Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

7th August 2019

together we will

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 7 AUGUST 2019
COMMENCING AT 9AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v	
2	**Declarations of Interest** Chair	v	
3	**Chair's Business** Chair	v	
4	**Key Strategic Issues** Chair	v	
5	**Board of Directors**		
	5.1 Minutes of the Previous Meeting – 3 July 2019	d	Page 4
	5.1.2 Board Action Log Board Secretary	d	Page 14
6	**Chief Executive's Report** Chief Executive	d	Page 15
7. Quality and Safety			
7.1	**Patient Story** Head of Patient Experience	v	
7.2	**Infection Prevention and Control Update** Acting Chief Nurse / Director of Governance & Quality	d	Page 17
8. Performance & Improvement			
8.1	**Integrated Performance Report**		
	8.1.1 Quality and Performance Dashboard and Exception Reports Chief Operating Officer, Medical Director, Director of Workforce, Director of Governance & Quality and Acting Chief Nurse	d	Page 24
	8.1.2 Month 3 Finance Report Acting Director of Finance	d	Page 45
8.2	**Six Facet Survey** Associate Director of Estates and Facilities	p	

9. Governance

9.1	**Report of Quality Committee** Deputy Chair of Quality Committee	d	Page 62
9.2	**Report of Finance Business Performance and Assurance Committee** Chair of Finance Business Performance and Assurance Committee	d	Page 64
9.3	**Report of Charitable Funds** Chair of Charitable Funds	d	Page 67
9.4	**Report of Programme Board** Chief Operating Officer	d	Page 70
9.5	**Report of Trust Management Board** Medical Director	d	Page 100
9.6	**Report of Safety Management Committee Quality Committee** Chair of Safety Management Committee	d	Page103
9.7	**CQC Action Plan Progress Update** Director of Governance & Quality / Acting Chief Nurse	d	Page 105

10. Standing Items

10.1	**Any Other Business** Chair	v
10.2	**Date and Time of Next Meeting** Wednesday 4 September 2019	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

3rd JULY 2019

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Chair
Janelle Holmes	Chief Executive
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Helen Marks	Director of Workforce
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
Jane Kearley*	Member of the Public
Joe Gibson*	Project Transformation
Leslie Owens*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

Gaynor Westray	Chief Nurse
Jayne Coulson	Non-Executive Director
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute
Mr Jonathan Lund	Associate Medical Director, Women & Childrens

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 19-20/078	**Apologies for Absence** Noted as above.	
BM 19-20/079	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/080	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair informed the Board of Directors that discussions continue regarding agreement for the change of model following concerns raised over the confusing service around the "front door" of the	

Reference	Minute	Action
	Emergency Department, particularly the streaming to the adjacent walk in facility. The Emergency Care Intensive Support Team (ECIST), are to oversee change in the model as a pilot and provide an independent view based on best practice. The Board of Directors then discussed options regarding current barriers to progressing change. It was agreed to establish a task and finish group to scope options to deliver efficiencies and financial sustainability – Sir David Henshaw, Sue Lorimer and Steve Igoe to attend.	**KE,NS, AM**
BM 19-20/081	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Acting Director of Finance** – informed the Board that further to the request from NHS Improvement to resubmit capital plans, the Trust has subsequently received notification that collectively Trusts need to identify at least a 20% reduction to the plans submitted in April 2019. Providers are to work together on an STP level with revised plans submitted by 15th July. A review of the Trusts capital programme based on risk is underway to understand the implications for 2019/20 plan. **Medical Director** – provided feedback following the recent 'big debate' with consultants at WUTH and GP's. The event was an opportunity to shape the future direction of the Wirral health system and take through improvements that can be made. Turnout and discussion was very encouraging with actions with identified leads to be circulated. Further events will be planned for later in the year. **Chief Operating Officer** – as discussed earlier in the meeting the Trust is working with NHSE/I on a new approach to the used of the Emergency Care Intensive Support Team (ECIST) across the Cheshire and Mersey footprint. This will mean the team are on site for a period of 3 months to support the Trust in using best practice techniques for improvements in A&E functionality and systems to expedite medically optimised patients discharge from hospital. **Director of Workforce** – advised that Board of Directors a copy of the presentation from the Top Leaders event was to be circulated. She also reported that subsequent to the launch of the new values and behaviours a formal process relating to partnership working and training focused on 'respect' is to be implemented. **Associate Medical Director, Surgery –** Dr Mehra informed the Board that the Division are reviewing day case unit / theatre plans for next winter. Updates will be provided at future meetings. **Mr John Sullivan – Non-Executive Director –** reported that at the Cheshire & Merseyside health and Care Partnership Chairs meeting they discussed the options to seek to appoint a substantive independent Chair. A job description is to be circulated for comment with the role to be advertised in the summer followed by a selection process in September.	**KE**

Reference	Minute	Action
	Director of Quality & Governance – reported that the Trust had received notification from the Care Quality Commission (CQC) for the Routine Provider Information Return (RPIR). It is anticipated that the inspection would take place in the Autumn and this is an opportunity for the Trust to celebrate its achievements during the last 12 months. Following attendance at the Local Authority Overview & Scrutiny Committee (OSC) and subsequent press interest regarding bed shortages and infection control challenges, Mr Moore informed the OSC of the Trusts improvement plans and that they appreciated the open and honest discussions to address the challenges. ***The Board noted that although some members did not have detailed updates there were a number of topics already covered within agenda items.***	
BM 19-20/082	**Board of Directors** **Minutes** The Minutes of the Board of Directors meeting held on 5th June 2019 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 19-20/083	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including: • Serious Incidents • RIDDOR Update • A&E Board • CQC Inspection **Vision and Values** – the positive feedback received from staff following the launch of the new Vision and Values on 1st July 2019 and how these will underpin the cultural work that is ongoing. On behalf of the Board the Chief Executive noted a special thanks to the Communications and Estates Teams for all their hard work. ***The Board noted the information provided in the June Chief Executive's Report.***	
BM 19-20/084	**Patient Story** The Board was joined by Leslie Owens who apprised the Board of his recent experience as a patient. Leslie was brought to the A&E department in April after a period of feeling unwell. In acknowledging that the treatment he received from all staff was excellent, he was particularly grateful to the staff who were quickly able to manage his pain. Following diagnosis he was admitted to the Older Persons	

Reference	Minute	Action
	Assessment Unit (OPAU) to receive treatment and commented that the staff treated him with kindness, dignity and respect. Whilst on the ward he became friends with a patient in the next bed who became very poorly and the crash team need to attend. This was a very frightening time for Leslie who thought he had lost his new found friend and he expressed his gratitude to all those that worked hard to save his friend. He stated that "*this experience really opened my eyes and made me feel much more appreciative of our local hospital. I felt very upset due to the bad press I have recently read about Arrowe Park Hospital, but the press obviously haven't been made aware of the brilliant skills the staff have and the wonderful experiences patients, such as me have*." Leslie was then transferred to Clatterbridge, Ward M1 and again praised the staff. He acknowledged that the treatment and kindness that I have received from all staff, at both hospital sites, has helped, tremendously, with my recovery. On behalf of the Board, the Chair expressed his thanks and appreciation to Leslie for sharing his experience. ***The Board noted the positive feedback received from Mr Owens that he would write to the Wirral Globe to tell his story in the hope it would be published.***	
BM 19-20/085	**Learning from Deaths** Dr Stevenson reported that to date mortality reports 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. Dr Stevenson highlighted that the number of acute admissions increases year on year and the number of deaths within ED has risen significantly in 2018. Data for deaths within Ed are not included in the PMR as this process is only for patients who have been admitted. A review of deaths within ED is to be undertaken and reported to Patient Safety Quality Board (PSQB). Information is being gathered from other Trusts to see if there are different ways to undertake the reviews. ***The Board noted the learning from deaths report.***	
BM 19-20/086	**Review of the Outbreak of *Clostridium difficile*** Jay Turner-Gardner, Associate Director of Nursing – Infection Prevention and Control presented the report regarding the outbreak of *Clostridium difficile (CDI)* at the Trust and three deaths related to CDI. The deaths were	

Reference	Minute	Action
	investigated as serious incidents and were reported under Strategic Executive Information System (StEIS). As previously reported, reporting guidance for this indicator has changed and as a consequence it is estimated that whilst the total number of cases will not increase the shift in the number of cases which are trust assigned, particularly those associated as community onset will increase to around 65% of the total number of cases. Since April 2019 we have reported 37 cases of CDI, of which 23 have been hospital onset and 14 community onset healthcare associated. The Board of Directors were apprised of the common themes from the Post Infection Review (PIR) for each CDI in 2018/19 along with the themes regarding the current outbreak across the wards. 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. Mr Moore summarised the immediate actions being undertaken to address current performance and outlined the plan under development to embed basic, better, best practices. The Board acknowledged that it may be a few months before performance is under control. Discussion took place encompassing a broad range of concerns and how these could be reflected in the plan to be presented to the Board. It was recognised that whilst the Director of Infection Prevention & Control (DIPC) was the Executive lead for IPC, there is a responsibility for all Directors and senior leaders of the organisation to ensure performance is brought under control. ***The Board approved the recommendations identified in the report to avoid further harm.***	
BM 19-20/087	**Health & Safety Quarterly Update** The report outlined 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). The Director of Quality & Governance explained that the analysis of health and safety performance had utilised a combination of 'lagging' and 'leading' indicators in line with best practice. A summary of both sets of indicators was provided with a particular focus on the six most frequently reported categories contained within the report. The draft Safety Management Strategy has been developed and is currently out for consultation. The Strategy has a number of key objectives outlined with a high level plan of how these objectives can be a achieved. It was agreed that a review of actions is to be undertaken at Trust Management Board and Safety Management Assurance Committee during August with a report to be provided to the Board in September. ***The Board noted the quarter 1 performance.***	**PM**

Reference	Minute	Action
BM 19-20/088	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Of the 50 indicators with established targets or thresholds 24 are currently off-target or not currently meeting performance thresholds. The Director of Quality & Governance summarised progress to date across each of the domains highlighting areas of good progress such as, Friends & Family Test regarding service received, Serious Untoward Incidents (SUI's), complaints and mandatory training. The lead Director for a range of indicators provided a brief synopsis of the issues and the actions being taken. Areas of focus for discussion were: • Infection Prevention Control (IPC) indicators – due to concerns raised previously, discussion regarding this indicator is covered within agenda item BM 19-20/086, earlier in the minutes. • VTE – whilst disappointment at the recent dip in performance was expressed it was accepted that overall performance was improving. • Attendance (previously sickness) – pilot of the attendance management system 'First Care' to be undertaken in Estates and Facilities from 1st September 2019. In conjunction new attendance policies are under development more of a focus on Health and Wellbeing with other support facilities being introduced such as Employee Assistance Programme (EAP). • 4 hour A&E – achieving trajectory following introduction of escalation area which in turn has also enabled delivery of triage within 15 minutes and reduced ambulance hand over time releasing approximately 500 hours more ambulance time. • RTT – although currently above trajectory due to MSK service, tracking in place to ensure compliance by end of July. • 2 week and 62 day cancer waits – expected to achieve quarter 1 target, non compliance within April was due to illness of a key surgeon. Research – metrics to be reviewed and linked to strategy. • Appraisal – revised metric to reflect 12 month period. ***The Board noted the current performance against the indicators to the end of May 2019 and expressed congratulations to the Emergency Department team for the improved performance.***	
BM 19-20/089	**Month 2 Finance Report** The Acting Director of finance apprised the Board of the summary financial position and at the end of month 2, the Trust reported an actual deficit of £4.8m versus planned deficit of £3.9m. 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 £0.4m to the position. The VAT issue should be resolved by 8th July with the new model coming into place. The key headlines for month 2 include:	

Reference	Minute	Action
	• the in-month position is a deficit of £1.4m against a planned deficit of £0.8m, being £0.6m worse than plan. in month, income was on plan but lower than month 1. Elective activity is below plan due to operational capacity gaps but this has been offset by other areas. • in month, pay was overspent by £0.2m in line with month 1. However, corporate pay underspends have significantly mitigated the position. The key areas of concern are medical pay where consultant agency and locum spend are presenting as pressures. The Medical staffing review is underway but early recommendations on management oversight and process have been brought forward for implementation, led by Deputy Medical Director. • in month, non-pay was overspent by £0.4m, higher than month 1 but a proportion is offset at a divisional level by income and pay underspends. The balance relates to drug pressures, the aseptic unit closure and CIP delivery. • CIP year to date is £1.0m against a plan of £1.2m, quarter 2 will see an increase in the profile which will required workforce schemes to commence delivery. • Cash balances at the end of month 2 were £3.0m which is £0.4m above plan. • Capital spend is slightly behind plan but expected to deliver full year. Due to some slippage of CIP schemes Finance, Business, Performance Assurance Committee are to review progress at its July meeting. The Acting Director of Finance highlighted further measures to introduce financial control and mitigation that have been actioned in month: ○ Non stock non-pay ordering increase in level of authorisation ○ Medical junior doctor rota's sign off process ○ Divisional forecasting of key issues affecting overspends and weekly review of mitigating actions ○ Review of NHSI grip and control checklist for additional measures ○ Mark Brearley review. The Board were requested to approve £269k spend for refurbishment of Ward 30, being an escalation from the Medicine Division and replacement of the Ward M1 scheme as a higher priority. It was noted that this will require £135k from contingency. **The Board noted the M2 finance performance and approved funding for the refurbishment of Ward 30.**	
BM 19-20/090	**Interim NHS People Plan** This report provided an overview of the NHS Interim People Plan which was published in May 2019. The 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	

Reference	Minute	Action
	• **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. The report also described the next steps for the Trust and triangulation with the Organisational Development programme which has been externally validated by Professor Michael West. It was reported that universities have seen a significant increase in nursing applications and the Trust could benefit if it established links earlier in the programme. It was agreed that the Director of Workforce in conjunction with Steve Igoe could facilitate this engagement. **The Board noted the Interim NHS People Plan.**	
BM 19-20/091	**Report of Programme Board** Joe Gibson, External Assurance provided an outline of the Change Programme amendments during the past month and performance relating to the three large priority projects; Patient Flow, Outpatients and Theatres Productivity. It was reported that the governance ratings has remained the same with delivery ratings seeing a slight deterioration due to slippage in the diagnostics programme. 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 were endorsed by the Programme Board at its meeting on 19th June 2019 and were provided for information. A presentation providing a summary of progress and ongoing work within the Perioperative Medicine Pathway was provided by the Surgical Division. The team outlined the objectives including: • Theatre utilisation • Lock down of theatre schedule to allow for better planning • Reduction in cancellations • Streamlining booking processes for surgery The benefits realisation along with the key performance indicators, key achievements and challenges going forward were provided.	

Reference	Minute	Action
	Dr Ranjeev Mehra, Associate Medical Director – Surgery summerised the progress to date and sought clarification regarding the Clatterbridge site to enable planning to minimise effect of winter pressures. The Board supported the view to optimise use of the Clatterbridge facilities. On behalf of the Board the Chair thanked the team for the hard work and that this message is passed to colleagues in the Division. ***The Board noted the Change Programme summary, delivery and assurance report and the presentation regarding the Perioperative medicine pathway programme.*** **FS**	
BM 19-20/092	**Report of Trust Management Board** The Chief Executive provided a verbal report of the Trust Management Board (TMB) meeting on 27th June 2019 which covered: • Quality & Performance Dashboard • Health & Safety Quarter One Report • Facilities Strategy Update • Ward Accreditation Update • Legionella and Pseudomonas Aeruginosa testing • Use of Resources • Protecting vulnerable people training • Emergency Department benchmarking 2019 scoping documents • Pathology collaboration • Business cases: Histology biomedical science, Employee Assistance Programme and Recruitment Services • Chair reports from other meetings ***The Board noted the verbal report of the Trust Management Board.***	
BM 19-20/093	**CQC Action Plan progress Update** The Director of Quality & Governance apprised the Board of the continued progress pertaining to the CQC Action Plan. He reminded Board members that the report has been expanded to include the actions following the unannounced inspection of urgent care facilities. The Director of Quality & Governance confirmed that following the 'confirm and challenge' meetings held in June there is one action which has been 'red rated' within the original plan which concern patient flow management. The Board were reminded that a separate Patient Flow Improvement Plan pre-dated the CQC plan and it was agreed to refer to the Patient Flow Improvement Plan in the CQC Action Plan to avoid unnecessary duplication of effort. Whilst progress is being made, the Patient Flow Improvement plan has yet to deliver in full and therefore rated as red. The original CQC action plan is expected to be closed down within the next four weeks. Good progress is being made against the Urgent Care plan with expectation that actions will be rated blue/green in a short period.	

Reference	Minute	Action
	The Director of Quality & Governance advised the Board that 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. ***The Board noted the progress to date of the CQC Action Plan.***	
BM 19-20/094	**Any Other Business** There were no items to report this month.	
BM 19-20/095	**Date of next Meeting** Wednesday 7th August 2019.	

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Chair

……..

Date

Board of Directors Action Log
Updated – 3rd July 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 03.07.19						
1	BM 19-20/080	Establish a 'task & finish' group to scope options to deliver efficiencies and financial sustainability across the health economy	**KE,NS, AM**	Complete	August '19	Meeting arranged for 30.7.19
2	BM 19-20/081	A risk based review of capital programme to be undertaken following notification from NHSI to identify 20% reduction across the STP	**KE**	Complete	August '19	Reduced capital programme by £1.6m – Car Park scheme deferred to 2020/21.
3	BM 19-20/087	Safety Management Strategy actions to be reviewed at Trust Management Board (TMB) and Safety Management Assurance Committee (SMAC) during August	**PM**	Complete	Sept '19	Item included for August Trust Management Board and Safety Management Assurance Committee
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	October '19	Acting Chief Nurse requested to review and therefore timeframe revised

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	7th August 2019
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

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

CQC

Following receipt of the request from the CQC on the 20th June to submit information under what is called the 'Provider Information Request', the Trust has now submitted the documentation. As Board members will appreciate, the CQC do not give details of exact dates for inspection.

Serious Incidents

The Trust declared 4 Serious Incidents in June 2019. The first case involved the care of a deteriorating patient; the second case concerned an incidental diagnostic finding that was not immediately acted upon; the third a delayed diagnosis of cancer; and the fourth was a death associated with hospital acquired *Clostridium difficile*. Full investigations are underway and will be monitored and reported via the Quality Committee.

RIDDOR Update

The Trust reviewed 4 RIDDOR reportable incidents at the SI panel in the month of June. 2 were due to lifting loads, 1 was a slip/trip/fall and the 4th was an incident involving a staff member who injured their back whilst supporting a patient who fell. All are being appropriately investigated and reported and monitored via the Quality Committee.

Wirral A&E Delivery 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 support from the Community. It was also reaffirmed that the onsite support from ECIST had commenced, 29th July, to support Patient Streaming and to improve overall length of stay, enabling Patients to return to their homes or an alternative community setting. The Board also received a presentation from NWAS, in recognition of the positive collaboration between the Trust and NWAS leading to improved ambulance handover times.

Janelle Holmes
Chief Executive
August 2019

BOARD OF DIRECTORS	
Agenda Item	7.2
Title of Report	Update - Outbreak of *Clostridium difficile*
Date of Meeting	7th August 2019
Author(s)	Jay Turner-Gardner, Associate Director of Nursing, Infection Prevention & Control Paul Moore, Director of Quality & Governance and Acting Chief Nurse
Accountable Executive	Paul Moore, Director of Quality & Governance and Acting Chief Nurse
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	PR4 Patient Safety & Quality
Level of Assurance **Positive** **Gap(s)**	Bronze
Purpose of the Paper **Discussion** **Approval** **To Note**	To update and provide for **assurance** to the Board **The Board is invited to receive and consider this report**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

UPDATE – OUTBREAK OF CLOSTRIDIUM DIFFICILE
POSITION AS AT 27TH JULY, 2019

1. Executive Summary

The purpose of this paper is to keep the Board informed of the current situation regarding an ongoing outbreak of *Clostridium difficile* (CDI) at Arrowe Park University Hospital Trust (WUTH).

At the time of writing, in the 2019/20 year-to-date, there have been 43 reported *Clostridium difficile* infections (n=39 during Q1 against a Q1 trajectory of 22); the annual threshold for WUTH is 88 in 2019/20. The Trust is therefore 17 cases above trajectory in Q1. The Trust is identified as an outlier with a statistically significant variance from other providers in the North West.

The outbreak has associated mortality. At the last update to the Board it was reported that there had been three *Clostridium difficile* related deaths (named on part 1a of their death certificate); at the time of this report a fourth case has been identified and reported in June 2019 (named on part 1b of their death certificate) which is at present under investigation as a serious incident and has been reported externally using StEIS.

2. Background

The Trust declared an outbreak of CDI in February 2019. The outbreak was subsequently closed in April 2019. However, as cases continued to be identified following closure of the outbreak in April 2019, the outbreak was extended and re-declared in May 2019. The Chief Nurse was leading the Trust's coordinated response to the outbreak with support from NHS Improvement, NHS England and Public Health England. The substantive Associate Director of Nursing for Infection Prevention and Control started in post at the end of May 2019. The Director of Quality & Governance took on the role of Director of Infection Prevention and therefore assumed overall control over the Trust's response from June 2019.

The outbreak was initially declared on five wards at Arrowe Park Hospital where the *Clostridium difficile* cases appeared to be concentrated. Weekly outbreak meetings have been and continue to be held, now chaired by the Director of Quality & Governance. In the designated outbreak wards, and subsequently extended to cover all patient-facing clinical areas, specific interventions designed to enhance control have been, or are in the process of being, implemented. These include:

(i) increased focus on hand hygiene compliance;
(ii) enhanced and effective equipment decontamination including commode cleaning;
(iii) the frequency and standard of environmental cleaning in patient-facing clinical areas;
(iv) as quickly as possible, assuring the completion of outstanding essential repairs, maintenance and refurbishment requirements;
(v) purchase of replacement bedside equipment (lockers, chairs, tables and mattresses) that could not be effectively decontaminated between patient use; and
(vi) increasing staff training and awareness.

These interventions appear to be helping to stabilise the risk. At the time of report no further infections were reported on the designated outbreak wards. Subsequent cases have been identified across other wards at Arrowe Park Hospital. The rate of CDI remains high across the Trust as a whole.

Clostridium difficile 2019/20													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Monthly trajectory	7	7	8	7	7	6	7	7	8	8	8	8	88
Incidence	19	9	11	4									43

Following Post Infection Review of the 39 patients diagnosed with CDI in Q1, 19 had lapses in the quality of care provided to the patient, which probably contributed to the patient acquiring their infection, and 17 of the 39 cases had had a previous admission in the preceding 4 weeks.

Thematic analysis of cases within the designated outbreak wards identified a range of learning opportunities, which are being acted upon, but also apply to those cases which have been identified elsewhere at Arrowe Park Hospital. The key learning points include:

- **Failure/inability to isolate appropriately and in a timely manner** - resulting in patients with diarrhoea being nursed on the open ward putting other patients at risk of cross infection.
- **Delay in sample taking** - which delays diagnosis and timely treatment to control the infection.
- **Inconsistent/ineffective cleaning standards** – Widespread environmental contamination with CDI spores
- **Cluttered clinical environment** - which does not facilitate effective cleaning and harbors harmful spores
- **Poor repair and maintenance of the estate** - does not facilitate effective cleaning
- **Damaged patient shared equipment** – does not facilitate effective decontamination between different patients, potentially exposing patients to equipment contaminated with potentially harmful pathogens.

3. Performance Indicators – Perfect ward

Hand hygiene compliance (Designated Outbreak Wards)

Hand Hygiene compliance				
Ward	April	May	June	July
17	94%	93%	88%	95%
18	100%	95%	96%	99%
21	100%	100%	98%	100%
33	85%	91%	92%	89%
36	83%	98%	100%	99%

Infection Prevention & Control Environmental Audit Tool (Perfect Ward App)

Infection Prevention				
Ward	April	May	June	July
17	69.5%		77%	
18			82.9%	
21	69.7%		64.1%	
33	78.6%			
36		87%		

The conventions adopted by the Trust to obtaining infection prevention environmental assurances was established as follows: environmental audits are to be completed on an annual basis and those that fall below the acceptable threshold must be re-audited within a 3-month period in order to allow time for improvements to take place. The Associate Director of Nursing for Infection Prevention and Control is currently reviewing these conventions to ensure they remain fit for purpose.

Environmental decontamination audit (Designated Outbreak Wards)

Adenosine triphosphate[1] (**ATP) swabbing /Ultra Violet light pen[2] (LP)**			
Ward	**May**	**June**	**July**
17	**ATP 100% LP 100% (PASS)**	**ATP 80% LP 100% (PASS)**	**ATP 80% LP 100% (PASS)**
18	**ATP 100% LP 100% (PASS)**	**ATP 40% LP 60% (FAIL)**	**ATP 100% LP 80% (PASS)**
21	**ATP 100% LP 100% (PASS)**	**ATP 100% LP 100% (PASS)**	**ATP 100% LP 100% (PASS)**
33	**ATP 100% LP 80%% (PASS)**	**ATP 100% LP 100% (PASS)**	**ATP 100% LP 100% (PASS)**
36	**ATP 80% LP 20% (FAIL)**	**ATP 100% LP 80% (PASS)**	**ATP 100% LP 100% (PASS)**

Antimicrobial stewardship (Designated Outbreak Wards) [3]

Ward	April		May		June		July		Total % compliance
	No. ABX prescribed	No. ABX compliant or doc'd deviation	No. Abx prescribed	No. ABX compliant or doc'd deviation	No. Abx prescribed	No. ABX compliant or doc'd deviation	No. Abx prescribed	No. ABX compliant or doc'd deviation	
17	7	7	7	7	8	8	7	5	93%
18	8	8	5	5	9	7	6	6	93%
21	5	5	8	8	5	5	5	5	100%
33	6	6	8	8	5	8	6	6	89%
36	6	6	8	8	5	6	5	5	96%

[1] Adenosine triphosphate* is a molecule that carries energy within cells, the swab results reveal detection of organic matter but does not determine what it is

[2] Ultra violet light pen** invisible UV pen is used to mark equipment, the following day a UV light is used to detect if UV ink remains or if it has been cleaned of

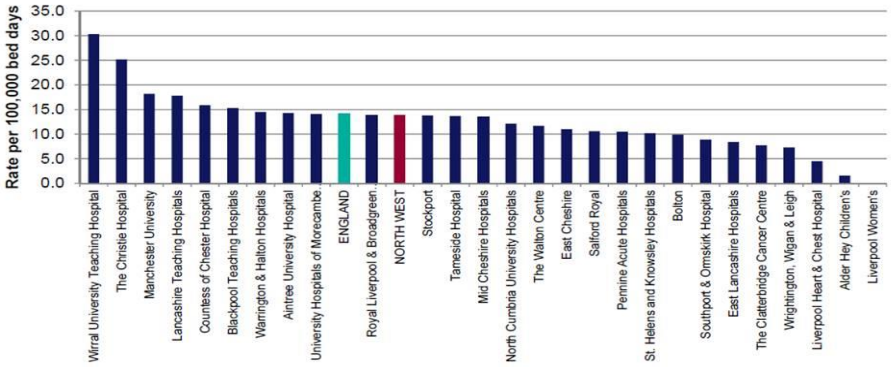
[3] Deviations from the antimicrobial policy are permitted providing there has been clinical review.

4. Northwest HCAI monthly reports

Public Health England

Clostridium difficile infection

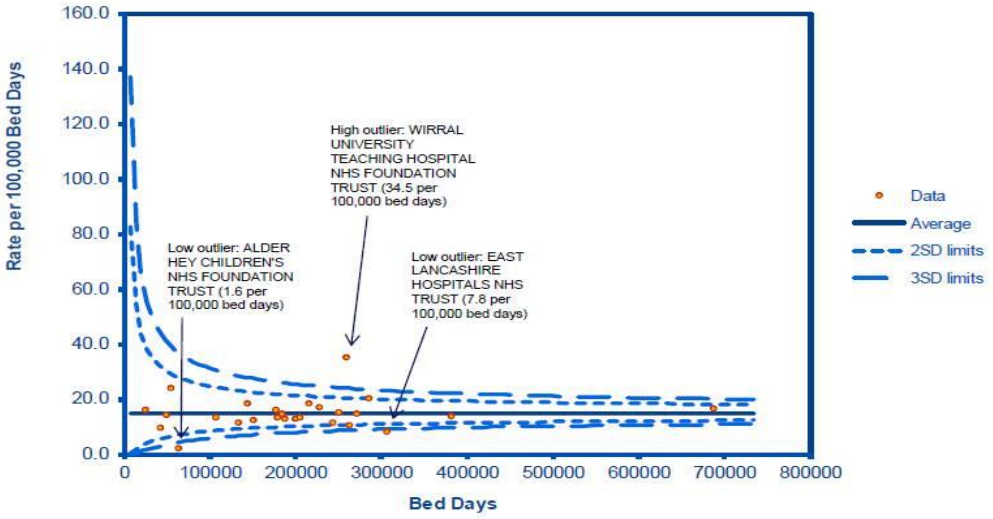
2018/19 rates by NHS acute Trust (hospital onset, healthcare associated), North West



Public Health England

C. difficile annual charts: Trust rates (hospital onset)

C. difficile (hospital onset), North West Trusts, July 2018 - June 2019



Source: HCAI Data Capture System

5. Controls that have been developed and strengthened since the outbreak commenced

- Enhanced monitoring and accountability for hand hygiene and dress code compliance
- Commenced trial of Antibiotic Review Kit
- Introduced proactive HPV fogging of all wards as a pre-emptive intervention
- SOP for thermo-disinfection of jugs and beakers developed and implemented
- SOP for the use and changing frequency of toilet brushes developed and in the process of being implemented
- SOP for mattress removal, cleaning and storage developed and in the process of being implemented
- Reviewed and in the process of clarifying Ward 25 (Isolation ward) admission criteria
- Reviewed cleaning standards and recommendations being drafted to simplify them
- *Clostridium difficile* antimicrobial treatment guidelines reviewed and strengthened
- Outbreak threshold and management defined more directly and process implemented
- Implemented root cause analysis (RCA) investigation which has now replaced the previous Post Infection Review (PIR) tool following each CDI diagnosed
- Incident report has been clarified as a requirement for all CDI with completed summary embedded and clarity on actions taken.
- Undertaken spot check of all bedside equipment which identified unserviceable equipment and has resulted in a purchase order to replace 392 patient lockers, 354 bedside tables, 381 patient chairs, 114 visitor chairs and 150 static foam mattresses. The costs have been met through a combination of charitable funds and equipment budgets.
- Monthly meetings have commenced with Wirral Health & Care Commissioning Group to ensure that the process of case assessment is reviewed and ratified by a Multi-disciplinary Team.

6. Assessment of Risk

The incidence of *C.diff* appears to be stabilising. This is being achieved using a combination of controls, some of which draw on contingencies which may not be sustainable in the long term. In addition, isolation facilities remain limited, environmental cleaning has limitations due to the extent to which clinical areas can be thoroughly decontaminated given the maintenance and repairs outstanding (which vary between wards), and the Trust is not yet in a position to bring a decant facility (which would enable accelerated maintenance, repairs and refurbishment to be undertaken more effectively) into operational use. Therefore the residual risk of *C.diff* remains volatile and has been kept at a magnitude of 20.

7. Decant Facility

The weekly Outbreak Meetings review implementation of interventions designed to bring the risk of *Clostridium difficile* infections under better control. The Acting Chief Nurse has reflected carefully on his earlier advice to the Board regarding the benefits of bringing a decant facility into operational use, as an adjunct to the suite of interventions already in train, **in order to accelerate completion of safety-critical maintenance, repair and refurbishment of patient-facing areas**. The use of a decant facility is an issue which divides opinion internally and externally, which is important to acknowledge. However, after careful consideration, it remains the view of the Acting Chief Nurse that bringing a decant facility into operational use as soon as reasonably practicable is a necessary intervention to contain and further reduce the risk of exposure to *Clostridium difficile* infections at Arrowe Park Hospital. To this end the Executive Team have debated and agreed in principle to bring a decant facility into operational use as soon as reasonably practicable; further discussions however would be necessary beforehand to understand precisely how any potential consequential risks could be mitigated as a prerequisite.

8. Conclusion

The hospital-wide outbreak is a consequence of having an environment and equipment that is used on a daily basis that is in a poor state of repair, neither of which facilitates effective cleaning. Lack of facilities to isolate patients and insufficient priority being given to allow staff to follow essential Infection Prevention strategies to prevent the spread of Infection has also had an impact on how quickly the outbreak of CDI has become established.

9. Action Required by the Board

The Board of Directors are invited to:

(i) note this update;
(ii) continue to support the efforts to reduce the risk; and
(iii) advise on any other additional control measures that could accelerate the Board's control over the outbreak.

Board of Directors	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	7th August 2019
Author	WUTH Information Team and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of June 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 52 indicators with established targets that are reported for June 2019:

- 19 are currently off-target or failing to meet performance thresholds
- 33 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.

Appendix 2 details the indicators that are not meeting the required standards within month in an exception report, excluding finance indicators which are covered in the separate finance report. The report includes a brief description of the **I**ssue, the remedial **A**ction and expected **I**mpact.

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. Quarterly exception reporting on qualifying metrics 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 June 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

July 2019
updated 22-07-19

	Indicator	Objective	Director	Threshold	Set by	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019/20	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	DoN	≤0.24 per 1000 Bed Days	WUTH	0.27	0.22	0.18	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.18	0.22	0.09	0.16	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (audit sample size 150)	Safe, high quality care	MD	≥95%	WUTH	83.3%	84.8%	80.1%	82.9%	81.6%	78.4%	80.6%	89.9%	95.0%	98.7%	96.2%	86.0%	91.9%	91.4%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	94.7%	95.3%	95.0%	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	96.4%	96.3%	96.8%	96.5%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.4%	96.5%	95.7%	95.5%	95.9%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	13	3	2	1	3	2	4	2	4	2	1	1	4	2	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	1	0	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	5	1	0	0	0	0	0	1	0	0	0	0	0	0	
	Clostridium Difficile (healthcare associated)	Safe, high quality care	DoN	≤88 for WUTH FY19-20, as per mthly trajectory	SOF	3	1	3	0	3	4	2	7	10	5	19	9	11	39	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	6	7	2	3	5	4	2	3	4	2	5	2	0	7	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	17	18	18	15	13	23	9	10	6	5	12	9	8	10	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	0	0	1	0	0	0	2	0	0	0	0	
	Hand Hygiene Compliance	Safe, high quality care	DoN	≥95%	WUTH	88%	89%	90%	81%	87.0%	85%	76%	83%	99%	99%	98%	91%	98%	98%	
	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%	98%	98%	
	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%	93.7%	93.7%	
	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%	90.7%	90.7%	
	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%	91.5%	91.5%	
	Attendance % (12-month rolling average) (*)	Safe, high quality care	DHR	≥95%	SOF	95.16%	95.13%	95.13%	95.09%	95.06%	95.07%	95.06%	95.05%	94.98%	94.90%	94.81%	94.74%	94.63%	94.63%	
	Staff turnover	Safe, high quality care	DHR	≤10%	WUTH	9.7%	10.4%	9.9%	9.9%	10.0%	9.7%	9.6%	9.7%	9.7%	9.8%	10.0%	10.2%	10.5%	10.5%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	Between 6 and 10	WUTH	7.4	7.6	7.5	7.1	6.9	7.1	7.0	7.3	7.2	7.2	7.2	7.3	7.4	7.30	

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	Indicator	Objective	Director	Threshold	Set by	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019/20	Trend
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	97.06	–	–	97.22	–	–	104	–	–	–	–	–	–	104	
	HSMR	Safe, high quality care	MD	≤100	SOF	93.0	95	95	92	92	97	97	98	99	99	–	–	–	99	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	–	–	–	86%	71%	56%	49%	46%	22%	39%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	59%	71%	78%	67%	74%	84%	87%	83%	81%	94%	92.0%	95.0%	90.0%	92.3%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	16.4%	12.8%	15.7%	15.0%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	409	386	387	411	409	408	397	437	457	438	421	415	403	413	
	Long length of stay - number of patients in hospital for 21 or more days (*)	Safe, high quality care	MD / COO	Reduce to 107 by March 2020	WUTH	-	-	-	-	-	-	-	-	-	-	199	190	171	171	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	3.8	5.2	4.1	4.2	4.3	3.8	4.8	3.0	4.4	4.4	4.8	3.9	4.8	4.5	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.8	5.5	5.1	5.5	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	873	913	961	888	936	925	917	903	788	914	871	970	884	908	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	13	13	6	18	12	17	14	10	16	14	11	14		13	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	89.5%	86.3%	85.5%	87.1%	

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Wirral University Teaching Hospital NHS Foundation Trust

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July 2019
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	Indicator	Objective	Director	Threshold	Set by	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	10	8	16	14	19	18	15	20	14	13	13	13	17	43	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	91%	89%	89%	86%	87%	84%	92%	85%	87%	87%	87%	89%	91%	89%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	8%	11%	12%	11%	10%	11%	10%	11%	11%	13%	9%	11%	10%	10%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	98%	98%	97%	98%	98%	98%	98%	97%	97%	98%	97%	96%	97%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	20%	25%	14%	22%	24%	18%	18%	19%	15%	13%	19%	22%	31%	24%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	94%	95%	94%	94%	94%	95%	94%	95%	94%	95%	94%	94%	95%	94%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	99%	96%	100%	100%	96%	100%	100%	99%	98%	96%	94%	97%	99%	97%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	46%	37%	17%	28%	11%	19%	37%	27%	36%	44%	25%	29%	44%	33%	

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	Indicator	Objective	Director	Threshold	Set by	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-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	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	73.6%	81.1%	83.5%	83.5%	
	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	2	0	0	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	291	213	326	474	371	440	393	379	323	273	437	118	54	203	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% through 2019-20	SOF	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	79.04%	80.72%	80.12%	80.12%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	26,957	26,836	27,308	26,556	26,862	27,367	26,157	27,506	28,367	27,309	26,223	27,317	25,733	25,733	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019-20	National	79	57	56	40	43	30	28	28	19	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	99.5%	99.3%	99.5%	99.5%	
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	91.9%	94.0%	93.9%	93.2%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	96.8%	96.5%	96.7%	96.6%	96.6%	
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	86.2%	85.4%	86.5%	85.8%	85.3%	87.9%	76.0%	83.1%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	DoN	TBC	WUTH	110	140	123	155	119	165	118	178	153	157	162	195	180	179	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	DoN	TBC	WUTH	36	24	25	22	19	13	13	27	28	17	17	12	15	15	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	≥90%	National	95%	72%	75%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	7	5	0	4	2	3	2	2	1	3	4	4	4	4	

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Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	-	-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	500 for FY19/20 (ave min 42 per month until year total achieved)	National	336	70	48	42	38	57	38	43	41	59	31	30	40	101	
	% 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%	82.1%	82.1%	

	Indicator	Objective	Director	Threshold	Set by	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019/20	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-3.340	-1.458	-0.098	-4.896	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-0.237	-0.630	0.914	0.047	
	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	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-6.0%	-6.8%	-5.2%	-5.2%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-19.5%	-26.8%	-15.6%	-15.6%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-14.0	-21.3	-15.9	-15.9	
	Capital Programme		DoF	On Plan	WUTH	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	52.1%	31.0%	28.0%	28.0%	

(*) Updated Metrics

Effective: Long length of stay

Metric Change

New metric - reflecting the national target of reducing number of patients with a LoS of 21 days or more.

(**) Updated Thresholds

Threshold Change

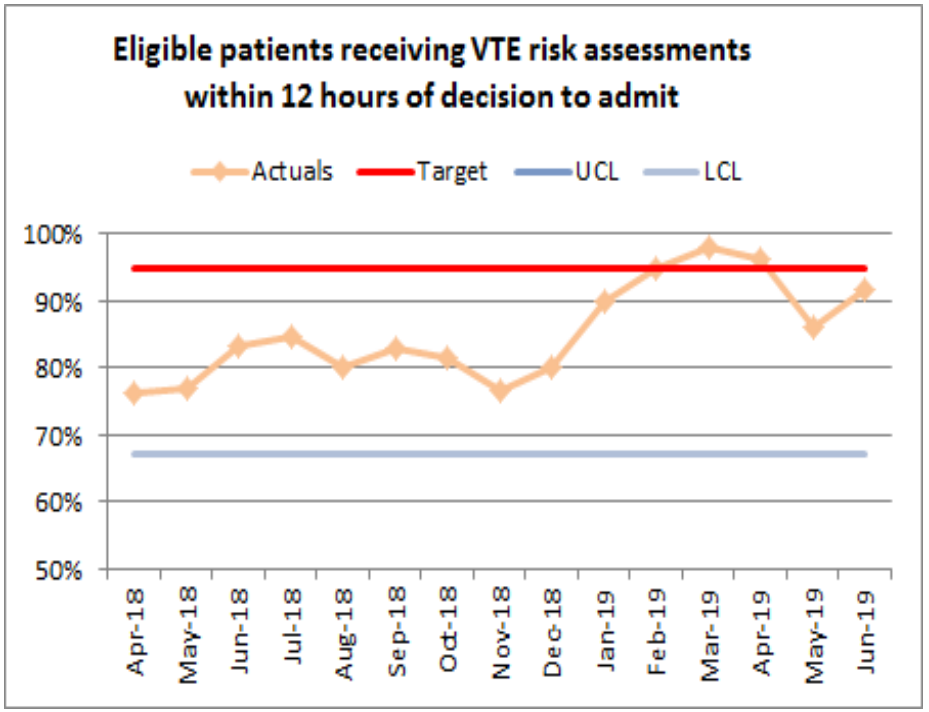
Wirral University Teaching Hospital NHS Foundation Trust

WUTH Quality Dashboard Exception Report Template July 2019

Safe Domain

Eligible patients having VTE risk assessment within 12 hours of decision to admit

Executive Lead: Medical Director
Performance Issue: A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. This was not achieved since April 2019 with the average for 2019/20 at 91.4%.
Action: *Baseline in 2018 was low, performance improved with VTE alert introduction in January 2019 but has declined as increased "by-passing" therefore reporting on alert "by-passing" to be introduced August 2019.* *'Live' dashboard compliance tool being used to highlight problem locations/specialties. Feedback to AMD/CD/CL's.*
Expected Impact: Gradual improvement to occur over 2019. Increased awareness of areas of failure by location/specialty and further targeted actions.



Clostridium difficile – healthcare associated

Executive Lead:

Acting Chief Nurse

Performance Issue:

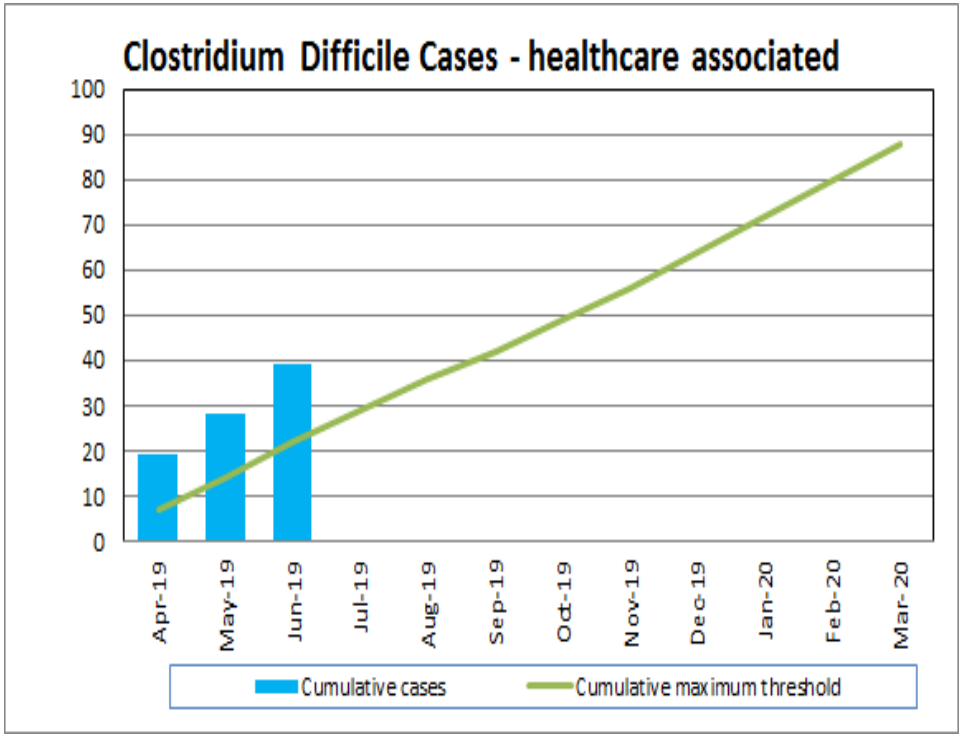
An annual objective has been set by NHSI for WUTH to have no more than 88 *Clostridium difficile* cases (healthcare associated) for 2019-20. A monthly trajectory was mapped out for the year. Up to June 2019 there have been 39 cases against the cumulative monthly trajectory of a maximum 22 cases.

Action:

- Outbreak declared and weekly meetings commenced
- Ward IP improvement plans developed
- Outstanding estates issues escalated
- Cleaning standards reviewed and improved
- Programme of de-cluttering initiated
- Broken and damaged equipment being replaced
- Investigation process reviewed and a more robust accountability framework process implemented
- Trust wide awareness campaign introduced

Expected Impact:

- All staff become empowered in how they can help to reduce infections
- Reduction in CDI anticipated, there has been a reduction in July (N=5)



Staff attendance % (12 month rolling average)

Executive Lead:

Director of Workforce

Performance Issue:

WUTH has a target set at a minimum 95% attendance of staff, calculated as a 12-month rolling average. This standard is scrutinised by NHSE&I under the Single Oversight Framework. The 95% standard has not been achieved since January 2019, with the monthly position deteriorating.

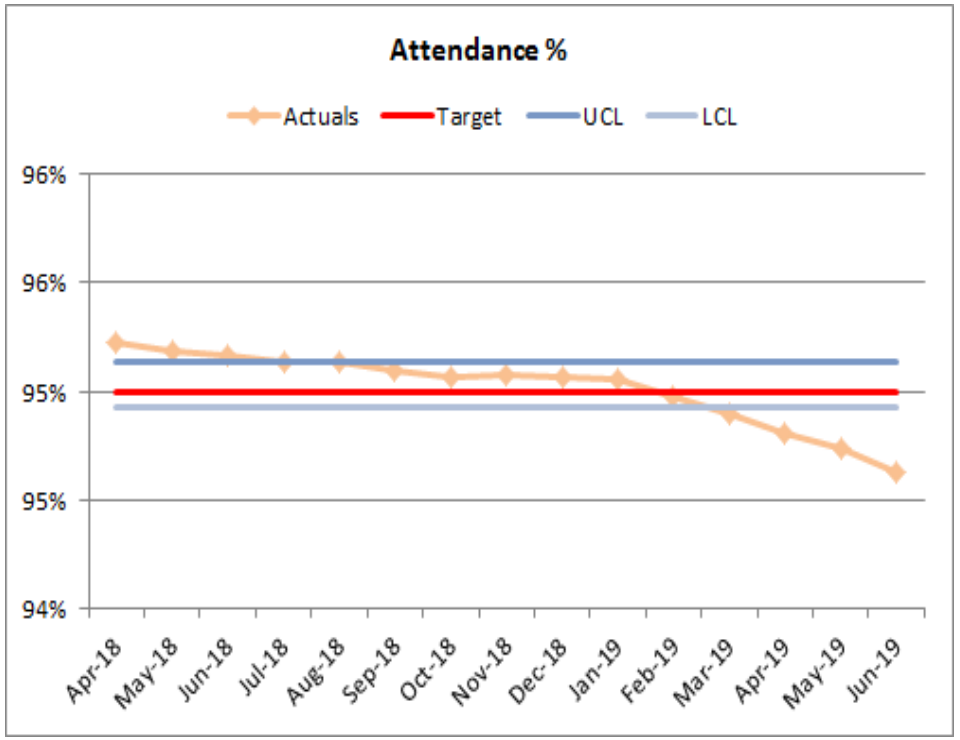
Action:

External sickness management solution to be introduced – pilot to start in August 2019 in Estates & Facilities. This is in conjunction with introduction of a new Attendance policy that includes the 'Bradford Factor' with effect from 1st July 2019.

Introduction of additional health and wellbeing support processes such as the introduction of an employee assistance programme from 1st September 2019. In addition the 'effective manager programme' to be rolled out from 1st September starting with ward managers.

Expected Impact:

To improve attendance over the next six months.



Staff turnover %

Executive Lead:

Director of Workforce

Performance Issue:

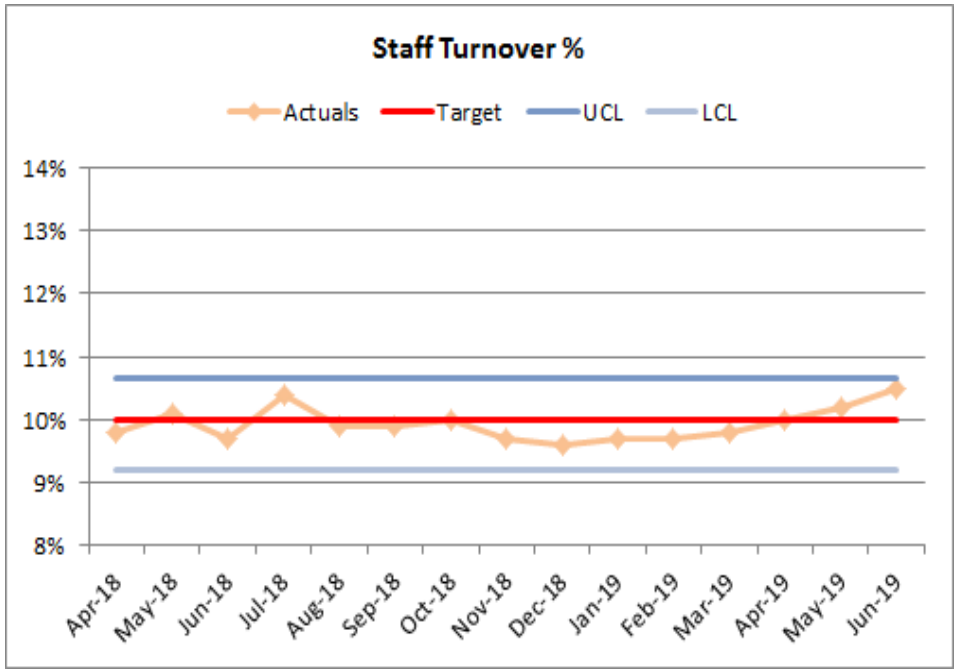
WUTH has an internal target set at a maximum 10% staff turnover. This standard has not been met since April 2019, with the average for 2019-20 at 10.5%

Action:

Recruitment and Retention group in place with a number of initiatives being introduced to support flexible working as well as supporting staff to move into different areas of the Trust**.** Pension group has also been established to explore options in relation to the national issues. A number of recruitment campaigns and various activities planned. Hard to recruit to posts being monitored through the Finance and HR scrutiny group.

Expected Impact:

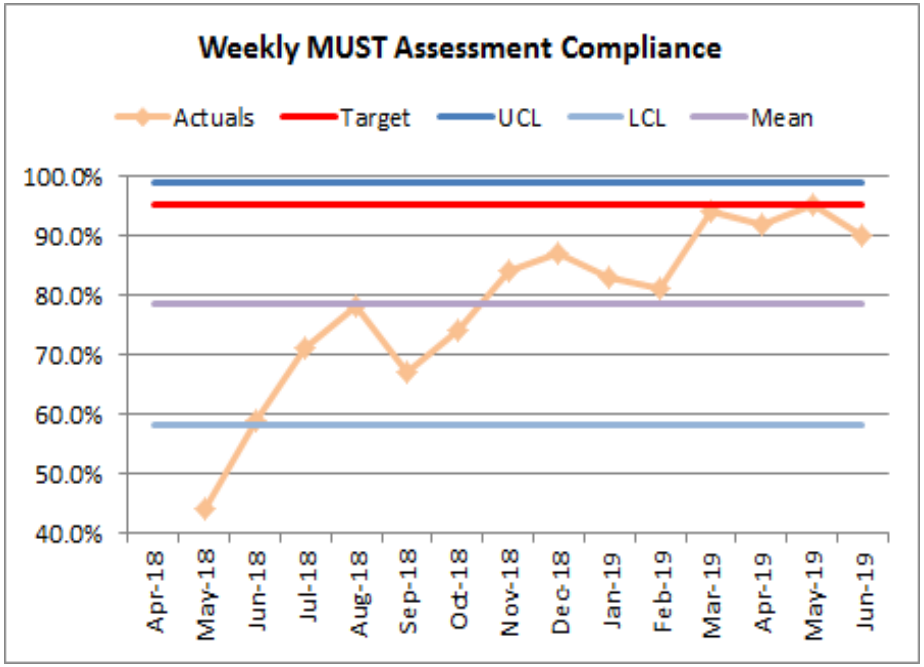
To stabilise the turnover rate at healthy level.



Effective Domain

Nutrition and hydration – MUST completed at 7 days

Executive Lead: Acting Chief Nurse
Performance Issue: An internal WUTH target is set at a minimum 95% compliance with MUST for patients with a length of stay of 7 days or more, re-assessed every seven days. Although achieved in May 2019 for the first time, performance deteriorated slightly to 90.0%. Overall there has been a dramatic improvement. The driver for the deterioration is associated with compliance failure in a small number of cases which is being addressed with the relevant teams.
Action: Combined harms panel in place to confirm and challenge. Additional trigger added to Wirral Millennium to flag due risk assessments. Next MUST audit results are due 2nd August. Midway compliance indicates a 94% compliance
Expected Impact: The Trust is anticipating recovery and compliance from July 2019.



SAFER bundle: % of discharges taking place before noon

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. This standard is consistently not achieved, with the average for 2019-20 at 15.0%.

Action:
Plan workshop to coach IDT staff on input, preparation and feedback into board rounds & huddles.

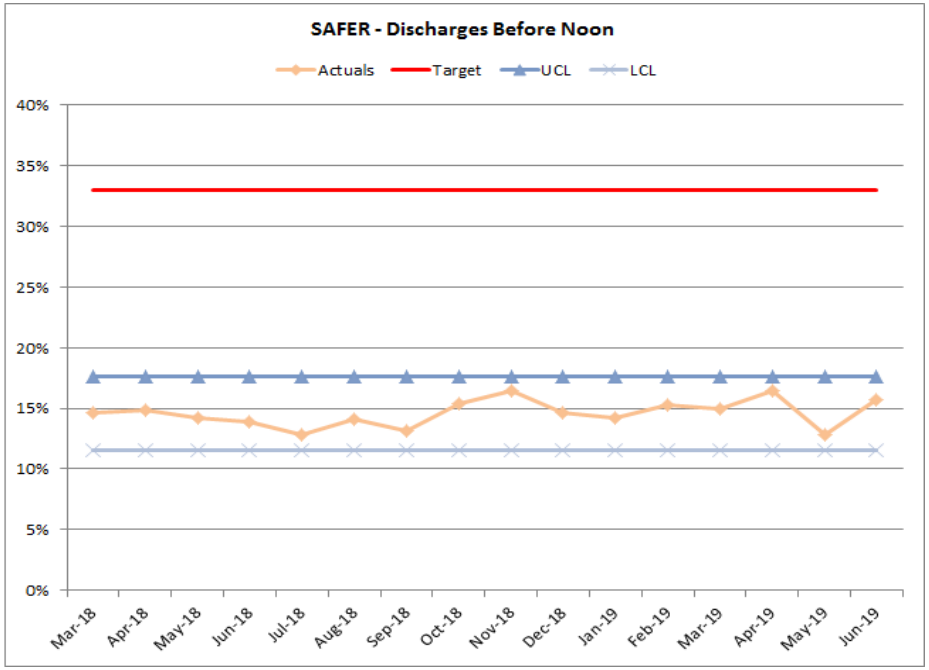
Capacity Manager roll out planned for October 2019.

Ambulatory Care Unit referral criteria 'go-live' date 22nd July 2019.

Expected Impact:

Improved communication on board round on patients on IDT caseload.

Greater visibility of ward bed states and real time discharge on Cerner.
GP referrals signposted to most appropriate clinical setting.



SAFER bundle: average number of patients in hospital for 7 days or more

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

A WUTH target has been set to reduce the number of patients in hospital for seven days or more to a maximum 156. The numbers remain considerably above this target, with an average for 2019-20 of 413.

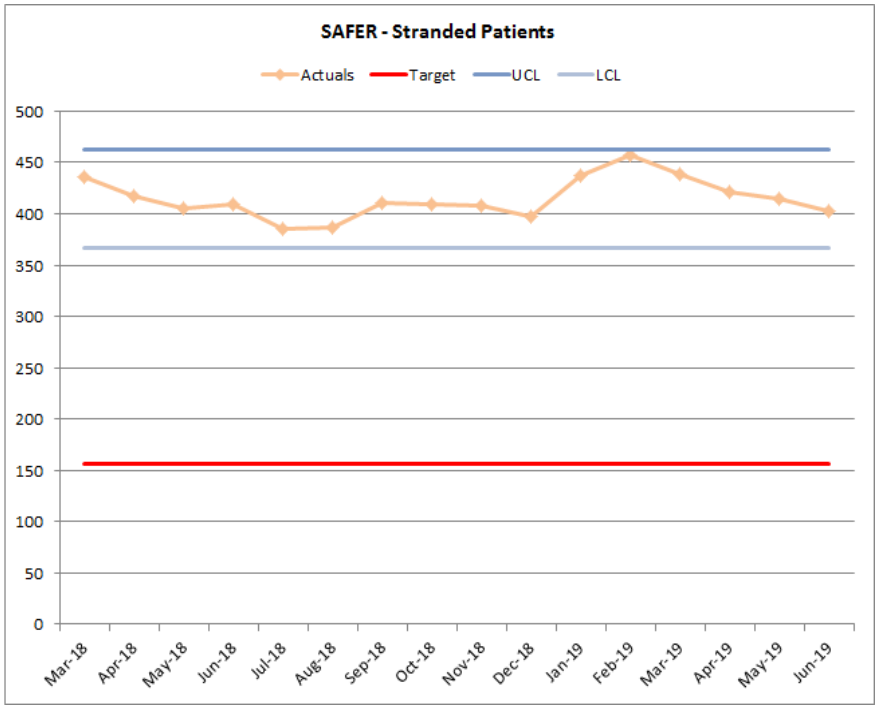
Action:

Revamped long length of stay reviews focusing on ≥21 day Length of Stay (LOS) from July 2019.

Assigned named social worker & IDT nurse/tracker on each ward.

Expected Impact:

WUTH to continue to achieve 21 day LOS reduction trajectory.



Caring Domain

Same sex accommodation breaches

Executive Lead:

Acting Chief Nurse

Performance Issue:

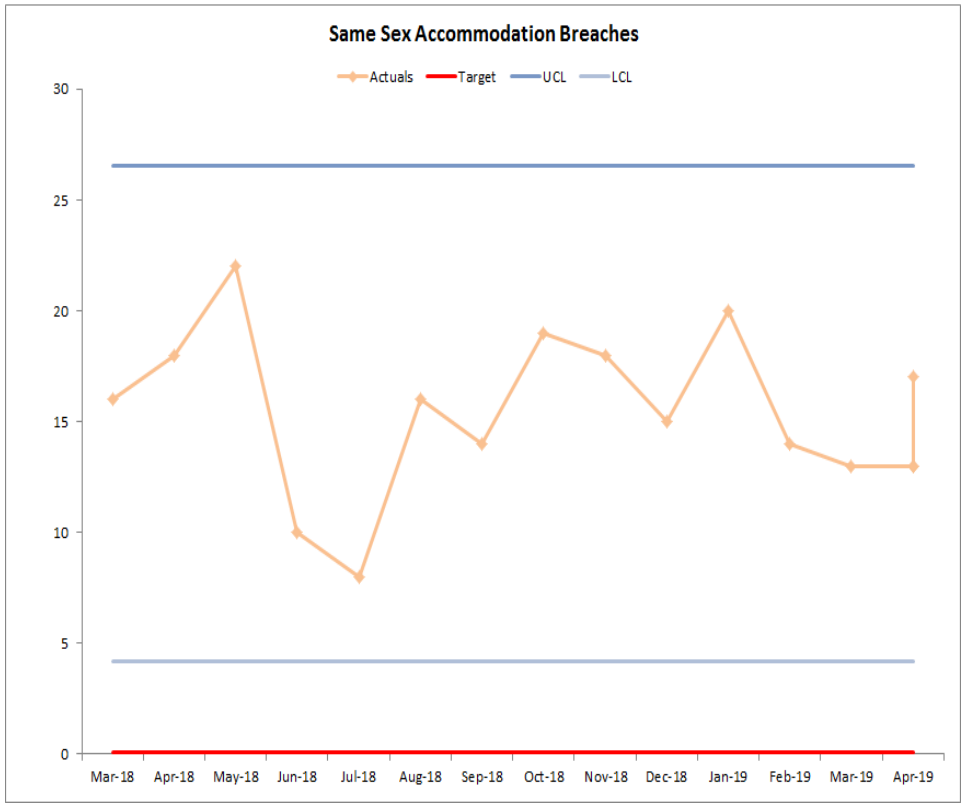
A national standard is set that providers should not have mixed-sex accommodation, except where it is the overall best interests of the patient or reflects personal choice. Patients in critical care areas do not count as a breach of these guidelines on clinical grounds, until 24 hours after they are well enough to be transferred to a more general ward area. WUTH breaches of the guidelines are consistently in relation to patients waiting more than 24 hours for transfer from critical care areas to general wards.

There are no adverse safety or quality implications identified as a consequence of these breaches in Intensive Care Unit (ICU)

Action:
Monitored daily via bed management processes. Capacity and demand / bed modelling being identified (TMB August) to ensure Trust has capacity to meet the needs of level one patients in general bed base.

Expected Impact:

At the present time we are not forecasting any material change.



FFT recommend rate: ED

Executive Lead:

Acting Chief Nurse

Performance Issue:

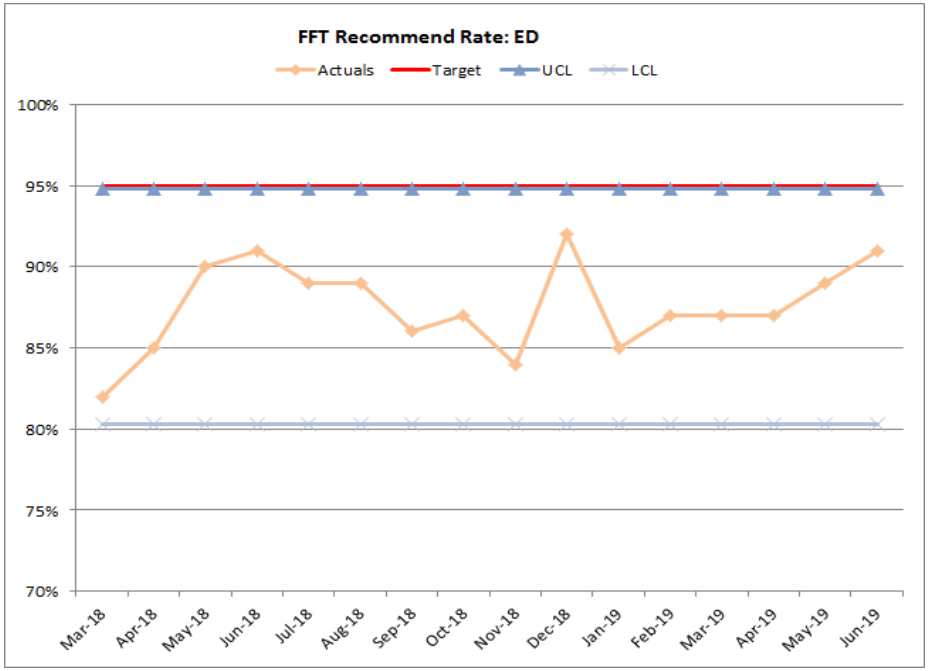
A WUTH target is set at a minimum 95% recommend rate. This standard is consistently not achieved, with the average for 2019-20 at 89%.WUTH has remained on an upward trajectory for this since December following actions below 2019

Action:

Additional patient experience rounds have been introduced in times of pressure apologising for delays and offering refreshments. Emergency Department (ED) have recruited to all nursing vacancies in this area enabling improvements in the quality and experience of care received.

Expected Impact:

It is anticipated the Trust will continue with an upward trajectory achieving compliance by Q4.



FFT overall response rate: ED

Executive Lead:

Acting Chief Nurse

Performance Issue:

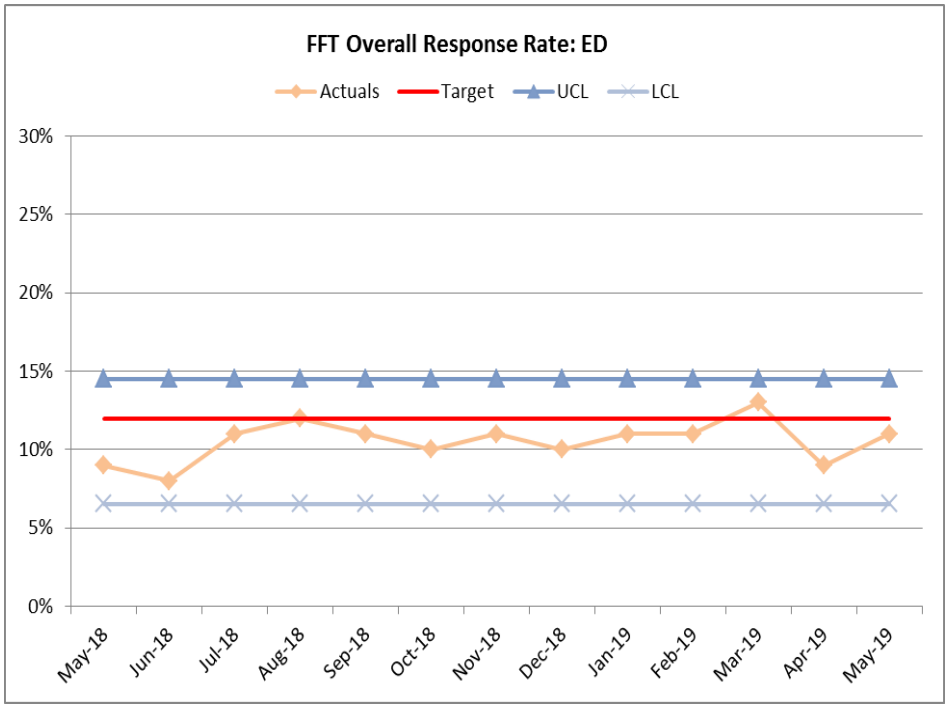
An internal WUTH target is set at a minimum 12% response rate. This has been achieved only twice in the last 12 months. The current average for 2019/20 is 10%. Children's ED only had a return of 29 exit cards out of a 1424 which equals 2% affecting overall performance. The response rate is broadly in line with the England average.

Action:

Children's ED introducing IPAD technology (Fabio Frog) and drawing cards to encourage children's feedback. Additional patient experience volunteers have been deployed to this area.

Expected Impact:

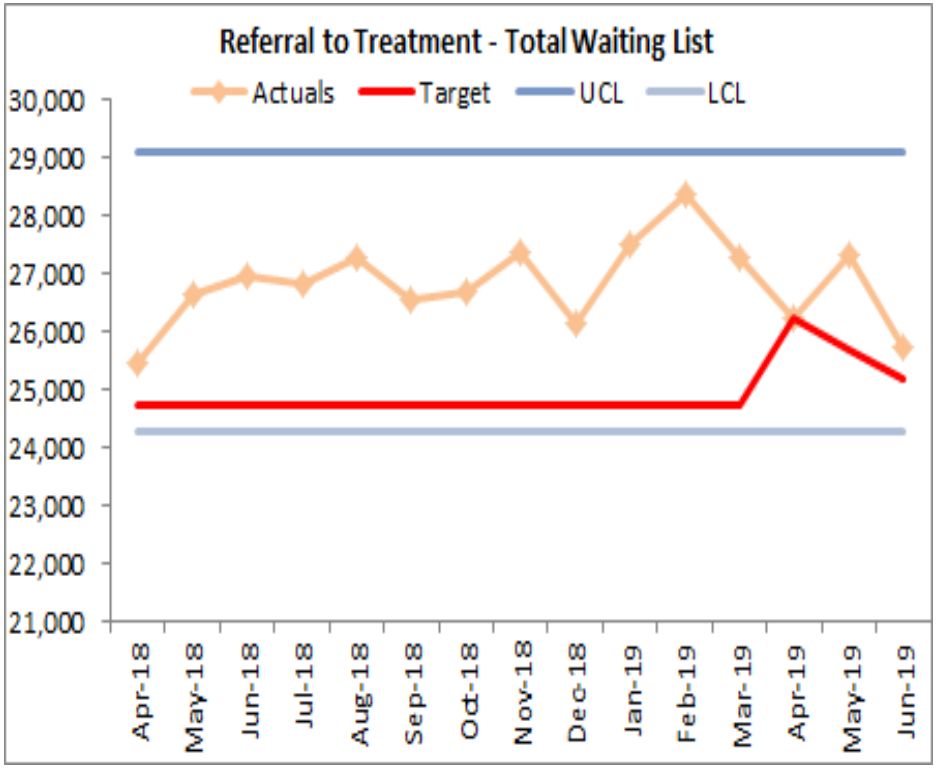
We anticipate the response rate to remain broadly in line with the England average.



Responsive Domain

Referral to Treatment: total open pathway waiting list

Executive Lead: Chief Operating Officer
Performance Issue: WUTH has an improvement trajectory set with NHSI to reduce the number of patients still waiting for treatment back to below the position in March 2018 by March 2020. The number waiting at the end of June was 527 higher than the trajectory for that month.
Action: Divisional plans are in place to reduce the total waiting list. Progress towards the target is monitored and managed via the weekly Senior Operations Performance Meetings chaired by the COO.
Expected Impact: The required reduction in RTT open waiting list is expected to be back on track by the end of July, which will meet the agreement reached with regulators following the MSK service change.



Cancer waiting times – 62 days to treatment

Executive Lead:

Chief Operating Officer

Performance Issue:

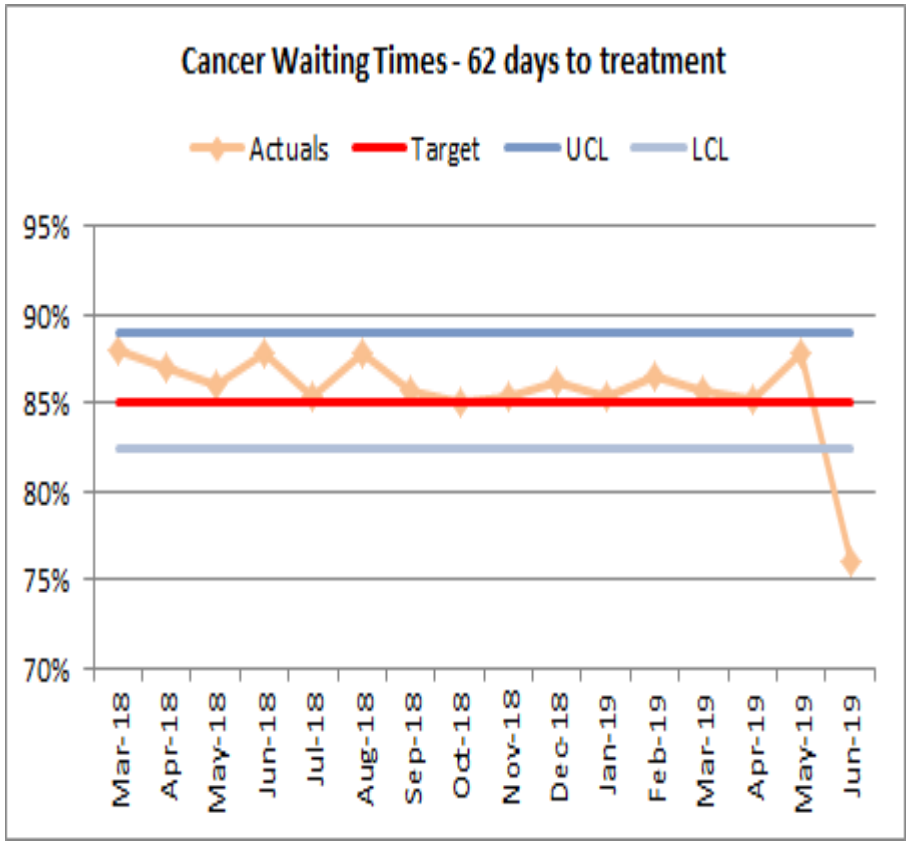
National cancer waiting time standards require a minimum of 85% of patients treated following urgent two week referral to commence that treatment within 62 days. For patients identified so far as treated in June 2019, only 76% were within 62 days.

Action:

Providers are judged on cancer waiting times on a quarterly basis, with no requirement to meet each standard in each month. Quarterly performance is also only finalised six weeks after quarter end, due to required confirmation of cancer status and shared pathways between providers. WUTH performance and any issues of concern are managed by weekly Senior Operations Performance Meetings.

Expected Impact:

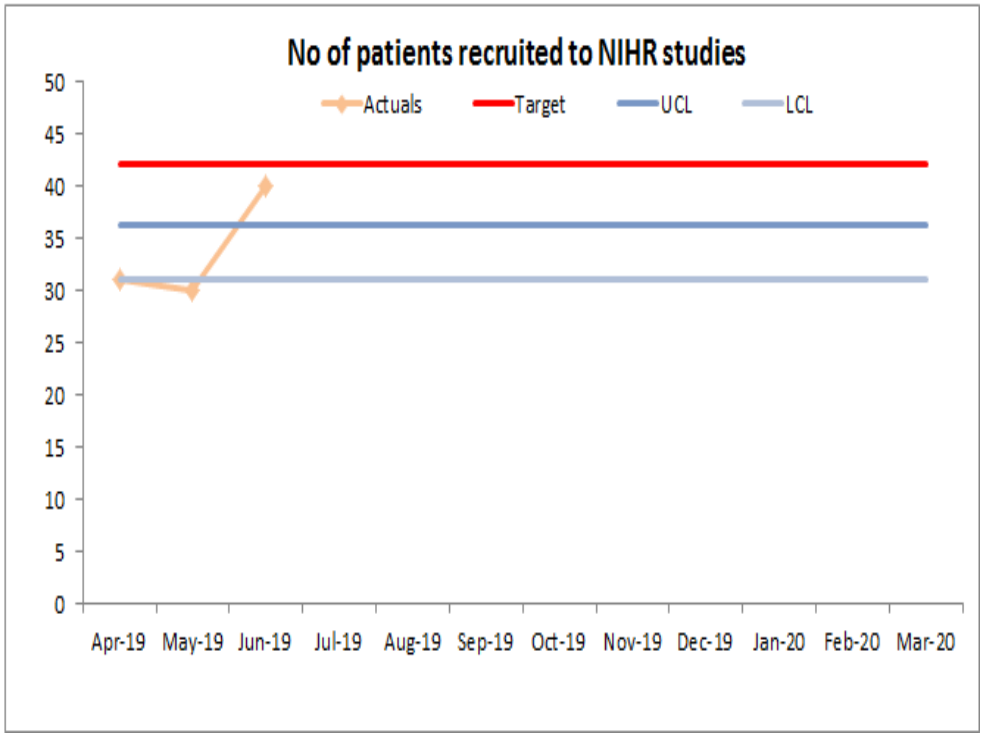
WUTH expects to meet all cancer waiting time standards for the quarter.



Well-led Domain

Number of patients recruited to National Institute for Health Research studies

Executive Lead: Medical Director
Performance Issue: A WUTH target had been set to recruit 500 patients to National Institute for Health Research (NIHR) studies in 2019-20. This had been based on 2018/19 data which included high volume recruitment to a questionnaire study in a single month.
Action: The aim is a 10% increase in the number of specialties involved in research, and to focus on high calibre research. The total number of participants recruited to trials will continue to be tracked. The Research Department will continue to ensure recruitment to open studies is maximised. 4 Clinical Research Leads, one for each Division, will be appointed. The overall aim of these new posts will be to promote and increase research activity.
Expected Impact: Increased opportunity for patients involved in high quality research.



Appraisal compliance %

Executive Lead:

Director of Workforce

Performance Issue:

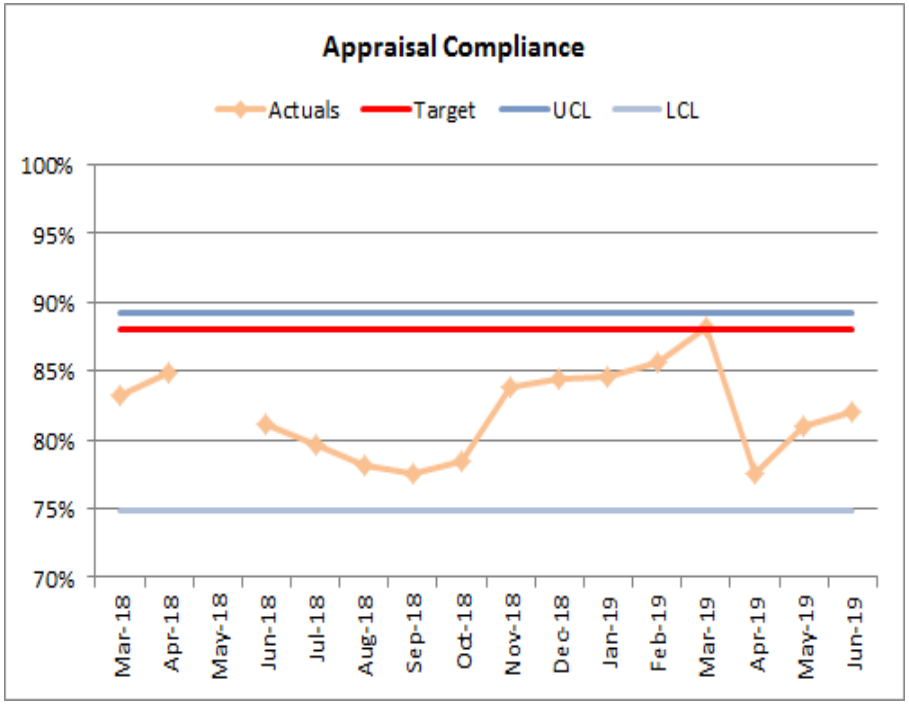
WUTH has a target set at a minimum 88% of staff to have had an appraisal within the expected timeframes. The 88% standard has not been achieved since March 2019, with the average for 2019-20 being 82.1%.

Action:

Introduction of revised appraisal process 'Contribution Framework' as part of the wider values and behavior work. Performance metric revised to reflect 12 month period as previously advised. Appraisal compliance is monitored through the Divisional Performance Reviews which is showing an upward increase.

Expected Impact:

Improved appraisal rate within the next 6 months.



Board of Directors	
Agenda Item	8.1.2
Title of Report	Month 3 Finance Report
Date of Meeting	7th August 2019
Authors	Shahida Mohammed, Acting Deputy Director of Finance
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 3 Finance Report 2019/20

Contents

1. Executive summary

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

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

The following summary details the Trust's financial performance during June (Month 3).

The plan to deliver a "breakeven" position has been profiled to reflect the anticipated delivery of cost reductions, QUIP and transformation schemes during the year.

On that basis for Mth 3 the Trust's planned an operational deficit of (c£1.0m), actual performance was a deficit of (c£0.1m), a favourable performance against plan of (c£0.9m).

The cumulative performance position is broadly balanced, the YTD plan is a deficit of (c£4.9m), and the actual position is a deficit of (c£4.8m).

1.1 Key Headlines

- To ensure a "break-even" position was achieved the Trust accessed "accelerated" support from WCCG of c1.4m, this will be repaid during Q3 and Q4.
- Delivering the plan or "control total" for Q1 ensured the Trust received FRF/PSF central monies of £1.9m.
- Excluding the additional support, the Trusts underlying position was a deficit of (c£1.3m).
- The key components of this position are:

	Qtr 1
Depreciation	(£0.3)
VAT (medical locums)	(£0.3)
Aseptic Unit - closure	(£0.2)
Divisional restructure	(£0.1)
18/19 costs	(£0.1)
Pay Pressures	(£0.4)
TOTAL	**(£1.4)**

- Patient-related income is broadly in-line with plan. Although elective activity under performed, this has been offset by the MSK "prime provider" contract benefit. Also the position reflects the application of local contract terms that support the Trust to deliver the control total.

- Pay costs exceeded plan by a further (£0.3m) in June, increasing the year to date overspend to (c£0.7m). The main driver is agency spend on Consultants to cover gaps and pressures in ED and includes the VAT pressure of (c£0.3m). Premium costs have also been incurred to cover gaps in the Junior Drs. rotas. Non pay costs were below plan by c£0.1m in month, however, this included exceptional items of a credit of £0.3m in respect of energy charges and a redundancy payment of £0.1m.

- Cash balances at the end of June were £3.5m which was £1.5m above plan. This is due to 19/20 opening cash above plan (£2.5m), EBITDA and donations above plan (£0.2m), and capital outflows below plan (£4.1m), offset by controlled variances in the working capital cycle (£5.3m).

- The delivery of cost improvements YTD is c£2.0m against a plan of £1.8m. This includes the exceptional energy credit received in month of £0.3m which has improved the delivery against the profile.

- Although the year to date capital spend is slightly behind plan (c£0.4m), the Trust is forecasting to deliver the revised capital plan submitted in July 2019. The plan has been reduced by £1.6m as a result of the national directive. The car park scheme will be deferred into 2020/21.

- The Trust delivered a UoR rating of 3 as planned.

2. Financial performance

2.1 Income and expenditure

Month 3 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	325,975	26,941	28,155	1,214	79,992	81,185	1,193
Non NHS income from patient care	3,382	276	287	11	815	957	142
Income - PSF/FRF/MRET	18,804	1,148	1,148	(1)	3,450	3,450	(1)
Other income	28,010	2,291	2,306	14	7,003	7,070	67
Total operating income before donated asset income	376,170	30,656	31,895	1,238	91,260	92,661	1,401
Employee expenses	(254,838)	(21,620)	(21,963)	(343)	(65,674)	(66,414)	(739)
Operating expenses	(108,129)	(8,956)	(8,880)	76	(27,261)	(27,699)	(438)
Total operating expenditure before depreciation and impairmer	(362,967)	(30,576)	(30,843)	(267)	(92,935)	(94,113)	(1,178)
EBITDA	**13,203**	**80**	**1,052**	**971**	**(1,675)**	**(1,452)**	**223**
Depreciation and net impairment	(9,219)	(743)	(804)	(61)	(2,230)	(2,413)	(183)
Capital donations / grants income	0	0	0	0	0	0	0
Operating surplus / (deficit)	**3,984**	**(663)**	**247**	**910**	**(3,905)**	**(3,865)**	**40**
Net finance costs	(4,233)	(348)	(345)	3	(1,039)	(1,031)	8
Gains/(losses) on disposal	0	0	0	0	0	0	0
Actual surplus / (deficit)	**(249)**	**(1,011)**	**(98)**	**914**	**(4,943)**	**(4,896)**	**48**
Reverse capital donations / grants I&E impact	249	21	21	(0)	63	63	(0)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	**0**	**(990)**	**(77)**	**914**	**(4,881)**	**(4,833)**	**47**

- Excluding the the additional support, the Trust's position for the period is an over-spend of (c£0.4m), and (c£1.3m) cumulatively.
- Some of the pressures are non recurrent, actions have been taken in relation to authorisation of non-core medical costs, all non-stock orders are now approved by Divisional Directors or Executive Directors only.
- 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 and provided some mitigation against clinical pay pressures.
- The Aseptic Unit is due to resume manufacturing in July, the remaining pressures need to be closely managed going forward.
- This is supported by the weekly "scrutiny panels" lead by the HR & Finance Executive Directors, which are now reviewing both clinical and non-clinical vacancies, non-core spend, discretionary non pay spend, medical agency staff 'hotlist' and tracking CIP deliverables. Medical rota pressures escalation is also to be introduced and managed at a higher level from this point forward.

Items not included in the original Plan

- **<u>Locum pay VAT</u>**

The Month 3 pay position includes the continuing impact of (c£0.3m) 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 and Finance teams have been working closely with the supplier during June 2019 to transition to an alternative model, which has been confirmed by HMRC as 'outside scope' for VAT, whereby locums pass through an outsourced pay-

roll as employees. This has been implemented and is operational from week commencing 8th July. This will mitigate the financial pressure going forward.

- **Depreciation**

  There is a pressure of (c£0.3m) 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£1.2m) are not included in the 2019/20 plan.

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 3 Budget Reconciliation	Breakdown by Budget Type		
	Income £'000	Expenditure £'000	Deficit £'000
Base Budget 19/20	91,466	(96,409)	(4,943)
CIP - Increase Clinical Income Oral Surgery	38	(38)	0
CIP - Realignment of Target	(30)	30	0
Extra Day adjustment value	(50)	50	0
NNU Block adjustment	20	(20)	0
Drugs inflation adjustment	28	(28)	0
Non Recurrent Income Targets	40	(40)	0
PbR excluded drugs, devices & bloods adjustment	(246)	246	0
Realignments	20	(20)	0
M3 Closing Budget	91,286	(96,229)	(4,943)
Net Trustwide (Increase)/Reduction	**(180)**	**180**	**0**

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	4,246	4,061	(185)	12,423	12,123	(300)	4,710	4,436	(274)	13,768	13,400	(368)
Elective excess bed days	290	308	18	833	874	41	79	86	7	227	216	(11)
Non-elective	3,747	3,550	(197)	11,196	11,067	(129)	8,201	8,279	78	24,518	24,618	100
Non-elective Non Emergency	404	439	35	1,176	1,307	131	892	941	49	2,582	2,803	221
Non-elective excess bed days	1,032	990	(42)	3,086	3,545	459	280	249	(31)	835	955	120
A&E	7,322	7,490	168	21,737	22,856	1,119	1,260	1,249	(11)	3,741	3,753	12
Outpatients	26,210	23,865	(2,345)	76,015	72,485	(3,531)	3,124	3,083	(41)	9,031	8,948	(83)
Diagnostic imaging	2,494	2,333	(161)	7,235	7,430	195	187	164	(23)	542	541	(1)
Maternity	467	485	18	1,391	1,494	103	426	426	0	1,291	1,307	16
Non PbR							6,501	8,012	1,511	19,475	20,801	1,326
HCD							1,195	1,195	0	3,703	3,703	0
CQUINs							186	186	0	559	559	0
PSF/FRF/MRET							1,148	1,148	(1)	3,450	3,450	(1)
Total NHS Clincial Income	46,212	43,521	(2,691)	135,091	133,179	(1,912)	28,189	29,453	1,265	83,722	85,053	1,332
Other patient care income							57	73	16	178	222	44
Non-NHS: private patients & overseas							30	19	(11)	90	96	6
Injury cost recovery scheme							89	44	(45)	267	220	(47)
Total income from patient care activities							28,365	29,589	1,224	84,257	85,591	1,335
Other operating income							2,291	2,306	14	7,003	7,070	67
Total income							30,656	31,895	1,238	91,260	92,661	1,401

- The income position includes the accelerated transformation support from Wirral CCG of c£1.4m. Excluding this the month 3 position is broadly balanced.
- The elective performance is driven by an under performance in Colorectal, Urology, Upper GI and T&O. The Orthopaedic under performance has been mitigated by the MSK block benefit of £0.6m.
- NEL activity slightly exceeded plan from an activity perspective, however the casemix was less complex. In-line with the contractual agreement for NEL cumulatively c£0.8m has been included reflecting the support from Wirral CCG.
- Although overall Outpatients attendances are under performing, for Wirral CCG the position is supported by the "block" agreement.
- Year to date Obstetric activity exceeds plan by 70 spells, benefitting the position by c£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 exceed plan by (£0.3m), increasing the cumulative overspend to (c£0.7m).

The table below details pay costs by staff group for June and cumulatively.

STAFF GROUP	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
CONSULTANTS	(3,357)	(3,650)	(293)	(10,079)	(10,806)	(727)
OTHER MEDICAL	(2,398)	(2,556)	(158)	(7,217)	(7,690)	(473)
TOTAL MEDICAL	**(5,755)**	**(6,205)**	**(450)**	**(17,295)**	**(18,496)**	**(1,200)**
NURSING & MIDWIFERY	(6,142)	(5,932)	210	(18,663)	(18,056)	607
CLINICAL SUPPORT WORKERS	(3,991)	(4,179)	(188)	(12,168)	(12,633)	(465)
TOTAL NURSING	**(10,133)**	**(10,111)**	**22**	**(30,831)**	**(30,689)**	**142**
AHP'S, SCIENTIFIC & TECH	(2,620)	(2,666)	(46)	(8,000)	(8,126)	(126)
ADMIN & CLERICAL & OTHER	(3,112)	(2,981)	131	(9,548)	(9,103)	445
TOTAL	**(21,620)**	**(21,963)**	**(343)**	**(65,674)**	**(66,414)**	**(739)**

- The table above details pay (for all substantive and non-core spend) by staff category.
- The spend on Consultants reflect pressures in some specialties where agency is being used and premium costs are incurred to cover vacancies and sickness as well as the use of WLIs.
- Other medical pressures reflect shortages in the trainee grades on the February rotation. There is a medical staffing review underway to understand the issues/impact of the trainee grades and alternatives for managing the rotas. The junior doctor rotation for August 2019 looks to be more favourable, which will alleviate some of the additional costs.
- Nursing and midwifery staff costs are underspent reflecting the levels of qualified nursing vacancies across the organisation. Following the nurse review last year the ward budgets now reflect the approved ward staffing models including the new nurse investment in the Acute Medicine Unit and the Bed Management Team, substantive recruitment initiatives are ongoing. Costs in relation to clinical support workers and trainee nurse associates, partially mitigating the nurse vacancies.
- The position in relation to administrative and infrastructure posts reflect vacancies which has supported the non pay overspends in certain areas.

The table below details pay costs by category for June and cumulatively

Pay analysis	Annual Budget £'000	Current period Budget £'000	Current period Actual £'000	Current period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(243,110)	(20,553)	(19,523)	1,030	(62,494)	(59,214)	3,280
Bank	(241)	(20)	(916)	(896)	(64)	(2,673)	(2,608)
Medical bank	(3,072)	(315)	(687)	(372)	(909)	(1,923)	(1,014)
Agency	(7,415)	(650)	(750)	(101)	(1,956)	(2,359)	(403)
Apprenticeship Levy	(1,000)	(83)	(87)	(3)	(250)	(245)	5
Total	(254,838)	(21,620)	(21,963)	(343)	(65,674)	(66,414)	(739)

- The underspend in substantive costs increased further, offset by an increase in non-medical bank staff costs.
- Agency costs are £0.4m above the NHSI cap as at the end of Month 3. The NHSI agency cap was set before the VAT implications of the current medical locum provider contract that occurred in the latter months of last financial year, this represents a pressure of c£0.1m per month.

2.5 Non pay

Non Pay Analysis	Annual Budget £'000	Current period Budget £'000	Current period Actual £'000	Current period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
Supplies and services - clinical	(34,190)	(2,841)	(2,931)	(90)	(8,556)	(8,739)	(183)
Supplies and services - general	(4,578)	(375)	(386)	(11)	(1,137)	(1,172)	(34)
Drugs	(23,506)	(1,857)	(1,821)	36	(5,713)	(5,683)	29
Purchase of HealthCare - Non NHS Bodies	(7,490)	(619)	(646)	(27)	(1,916)	(1,993)	(77)
CNST	(12,948)	(1,128)	(1,128)	0	(3,385)	(3,385)	0
Consultancy	(0)	(0)	(20)	(20)	(0)	(96)	(96)
Other	(25,418)	(2,136)	(1,949)	188	(6,554)	(6,632)	(77)
Total	(108,129)	(8,956)	(8,880)	76	(27,261)	(27,699)	(438)

- Non pay expenditure is (c£0.4m) above plan as at the end of Q1 as detailed in the table above and below plan in June.
- Clinical supply costs are showing a pressure and largely reflect increased activity and acuity, the year to date position also includes theatre loan kit costs some of which relate to 2018/19.
- Purchase of healthcare non-NHS is largely in Radiology and reflects capacity constraints and the use of outsourcing for radiology reporting.
- Consultancy costs continue in-month largely to support transformation and governance. This cost is offset by vacancies in these areas.
- Other costs include all areas of discretionary spend which are reviewed in detail at the monthly scrutiny panel. The June position reflects the energy rebate credit in Estates. This category also includes the impact in mth and year to date of the closure of the Aseptic Unit.

2.6 CIP Performance

Programme	Executive Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	In Year Forecast Fully Developed £k	In Year Forecast Variance £k	In Year Forecast In Progress £k	In Year Forecast Total £k	In Year Forecast Variance £k
Transformation										
Patient Flow	Antony Middleton	377	294	(83)	1,500	1,417	(83)	0	1,417	(83)
Theatre Productivity	Antony Middleton	199	55	(144)	1,000	445	(555)	411	856	(144)
Outpatients	Antony Middleton	225	225	**0**	1,000	1,000	**0**	0	1,000	**0**
Demand Management	Antony Middleton	15	0	(15)	500	0	(500)	500	500	**0**
Digital	Paul Charnley	92	4	(88)	500	0	(500)	399	399	(101)
Sub total - transformation		**909**	**579**	(330)	**4,500**	**2,862**	(1,638)	**1,310**	**4,172**	(328)
Quipp & Cross cutting workstreams										
Workforce	Helen Marks / Tracy Fennell	0	0	**0**	1,500	0	(1,500)	1,475	1,475	(25)
CNST	Antony Middleton	0	0	**0**	653	590	(63)	0	590	(63)
GDE	Paul Charnley	0	0	**0**	500	500	**0**	0	500	**0**
Endoscopy	Antony Middleton	0	0	**0**	150	0	(150)	13	13	(138)
Meds Management	Pippa Roberts	102	121	**20**	568	471	(97)	97	568	(0)
Procurement	Karen Edge	69	78	**9**	526	359	(167)	146	504	(21)
Tactical and transactional										
Divisional and Departmental	Divisional Directors	759	1,246	**487**	4,784	3,764	(1,020)	994	4,758	(26)
Unidentified		0	0	**0**	0	0	**0**	0	0	**0**
Total		**1,838**	**2,025**	**187**	**13,181**	**8,546**	(4,634)	**4,033**	**12,579**	(601)

- As at the end of Q1 the CIP delivery is £0.2m above plan as detailed in the table above, this has been supported by non-recurrent CIP. Of the £2m delivered to date there is £0.8m non-recurrent CIP including a £0.3m energy rebate credit in June.
- The key transformational variances reflect productivity gains expected from the perioperative / theatre productivity programme based on specialty theatre KPIs in Ophthalmology, Urology and Colorectal, work continues to track theatre utilisation across other specialties. The Patient flow position reflects the net impact of costs, the outpatient scheme is progressing. The transformational schemes are mitigated in the financial position by the allocation of the Growth reserve to Divisions during budget setting.
- Part of the efficiencies from the digital transformation schemes have been subsumed into the review of the admin. and clerical function, the remaining target will be redistributed to all Divisions including Corporate areas.
- The workforce cross cutting schemes are profiled to deliver from Q2 and are progressing.
- The business as usual (BAU) schemes from the divisions are well under way and any shortfalls have been largely mitigated by non re-current vacancies in addition to the energy rebate credit.

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%	-17.0	4	-15.9	4	-30.4	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-1.5	4	-1.3	4	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-5.3%	4	-5.2%	4	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	0.1%	1	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	0.0%	1	21.0%	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, and this went live on 8 July.
- The *Distance from financial plan* metric is currently above plan as a result of the year to date EBITDA position.
- The month 3 UoR rating is 3 overall, which matches the 2019/20 plan UoR rating of 3.

4. Forecast

The Trust has completed a detailed bottom up forecast for Q2 and is forecasting a (£2.5m) cumulative deficit. Assuming a steady run rate, excluding non-recurrent pressures and recovery of slippage on CIP, a (£4.3m) deficit is predicted at year end.

The key components of the forecast position are included in the table below:

Forecast Outturn (2019/20)	£m
Medical Locums VAT	(0.3)
Depreciation Charges (RICS change)	(1.2)
Aseptic Unit Closure/PY charges	(0.3)
Clinical Pay Pressures	(4.6)
Corporate Pay Underspends	1.5
Business Case Slippage	0.6
TOTAL	**(4.3)**

The medical locum VAT issue and the depreciation charges were known risks that were not included in the plan. The VAT issue has been resolved from July.

The Aseptic Unit closure was unplanned and unexpected. This will become fully operational from September. This accounts for a pressure of £0.2m. A further pressure of £0.1m in respect of theatre loan kit from the prior year is included in the Q1 position.

The clinical pay pressures are predominately related to temporary medical staffing premium costs to cover vacancies in consultants and gaps in the junior doctor rotation. It was expected at the time of agreeing the plan that temporary medical staffing costs would be a continuing pressure in Medicine and that they would be mitigated due to the high levels of nursing vacancies,similar to 18/19, and that the gaps in nursing rota's would not be filled by NHSP bank. In addition there was also an assumption of a level of corporate pay underspends.

Whilst Nursing is not overspent overall, the expected level of underspend has not occurred due to an increase in the "fill" rates on NHSP bank. The actual "fill" rate in Q1 (18/19) was 57%, compared to 71% in Q1 (19/20)..

In addition, the level of temporary medical staffing pay pressures has been compounded due to a less than favourable February rotation of junior doctors and the level of consultant vacancies in Surgery.

The next junior doctor rota from August is more favourable and should reduce the need for temporary cover for this group of staff.

The Trust has received additional non-recurrent support from Wirral CCG in Q1 to ensure the PSF/FRF is received and the system benefit is achieved.

The Trust has identified further mitigations of £0.8m against the current forecast deficit as detailed in the table below:

Actions to reduce the deficit further	Cost Reductions Per Mth £k	Full Year Impact £k	Risk Rating	Date
Reduce planned staffing in the RCA/ED	20	160	A	Aug-19
Impact of addl control on discretionary spend	40	360	G	Jul-19
Reduce sickness levels - pro-active management E&HS	30	180	A	Sep-19
Use of Research Accounts	10	70	A	Aug-19
Revenue-Capital Transfers	50	50	G	Oct-19
TOTAL	**150**	**820**		

This reduces the forecast deficit to (£3.5m) which has been shared with Healthy Wirral partners and for which system mitigation is being developed. It should be noted that no winter costs have been assumed in this forecast.

The Trust continues to seek further mitigation and a detailed review of temporary medical staffing costs is to be provided to an extraordinary meeting of FBPAC in August.

5. Risks & Mitigations

Risk 1 - Operational Management of the position

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

Risk 2 – CIP Performance

- Performance against milestones is monitored on a weekly basis by the Executive Directors with weekly CIP gateway monitoring of all programmes.
- Support from the Service Improvement team to ensure transformation schemes are delivered and the pace is maintained to deliver productivity improvements on flow and efficiency.
- 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 schemes 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 asked trusts to adjust capital expenditure plans as the initial plans were too high, at a national level, for 2019/20. Initially, the Trust refused, on the basis that capital plans were based on necessity. Subsequently, a 20% reduction was nationally mandated. The Trust has therefore deferred £1.6m (17.5%) to 2020/21 in relation to the Car Park scheme. The adjusted capital plan for 2019/20 is £7.5m.

6. Conclusion

Although the Trust's cumulative underlying position at Qtr 1 is a deficit of (c£1.3m), Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan. The weekly executive lead scrutiny panel is also reviewing both clinical and non-clinical vacancies.

Exceptional items such as the impact of VAT on medical locums and depreciation have impacted the position (c£0.6m) year to date. The VAT issue will abate from early July as an alternative VAT compliant model has been adopted.

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 in further premium costs in Month 3.

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 3 plan was exceeded. The meetings are chaired by the Chief Executive.

The 19/20 plan was 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.

This was further evident in the "accelerated" support offered by Wirral CCG of c£1.4m to ensure the control total for Qtr 1 was achieved, thus enabling the Trust and the System to receive the PSF/FRF allocation of £1.9m.

Going forward the Trust is actively working with partners in the Wirral System to develop a system-wide financial recovery plan for 2019/20, to ensure the control total for both the Trust and the System are delivered, which will enable the full allocation of PSF and FRF monies to be accessed.

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

Karen Edge
Acting Director of Finance
August 2019

Board of Directors

Subject:	Agenda 9.1 Proceedings of the Quality Committee	**Date:** 7.8.2019	
Prepared By:	Steve Igoe, Non-Executive Director		
Approved By:	Steve Igoe, Non-Executive Director		
Presented By:	Steve Igoe, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**None identified**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care:** • **Exposure to infection and infection control indicators (beyond trajectory level for C.diff)** • **Quality dashboard improving but not yet completely reassuring** • **CQC plan on track** • **Attendance management – introduction of services to support return to work and manage short term periods of absence.**
Staff Impact	**Staff vacancy, attendance management and completion of mandatory training requirements represent a risk to workforce effectiveness**
Services	**None identified**
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.** **CQC Insight Tool improved – noted time lag with some data therefore may not be in line with Trust data.**

Committees/groups where this item has been presented before

N/A

Executive Summary

Executive Summary

- The Quality Committee met on 24/07/2019. This paper summarises the proceedings.

Patient Safety Quality Board (PSQB) - matters relating to the reports for June and July

- The apparent increase in mortality is being monitored. Whilst rates remain below expected levels, the trajectory is deteriorating.
- Positive assurance was given on the clinical audit programme.
- The work on the CPR training plan and the need for greater clarity on the extent of the issue and the mitigations in terms of training and plan.
- The successful and embedded nature of the controls in relation to serious incident handling and the fact that Duty of candour requirements had been assured for all qualifying incidents since September 2018.Root cause analysis confirms key causes for such incidents as relating to; failure of communication, failure to follow policy, poor documentation or failure to complete adequate patient assessments.
- Positive assurance on Nutrition and Hydration with the >95% compliance rating for MUST assessments being achieved.
- The ongoing challenges with Infection prevention and control. The trust is performing well against a zero tolerance for MRSA with no bacteraemia reported in Q1.More generally significant progress has been made against the trust wide action plan although IPC remains the highest operational risk within the Trust.

Quality Dashboard

- 2 C-diffs recorded in July, down from 11 in July. Cautious optimism that the execution of the plan referred to above was having some effect however it is too early to confirm that the issue has been resolved.
- Strong performance on hand hygiene recorded in June of 98%.
- VTE for all patients continues to be in excess of 96%
- Sickness and absence rates continue to be higher than the Trust would wish .Work is ongoing on employee support programmes. IT was agreed that the headline figures may be skewed due to certain types of illness i.e. long term versus short term and that greater granularity was necessary to understand the detail. For example Estates was running at 12%. This will be reviewed by the Workforce Assurance Committee.

Serious Incidents & Duty of Candour

- Positive assurance that the trust remains at or below the Trust's threshold for serious incidents declared since July 2018.
- Failure to follow policy was the most frequently cited root cause with communication as the most frequently cited contributory factor.

Update on CNST Maternity Incentive Scheme

- Received a detailed report on the trust's compliance with the 10 standards and assurance of evidence required. We discussed the contents of the paper and recognised the fact that it was only recently that the Trust had been able to satisfy all 10 requirements .We recognised the substantial financial benefit in so doing, i.e. a reduction of 10% on the Trust's CNST premium amounting to £590k. The Committee were content to approve the paper as presented and to recommend to the Board its approval.

CQC Insight Tool

- The Committee noted that this reported data as gathered by CQC and recognised the time lag with some of the data meaning it was not as contemporaneous as might be the case with the Trust's data. It was accepted that the report probably needed some further expansion to explain what the Trust was doing in relation to the data although it was accepted that this detail is probably held in other reports and therefore this detail might be best reproduced here to effectively close off the report .

CQC Action Plan Report

- The Committee noted the strong performance in resolving the numerous issues in the original CQC action plan. As discussed at the Board the Committee supported the removal of the flow actions as being separately managed and that the plan was on track to be fully completed and laid down in advance of any subsequent CQC visit.

Board Assurance Framework and Risk Register

- The Committee reviewed the BAF, risk register and contents. The Committee considered the individual elements delegate to the Quality Committee. The Committee confirmed that the information included including risks and mitigations were appropriate in the circumstances . The Committee also confirmed that to the best of its knowledge there were no gaps in coverage.

Matters for the Board

The Committee asked that the Board :

- Notes the ongoing work on Infection Prevention and Control and the cautious optimism regarding C-Diff notifications.
- The recommendation to approve the Trust's compliance with the CNST scheme.
- The positive assurances in relation to the management of serious incidents and the application of the Duty of Candour.
- The positive consideration and confirmations regarding the BAF and Risk Register.

Summarised and drafted by the Quality Committee Chair by:
Steve Igoe
30th July 2019

BOARD OF DIRECTORS	
Agenda Item	9.2
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	7.8.2019
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

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

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

1. BAF

The Committee reviewed the primary risk scenarios of the BAF for which it has delegated responsibility from the Board. It noted the changes to risks, assurances and controls proposed by the Acting Director or Finance and Chief Operating Officer and these were agreed. In particular, the score related to delivering the annual control total was changed from 15 to 20 as a result of the underlying Q1 financial performance and uncertainties regarding mitigations.

The assurance ratings based on the identified risks were considered by the Chair and were unchanged. The ability to make a judgement on cyber security was questioned and it was agreed that a report would be provided in future meetings.

2. Month 3 Finance Report

The committee received the Month 3 Finance report. The key points noted were the year to date deficit of (£4.8m), this being £0.1m better than plan. However, this includes £1.3m of additional non-recurrent support from the CCG to achieve the Q1 planned position. The underlying deficit is (£1.3m) worse than plan and the adverse performance has been driven primarily by the costs of covering higher than expected consultant and junior doctor vacancies, the additional depreciation charges as a result of RICS guidance and the VAT impact of the medical locum supply. Income performance is balanced to plan and some under-performance in elective activity has been offset by higher birth and diagnostic income.

The committee discussed the reasons for the financial overspends occurring so early in the year and why this had happened after the high level of assurance provided by the executive team when the plan was agreed. The principal reason was cited to be medical pay and the cost of using locums to cover consultant vacancies and gaps in the junior doctor rotas. The assumption at budget setting was that underspends from nursing vacancies would be available to cover medical pay but NHSP has been successful at achieving higher fill rates in nursing and this has reduced the underspends available. The chair asked for an extraordinary meeting of the committee to be held in August to undertake a deep dive on medical pay as although there is work going on in this area there was no assurance given regarding a timescale for a reduction in the medical paybill.

The Trust delivered £2.0m against a plan of £1.8m CIP for Q1. Significant progress was noted against the Trust target of £13.2m with £12.6m of schemes identified.

Cash at £3.5m was favourable to plan. The capital spend year to date totalled £0.4m with a forecast of £7.5m; the submitted plan to NHSI being £9.1m. The Trust at the request of the central capital team and NHSI/E have agreed to defer £1.6m of spend to 2020/21 being the car park scheme which is deemed a low clinical risk.

3. Q2 and 19/20 FY Forecast

The Acting Director of Finance presented the committee with the Q2 and FY forecast. The full year forecast assuming current slippage on CIP is recovered is a (£4.3m) deficit and a further £0.8m of mitigations have been identified, leading to a position of (£3.5m) deficit. Key pressures excluding known exceptional items such as depreciation and VAT include temporary medical staffing costs to cover vacancies and junior doctor gaps. The Trust has shared the position with the local system as a Financial Recovery Plan is being sought from the system by NHSI/E and any system mitigations will first support the gap against plan. The position does not include any costs for winter and assumes full delivery of CIP and assumes system support to ensure full recovery of PSF/FRF.

4. Financial Strategy Update

The Acting Director of Finance presented a Financial Strategy update which incorporated financial modelling over the 4 year period from 2019/20 and which outlined a likely scenario of a system aligned approach of management of growth and a joint approach to delivery of financial sustainability. CIP resulting from the scenario would be c3.5% pa with 1.6% to be delivered through internal improvement strategies and the balance for the system to manage through the Healthy Wirral programme. Further work is required to develop the strategy to inform the LTP submission in Sept/Nov by reference to the expected Estates and Clinical Service Strategies also due in Sept. The committee discussed the need for major capital requirements to be included in the strategy to support the development of the Clatterbridge site in particular and it was agreed that a high level plan should be developed for inclusion.

5. Update on the 6 Facet Survey

The Chief Operating Officer presented a report on the progress of the 6 Facet survey. The key points noted were the value of the current backlog maintenance at Arrowe Park at £33m and Clatterbridge as £5m, high risk elements totalled £7m. These values were in line with the Associate Director of Estates expectations. In addition, space utilisation was found to be pressurised at Arrowe Park with opportunity for expansion at Clatterbridge which fits with the expected Clinical Services Strategy of an elective hub being located at Clatterbridge. The environmental management audit was noted as positive with energy efficiency gains achieved in excess of targets. The committee was assured that the survey had not revealed any major new risks to the estate but were keen to see more detail in view of the fact that it was a substantial piece of work. The full assessment and evaluation will support the development of the Estates strategy due in September.

6. Quality Performance Dashboard

The Chief Operating Officer presented the 'responsive' element of the Quality performance dashboard. Discussion took place in regard to the improvement over recent months in the A&E performance and ambulance handover facilitated by the opening of the new area (RCA) to support ED capacity which was significantly reducing corridor care. The total waiting list size was higher than trajectory but showing improvement and is expected to meet the required target by July as agreed. Cancer targets have been delivered for the Quarter despite pressures on the 2ww target due to consultant sickness absence.

In addition, it was noted that c-diff performance continues to be a concern and an update on the improvement plan was provided by Paul Moore.

7. Cheshire & Merseyside Collaboration @Scale

The Acting Director of Finance presented to the Committee a brief report on the work of the above programme. It was noted that opportunities have been identified and are being scoped but benefits at an organisational level are yet to be attributed. The Trust will continue to engage with the programme.

8. Terms of Reference

An updated Terms of Reference was tabled and agreed.

9. Reports from other committees

The committee received and noted the report from:

- Finance and Performance Group

10. Recommendations to the Board

- To note the risk of non-achievement of the financial control total and subsequent loss of central funding.

Board of Directors	
Agenda Item	9.3
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	7 August 2019
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Charitable Funds Committee 30 July 2019

This report provides a summary of the progress of the Charitable Funds Committee which met on 30 July 2019. The Committee welcomed Public Governor, Paul Dixon, in attendance for the first time.

1. Head of Fundraising Report

The Committee was very pleased to see progress since the last meeting. Key developments are as follows.

- Charity Office opening
- Website launch: wuthcharity.org
- Recruitment of a Community and Events Fundraiser
- Events, such as the Wirral Coastal Walk
- Cross-team working on *sponsorship procedures* for completion in 2019
- *Tap to donate* units
- Tiny Stars appeal launch, and the Arrowe Park Abseil

The Committee was interested to hear some ideas relating to staff and visitor engagement and service, and income generation, in the vicinity of APH main entrance, with proposals being drawn up for consideration in 2019.

2. Tiny Stars Appeal

The Head of Fundraising gave a comprehensive update on the appeal, including brand and resources, the launch and abseil, and engagement plans. A business case was also presented which outlined the appeal's ambitious financial targets, project risks, and project planning.

A further post was approved, and it was agreed that resourcing would be revised at the end of 2019/20, to ensure that the Charity team would be well-positioned to take advantage of all opportunities arising.

3. Community and Events Fundraiser (CEF) – First Impressions and Future Look

The Committee was impressed with the enthusiasm and commitment of the Charity's latest recruit, who has experience in leading volunteer teams. Future events such as the Charity Golf Day at Wallasey Golf Club and a Zumbathon were discussed. The CEF's targets include growing the team's volunteer capacity, and connecting with the local community in 2019.

4. Finance Report

- The income, expenditure and closing positions, as at 31 March 2019 and 30 June 2019, for each of the Charity's funds were presented and reviewed.
- The administrative fee for 2019/20 was approved, with no increase from 2018/19.
- The method of apportionment of overheads to funds was adjusted to better reflect activity undertaken, whilst supporting funds with lower balances. The Charity team plans to re-engage with champions of the specialty funds to boost incomes.
- The Charity's Reserves Policy was temporarily suspended to enable the formal approval of an expenditure request (c.£220k) for the trust-wide replacement of patient amenities (mostly bedside furniture). The Charity team continues to work on an external grant relating to this project.

5. Other items

The Charity's updated Risk Register was approved, and the Terms of Reference were also approved for recommendation to the Board.

6. Recommendations to the Board of Directors

The Committee wishes to bring to the Board's attention the following items.

- The significant progress made across a number of key workstreams, including the launch of Tiny Stars.
- The approval of a significant expenditure project to improve the Trust's inpatients' experience (c.£220k).
- The approval of an additional post, primarily in support of the Charity's appeal targets, specialty funds, and to further progress community projects.
- Recommendation of the Committee's Terms of Reference for approval (Appendix 1).

Board of Directors	
Agenda Item	9.4
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	7th August 2019
Author	Joe Gibson, External Programme Assurance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Choose an item	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

SUMMARY

1. Overview

The scope (see slide **2**) of the Change Programme has changed during the past month. The 'Improving Patient Flow' programme of work has added a project: 'Assessment Review' for which Shaun Brown will be the Corporate Lead under the sponsorship of Nikki Stevenson as Senior Responsible Owner (SRO).

Otherwise, the Executive Team continues 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

In line with previous advice, 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 and one project moving from amber to red. For the sake of clarity, amber rating remains indicative of substantive issues albeit considered within the competency of the project team to resolve. The areas for attention of project teams remain the definition and realisation of benefits and robust tracking of milestone plans.

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 slide **7**.

2.3 Outpatients. The metrics for the Outpatients project are shown at slide **8**.

3. Service Improvement Team

Recruitment into the new Service Improvement Team (formerly known as the Strategic Transformation Team) structure is ongoing; Appendix 1 refers. Interviews for the Lead role will

take place on 29th July 2019 with a 'cascade' of interviews on 13th, 14th and 15th August to appoint to Band 8a, Band 7, Band 6 and Band 5 roles.

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 17th July 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.

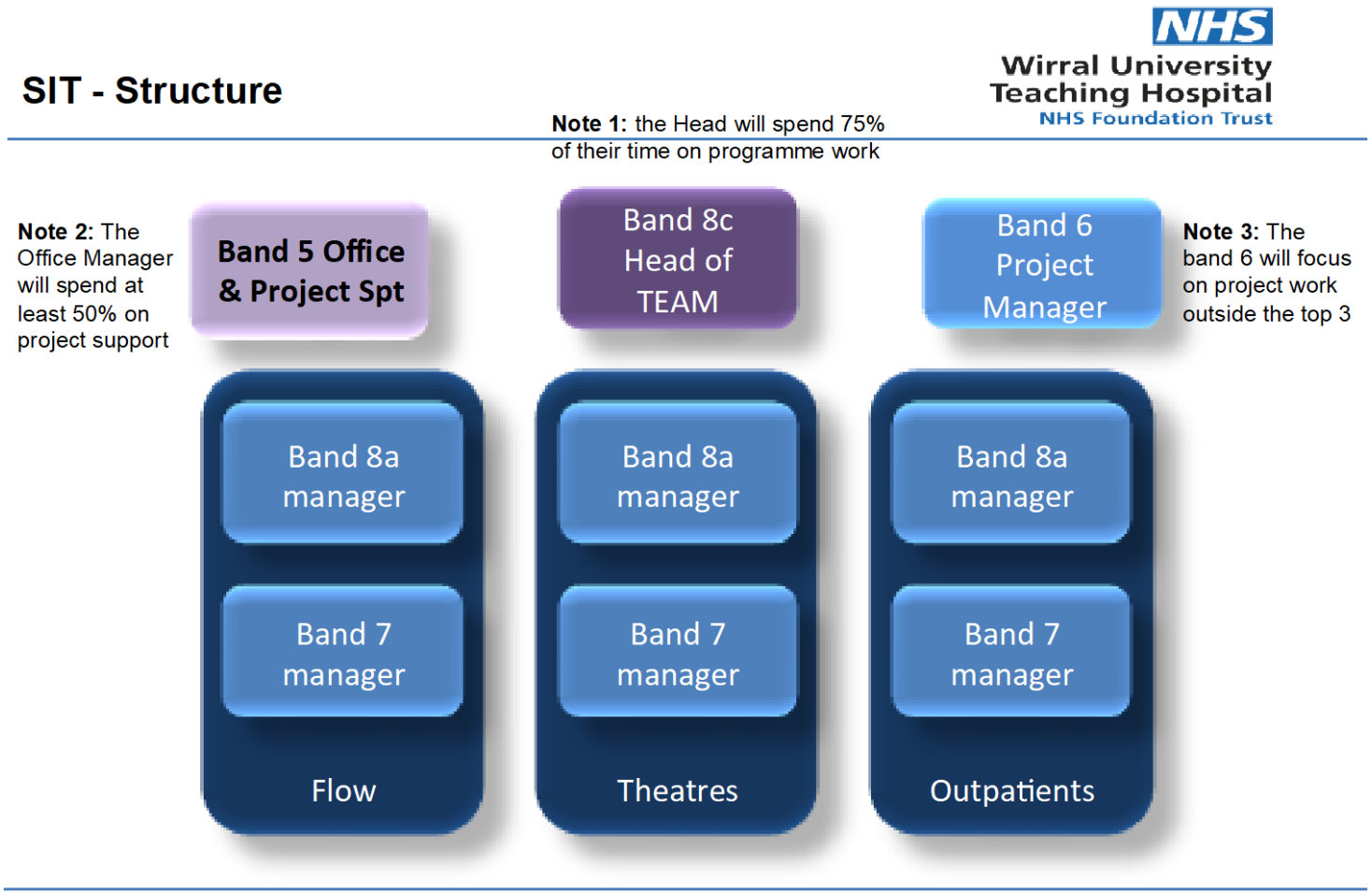
The first page (slide **10**) of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress.

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.

Appendix One – Resource Structure of the Service Improvement Team



Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

External Programme Assurance

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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

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

Operational Transformation
SRO - Anthony Middleton

- P Perioperative **Lead: Jo Keogh**
- P 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**

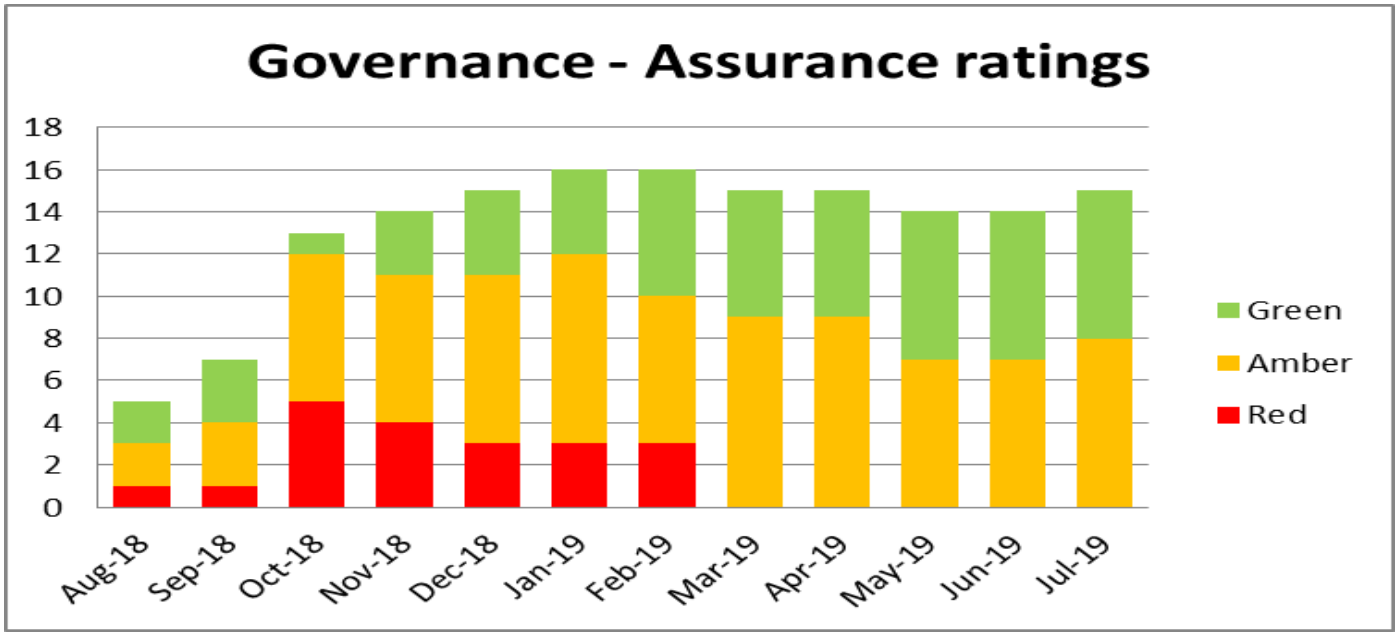
Partnerships (GDE Enabled)
SROs - per programme

- **Healthy Wirral** Medicines Optimisation **Lead: Pippa Roberts**
- S **Wirral West Cheshire Alliance** Pathology **Lead: Alistair Leinster**

Change Programme Assurance Report - Trust Board Report - July 2019

S Brimble – Project Support

Wirral University Teaching Hospital NHS Foundation Trust



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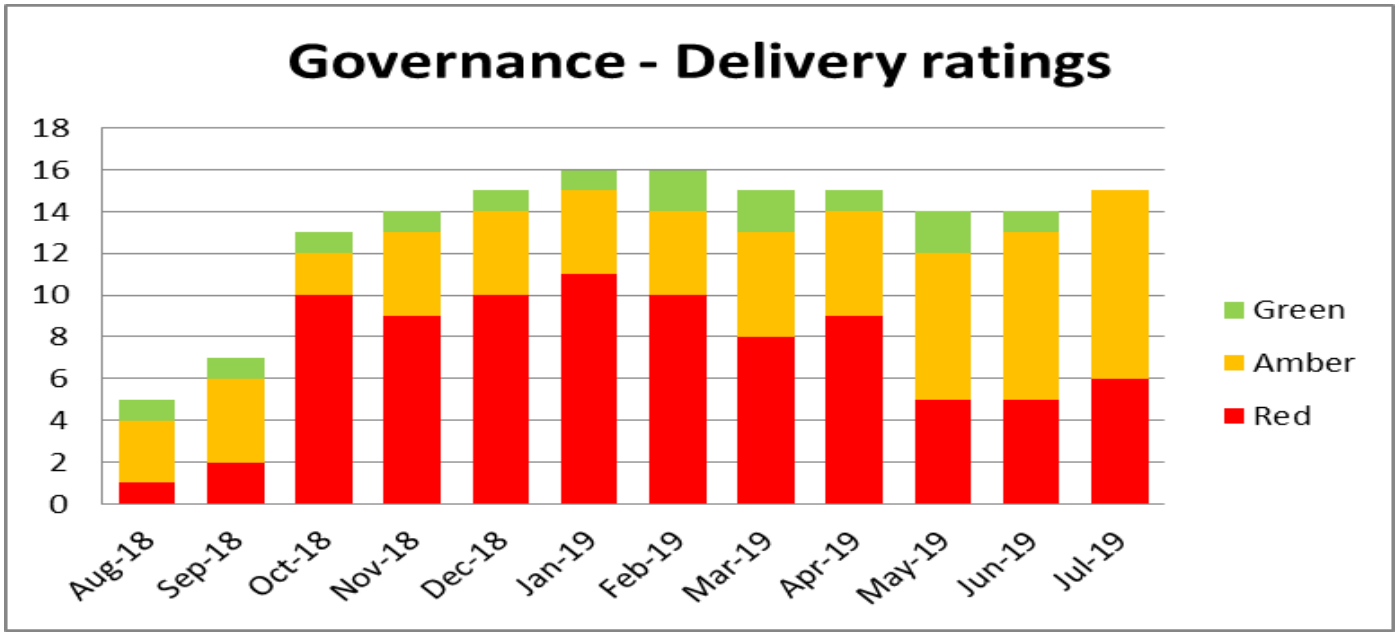
Change Programme Assurance Report - Trust Board Report - July 2019

S Brimble – Project Support

Wirral University Teaching Hospital NHS Foundation Trust



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Priority Projects Highlight Report - Metrics

Senior Responsible Owners

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

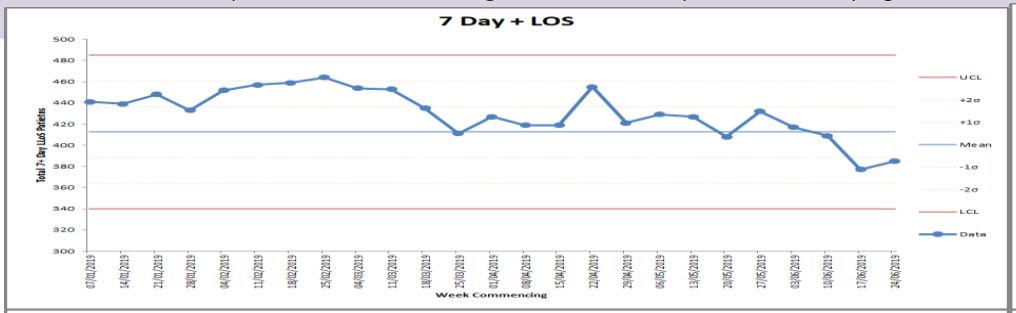
Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	Ward Based Care: PID, TOR & Milestone plan being revised to incorporate Transformation of Discharges Medical Assessment Unit: expected benefits and metrics to be confirmed
Green	Red	Command Centre: expected benefits and metrics to be confirmed

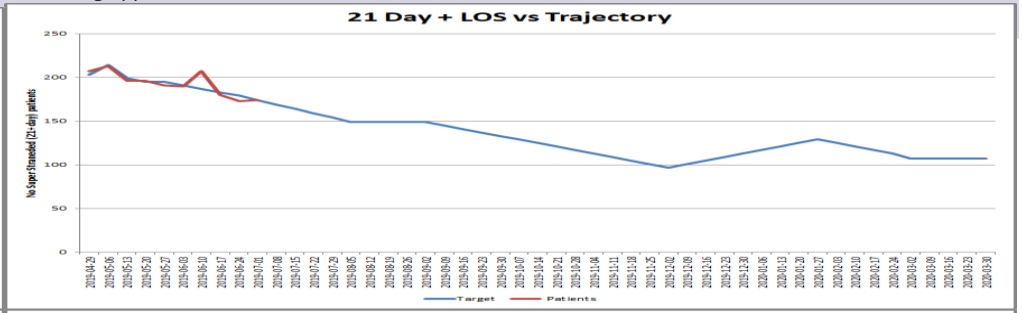
3 things you need to know

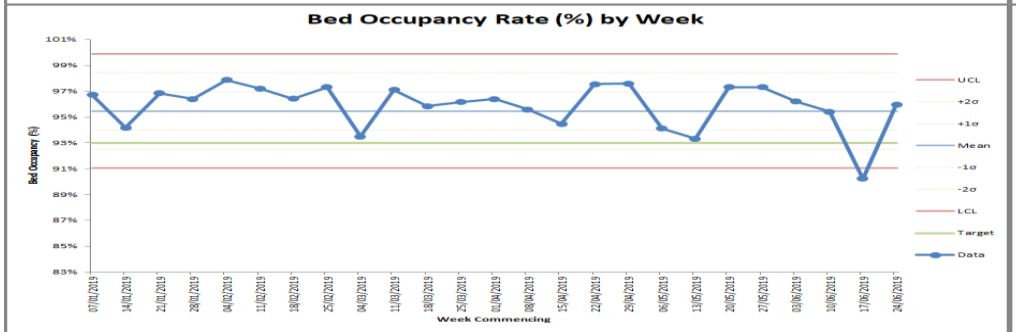
Commenced new process and focus on 21 day + LOS patients in line with ECIST reporting requirements. ECIST support in place. Meeting the trajectory for 40% reduction by October 2019

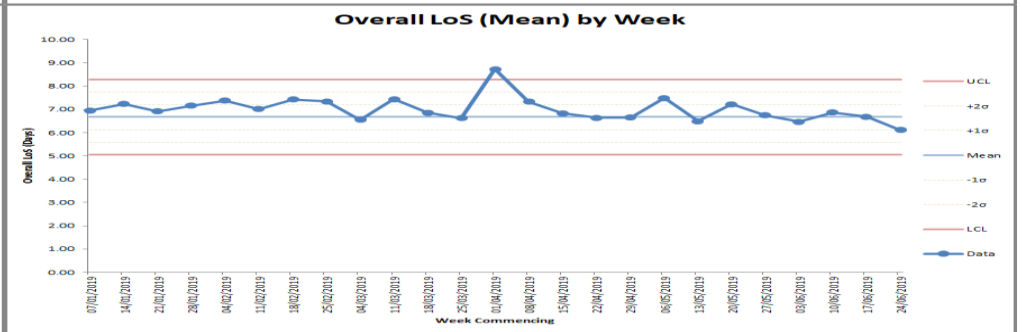
Proposed go live date for Capacity Management is October 2019. Engagement events with clinical staff has commenced and will continue throughout July and August 2019

Rebranding of ACU to UMAC (Urgent Medical Assessment Unit) to 'go-live' with new referral criteria on 22nd July 2019. Ward 17 and SAU are swapping locations on 22nd July which will facilitate the surgical assessment review. Scopes for SAU & GAU are being defined and will be presented to next programme board following approval at PFIG.









Escalation

Frontline staff have received no refresher training on EPR which they require to ensure they are using it optimally to support patient care & flow. Real time data entry into EPR is essential to realising the full benefits of Capacity Management. A paper on an EPR optimisation team will be presented to TMB on 31st July. The outcome of this may impact on Capacity Management approach & Go Live date.

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

Overall Governance	Overall Delivery	Plan to Turn Green
Green	Amber	A review of current KPI's thresholds will be undertaken to ensure that they are fully reflective of programme progress and position.

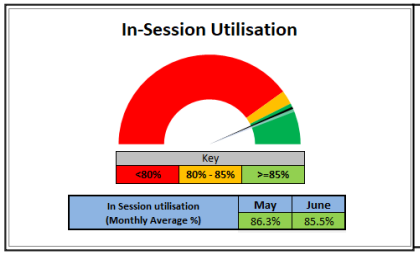
4 things you need to know

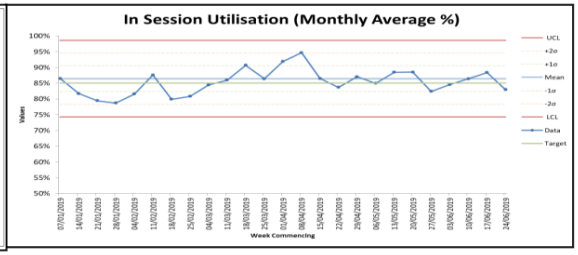
Main Focus: Three phase recovery options appraisal has been produced for Divisional review. Further risk review and costing analysis was requested to support case for change as part of a review of the capital priority programme.

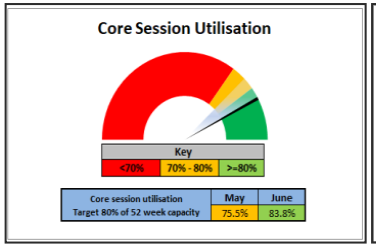
Theatre scheduling system design specification was re-issued for on a separate framework ; three external responses have been received. A further system demonstration has been organised with Four Eyes insight as part of a collaboration opportunity with Alder Hey and Royal Bolton NHS Trusts.

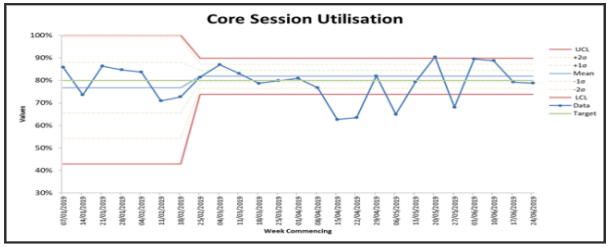
Pre-Op move to main outpatients has been deferred for two weeks so the Division can resolve some operational issues that exist and undertake a risk assessment of the room space identified for pre-op to occupy.

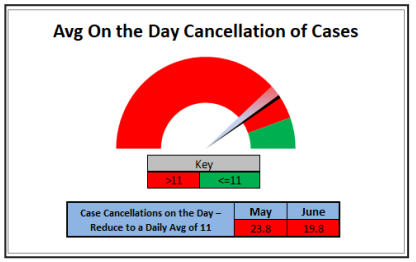
Go live of the New Periop PowerBI dashboard set for October with the test version now being available to Directorate Managers.

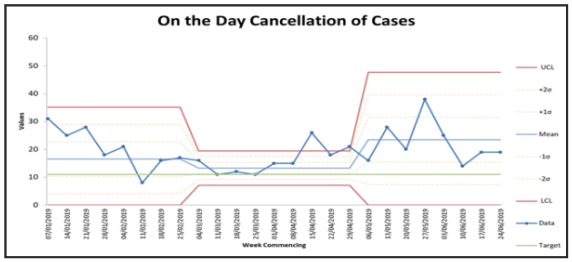


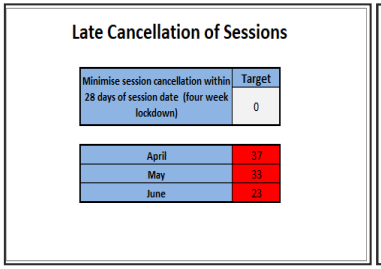


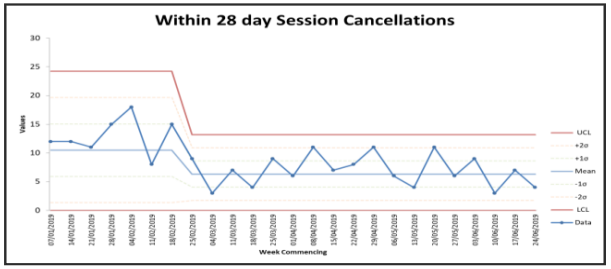












Escalation

Nil.

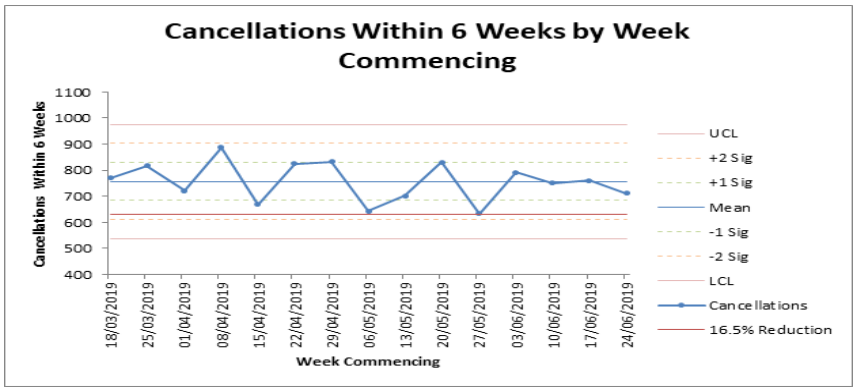
Highlight Report – Outpatients
Reporting Period – June 19
Programme Lead – Alistair Leinster

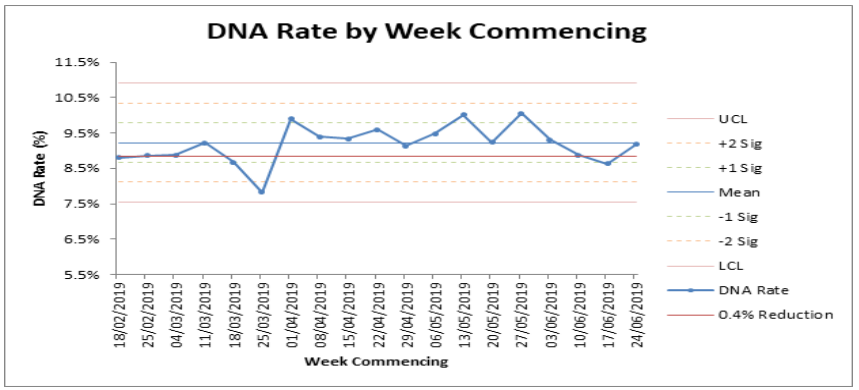
Overall Governance	Overall Delivery	Plan to turn green
Green	Amber	Project plan to be developed for each workstream

3 things you need to know

Resource to support the management of consultant annual/study leave requests will be in post 15th July. This will support the reduction in provider cancellations within 6 weeks. A cancellation authorisation form is also being developed for discussion with Directorate Managers.

Outpatients Engagement Workshop with DDs, DMs and Clinical Leads being arranged for September to communicate the outpatients vision & objectives and to provide specialty specific clinic information to support the identification of opportunities for providing non face to face activity. Rapid improvement work to develop models for 'enablers'.





- Activity vs plan in development
- New : Follow up ratio will be available once benefit start date has been identified

Escalation

Potential for scope of outpatient work to increase and risk delivery

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Programme Assurance Ratings

Joe Gibson
17 July 2019

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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'** The PID 'Ward Based Care for Earlier Discharges and TOD' Version 1.4 dated 23 June 2019 describes the project; this new PID reflects the decision to combine 'Ward Based Care' and 'Transformation of Discharges'. There is also a new SOP: Long Stay Review for Patients with a Length of Stay of 21 Days and Over, Standard Operating Procedure (SOP) dated 28th June 2019.
- The **'Command Centre'** PID, draft v0.4 dated 23 Apr 19, still lacks metrics by which benefits will be measured and these are in the process of being developed. . The new Command Centre Project Plan has been updated to 8 Jul 19 shows a number of delays of 2 to 3 months.
- For **'Transformation of Discharge Services',** The key KPI is the focus on 21 day + LOS patients in line with ECIST reporting requirements (ECIST support in place) of meeting the trajectory for 40% reduction by October 2019; the trend is positive but now needs to be sustained.
- The new '**Assessment Review (Medical)'** project has been initiated; milestone plan has been updated to 4 Jul 19 and needs minor formatting issues addressing - there are some delays to key milestones.

Perioperative Medicine Improvement	Governance		Delivery	

- The **'Perioperative Medicine Improvement'** The revised milestone plan, dated 2 Jul 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.
- The four metrics being tracked, monthly – Core Session Utilisation; In-session Utilisation; Avg On the Day Cancellation of Cases; and Late Cancellation of Sessions . These KPIs, developed in the PID, are tracked on the dials and supporting data - uploaded on 8 Jul 19 - show an overall 'amber' rating but with positive trends. show an average of 'amber' performance.
- Following concerns raised in the previous assurance report, evidence is now 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'** Issue version of PID v1.0 dated 10 Jun 19 was approved at Operational Transformation Steering Group on 10 Jun 19. The vacant 'Programme Director' position has now been filled by Alistair Leinster.
- 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 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 – 17th July 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 this still 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 1 Jul 19.**

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

Ward Based Care for Earlier Discharges - Programme Assurance Update – 17th July 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. The PID 'Ward Based Care for Earlier Discharges and TOD' Version 1.4 dated 23 June 2019 describes the project; this new PID reflects the decision to combine in to one project the previous two projects of 'Ward Based Care' and 'Transformation of Discharges'. There is also a new SOP: Long Stay Review for Patients with a Length of Stay of 21 Days and Over, Standard Operating Procedure (SOP) dated 28th June 2019. **2. & 3.** Names of the project team on this dashboard are now completed. Minutes for the Ward Based Care for Earlier Discharges meetings up to 2 Jul 19 are in evidence. Trello Board has been in use for this project. **4. E**xtensive evidence of stakeholder engagement submitted up to 8 Jul 19. **5.** EA/QIA are now completed. **6.** A 'Ward Based Care Milestone Plan' dated 2 Jul 19; however, activity lines past due date need to be RAG rated. **7.** 'Benefits and Measures': these are covered in the slide 'Metrics: Ward Based Care for Earlier Discharges June 2019'. **8 & 9.** There is now evidence of risk and issue management in the form of a RAID Log with risks reviewed up to 2 Jul 19. **Most recent assurance evidence submitted 8 Jul 19.**

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

Command Centre - Programme Assurance Update – 17th July 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Shaun Brown	Clare Jefferson	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. There is also a 'WUTH BUSINESS CASE DOMESTIC VACATION CLEANING TEAM' uploaded on 8 Jul 19. **2. & 3.** Evidence of documented project meetings is available up to the minutes of the meeting of 28 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 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 8 Jul 19 shows a number of delays of 2 to 3 months. **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 8 Jul 19.**

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

Transformation of Discharge Services - Programme Assurance Update – 17th July 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 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 Jul, now with significant delays (in excess of 2-3 months) 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 June 2019; there is clear improvement but not yet achieving target trajectory. **8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed up to 2 Jul 19. **Most recent assurance evidence submitted 8 Jul 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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												

Assessment Review - Programme Assurance Update – 17th July 2019

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

Independent Assurance Statement

1. The scope document comprises the PID v0.6 dated 24 Jun 19, for the 'Medicine & Acute Assessment Unit Review'; this has now been signed off by the Steering Group. **2.** Project Team names are now complete on this dashboard. **3.** Agenda and papers in evidence for the 'Acute Medicine Clinical Governance Team Meeting' of 17 May 19 with Action Log to 28 Jun 19. **4.** There is a communications plan dated 5 Jul 19 which will need tracking to assure delivery. **5.** EA/QIA have been drafted and await sign-off. 6. The milestone plan has been updated to 4 Jul 19 and needs some minor formatting issues addressing; there are some delays to key milestones. **7.** There is no evidence yet of measurement of KPIs. **8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed up to 28 Jun 19. **Most recent assurance evidence submitted 8 Jul 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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															
2.4	**Assessment Review**	To reduce patients length of stay in acute hospital beds by early identification of patients able to be discharged through transfer to assess home and bed based pathways.	Nikki Stevenson												

Perioperative Medicine Improvement – Programme Assurance Update – 17th July 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 2 Jul 19; an action log is now in place to assist governance. **4.** There is extensive evidence of wider stakeholder engagement uploaded to 8 Jul 19 and including the May-July Divisional Newsletter. A communications plan is now available, this will need to be tracked. **5.** The QIA has now been revalidated. **6.** The revised milestone plan, dated 2 Jul 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 8 Jul 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 8 Jul 19.**

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

Outpatients Improvement - Programme Assurance Update - 17th July 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. Issue version of PID v1.0 dated 10 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 4 Jul 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; detailed engagement/information packs developed for all specialties, an example is on SharePoint. **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 uploaded on 8 Jul 19. **Most recent assurance evidence submitted 8 Jul 19.**

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

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

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Clare Jefferson	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 3 Jul 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, dated 8 Jul 19, on which June tasks have not yet been (in the main) updated and 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 been delayed to July 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 8 Jul 19.**

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

Digital: GDE Medicines Management – Programme Assurance Update – 17th July 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 2 Jul 19.**

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

Digital: GDE Device Integration – Programme Assurance Update – 17th July 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 Proj. Board and not evidence of engagement. **5.** No EA/QIA in evidence. **6.** SECA Project Plan, 5 Jul 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 fm Jun 18; plan now completes Feb 19. PCECG Roll Out Plan 4 Jul 19, largely on track. Vitalslink Roll-Out Plan of 27 Jun 19 is just commencing. **7.** No evidence of tracking of benefits. **8 & 9.** Evidence of review of risks on SharePoint to 12 Feb 19 (register needs date of last review). **Most recent assurance evidence received 5 Jul 19.**

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

Digital: GDE Image Management - Programme Assurance Update - 17th July 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 4 Jul 19, received for Med Photo which appears largely on track. Bronchoscopy Plan previously updated to March 2019 and now significantly out of date. Theatre Plans updated to 3 Jul 19 and appear largely on track. 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 20 Jun 19, and needs a 'date of last review' column for risks. **Most recent assurance evidence received 4 Jul 19.**

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

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

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

1. PID v1.5, 25 Oct 18, approved by project board on 28 Jun 17. 3 benefits reducing follow-up O/P appts for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit baseline cited for Urology with £36.5k target). Patient Story defines patient benefit. **2.** The 'Programme Core Team' names on this dashboard to be completed. 3. Minutes of the Project 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 8 May 19.**

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

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

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Gary Price/Joe Downie	TBD	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	Quality Gate	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 - 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	TBD												

As agreed at the Programme Board on 19 June 2019: project removed from change programme scope, it will be re-initiated if the collaborative launch a project

Healthy Wirral: Medicines Optimisation - Programme Assurance Update - 17th July 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: HW DOAC, HW MOCH, HW Pan Mersey, HCD, and HW Stoma; eTCP, HWMO and Waste PIDs were updated and uploaded 5 Jul 19. 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. Highlight reports uploaded 5 Jul 19 include: Waste, GPHCP, PCN and Stoma. **3.** Governance structure shows how the 'Medicines Optimisation' now fits as part of the revised 'Healthy Wirral' programme structures. The ToR were updated as of 9 Jul 19. **4.** There is continuing evidence of GPCP stakeholder engagement and comms. **5.** EA/QIA signed off 18 Mar 19. **6.** There is no milestone plan. **7.** Biosimilar financial savings are shown in 'Adalimumab Biosimilar Implementation: January 2019 Update' but there is no evidence of measurement of other benefits. **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 5 Jul 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	Quality Gate	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 - 17th July 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	Quality Gate	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

Subject:	Agenda Item 9.5 Proceedings of the Trust Management Board held 31.07.2019	**Date:** 7th August 2019	
Prepared By:	Andrea Leather – Board Secretary		
Approved By:	Nikki Stevenson, Medical Director		
Presented By:	Nikki Stevenson, Medical Director		
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 M3 outturn.**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care, particularly exposure to infectionand nutrition. .**
Staff Impact	**Staff vacancy, reliance on agency staff, and 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. Executive Summary

- The Trust Management Board (TMB) met on 31/7/2019. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors.

2. Quality and Performance Dashboard

- TMB received the revised Quality Performance Dashboard covering the 12 months ended 30th June 2019.
- There are currently 19/52 indicators outside tolerance.
- TMB noted the progress to date and the number of indicators that were now coming under control.
- Whilst progress is being made across some indicators TMB considered the matters of concern for escalation, in particular Infection Prevention Control (IPC), Nutrition and hydration (MUST) and sickness absence.

3. Medical Staffing Review

- Committee received and noted the recommendations of the medical staffing review.
- Project group to be established with representation across the Divisions, Corporate Nursing and IT to review actions and develop a project plan. TMB to oversee implementation and progress of the project plan.

4. Pension Group Update

- Working group established to consider impact for both individuals and consequently services provided.
- Options to mitigate risks to be discussed at future TMB.
- Awareness of the change in pension rules to be highlighted across the Trust.

5. Bed Capacity Model

- Presentation summarised how the model would be built and its functionality including flexibility to adapt data by speciality rather than by capacity and how the model could be utilised by clinical leads to inform business plans.
- Template to be circulated to Divisions to support their model strategies under development.
- Nursing model not aligned as provided by acuity, to be reviewed to see how best this could be mapped across.
- Meetings to be arranged with each Division and update to be provided at next TMB.

6. Divisional Updates

Updates from each of the clinical Divisions were provided for information with the following actions noted:

(i) Surgery – business case outlining an option appraisal for the future provision of Chronic Pain Service and Lymphoedma Services to be prepared.

(ii) Women & Children's – impact on service following community midwifery service provided by One to One going into administration. Daily calls with NHS England/CCG to monitor impact for service users/providers

(iii) Diagnostics and Clinical Support – impact of change in community Phlebotomy service, communication to be drafted to explain changes and impact with patients and WUTH.

(iv) Medical & Acute – meeting to discuss Palliative Care funding with CCG and Wirral Community Trust to be rearranged.

7. Wirral Integrated Musculoskeletal (MSK) Service – Outline three month review

- TMB received a review of the MSK service for the period July 2018 – June 2019.
- Action plan developed to address performance management in relation to waiting times – trajectory for each speciality identified and monitoring through the Finance Performance Group.

8. Integrated Pharmacy and Medicines Optimisation Service – Wirral Place

- TMB received a report outlining workforce and service delivery models for medicines services in Wirral Place and outlines potential changes to further integrate clinical pharmacy services with associated benefits for the system.
- TMB approved WUTH/PCW partnership approaching newly formed Primary Care Networks (PCN's) to discuss the service offer for the newly created PCN roles – service to be managed to SLA's.
- TMB supported discussions with Wirral CCG for the appetite for integration of medicines optimisation services and timeframes towards this model.
- Consider opportunity to adopt similar models for other services eg MSK and Physiotherapy.

9. Acuity and Dependency Solution – SafeCare

- Benefits realisation for this proposal discussed in detail.
- TMB approved purchase of SafeCare system.

10. M3 Financial Position

- Members received and noted the financial position for the end of month 3.
- Members noted the underlying deficit of £1.4m and the key components namely pay relating to agency spend on consultants, cover for junior medical vacancies and bank costs for nursing. TMB considered the interim measures in place to address the deficit.
- Members noted that to ensure a "break-even" position was achieved the Trust accessed "accelerated" support from WCCG of c1.4m, this will be repaid during Q3 and Q4.

11. Orthopaedic Consultant Programmed Activities – Business Case

- TMB received a report seeking approval to undertake specific consultant job plan changes to support a consultant flexible working request and to facilitate the reduction of consultant specific programmed activities.
- The proposal was agreed on an interim basis and is to be reviewed on a quarterly basis. This will enable review of opportunity, any adverse effects and mitigations for other divisions and also the outcome of national guidance particularly in relation to pensions and consultant contracts.

12. Chair's Reports

- The following Chair reports were provided for information:
  - Finance & Performance Group Report – 19/7/19
  - Patient Safety & Quality Board Report – 18/7/19
  - Risk Management Committee Report – 16/7/19
  - Workforce Steering Group Report – 14/6/19

Written and summarised on behalf of the Medical Director by
Andrea Leather, Board Secretary
5th August 2019

Board of Directors

Subject:	Agenda Item 9.6 Proceedings of the Safety Management Assurance Committee	**Date:** 7.8.2019	
Prepared By:	Steve Igoe, Non-Executive Director		
Approved By:	Steve Igoe, Non-Executive Director		
Presented By:	Steve Igoe, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**None identified**
Patient Impact	**Several areas currently represent a potential risk to health and safety of care:** • **Impact on Infection Prevention Control indicators eg C.diff** • **Quality of overall Trust estate adversely impacting on backlog maintenance programme.**
Staff Impact	**Attendance management and completion of mandatory training requirements represent a potential risk to effective safety management.**
Services	**None identified**
Reputational/ Regulatory	**Comparatively high number of public liability claims.** **Several areas currently represent a potential risk to compliance with HSE /CQC Registration Regulations.** **Local Authority concerns regarding water safety management.**
Committees/groups where this item has been presented before	
N/A	

Executive Summary

Executive Summary
The Safety Management Assurance Committee met on 01/08/2019. This paper summarises the proceedings.

Introduction
This was the inaugural meeting of this time limited committee following recent discussions at the Board regarding a number of safety related issues

Health and safety position status and update
We discussed a range of matters relating to the above .We received and noted:

- An update on the background to the committee and in particular referenced the recent issues which gave rise to its initiation.
- The high number of public liability claims providing further corroborative evidence of the issues requiring resolution.
- Concerns about the transparency and frequency of incident reporting .
- High rate of sickness and absence, particularly in Estates and arising as a result of Musculoskeletal issues.
- Less than positive feedback from staff on H&S matters in the staff survey
- Evidence that policies are available but neither implemented nor necessarily communicated.

Immediate response

- Used ISO 45001 an international standard to benchmark current “as is” position as this aligns with the Trust’s risk management framework.

- Undertook an independent audit under ISO 45001 and reviewed a number of recent incident reports.
- Validated response due to go to Trust's Health & Safety (H&S) Committee on 21st August 2019.
- The committee recognised the less than positive picture but were supportive of the use of the international standard as a benchmark and the fact that the outcome of that review was not unexpected.

Work done to date:

- Efforts undertaken to improve the quality of underlying data.
- The development of a draft H&S dashboard.
- The development of a draft safety strategy and health and safety responsibility matrix.
- The launch of the H&S enforcement notice internally and the fact that it had already been used and enforced.
- It was accepted that there remains much work to do to engage managers and staff and to embed the safety culture across the Trust.
- That it would be helpful to have a "Universe" of systems and controls against which a Health and safety Audit plan could be mapped. That work being risk based and proportionate.
- That work would need to continue to drive out the importance of the culture in relation to safety management .That culture and lead being set from the top.

Governance arrangements

- The Committee noted and supported the draft governance arrangements and information flows.
- The Committee noted and supported the revised organisational responsibilities for the management of Health and Safety at the Trust.
- The committee reviewed the draft terms of reference for the Health and Safety Management Committee. A final version to be presented to this committee following the meeting on 21st August 2019 for approval.
- The Committee reviewed the draft executive report and divisional dashboard format and supported the requirement for reporting units to provide positive assurance on compliance matters in their reports.

AOB

- A common theme throughout the discussions was the need for cultural change and the need for individuals in the trust to all see successful Health and safety /safety management as a personal responsibility.
- The importance of mandatory training and ensuring that all items relating to Health and Safety are completed on a timely basis.
- That there needs to be a substantial focus on infrastructure and estates issues particularly in relation to statutory compliance and safety issues

Conclusion

Colleagues were thanked for the substantial amount of work done in a very short space of time to regularise and understand the current Trust position and provide a pathway (externally validated via ISO 45001) to resolve/manage the various H&S / compliance issues which were the catalyst for initiating this Committee. It was accepted that there is much to do however there is at least now a pathway to resolution and a move past compliance to enhancement .

Summarised and drafted by the Safety Management Assurance Committee Chair by:
Steve Igoe
3rd August 2019

BOARD OF DIRECTORS	
Agenda Item	9.7
Title of Report	CQC Action Plan Progress Update
Date of Meeting	7th August 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	To be confirmed.
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for **assurance** to the Board **The Board is invited to receive and consider this report**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 27TH JULY, 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:

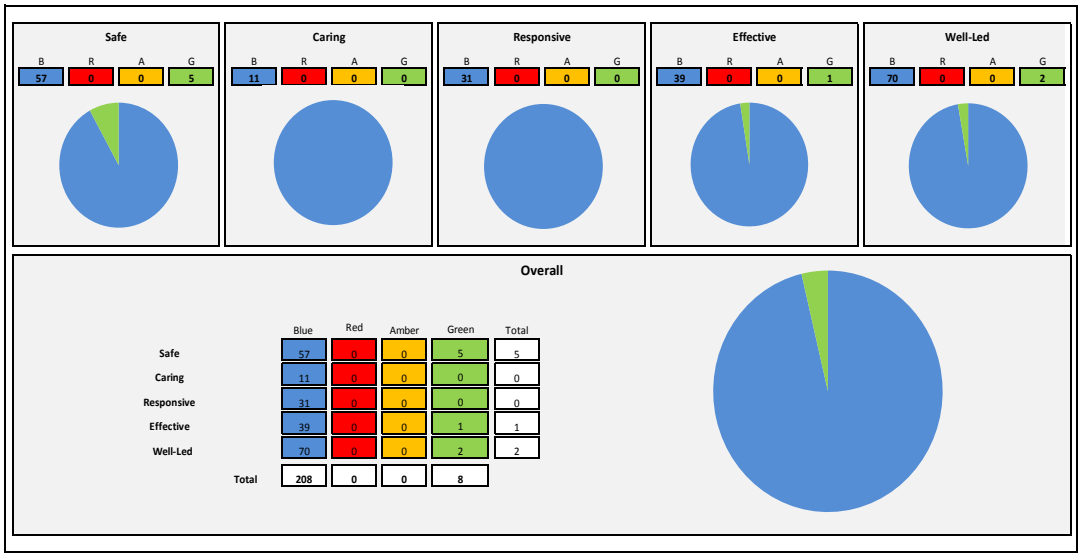
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

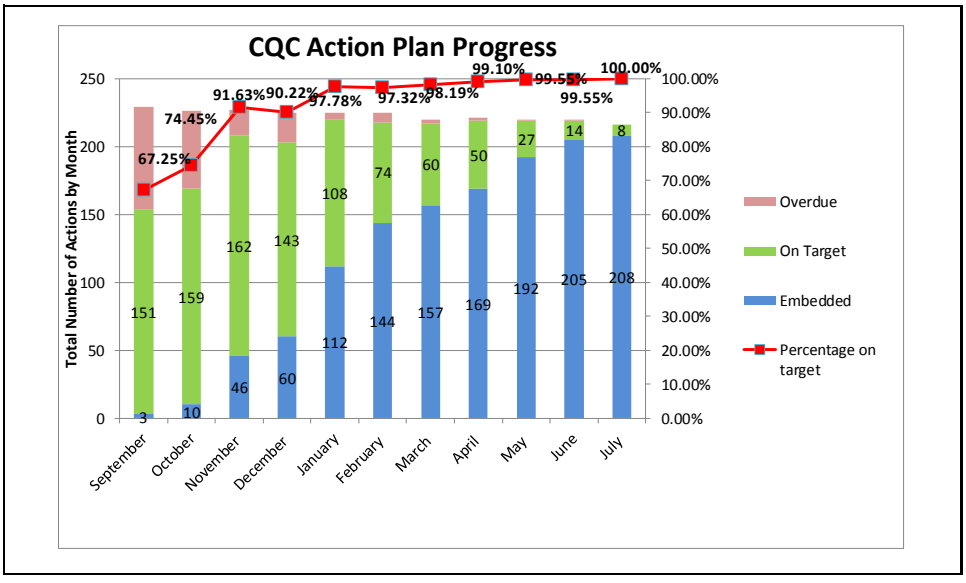
The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **220** specific actions/work-plans for implementation on or before **31st August 2019.**

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 – 29th July 2019

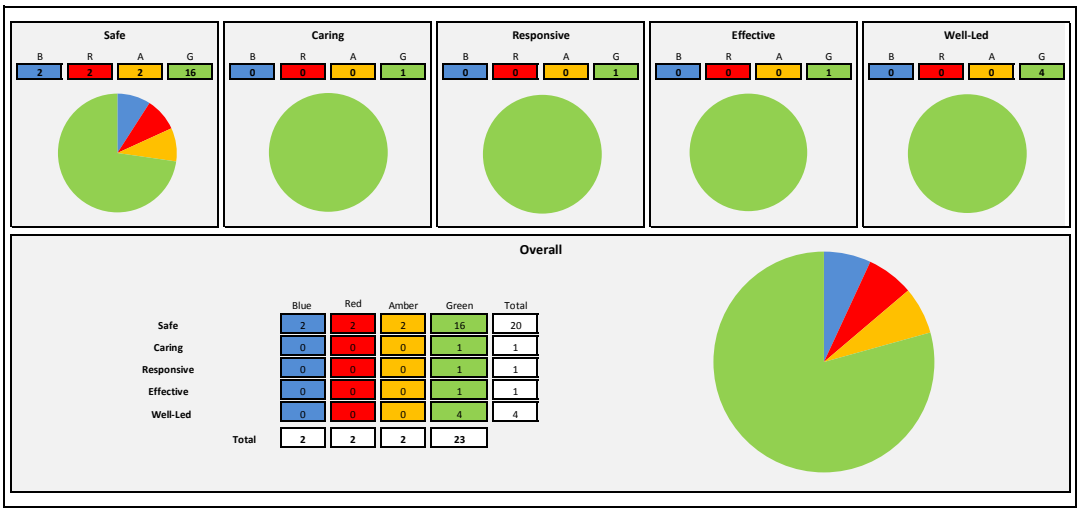
The graphs below summarises the current position of the original CQC action plan following review at its respective monthly confirm and challenge meetings. It is pleasing to report that there no overdue actions for this reporting period following trust Board decision to omit actions pertinent to patient flow from the CQC action plan.

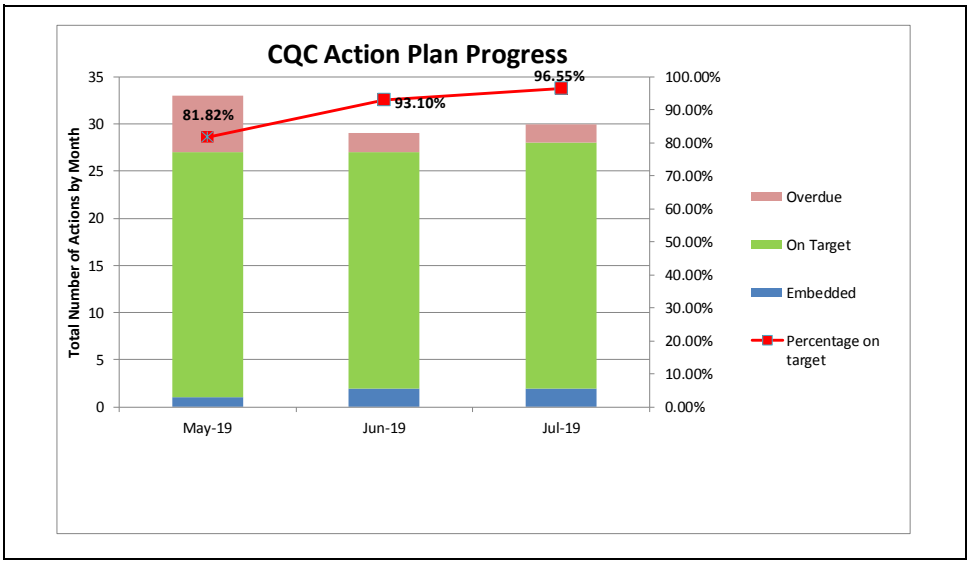




4.1 CQC Urgent Care Actions

The graphs below summarise the current position of the Emergency Department CQC action plan. There are 2 overdue action and two ‘at risk’ items for this reporting period.





5. EXCEPTIONS

The following actions detailed in **Annex A(ii)** are overdue and off track:

(i) **All GP referrals to go to go directly to speciality assessment facilities not ED** – initially scheduled for conclusion by April 2019;

(ii) **Conclude an audit of specialty response/ review times and address delays** – initially scheduled for conclusion by April 2019;

We anticipate some risk of delay in respect of the following actions detailed in **Annex A(ii)**:

(iii) Integrate streaming process for community trust – scheduled for conclusion by end of July 2019; and

(iv) Ensuring the availability of paediatric trained nurses in the Paediatric ED in accordance with intercollegiate recommended RSCN staffing levels – scheduled for conclusion by end of September 2019.

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 **5** 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:

- 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) - 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 23.07.2019** SOP and Data collection has been agreed. Currently there are some specialities within the Trust that have patients attending ED for the speciality to review. This can impact on triage times and capacity within ED. The Divisional Medical Directors are undertaking a review of their specialities to produce a plan were by all GP referrals by pass ED and go straight to the speciality, except is they require emergency intervention. NHSI have developed inter professional standards for acute trust's to implement and GP referrals are within the standards. WUTH plan to 'go live' with the standards on 6th August 2019. The standards also support speciality response of 30 minutes to review a patient in ED. To support this process before the 'go live' date ED have requested a report from IT to establish current state. ED has also commenced breach analysis meetings with all specialities.	30/04/2019	
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 23.07.2019** Assurance required, not yet provided, regarding audit results for specialty response times following referral via ED. Action to be escalated to Medical Director. NHSI have developed inter professional standards for acute	30/04/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
							trust's to implement standards which support speciality response of 30 minutes to review a patient in ED. To support this process before the 'go live' date ED have requested a report from IT to establish current state. ED has also commenced breach analysis meetings with all specialities. WUTH plan to 'go live' with the standards on 6th August 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 23.07.2019** 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. The streaming governance meeting takes place monthly and is attended by the ADN for acute care and an ED consultant. There is a standard agenda and an ED consultant chairs the meeting	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 23.07.2019** CQC confirmed that the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (June 2018) apply. 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	30/09/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
							this guideline, and what actions will be implemented to mitigate against this risk.		

ANNEX B (Embedded actions in July 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
18	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	Chief Operating Officer	Well Led	**Updated 23.07.2019 – Embedded process.** 23 July 2019 Permanent storage has been built into the design for the redevelopment of the handover area	07/03/2019	
20	Must Do	Corporate / Trust-Wide Issues	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	Review and develop the supply chain management so that storage requirements are kept to an absolute minimum	Chief Operating Officer	Well Led	**Updated 23.07.2019 – Embedded process.**	07/03/2019	
208	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing SOPs (1/8/18)	Chief Operating Officer	Effective	**Updated 23.07.2019 – Embedded process.** Standard is being met and is evidence in Divisional Performance Review information packs	10/06/2019	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
5	Should Do	Corporate / Trust-Wide Issues	**COUNCIL OF GOVERNORS** Review the agenda of the quarterly Council of Governors meetings to ensure that appropriate Trust staff attend	Review the agenda of the quarterly Council of Governors meetings to ensure that appropriate Trust staff attend in order to provide the meetings with sufficient information in order that they can fulfil their responsibilities effectively	Chief Executive Executive Director of Quality Governance	Well Led	**Updated 23.07.2019 – Embedded process.** A review of the terms of reference has been undertaken	31/03/2019	
141	Should Do	Corporate / Trust-Wide Issues	**RECORD KEEPING** *These issues arose within the Emergency Department only but require Trust-wide action.* The service should ensure that records for children are completed consistently, including using the mandatory safeguarding questions for children at all times and correctly using the paediatric early warning score. The service should consider ways to make sure that patient pathways for different conditions are included in all patient records and completed fully when appropriate.	Carry out clinical audit to verify capture of this key information within the record	Executive Director of Nursing and Midwifery	Safe	**Updated 23.07.2019 – Embedded process.** Audit evidence submitted	01/04/2019	