 44 were identified as being avoidable. This was an increase of 19% from the previous year

Objectives for this year have been set using the data from 1 April 2018 to 31 December 2018.This data has been annualised and a count of cases calculated for each clinical commissioning Group (CCG) and NHS acute provider using the new case assignment definitions using these two categories.

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

It is estimated that whilst a total number of cases will not increase the shift in the number of cases which are trust assigned, particularly those associated as community onset as explained above will increase to around 65% of the total number of cases. Our new trajectory takes account of this.

Since April 2019 we have reported 37 cases of CDI, of which 23 have been hospital onset and 14 community onset healthcare associated.

Reported CDI Toxin per month since 2015/16

| | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 |
|---|---|---|---|---|---|
| Apr | 4 | 1 | 4 | 5 | 19 |
| May | 9 | 4 | 7 | 11 | 28 |
| Jun | 11 | 6 | 10 | 16 | 38* |
| Jul | 16 | 8 | 12 | 19 | |
| Aug | 19 | 11 | 21 | 24 | |
| Sep | 22 | 19 | 24 | 25 | |
| Oct | 27 | 21 | 32 | 33 | |
| Nov | 30 | 24 | 35 | 40 | |
| Dec | 35 | 27 | 41 | 48 | |
| Jan | 38 | 30 | 43 | 58 | |
| Feb | 48 | 33 | 46 | 70 | |
| Mar | 48 | 35 | 51 | 78 | |
| Trajectory | 29 | 29 | 29 | 28 | 88 |

*At the time of writing the report

The increase in reported infections prompted further testing to identify any common strain and samples were sent for ribotyping. The overwhelming ribotype identified is 027, which is a particularly virulent strain associated with more severe infection and is related as being one of the causative factors of outbreaks across UK and Europe.

The first two deaths at Arrowe Park Hospital were around the same time and the investigation team named patient flow and high bed occupancy, which prevented effective environmental cleaning as the main contributory factors. A contaminated environment was named as one of the causes of cross infection during the period of increased incidence of CDI in the Trust at the time.

Common 'themes' from the post infection review (PIR) of each CDI case in 2018/19 identified the following:

- incorrect completion of the management of diarrhoea flow chart causing delays in detection
- delay in isolation,
- inappropriate sample collection,
- lack of clinician engagement
- lack of assurance in cleaning of the patient environment which was hindered by the poor state of repair and maintenance of the building.
- poor decontamination of patient shared equipment

Overwhelming themes that have been identified from the present outbreak across 5 different wards, which are also replicated across the trust:

- failure to isolate the patient in a timely manner
- delay in sample taking
- inconsistent cleaning standards
- cluttered environment
- poor maintenance of the estate, which in itself does not permit effective cleaning

During the last month the Trust has been engaged in discussions with and has also had visits from Public Health England, NHSI/E, representatives from the CCG and an independent consultant to offer advice and support.

A CDI action plan has been submitted to the CQC as a result of the overarching improvement plan and the CDI outbreak meetings.

Wards under outbreak status have developed local improvement plans which include compliance to hand hygiene, equipment cleaning, commode cleaning, environmental audits, listing repairs required and new equipment needed, and staff training.

For 2019/20, the contractual sanction that can be applied to each CDI case in excess of an acute organisation's objective remains at £10,000. Sanctions remain an option to ensure organisations continue to prioritise this important area, while focusing on a new dataset and keeping patient safety as a top priority for all providers and commissioners. The option to apply contractual sanctions remains at the discretion of the coordinating commissioners.

The paper entitled '*The financial burden of hospital –acquired Clostridium difficile infection'* M.H.Wilcox, J.G.Cunniffe, C.Trundle, C.Redpath in 1996 estimated the cost then in excess of £4,000 per patient identified with CDI.

**3. Key Issues/Gaps in Assurance**

Not achieving last year's objective for *Clostridium difficile* resulted in an improvement plan being developed of which there continues to be actions outstanding.

Several themes have been identified including high bed occupancy and patient flow which does not allow for dedicated cleaning time.

The estate remains in a poor state of repair as a result of no allocation for Pre Planned Maintenance.

The defects in the environment do not allow for effective cleaning.

The present cleaning programme does not reflect the patients' needs.

The cluttered environment and lack of storage space means that it is difficult to clean the environment and the clutter itself becomes a reservoir for micro-organisms.

Staff engagement needs to improve

**4. Next Steps**

It is essential that staff are reminded of their roles and responsibilities regarding patient safety and how they have an impact on the Infection Prevention agenda.

De-cluttering, maintenance of the environment, including replacement of some equipment, and effective cleaning are the main issues that need to be addressed.

As a result of the outbreak there are a number of steps that have already been taken.

A presentation has been given to the Executive team by the Associate director of Infection Prevention and Control following which

- Communication campaign has commenced and important messages have been displayed on the screensaver trust wide so that all staff can see key ways in which they can help.

- Two wards have been identified to showcase how improvements can be made to promote clean safe care (ward 38 and ward 18).

- A multi-disciplinary task and finish group meet weekly involving Estates, Facilities, Health & Safety, Infection Prevention, Moving and Handling, Fire officer, Divisional Directors of Nursing and representatives from the two wards to discuss and address how improvements can be made.

- De-cluttering has started to take place across the trust as a result of a presentation of pictures of the environment to the Task & finish group.

- Cleaning processes have been reviewed to get back to basics and simplify what the fundamental requirements are to promote a clean and safe environment.

- Hand hygiene and compliance to the H/h policy is being promoted, staff are being empowered to challenge others that do not comply with 'bare below the elbows' or do not wash / gel their hands at the correct times.

## 5. Conclusion

The hospital-wide outbreak is a consequence of a sub-optimal environment, poor practice in the control of infection, lack of facilities to isolate patients and insufficient priority being given to the control of infection.

Many wards in Arrowe Park require repair. The nature of the environment and the facilities available means that the control of infection is particularly difficult.

It is difficult to isolate patients because there are few side rooms. Most of these do not have en-suites and some are not available for the isolation of patients with infections due to conflicting priorities, patient flow and high bed occupancy. Issues with patient flow can result in multiple bed moves for patients. Patient flow is being addressed through the patient flow improvement group.

Staff need to take personal responsibility for hand hygiene, being bare below the elbow and uniform compliance.

## 6. Recommendations

To avoid further harm action is needed immediately and support is requested to implement the recommendations below.

- De-clutter.
- Effective cleaning with a cleaning programme that reflects the patient's needs.
- Replacement of inappropriate/damaged equipment to promote effective decontamination
- Repair and ongoing maintenance of the patient's environment.
- Rapid identification and isolation of patients with diarrhoea
- Restricting the movement of infected patients between wards
- Re-enforce staff roles and responsibilities in keeping patients safe by preventing avoidable infections.
- Reduce bed occupancy via improvement in patient flow

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.4 |
| **Title of Report** | Health and Safety Management |
| **Date of Meeting** | 3 July 2019 |
| **Author(s)** | **Jacqueline Robinson**, Head of Quality Governance<br>**Andre Haynes**, Health and Safety Manager |
| **Accountable Executive** | Paul Moore, Director of Quality & Governance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | Safety |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive with some Gaps |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | Approval Required |
| **Data Quality Rating** | Silver - quantitative data that has not been externally validated |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

## 1. Executive Summary

Outlined within this report is an overview of Quarter 1 2019/20 Health and Safety performance and assurance activities, together with an update on progress against specific recommendations previously accepted by the Trust Management Board (March 2019) and the Board of Directors (April 2019).

Analysis of Quarter 1 incident data and comparison with previous data analysis identifies 6 non-clinical (or incidents incident types most frequently reported: Violence and aggression (to staff - patient condition related); Sharps; Slips/ Trips/ Falls; Manual handling; Collision with objects and unsafe environment. The report sets out a summary of the control measures the Trust already has in place to mitigate the risk and suggests further actions to further strengthen these arrangements.

In addition to incident data analysis 'leading' (proactive) measures are introduced and an outline is provided as activity undertaken to strengthen the monitoring and assurance arrangements in place.

## 2. Analysis: Health & Safety Performance

Historically Health and Safety performance measurement has been undertaken utilising 'lagging' indicators i.e. analysis of past incident statistics. Whilst lagging indicators are useful they are reactionary, require accurate incident reporting and coding and large amounts of data of over a significant period of time.

'Leading' indicators include safety initiatives or reported activities, with the goal of preventing unfavourable events before they happen e.g. inspections and audits, training and communication strategies. These indicators often have a more immediate impact and lead to a pro-active safety culture.

Best practice is to use a combination of leading and lagging indicators. Analysis was undertaken of both 'leading' and 'lagging' indicators. Data were extracted from the Trust's Safeguard Ulysses™ system and other Trust sources to support this analysis.

### 2.1. Lagging indicators

As reported previously, there are problems with the available data from within the Trust's electronic incident reporting system in terms of:

- **Outcomes are rarely recorded by managers/reviewers** in the Safeguard Ulysses™ System. This frequent absence of data disables us from determining the degree of loss or risk and consequently meaningful reporting. Without carrying out additional work, lost time cannot be determined.
- **Impact has been interpreted at face value** as it is recorded in the 'severity score'. This is the impact score assigned to the event by the person reporting the incident. It is often highly subjective. It involves self-reported severity in addition to reports made by others on behalf of the injured party. This may or may not be accurate at the time of reporting.
- **Exact locations are rarely captured in the incident report**, management areas are documented instead. It is therefore difficult to be precise about exact location of events.
- **Many fields are not used reliably**. Data is incomplete, particularly in respect of verifying the actual impact, exact location, outcome.
- **The cause 1 groupings are over-complicated**. These have been designed to categorise every conceivable dimension and thus produces a complex and complicated picture of broadly the same type of issue.
- **Lost time accidents.** At the time of report there was no data available to demonstrate lost time accident resulting in <7.
- **Statistical significance.** The data available from the electronic incident reporting system can only be used for comparison across Division and Directorate at an elementary level unless data on activity; and staffing numbers are also utilised.

2.1.1 Action taken

Significant work has been undertaken, and continues, in order to address these issues, such as:-

- Cause group coding on non-clinical safety incidents has been reduced (by 116 cause group codes)
- Impact indicator has been added to Ulysses system and Health and Safety team will provide a consistent indicator moving forward
- Exact location has now been made a mandatory field that must be completed when an incident is reported
- Options for establishing a mechanism to identify staff that have been absent from work following a workplace incident are being explored, including:-
    - Ulysses link with ESR (cost of £3,000)
    - Report generation from ESR to be compared through pivot tables with incidents reported on Ulysses

2.1.2 Next steps

- The Cause group codes will be further rationalised and the hierarchy of codes re-established
- Injury/ near miss incidents will be identified enabling us to calculate incident frequency rates and accident frequency rates which in turn will enable more effective benchmarking

High level lagging indicators

The following indicators are now able to be provided from the cleansed data.

Non-clinical safety incidents between 1st April 2019 and 18th June 2019 have been analysed in an attempt to ascertain the:

a) Total number of non-clinical safety incidents
b) most frequently reported accidents/illness by cause type;
c) length of time between the event and the reporting of that event;
d) compliance with statutory and procedural response requirements
e) Liability activity.

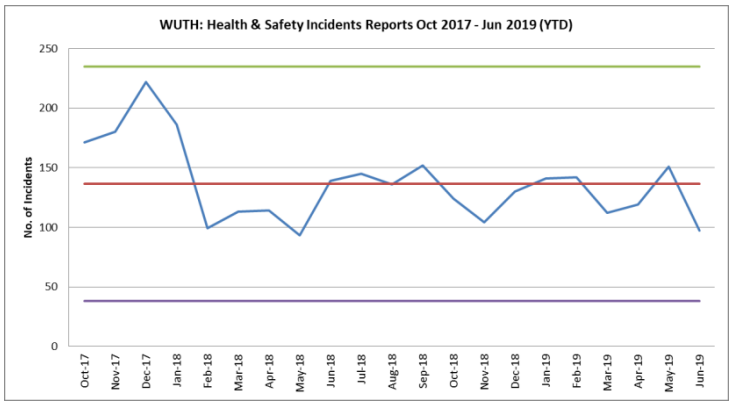
| **Total no. non-clinical safety incidents** | | | | |
|---|---|---|---|---|
| | **2018/19** | | **2019/20 (ytd)** | **Increase/ Decrease** |
| No reported (monthly average) | 1580 (131.66) | | 362 (120.66) | ↓ |
| % incidents managed in Ulysses within Trust Timescale | 49% | | 64% | ↑ |

| **RIDDOR incident** | | | | |
|---|---|---|---|---|
| | 2018/19 | | 2019/20 | **Increase/ Decrease** |
| No reported 2018/19 (monthly average) | 34 (2.83) | | 3 (1) | ↓ |
| % reported within timescale | 61% | | 100% | ↑ |

| **EL Claims settled** | | | | |
|---|---|---|---|---|
| | 2018/19 | | 2019/20 | **Increase/ Decrease** |
| No settled 2018/19 | 13 | | 2 | ↑ |
| No settled 2019/20 To date | 6 | | 4 | |

The number of incidents reported so far in this quarter shows a slight decrease from the monthly average calculated from last year. Extending across previous analysis undertaken from data extracted as far back as

2015 (not shown), this does appear to be a trend. Peaks in incident reporting within the winter months could be attributable to bad weather or increased activity or a combination of both but further deeper analysis would be required to establish causes and identify any additional mitigation that could be implemented.




This is also reflected in the lower average number of RIDDOR reportable incidents reported this quarter.

**Top 6 most frequently reported incidents in Qtr 1**


**Violence and aggression:** The majority of V&A incidents are related to patients' clinical condition. **Controls include:** Policy in place, clinical risk assessments; appropriate treatment plans; supervision arrangements; flags on IT system and access to LSMS. **Action taken:** Local investigators requested to check all of these controls appropriately implemented.
**Sharps:** Majority incidents relate to clinical sharps. **Controls include:** Policy, safe disposal and response included in Mandatory training; sharps containers; IPC/Perfect Ward/Occ health audits; needle safety devices.
**Slips, trips and falls:** these do not include clinical falls. Range of causes including wet floors, uneven surfaces, trailing wires and tripping over objects. **Controls include:** Policy; numerous inspections/ audits incl. estates & facilities; perfect ward; housekeepers audit etc. **Further action to be taken:** All information sources to be collated and analysed to determine high risk areas where targeted action can be taken.
**Manual handling:** Clinical staff report the highest number of manual handling injuries. **Controls include:** Induction and mandatory training; MH risk assessments; Moving and handling aids and specialist Manual handling advisor employed. **Further action:** detailed review of control measures in place for this staff group to be undertaken in Qtr 2.
**Collision & unsafe environment**: No specific theme identified. **Further action**: Explore possibility of link between incident reporting system and maintenance request system.

2.1.3 Other key issues emerging from the incident data analysis

The data indicates the following:

- The 6 most frequently reported incidents remain consistent with the previous years analysis
- There is a significant drop in the average number of non-clinical safety issues reported, however, this is likely to be the result of data cleansing
- There is currently a lower monthly average of RIDDOR incidents
- The management response rate relates to the response recorded within the Ulysses system and does not provide an indication of how quickly the manager responds to ensure the hazard is addressed
- The response to RIDDOR reportable incidents has significantly improved since the process for presenting reports to the SI panel was introduced.

- There is a significant time lag between when an incident occurs and a subsequent claim is either settled or successfully defended (can be up to 3 years) and therefore learning may be limited and improvements are slow to show impact.

2.1.4 Next steps

- The 6 most frequently reported incident type will form targeted preventative safety management improvements over the coming quarter. This will include:
  - Implementing the further actions detailed above
  - Focus on addressing data quality and Ulysses system changes to allow more detailed analysis and drill down to consider time/ location/ staff group etc.
- Consideration of a communications and messaging campaign to be delivered in collaboration with the Communications team and Estates and Facilities targeted in these areas of high incident reports.
- A draft performance dashboard has been developed for Trust level data and is currently in consultation. More detailed indicators will be developed for Divisional level data following further work on addressing the data quality issues and system changes required for data generation

- Options for establishing reliable indications of lost time incidents are being explored. A technical solution in the form of programming between ESR and Ulysses Safeguard may be available but there are cost implications. An enquiry has been submitted to the company to establish whether the staff import function would actually provide the appropriate solution. Other options, such as the use of a flag within ESR for staff that are off due to a work related incident may provide a no cost solution. This currently exists but HR undertakes a review and may remove the flag if it is assessed as being incorrectly flagged. We are exploring the possibility of receiving a report prior to this assessment being done so that we may undertake a comparison between the data sets within ESR and Ulysses to identify incident reports submitted by staff within the specified time period that may be connected to the absence.

2.2 Leading indicators

2.2.1 Safety interventions

| Safety interventions |
| --- |
| No. of informal advice<br>**6**<br>No.of letters of recognition<br>**0**<br>No. notice of urgent action<br>**0**<br>No. of suspension notices<br>**0** |

The Health & Safety team provide regular advice and support on Safety management issues. Often responding to hazards identified during their normal routine.

Last month the Trust Management Board introduced a local enforcement procedure to facilitate effective safety management; support duty holders in discharging their duties and ensure appropriate response to safety critical issues (see appendix 2).

The local enforcement procedure will ensure that escalation and visibility are provided to Executive Management. It also ensures that actions required under the local enforcement procedure carry Executive Management authority.

The procedure operates at 3 levels:

- Letter of recognition – issued where outstanding good safety practice identified;
- Notice of urgent action – high risk safety issue that needs immediate action to mitigate risk to prevent possible injury or ill health;
- Suspension notice – issued where safety critical issue identified that is likely to imminently present a

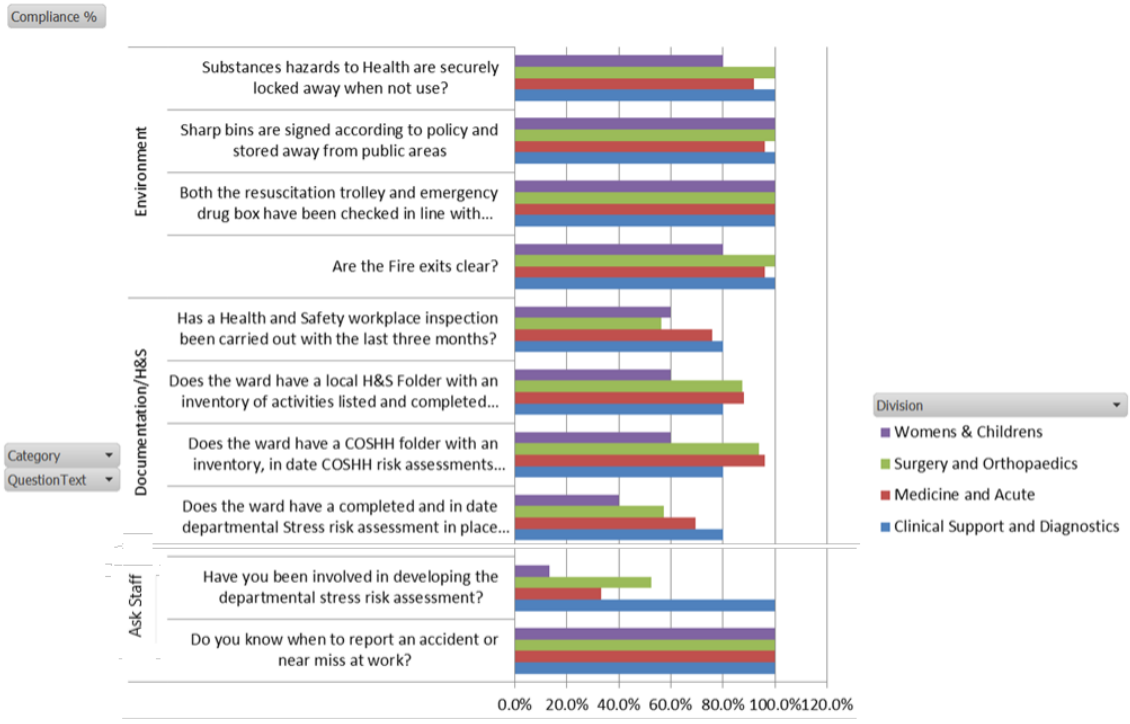
No notices have been issued as yet, however the safety team have undertaken 6 informal interventions to correct safety issues. These included: 2 tripping hazards; 1 electrical safety issue; 1 unsafe environment; 1 crushing & security risk; and 1 safe storage of substances.

2.2.2 Audits and inspections

**Independent H&S Audit:** The independent H&S auditors have commenced work. They have undertaken a H&S management audit assessing against ISO 45001 standards across both Arrowe Park Hospital and Clatterbridge sites. Inspections are currently taking place and it is anticipated that reports will be received into the Trust by the end of July.

**Local inspections and audits:** Perfect ward and Ward Accreditation programme is now utilised across 43 clinical areas. The audits are undertaken by ward managers, matrons, IPC; Housekeepers. There are a number of questions within these audits that relate specifically to Health and Safety. Additional questions have been developed and embedded into the WISE Accreditation programme. A number of audits have now been undertaken utilising the tool and local areas have developed action plans to address areas of non-compliance. **Further action:** We are currently working with the developers to establish a performance dashboard to provide meaningful metrics relating specifically to Health and Safety. This does not require additional audit production for which there would be a cost. H&S questions are embedded into existing audits; the questions are tagged and themed reporting is provided through the system. An example of one example chart is provided below for information.

**Example of Perfect ward audit dashboard**



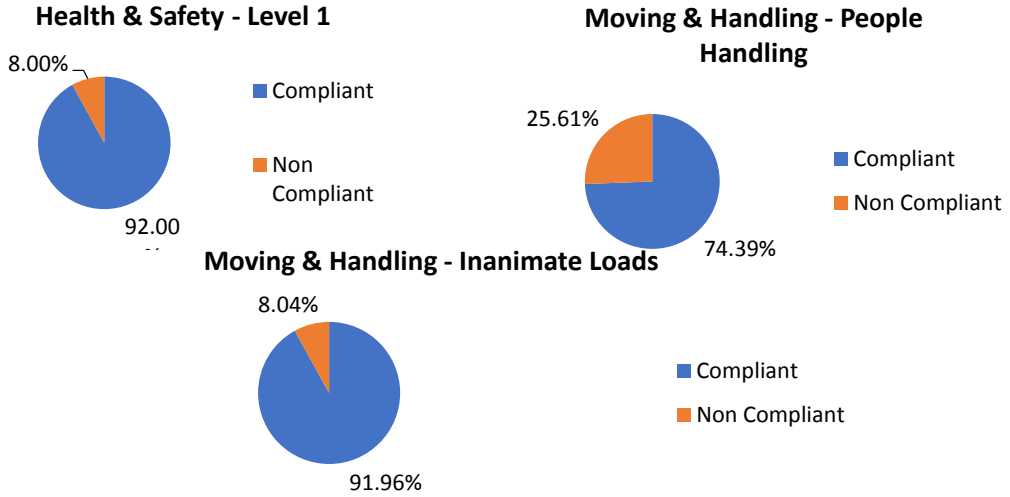

**H&S team audits:** The H&S team have conducted 2 targeted audits across the Trust to confirm that the COSHH cabinets have been correctly placed and are being used; and that hazard warning labels have been adhered to the new Chlor Clean bottles. Any non-compliance issues were immediately rectified.

**Further actions:** The Trusts Quality Strategy sets an objective to achieve RoSPA gold by 2022. In order to achieve Gold Standard evidence of auditing aligned to ISO45001 is recommended. The external audit will suffice for the year 1 target of Bronze award, however moving forward a full audit schedule against specific Trust policies will be necessary.

- An improvement plan will be developed which captures all actions from auditing and inspection activity including the Independent auditors recommendations.
- A programme of H&S audit against relevant policies will be established.

2.2.3 Training

H&S awareness training and Manual handling is provided through induction and mandatory training.



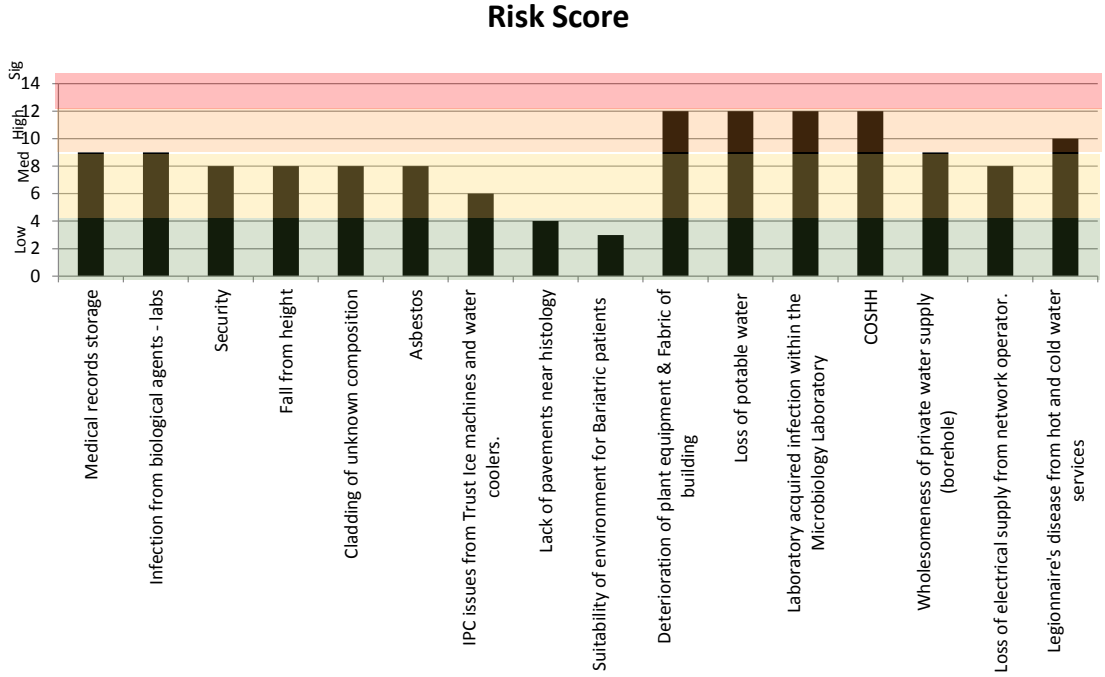

Compliance rates for Moving and Handling people is the lowest at 74.39%, this may be significant given that the highest group of staff reporting manual handling incidents are clinical staff. **Action:** A review of the Moving and handling training provided to medical staff has been undertaken and a targeted risk based approach implemented.

**Further action:** Gaps in ward managers' knowledge of risk assessment and incident investigation have been identified. An e-learning package to support incident investigation is being developed. A half day session has been incorporated into the ward managers training programme, which will include practical exercises to support a blended learning approach to these 2 areas.

2.2.4 Risk register

The Trusts risk register to identifies a number of non-clinical safety risks. The inclusion of these risks aligns with HSE guidance HS(G) 65, whereby it is advocated that the management of H&S risks is integrated into the Trust's risk management arrangements and that the Trust should adequately understand its H&S risk profile.

The chart below shows current non-clinical safety risks on Trust risk register by residual risk rating.



However, most of these risks have been identified due to specific issues occurring and therefore remain somewhat reactive. For example, COSHH; laboratory acquired infection and loss of potable water all have higher risk ratings due to recent identified gaps in control.

**Further actions:** A responsibilities matrix has been developed which outlines the control and assurances for each of the major non-clinical safety hazards and this is currently in consultation phase. It is proposed that each of these hazards are considered for entry to the risk register in order to inform the Trust of its current H&S risk profile.

## 3. Progress against recommendations from March / April presentations to TMB and Board

Specific recommendations accepted by the Trust Management Board (March 2019) and the Board of Directors (April 2019) have significantly progressed. A full update is provided against each action in Appendix 1.

## 4. Recommendations

The analysis of quarter 1 incident data and implementation of the actions previously agreed has identified a number of areas for further development in addition to the original actions agreed.

The Independent audits and inspections are currently underway and are also likely to generate an action plan.

In addition, a Health and Safety strategy has been developed and is currently in consultation. The Strategy has a number of key objectives outlined with a high level plan of how these objectives can be achieved.

It is therefore recommended that all of these actions are consolidated into one action plan with priority ratings to be presented to the Trust Management Board and Safety Management Assurance Committee in August and approved by the Board early September 2019.

## 5. Decision Required

The Board of Directors are invited to:

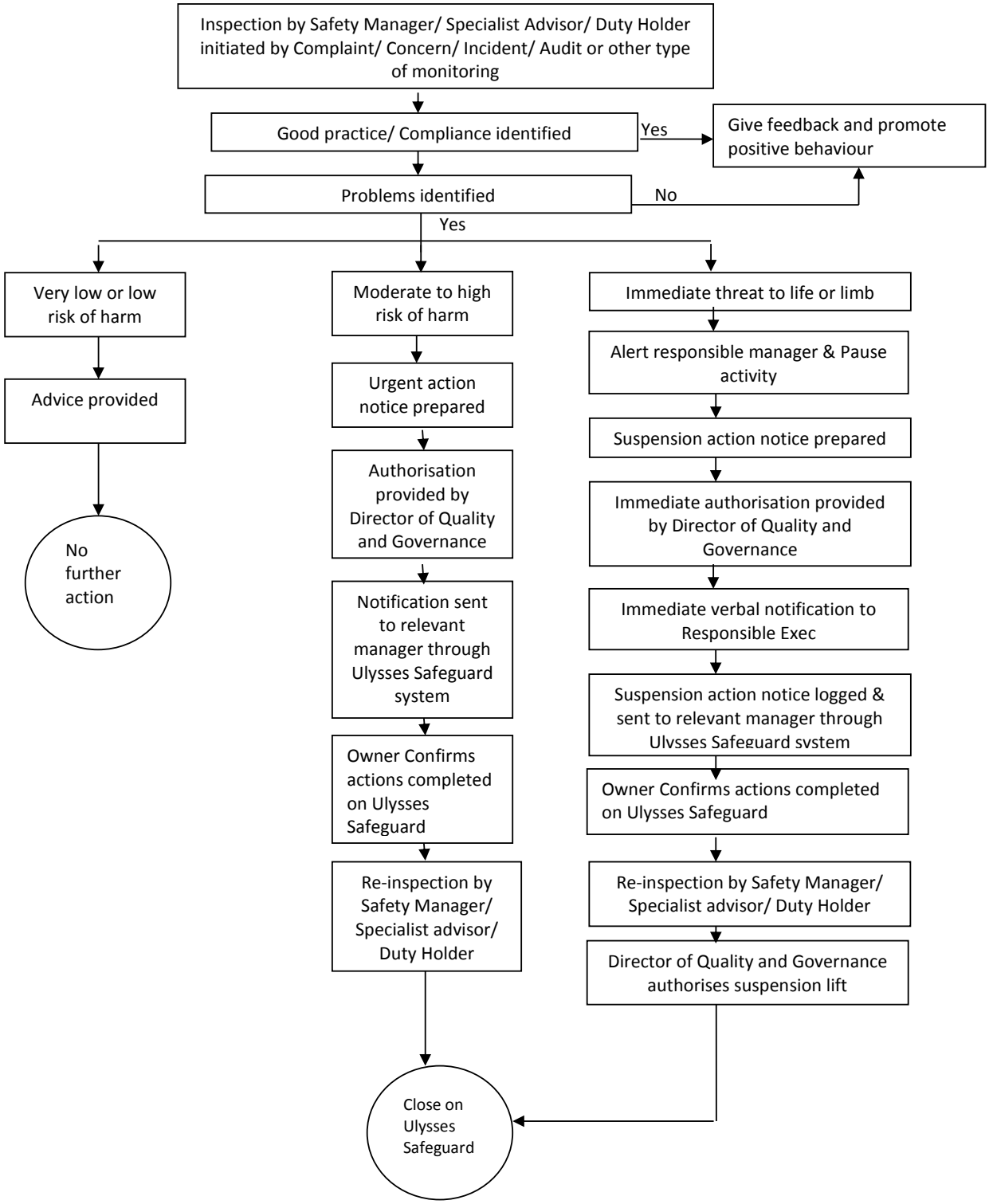
a) note and discuss the performance of the safety management system;
b) consider approval of the recommendations made in this report.

Appendix 1: Action plan

| Action | Progress | Completion date | Responsible | RAG |
|---|---|---|---|---|
| Independent safety management audit to be commissioned | The audit has been commissioned and is currently underway | **30/07/19** | Dir. Governance & Quality | |
| Develop a Duty Holder's Matrix which sets out how the Chief Executive's statutory duties for safety management are discharged | A Duty holders matrix has been developed and is currently under consultation | **30/06/19** | Dir. Governance & Quality | |
| Incorporate health & safety into the Trust's performance management framework; ensuring proactive as well as reactive indicators | A proposed dashboard has been developed and reporting arrangements to Board agreed. The dashboard contains both 'leading' and 'lagging' indicators.<br><br>Investigation response time is monitored through PSQB and SI panel.<br><br>H&S questions are integrated into Perfect ward and performance data fed back through this mechanism but plans to specifically draw out H&S questions onto a dashboard are progressing.<br><br>The provision of other incident statistics by Division and Directorate requires the data 'cleansing' to be completed first in order to provide reliable data | **30/08/19** | Dir. Governance & Quality | |
| H&S strategy developed articulating safety management objectives, priorities, how to achieve them, and how success will be measured. | H&S strategy has been developed and is currently in consultation | **30/06/19** | | |
| Establish a reliable link between the Electronic Staff Record and Safeguard Ulysses™ system to capture contemporaneously all incidents resulting in lost time from work (such as all incidents where the employee was unable to finish their shift and/or was not able to return to work for their next shift); | Currently the link offered by Safeguard Ulysses™ does not appear to meet our requirements but we have requested further advice as to whether this could be developed.<br><br>We are also exploring other options for developing procedures to establish this link between HR/ payroll and Occ Health. | **30/07/19 – for proposal to preferred option to be presented** | **Dir HR/** Dir. Governance & Quality | |
| Ward-based health & safety risk assessments to be updated | All wards were requested to update risk assessments. This is also a question within Perfect ward audits. However, not all areas are compliant and a significant review of how we undertake and utilise risk assessments will form part of the H&S improvement plan moving forward. | **30/05/19** | Ch. Nurse | |
| Review the effectiveness of the | Draft Terms of Reference for Safety | **30/06/19** | Director of | |

| | | | | |
|---|---|---|---|---|
| Health & Safety Committee and take whatever steps are necessary to ensure its success going forward | Assurance Committee developed and in consultation. First meeting currently being scheduled by Trust Secretary.<br><br>A meeting with Senior Union Representatives has been arranged to engender support for H&S improvement programme and re-launching H&S partnership Committee.<br>All responsible persons identified within Duty Holders matrix will be asked to nominate members for the meeting and provide a commitment to ensure required level of attendance. | | Quality & Governance | |

**Appendix 2: Flowchart Process for WUTH Local safety enforcement**
The following flowchart outlines the proposed process:-




**WUTH HEALTH & SAFETY LOCAL ENFORCEMENT PROCEDURE ACTION NOTICE**

| | | |
|---|---|---|
| **Type of Notice** | | Letter of Recognition |
| | | Urgent Action Notice |
| | | Suspension Notice *(where a breach represents an imminent and serious threat to the health, safety or welfare of staff, patients, visitors or contractors)* |

| | |
|---|---|
| **Issued To** | |
| | |
| **Recommended By** | |
| **Date of Issue** | |
| | |
| **Response Required by** | |
| | |
| **Summary of Concerns** | |

| | |
|---|---|
| **Copied to (for information)** | |

**BACKGROUND AND NATURE OF PROBLEM**

**RECOMMENDATIONS**

| Improvement Notice Issued by: | | | |
|---|---|---|---|
| Name: | | Designation: | |
| Signed: | | Date | |

| Improvement Notice Authorised by: | | | |
|---|---|---|---|
| Name: | | Designation: | |
| Signed: | | Date | |

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.1.1 |
| **Title of Report** | Quality and Performance Dashboard |
| **Date of Meeting** | 3rd July 2019 |
| **Author** | WUTH Information Team and Governance Support Unit |
| **Accountable Executive** | COO, MD, CN, DQG, HRD, DoF |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | Quality and Safety of Care<br>Patient flow management during periods of high demand |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | Gaps in Assurance |
| **Purpose of the Paper**<br>**Discussion**<br>**Approval**<br>**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**<br>**Yes**<br>**No** | No adverse equality impact identified. |

## 1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of May 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 50 indicators with established targets that are reported for May 2019:

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

Any 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, so performance this year is shown against the 2018/19 monthly threshold.

## 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 quarterly report on exceptions 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 May 2019.

**Appendix 1**
Wirral University Teaching Hospital NHS Foundation Trust

# Quality Performance Dashboard

**June 2019**
updated 21-06-19

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-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 | 0.17 | 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 | 77.0% | 83.3% | 84.8% | 80.1% | 82.9% | 81.6% | 78.4% | 80.6% | 89.9% | 95.0% | 98.7% | 96.2% | 86.0% | 91.1% | |
| | 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% | 94.7% | 95.3% | 95.0% | 95.6% | 95.2% | 95.6% | 95.3% | 96.6% | 96.8% | 96.9% | 96.4% | 96.3% | 96.4% | |
| | Harm Free Care Score (Safety Thermometer) | Safe, high quality care | DoN | ≥95% | National | 95.6% | 95.4% | 95.2% | 95.0% | 96.3% | 97.0% | 95.9% | 95.3% | 95.5% | 97.1% | 96.4% | 96.5% | 95.7% | 96.1% | |
| | Serious Incidents declared | Safe, high quality care | DQ&G | ≤4 per month | WUTH | 14 | 13 | 3 | 2 | 1 | 3 | 2 | 4 | 2 | 4 | 2 | 1 | 1 | 1 | |
| | Never Events | Safe, high quality care | DQ&G | 0 | SOF | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | CAS Alerts not completed by deadline | Safe, high quality care | DQ&G | 0 | SOF | 1 | 5 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| | Clostridium Difficile (healthcare associated) (*) | Safe, high quality care | DoN | ≤88 for WUTH FY19-20, as per mthly trajectory | SOF | 1 | 3 | 1 | 3 | 0 | 3 | 4 | 2 | 7 | 10 | 5 | 19 | 9 | 28 | |
| | E.Coli infections | Safe, high quality care | DoN | ≤42 pa (Max 3 per mth) | WUTH | 2 | 6 | 7 | 2 | 3 | 5 | 4 | 2 | 3 | 4 | 2 | 5 | 2 | 7 | |
| | CPE Colonisations/Infections | Safe, high quality care | DoN | To be split | WUTH | 14 | 17 | 18 | 18 | 15 | 13 | 23 | 9 | 10 | 6 | 5 | 12 | 9 | 11 | |
| | MRSA bacteraemia - hospital acquired | Safe, high quality care | DoN | 0 | National | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | |
| | Hand Hygiene Compliance (*) | Safe, high quality care | DoN | ≥95% | WUTH | 97% | 88% | 89% | 90% | 81% | 87.0% | 85.0% | 76.0% | 83.0% | 99.0% | 99.0% | 98.0% | 91.0% | 94.5% | |
| | 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% | 99% | |
| | Protecting Vulnerable People Training - % compliant (Level 1) | Safe, high quality care | DoN | ≥90% | WUTH | - | - | 87.4% | - | 85.6% | 90.4% | 91.5% | 91.4% | 91.6% | 92.8% | 93.9% | 93.6% | 93.9% | 93.9% | |
| | Protecting Vulnerable People Training - % compliant (Level 2) | Safe, high quality care | DoN | ≥90% | WUTH | - | - | 82.7% | - | 82.2% | 86.0% | 87.2% | 87.1% | 87.6% | 88.7% | 90.7% | 90.9% | 91.0% | 91.0% | |
| | Protecting Vulnerable People Training - % compliant (Level 3) | Safe, high quality care | DoN | ≥90% | WUTH | - | - | 85.6% | - | 86.5% | 87.2% | 91.7% | 91.4% | 93.6% | 92.6% | 93.5% | 91.4% | 92.8% | 92.8% | |
| | Attendance % (12-month rolling average) (*) | Safe, high quality care | DHR | ≥95% | SOF | 95.18% | 95.16% | 95.13% | 95.13% | 95.09% | 95.06% | 95.07% | 95.06% | 95.05% | 94.98% | 94.90% | 94.81% | 94.74% | 94.74% | |
| | Staff turnover (*) | Safe, high quality care | DHR | ≤10% | WUTH | 10.1% | 9.7% | 10.4% | 9.9% | 9.9% | 10.0% | 9.7% | 9.6% | 9.7% | 9.7% | 9.8% | 10.0% | 10.2% | 10.2% | |
| | Care hours per patient day (CHPPD) | Safe, high quality care | DoN | Between 6 and 10 | WUTH | 7.3 | 7.4 | 7.6 | 7.5 | 7.1 | 6.9 | 7.1 | 7.0 | 7.3 | 7.2 | 7.2 | 7.2 | 7.3 | 7.25 | |

**Appendix 1**
Wirral University Teaching Hospital NHS Foundation Trust

# Quality Performance Dashboard

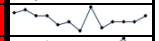
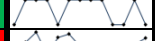
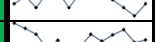
**June 2019**
updated 21-06-19

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | 2019/20 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Effective | SHMI | Safe, high quality care | MD | ≤100 | SOF | – | 97.06 | – | – | 97.22 | – | – | – | – | – | – | – | – | 97.22 | |
| | HSMR | Safe, high quality care | MD | ≤100 | SOF | 93.0 | 93.0 | 95 | 95 | 92 | 92 | 97 | 97 | 98 | 99 | – | – | – | 97 | |
| | Mortality Reviews Completed. Monthly reporting finalised 3 months later | Safe, high quality care | MD | ≥75% | WUTH | – | – | – | – | – | – | – | – | 86% | 71% | 54% | 44% | 38% | 41% | |
| | 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% | 95.0% | 93.5% | |
| | SAFER BUNDLE: % of discharges taking place before noon | Safe, high quality care | MD / COO | ≥33% | National | 14.3% | 13.9% | 12.9% | 14.1% | 13.1% | 15.4% | 16.4% | 14.6% | 14.2% | 15.3% | 14.9% | 17.1% | 15.0% | 16.1% | |
| | SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual | Safe, high quality care | MD / COO | ≤156 (WUTH Total) | WUTH | 405 | 409 | 386 | 387 | 411 | 409 | 408 | 397 | 437 | 457 | 438 | 421 | 415 | 418 | |
| | Length of stay - elective (actual in month) | Safe, high quality care | COO | TBC | WUTH | 4.3 | 3.8 | 5.2 | 4.1 | 4.2 | 4.3 | 3.8 | 4.8 | 3.0 | 4.4 | 4.4 | 4.9 | 4.0 | 4.5 | |
| | Length of stay - non elective (actual in month) | Safe, high quality care | COO | TBC | WUTH | 5.2 | 5.1 | 5.4 | 5.0 | 4.9 | 5.3 | 5.1 | 5.0 | 5.2 | 5.6 | 5.2 | 5.8 | 5.5 | 5.7 | |
| | Emergency readmissions within 28 days | Safe, high quality care | COO | TBC | WUTH | 923 | 873 | 913 | 961 | 888 | 936 | 925 | 917 | 903 | 788 | 914 | 871 | 970 | 921 | |
| | Delayed Transfers of Care | Safe, high quality care | COO | TBC | WUTH | 12 | 13 | 13 | 6 | 18 | 12 | 17 | 14 | 10 | 16 | 14 | 11 | | 11 | |
| | % Theatre Utilisation | Safe, high quality care | COO | ≥85% | WUTH | 86.6% | 88.6% | 86.7% | 92.3% | 89.2% | 88.9% | 87.1% | 86.0% | 81.7% | 83.6% | 85.7% | 89.5% | 86.3% | 87.9% | |

**Appendix 1**
Wirral University Teaching Hospital NHS Foundation Trust

# Quality Performance Dashboard

**June 2019**
updated 21-06-19

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | 2019/20 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caring | Same sex accommodation breaches | Outstanding Patient Experience | DoN | 0 | SOF | 22 | 10 | 8 | 16 | 14 | 19 | 18 | 15 | 20 | 14 | 13 | 13 | 13 | 26 |  |
| | FFT Recommend Rate: ED | Outstanding Patient Experience | DoN | ≥95% | SOF | 90% | 91% | 89% | 89% | 86% | 87% | 84% | 92% | 85% | 87% | 87% | 87% | 89% | 88% |  |
| | FFT Overall Response Rate: ED | Outstanding Patient Experience | DoN | ≥12% | WUTH | 9% | 8% | 11% | 12% | 11% | 10% | 11% | 10% | 11% | 11% | 13% | 9% | 11% | 10% |  |
| | FFT Recommend Rate: Inpatients | Outstanding Patient Experience | DoN | ≥95% | SOF | 97% | 98% | 98% | 98% | 97% | 98% | 98% | 98% | 98% | 97% | 97% | 98% | 97% | 98% |  |
| | FFT Overall response rate: Inpatients | Outstanding Patient Experience | DoN | ≥25% | WUTH | 15% | 20% | 25% | 14% | 22% | 24% | 18% | 18% | 19% | 15% | 13% | 19% | 22% | 21% |  |
| | FFT Recommend Rate: Outpatients | Outstanding Patient Experience | DoN | ≥95% | SOF | 95% | 94% | 95% | 94% | 94% | 94% | 95% | 94% | 95% | 94% | 95% | 94% | 94% | 94% |  |
| | FFT Recommend Rate: Maternity | Outstanding Patient Experience | DoN | ≥95% | SOF | 97% | 99% | 96% | 100% | 100% | 96% | 100% | 100% | 99% | 98% | 96% | 94% | 97% | 96% |  |
| | FFT Overall response rate: Maternity (point 2) | Outstanding Patient Experience | DoN | ≥25% | WUTH | 54% | 46% | 37% | 17% | 28% | 11% | 19% | 37% | 27% | 36% | 44% | 25% | 29% | 27% |  |

**Appendix 1**
Wirral University Teaching Hospital NHS Foundation Trust

# Quality Performance Dashboard

**June 2019**
updated 21-06-19

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-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 | 83.5% | 83.4% | 85.6% | 83.6% | 77.8% | 77.8% | 75.2% | 75.0% | 74.0% | 74.0% | 76.7% | 73.6% | 81.1% | 81.1% | |
| | 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 | 2 | 0 | 0 | 0 | 0 | 0 | |
| | Ambulance Handovers >30 minutes | Safe, high quality care | COO | TBC | National | 327 | 291 | 213 | 326 | 474 | 371 | 440 | 393 | 379 | 323 | 273 | 437 | 118 | 278 | |
| | 18 week Referral to Treatment - Incomplete pathways < 18 Weeks | Safe, high quality care | COO | NHSI Trajectory: minimum 80% through 2019-20 | SOF | 74.6% | 75.7% | 76.3% | 77.2% | 78.3% | 78.98% | 79.34% | 80.08% | 78.32% | 79.12% | 80.00% | 79.04% | 80.72% | 80.72% | |
| | Referral to Treatment - total open pathway waiting list (*) | Safe, high quality care | COO | NHSI Trajectory: maximum 24,735 by March 2020 | National | 26,648 | 26,957 | 26,836 | 27,308 | 26,556 | 26,862 | 27,367 | 26,157 | 27,506 | 28,367 | 27,309 | 26,223 | 27,317 | 27,317 | |
| | Referral to Treatment - cases exceeding 52 weeks | Safe, high quality care | COO | NHSI Trajectory: zero through 2019-20 | National | 67 | 79 | 57 | 56 | 40 | 43 | 30 | 28 | 28 | 19 | 0 | 0 | 0 | 0 | |
| | Diagnostic Waiters, 6 weeks and over -DM01 | Safe, high quality care | COO | ≥99% | SOF | 98.2% | 97.9% | 98.5% | 97.9% | 99.2% | 99.4% | 98.9% | 98.6% | 99.1% | 99.7% | 99.9% | 99.5% | 99.3% | 99.3% | |
| | Cancer Waiting Times - 2 week referrals | Safe, high quality care | COO | ≥93% | National | 93.4% | 95.2% | 95.7% | 92.3% | 94.5% | 95.2% | 93.9% | 93.1% | 87.8% | 93.1% | 98.1% | 91.9% | 93.8% | 92.8% | |
| | Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis | Safe, high quality care | COO | ≥96% | National | 96.4% | 95.5% | 98.2% | 96.3% | 96.2% | 96.8% | 96.7% | 96.9% | 97.1% | 96.7% | 96.8% | 96.5% | 96.9% | 96.7% | |
| | Cancer Waiting Times - 62 days to treatment | Safe, high quality care | COO | ≥85% | SOF | 86.1% | 87.8% | 85.4% | 87.9% | 85.7% | 85.1% | 85.3% | 86.2% | 85.4% | 86.5% | 85.8% | 85.3% | 82.9% | 84.1% | |
| | Patient Experience: Number of concerns received in month - Level 1 (informal) | Outstanding Patient Experience | DoN | TBC | WUTH | 134 | 110 | 140 | 123 | 155 | 119 | 165 | 118 | 178 | 153 | 157 | 162 | 195 | 178.5 | |
| | Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal) | Outstanding Patient Experience | DoN | TBC | WUTH | 23 | 36 | 24 | 25 | 22 | 19 | 13 | 13 | 27 | 28 | 17 | 17 | 12 | 14.5 | |
| | Complaint acknowledged within 3 working days | Outstanding Patient Experience | DoN | ≥90% | National | 81% | 95% | 72% | 75% | 80% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.0% | |
| | Number of re-opened complaints | Outstanding Patient Experience | DoN | ≤5 pcm | WUTH | 2 | 7 | 5 | 0 | 4 | 2 | 3 | 2 | 2 | 1 | 3 | 4 | 4 | 4 | |

**Appendix 1**
Wirral University Teaching Hospital NHS Foundation Trust

# Quality Performance Dashboard

**June 2019**
updated 21-06-19

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | 2019/20 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Well-led | Duty of Candour compliance (for all moderate and above incidents) | Outstanding Patient Experience | DQ&G | 100% | National | - | - | - | - | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.0% | |
| | 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 | 39 | 336 | 70 | 48 | 42 | 38 | 57 | 38 | 43 | 41 | 59 | 26 | 23 | 49 | |
| | % Appraisal compliance | Safe, high quality care | DHR | ≥88% | WUTH | | 81.1% | 79.7% | 78.2% | 77.5% | 78.4% | 83.8% | 84.5% | 84.6% | 85.7% | 88.2% | 77.6% | 81.1% | 81.1% | |

| | Indicator | Objective | Director | Threshold | Set by | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | 2019/20 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Use of Resources | I&E Performance | | DoF | On Plan | WUTH | -2.337 | -2.659 | -3.139 | -3.426 | -2.334 | -1.246 | -1.445 | -4.038 | -1.755 | -4.037 | -5.402 | -3.340 | -1.458 | -4.798 | |
| | I&E Performance (Variance to Plan) | | DoF | On Plan | WUTH | -0.103 | -0.340 | -0.184 | -0.515 | -0.319 | -0.121 | -0.761 | -1.127 | -1.002 | -1.338 | -4.690 | -0.237 | -0.630 | -0.867 | |
| | 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 | -36.3% | -27.2% | -22.1% | -15.4% | -11.7% | -10.6% | -5.4% | -6.1% | -13.9% | -13.5% | -13.0% | -6.0% | -6.8% | -6.8% | |
| | NHSI Agency Ceiling Performance | | DoF | NHSI cap | NHSI | 1.1% | 20.7% | -28.8% | -5.4% | 8.7% | -11.1% | -7.4% | -0.5% | 11.9% | -22.1% | -44.0% | -19.5% | -26.8% | -26.8% | |
| | Cash - liquidity days | | DoF | NHSI metric | WUTH | -12.5 | -13.3 | -13.5 | -14.4 | -12.7 | -12.0 | -13.0 | -12.5 | -12.9 | -12.8 | -20.9 | -14.0 | -21.3 | -21.3 | |
| | Capital Programme | | DoF | On Plan | WUTH | 9.8% | 32.9% | 45.0% | 4.9% | 5.2% | 35.8% | 41.4% | 50.3% | 62.3% | 56.6% | 12.2% | 52.1% | 31.0% | 31.0% | |

**(*) Updated Metrics** — **Metric Change**

**(**) Updated Thresholds** — **Threshold Change**

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.1.2 |
| **Title of Report** | Month 2 Finance Report |
| **Date of Meeting** | 3 July 2019 |
| **Author** | Shahida Mohammed – Acting Deputy Director of Finance |
| **Accountable Executive** | Karen Edge<br>Acting Director of Finance |
| **BAF References**<br><br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 8<br><br>8c,8d |
| **Level of Assurance**<br><br>• **Positive**<br>• **Gap(s)** | Gaps: Financial performance below plan |
| **Purpose of the Paper**<br><br>• **Discussion**<br>• **Approval**<br>• **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**<br><br>• **Yes**<br>• **No** | No |

# Month 2 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 Operational financial performance during May (Month 2).

The plan to deliver a "breakeven" position has been profiled to reflect the expected variation in income recovery and the anticipated delivery of the Cost Improvement Programme during the year.

On that basis for Month 2 the Trust's planned an operational deficit of (£0.8m), actual performance was a deficit of (c£1.4m), an under delivery of (c£0.6m). This increases the cumulative under-delivery to (£0.9m), as the YTD plan is a deficit of (c£3.9m), and the actual position is a deficit of (c£4.8m). This includes anticipated risks in relation to VAT on medical locum spend and depreciation charges of (£0.4m). Mitigation and control measures are outlined in section 4.

**1.1 Key Headlines:**

- Patient-related income is in line with plan reflecting the benefit of local contract terms and the MSK contract. Elective activity is behind plan by (c£0.3m) but this has been offset by over-performance on maternity care and diagnostics.
- Pay costs exceeded plan by (£0.2m) in May, increasing the year to date overspend to (c£0.4m). The position is supported by significant pay underspends in the Corporate areas. The main drivers are agency spend on consultants and locums for junior doctors to cover gaps, pressures in ED and staffing of escalation areas.
- Non pay costs were higher than plan by (c£0.4m) in May, the cumulative position being (£0.5m) worse than plan. A proportion of the non-pay overspend is being managed within the overall budgets of Divisions, offsetting pay underspends and supporting delivery of income above plan. The underlying pressures relate to drug costs; the closure of the Aseptic unit and CIP slippage. The Aseptic unit is due to reopen in July.
- Cash balances at the end of May were £3.0m which was £0.4m above plan.
- The delivery of cost improvements year to date is c£1.0m against a plan of c£1.2m.
- Although the year to date capital spend is slightly behind plan (c£0.3m), the Trust is forecasting to deliver the full 19/20 plan.
- The Trust delivered a UoR rating of 3 as planned.

The Board is asked to ratify the approval of the Medicine divisions capital scheme for Ward 30 refurbishment (£269k), which was debated at June FPG.

- The approval is subject to the current review of capital contingency affordability in light of the NHSI CDEL restrictions.
- The Medicine division will vire £134k from its capital plan for the refurbishment of ward M1, the remaining funding will come from contingency.
- The ward 30 scheme has been brought forward from the indicative 2020/21 capital plan due to increased concerns regarding infection control.

## 2. Financial performance

### 2.1 Income and expenditure

| **Month 2** Financial performance | Annual Budget £'000 | Current Period Budget £'000 | Current Period Actual £'000 | Current Period Variance £'000 | Year to date Budget £'000 | Year to date Actual £'000 | Year to date Variance £'000 |
|---|---|---|---|---|---|---|---|
| NHS income from patient care activity | 326,066 | 27,322 | 27,258 | (64) | 53,051 | 53,030 | (21) |
| Non NHS income from patient care | 3,382 | 274 | 356 | 83 | 539 | 670 | 131 |
| Income - PSF/FRF | 18,804 | 1,151 | 1,152 | 1 | 2,302 | 2,302 | 0 |
| Other income | 27,896 | 2,294 | 2,281 | (13) | 4,712 | 4,764 | 52 |
| Total operating income before donated asset income | 376,148 | 31,041 | 31,047 | 6 | 60,604 | 60,766 | 162 |
| Employee expenses | (254,681) | (21,572) | (21,759) | (186) | (44,054) | (44,451) | (397) |
| Operating expenses | (108,263) | (9,204) | (9,595) | (390) | (18,305) | (18,819) | (514) |
| Total operating expenditure before depreciation and impairmer | (362,944) | (30,777) | (31,354) | (577) | (62,359) | (63,270) | (911) |
| **EBITDA** | **13,203** | **264** | **(306)** | **(570)** | **(1,755)** | **(2,504)** | **(748)** |
| Depreciation and net impairment | (9,219) | (743) | (804) | (61) | (1,486) | (1,609) | (122) |
| Capital donations / grants income | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Operating surplus / (deficit)** | **3,984** | **(479)** | **(1,111)** | **(631)** | **(3,242)** | **(4,112)** | **(870)** |
| Net finance costs | (4,233) | (349) | (348) | 2 | (690) | (686) | 4 |
| Gains/(losses) on disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Actual surplus / (deficit)** | **(249)** | **(828)** | **(1,458)** | **(630)** | **(3,932)** | **(4,798)** | **(866)** |
| *Reverse* capital donations / grants I&E impact | 249 | 21 | 21 | (0) | 42 | 42 | (0) |
| **Adjusted financial performance surplus/(deficit) [AFPD] including PSF** | **0** | **(807)** | **(1,437)** | **(630)** | **(3,890)** | **(4,757)** | **(866)** |

- The overall position deteriorated during May by (£0.6m), this reflects a number of pressures, mainly agency spend on Consultants, cover for Junior Medical vacancies and bank costs for nursing staff, covering sickness and patient acuity and closure of the Aseptic Unit, affecting drug costs.
- Some of the pressures are non recurrent such as “one off” claims, where costs were incurred in Month 1 such as Consultant agency or Junior Dr rota cover which continued into May, were largely mitigated in April due to one-off benefits such as release of prior year accruals and credits against costs in Diagnostics.
- High levels of qualified nurse vacancies continue which has resulted in the use of bank nurses to maintain safe staffing levels across the wards. Vacancies remain in non-clinical areas and have non-recurrently supported the delivery of CIP.
- The Aseptic Unit is due to re-open in July, the remaining pressures need to be closely managed going forward and actions are outlined in Section 4.

## 2. Financial performance

Items not included in the original Plan

**Locum pay VAT**

- The M2 pay position includes the continuing impact of (c£0.2m) YTD 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 pressure of (c£0.2m) YTD in operating expenditure from additional depreciation charges which relate to changes in estimates of asset lives provided by the Trust's external valuer. These changes were mandated by amendments to valuation instructions issued by the Royal Institute of Chartered Surveyors (RICS) in February 2019.
- Although this is a national issue, NHSI has maintained the view that this is a matter for individual trusts to manage and mitigate locally.
- As discussed during the planning process, the additional costs (c£1.3m) are not included in the 2019/20 plan.

## 2. Financial performance

### 2.2 Operational adjustments to the 2019/20 Plan (net zero impact)

The table below details in-year operational adjustments to the initial plan submitted to NHSI in April 2019.

| Month 2 Plan Reconciliation | Income £'000 | Expenditure £'000 | Net £'000 |
|---|---|---|---|
| **Final NHSI Plan submission 19/20 YTD Mth 2** | 60,665 | (64,597) | (3,932) |
| CIP - Increase Clinical Income Oral Surgery based on capacity and demand assumptions. | 25 | (25) | 0 |
| CIP - Realignment of Target | (15) | 15 | 0 |
| Extra Day 19/20 reduced activity assumption | (34) | 34 | 0 |
| Agreement of Neonatal "block" contract with NHSE - Spec. Comm. | 12 | (12) | 0 |
| Drugs inflation adjustment | 28 | (28) | 0 |
| Non Recurrent Non Clinical Income Targets | 63 | (63) | 0 |
| Monthly High cost drugs (pass through) adjustment | (154) | 154 | 0 |
| Realignments | 14 | (14) | 0 |
| **Adjusted Operational budget YTD Mth 2** | 60,604 | (64,536) | (3,932) |
| **Net Trustwide (Increase)/Reduction** | **(61)** | **61** | **0** |

## 2. Financial performance

### 2.3 Income

| | Current month | | | Year to date | | | Current month | | | Year to date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Actual £'000 | Variance £'000 |
| **Income from patient care activity** | | | | | | | | | | | | |
| Elective & Daycase | 4,284 | 4,197 | (87) | 8,177 | 8,061 | (116) | 4,857 | 4,529 | (327) | 9,060 | 8,725 | (335) |
| Elective excess bed days | 286 | 320 | 34 | 543 | 566 | 23 | 78 | 87 | 9 | 148 | 154 | 6 |
| Non-elective | 3,740 | 3,765 | 25 | 7,448 | 7,516 | 68 | 8,605 | 8,551 | (54) | 17,077 | 17,098 | 21 |
| Non-elective Non Emergency | 397 | 452 | 55 | 772 | 867 | 95 | 872 | 940 | 68 | 1,689 | 1,862 | 173 |
| Non-elective excess bed days | 1,034 | 1,436 | 402 | 2,054 | 2,556 | 502 | 280 | 414 | 134 | 556 | 706 | 150 |
| A&E | 7,570 | 7,732 | 162 | 14,414 | 15,366 | 952 | 1,303 | 1,292 | (11) | 2,481 | 2,504 | 23 |
| Outpatients | 26,596 | 25,287 | (1,309) | 49,805 | 48,620 | (1,185) | 3,160 | 3,093 | (67) | 5,908 | 5,826 | (82) |
| Diagnostic imaging | 2,531 | 2,668 | 138 | 4,741 | 5,096 | 356 | 191 | 205 | 14 | 355 | 379 | 24 |
| Maternity | 475 | 505 | 30 | 923 | 1,009 | 86 | 444 | 446 | 2 | 865 | 881 | 16 |
| Non PbR | | | | | | | 6,158 | 6,360 | 202 | 12,209 | 12,278 | 69 |
| HCD | | | | | | | 1,283 | 1,284 | 1 | 2,511 | 2,511 | 0 |
| CQUINs | | | | | | | 186 | 186 | 0 | 372 | 372 | 0 |
| PSF/FRF/MRET | | | | | | | 1,151 | 1,152 | 1 | 2,302 | 2,302 | 0 |
| Total NHS Clincial Income | 46,914 | 46,363 | (551) | 88,878 | 89,658 | 780 | 28,567 | 28,540 | (26) | 55,533 | 55,598 | 65 |
| Other patient care income | | | | | | | 60 | 76 | 15 | 120 | 150 | 30 |
| Non-NHS: private patients & overseas | | | | | | | 30 | 40 | 10 | 60 | 77 | 17 |
| Injury cost recovery scheme | | | | | | | 89 | 110 | 21 | 178 | 176 | (2) |
| Total income from patient care activities | | | | | | | 28,746 | 28,766 | 20 | 55,892 | 56,002 | 110 |
| Other operating income | | | | | | | 2,294 | 2,281 | (13) | 4,712 | 4,764 | 52 |
| Total income | | | | | | | 31,041 | 31,047 | 6 | 60,604 | 60,766 | 162 |

- The income position in month 2 has remained balanced, with a year to date over performance of c£0.2m.
- Non-elective activity slightly exceeded plan from an activity perspective, however the casemix was less complex. In-line with the contractual agreement for Non-elective cumulatively c£0.2m has been included reflecting the support from Wirral CCG.
- The Elective performance is driven by an under performance in Colorectal, Urology, Upper GI and Orthopaedics. The Orthopaedic under performance has been mitigated by the MSK block benefit of £0.4m.
- Although overall Outpatients attendances are under performing, for Wirral CCG the position is supported by the “block” agreement.
- Year to date births exceed plan by 51 deliveries, benefitting the position by £0.2m.
- Neonatal activity is based on a “block” for 2019/20 this has benefitted the position by c£0.1m.

### 2.4 Pay

Pay costs exceeded plan by (£0.2m), increasing the cumulative overspend to (c£0.4m).

The table below details pay costs by staff group for April and May, and cumulatively.

| | MONTH 1 (£'000) | | | MONTH 2 (£'000) | | | CUMULATIVE (£'000) | | |
|---|---|---|---|---|---|---|---|---|---|
| STAFF GROUP | BUDGET | ACTUAL | VARIANCE | BUDGET | ACTUAL | VARIANCE | BUDGET | ACTUAL | VARIANCE |
| CONSULTANTS | (3,375) | (3,593) | (218) | (3,347) | (3,563) | (216) | (6,722) | (7,156) | (434) |
| OTHER MEDICAL | (2,417) | (2,544) | (127) | (2,401) | (2,590) | (189) | (4,818) | (5,134) | (316) |
| **TOTAL MEDICAL** | **(5,792)** | **(6,137)** | **(345)** | **(5,748)** | **(6,153)** | **(405)** | **(11,540)** | **(12,290)** | **(750)** |
| NURSING & MIDWIFERY | (6,468) | (6,187) | 281 | (6,052) | (5,937) | 115 | (12,520) | (12,124) | 396 |
| CLINICAL SUPPORT WORKERS | (2,122) | (2,295) | (173) | (2,019) | (2,243) | (224) | (4,141) | (4,538) | (397) |
| **TOTAL NURSING** | **(8,590)** | **(8,482)** | **108** | **(8,071)** | **(8,180)** | **(109)** | **(16,661)** | **(16,662)** | **(1)** |
| AHP'S, SCIENTIFIC & TECH | (2,770) | (2,833) | (63) | (2,610) | (2,626) | (16) | (5,380) | (5,459) | (79) |
| ADMIN & CLERICAL & OTHER | (5,329) | (5,239) | 90 | (5,142) | (4,798) | 344 | (10,471) | (10,037) | 433 |
| **TOTAL** | **(22,481)** | **(22,691)** | **(210)** | **(21,571)** | **(21,757)** | **(186)** | **(44,052)** | **(44,448)** | **(397)** |

- Part of the overspend is related to the additional VAT for medical locums, as discussed earlier in the report.
- The key themes are medical staffing pressures across a number of specialities continuing, including on-call cover, maternity leave and vacancies.
- Although nursing costs are showing an underspend, reflecting the number of vacancies, the level of underspend has reduced in May, compared to April, offset by the overspend in the clinical support staff costs shown above. The nursing budget also includes the funding set aside for business cases approved during the budget setting exercise. This is supporting the position by c£0.2m.
- The position also reflects the costs of escalation areas.
- The admin & clerical line includes c£100k where IT revenue costs have been moved to capital in Month 2.

## 2. Financial performance

The table below details pay costs by category for April, May and cumulatively.

| Pay analysis | Annual Budget £'000 | Mth 2 Budget £'000 | Mth 2 Actual £'000 | Mth 2 Variance £'000 | Mth 1 Budget £'000 | Mth 1 Actual £'000 | Mth 1 Variance £'000 | Year to date Budget £'000 | Year to date Actual £'000 | Year to date Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Substantive | (249,320) | (21,053) | (19,297) | 1,756 | (21,940) | (20,395) | 1,545 | (42,993) | (39,692) | 3,301 |
| Bank | (241) | (25) | (962) | (936) | (20) | (795) | (775) | (45) | (1,757) | (1,712) |
| Medical bank | (2,891) | (287) | (602) | (315) | (308) | (634) | (327) | (594) | (1,236) | (642) |
| Agency | (1,229) | (124) | (823) | (700) | (132) | (785) | (653) | (255) | (1,608) | (1,353) |
| Apprenticeship Levy | (1,000) | (83) | (75) | 9 | (83) | (83) | 0 | (167) | (158) | 9 |
| Total | (254,681) | (21,572) | (21,759) | (186) | (22,482) | (22,692) | (210) | (44,054) | (44,451) | (397) |

- The under spend in substantive costs increased further; offset by an increase in non- medical bank staff costs.
- Actual agency costs and medical bank cost, continue to overspend, the level of spend has remained relatively static over the months,
- To note both the budget and actual costs in the substantive category for Month 1 includes the additional funding for those staff on AfC pay scales reflecting the ”one-off” non-consolidated pay award for those employees at the top of the band, this was c£1.0m.

## 2. Financial performance

### 2.5 Non Pay

Non pay costs exceeded plan by c£0.5m during the month, an increase of c£0.3m from the position reported in Month 1.

| Non Pay Analysis | Annual Budget £'000 | Mth 2 Budget £'000 | Mth 2 Actual £'000 | Mth 2 Variance £'000 | Mth 1 Budget £'000 | Mth 1 Actual £'000 | Mth 1 Variance £'000 | Year to date Budget £'000 | Year to date Actual £'000 | Year to date Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Supplies and services - clinical | (34,228) | (2,947) | (3,000) | (54) | (2,769) | (2,809) | (40) | (5,716) | (5,809) | (93) |
| Supplies and services - general | (4,578) | (381) | (409) | (28) | (382) | (377) | 4 | (762) | (786) | (24) |
| Drugs | (23,643) | (1,977) | (1,994) | (17) | (1,879) | (1,869) | 10 | (3,856) | (3,863) | (6) |
| Purchase of HealthCare - Non NHS Bodies | (7,490) | (621) | (665) | (44) | (675) | (682) | (6) | (1,296) | (1,346) | (50) |
| CNST | (12,948) | (1,128) | (1,128) | 0 | (1,128) | (1,128) | 0 | (2,256) | (2,256) | 0 |
| Consultancy | (0) | (0) | (32) | (32) | (0) | (44) | (44) | (0) | (76) | (76) |
| Other | (25,377) | (2,151) | (2,367) | (217) | (2,267) | (2,315) | (48) | (4,418) | (4,683) | (265) |
| Total | (108,263) | (9,204) | (9,595) | (390) | (9,100) | (9,224) | (124) | (18,305) | (18,819) | (514) |
| Depreciation | (9,219) | (743) | (804) | (61) | (743) | (804) | (61) | (1,486) | (1,609) | (122) |
| Total | (117,483) | (9,948) | (10,399) | (451) | (9,844) | (10,028) | (185) | (19,791) | (20,428) | (636) |

The movement relates to a number of areas:

- Impact of the closure of the Aseptic Unit which was offset in Month 1 by non-recurrent benefit of accruals;
- Clinical supplies and drug costs reflecting increased activity and patient acuity;
- IT equipment costs noting the IT budget overall did not overspend in month;
- Expenditure on Training  increased;
- Reduced occupancy of the Frontis building caused a pressure.

## 2. Financial performance

### 2.6 CIP Performance

| Programme | Director | YTD NHSI Plan £k | YTD Actual £k | YTD Variance £k |
|---|---|---|---|---|
| **Transformation** | | | | |
| Patient Flow | Antony Middleton | 267 | 184 | (83) |
| Theatre Productivity | Antony Middleton | 133 | 35 | (98) |
| Outpatients | Antony Middleton | 147 | 47 | (100) |
| Demand Management | Antony Middleton | 0 | 0 | 0 |
| Digital | Paul Charnley | 41 | 3 | (37) |
| **Sub total - transformation** | | **587** | **269** | (318) |
| **Quipp & Cross cutting workstreams** | | | | |
| Workforce | Helen Marks / Tracy Fennell | 0 | 0 | 0 |
| CNST | Antony Middleton | 0 | 0 | 0 |
| GDE | Paul Charnley | 0 | 0 | 0 |
| Endoscopy | Antony Middleton | 0 | 0 | 0 |
| Meds Management | Pippa Roberts | 68 | 85 | 17 |
| Procurement | Karen Edge | 45 | 15 | (30) |
| **Tactical and transactional** | | | | |
| Divisional and Departmental | Divisional Directors | 457 | 609 | 153 |
| **Unidentified** | | 54 | 0 | (54) |
| **Total** | | **1,211** | **978** | (233) |

- The overall CIP delivery for Month 2 is (c£0.2m) below the NHSI plan.
- The table above details the CIP delivery by programme including the business as usual departmental schemes.
- Transformational schemes are slightly behind plan to date, plans are progressing and it is anticipated the schemes will recover the shortfall.
- The position on Patient Flow and the Outpatients reflects the net impact of costs incurred to deliver this, which are funded from the Growth reserve allocated to the Divisions during budget setting, this is in-line with the principles agreed at the beginning of the year.
- Workforce schemes (nursing and medical) are in development and are profiled to be delivered from Q2.
- Drugs / Medicines Management schemes are over-delivering and further procurement schemes are in development to mitigate and catch up the current delivery gap.
- Included in the £0.6m of divisional / departmental savings are c£0.4m of non-recurrent mitigation largely in the Corporate and Clinical Support division and largely due to vacancy mitigation.

# 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% | -20.8 | 4 | -21.3 | 4 | -30.4 | 4 |
| Financial sustainability | **Capital service capacity (times)** | Revenue available for capital service: the degree to which generated income covers financial obligations | 20% | -2.4 | 4 | -3.5 | 4 | 2.5 | 2 |
| Financial efficiency | **I&E margin (%)** | Underlying performance: I&E deficit / total revenue | 20% | -6.4% | 4 | -7.8% | 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 | -1.4% | 3 | 0.0% | 1 |
| Financial controls | **Agency spend (%)** | Distance of agency spend from agency cap | 20% | 0.0% | 1 | 23.0% | 2 | 0.0% | 1 |
| | **Overall NHSI UoR rating** | | | | **3** | | **3** | | **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 supplier 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 2 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 dependency on non-core capacity.
- The activity performance position is monitored weekly by the Chief Operating Officer to ensure the elective program, RTT 18wk and 52wk quality standards are delivered.
- Non stock ordering process introduced to stop orders proactively for any non-essential requests without due process and sign off by Divisional/Executive Directors.
- Medical junior doctor rota's to be signed–off by Divisional Directors and additional process controls introduced. External review underway of medical staffing processes.
- The weekly performance "scrutiny" panel review non-clinical vacancies, discretionary non pay spend, non-core spend and the agency 'hotlist'.
- 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.
- Monthly review of Divisional performance is undertaken by the Executive Directors as well as a more detailed Director of Finance review.
- Divisional forecasting of spend (pay and non pay) to be proactively managed on a weekly basis by the Acting Director of Finance and Chief Operating Officer, to ensure mitigating actions are taken in over spending areas, to manage the position.
- Review of NHSI Grip & Control checklist for further measures to mitigate pressures

**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 has not delivered the financial plan for May, the Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan. The weekly vacancy panel is now reviewing both clinical and non-clinical vacancies.

Exceptional items such as the impact of VAT on medical locums have impacted the position (c£0.4m) year to date; 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, and this has manifested itself further in Month 2. 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 2 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**
**June 2019**

| Board of Directors | |
|---|---|
| **Agenda Item** | 9.1 |
| **Title of Report** | Interim NHS People Plan |
| **Date of Meeting** | 3rd July 2019 |
| **Author(s)** | Helen Marks, Director of Workforce |
| **Accountable Executive** | Helen Marks, Director of Workforce |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | PR2 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | To note |
| **Data Quality Rating** | |
| **FOI status** | Yes |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

## 1. Executive Summary

1.1 The following report provides the Trust Board with an overview of the NHS Interim People Plan which was published in May 2019. The report will also describe the next steps for the Trust.

## 2. Background

2.1 In January this year the NHS published its 'Long Term Plan' which detailed the ambitious 10 year vision for healthcare in England. The plan set out new models models, in which there is a greater focus on prevention and health inequalities, improving the quality of care and heatlh outcomes across all the major health conditions and where technology plays a signifincant role in transforming services.

2.2 The 'Long Term Plan' also recognises that in order to meet the demand on healthcare and to deliver the vision will require more people working in the NHS over the next 10 years working across most of the disciplines. In addition it acknowledges that the entire workforce, including volunteers, will need to work together to transform services in order to meet patient ad service users expectations of jointed up services.

2.3 The interim Pople Plan (www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/) describes the foundations that need to be put in place to deliver the ambiltions set out in the plan. The interim people plan is structured under six key themes:

- **Making the NHS the best place to work** – Making the NHS an employer of excellence – valuing, supporting , developing and investing in our people
- **Improving the leadership culture –** Positive, compassionate and improvement focused leadership creates the culture that delivers better care. Improving the leadership culture nationally and locally
- **Prioritise urgent action on nursing shortages –** There are shortages across a wide range of NHS staff groups. However, the most urgent challenge is the current shortage of nurses. We need to act now to address this.
- **Develop a workforce to deliver 21st century care –** To grow and transform a workforce with a varied skill mix, new types of roles and different ways of working.
- **Develop a new operating model for the workforce** – To continue to work collaboratively being clear what needs to be done locally, regionally and nationally with people planning activities undertaken by the local integrated care system**.**
- **Developing the full People Plan** – taking immediate action in 2019/20 while a full five year plan is being developed.

## 3. Key Issues

Under each theme are supporting actions which are detailed below:

3.2 **Making the NHS the best place to work**

- Creating a healthy, inclusive and compassionate culture focusing on valuing and respecting all, promoting equality and inclusion and tackling bullying and harassment, violence and abuse.

- Enabling development and fulfilling careers with a focus on education and training (including mandatory training), career development, recognition of qualifications and training and line management and supervision.

- Ensuring everyone has a voice, control and influence which includes whistleblowing and freedom to speak up, physical and mental health and wellbeing and reducting sickness absence and flexible working.

### 3.1 **Improving the leadership culture**

- Sytem leadership for staff who are working with partners in other local services on joining up local health and care services for their communities.

- Establish quality improvement methods that draw on staff service users knowledge and experience to improve service quality and effeciciency

- Inclusive and compassionate leadership so that all staff are listened to, understood and supported and so that leaders at every level of the health system.

- Talent management to support NHS-funded services to fill senor posts and develop future leadership pipelines with the right numbers of diverse appropriately experienced people.

### 3.2 **Prioritise urgent action on nursing shortages**

- Increasing supply through undergraduate nursing degree corses as the largest and most effective supply route and reducing attrition from training

- Providing clear patheways into profession and further developing addional entry routes.

- Improving retention of our existing workforce through expanding direct support programmes

- Supporting and encouraging more nurses to return to practice

- Ensuring that any nurses wising to increase their part-time working hours are able to do so

- Providing continuing support to our people to develop their careers and their skills to respond to the changing needs of patients and citzens

- Continuing to focus on safe and effective staffing

- Develop a new procurement framework of approved international recruitment agencies for 'lead recruiters' to draw on, to support increased international recruitment

### 3.4 **Develop a workforce to deliver 21st century care**

- Agreeing objectives for workforce expansion
- Releasing time to care
- Building an adaptive workforce
- Enabling scientific and technological developments

### 3.5 Develop a new operating model for the workforce

- Co-produce an Integrated Care System maturity framework that benchmarks workforce activities in STPs/ICS, informs the support that STPs/ICTs can expect from NHS England/NHSI and Health Education England regional teams and informs decisions on the pace and scale at which ICS take on workforce and people activities.

- Regional teams and ICS to agree respective roles and responsibilities associated resources, governance and ways of working.

- Implement a collaborative system-level approach to delivery of international recruitment and apprenticeships.

- Agree development plans to improve STPs/ICS workforce planning capability and capacity.

- Develop an action plan to ensure more comprehensive and timely workforce data, available across national regional system and organisations

### 3.6 Developing the full People Plan

- To set out how the NHS will embed the culture changes and develop leadership capability needed to make the NHS the best palce to work over the next 5 years

- To set out in more detail the changes to multiprofessional education and training career paths, skill mix and ways of working needed to deliver 21st Century care

- Quantify in more detail the full range of additional staff needed for each the NHS Long Term Plan priorities

- Aggregate the people plans developed by local systems to build a more detailed national picture of demand and supply by skill sets

- Iterate local and national workforce requirements with the five year digital transformation and efficiency plans.

Further changes are proposed such as a series of commistment to the workforce whish will supplement or could (subject to consultation) replace those currently set out in the NHS constitution. This new offer to staff will form the basis of a balanced scorecard which all NHS employers will be able to use to assess progress and target improvement.

The aim is to publish a full, costed five-year People Plan later this year after the development of the five-year STP/ICS plans and following the Spending Review. The five-year plan will build on the vision and actions of the interim plan.

## 4. Next Steps

Following the publiciation a review was undertaken of the Trust's two year OD plan against the NHS 'Long Term Plan' to understand if there were any gaps. In addition the Trust has also been working with Professor Michael West (Professor of organisational psychology at Lancaster University and senior visiting fellow at the Kings Fund) to critically assess the od plan to ensure that it fit for purpose in the context of the interim NHS People plan.

The outcome of that work shows that the OD plan was a "systemic and sophisticated approach that will pay dividends in developing its culture and leadership" (https://vimeo.com/344280035 ). However, it was identified that the following areas that could be strengthend:

- Creation of a talent management pipeline which includes leadership analysis to identify those leaders who are ready to take on key leadership roles immediately
- Effective team-working
- Creating a positive climate for diversity and becoming a model for diverse leadship across the professions
- Values based recruitment
- Board playing a key role in championing the culture and leadership programme in the organisation
- Board to model compassionate, inclusive, collective behaviours as core values of the organisation

Work will be undertaken to build on the areas identified above. The OD plan is regularly reviewed by Trust Management Board and the Workforce Assurance Committee to track progress.

## 5. Recommendations

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

| Board of Directors | |
|---|---|
| **Agenda Item** | 10.1 |
| **Title of Report** | Change Programme Summary, Delivery & Assurance. |
| **Date of Meeting** | 3 July 2019 |
| **Author** | Joe Gibson, External Programme Assurance |
| **Accountable Executive** | Janelle Holmes, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | For Noting |
| Choose an item | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

## SUMMARY

### 1. Overview

The scope (see slide **2**) of the Change Programme has changed during the past month. The West Cheshire / Wirral Alliance Pathology Project has had assurance ratings suspended, as agreed at the Programme Board on 17 Apr 19, until a decision on the way ahead has been made. Moreover, the Womens' & Childrens' Collaboration Project has been removed from the scope, as agreed at the Programme Board on 19 Jun 19, as there is no active change programme ongoing; however, collaborative discussions continue and the initiative may come back into scope if a programme of change is agreed.

Otherwise, the Executive Team is continuing to direct enhanced focus on the three large **priority** projects within the Change Programme; Patient Flow, Outpatients and Perioperative care.

The overall ratings assessments (see slides **3 and 4**) have remained largely static:

1.1. Governance Ratings

The diagram shows the programme maintaining the previous ratings but no further improvement. SROs should direct project teams to re-double the focus in an effort to secure an increase in green ratings underpinned by assurance evidence; all change, in a safety critical system, needs to be transacted within a transparent and safe framework.

1.2. Delivery Ratings

This month has seen a slight deterioration in delivery ratings, to the tune of one project moving from green to amber rated; amber rating remains indicative of substantive issues albeit considered within the competency of the project team to resolve. Renewed focus on defining/realising benefits and tracking milestone plans is advised.

The assurance ratings are leading indicators of whether the desired grip and pace are being achieved resulting in a more significant 'shifting of the dials' in terms of the desired improvement.

## DELIVERY

### 2. Programme Delivery – Priority Areas

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

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

2.2 Perioperative. The metrics for the Perioperative Medicine project are shown at slides **7-8**.

2.3 Outpatients. The metrics for the Outpatients project are shown at slide **9**.

### 3. Service Improvement Team

One year into the revised programme governance, assurance and delivery framework, the opportunity has been taken to review the function and form of the Service Improvement Team (formerly known as the Strategic Transformation Team). The revised 'Terms of Reference' for

the Team are at Annex A to this report and were endorsed by the Programme Board at its meeting on 19th June 2019.

The key principles underpinning these ToRs are:

- The ownership of change remains with the Senior Responsible Owner and the line management of the service being 'changed for the better'. The Service Improvement Team provides a specialist service into these SROs/change programmes as directed by the Programme Board.
- The Service Improvement Team is focussed on the priority projects, with 3 teams of 2 managers allocated to that end. Some limited resource will be dedicated to projects outside the 'top three'. Any other corporate responsibilities, tasks, are out of scope for the Team, their focus should be 100% on the change programme.
- Additional resource requests, whether for priority projects or other projects, must come from SROs to the Programme Board for consideration and approval. Limiting the size of the Service Improvement Team allows for some budget to be allocated to highly specialised resource requirements of limited duration.

## ASSURANCE

### 4. Programme Assurance - Ratings

The attached assurance report has been undertaken by External Programme Assurance and provides a detailed oversight of assurance ratings per project. The report provides a summary of the assurance provided to the Trust's Programme Board as a gauge of the confidence in eventual delivery. The actions needed to improve those confidence levels are described in the assurance statements for each project and this independent monitoring will continue to assess the assurance evidence. The assurance evidence has been discussed at the Programme Board meeting (the membership of which includes a non-executive director) held on Wednesday 19th June 2019.

### 5. Assurance Focus

In aggregate, the assurance ratings for the top 3 priority projects - namely Flow, Perioperative Care and Outpatients - carry much greater weight than the other 6 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 **11**) of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress.

### 6. Recommendations

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

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

**Annex A: Service Improvement Team - ToR**

# Terms of Reference – Service Improvement Team

## 1. Aim

The aim of this document is to define the role and responsibilities of the Service Improvement Team (SIT). It amends and supercedes the ToR signed off at the Programme Board in July 2018.

## 2. Introduction

Focussed leadership, robust programme management and working to quality standards (assurance) are essential to the success of the portfolio of change at Wirral University Teaching Hospital NHS Foundation Trust. Therefore, arrangements for the effective deployment of the capabilities within the SIT are vital to provide the drive and cohesion for this and subsequent phases of the programme.

## 3. Scope and Programme Management

Wirral University Teaching Hospital NHS Foundation Trust has, by mandate of the Trust Board, agreed to sponsor the delivery of the current portfolio of change; this is illustrated at Appendix One. The top three 'priority programmes' have been identified as:

- Improving Patient Flow
- Perioperative Care (Theatres)
- Outpatients

The Trust Board has also endorsed the overall approach to be taken; namely, a systematic programme management framework supported and facilitated by the professional Service Improvement Team function.

The 'Guide to Programme Management Standards', as approved by the Programme Board in July 2018, continues to makes explicit the evolved change management architecture that the SIT will need to maintain.

The programme management regime applied to the whole programme will be the same framework enacted by the SIT; this follows the endorsement by the Programme Board in July 2018. The detailed capabilities brought to bear by the Service Improvement Team (SIT) are shown at Appendix Two.

The primary role of the SIT is to be at the heart of the delivery arm of the Programme Board to drive both transformational change and also those work streams designed to improve operational grip. However, it is the SRO for each programme and the programme team, in its entirety, that is accountable for overall delivery. In addition, where capacity allows, the SIT will provide comprehensive advice and guidance to all project teams (outside the priority programmes); however, it is the project teams that remain responsible for the delivery of project milestones, implementation, benefits realisation and sustainability.

## 4. Service Improvement Team (SIT)

The Service Improvement Team (SIT) will comprise (initially) the following resources to support the priority programmes (and advise all other projects) work streams.

- Head of SIT
- Senior Programme Managers (x3)
- Programme Managers (x3)
- Project Manager
- Officer Manager/Project Support Officer

This resource structure is illustrated at Appendix Three. Additional resource may, during the course of implementation, be required by the change programmes; however, this will be done on a strict needs basis and only when those needs can be demonstrated by the SRO and endorsed by the Programme Board. Dependent on the type of resource, they may or may not be co-located with the SIT. The aim is to have a highly productive, dynamic and lean core resource facilitating the work in each of the priority programmes.

The purpose of the SIT will be to, under the direction of the SROs, programme manage all aspects of the priority programmes through the development and implementation phases and to complete the sustainability & review phase before closure. The responsibilities will cross both departmental and specialty boundaries in the need to ensure that the aims of the priority programmes retain primacy over other considerations.

## 5. Accountability

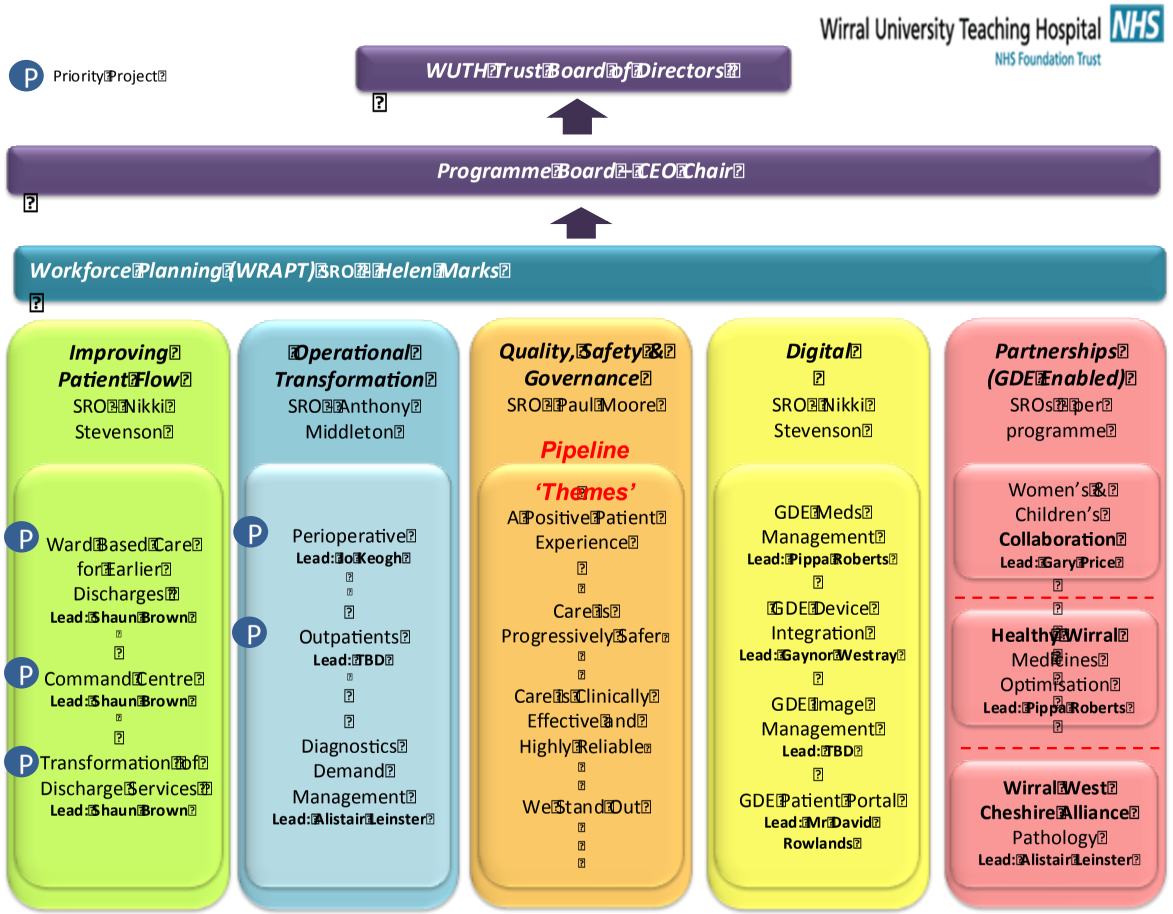
The Trust Board will provide the statutory accountability for the activities of the portfolio of change, as delegated to the Programme Board. This will provide the framework to maintain accountability. As such, the Programme Board will operate as the sponsor for all the work of the SIT.

## 6. Reporting

The SIT will report to the Programme Board on a monthly basis and, by exception, to the SROs of the priority programmes by means of the Steering Groups.

## Appendix One – WUTH Portfolio of Change

**Note:** this scope is correct at the time of drafting these updated ToRs. For the latest scope refer to the change portfolio SharePoint site.

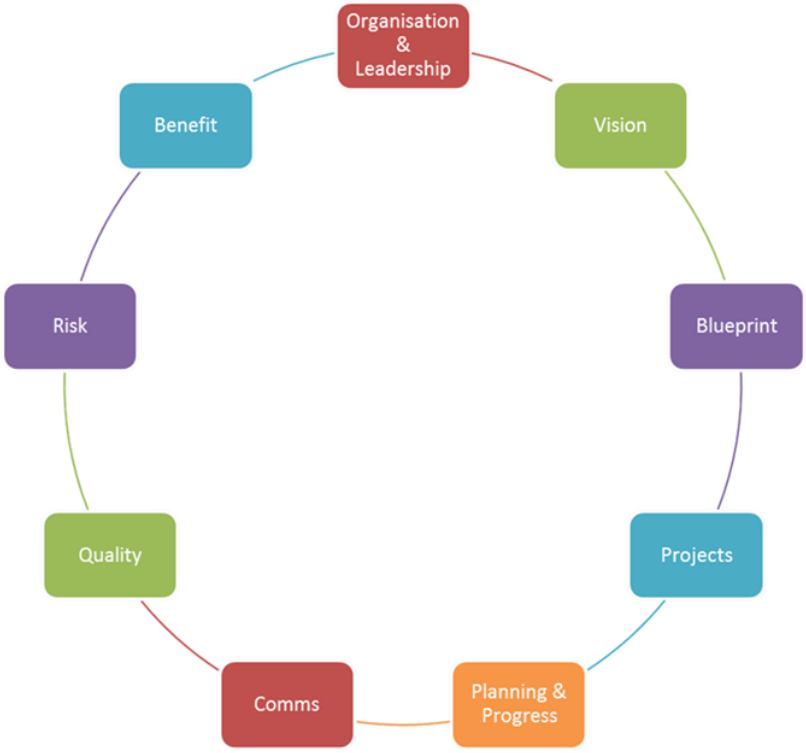


**Appendix Two – Capabilities of the Service Improvement Team**

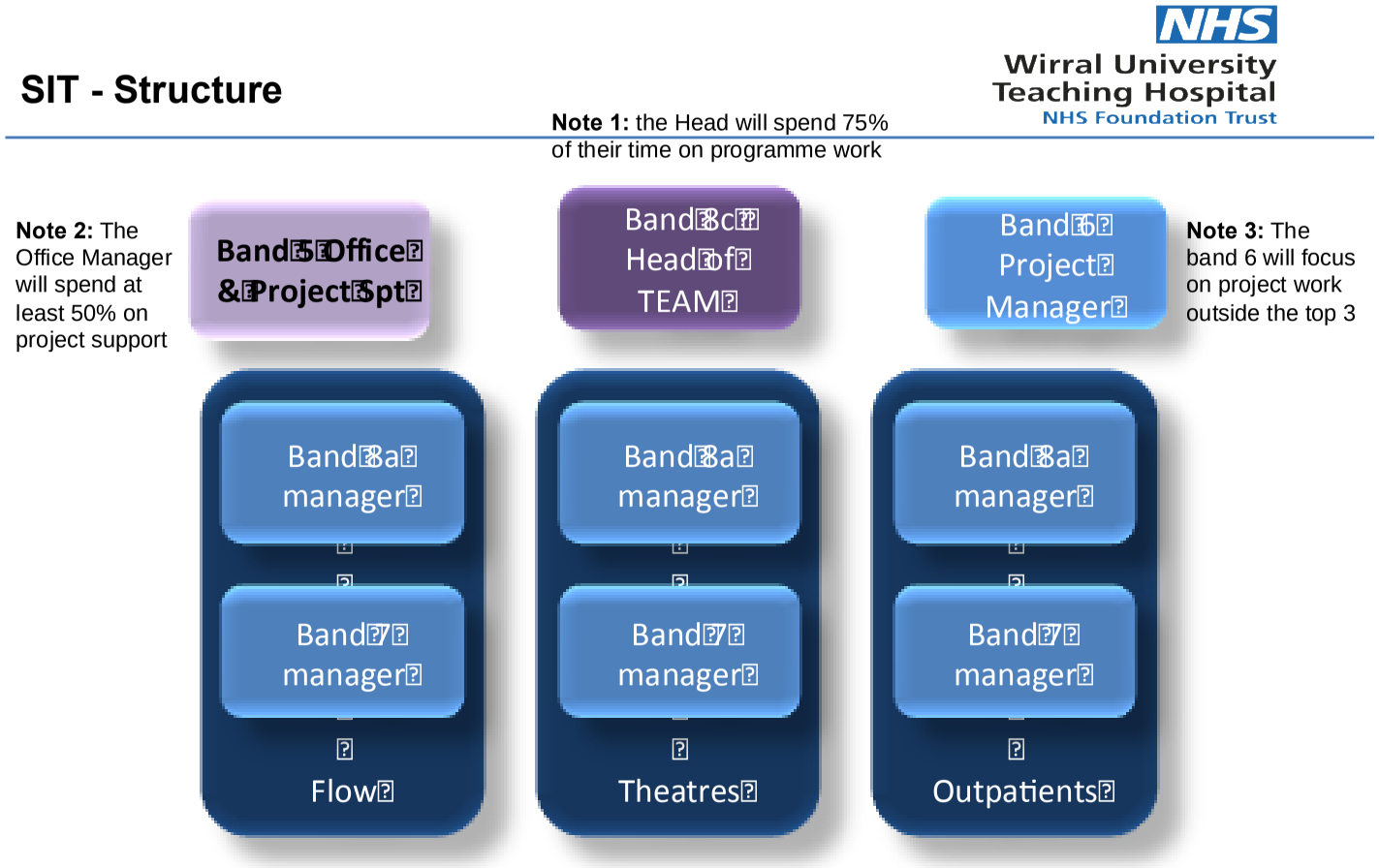
The capabilities of the SIT should be deployed in:

- Ensuring that the priority programmes are delivered in a way that maintains quality standards in line with the organisations vision and strategic objectives.
- Guiding the programmes in developing comprehensive processes for managing risks and improving confidence in project delivery.
- Overseeing the delivery of planned results by monitoring performance against agreed strategic objectives and targets.
- Verifying the benefits targets to be achieved by the programmes and monitoring achievement.
- Supporting Divisions and Corporate Services to develop the case for change through evidence based business cases / options appraisals.
- Monitor detailed project plans & associated milestones for each of the priority programmes.
- Provide input on minimum requirements for deliverables together with associated guidance and templates.

The Service Improvement Team will ensure that all nine domains of programme management are being properly and consistently applied in accordance with the standards set out in the 'Guide to Programme Management Standards':



**Appendix Three – Resource Structure of the Service Improvement Team**

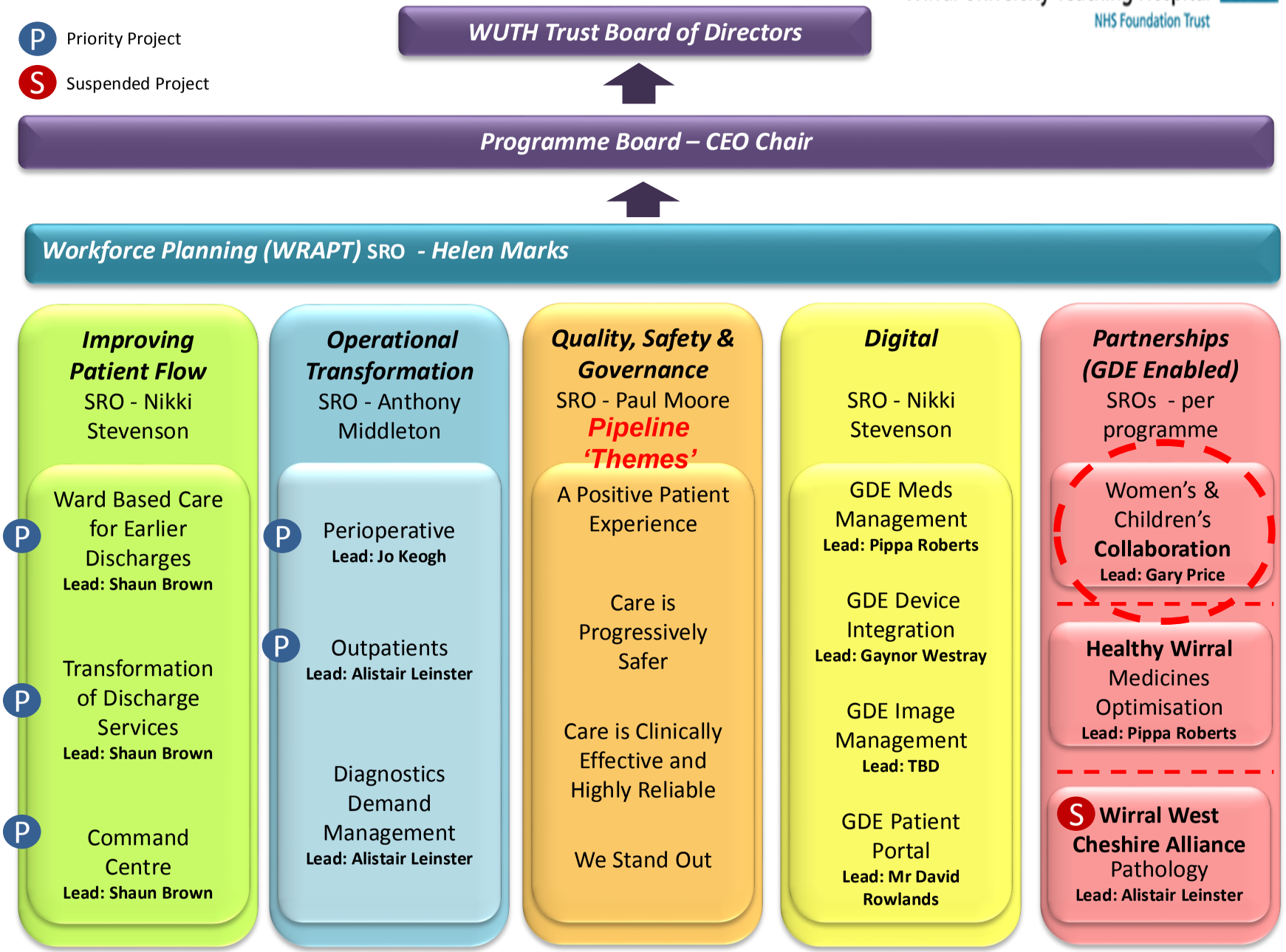


NHS
Wirral University Teaching Hospital
NHS Foundation Trust

# Change Programme Summary



External Programme Assurance

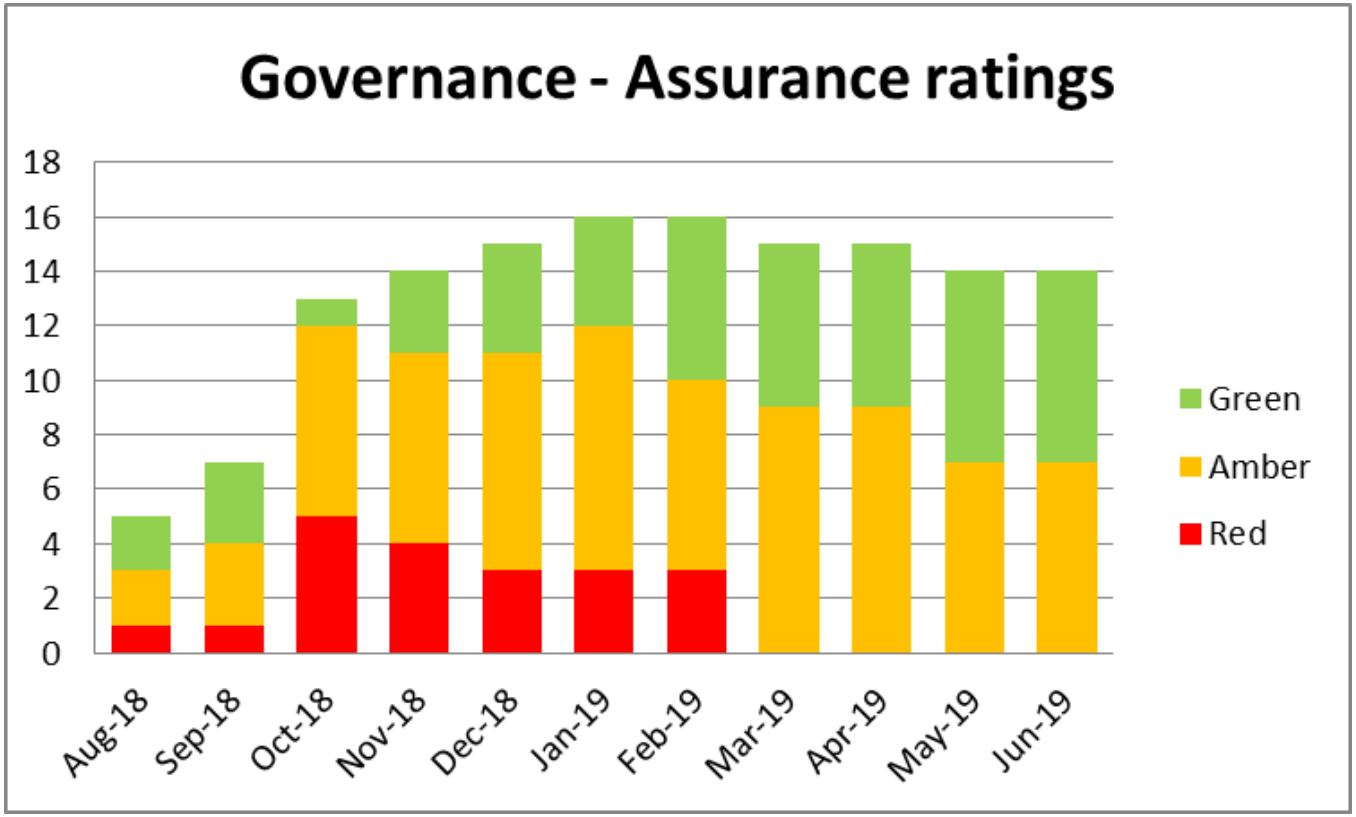

P Priority Project
S Suspended Project
WUTH Trust Board of Directors
Programme Board – CEO Chair
Workforce Planning (WRAPT) SRO - Helen Marks
Improving Patient Flow
SRO - Nikki Stevenson
Ward Based Care for Earlier Discharges
Lead: Shaun Brown
Transformation of Discharge Services
Lead: Shaun Brown
Command Centre
Lead: Shaun Brown
Operational Transformation
SRO - Anthony Middleton
Perioperative
Lead: Jo Keogh
Outpatients
Lead: Alistair Leinster
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

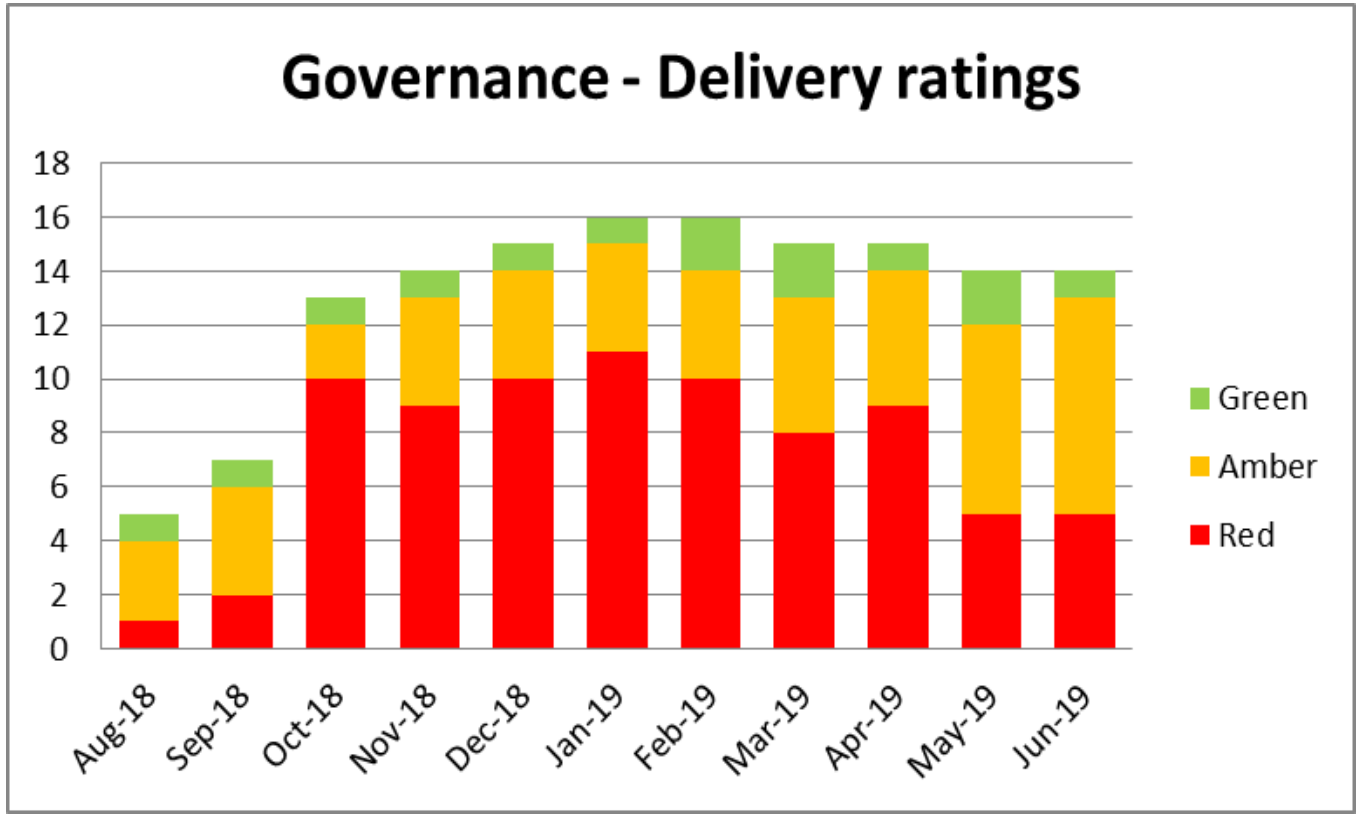
## Change Programme Assurance Report - Trust Board Report - June 2019

S Brimble – Project Support

Wirral University Teaching Hospital NHS Foundation Trust






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

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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

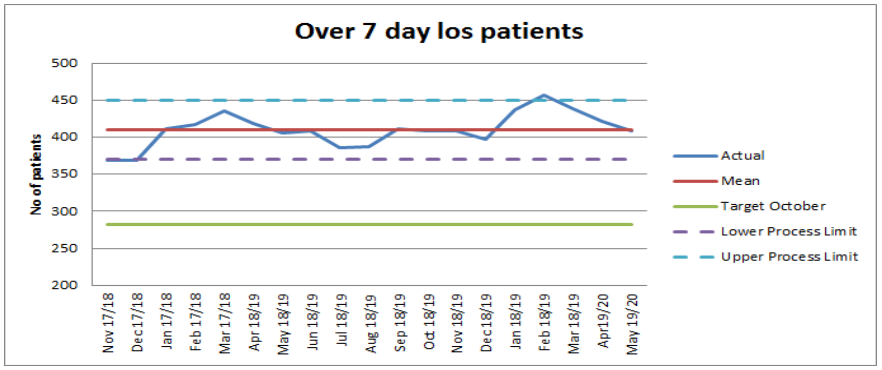
| Overall Governance | Overall Delivery | Plan to Turn Green |
|---|---|---|
| Green | Amber | Ward Based Care and Transformation of Discharges – PIDs will be signed off once LOS trajectories are agreed |
| Green | Red | Command Centre: Capacity Manager – Some metrics still to be defined and baselined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

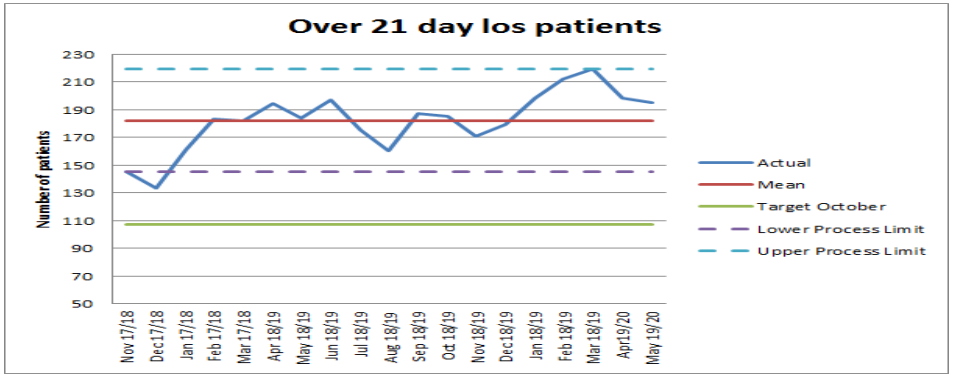
### 3 things you need to know

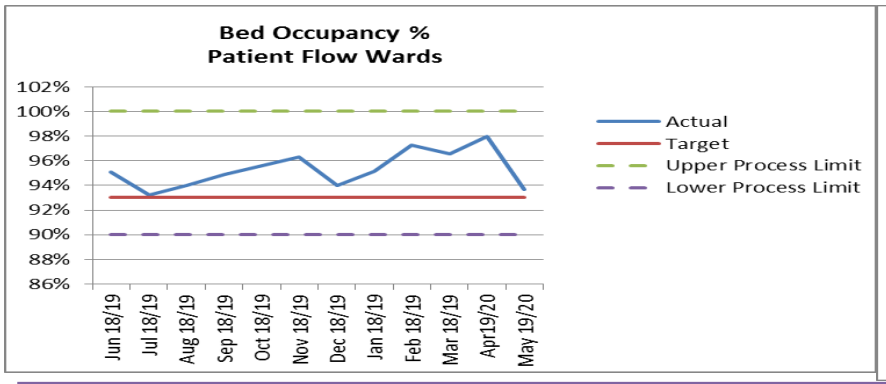
MDT workshop for Medicine & Acute wards to develop approach to Board rounds took place on 10th June: 63 participants, very positive engagement, plans identified to improve board rounds & team working

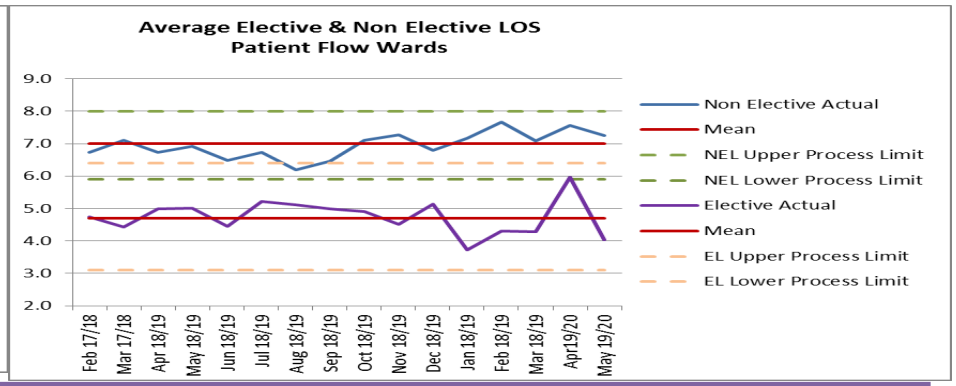
Ward Based Care & Transformation of Discharge projects are being combined. ED Paperlite project is being brought into governance of Patient Flow Improvement Group

Roadmap & timeline for capacity management system launch is being developed & will be available in July to determine go live date




### Escalation

Number of long stay patients has not reduced in line with improvement trajectory this month, 2 month rapid improvement approach is proposed to focus on 21+ patients in line with ECIST reporting requirements. Decision is being ratified at UCOG 19/6

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

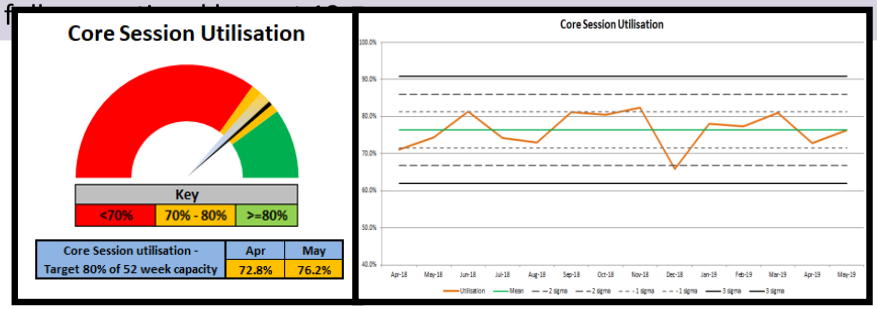
| Overall Governance | Overall Delivery | Plan to Turn Green |
|---|---|---|
| Green | Amber | Continue to improve performance against programme KPI's |

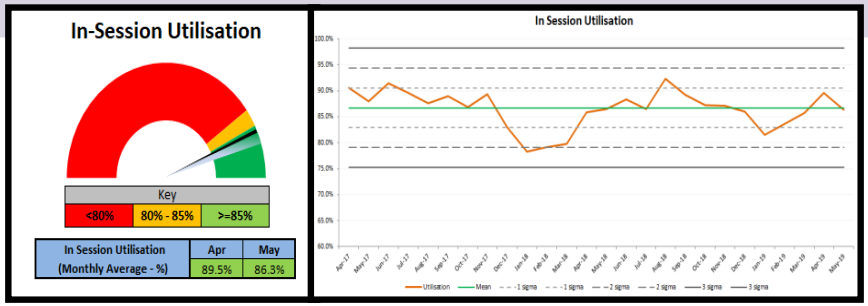
### 3 things you need to know

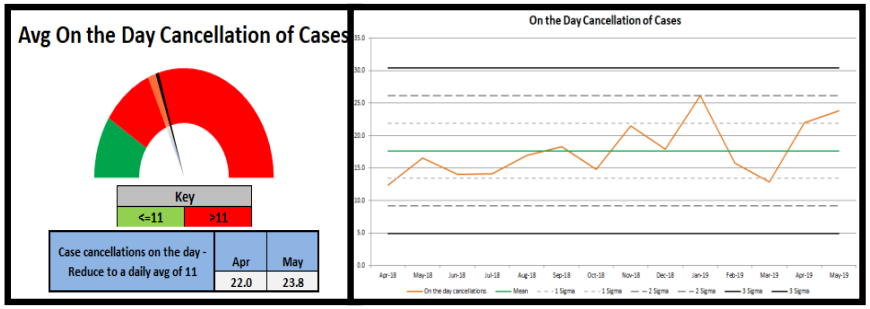
**Main focus:** Three phase recovery options appraisal has been produced for Divisional review. Further costing analysis is underway to support case for change and proposals will be submitted to Exec team for review.

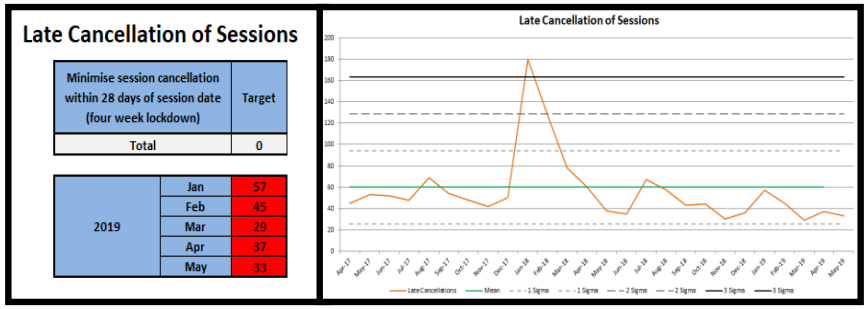
Theatre scheduling system design specification was issued for expressions of interest. No external responses received. Working with IT colleagues to explore internal solution with Cerner system interface. First proposal outline due 3rd July 19 for Project team review.

Electronic booking form proposals are slightly behind plan for 80% consultant roll out by June 19, however this is being mitigated by 'drop in sessions' within Outpatients from w/c 17th June for 3 weeks, enabling us to reach as many consultants as possible, with the remaining specialties f




### Escalation

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

# Perioperative Medicine KPI's – Theatre Utilisation by Specialty

Wirral University Teaching Hospital NHS Foundation Trust

## Month on month increase in CGH utilisation

| In Session Utilisation (Monthly Average - %) | Target | 2018 | | | | | | | | | 20 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | | Feb | Mar | Apr | |
| **Total** | **85%** | 85.8% | 86.4% | 88.4% | 86.5% | 92.3% | 89.2% | 87.3% | 87.1% | 86.0% | 81.5% | 83.6% | 85.7% | 89.5% | 86.3% |
| APH | **85%** | 86.5% | 89.3% | 91.3% | 89.1% | 95.5% | 91.5% | 90.1% | 89.9% | 89.3% | 82.2% | 84.6% | 87.2% | 91.9% | 87.3% |
| CGH | **85%** | 84.2% | 79.0% | 80.1% | 77.5% | 83.2% | 82.5% | 79.6% | 79.2% | 75.3% | 80.1% | 81.6% | 82.2% | 83.1% | 83.8% |
| Anaesthetics | **85%** | 67.3% | 60.2% | 62.6% | 50.9% | 77.3% | 53.5% | 65.7% | 60.6% | 74.2% | 70.2% | 69.2% | 57.9% | 60.5% | [illegible] |
| Breast | **85%** | 93.0% | 85.6% | 79.6% | 70.7% | 79.8% | 85.7% | 83.8% | 84.5% | 85.5% | 81.2% | 81.8% | 87.6% | 79.2% | 91.9% |
| Colorectal | **85%** | 91.0% | 95.0% | 107.9% | 102.9% | 101.8% | 95.0% | 103.2% | 94.3% | 102.0% | 86.3% | 81.3% | 99.1% | 85.8% | 99.1% |
| ENT | **85%** | 82.4% | 93.0% | 93.6% | 80.8% | 87.1% | 77.3% | 77.4% | 85.0% | 78.9% | 66.9% | 66.0% | 79.3% | 78.0% | 76.7% |
| Gynaecology | **85%** | 95.8% | 95.6% | 92.6% | 94.5% | 100.7% | 96.3% | 88.0% | 98.6% | 98.5% | 86.7% | 94.7% | 94.6% | 93.7% | 97.0% |
| Obstetrics | **85%** | 71.8% | 81.5% | 79.8% | 75.9% | 73.2% | 73.8% | 65.7% | 69.8% | 78.6% | 83.2% | 72.8% | 67.9% | 87.8% | 65.5% |
| Opthalmology | **85%** | 67.9% | 76.3% | 79.4% | 70.8% | 79.7% | 88.8% | 84.2% | 78.4% | 73.0% | 70.9% | 76.4% | 77.4% | 91.2% | 81.4% |
| Oral & Max Fax Surgery | **85%** | 79.5% | 83.8% | 83.5% | 76.8% | 81.7% | 84.6% | 98.3% | 81.9% | 86.4% | 73.8% | 76.7% | 81.0% | 75.3% | 85.2% |
| Orthopaedics | **85%** | 88.4% | 90.9% | 92.7% | 97.8% | 95.7% | 98.9% | 88.5% | 91.5% | 87.7% | 86.2% | 87.4% | 94.4% | 97.5% | 92.0% |
| Paediatric Surgery | **85%** | 34.2% | 63.3% | 68.3% | 48.8% | 115.4% | 69.2% | 62.1% | 92.1% | 92.5% | 69.6% | 68.8% | 80.8% | 105.4% | 76.7% |
| Trauma | **85%** | 90.7% | 85.0% | 86.2% | 97.0% | 100.6% | 85.4% | 92.9% | 87.1% | 87.1% | 90.7% | 90.6% | 82.3% | 103.8% | 90.3% |
| Upper GI | **85%** | 92.2% | 85.0% | 86.0% | 86.2% | 97.0% | 96.1% | 87.2% | 90.8% | 93.1% | 84.4% | 81.6% | 82.6% | 84.6% | 85.1% |
| Urology | **85%** | 85.4% | 79.6% | 83.0% | 78.2% | 90.8% | 87.7% | 83.5% | 83.3% | 77.3% | 80.6% | 86.7% | 85.4% | 83.1% | 81.6% |
| Vascular | **85%** | 80.3% | 79.0% | 79.0% | 82.4% | 87.5% | 63.1% | 84.8% | 85.9% | 82.5% | 59.2% | 90.5% | 69.8% | 93.1% | 64.0% |

**Highlight Report – Outpatients**
**Reporting Period – May 19**
**Programme Lead – Alistair Leinster**

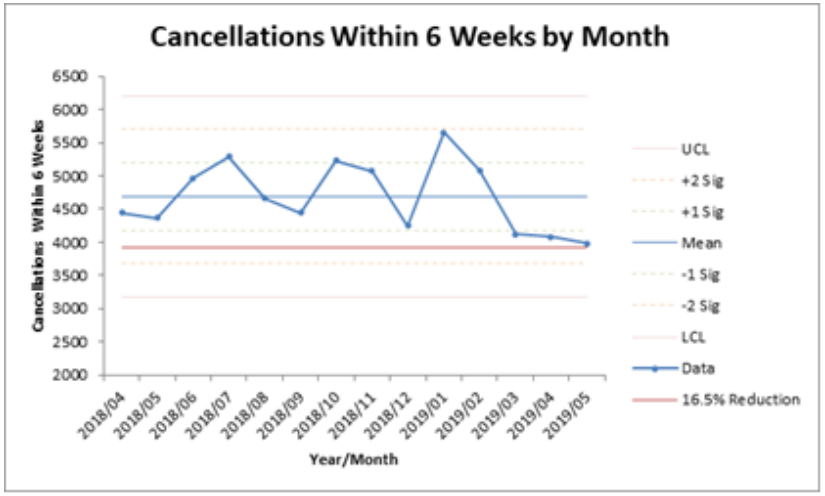
| Overall Governance | Overall Delivery | Plan to turn green |
|---|---|---|
| Green | Amber | Milestone plan to be developed. |

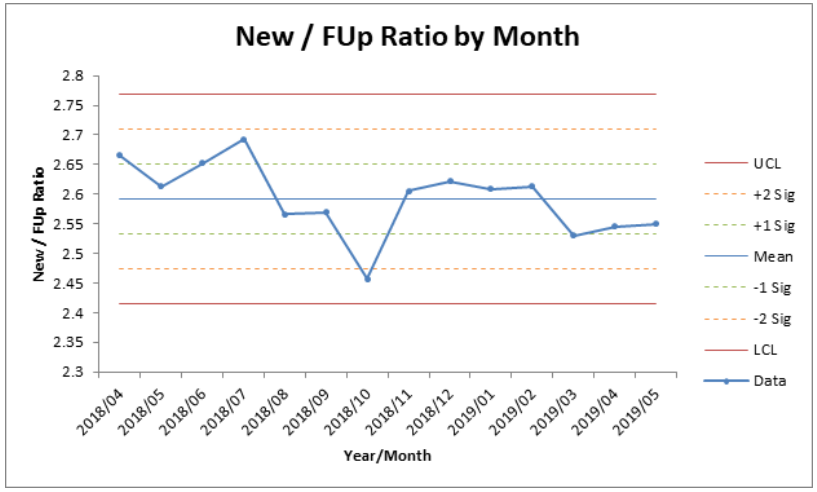
## 3 things you need to know

PID approved at Operational Transformation Steering Group on 10 June.

Weekly Outpatients Access and Performance meetings with Office Managers and BSMs to increase slot utilisation and support additional clinics now being held.

Divisions have been asked to produce a plan at specialty level for how they will provide non face to face appointments. This can be in the form of telephone appointments or virtual clinics. Telephone appointments have already been set up in Gynae, Gastro and Haematology with conversations being held in Respiratory. Work is also underway to set up a virtual clinic in T&O for hip and knee replacement patients.




## Escalation

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

# Programme Assurance Ratings



Joe Gibson
19 June 2019

# Change Programme Assurance Report -
# Trust Board Report - July 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' again shows 4 of 8 metrics are still being developed.
- 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 Command Centre Project Plan has been updated to 6 Jun 19 shows a number of delays.
- 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.

| Perioperative Medicine Improvement | Governance | | Delivery | |
|---|---|---|---|---|

- The **'Perioperative Medicine Improvement'** revised milestone plan, dated 4 Jun 19, is a detailed and well tracked document and has been re-baselined (to archive previous delays) by means of an Exception Report to the May Programme Board.
- KPIs are developed in the PID. The dials and supporting data, uploaded on 10 Jun 19, show an overall 'amber' rating but with positive trends. The four metrics being tracked, monthly, are: Core Session Utilisation; In-session Utilisation; Avg On the Day Cancellation of Cases; and Late Cancellation of Sessions.
- Evidence in place concerning risk and issue management and 'date of last review' information now added to 4 June 19.

| Outpatients Improvement | Governance | | Delivery | |
|---|---|---|---|---|

- The **'Outpatients Improvement'** 'Project Director' position has now been filled by Alistair Leinster as confirmed at the Programme Board on 19 Jun 19.
- An updated version of PID v0.4 dated 3 Jun 19 was approved at Operational Transformation Steering Group on 10 Jun 19.
- A high level summary plan, uploaded 10 Jun 19, has been produced to cover 2019/20 following approval of the revised PID; this will need tracking to show progress against milestones.
- KPIs are now in being tracked and included in OPD Highlight Reporting for 2019/20; the benefits are rated 'amber' until the initial 3-month trend emerges.

# Workforce Planning - Programme Assurance Update – 19th June 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**. There is now evidence - Workforce Planning Update dated 13 Jun 19 - 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 now evidence of some stakeholder engagement in the form of engagement events in Oct/Nov 18. **5**. EA/QIA are now signed off. **6.** High level planning dates are in the PID (delays from original dates are not explicit) and there is now a trackable Gantt chart plan that exists as a stand alone document but needs milestones for May 19 updating (with dates for some work streams to be completed). **7.** There is now evidence of a Workforce Dashboard (Trust Level) dated 22 May 19 but no explicit link to programme metrics or start dates attached; it is stated that these will be completed following the pilot stage. **8 & 9**. There is a risk register v1 and last review date of 7 Jun 19 - the RAID Log also records the 1 live issue. **Most recent assurance evidence submitted 10 Jun 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 – 19th June 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 5 Jun 19 are in evidence. Trello Board has been in use for this project. **4.** There is now extensive evidence of stakeholder engagement submitted up to 10 Jun 19. **5.** EA/QIA are now completed. **6.** A 'Ward Based Care Milestone Plan' dated 6 Jun 19; however, activity lines in progress need to be RAG rated (the new weekly granularity has added further precision). **7.** 'Benefits and Measures: Revised 4th June following PFIG' shows the benefits as currently defined with 5 of 12 needing targets set for 19/20. **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 10 Jun 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 – 19th June 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 4 Jun 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 up to 3 Jun 19. **5.** EA has been drafted and QIA signed-off. **6.** The new Command Centre Project Plan has been updated to 6 Jun 19 shows a number of delays. **7.** As described above, there are no metrics for the benefits to be measured by. **8 & 9** There is a RAID Log showing the date of risks last reviewed as 29 May 19. **Most recent assurance evidence submitted 7 Jun 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 – 19th June 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 Issue v1.0 dated 7 May 19, for the 'Transformation of Discharge Services Sustainability Programme'. **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 3 Jun 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 significant evidence of stakeholder engagement uploaded to 7 Jun 19. **5.** EA/QIA have been completed for an 'Independent Provider Led Discharge Unit'. **6.** There is a 'TDS Internal Plan' updated to Jun, now with significant delays (in excess of 2 months) to Workstream 3 'Transfer of Care Form' and no revised milestone plan to deliver this element. **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 4th and 5th Jun 19. **Most recent assurance evidence submitted 13 Jun 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 – 19th June 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 v5 dated 8 Apr 19 has a comprehensive set of objectives and measurable benefits defined with metrics; it was signed off by the Project Board on 8 Apr 19. **2.** A Project Team is in place with a wide range of activity in evidence. **3.** The Perioperative Medicine Steering Group is governing with evidence of meetings to 4 Jun 19; an action log is now in place to assist governance. **4.** There is extensive evidence of wider stakeholder engagement uploaded to 14 Jun 19 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 4 Jun 19, is a detailed and well tracked document and has been re-baselined (to archive previous delays) by means of an Exception Report to the May Programme Board. **7.** KPIs are developed in the PID. The dials and supporting data, uploaded on 10 Jun 19, show an overall 'amber' rating but with positive trends. **8 and 9.** Evidence in place concerning risk and issue management and 'date of last review' information now added to 4 June 19. **Most recent assurance evidence submitted 14 Jun 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 - 19th June 2019

| Exec Sponsor | Programme Lead | Transformation Lead | Stage of Development | Overall Governance | Overall Delivery |
|---|---|---|---|---|---|
| Anthony Middleton | Alistair Leinster | Sarah Thompson | Implementation | Green | Amber |

## Independent Assurance Statement

**1.** An updated version of PID v0.4 dated 3 Jun 19 was approved at Operational Transformation Steering Group on 10 Jun 19. **2.** A project team is in place. **3.** The 'Outpatients Transformation Group' is in place with ToR agreed at the meeting of 1 Nov 18 and documents to evidence the meetings up to 3 Jun 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; further evidence will be required to maintain a green rating. **5.** The signed QIA has been submitted. **6. A** high level summary plan, uploaded 10 Jun 19, has been produced to cover 2019/20 following approval of the revised PID; this will need tracking to show progress against milestones. **7.** KPIs are now in being tracked and included in OPD Highlight Reporting for 2019/20; the benefits are rated 'amber' until the initial 3-month trend emerges. **8 and 9.** There is a comprehensive RAID Log in evidence with risks and issues last reviewed on 10 Jun 19. **Most recent assurance evidence submitted 10 Jun 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 - 19th June 2019

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

## Independent Assurance Statement

**1.** The project PID, ISSUE v1.0 was approved (as draft version 0.9) at the Operational Transformational Steering Group meeting on 13 May 19. It is supplemented by a BOSCARD, 'Initiation Pack' and the paper 'Unwarranted Variation & Demand Management: Pathology Tests', A Bamber. **2.** A project team is defined. **3.** There is a comprehensive meetings log with agendas and action notes to 29 May 19 and associated action log. **4.** There is a stakeholder mapping assessment and the Comms Plan has been incorporated into the Project Milestone Plan where it is tracked. There is evidence of stakeholder engagement uploaded to May 19. **5.** A QIA/EA has been drafted and QIA has been signed off on 18 Mar 19. **6.** A comprehensive milestone Gantt chart plan has been developed, v1.9 dated 14 Jun 19 which shows delays to some 50% of milestones (albeit many delays are short lived). **7.** There is now a comprehensive document describing baselines, targets and trajectories together with a full financial profile; however, the first benefit start date planned for June 2019 has now been delayed and so an advisory 'amber' rating has been applied. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 29 May 19. **Most recent assurance evidence submitted 14 Jun 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 – 19th June 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 – 19th June 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 - 19th June 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 - 19th June 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 – 19th June 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 Optimisation - Programme Assurance Update - 19th June 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.** PIDs have now been uploaded for the following projects: eTCP, HW DOAC, HW MOCH, HW Pan Mersey, HCD, and HW Stoma. Some of these PIDs are only partially complete and benefits are either only partly defined or cross-referred to the GDE SoPB. **2.** Notes of Healthy Wirral Meetings and Highlight Reports are available up to Jun 19, including minutes of the 'Medicines Optimisation Programme Board' of 4 Jun 19. **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 place for June 2019 although in non-standard format and lacks 'date of last review' for each risk. **Most recent assurance evidence submitted 7 Jun 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 - 19th June 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 | **As agreed at the Programme Board on 17 April 2019: assurance ratings suspended pending a decision on project initation** | | | | | | | | | | |

**Board of Directors**

| | | | |
|---|---|---|---|
| **Subject:** | Proceedings of the Trust Management Board held 27.6.2019<br>Agenda Item 10.2 | **Date:** 3 July 2019 | |
| **Prepared By:** | Paul Moore - Director of Quality & Governance | | |
| **Approved By:** | Janelle Holmes, Chief Executive | | |
| **Presented By:** | Janelle Holmes, Chief Executive | | |
| **Purpose** | | | |
| For assurance | | **Decision** | |
| | | **Approval** | |
| | | **Assurance** | **X** |

| | |
|---|---|
| **Risks/Issues** | |
| Indicate the risks or issues created or mitigated through the report | |
| **Financial** | **Risk associated with non-delivery of financial control total based on M2 outturn.** |
| **Patient Impact** | **Several areas currently represent a potential risk to quality or safety of care – exposure to infection, venous thromboembolism prevention, and attendance management.** |
| **Staff Impact** | **Staff vacancy, attendance management represent a risk to workforce effectiveness** |
| **Services** | **None identified** |
| **Reputational/ Regulatory** | **Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.** |

**Committees/groups where this item has been presented before**

N/A

**Executive Summary**

1) Quality and Performance Dashboard

(i) It was noted with concern that there had been a drop in VTE performance in May 2019. At the meeting it was not clear the reasons for this dip. Action will be taken to analyse and isolate the precise reasons for the change in performance and will be brought back to the next meeting. In the meantime, checks will be carried out to ensure that the alert mechanisms are active and therefore properly reminding clinicians.

(ii) Hand hygiene compliance. Members of the TMB expressed their concern at the apparent decrease in hand hygiene performance. The Director of Quality & Governance reminded members that the trust is it in the middle of an outbreak of Clostridium Difficile infection and therefore it is of the upmost concern that hand hygiene performance would drop it at this time. The Director of Quality & Governance will be holding an outbreak meeting after this meeting and will explore with operational teams and infection prevention teams the reasons for the change.

(iii) Attendance management. The TMB took account of the current levels of sickness/absence. Members confirmed their commitment to robust management of sickness and absence, and noted that the new arrangements for sickness absence come into effect on 1 August 2019.

(iv) HSMR. Members noted the shift in mortality outcomes within the hospital standardised mortality ratio indicator. Members took advice from the PSQB who informed the TMB that analyses were currently underway to understand and isolate the reasons for the change. The outcome will be reported to and monitored by PSQB in due course. Members were advised that mortality ratio remains in line with expectations and thus there is no cause for concern at present.

(v) Mixed-sex accommodation. Members of the TMB made enquiries into the ongoing breeches and then management. Members were advised that although additional side rooms have been provided it remained the case that some patients experience delays in stepdown to a lower acuity bed.

2) Health and safety quarter one report

(i) Members received and noted the health and safety performance in quarter one.
(ii) Members were advised that exposure to RIDDOR cases is lower than the same period in 2018/19.
(iii) Members were informed that the top six incidents are as follows: (a) violence and aggression (n= 44); (b) Manual handling incidents (n=30); (c) Unsafe environment (n=29); (d) Slip/Trips/Falls (n=28); (e) Sharps injuries/Incidents (n=23); (f) collision with an object (n=16).
(iv) Members welcomed the emphasis on a combination of leading and lagging indicators.
(v) Members welcomed the visibility of health and safety risks which clearly point to higher exposure in relation to the estate, water safety management and control of substances hazardous to health.
(vi) Members received the details of the draft safety management strategy. This document was put forward for consideration and that consultation is now open and will close at the end of July 2019.
(vii) Members received a draft responsibilities matrix and approved the for the document and contents to be put into operational use.

3) Facilities strategy update

(i) Members received the facilities strategy update and supported the plans as outlined in the document.

4. Ward accreditation update

(i) Members received details of the ward accreditation updates for the period December 2018 2 June 2019. Members were informed of the outcomes on each ward. Although it is evident that improvements are required across all domains members of the management board welcome the programme and the benefit and focus it will bring to leadership at ward and departmental levels.
(ii) Members requested a focus on improvement and implementation before any further expansion of the program is carried out.

5. Legionella and Pseudomonas aeruginosa testing

(i) Members received a proposal considered by the Risk Management Committee to initiate routine testing of water outlets in augmented care areas for the presence of legionella and pseudomonas aeruginosa.
(ii) The TMB agreed to tender and commence testing as soon as possible.
(iii) Members noted that the cost associated with testing will be funded through additional CIP which has yet to be identified.

6. Financial Position

(i) Members received and noted the financial position for the end of month 2.
(ii) Members noted that the month 2 position was £600K worse than plan in month, £900K worse than plan in the year-to-date.
(iii) Members considered the underlying reasons for this deterioration and agreed to revisit a number of cost centres in order to enhance control over expenditure and cost improvement activities.

7. Protecting vulnerable people training

(i) Members considered in detail the requirements to comply with the intercollegiate guidelines for the prevention of vulnerable people training.
(ii) Members noted these guidelines place a large burden on an already busy training schedule. However, it was agreed that the trust will comply with the requirements and in so doing absorb the training burden within current provisions for training. Therefore, the Trust is not anticipating additional cost pressures providing requirements for training are incorporated into individual rotas for the year ahead.

8. Emergency department benchmarking 2019 scoping documents

(i) Members noted the benchmarking report but felt that benchmarking is somewhat limited because comparing emergency departments is unreliable as staffing requirements can vary considerably between different departments. A further review supported by ECIST is underway.

9. Pathology collaboration

(i) Members received, supported and approved the proposed governance arrangements for the pathology collaboration in Wirral and West Cheshire.

10. Histology biomedical science business case light

(i) Members received, supported and approved the histology business case. The case will now proceed to the next phase.

11. Employee assistance program business case

(i) Members received, supported and approved the employee assistance program business case. This will now proceed to the next phase.

12. Recruitment services business case

(i) Members received, supported and approved the recruitment services business case. The case will now proceed to the next phase.

13. PSQB report June 2019

(i) Members received and noted the escalations from the patient safety and quality board meeting held on 30th of June 2019. The matters raised in the report were considered in detail under the agenda item Quality and Performance Dashboard.

14. Risk management committee report June 2019

(i) Members received and noted the escalations from the Risk Management Committee meeting held on 11th of June 2019. The matters raised in the report were considered under the substantive agenda item Legionella and Pseudomonas aeruginosa testing.

15. Divisional updates

(i) members received and noted performance updates from each division, giving divisional teams an opportunity to highlight key concerns, areas for discussion, and other points of interest.
(ii) The Division of Diagnostics and Clinical Support drew TMB's attention to a significant concern regarding PACS. As a consequence of protracted concerns with the system vendor, urgent action is being taken to consider serving notice

and expediting a change of supplier for this system.

(iii) The Medicine and Acute Division advised of the support from the emergency care intensive support team and the focus on two key priorities: (a) decongest the emergency department; and (b) focus on reducing extended length of stay throughout the hospital.

(iv) The Division of Surgery advised of a planned change to move to the surgical assessment unit to Ward 17. This will take place on 22 July 2019. Plans are being worked on at the present time. The Division confirmed there is no adverse impact of the change on the bed model and nursing establishments. The Chief Operating Officer advised that in light of the range of pressures being identified, he has initiated and brought forward a review of the risks in in order to identify the most pressing requirements for capital in the year ahead.

(v) The Women's and Children's Division outlined their plans to achieve CNST compliance and requested the support of the Division of Surgery in relation to obstetric emergency training.

Written and summarised on behalf of the Chief Executive by
Paul Moore, Director of Quality and Governance
27 June 2019

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 10.3 |
| **Title of Report** | CQC Action Plan Progress Update |
| **Date of Meeting** | 3rd July 2019 |
| **Author** | Paul Moore, Director of Quality & Governance |
| **Accountable Executive** | Janelle Holmes, Chief Executive |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | Quality and Safety of Care<br>Patient flow management during periods of high demand |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | To be confirmed. |
| **Purpose of the Paper**<br>**Discussion**<br>**Approval**<br>**To Note** | Provided for **assurance** to the Board<br><br>**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**<br>**Yes**<br>**No** | No adverse equality impact identified. |

**CQC ACTION PLAN UPDATE REPORT**
**POSITION AS AT 14TH JUNE, 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:

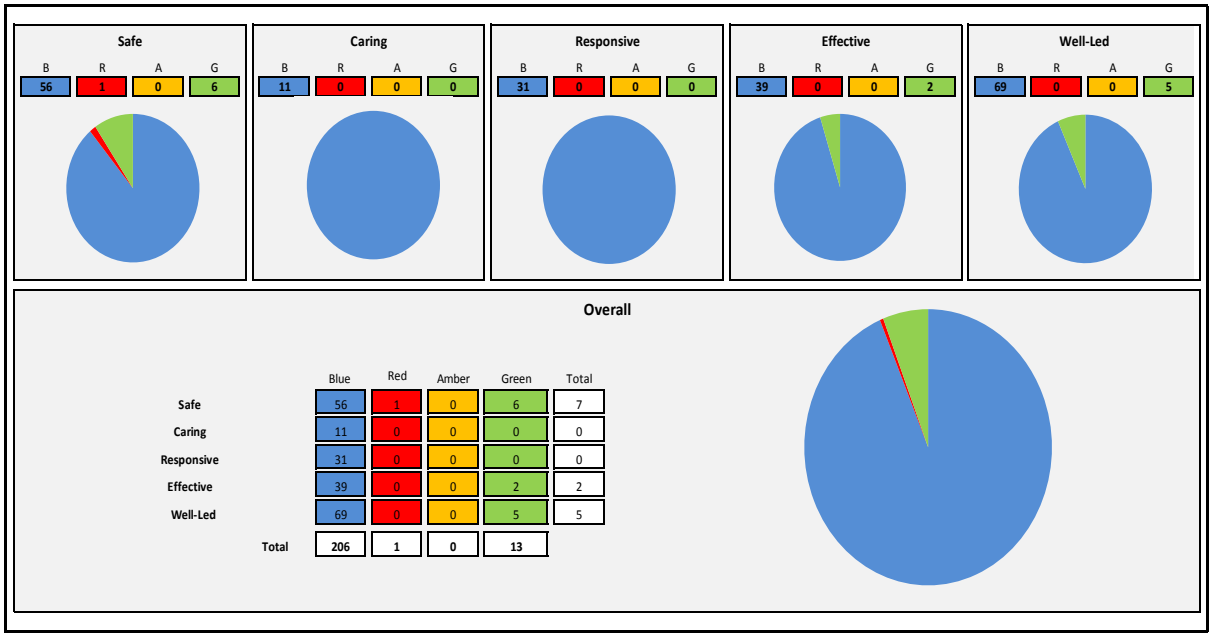
| | | |
|---|---|---|
| Safe | Requires improvement |  |
| Effective | Requires improvement |  |
| Caring | Good |  |
| Responsive | Requires improvement |  |
| Well Led | Inadequate |  |
| OVERALL | REQUIRES IMPROVEMENT |  |

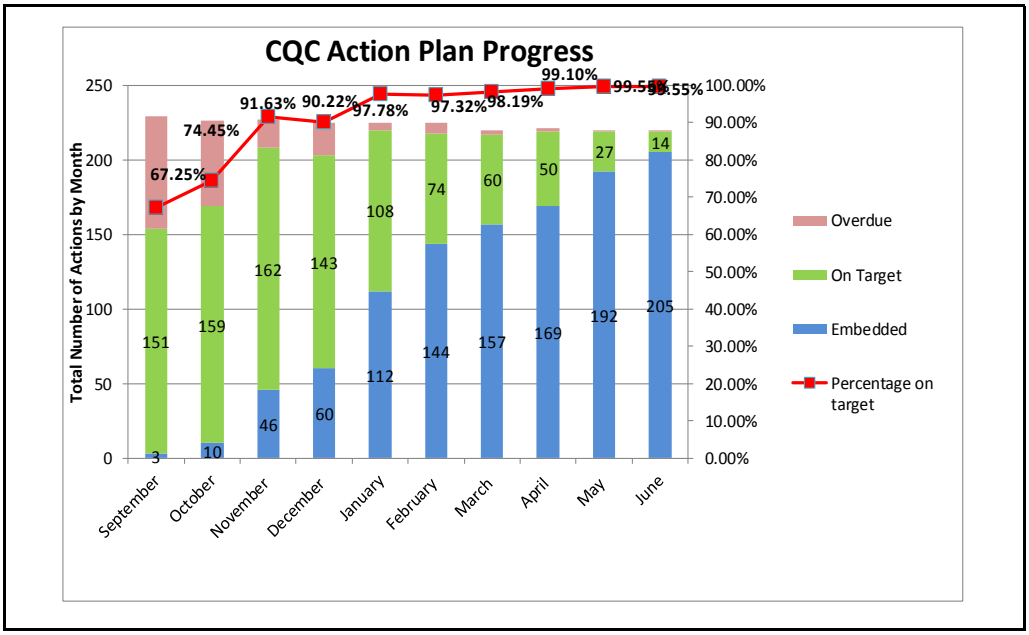
The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **220** specific actions/work-plans for implementation on or before **31st August 2019.**

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 – 10th June 2019

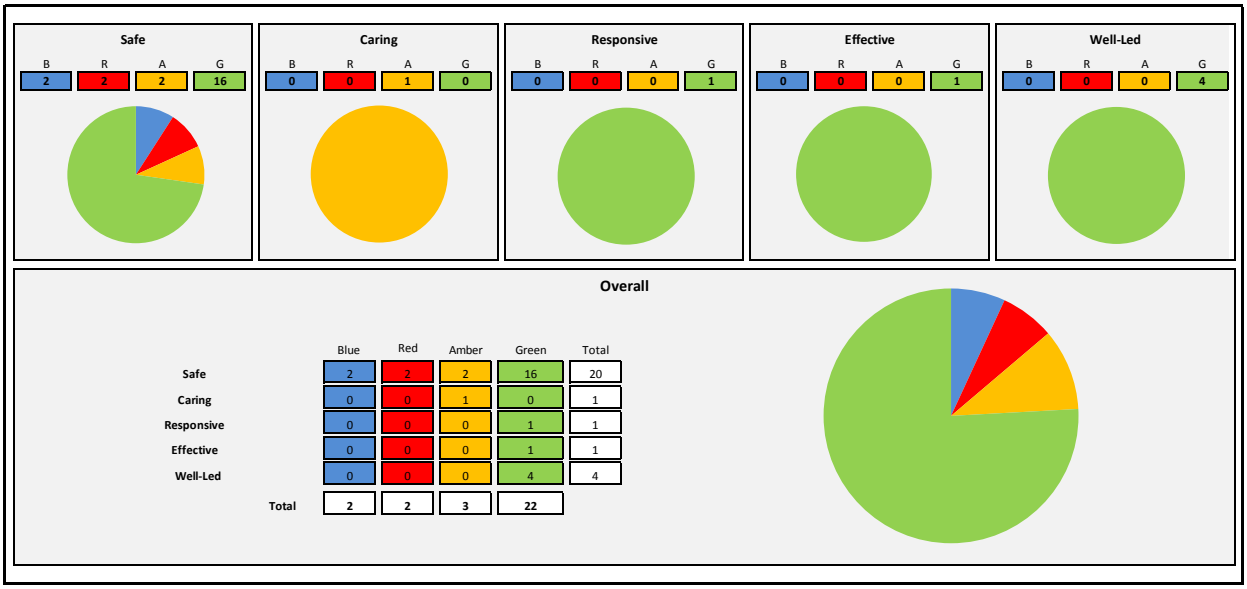
The graphs below summarises the current position of the original CQC action plan following review at its respective monthly confirm and challenge meetings. There is one overdue action to for this reporting period and relates to patient flow.

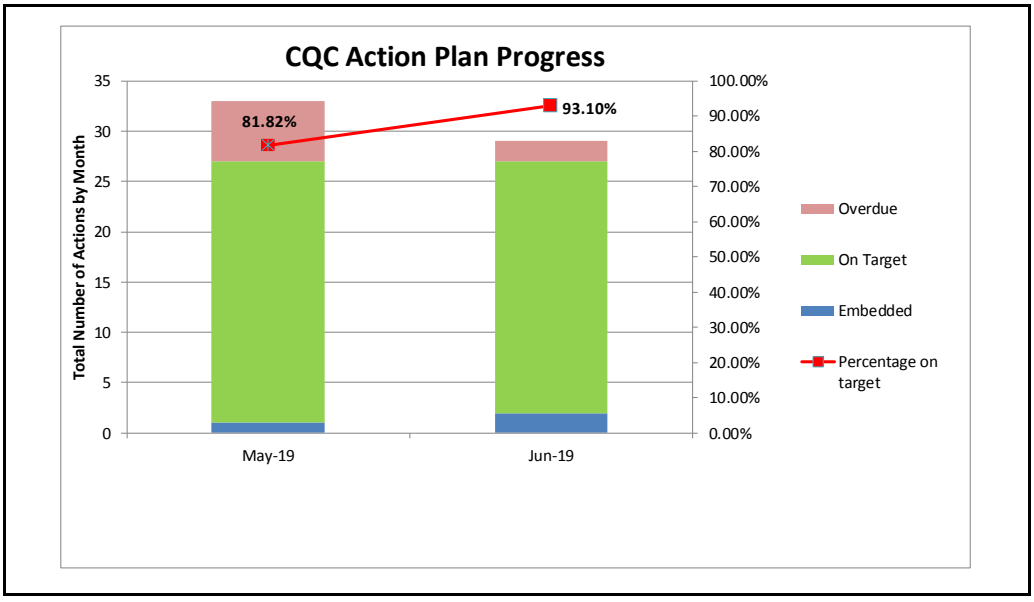



## 4.1 CQC Urgent Care Actions

The graphs below summarise the current position of the Emergency Department CQC action plan following review at its confirm and challenge meeting, held on 11th June 19. Subsequent to a further review of the urgent care action pan 4 actions have been deleted, as it was acknowledged that these actions were duplicated in the original plan, and as such progress was already being reported.




## 5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held during June 2019, in respect of action 173, the Board will recall that a separate Patient Flow Improvement Plan pre-dates the CQC plan. It was agreed to refer to the Patient Flow Improvement Plan in the CQC Action Plan to avoid unnecessary duplication of effort. The Patient Flow Improvement Plan has been overseen by the Patient Flow Improvement Group independent, of the confirm & challenge meetings for CQC compliance. Whilst it is reported that progress is being made, the Patient Flow Improvement Plan has yet to deliver in full. For this reason this action is rated 'red' in the CQC action plan.

As can be seen for those matters arising from the CQC's focussed review of Urgent & Emergency Care (March 2019), there remain a number of specific and ongoing

problems requiring action dependent upon effective and sustainable patient flows at all times. To avoid duplication and potential confusion, we seek the Board's consent to consolidate action 173 and incorporate into those actions concerning patient flow which have been specifically itemised in the CQC Action Plan (Urgent & Emergency Care).

In addition, the Urgent Care overdue actions concern the triage responsiveness of speciality reviews, streaming and paediatric trained nurses within ED compliance with RCPCH recommended staffing levels and 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 **13** actions moving into the embedded category. This can be interpreted by the Board as positive evidence of implementation, and the progressive work that is happening across the Trust to address each element of the action plan.

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

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

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

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

## 7. RECOMMENDATION

The Board of Directors are invited to:

- **AGREE** recommendation to remove patient flow related actions from CQC compliance reporting
- 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**<br>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:<br><br>Ward Based Care and Transformation of Discharges Bed Management<br>Medical Assessment Unit Review - outline key elements of plan | Medical Director | Well Led | **Updated: 10. 05.2 019**<br>A separate Patient Flow Improvement Plan pre-dates the CQC plan. It was agreed to refer to the Patient Flow Improvement Plan in the CQC Action Plan to avoid unnecessary duplication of effort. The Patient Flow Improvement Plan has been overseen by the Patient Flow Improvement Group independent of the confirm & challenge meetings for CQC compliance. | 31/11/2018 | |



## 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 | Should 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 11.06.2019**<br>SOP and Data collection has been agreed. AMD meeting has taken place and outcomes agreed. This is currently being picked up and assured as part of PFIG governance arrangements. Follow up meeting due end of June 19 to agree inter professional standards and GP referrals remains part of that. Divisional Triumvirates are meeting up to discuss resolution proposals for | 30/04/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Orthopaedics specifically. | | |
| 242 | Should 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 11.06.2019**<br>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 | |
| 237 | Should Do | Urgent And Emergency Care (Acute & Medical Division) | Streaming | Integrate streaming process for community trust | Executive Medical Director/ Chief Operating Officer | Well Led | **Update 11.06.2019**<br>A process has been agreed for integration across the health economy. Model is due to be ratified end of June 19, with a view to implementation end of July 19. Extension agreed due to the delivery of action involving complex engagement with a number of key external stakeholders. | 31/07/2019 | |
| 256 | Should Do | Urgent And Emergency Care (Acute & Medical Division) | Paediatric ED and APLS/PLS actions | Ensure the availability of paediatric trained nurses in the Paediatric ED complies with RCPCH recommended staffing levels | Executive Medical Director / Chief Operating Officer | Safe | **Update 11.06.2019**<br>Clarification sought via CQC. Challenge not accepted. CQC confirmed that the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (June 2018) apply.<br>As such, the emergency department need to reach a decision on a) recruitment of specialist nurse or b) reaching a considered decision on why they are unable to comply with this guideline, and what actions will be implemented to mitigate against this risk. | 30/09/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| 259 | 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 11.06.2019**<br>Leadership has been strengthened in EDRU in order to support staff. Additional work required in regard to specific customer care training. | 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 |
|---|---|---|---|---|---|---|---|---|---|
| 148 | Must Do | Corporate / Trust-Wide Issues | **GOVERNANCE**<br>**Trust wide :**<br>The trust must ensure that all governance, incident and risk systems and processes are effective and fully implemented.<br>**Emergency Department :**<br>The service must ensure that all incidents, including serious incidents are reported and investigated in line with trust policy and the NHS Serious Incident Framework 2015.<br>**Surgery**:<br>The service should ensure consistent reporting of incidents by all staff. | Develop, agree and implement a model of board assurance incorporating *the three lines of defence* (against failure to mitigate risk) | Executive Director of Quality & Governance | Well Led | **Updated 17.06.2019** - **Embedded process**<br>Completed 1/04/2019 a new board assurance framework has been rewritten to include three lines of defence | 31/03/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream, | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| 167 | Must Do | Corporate / Trust-Wide Issues | **RISK REGISTER**<br>*This issue affects all divisions but the report highlighted the Critical Care, Medicine and End of Life Care core services*<br><br>**Critical Care :**<br>The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service.<br><br>**Medicine :**<br>The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way.<br><br>**End of Life Care:**<br>The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers. | Review and refresh the divisional risk profile and standardisation of existing risk registers<br>Record those risks on the divisional risk register (inside Ulysses) | Executive Director of Quality & Governance | Well Led | **Updated 17.06.2019 – Embedded process.**<br>Updated risk registers have been provided for each clinical divisional and will be presented at Risk Management committee | 01/02/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream, | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| 169 | Should Do | Corporate / Trust-Wide Issues | **QUALITY STRATEGY**<br>The trust should ensure that the quality strategy is reviewed and monitored effectively | Develop a 3 year Quality Improvement Strategy | Executive Director of Quality & Governance | Well Led | **Update 17.06.2019 – Embedded process.**<br>Quality Strategy delivered. | 01/04/2019 | |
| 173 | Should Do | Maternity Services (Women's & Children's Division) | **PERFORMANCE MONITORING**<br>The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles. | Establish monthly performance review of Women's and Children's division | Executive Director of Quality & Governance | Well Led | **Update 17.06.2019 - Embedded process.**<br>Included as part of Divisional Performance Review. | 01/04/2019 | |
| 195 | Should Do | Medical Care (Acute & Medical Division) | **OUTLIERS**<br>The service should ensure all patients who are not on the correct speciality ward, have regular senior medical reviews.<br><br>**BOARDING - ACCELERATED TRANSFER**<br>The service should ensure that a standard operating policy is in place for the practice of 'boarding' patients and there is an effective governance process. | The service will develop a Standard Operating Procedure which provides assurance that patients in outlying wards and those in non-standard escalation areas receive medical review by a senior clinician at least once a day | Executive Medical Director | Safe | **Update 03.05.2019 - Embedded process.**<br>SOP and standard operating procedures in place | 15/01/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream, | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| 197 | Should Do | Surgery (Surgical Division) | **WHO' CHECKLIST** The service should audit the implementation of the World Health Organisation Surgical Safety Checklist Five Steps to Safer Surgery. | Conclude a review of the Trust's arrangements for Safer Surgery, specifically including NATSSIPs and LOCSSIPs | Executive Medical Director | Safe | **Update 10.06.2019 - Embedded process** Audit has taken place and assurance submitted to PSQB | 31/03/2019 | |
| 198 | Should Do | Surgery (Surgical Division) | **WHO' CHECKLIST** The service should audit the implementation of the World Health Organisation Surgical Safety Checklist Five Steps to Safer Surgery. | As a second line assurance, carry out observational audits to demonstrate compliance with the checking procedures. Report the outcome of observational audits to the PSQB | Executive Medical Director | Safe | **Update 10.06.2019 - Embedded process** Audit has taken place and assurance submitted to PSQB | 31/03/2019 | |
| 199 | Should Do | Critical Care (Diagnostics and Clinical Support Division) | **STRATEGIC VISION** The service should ensure that it has a vision and strategy which is communicated to its staff. | Develop and approve the clinical strategy for Critical Care | Executive Medical Director | Responsive | **Update 10.06.2019 –** embedded process. Review undertaken and evidence submitted to satisfy compliance and accepted. Monthly reports are produced and issued to MD to follow up. | 31/03/2019 | |
| 218 | 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. | Introduce a mechanism for performance managing completion of level 1 reviews within 30 days of death, and where indicated structured judgement review completed within 60 days of days (in operation by 01/01/19) | Executive Medical Director, Executive Director of Quality & Governance | Well Led | **Update 04.05.2019** - **Embedded Process.** Reporting mechanisms are in place and are presented to MD. | 31/03/2019 | |
| 99 | 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** | Monitor impact of recent refocusing of matron role on medicines management and secure storage | Executive Director of Nursing and Midwifery | Effective | **Update 04.06.2019 – Embedded process** A further month of reported high compliance | 31/03/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream, | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| | | | **ROOMS**<br>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.<br>**Maternity:**<br>The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations. | | | | | | |
| 106 | Should Do | Corporate / Trust-Wide Issues | **PATIENT SAFETY ASSESSMENTS**<br>The service must ensure that patient safety checklists and patient risk assessments, including falls and pressure ulcers are completed in line with trust policy and best practice guidance. | Establish a clinical audit for this process | Executive Director of Nursing and Midwifery | Effective | **Update 04.06.2019 – Embedded process.**<br>Evidence provided of further audit and improved compliance. | 31/03/2019 | |
| 140 | Should Do | Corporate / Trust-Wide Issues | **RECORD KEEPING**<br>*These issues arose within the Emergency Department only but require Trust-wide action.*<br><br>The service should ensure that records for children are completed consistently, including using the mandatory safeguarding questions for children at all times and correctly using the paediatric | Verify the process for recording the care plans for patients with multiple conditions or co-morbidities requiring treatment | Executive Director of Nursing and Midwifery, Executive Medical Director | Safe | **Update 04.06.2019 – Embedded process.** | 31/03/2019 | |

| No | Must/ Should do | Dept | CQC recommendation/action | APH action | Director | Workstream, | Progress | Due Date | RAG |
|---|---|---|---|---|---|---|---|---|---|
| | | | early warning score.<br><br>The service should consider ways to make sure that patient pathways for different conditions are included in all patient records and completed fully when appropriate. | | | | | | |
| 55 | Must Do | Corporate / Trust-Wide Issues | **RECORDS MANAGEMENT**<br>**Medicine :**<br>The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.<br><br>**Surgery :**<br>The service should ensure all medical records are stored securely.<br><br>**Maternity :**<br>The service must ensure that women's care records are kept securely in locked cabinets at all times. | Ward Managers / Departmental heads to confirm and sign up to those arrangements | Director of IT and Information | Well Led | **Update17/06/2019 Embedded process**<br>Director of IT and Information has confirmed assurances received to demonstrate that Ward Managers and Departmental Leaders understand their responsibilities. Monitoring incorporated into the Perfect Ward App. | 05/03/2019 | |