Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

2 October 2019

together we will

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
9am - Wednesday 2nd October 2019
The Board Room, Education Centre

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
1.	Apologies for Absence	Deputy Chair	Verbal	N/A
2.	Declaration of Interests	Deputy Chair	Verbal	N/A
3.	Chair's Business	Deputy Chair	Verbal	N/A
4.	Key Strategic Issues	Deputy Chair	Verbal	N/A
5.	Minutes of Previous Meeting – 4 September 2019	Board Secretary	Paper	1
6.	Board Action Log	Board Secretary	Paper	13
7.	Chief Executive's Report	Chief Executive	Paper	14
Quality and Safety				
8.	Patient Story	Head of Patient Experience	Verbal	N/A
9.	Emergency Care Intensive Support Team (ECIST) Update	Karen McCracken (NHSI)	Verbal	N/A
10.	Infection Prevention & Control (IPC) Update (i) Outbreak status update	Acting Chief Nurse / Director of Quality & Governance	Paper	18
11.	Learning from Deaths – Quarterly Update	Medical Director	Paper	20
12.	Health & Safety Quarterly Update	Director of Quality & Governance	Paper	23
Performance & Improvement				
13.	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce, Director of Quality & Governance and Acting Chief Nurse	Paper	31
14.	Month 5 Finance Report	Acting Director of Finance	Paper	53
Workforce				
15.	Draft Workforce Strategy 2019-22	Director of Workforce	Paper	74
16.	Influenza Plan	Director of Workforce	Paper	105
Governance				

17.	Change Programme Summary, Delivery & Assurance	Joe Gibson	Paper	116
18.	Report of Trust Management Board	Chief Executive	Paper	145
19.	Report of Quality Committee	Chair of Quality Committee	Paper	149
20.	Report of Finance Business Performance and Assurance Committee	Chair of Finance Business Performance and Assurance Committee	Paper	150
21.	Report of Workforce Assurance Committee	Chair of Workforce Assurance Committee	Paper	153
22.	Report of Audit Committee	Chair of Audit Committee	Paper	157
23.	CQC Action Plan Progress Update	Director of Governance & Quality / Acting Chief Nurse	Paper	160
24.	Board/Board Assurance Committees – Annual Meeting Cycle	Board Secretary	Paper	171
25.	Receipt of Governor Election Reports	Board Secretary	Verbal	N/A
Standing Items				
26.	Any Other Business	Deputy Chair	Verbal	N/A
27	Date of Next Meeting – 6 November 2019	Deputy Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

4th SEPTEMBER 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
Karen Edge	Acting Director of Finance
John Coakley	Non-Executive Director
Jayne Coulson	Non-Executive Director
Chris Clarkson	Non-Executive Director
Paul Moore	Acting Chief Nurse / Director of Quality & Governance

In attendance

Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Paul Charnley	Director of IT and Information
Andrea Leather	Board Secretary [Minutes]
Lynsday Young	Communications & Marketing Officer
Steve Evans	Public Governor
Angela Tindall	Public Governor
Ann Taylor	Staff Governor
Joe Gibson*	Project Transformation
Jeremy Weetch	Outpatients Clinical Lead
Alistair Leinster*	Divisional Director – Diagnostics & Clinical Support
Jay Turner-Gardner*	Associate Director of Nursing for Infection Prevention & Control
Jane Kearley*	Member of the Public
Sharon Achefon	Member of the Public
Sally Rodgers*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

Gaynor Westray	Chief Nurse
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 19-20/114	**Apologies for Absence** Noted as above.	
BM 19-20/115	**Declarations of Interest** There were no Declarations of Interest.	

Reference	Minute	Action
BM 19-20/116	**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 key issues would be captured within items already contained on the agenda.	
BM 19-20/117	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Mr John Sullivan – Non-Executive Director –** advised that the caliber of candidates for recent consultant recruitment was of a high standard and the positive message this should have for the organisation. **Director of Workforce** – reported the launch of the NHS Rainbow Pin Badges today, this is part of the NHS rollout showing commitment to LGBT+ inclusion. From today staff can pledge their commitment and collect a badge. Information is available on the **Diversity and Inclusion LGBT+ page** of the staff website. Choosing to wear an NHS Rainbow Badge, shows patients and staff they can be open about their identity and WUTH colleagues will support those who may need it. **Chief Operating Officer** – provided an update regarding the funding of £18m for an Urgent Treatment Centre. Preparatory work was now underway and the Trust is liaising with NHS England/Improvement regarding business case requirements. **Medical Director** – apprised the Board of Directors regarding the progress of the streaming pilot currently being undertaken with the support of the Emergency Care Intensive Support Team (ECIST). ECIST have highlighted areas of good practice and those that the Trust could improve along with recommendations that will require the support of the wider health economy. The Board requested an invitation be extended to the ECIST lead, Karen McCracken to attend the October Board of Directors meeting to provide an update. **Director of IT and Information** – advised that a report would be provided at the next meeting regarding the Global Digital Exemplar (GDE) Fast Follower Programme in relation to the Countess of Chester Hospital (CoCH). **Associate Medical Director, Women & Children's –** Mr Lund advised the Division continue to provide support to women impacted by the One to One' community maternity service going into administration. **Acting Chief Nurse /Director of Quality & Governance** – informed the Board of the positive feedback from received from patients and the safety management progress to date. Preparation for the forthcoming CQC inspection is underway and updates would be provided to the Board. **Associate Medical Director, Surgery –** Dr Mehra informed the Board that the new theatre scheduling was due to 'go live' in October and the Division	

Reference	Minute	Action
	had undertaken external benchmarking. **Mr John Coakley – Non-Executive Director –** enquired as to the Trusts contingency plans for Brexit. Mr Middleton advised that daily SITREPs had been stood down nationally although this may be reintroduced shortly. The Trust is reviewing national and local guidance with Risk Management Committee monitoring areas for escalation. ***The Board noted that although some members did not have detailed updates there were a number of topics already covered within agenda items.***	
BM 19-20/118	**Board of Directors** **Minutes** The Minutes of the Board of Directors meeting held on 7th August 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 19-20/119	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report including: • Additional capital funding • Cyber security • Serious Incidents • RIDDOR Update • A&E Board • Executive team recruitment The Board of Directors were informed that CQC has notified the Trust of the Well-led inspection 12th – 14th November 2019, the NHS Improvement 'Use of Resources' element will take place on Friday 25th October. The Provider Information Return (PIR) has been submitted with no significant queries raised and documentation is available for Board members to view. It was agreed to arrange a CQC preparation session for Board members. ***The Board noted the information provided in the August Chief Executive's Report.***	**AL**
BM 19-20/120	**Patient Story** The Board were joined by Sally Rodgers who has previously provided feedback following her mother's poor patient experience. This time she talked about her father's positive patient experience and explained how reassured she felt at the improvements that had been made. Her 97-year-old father attended the Emergency Department (ED) following a fall resulting in a cut to his face. Sally initially had concerns when her father was admitted to Ward 19, where her mother had previously been treated.	

Reference	Minute	Action
	However, she commended the Trust for changes that had been made and thanked Julie Reid, Associate Director of Nursing, for leading those improvements. Staff reassured her they were trained in caring for elderly patients and Sally noticed how cheerful, kind and compassionate the staff were on the ward, as well as how clean and welcoming the ward was. When her father attended Maxillofacial, Sally said despite his age, staff were keen to ensure his surgery didn't leave him with a facial scar. When her father was transferred to Ward 21, he was placed in a comfortable chair and there was an aid to ensure he had something to hold on to if needed. The family felt encouraged to stay with her father and staff also provided advice to the family. Sally was keen to stress the positive changes that had taken place to improve patient experience and thank the staff both on ward 19 and 21 for all their hard work. The Board thanked Sally for sharing her experiences and highlighting the improvements that had been made. ***The Board noted the positive feedback received from Mrs Rodgers.***	
BM 19-20/121	**Update – Outbreak of *Clostridium difficile*** A progress report concerning the outbreak of *Clostridium difficile (CDI)* was provided. The report outlined the cause of the hospital-wide outbreak is multi-factorial, namely around four key factors: environment, equipment, cleaning and policies and procedures. The weekly outbreak meetings continue. The Board were provided assurance that substantial improvements have been made following the interventions implemented in recent weeks, such as environmental cleaning, hand hygiene and the correct use of policies and procedures to help keep risk under control. Such is the importance of good infection prevention, the Board have prioritised and agreed a detailed programme of essential maintenance, refurbishment and renewal of the clinical environment The development programme agreed is in three phases: **Phase 1** Option 1 - maintenance works to start with immediate effect, based on priority **Phase 2** Option 2 - a rolling programme based on patient risk / estate - Ward 30 – refurbishment of patient ensuite hand wash basins to commence, previously agreed within the 2019/20 capital programme, this will also enable opportunity to plan works for Ward 20 at the same time. **Phase 3** Option 5 – a schedule to be developed as part of capital programme (2 wards per year). The schedule to include all elements of risk: IPC, Health & Safety and Fire.	

Reference	Minute	Action
	The Acting Chief Nurse / Director of Quality & Governance stated that although compliance has improved, he stressed it would be a few more months with lower instances before he could confirm IPC was under control. He emphasised that the risk remains high due to demand on the service and that Public Health England has also advised caution as they anticipate the trajectory may be not be linear. The Board sought assurance that the estates team would have the capacity to deliver the programme. Following a recent change management programme within the Estates and Facilities department, the Chief Operating Officer confirmed recruitment processes are currently underway to address any gaps and in the meantime additional resource has been identified to support the team. The Board acknowledged the complexities faced by the department in developing a medium term solution, mainly due to lack of investment over a prolonged period of time and how best to allocate resources to address the concerns as discussed. The Board thanked the teams for their hard work and effort to work towards better control of infection, prevention measures. The Acting Chief Nurse/ Director of Quality & Governance presented the Infection Prevention & Control Annual Report 2018/19. The recommendations identified would be considered as part of the overall IPC plan. ***The Board noted the advice from the Acting Chief Nurse in their capacity as Acting Director of Infection Prevention Control (DIPC).***	
BM 19-20/122	**Learning from deaths annual summary report** The Annual Summary Report seeks to bring together the progress to date and work undertaken through 2018/19, to highlight the key learning themes and outline the plans to further enhance the agenda through 2019/20. Divisions and Clinical Services share learning from Deaths internally through their local Divisional arrangements e.g. good practice meetings/ specialty meetings etc. Mechanisms for sharing lessons learnt across the Trust include Safety Bites Bulletins; Monthly Safety Summits and through the Trust Governance arrangements. Sharing also occurs across the system through regional networks such as North West Coast. It was noted that whilst the number of acute admissions increases year on year, the number of deaths within ED has risen significantly in 2018. A review of each case was undertaken to outline lessons learned and inform a more robust process and introduce more useful and active learning / dissemination. The Board were assured that the Trust was not an outlier and has appropriate measures in place. The Board were informed of the forthcoming approach to introduce a medical examiner system nationally. Trusts have been asked to begin setting up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation. The Medical Director reported that local system discussions are underway to establish how best address this	

Reference	Minute	Action
	requirement. An update will be provided once the guidance is received to inform a Board decision. ***The Board noted the Learning from deaths annual summary report.***	**NS**
BM 19-20/123	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Of the 56 indicators with established targets or thresholds 15 are currently off-target or not currently meeting performance thresholds. The Board recognised the significant improvement across a range of indicators particularly in the safe and responsive domains and acknowledged the continuing work in relation to indicators underperforming. 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: • 4 hour A&E – there was a dip in performance in July which has seen further deterioration in August and it was noted this was also the national picture. Length of stay which is currently above the national average has an impact on this indicator. • RTT (total open pathway) – impacted by transfer of MSK service to WUTH, now back on track to achieve the objective to reduce the waiting list by July 2019 to below that of March 2018. • 12 hour ED waits – inconsistency in process for patients with mental health issues, revised admittance process agreed to reflect impact on an Acute Trust if a mental health provider is unable to identify a bed in time. This is the correct process for patients. • Friends & Family Test – in-patient satisfaction remains strong • Infection Prevention Control (IPC) indicators – these indicators are covered within agenda item BM 19-20/121, earlier in the minutes. • Same sex accommodation – whilst breaching this indicator, this was acknowledged as a tolerable risk mainly due to patient satisfaction with care. • Attendance management– it was acknowledged that a dual approach to addressing attendance is required, therefore a detailed exception report outlining the actions undertaken to address concerns was provided, progress is to be monitored by the Workforce Assurance Committee. The Board recognised the continued improved performance across a significant proportion of indicator but raised concern regarding the downward trajectory of attendance management. Workforce Assurance Committee (WAC) Chair stated that the Committee were assured that the introduction of revised actions as detailed in the exception report are a comprehensive approach to managing attendance and Jayne Coulson added that the actions now in place in relation to addressing attendance were 'best in class'. An initial report regarding the 'First Care' pilot will be presented at the September WAC meeting. ***The Board noted the current performance against the indicators to the***	

Reference	Minute	Action
	end of July 2019 and expressed appreciation of the achievement of having no never events to report for a period of 12 consecutive months and how difficult this is to achieve.	
BM 19-20/124	**Month 4 Finance Report** The Acting Director of finance apprised the Board of the summary financial position and at the end of month 4, the Trust reported an actual deficit of £5.6m versus planned deficit of £4.8m. However, this includes c£1.3m of non-recurrent support from Wirral Clinical Commissioning Group (CCG) to achieve the Trust planned position and allow the PSF/FRF to flow to the Trust and the system. The key headlines for month 4 include: • The underlying position is £2.1m worse than plan cumulative and £0.8m worse in month. • The key drivers of the worse than plan position include depreciation and VAT c£0.7m, Aseptics unit closure £0.3m and pay pressures, primarily related to temporary medical staffing costs and costs of ED capacity. In addition, risks are emerging on non-pay in terms of clinical supplies and outsourcing. • Income is broadly in line with plan with under performance in elective offset by maternity and diagnostics; noting non-elective activity/out patients being subject to block contract terms. • Cost Improvement Programme (CIP) delivered in month and year to date with £3.0m against a plan of £2.8m. The profile of the CIP increases in Quarter 2 and some slippage is expected. • Cash is £3.7m, being above plan. • Capital is slightly behind plan but the available £7.5m is fully committed. The programme has been reduced by £1.6m related to the car park scheme which was deferred at national request and has subsequently been reinstated but the timeline to deliver means this would not be completed in 2019/20. A revised capital forecast and plan is being developed and will be presented at Finance, Business, Performance and Assurance Committee (FBPAC). However, in the interim the Board were asked to approve a recommendation of FPG to vire GDE capital projects funding (£0.2m) and contingency (£0.1m) to fund the replacement of 400 PC's to ensure Windows 10 is rolled out within year to avoid excessive licence costs and cyber security threats associated with Windows 7 no longer being supported post January 2020. Due to concerns raised regarding the continuing temporary medical pay overspend, the Board requested FBPAC consider the short, medium and long term plans to mitigate pressures and provide a report to the next Board meeting. It was noted that some non pay pressures relate to national changes in the clinical supplies procurement and the Sustainability and Transformation Partnerships (STP's) is to raise this issue on behalf of Trusts. **The Board noted the month 4 finance performance and approved the virement of GDE capital projects funding (£0.2m) and contingency (£0.1m).**	**KE/HM**

Reference	Minute	Action
BM 19-20/125	**Long Term Plan** As reported at the last Board of Directors meeting the Trust is required to submit a 5 year plan by the end of September which will subsequently be reflected in both the wider Wirral health economy and Sustainability and Transformation Partnership (STP) footprint plans. A workshop facilitated by Cheshire & Mersey Health Care Partnership (HCP) is to be arranged and will encompass: • Review of the draft aggregate submissions • An oversight of the Strategy, Financials, Activity and Workforce picture • Present the plans for the top four or five programmes of work to transform I.e. acute sustainability collaboration at scale, cancer and mental health • Agree assumptions to include in the final plan The Acting Director of Finance provided a brief overview of the requirements and explained that due to the timelines Finance, Business, Performance Assurance Committee is to review progress at its meeting on the 24th September with a recommendation to the Board on the 6th November. The plan will need to include a 5 year capital programme and will initially contain an extrapolation of our 3 year plan and the additional Urgent Treatment Centre allocation of £18m. The Trusts intention to develop the Clatterbridge site was recognised and therefore it was agreed to include capital provision for this in the plan submitted to NHSI. **The Board noted the update regarding the Long Term Plan.**	**KE** **KE**
BM 19-20/126	**Consultant Appraisal and Revalidation Annual Report** The Medical Director provided a summary of the consultant appraisal and revalidation report for 2019. The Trust continues to perform well compared with benchmarking data in terms of both appraisal compliance and revalidation rates. A key area of focus for the year ahead is to address the reduced rates of appraisal compliance within the Speciality and Associate Specialist (SAS) doctor group. This is a small group, so periods of ill-health/maternity leave etc. for a few individuals can distort the data considerably. However, we are keen to ensure that our SAS doctors have all possible support to facilitate engagement in the appraisal process, and are committed to the implementation of the SAS Charter. There are key actions agreed for the year ahead in relation to this, and these will be a focus for the named SAS Lead. **The Board noted the Consultant Appraisal and Revalidation report and approved the Statement of Compliance for submission.**	**AL**

Reference	Minute	Action
BM 19-20/127	**Communications, Marketing and Engagement Plan** A draft of the Communications, Marketing and Engagement Plan that spans a two year period. The plan describes the focus, interventions and deployment of resources to support the delivery of the objectives and is aligned to the Trust's newly developed vision to deliver the best patient care and to make the organisation a great place to work. Following discussion it was recognised that the marketing section could be more proactive rather than reactive and the plan should describe how best to launch the internal and external communications/branding, the Workforce Assurance Committee to consider these agree final document. **The Board noted the draft Communications, Marketing and Engagement Plan.**	**HM**
BM 19-20/128	**Change Programme Summary, Delivery & Assurance** 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 overall governance ratings has remained stable and there is improvement in the programme delivery. It was agreed that the elements of the 'Digital' work stream should be transferred to others as an enabler to transform programmes. It was recognised that to ensure the appropriate escalation of digital enablers a review of the programme of works with Cerner will be required. This would lead to optimisation of systems in place and the alignment of digital and operational transformation. A new work stream to be created to encompass the hospital upgrade project – emergency village. Recruitment into the new Service Improvement Team has been completed with all posts being successfully recruited to. It is expected that the full compliment of the team should be in place by the end of November. Going forward the 'perioperative medicine' highlight report to exclude medical cancellations from the data reports as this is impacted by day case scheduling due to pressure on beds in the system. A presentation providing a summary of progress and ongoing work within the Outpatient Improvement Programme was provided by Jeremy Weetch, Clinical lead and Alistair Leinster, Programme lead. A summary of the key drivers for change were provided and an outline of the objectives: • 2019/20 contracted activity plan • Reduction of clinic cancellations • Increase use of technology across outpatient service Discussions regarding the long term strategy for patients to access out-patient services are underway within specialties although it was recognised that one solution may not fit all. The Board of Directors stressed the importance to deliver this programme as the benefits are broader than the Trust, this would be an opportunity to improve services across the health economy.	

Reference	Minute	Action
	On behalf of the Board the Chair thanked the team for the hard work and that this message is passed to colleagues. ***The Board noted the Change Programme summary, delivery and assurance report and the presentation regarding the Outpatient Improvement programme.***	

BM 19-20/129	**Report of Trust Management Board**
	
	The Chief Executive provided a report of the Trust Management Board (TMB) meeting on 22nd August 2019 which covered:
	
	• Quality & Performance Dashboard
	• Divisional updates
	• Safety Management Strategy Action Plan
	• Values Based Recruitment Questions
	• Consultant Replacement Process
	• Month 4 Financial Position
	• Business cases:
	  ○ Capacity Management Handheld Devices for Porters
	  ○ Acute Medicine Nursing Establishment Investment
	  ○ Resource for the Management of Medicines Shortages
	• Chair reports from other meetings
	• Infection Prevention Control
	• Capital Programme
	
	The Board noted the report of the Trust Management Board.	

BM 19-20/130	**Safety Management Assurance Committee** Mr Steve Igoe, Non-Executive Director, provided a verbal report of the key aspects from the recent Safety Management Assurance Committee, held on 3rd September 2019 which covered: • Health & Safety, including progress against ISO45001 standards • Chairs report of the Health & Safety Committee • Safety Management Action Plan • First letter of recommendation for good practice has now been issued • Submission for the Royal Society for the Prevention of Accidents (RoSPA) Bronze Award between October 2019 and January 2020. Good progress continues across a range of indicators and the Committee were provided positive assurance regarding the trajectory and pace of change. ***The Board noted the verbal Safety Management Assurance Committee report.***	

Reference	Minute	Action
BM 19-20/131	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee, held on 14th August 2019 which covered: • Staff story – Ophthalmology • Workforce KPI's dashboard • Workforce Race Equality Standards • Workforce Disability Equality Standard (WDES) • Safe Employment / Recruitment Quarterly Report • Draft Communication & Engagement Strategy • Health & Wellbeing Plan • Chairs Report of the Workforce Steering Group The Committee acknowledged the significant progress captured by measurable improvements within the Ophthalmology service and Sharon Landrum, Diversity and Inclusion Lead for all her work in moving the agenda forward. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 19-20/132	**CQC Action Plan progress Update** The Acting Chief Nurse/Director of Quality & Governance apprised the Board of the continued progress pertaining to the CQC Action Plan based on the 2018 inspection. He was pleased to report there were no overdue actions. Of the 219 actions 218 have been completed and fully embedded, the exception is due to a delay launching the Patient Experience Strategy main due to nursing priorities being focussed upon infection prevention and control and managing patient flow. In completing the actions the Board of Directors acknowledged the achievement within the identified timeframes and this was a clear demonstration of a success story for all involved. The Urgent Care overdue actions relate to the triage responsiveness of speciality review, streaming and compliance with RCPCH recommended staffing levels regarding paediatric trained nurses within the Emergency Department. ***The Board noted the progress to date of the CQC Action Plan and congratulated all concerned with the delivery of actions identified.***	
BM 19-20/133	**Board Assurance Framework** The Board Secretary provided the update of Board Assurance Framework (BAF) 2019/20. Relevant Assurance Committees have reviewed the updates identified in the report along with providing an assurance rating for each of the risk vectors. The risk rating regarding 'primary risk 6' was considered and the proposed revised risk score was approved. In reviewing the overall BAF it was realised that timeframes against some controls had slipped and these should be reviewed by the assurance committee's.	**AL**

Reference	Minute	Action
	The Board of Directors noted the Board Assurance Framework and approved the revised assurance ratings.	
BM 19-20/134	**Any Other Business** There were no items to report this month.	
BM 19-20/135	**Date of next Meeting** Wednesday 2nd October 2019.	

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Chair

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Date

Board of Directors Action Log
Updated – 4th September 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 04.09.19						
1	BM 19-20/119	CQC preparation session to be arranged for Board members	**AL**	Session arranged following October Board meeting.	October '19	
2	BM 19-20/122	Medical Examiner office – provide update following receipt of local guidance	**NS**		November '19	
3	BM 19-20/124	Short, medium and long term plan to be presented to FBPAC	**KE/HM**		October '19	
4	BM 19-20/125	Finance, Business, Performance & Assurance Committee (FBPAC) to review draft Long Term Plan (including capital programme) and provide recommendation for November Board.	**KE**	Agenda item for September FBPAC	October '19	
5	BM 19-20/126	Consultant appraisal and revalidation – statement of compliance to be submitted	**AL**	Statement of compliance submitted	October '19	acknowledgement of receipt received
6	BM 19-20/127	Workforce Assurance Committee (WAC) to review Communication, Marketing & Engagement Plan	**HM**	Agenda item for September WAC		
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 prepared	October '19	Awaiting timeframe for process, yet to be determined by NHSI
2	BM 19-20/028	Patient Experience Strategy under development	**PM**	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	7
Title of Report	Chief Executive's Report
Date of Meeting	2nd October 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 September 2019.

Internal

Together Awards

We have had a fantastic response to our Together Awards nominations this year. The awards have been aligned to our new Vision "Together we will" and will reflect our Values: "**caring** for everyone"; "**respect** for all"; "embracing **teamwork"** and "committed to **improvement**."

Together Awards 2019 categories are detailed below:

- Patient Choice Award
- Excellence in Patient Care
- Together we will Team of the Year
- Non-clinical Team Award
- Innovation and improvement Awards
- Partnership Award
- Trainee/Apprentice of the Year
- Volunteer of the Year

The event this year will take place on **Friday 11th October** at Thornton Hall Hotel and Spa. Celebrity chef Simon Rimmer is set to host the event with a night of carnival themed entertainment.

In Touch with the Board

September saw the first session of 'In Touch with the Board'. This is a new forum for staff to chat openly with the Chief Executive and members of the Executive Team.

Staff are informally invited to meet up for a coffee and a catch up a week or so after the monthly Board meeting and 'Messages from the Board' communication.

Items for discussion last month by staff included current financial position and plans heading into winter. The subject of the EU Exit was also raised and how WUTH is fully prepared for a possible 'no deal' exit. As an imminent CQC inspection is likely in the coming weeks, this was also discussed by those in attendance.

Serious Incidents

There were no serious incidents declared in September.

RIDDOR Update

The Trust reported 4 RIDDOR reportable incidents in September. Three were reported due to members of staff being absent from work after a fall or manual handling injury. One was a patient fall that fell under the scope of the regulations.

Executive Team Recruitment

Chief Finance Officer
Claire Wilson was recruited to the position of Chief Finance Officer on 20th September 2019. A start date is yet to be agreed.

Chief Nurse
The recruitment process for the Chief Nurse is currently underway, the process will conclude with interviews schedule to take place in November 2019.

National

EU Exit

In preparation for the 31st October leave date, the original EU Exit risk assessment has been re-assessed in line with the EU Exit Operational Readiness Guidance. No significant issues were raised during the first preparations, and none were raised at the WUTH EU Exit planning meeting held in August. The Trust is participating in all NHS England webinars and workshops; regional and local system meetings relating to EU Exit, in order to ensure that robust safe plans are in place. Daily reporting into NHS England/Improvement is expected to commence from 21st October.

Opthlamology - Getting It Right First Time (GIRFT)

The Opthalmology team were asked to present at the national GIRFT event to outline improvements in the cataract pathway that have been made over the past year which has resulted a reduction in patient waits and have moved the Trust from one of the worst performing Trusts nationally to one of the best.

This has been done by using GIRFT 'right care data' to drive improvement in pre-operative process, set up a 'one stop shop' and high turnover operating lists. In 2018 we used to perform 4 cataract operations on an operating list. With the above work we have are now in a position to undertake 10 cataracts on the high turnover lists.

Dementia Friendly Wards

As part of world Alzheimers day, the Trust along with other NHS organisations received recognition for the dementia friendly wards. At Wirral the memories pub complete with replica beer taps and vintage posters was introduced to help dementia patients cope with stress and anxiety and provide them with a familiar environment. See link below to one of many articles.

https://www.nursingtimes.net/news/older-people/nhs-leaders-showcase-examples-trust-innovation-dementia-care-23-09-2019/

Florence Nightingale Award

Christinah Makondo, Clinical Skills manager, won the national Florence Nightingale award for a quality improvement project regarding Aseptic Non Touch Technique (ANTT). She was part of the Windrush Leadership Programme.

Maternity Services Awarded

The Trust has been warded 'Best Performing GAP Trust' at a national event by the Perinatal Institute. The aim of GAP (Growth Assessment Protocol) programme is to ensure all maternity staff are trained in assessing risk affecting fetal growth and that appropriate antenatal measure are taken to prevent or reduce fetal growth restriction. The Trust has a Growth clinic service led by a fetal medicine specialist and a team of high risk midwives. Since it was set up three years ago, we are now the top performing organization in the country.

Regional & Local

Visit of Health Minister, Edward Argar - 18th September 2019

The Health Minister has travelled to Wirral following the announcement of £18 million Government funding to improve urgent treatment services at Arrowe Park Hospital.

Edward Argar visited the Emergency Department, where the upgrade, including a new Urgent Treatment Centre, is planning to be built. The scheme will transform urgent care in Wirral and will include a redesign of the current Emergency Department.

Talking about the visit, Health Minister Edward Argar said: "It was great to visit Wirral University Teaching Hospital and NHS Wirral CCG and to see first-hand the dedication of our fantastic NHS staff. I was pleased to hear about the impressive, clinically-led plans to create an Urgent Treatment Centre to improve care at Arrowe Park Hospital, which has been made possible as a result of an £18m investment from the government."

This is the biggest investment seen at Arrowe Park since the hospital was built almost 40 years ago. This is really good news for staff and patients that Wirral's only Emergency Department will be given the chance to transform itself into a much improved urgent treatment service.

System meetings

NHS England/Improvement has introduced a quarterly Wirral System Assurance which will reduce duplication and enable closer alignment and management of the wider health economy. The augural meeting took place on 25th September 2019.

Regulators will continue to hold the Trust's System Improvement Board where progress against the improvement plans will be monitored.

Janelle Holmes
Chief Executive
October 2019

Board of Directors	
Agenda Item	10
Title of Report	IPC – Clostridium difficile Outbreak Update
Date of Meeting	2 October 2019
Author	Jay Turner-Gardner, Associate Director of Nursing for Infection Prevention and Control
Accountable Executive	Paul Moore, Director of Quality & Governance and Acting Chief Nurse
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 4 Patient Safety and 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
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No adverse equality impact identified

Clostridium difficile Outbreak update

In the 2019/20 year-to-date, there have been 52 reported *Clostridium difficile* infections against a cumulative trajectory of 42.
There were 39 in Quarter 1 against a trajectory of 22 and 13 in Quarter 2 against a trajectory of 20.

2019-20	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Trajectory	7	7	8	7	7	6	7	7	8	8	8	8
Actual	19	9	11	4	6	3						
	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**		
Trajectory	22			20			22			24		
Actual	39			13								
Cumulative	22/39			42/52			62			88		

The Trust declared an outbreak of CDI in February 2019, it was initially declared on the five wards at Arrowe Park Hospital where the *Clostridium difficile* cases were first identified. The outbreak was subsequently closed in April 2019. When cases continued to be identified following closure of the outbreak the outbreak was extended and re-declared in May 2019. Following reported incidences throughout the rest of the trust the Outbreak was declared closed on the five wards in July and extended to a Trust wide outbreak. Weekly Outbreak meetings continued, in September these became bi-monthly.

The cause of the hospital-wide outbreak is multi-factorial, namely around four key factors, all of which are in the process of being addressed

- ***Environment*** - The schedule of agreed ward improvements has commenced as detailed in the 'Infection prevention in the built environment' report which went to the Board of Directors in August 19, progress of which is being monitored by the Trust management board.

- ***Equipment*** – Over 1,000 items of equipment, including patient bed side chairs, patient bed side tables, patient lockers and visitor's chairs have been ordered and these have started to arrive in the trust and are being distributed to the required areas.

- ***Cleaning –*** The Facilities department has undergone some internal restructure, the standards of cleaning along with the cleaning frequencies are under review. Repair and maintenance of the estate along with the arrival of new patient equipment will allow for effective cleaning.

- ***Policies and procedures –*** Key policies are under review and a more robust investigation process has been commenced following each diagnosis of *Clostridium difficile. A*n accountability framework has been introduced to ensure that any lapses in the quality of the care that we deliver are recognised in real time and learning outcomes documented and shared to avoid future failures. A paper will be prepared for next IPC to identify common themes and lessons to be learnt.

Clostridium difficile action plan – This has been shared with the Divisions and monthly updates are discussed at Divisional IP meetings with exceptions reported to the monthly IP Committee meeting.

*'**Clean between' to break the chain of infection*** – week long campaign took place in September, as advertised via daily screen saver. The IP team along with colleagues from Clinell took the safety bus to all wards to discuss the importance of cleaning the environment and pt shared equipment in order to remove contamination and interrupts the transmission of potentially harmful microorganisms.

Board of Directors	
Agenda Item	11
Title of Report	Learning From Deaths – Lessons Learnt Qtr1 2019-2020
Date of Meeting	2nd October 2019
Author	Dr Mike Ellard, Deputy Medical Director (interim)
Accountable Executive	Dr Nicola Stevenson, Executive Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 4 Catastrophic failure in standards of safety and care
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	Yes

1. Executive Summary

The purpose of this paper is to provide the Board of Directors with the Quarter One (2019/20) update on compliance against the Learning from Deaths Guidance and the wider Mortality agenda.

Progress continues in further developing the mortality review process to ensure the opportunity for learning is optimized. The utilizing of Ulysses Safeguard has supported the process and the number of PMR/ SJR's being undertaking is increasing with ≥75% of mortality reviews completed within Quarter 1. The number of SJR's undertaken has also increased but further work is required to ensure all speciality reviews report into the trust mortality processes. Documentation issues continue to be identified through the mortality review process.

2. Background

CQC published its report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS.

From April 2017 onwards, Trusts were required to collect new quarterly information on deaths, reviews, investigations and resulting quality improvement and publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings. In addition the percentage of mortality reviews completed (along with SHMI; HSMR) are now recorded within the Trusts Quality Performance dashboard which is presented monthly to PSQB and the Board.

The purpose of this paper is to provide PSQB with the Quarter One (2019/20) update on compliance against the Learning from Deaths Guidance and the wider Mortality agenda.

3. Key Issues/Gaps in Assurance

The Annual learning from Deaths was presented to PSQB last month and set out next steps to further develop and enhance the review process and thus optimize the opportunities for learning. Progress has been made against these areas including:-

- Liaison with clinical end of life care lead to facilitate shared learning form mortality reviews and SJRs from bereavement carers feedback took place and work is ongoing to link any concerns raised to the bereavement service by carers into the SJR process is progressing.
- The learning from deaths dashboard has been reviewed and improved, however work is still ongoing to enable trend analysis. This is expected to be completed by end of September 2019.

3.1 Learning from Deaths Dashboard

The overall performance of mortality reviews completed has reached 75% for the quarter at the time of writing this report. The number of SJR's completed is showing an increase on previous quarter's performance. It is worth noting that reviews continue to be undertaken following this period and thus quarter performance numbers are adjusted throughout the year.

Total No. of Deaths subject to review	Primary Mortality Reviews	SJR'S	SI's	Elective Surgical deaths	Patients with severe learning disabilities	Patients with severe mental health needs	Maternal	Neonatal patients	Still Births (from 22 weeks)
				Identified through PMR					
366	275	27(19)	2(1)	6(2)	4(4)	1(1)	3(3)	0(0)	4(4)

()= In Progress

*= No. of deaths investigated under SI framework (and declared as serious incidents)

All SJR reviews undertaken within the quarter have indicated adequate care or good care was provided.

Score 1 Very Poor Care		Score 2 Poor Care		Score 3 Adequate Care		Score 4 Good Care		Score 5 Excellent Care		Total Number of deaths considered more likely than not due to problems in care. (From SJR and other Investigations)	
Q1 19/20	0	Q1 19/20	0	Q1 19/20	2	Q1 19/20	6	Q1 19/20	0	Q1 19/20	0

3.2 Learning identified from reviews

Documentation issues continue to be identified through the mortality review process. This includes:-

- Unnecessary distress to family by sending letters out to deceased patients (within screening programs) several months after death
- Use of copy and paste function, particularly for inpatient reviews leads to factual inaccuracies (not referencing date of events), poor coding and poor correlation between GP discharge summaries and actual death certification
- Inadequate coding during inpatient stays >60 days leads to an increased number of "residual codes unclassified"
- Inconsistent documentation DNCPR across all patient records (ie CERNER vs Buff notes) leading to confusion about arrest calls
- No use of the "Care in the last days of life" document when the dying phase has been identified in the majority of cases. This is a significant change compared to Q1 in 18-19
- In 2 SJRs the global assessment was adequate for both. In both cases it related to delay of investigation (CT scan) and treatment (timing of end of life pathway assessment). In neither case was it felt to have affected outcome. All other SJR assessments had a "good" for global score

3.3 Actions initiated to support improvement

- Share learning via safety summits (September, already done in August) and safety bites- **process ongoing**
- DNCPR work stream reviewing methods of recording DNCPR in IT system - **ongoing**
- Meet with screening leads to understand current processes and identify mechanism for removing deceased patients form screening lists

4. Next Steps

1. Speciality reviews to report into trust mortality processes facilitating maximum learning opportunity
2. Staff education on use of CERNER End Of Life documentation
3. Identify locally key staff for LeDeR death reviews
4. Perform audit of LeDeR deaths in last 4 quarters to identify cause of death, DNACPR process, nutrition and use of NEWS2
5. Audit case notes where in hospital DNACPR is documented on CERNER to identify compliance with documentation
6. Improve coding of causes of death through clinical teams reviewing deaths in a timely manner with coding staff
7. Review palliative care / community DNACPR pathways with local partners
8. Examine GIRFT or other available resources for regional comparison of ED death categories to identify areas for service improvement.

5. Conclusion

The utilising of Ulysses Safeguard has supported the process and the number of PMR/ SJR's being undertaking is increasing with ≥75% of mortality reviews completed within Quarter 1. The number of SJR's undertaken has also increased but further work is required to ensure all speciality reviews report into the trust mortality processes. Documentation issues continue to be identified through the mortality review process

6. Recommendations

The Trust Board of Directors are asked to note the improvements made to ensure learning from deaths is optimised.

Board of Directors	
Agenda Item	12
Title of Report	Health and Safety Management Quarter 2 update
Date of Meeting	2 October 2019
Author(s)	Jacqueline Robinson, Head of Quality Governance
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Safety
Level of Assurance • **Positive** • **Gap(s)**	Positive with some Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

Outlined within this report is an overview of Quarter 2 2019 Health and Safety performance and assurance activities, together with an update on progress against the Health and Safety Action plan developed utilising recommendations from the independent Health and Safety Audit and other sources of intelligence.

Significant progress has been made in building the Health and safety management framework in accordance with ISO45001 and Divisions are currently progressing the actions from the inspection reports.

The H&S performance dashboard has been further developed and now provides a good range of leading and lagging indicators – provided in Appendix 1. This has now been replicated for Divisions to review and respond to H&S performance within their Divisions – though further development work will be required in line with consultation and feedback received.

Some improvements have been seen with regard to reduced EL/PL and RIDDOR reportable incidents however more time for the new framework to embed will be required before significant improvement in lagging indicators are seen.

There remains significant work to be undertaken in order to have a fully compliant H&S management system but progress is positive with strong engagement and the Trust are on track to achieve at minimum ROSPA bronze this year.

2. Health & Safety Management Arrangements

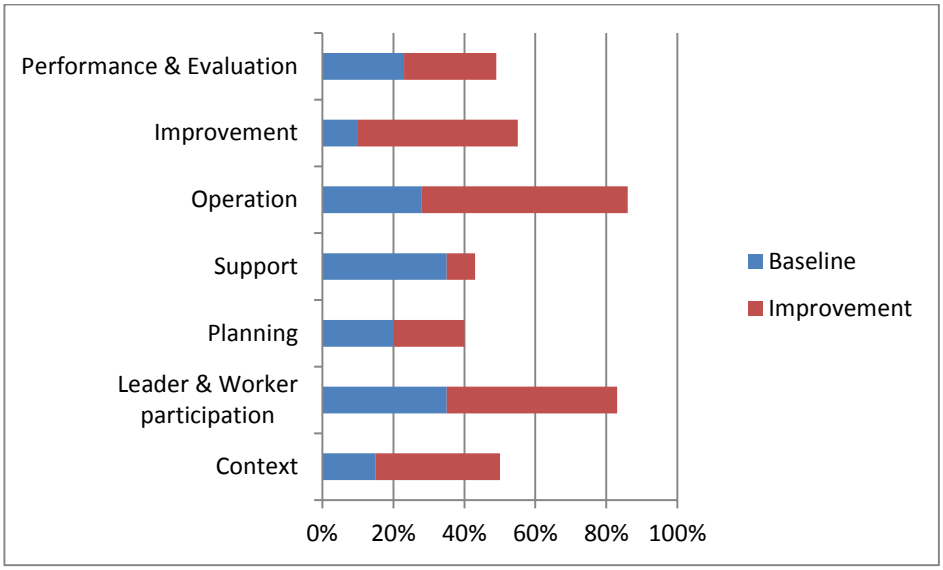
Following activities to establish a baseline for the Trusts current levels of Health and Safety Management arrangements utilising both internal and independent reviews, it was determined that the international standards ISO45001 would be utilised in order to support the organisation in building a robust, structured Health and Safety management framework which would support compliance with legislative and regulatory requirements structured framework and ensuring a safe and healthy workplace.

ISO45001 sets out seven core elements as illustrated in diagram 1 below:-

Diagram 1: 7 Seven core elements of ISO45001

In order to deliver the improvements required at pace, actions to build the required framework have been undertaken concurrently whilst ensuring a managed approach to communication and implementation is undertaken.

The audit undertaken by Arcadis scored the Trusts H&S management arrangements against ISO45001 standards and provided an action plan. The Chart below demonstrates progress against the action plan.



Summary of actions undertaken which have led to this improvement:-

Context	Leader & Worker Participation	Planning	Support	Operation	Improvement	Performance & Evaluation
H&S Risk Profile	Safety Management Assurance Committee	H&S Management Strategy - set out objectives	Communication Mechanisms with development of H&S reports/exception reports	Cycle of Business ensures risk, improvement plans & assurance communicated through H&S Committee.	Perfect Ward Audits - drive forward improvement, rationalisation of incident types with Ulysses.	Trustwide H&S dashboard,
Stakeholder Map	H&S Management Committee re-established with Union rep.	Topic of the Month - Div focus on areas of H&S Risk.	Presentation to DivDoNs, ADN's, Matrons, Ward Managers	Actions tracked through robust Governance Arrangements.	RIDDOR reportable incidents monitored at SIEG.	Draft Divisional Level dashboards,
Horizon Scanning	H&S Management Responsibilities Matrix	Divisions provided with Action Plan respond to Inspection Findings.	Operating Procedure & Poster Chlor-Clean.		Investigation of sample of near miss or dangerous occurrences.	Perfect Ward questions identified & pulled into H&S dashboard
H&S Strategy	The Needlestick Injuries Safety Group ToR	New COSHH Risk Assessment Proforma	H&S Training Seminars : Mandatory MH Prac Session. 20 H&S Theory			Local Enforcement Notice Protocol - recognising Good Practice.
	Chair's Report fed into H&S Management Committee	New Hand Book Developed around key H&S risks				
	Operational Level Initiated Development Matrix					

3. Performance

Significant progress has been made on developing a performance dashboard for Health and Safety performance measurement which incorporates both 'leading' and 'lagging' indicators as recommended in best practice guidance.

The Trust level performance dashboard continues to develop as more data sources become available to us and has been discussed at both the Health and Safety Management Committee and Safety Management Assurance Committee – See Appendix 1

Key Issues from performance dashboard:-

- ***RIDDOR***:
  - 14 RIDDOR Reportable incidents to date – 10 Manual handling, 4 Slips, trips or falls. 13 of these resulted in an over seven day absence and two were reported as specified injuries – slight reduction on monthly average compared to 2018/19.

    There has been an increase in RIDDOR reportable incidents being reported within the statutory timescale. Though significant work is still required in order to achieve the required 100%

- ***H&S Incident reports:***
  - The number of H&S incidents/ near misses through Ulysses Safeguard increase on monthly average from 2018/19 – likely can be attributed to increased awareness.
  - Top 6 highest non-clinical incidents:-
    - Physical Assaults
    - Unsafe Environment
    - Collision or Contact with Object
    - Clinical Sharps
    - Manual Handling
    - Slips Trips Falls

  Lessons learnt shared with Divisions through Health and Safety Management Committee. Specific actions requested and detailed within Divisional H&S reports sent to all Divisions.

  H&S incidents are being managed quicker than previously seen in 2018/19

- ***Claims***
  - There has been a reduction in the average number of new EL/PL claims received to date, compared with 2018/19 – Table 2 below provides a summary of claims received to date

Table 2: Summary of new EL/PL claims received to date

	Date	EL/PL	Division	Brief detail of claim	Outcome
1	Apr	EL	Surgery	Tripped over tape on the floor	
2		EL	Medicine	Sharps injury from waste bag	
3		**PL**	Infrastructure	Damaged car against entry barrier post	**Settled 2019**
4		EL	Infrastructure	Slipped on wet floor in toilet	
5	May	**PL**	Infrastructure	Struck by descending car park barrier	
6		**PL**	Med(or Inf)	Slipped on splashed water around sink & fell	
7	June	**PL**	Infrastructure	Slipped on wet floor – leaking ceiling CRC	

	Date	EL/PL	Division	Brief detail of claim	Outcome
8		**PL**	Infrastructure	Car damaged by falling car park barrier	
9		EL	Medicine	AMU nurse tripped over computer stand	
10		EL	Medicine	Assaulted by patient on AMU	
11	July	**PL**	Women's	Wheelie chair slipped out from under visitor	
12		EL	Medicine	Assaulted on AMU by aggressive patient	
13		EL	Medicine	Needlestick injury to domestic- Ward 27	
14	Sept	EL	Infrastructure	Hernia from pushing faulty trolley – wheel jam	
15		EL	Infrastructure	Lost footing on uneven flooring of lift.	
16		**PL**	Infrastructure	Trolley toppled due to floor defect- #wrist	
17		**PL**	Infrastructure	Slipped and fell – Ward 36. Shiny or wet floor.	

- ***Mandatory H&S Training compliance***
  - Overall compliance 86%
  - Health & Safety - Level 1 – 91.3%
  - Moving & Handling - Inanimate Loads - 91.4%
  - Moving & Handling - People Handling – 75.36%
- The H&S team have provided:-
  - 20 H&S/ Manual Handling training sessions; and
  - 76 moving and handling, people practical sessions to date this year.

- Additional training sessions have been arranged to support increased compliance in Moving & Handling - People Handling

- ***Regulator notifications***
  - The Department of Transport carried out an inspection at Chester & Wirral NHS Microbiology Services in September. A letter was subsequently received identifying areas of non-compliance with the Carriage of Dangerous Goods Act. This was in reference to transport of infectious substances between sites and to Public Health Laboratories. An action plan has been developed and submitted. Actions include:-
    - Establishing access to a Dangerous Good Safety Advisor
    - Developing a Safety Plan and risk assessment
    - Strengthening security training arrangements

- ***Attendance at H&S meetings***
  - Whilst attendance at the Health and Safety management committee appears low at 57% this actually equates to approx. 20 people. A further review of membership will be undertaken to ensure that each Division is appropriately represented.

4. Next Steps

Significant work has been undertaken to establish a framework by which Health and Safety can be effectively managed. Progress continues to be made on implementing the recommendations provided by the Arcadis External Audit and it is anticipated that this will be complete by December.

The Trust has entered the next phase of the improvement project and information to enable the Divisions to strengthen their Health and Safety arrangements has been developed. The Divisions are currently focusing on:-

- Ensuring H&S is integrated into Divisional Governance arrangements utilizing the communication tools provided
- Responding to actions identified through the Arcadis inspection
- Responding to 'Topic of the month'

Whilst this work continues, actions undertaken at a Corporate level will need to be replicated at a local level in order to establish Health and Safety Manuals for all areas i.e. determining the H&S risk profile for each division.

As key outcome of the Quality Strategy was to achieve ROSPA Bronze award in 2019/20. Applications for the award open in October and a self-assessment will be undertaken to establish any gaps before final submission which must be before February 2020.

5. Recommendations

The Board are asked to note the significant and rapid improvements made, the performance measures now available to us and the next steps identified.

Appendix 1

Trustwide H&S Performance dashboard (accurate as of 27/09/19)

Total no. non-clinical safety incidents			
	2018/19 (monthly Av.)	**2019/20** (monthly Av.)	**Increase/ Decrease**
No reported (monthly average)	1580 (131.66)	881 (146.83)	↑
% incidents managed in Ulysses within Trust Timescale	49%	53%	↑
RIDDOR incident			
	2018/19 (monthly Av.)	2019/20 (monthly Av.)	**Increase/ Decrease**
No reported 2018/19	34 (2.83)	15 (2.33)	↓
% reported within timescale	61%	73%	↑

EL & PL Claims			
	2018/19(monthly Av.)	**2019/20** (monthly Av.)	**Increase/ Decrease**
No. new claims received	45 (3.75)	17 (2.83)	↓

Riddor Injury Type	
Death	0
Specified injury	2
Over 7 day absence	12
No injury(DOcc)	0

Near Miss/ Non-compliance	
No. of near miss incidents reported	150
No. of near miss incidents investigated	0
No. of non-compliances identified	35
No. of non-compliances investigated	0

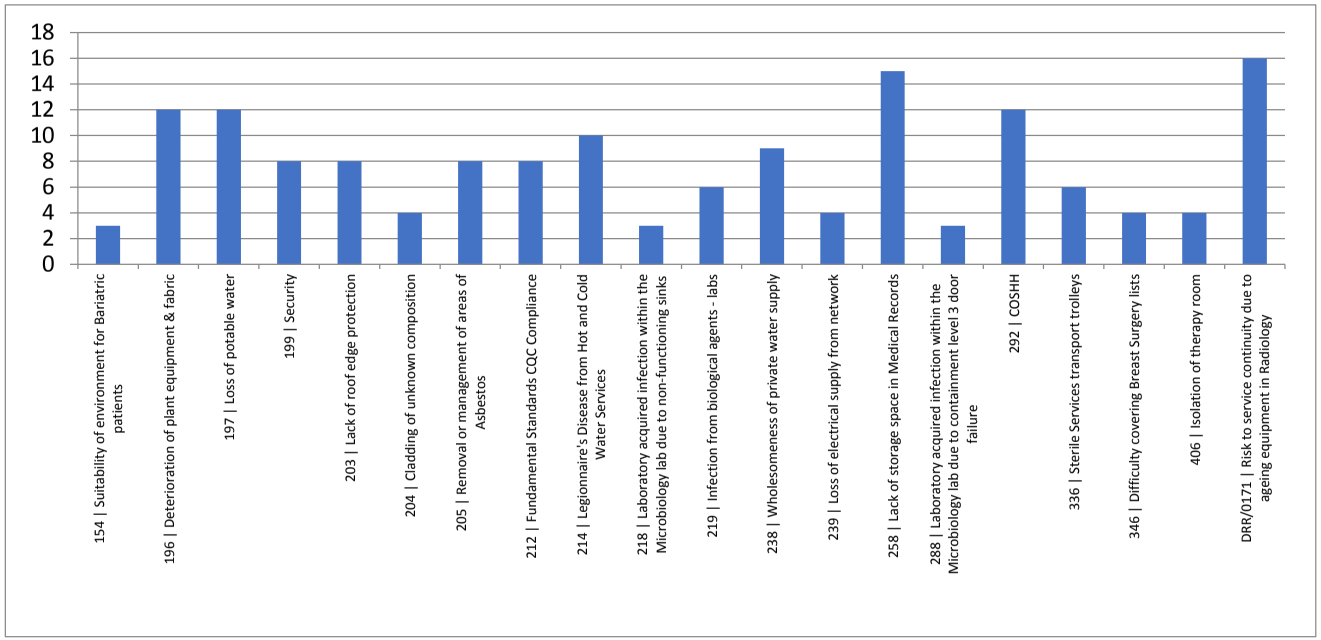
H&S Interventions	
No. of informal advice	**6**
No.of letters of recognition	**2**
No. notice of urgent action	**1**
No. of suspension notices	**0**
No. of duty of care notices	**2**

H&S Assurance activity	
No. of inspections	**2**
No.of audits	**0**
No. of investigations	**2**
No. of process reviews	0
No. of Senior team H&S tours	8

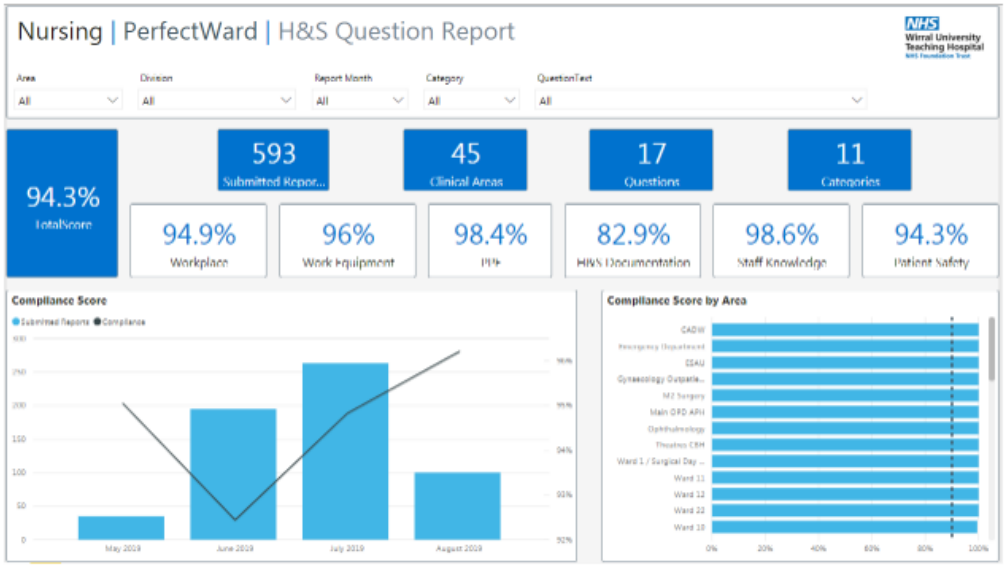
H&S Communication & Consultation			
No. of HSM Committees	2	% attendance	**57%**
No.of SMA Committees	2	% attendance	**88%**
No. of Formal training sessions delivered	96	% Compliance Mandatory Training	**86%**
No. of H&S Comms	2		
No. of Policies reviewed	2		

H&S Regulator	
No. of informal advice	**1**
No. of enforcement letters	**0**
No. notices served	**0**
No. of formal cautions	**0**
No. of prosecutions	**0**

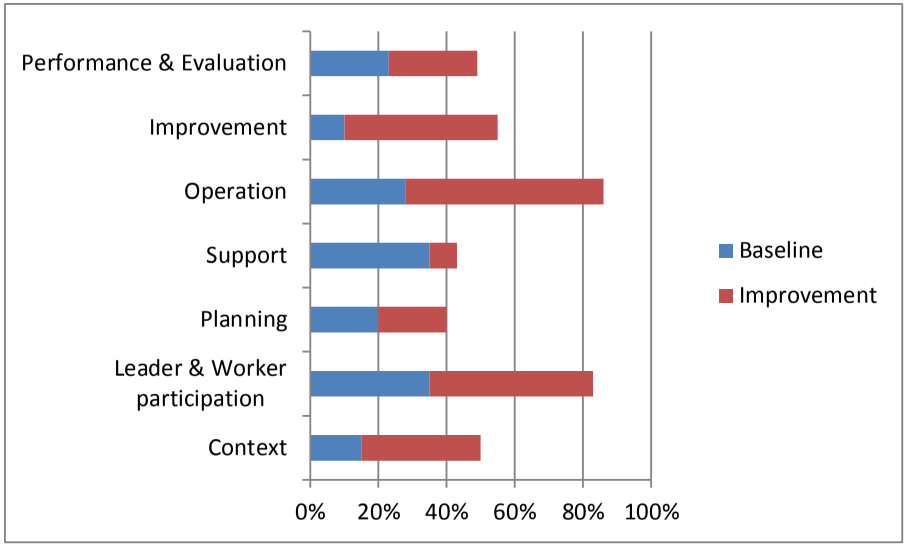
Operational H&S Risks on register



Perfect ward – Example



GAP Analysis Status September 2019



Board of Directors	
Agenda Item	13
Title of Report	Quality and Performance Dashboard
Date of Meeting	4 October 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 August 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 57 indicators that are reported for August (excluding Use of Resources):

- 21 are currently off-target or failing to meet performance thresholds
- 28 of the indicators are on-target
- 8 do not yet have an identified threshold and therefore not rated

The metrics included are under continual review with the Directors to consider the appropriateness and value of inclusion, and also the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

4. Next Steps

WUTH remains committed to attaining standards through 2019-20.

5. Conclusion

Actions to improve are noted in the exception reports on the qualifying metrics to 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 August 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2019
updated 23-09-19

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-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	0.18	0.18	0.13	0.04	0.13	0.17	0.14	0.13	0.18	0.22	0.09	0.09	0.09	0.13	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (audit sample size 150)	Safe, high quality care	MD	≥95%	WUTH	80.1%	82.9%	81.6%	78.4%	80.6%	89.9%	95.0%	98.7%	96.2%	86.0%	91.9%	94.6%	94.6%	92.7%	
	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	95.0%	95.6%	95.2%	95.6%	95.3%	96.6%	96.8%	96.9%	96.4%	96.3%	96.8%	96.0%	94.2%	95.9%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	97.1%	96.4%	96.5%	95.7%	95.5%	97.2%	95.0%	96.0%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	2	1	3	2	4	2	4	2	1	1	4	3	1	2	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	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	0	0	0	0	0	1	0	0	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	0	3	4	2	7	10	5	19	9	11	4	6	49	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	2	3	5	4	2	3	4	2	5	2	0	2	5	14	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	18	15	13	23	9	10	6	5	12	9	8	5	9	9	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	1	0	0	0	2	0	0	0	0	0	0	
	Hand Hygiene Compliance	Safe, high quality care	DoN	≥95%	WUTH	90%	81%	87.0%	85%	76%	83%	99%	99%	98%	91%	98%	99%	100%	100%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	DoN	0	WUTH	2	0	0	0	0	0	0	0	0	0	0	1	0	0	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	DoN	≥90%	WUTH							98%	99%	99%	99%	98%	98%	96%	98%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥90%	WUTH	-	85.6%	90.4%	91.5%	91.4%	91.6%	92.8%	93.9%	93.6%	93.9%	93.7%	93.6%	92.9%	92.9%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥90%	WUTH	-	82.2%	86.0%	87.2%	87.1%	87.6%	88.7%	90.7%	90.9%	91.0%	90.7%	90.4%	90.3%	90.3%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥90%	WUTH	-	86.5%	87.2%	91.7%	91.4%	93.6%	92.6%	93.5%	91.4%	92.8%	91.5%	92.3%	90.3%	90.3%	
	Attendance % (12-month rolling average) (*)	Safe, high quality care	DHR	≥95%	SOF	95.13%	95.09%	95.06%	95.07%	95.06%	95.05%	94.98%	94.90%	94.81%	94.74%	94.63%	94.51%	94.40%	94.40%	
	Staff turnover	Safe, high quality care	DHR	≤10%	WUTH	9.9%	9.9%	10.0%	9.7%	9.6%	9.7%	9.7%	9.8%	10.0%	10.2%	10.5%	9.5%	10.6%	10.6%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	Between 6 and 10	WUTH	7.5	7.1	6.9	7.1	7.0	7.3	7.2	7.2	7.2	7.2	7.4	7.3	7.7	7.36	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2019
updated 23-09-19

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019/20	Trend
Effective	SHMI	Safe, high quality care	MD	Band to be 'as expected' or 'lower than expected'	SOF	-	97.22	-	-	103.12	104.92	106.06	107.49	-	-	-	-	-	107.49	
	HSMR *	Safe, high quality care	MD	≤100	SOF	95	92	92	97	97	98	99	99	97.3	96.3	-	-	-	96.3	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	-	-	-	-	-	86%	71%	56%	76%	78%	63%	60%	44%	76%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	78%	67%	74%	84%	87%	83%	81%	94%	92.0%	95.0%	90.0%	93.0%	92.0%	92.4%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	14.1%	13.1%	15.4%	16.4%	14.6%	14.2%	15.3%	14.9%	16.4%	12.8%	15.7%	18.8%	16.1%	16.0%	
	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	387	411	409	408	397	437	457	438	421	415	403	383	410	406	
	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	-	-	-	-	-	-	-	-	206	190	171	171	210	210	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.1	4.2	4.3	3.8	4.8	3.0	4.4	4.4	4.8	3.9	4.8	4.1	4.2	4.4	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.0	4.9	5.3	5.1	5.0	5.2	5.6	5.2	5.8	5.5	5.1	5.2	5.5	5.4	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	961	888	936	925	917	903	788	914	871	970	884	887	872	897	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	6	18	12	17	14	10	16	14	11	14	10	11	tbc	12	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	83.6%	85.7%	89.5%	86.3%	85.5%	88.5%	85.0%	87.0%	

Quality Performance Dashboard

September 2019
updated 23-09-19

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	16	14	19	18	15	20	14	13	13	13	17	16	24	83	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	89%	86%	87%	84%	92%	85%	87%	87%	87%	89%	91%	91%	92%	90%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	12%	11%	10%	11%	10%	11%	11%	13%	9%	11%	10%	12%	12%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	97%	98%	98%	98%	98%	97%	97%	98%	97%	96%	98%	97%	97%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	14%	22%	24%	18%	18%	19%	15%	13%	19%	22%	31%	38%	34%	29%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	94%	94%	94%	95%	94%	95%	94%	95%	94%	94%	95%	95%	94%	94%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	100%	100%	96%	100%	100%	99%	98%	96%	94%	97%	99%	93%	94%	95%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	17%	28%	11%	19%	37%	27%	36%	44%	25%	29%	44%	29%	24%	30%	

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Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2019
updated 23-09-19

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-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	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	74.0%	76.7%	73.6%	81.1%	83.5%	81.9%	79.9%	79.9%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	2	0	0	0	0	0	0	1	1	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	326	474	371	440	393	379	323	273	437	118	54	76	108	159	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% through 2019-20	SOF	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	79.12%	80.00%	79.04%	80.72%	80.12%	80.06%	79.89%	79.89%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	27,308	26,556	26,862	27,367	26,157	27,506	28,367	27,309	26,223	27,317	25,733	24,733	24,846	24,846	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019-20	National	56	40	43	30	28	28	19	0	0	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	99.7%	99.9%	99.5%	99.3%	99.5%	99.2%	98.3%	98.3%	
	Cancer Waiting Times - 2 week referrals (latest month provisional)	Safe, high quality care	COO	≥93%	National	92.3%	94.5%	95.2%	93.9%	93.1%	87.8%	93.1%	98.1%	91.9%	94.0%	94.0%	94.0%	93.3%	93.4%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (latest month provisional)	Safe, high quality care	COO	≥96%	National	96.3%	96.2%	96.8%	96.7%	96.9%	97.1%	96.7%	96.8%	96.5%	96.7%	97.1%	96.7%	97.1%	96.8%	
	Cancer Waiting Times - 62 days to treatment (latest month provisional)	Safe, high quality care	COO	≥85%	SOF	87.9%	85.7%	85.1%	85.3%	86.2%	85.4%	86.5%	85.8%	85.3%	87.9%	86.3%	85.7%	85.7%	86.2%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	DoN	TBC	WUTH	123	155	119	165	118	178	153	157	162	195	180	178	184	179.8	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	DoN	TBC	WUTH	25	22	19	13	13	27	28	17	17	12	15	17	22	17	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	≥90%	National	75%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	0	4	2	3	2	2	1	3	4	4	4	1	2	3	

Quality Performance Dashboard

September 2019
updated 23-09-19

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019/20	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	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	48	42	38	57	38	43	41	59	31	31	48	50	37	197	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	78.2%	77.5%	78.4%	83.8%	84.5%	84.6%	85.7%	88.2%	77.6%	81.1%	82.1%	83.6%	83.4%	83.4%	

	Indicator	Objective	Director	Threshold	Set by	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019/20	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-4.037	-5.402	-3.340	-1.458	-0.098	-0.825	-1.498	-7.219	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.338	-4.690	-0.237	-0.630	0.914	-0.828	-1.106	-1.887	
	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	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.5%	-13.0%	-6.0%	-6.8%	-5.2%	-4.1%	-7.2%	-7.2%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	-22.1%	-44.0%	-19.5%	-26.8%	-15.6%	-46.4%	-8.2%	-8.2%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.8	-20.9	-14.0	-21.3	-15.9	-16.5	-17.4	-17.4	
	Capital Programme		DoF	On Plan	WUTH	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	56.6%	12.2%	52.1%	31.0%	28.0%	14.7%	19.8%	19.8%	

(*) Updated Metrics
Effective : HSMR

Metric Change
Report source from Dr Foster amended. Rolling 12 months rate, available with a three month lag.

(**) Updated Thresholds
Efective : SHMI

Threshold Change
Green if SHMI Band is 'as expected (2)' or 'lower than expected (3)'

Wirral University Teaching Hospital NHS Foundation Trust

WUTH Quality Dashboard Exception Report Template September 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 VTR+E 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 92.2%.

Action:

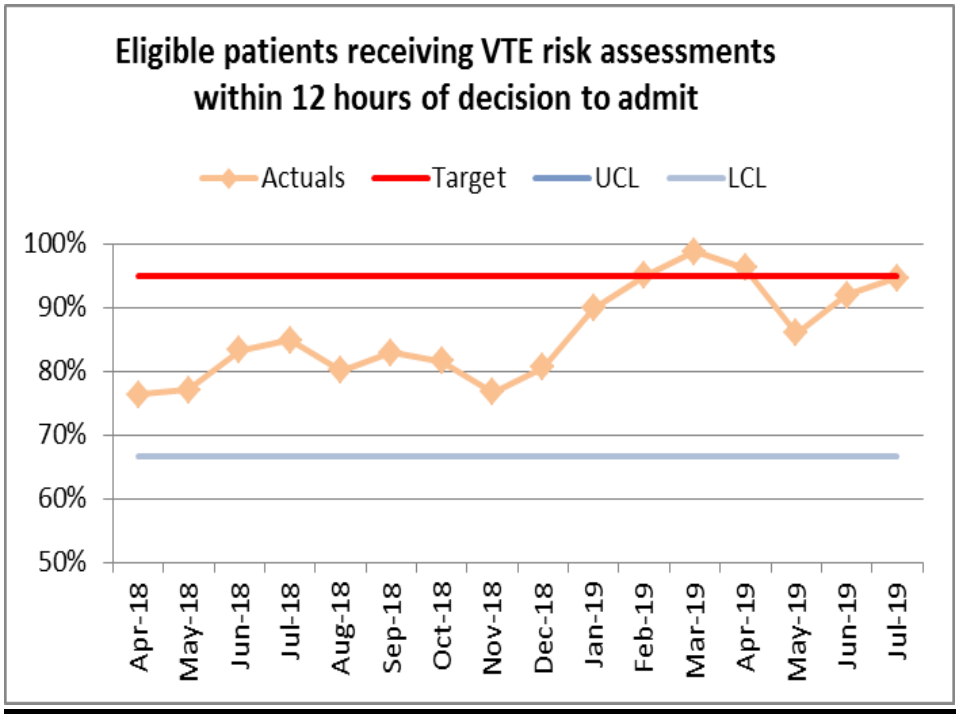
Baseline in 2018 was low, performance improved with VTE alert introduction in January 2019 but has declined as increased "by-passing" therefore reporting on alert "by-passing" to be introduced August 2019.

'Live' dashboard compliance tool being used to highlight problem locations/specialties. Feedback to AMD/CD/CL's.

Increased awareness of areas of failure by location/specialty and further targeted actions.

Expected Impact:

Gradual improvement to occur over 2019.



Clostridium difficile – healthcare associated

Executive Lead:

Acting Chief Nurse

Performance Issue:

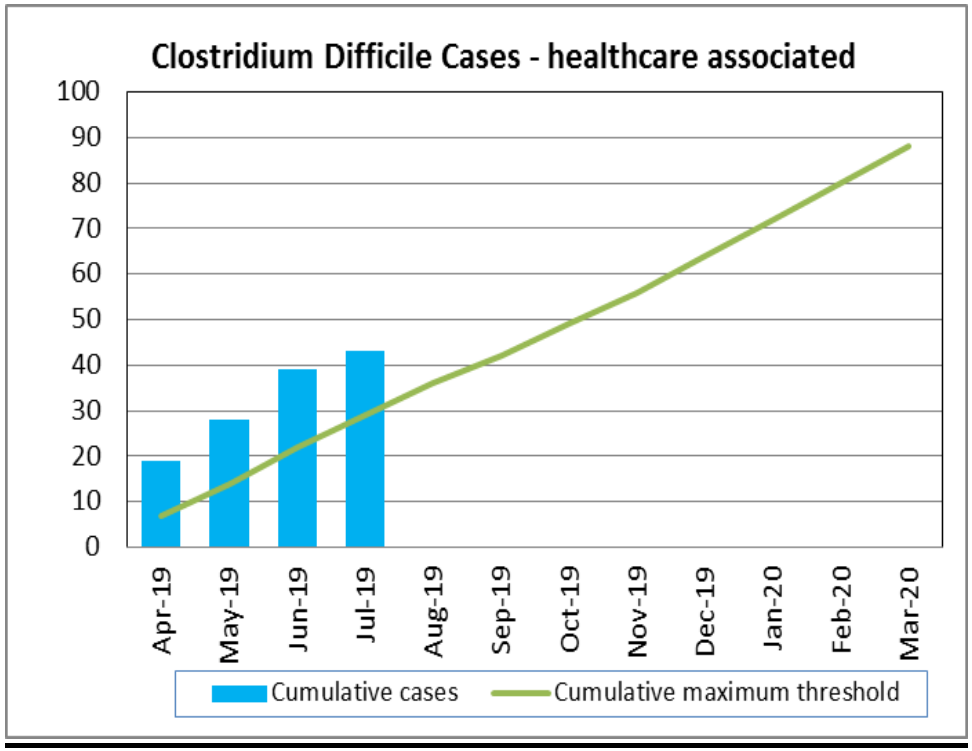
An annual objective has been set by NHSI for WUTH to have a maximum 88 *Clostridium difficile* cases (Hospital onset healthcare associated & Community onset healthcare associated) for 2019-20. A monthly trajectory was mapped out for the year. Up to July 2019 there have been 43 cases against the cumulative monthly trajectory of a maximum 29 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), although the nature of this outbreak is such that the Board should be prepared for increases, especially during periods of very high demand and occupancy.



E. coli infections

Executive Lead:
Acting Chief Nurse

Performance Issue:

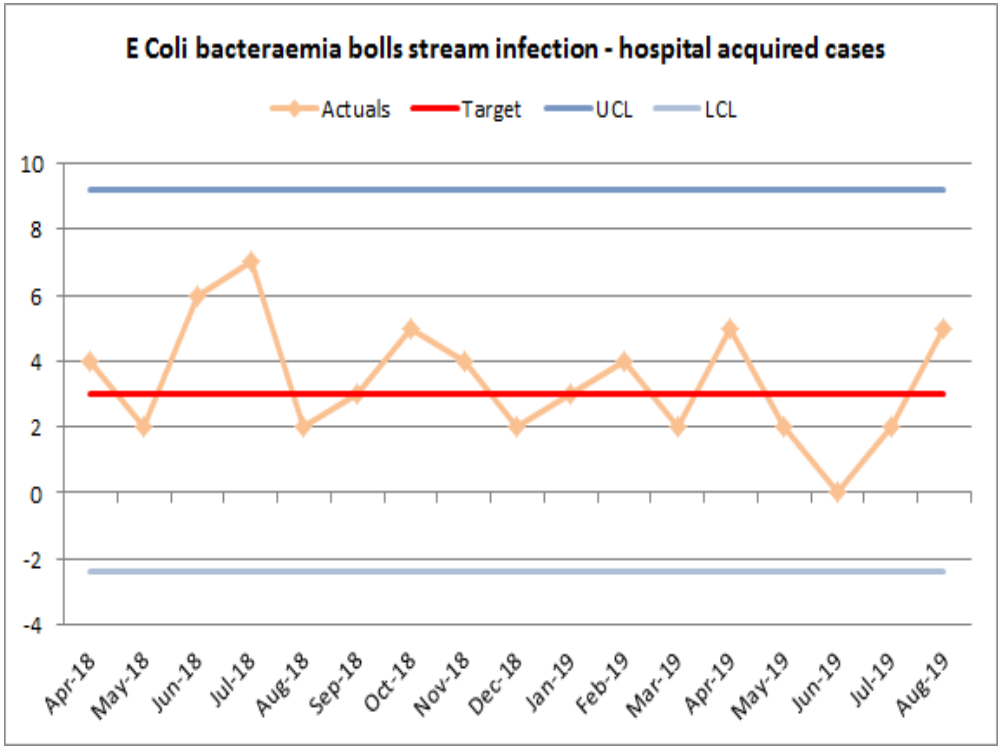
An internal annual objective has been set by WUTH to have a maximum 42 hospital acquired E.coli cases per annum. The monthly threshold is set at a maximum 3 per month

Action:

- A discrepancy has been noted in the annual data that has been collected and reported locally against data that has been reported externally by PHE since 2016, therefore it not possible to accurately determine where WUTH are in relation to the national ambition. A review of this data is in process.
- Divisions are completing SBARs for all E.coli bacteraemias to identify source of bacteraemia and identify lessons; these are discussed at the Divisional IPC meetings
- The source of all hospital acquired E.coli bacteraemias is reviewed by the Consultant Microbiologist
- A whole health economy action plan to reduce Gram-negative bloodstream infections, including E.coli is being developed and monitored by the Wirral Wide IPC Providers Forum
- The UTI Improvement Group, with representatives from the community, secondary care and the private sector is supporting the above action plan

Expected Impact:

- We anticipate greater confidence in reported data to emerge following review and, if necessary, reconciliation under appropriate supervision by PHE.



Staff attendance % (12 month rolling average)

Executive Lead:

Director of HR / OD

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:

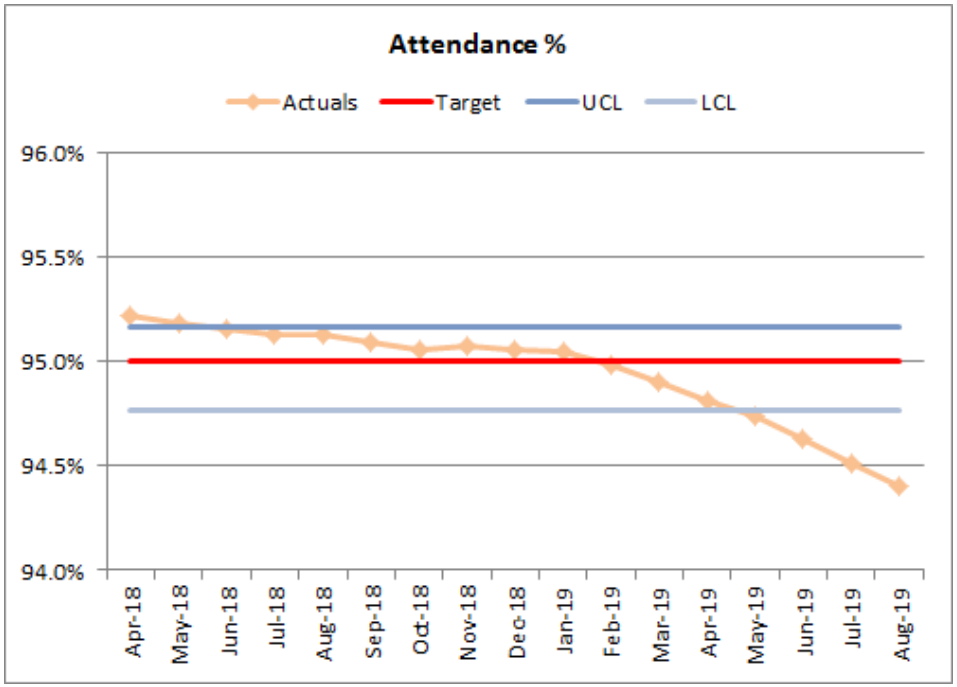
As detailed at September 2019 Board meeting.

Note: Workforce Assurance Committee (25.9.19) assured that the process and policies in place will support driving change.

The first set of monthly data collected by the First Care pilot project in the Facilities & Estates areas received and presented to WAC and TMB

Expected Impact:

To improve attendance to the 95% target over the next 6 months.



Effective Domain

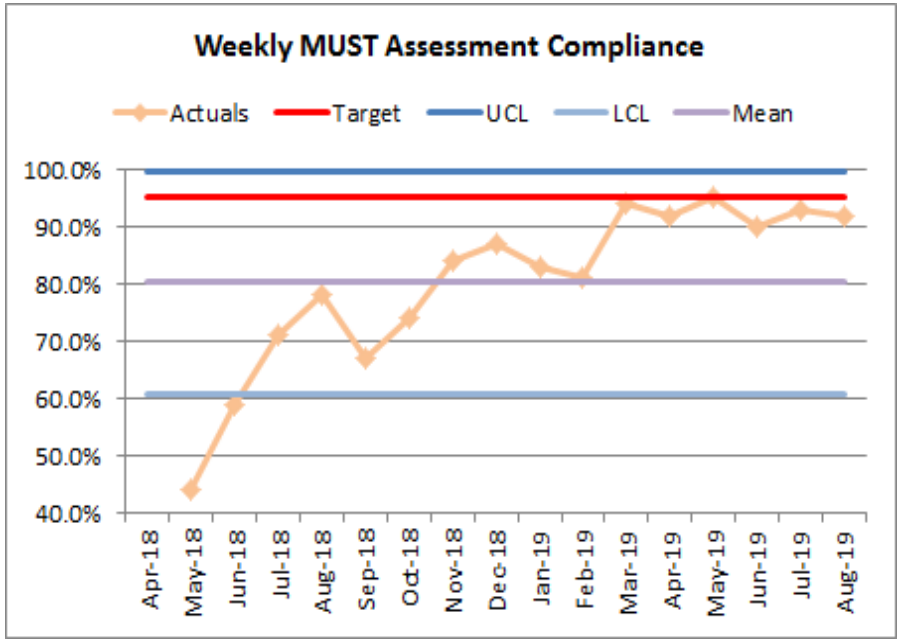
Nutrition and hydration – MUST completed at 7 days

Executive Lead: Acting Chief Nurse

Performance Issue:
An internal WUTH target is set at a minimum 95% compliance with MUST recording every seven days. Although achieved in May 2019 for the first time, performance from June onwards has been below compliance, with August showing a slight deterioration to 92%. The non compliance is predominantly in the Division of Surgery which has been raised and discussed. Corrective actions have been agreed.

Action:
MUST compliance is currently reported weekly. All non-compliance is being monitored and scrutinised via the patient harms panel. MUST assessments are now being monitored daily across all Divisions by Matrons and ADNs to ensure full compliance. This process will continue until significant progress is achieved. Within the Division of Surgery, a new process has been implemented where the MUST assessment is completed in the SEAL unit pre-operatively. Divisional Directors of Nursing are monitoring compliance on a daily basis.
The Trust Lead for Nutrition and Hydration is in the process of standardizing the MUST risk assessment process, ie ensuring individualised care (weighing on day 7 or more frequently as the patient's condition changes rather than having a 'weigh day' for the ward). All patient safety huddles to be patient/risk focused rather than information giving, ensuring that the Trust M Page on Cerner is incorporated into the safety huddle thus identifying all risk assessments which require updating in line with Trust policy and agreed national standards. Additional huddle to be introduced at 3pm across all wards to ensure that compliance is met.

Expected Impact:
This is monitored weekly. At the time of report performance for September 2019 is 97%



SAFER bundle: % of discharges taking place before noon

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

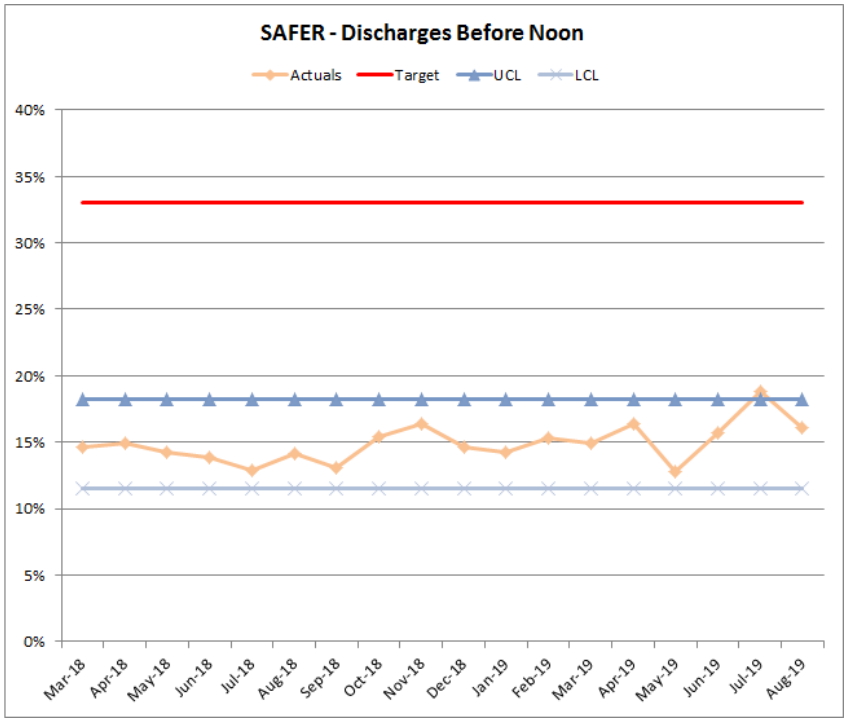
A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon

Action:

Continued focus with ward MDTs to reinforce the importance of preparing for early morning discharge through action focused board rounds and early afternoon huddles. Aiming for TTHs and discharge summaries to be done the afternoon/evening before discharge wherever possible.
With ECIST direction a new approach to board rounds is being deployed with the aim of consistency across all Acute and community beds by the 1st November.

Expected Impact:

To consistently deliver by over 20% by the year end, as part of staged improvement to 33%.



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 in the overall best interests of the patient or reflects their 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 is no adverse safety or quality implications identified as a consequence of these breaches in Intensive Care Unit (ICU).

Action: For delayed discharges – the Critical care teams ensure that specialist input continues on the unit. The patient will have daily ward round from their admitting consultant to compliment the critical care reviews. Physiotherapy and support service input will continue. Treatment plans will be adhered to. All delayed discharged patients have a privacy and dignity form completed daily on Wirral Millennium to make sure all their needs are being. This includes being placed into a side room, ensuring the patients are kept up to date and the reason for the delay is explained to them.

The unit has a 'service improvement lead 'who is reviewing 10 patients a month to ensure that all the above is happening. Any feedback will be acted on to improve the patients stay.

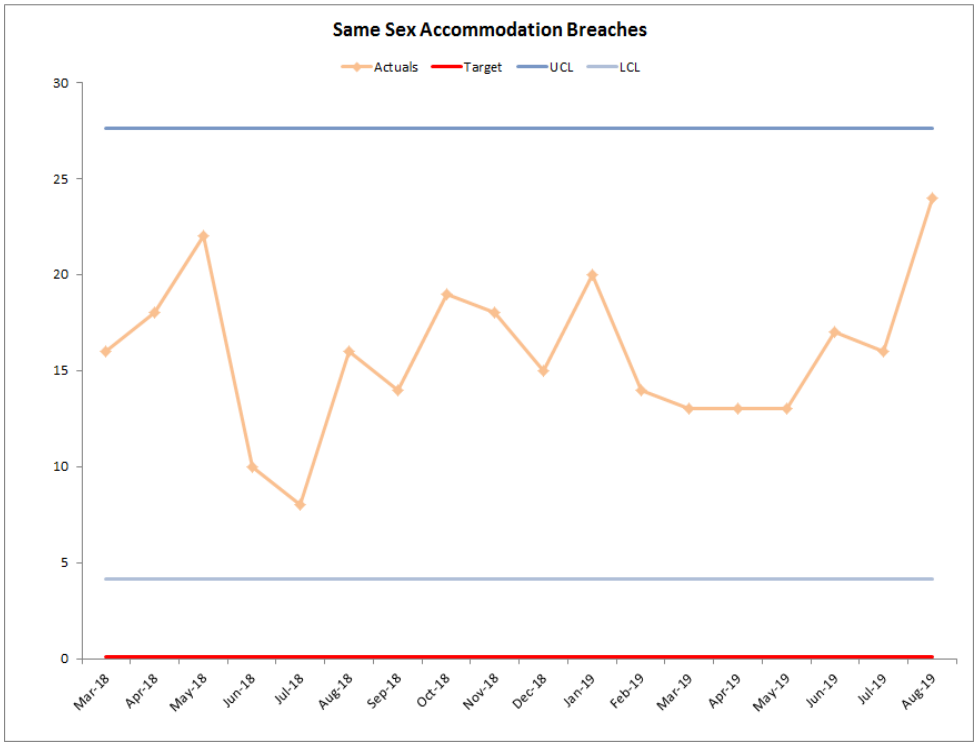
Critical care had received no complaints in the last 12 months from patients whose stay has been extended in Critical Care due a delayed discharge. Friends & Family Test results show 100% recommend rate and a 0% not recommend rate.

All critical care moves are discussed at every bed meeting and moves prioritised as needed. No Patient has been refused a critical care bed if they have needed one.

Actions to reduce extended length of stay and overall bed occupancy rates such as those outlined by the Patient Flow Programme should, if successful, minimise or eliminate same sex breaches occurring on the Intensive Care Unit.

Expected Impact:

The above actions will continue to contribute towards minimising the risk as far as possible given the prevailing operating conditions



FFT recommend rate: ED

Executive Lead:

Acting Chief Nurse

Performance Issue:

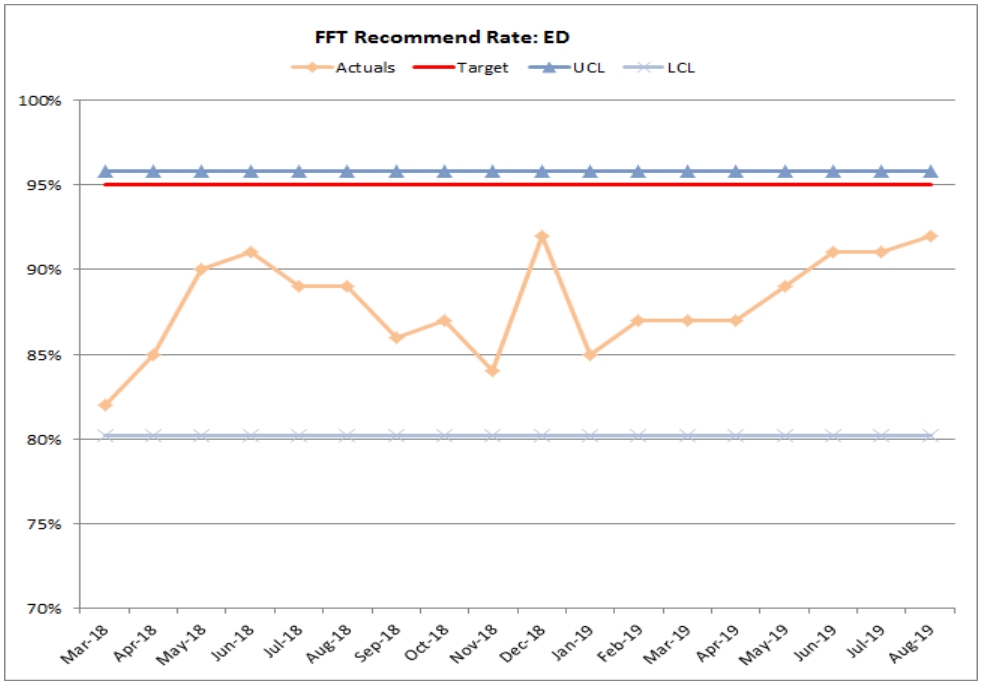
A WUTH target is set at a minimum 95% recommend rate. This standard is improving, with the average for 2019-20 at 90%. Feedback highlighted delays and poor communication as primary reasons for not recommending.

Action:

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

Expected Impact:

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



FFT recommend rate: Outpatients

Executive Lead:

Acting Chief Nurse

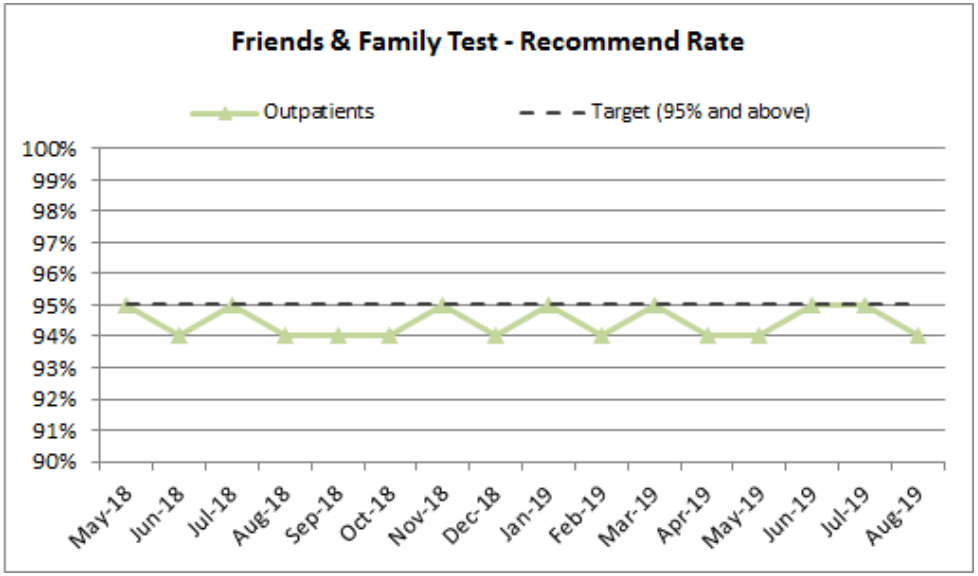
Performance Issue:

A WUTH target is set at a minimum 95% recommend rate. This standard was not met in April and May at 94%, was achieved in June and July at 95%, however August has returned to under-achievement at 94%. Feedback highlighted delays and poor communication as primary reasons for not recommending.

Action:
Additional patient experience rounds have been introduced in times of pressure apologising for delays, a focus has been made to improve communication for patients in the department. Outpatient flow is also being modernised to improve patient experience through assessment stations and phlebotomy centres reducing delays for patients.

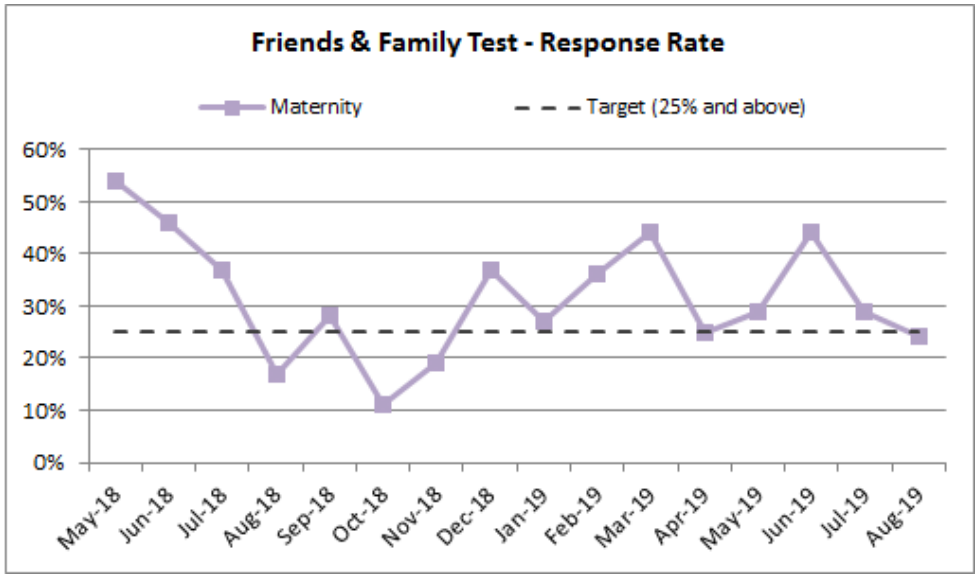
Expected Impact:

Uncertain, will continue to monitor.



FFT response rate: Maternity

Executive Lead: Acting Chief Nurse
Performance Issue: A WUTH target is set at a minimum 25% response rate. Although regularly achieved in Maternity, August's rate was 24%.
Action: Patient experience volunteers are targeting the area offering additional support to improve response rates within the department.
Expected Impact: The Trust is expected to achieve the target of 25% in October 2019.



Responsive Domain

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

Executive Lead:

Chief Operating Officer

Performance Issue:

The Trust has a recovery trajectory agreed with NHSI for 2019-20 for the 4-hour Accident and Emergency target. In May & June 2019 performance was above the trajectory, but since then has been below. August was 79.9% against a trajectory target of 85%.
In addition there was a single patient under the care of CWP in August that waited more than 12 hours in ED following a decision to admit

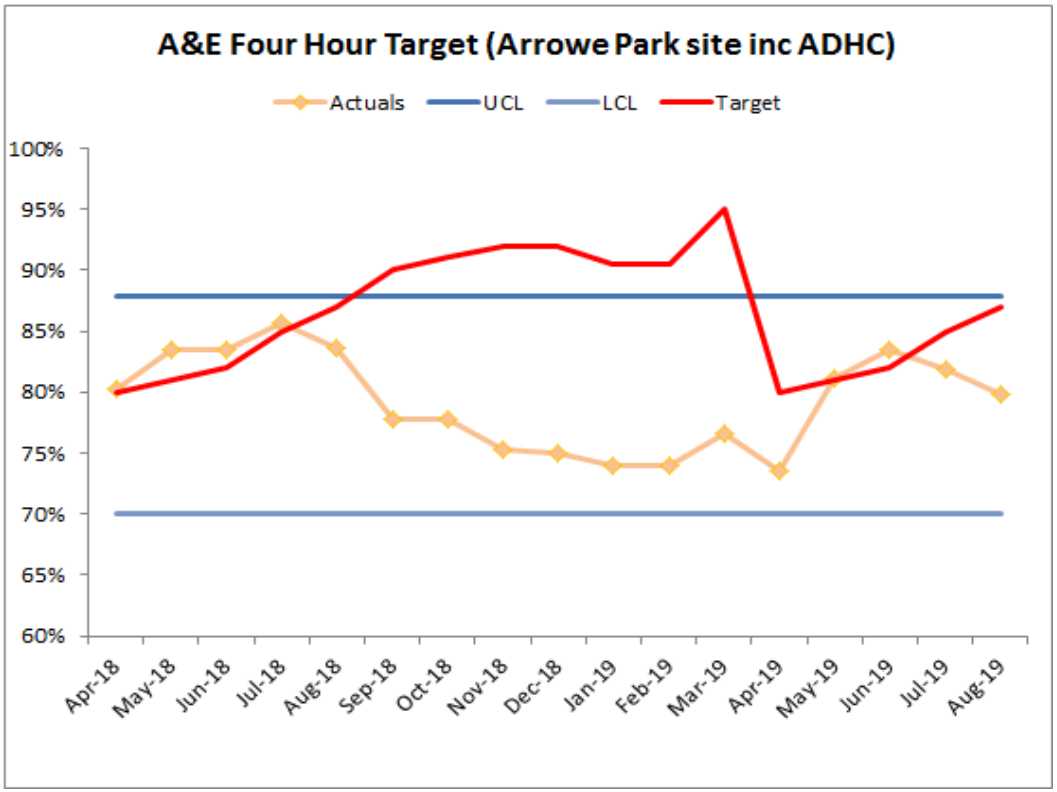
Action:

With national expertise provided by ECIST the Trust and wider system are working on 2 key workstreams:

1. The appropriate streaming of patients from arrival at ED
2. The reduction in over 21 day LOS patients. Daily meeting to escalate delays is underway as a short term call to action with more resilient improvements on board rounds across acute and community beds as well as integrated discharge team form and function actioned from October.

Expected Impact:

A 40% reduction in over 21 day patients by the end of October is the equivalent of 78 occupied beds.



Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead:

Chief Operating Officer

Performance Issue:

The Trust has a trajectory agreed with NHSI for 2019-20 to maintain at 80% of patients waiting on incomplete Referral to Treatment pathways to be under 18 weeks. This has been regularly achieved since May however August's position was fractionally short of the threshold target at 79.89%.

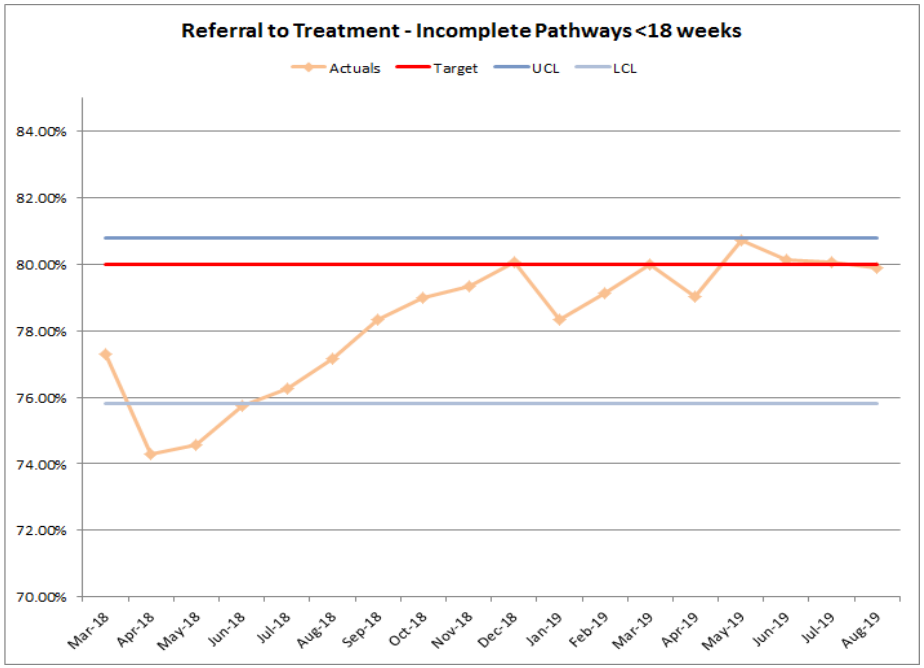
Action:

Patients on all open pathways are being tracked and actively managed according to clinical priority. The prime focus for elective standards remains the 52+ week waiters and total list size objective, however all actions are taken to also maintain the 80% position.

The total waiting list size rose in August in line with projections and submitted trajectory.

Expected Impact:

A return to compliance is expected during September as the total list size reduces to increased activity levels.



Diagnostic Waiters 6 weeks and over

Executive Lead:

Chief Operating Officer

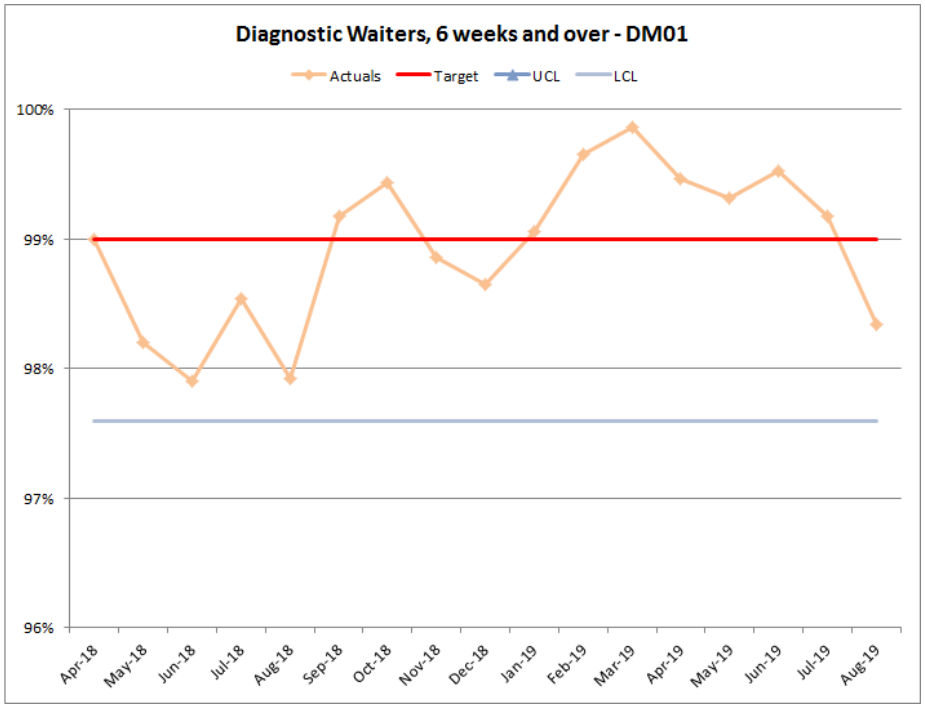
Performance Issue:

A national standard in support of Referral to Treatment waiting times is that patients should not wait longer than 6 weeks for diagnostic tests. The threshold target is set at a minimum 99% of patients waiting for a subset of investigations at month-end to be 6 weeks or less.
WUTH has achieved in excess of 99% since January however in August this slipped to 98.3%.

Action:
Departmental waiting lists are being actively managed and reported into the weekly Senior Operations Performance Meeting to allow for problem areas to be highlighted and escalated effectively.

Expected Impact:

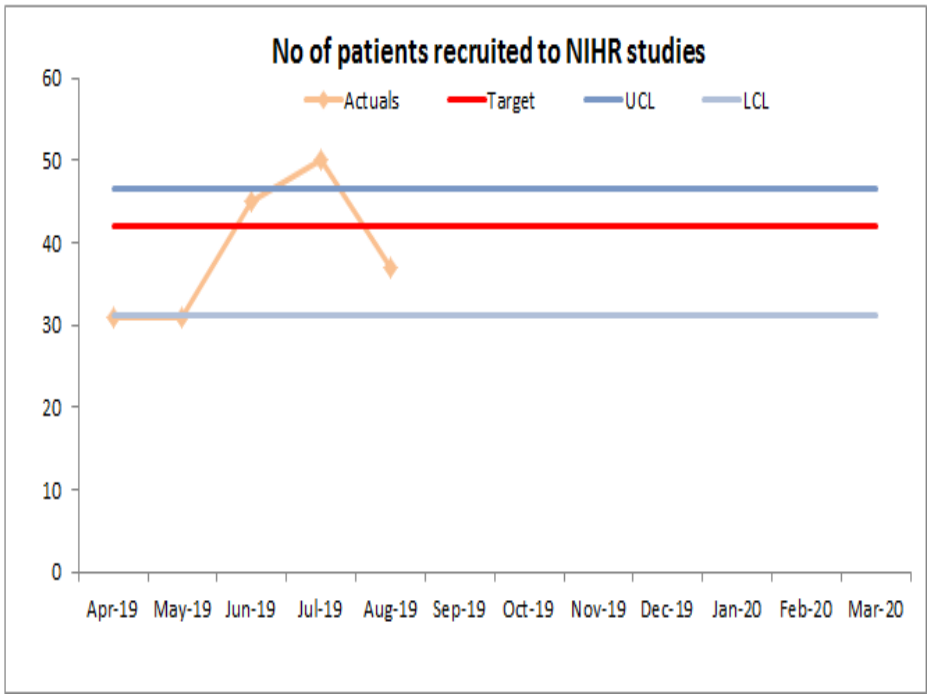
A return to compliance is expected at the end of September.



Well-led Domain

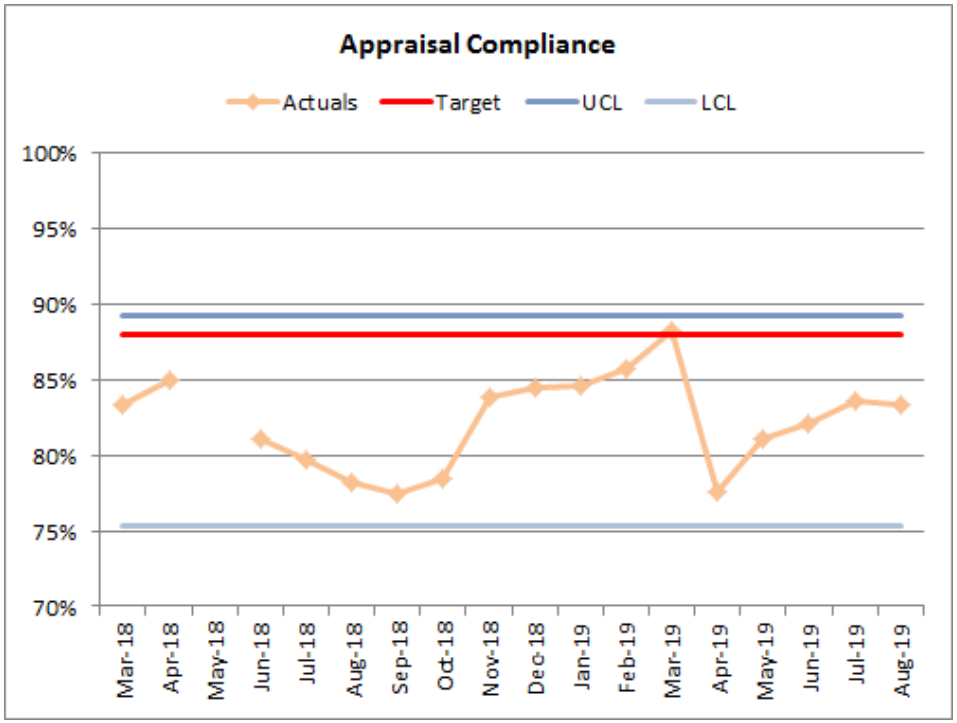
Number of patients recruited to National Institute for Health Research studies

Executive Lead: Medical Director
Performance Issue: A WUTH target has been set to recruit 500 patients to National Institute for Health Research (NIHR) studies in 2019-20. The trajectory has been set at a target 42 per month until the annual 500 is reached. This was reached in June and July, but August was 37 and the average for 2019-20 is 39.
Action: The Research Department will continue to ensure recruitment to open studies is maximised. AMDs asked for named Clinical Research Leads, one for each Division, to be identified. There are identified leads in 2 divisions thus far. 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 HR / OD
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 81.5%.
Action: Performance metric revised to reflect 12 month period as previously advised. As current performance is 83.4% appraisal compliance is being rigorously monitored through the Divisional Performance Reviews. **Note:** there is some time lag between appraisal taking place and recording this on ESR.
Expected Impact: Improved appraisal rate within the next 6 months.



Board of Directors	
Agenda Item	14
Title of Report	**Month 5 Finance Report**
Date of Meeting	2nd October 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 5 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 August (Month 5).

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

For Mth 5 the Trust had planned a deficit of (c£0.4m), actual performance was a deficit of (c£1.5m), an adverse performance against plan of (c£1.1m).

This is reflected in the cumulative performance position, the YTD plan is a deficit of (£5.2m), and the actual position is a deficit of (c£7.1m), a variance of (c£1.9m).

1.1 Key Headlines

- For Mth 5 the Trust had planned a deficit of (c£0.4m), actual performance was a deficit of (c£1.5m), an adverse performance against plan of (c£1.1m).

- The key components of the monthly position are:

	Qtr1 £m	Mth 4 £m	Mth 5 £m	YTD £m
Depreciation	(0.3)	(0.1)	(0.1)	(0.5)
VAT (medical locums)	(0.3)	(0.0)	0	(0.3)
Aseptic Unit - closure	(0.2)	(0.0)	(0.0)	(0.2)
Divisional Restructure	(0.1)	0	0	(0.1)
18/19 Costs	(0.1)	0	0	(0.1)
Pay Pressures	(0.4)	(0.3)	(0.8)	(1.5)
Income	1.4	(0.1)	0	1.3
Non Pay Pressures	0	(0.3)	(0.1)	(0.4)
TOTAL	**0**	**(0.8)**	**(1.1)**	**(1.9)**

- Pay costs exceeded plan by a further (£0.8m) in August, increasing the year to date overspend to (c£2.1m). The drivers of the in-month position are multi-faceted; nurse bank costs due to increased sickness, the commencement of nursing staff into substantive posts which were previously vacant requiring a supernumerary period, continued medical staff pressures, double-running costs during the junior doctor August rotation and staffing of escalation beds. The year to date overspend includes pressures in relation to agency consultants costs to cover gaps and pressures in ED. Premium costs had also been incurred earlier in the year to cover shortfalls in the Junior Drs. rotas; however this will reduce following the recent (August) rotation.

- Non pay costs were higher than plan by (c£0.1m), predominantly relating to outsourcing costs for MSK related activity to deliver operational standards and the "Prime Provider" contractual terms.

- During Mth 5 patient related income is broadly in-line with plan. Within this elective activity is below plan partly offset by the MSK "prime provider" contract benefit and the application of local contract terms which support the Trust to deliver the control total. In addition during the month, the Trust has generated c£0.1m maternity pathway income for patients transferring to WUTH following the decision taken by the Directors of One to One Ltd to place the company into Administration.

- To ensure a "break-even" position was achieved in Q1 the Trust accessed "accelerated" support from WCCG of c1.4m. This guaranteed the Trust received FRF/PSF central monies of £1.9m.

- Excluding the additional support, the Trust's YTD underlying position is an actual deficit of (c£8.5m) against a planned deficit of (c£5.2m), an overspend of (c£3.3m)

- Cash balances at the end of August were £2.6m which was c£0.2m above plan. This is due to 19/20 opening cash above plan (£2.5m), EBITDA and donations below plan (£1.6m), capital cash below plan (£3.6m) and controlled variances in the working capital cycle (£4.3m).

- Cost improvements planned to be delivered YTD amount to £3.9m, this target has been exceeded by c£0.1m.

- Although the year to date capital spend is slightly behind plan (c£0.4m), the Trust is forecasting to deliver at least the revised capital plan submitted in July 2019 which incorporated a NHSI requested reduction of £1.6m. The original capital limit of £9.1m has now been reinstated; however, the car park scheme will not be delivered.

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

2. Financial performance

2.1 Income and expenditure

Month 5 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	324,989	26,871	26,886	15	133,988	135,521	1,533
Non NHS income from patient care	4,532	392	284	(109)	1,905	1,615	(290)
Income - PSF/FRF/MRET	18,804	1,359	1,359	(1)	6,168	6,167	(2)
Other income	28,378	2,369	2,441	72	11,900	11,946	46
Total operating income before donated asset income	376,703	30,991	30,969	(22)	153,960	155,248	1,288
Employee expenses	(255,204)	(21,100)	(21,937)	(837)	(108,011)	(110,117)	(2,107)
Operating expenses	(108,296)	(9,162)	(9,296)	(133)	(45,771)	(46,485)	(714)
Total operating expenditure before depreciation and impairment	(363,500)	(30,262)	(31,233)	(971)	(153,782)	(156,602)	(2,820)
EBITDA	**13,203**	**729**	**(264)**	**(993)**	**178**	**(1,354)**	**(1,532)**
Depreciation and net impairment	(9,219)	(763)	(857)	(94)	(3,756)	(4,107)	(351)
Operating surplus / (deficit)	**3,984**	**(34)**	**(1,121)**	**(1,087)**	**(3,578)**	**(5,461)**	**(1,883)**
Net finance costs	(4,233)	(358)	(377)	(19)	(1,754)	(1,758)	(4)
Actual surplus / (deficit)	**(249)**	**(392)**	**(1,498)**	**(1,106)**	**(5,332)**	**(7,219)**	**(1,887)**
Reverse capital donations / grants I&E impact	249	21	(10)	(31)	104	66	(38)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	**0**	**(371)**	**(1,508)**	**(1,136)**	**(5,228)**	**(7,152)**	**(1,924)**

- The overall position deteriorated during August by (£1.1m); with a YTD overspend of (c£1.9m).
- Pay pressures have continued for agency Consultants, albeit at a reduced level from previous months. Medical bank costs increased from previous levels, some of this will be related to the "double running" of the Junior Dr August rotation.
- Nurse vacancies rates have reduced from the previous year, in addition to improvements in bank fill rates, high levels of sickness in some areas has resulted in the further use of bank nurses to maintain safe staffing levels across the wards. In addition ensuring the ED area is adequately staffed to manage demand appropriately and the opening of escalation areas when required have also exacerbated the pressure. Vacancies remain in non-clinical areas and have non-recurrently supported the delivery of CIP.
- The Aseptic Unit re-opened in July; however this is not manufacturing at full capacity until September, and is causing a cost pressure.
- In month non pay pressures include the impact of MSK outsourcing, year to date clinical supplies costs have increased exceeding plan, some of this will be offset by increased activity. The NHSSC savings are not delivering fully to expectations.
- Some of the pressures are non recurrent, and actions have been taken in relation to authorisation of non-core consultant costs, all non-stock orders are now approved by Divisional Directors or Executive Directors only.
- 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 are authorised by the Divisional Directors.

Items not included in the original Plan

- **Locum pay VAT**

  During July the Trust successfully transitioned to an alternative HMRC approved "VAT compliant" model for the supply of medical locums. This has ensured the financial pressure included in the year to date position relating to Quarter 1 of (c£0.3m), has been mitigated going forward.

- **Depreciation**

  There is a pressure of (c£0.5m) 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 5 Budget Reconciliation	**Breakdown by Budget Type** Income £'000	Expenditure £'000	Deficit £'000
Base Budget 19/20	153,729	(159,061)	(5,332)
CIP - Increase Clinical Income Oral Surgery	63	(63)	0
Extra Day adjustment value	(67)	67	0
NNU Block adjustment	29	(29)	0
PbR excluded drugs, devices & bloods adjustment	(95)	95	0
Non Recurrent Income Targets	161	(161)	0
Realignments (inc CIP)	140	(140)	0
M5 Closing Budget	153,960	(159,292)	(5,332)
Net Trustwide (Increase)/Reduction	**231**	**(231)**	**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	4,211	3,758	(453)	20,891	20,493	(398)	4,671	4,334	(337)	23,128	22,609	(518)
Elective excess bed days	276	225	(51)	1,389	1,554	165	75	67	(9)	379	392	13
Non-elective	3,748	3,430	(317)	18,735	18,187	(547)	8,339	8,221	(117)	41,154	41,075	(79)
Non-elective Non Emergency	403	451	48	2,006	2,185	179	920	1,039	119	4,452	4,807	355
Non-elective excess bed days	1,056	1,780	724	5,191	6,346	1,155	286	460	175	1,406	1,691	285
A&E	7,066	7,505	439	36,313	38,146	1,833	1,216	1,264	48	6,250	6,364	114
Outpatients	24,685	22,752	(1,932)	126,325	122,915	(3,409)	2,954	3,058	103	15,040	15,076	36
Diagnostic imaging	2,355	2,951	596	12,024	13,093	1,069	176	179	3	901	906	4
Maternity	499	630	131	2,413	2,637	224	449	606	157	2,227	2,356	129
Non PbR							6,549	6,343	(206)	32,612	33,593	981
HCD							1,244	1,244	0	6,481	6,481	0
CQUINs							186	186	0	931	931	0
PSF/FRF/MRET							1,359	1,359	(1)	6,168	6,168	(1)
Total NHS Clincial Income	44,299	43,483	(816)	225,287	225,557	270	28,424	28,359	(64)	141,128	142,448	1,321
Other patient care income							59	76	17	297	360	63
Non-NHS: private patients & overseas							50	34	(16)	190	166	(24)
Injury cost recovery scheme							89	58	(31)	445	328	(118)
Total income from patient care activities							28,622	28,528	(94)	142,060	143,302	1,242
Other operating income							2,369	2,441	72	11,900	11,946	46
Total income							30,991	30,969	(22)	153,960	155,248	1,289

- Patient-related income is broadly in-line with plan. PbR is over plan by £0.3m offset by an under performance against Non PbR, largely driven by reduced adult Critical Care bed days, rehab. and Welsh neonatal activity
- The YTD income position includes the accelerated transformation support from Wirral CCG of c£1.4m. Excluding this the position is broadly balanced. This is included in the "non PbR" position above.
- NEL is underperforming in month driven mainly by a reduction in activity. In-line with the contractual agreement for NEL cumulatively c£2.1m has been included reflecting the contract terms with Wirral CCG.
- Elective performance has deteriorated in month 5 due to a decrease in activity and casemix. The cumulative underperformance relates to Clinical Haematology, Colorectal, Upper GI, Urology and T&O. The Orthopaedic under performance has been mitigated by the MSK block benefit of £1.3m.
- Outpatients with Wirral CCG have cumulatively over performed by £0.1m. This has been adjusted within the position to reflect the "block" arrangement. The underperformance is with other CCG's.
- The Maternity pathways performance position includes £0.1m relating to One to One midwifery patient transfers.

2.4 Pay

Pay costs exceed plan by (£0.8m) in month, increasing the cumulative overspend to (c£2.1m).

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

STAFF GROUP	MONTH 5 (£'000)			CUMMULATIVE YTD (£'000)		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
CONSULTANTS	3,286	3,633	(347)	16,665	18,053	(1,389)
OTHER MEDICAL	2,342	2,546	(204)	11,922	12,718	(796)
TOTAL MEDICAL	**5,629**	**6,180**	**(551)**	**28,587**	**30,771**	**(2,184)**
NURSING & MIDWIFERY	5,942	5,919	23	30,649	29,923	726
CLINICAL SUPPORT WORKERS	1,967	2,266	(299)	10,148	11,264	(1,116)
TOTAL NURSING	**7,909**	**8,185**	**(276)**	**40,798**	**41,187**	**(390)**
AHP'S, SCIENTIFIC & TECH	2,791	2,800	(9)	13,987	14,170	(183)
ADMIN & CLERICAL & OTHER	4,771	4,773	(2)	24,639	23,989	650
TOTAL	**21,100**	**21,937**	**(837)**	**108,011**	**110,117**	**(2,107)**

- The tables below details all substantive and non-core spend by staff category, profile of budget, actual costs and year to date variance.

Medical staff			
Period	£m Budget	£m Actual	£m Variance
Mth 1	5,792	6,137	(345)
Mth 2	5,748	6,153	(405)
Mth 3	5,755	6,205	(450)
Mth 4	5,663	6,096	(433)
Mth 5	5,629	6,180	(551)
TOTAL	28,587	30,771	(2,184)

Nursing & CSW			
Period	£m Budget	£m F'cast	£m Variance
Mth 1	8,591	8,482	109
Mth 2	8,071	8,180	(109)
Mth 3	8,186	8,188	(1)
Mth 4	8,040	8,153	(113)
Mth 5	7,909	8,185	(276)
TOTAL	40,798	41,187	(390)

AHP's(Scientific & Tech.) and A&C/Other			
Period	£m Budget	£m F'cast	£m Variance
Mth 1	8,100	8,073	27
Mth 2	7,752	7,425	327
Mth 3	7,678	7,570	109
Mth 4	7,534	7,518	16
Mth 5	7,562	7,573	(11)
TOTAL	38,626	38,159	468

Note: The increase in budget and actual cost for Nursing and Other staff pay grade in Mth 1 reflects the AFC pay award for 2019/20.

- The spend on Consultants reflects 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. The agency consultant 'hotlist' as previously mentioned is reviewed monthly to monitor progress and explore alternative models if possible to mitigate the premium cost.
- Other medical pressures reflect shortfalls in the trainee grades during the February 2019 rotation. Following that rotation there was a "gap" of 31.00 wte across the Trust; this has reduced to 13.00 wte following the favourable rotation in August.
- Although Nursing and midwifery is underspent YTD, during August the position is largely breakeven reflecting the commencement of staff into previous vacant substantive posts and the support for escalation areas. To note the budget for nursing will vary dependent upon the number of nights, weekends and bank holidays in the month affected enhance pay.
- The Clinical Support Worker category includes non-registered nursing grades that are in clinical areas, and trainee nurse associates. The overspend in this group of staff was previously mitigated by underspends in qualified nursing costs. However the position shows the continued reliance on this group of staff to support patient acuity, cover sickness and staffing support for escalation areas.
- Within the year to date position there is (c£0.2m) of undelivered CIP in relation to workforce schemas, including Non-ward based nursing and e-rostering.
- The position in relation to administrative and infrastructure posts reflect vacancies which have supported the non pay overspends in certain areas. In Month 2 & 3, capitalisation of IT costs to GDE assets resulted in a favourable variance.

The table below details pay costs by category for August 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	(243,516)	(20,127)	(19,433)	694	(102,908)	(97,851)	5,057
Bank	(254)	(33)	(1,099)	(1,066)	(117)	(4,750)	(4,633)
Medical bank	(3,084)	(244)	(659)	(415)	(1,389)	(3,188)	(1,798)
Agency	(7,415)	(612)	(662)	(50)	(3,179)	(3,917)	(738)
Apprenticeship Levy	(1,000)	(83)	(83)	0	(417)	(411)	6
Total	(255,269)	(21,100)	(21,937)	(837)	(108,010)	(110,117)	(2,107)

- Although the underspend in substantive costs increased further, this is at a reduced rate than previous months, reflecting the commencement of staff into previously vacant posts. This has partially offset the increase in non-medical bank staff costs, which have increased compared to the previous months.
- Agency costs exceed the NHSI cap by (c£0.7m) as at the end of July. The NHSI agency cap was set before the VAT implications of the current medical locum provider contract where identified. Although the Trust now uses a VAT compliant model, within the year to date position this represents a pressure of (c£0.3m).
- A "deep dive" into the Medical pay costs has been undertaken as requested by the FPBAC committee in July; an action plan has been formulated and is being progressed, led by the Director of HR/Workforce.

Waiting List Initiatives (WLIs)

Detailed below is the spend incurred year to date relating to WLI sessions undertaken, number of patients seen, and costs incurred for both Inpatients and Outpatients by Division.

Inpatients	No. of Sessions	No. of Patients	Total Cost (£)
Surgery	244	763	133,797
Medicine	302	1676	162,711
W&C	1	2	564
Clinical Support	4	14	2,113
TOTAL	**551**	**2455**	**299,185**

Outpatients	No. of Sessions	No. of Patients	Total Cost (£)
Surgery	457	3941	250,061
Medicine	70	584	32,711
W&C	85	301	47,109
Clinical Support	20	174	11,270
TOTAL	**632**	**5000**	**341,151**

- The combined year to date actual costs for both inpatients and outpatients is (c£0.6m). The budget available to manage WLI requirements to deliver national cancer standards to Mth 5 is £0.2m, therefore an overspend of (c£0.4m).
- The main specialities in Surgery where WLI have been undertaken are Urology and Colorectal to deliver 62 day cancer standards.
- Within Medicine, additional sessions have been needed to ensure delivery of key elective access waiting time standards in Gastro, Endoscopy and Dermatology.
- Additional Breast outpatients sessions have been done in Women's and Children's to deliver cancer 2 week access standards.
- Clinical Support includes the Radiology sessions to support the above.

Unfunded areas including escalation

The table below details actual cost incurred year to date relating to unfunded areas and the utilisation of escalation beds.

Unfunded areas including escalation beds	Number of unbudgeted beds open	Utilisation in 2019/20	Configuration of nursing staff required	Actual cost of nursing staff utilised (Mth 1-5) £000	Actual cost of medical staff (Mth 1-5) £000	Staffing source (agency/bank/ locum)	Total Expenditure (Mth1-5) £000
Reverse Cohort Area	12 trolleys	From 1st May 2019 (as and when required)	2 .00 wte Nurses 2.00 wte CSW 24/7	162	33	Combination of bank/agency	195
Ward 26	4 beds	Used for Medical outliers throughout 19/20 when needed	1 .00 wte Nurses 1.00 wte CSW	36	0	Bank	36
Ward 1	20 beds	Used for Medical outliers throughout 19/20 when needed	2.00 wte Nurses 2.00 wte CSW (20 patients) 1.00 wte Nurses 1.00 wte CSW (>20 patients)	82	64	Bank	146
Fluid Room	2 trolleys 2 lounge chairs	July 2019 (Mon - Friday)	1.00 wte Band 6 Nurse	18	0	Transfer of substantive staff	18
Ward 54	4 beds	Used forSurgical outliers throughout 19/20 when needed	1.00 wte CSW (nights) 1.00 wte Nurses (Mon-Fri) 1.00 wte CSW (Sat-Sun)	60	0	Combination of bank/agency	60
TOTAL				**358**	**97**		**455**

- Ward 26, 1 and 54 are recognised escalation areas and are only used based upon need.
- The Reverse Cohort Area (RCA) was opened in May 2019 to eliminate the use of corridors for care and improve ambulance turnaround times. The RCA is used as escalation and during “in hours” is staffed by a rota from all divisions. Out of hours is provided by planned use of NHSP, which are deployed in ED should RCA not be needed. As escalation areas are opened as and when needed, NHSP costs are incurred to ensure safe staffing levels are maintained.

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	(33,990)	(2,989)	(2,944)	45	(14,368)	(14,507)	(139)
Supplies and services - general	(4,575)	(387)	(406)	(19)	(1,906)	(1,976)	(70)
Drugs	(23,678)	(1,910)	(1,863)	47	(9,830)	(9,781)	49
Purchase of HealthCare - Non NHS Bodies	(7,477)	(619)	(698)	(79)	(3,146)	(3,435)	(288)
CNST	(12,948)	(1,128)	(1,128)	0	(5,641)	(5,641)	0
Consultancy	(0)	(0)	(36)	(36)	(0)	(166)	(166)
Other	(25,628)	(2,130)	(2,221)	(91)	(10,880)	(10,980)	(100)
Total	(108,296)	(9,162)	(9,296)	(133)	(45,771)	(46,485)	(714)
Depreciation	(9,219)	(763)	(857)	(94)	(3,756)	(4,107)	(351)
Total	(117,516)	(9,925)	(10,153)	(227)	(49,527)	(50,592)	(1,064)

- Non pay expenditure excluding depreciation exceeds plan by (c£0.7m), during Mth 5 although the position is over spent by (c£0.1m), the run rate has reduced from previous months.
- Clinical supply costs cumulatively 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. The savings associated with the national procurement changes are not being fully delivered and represent a pressure of c£0.1m YTD.
- General supply costs include consumables and provisions for additional activity and infection control cleans pressures largely in Hotel Services.
- Purchase of healthcare non-NHS is relates to outsourcing costs with sub-contractors to manage waiting times as part of the MSK for Physio. and patient “choice”. Within Radiology, the cost reflects capacity constraints and the use of outsourcing for reporting.
- Consultancy costs continue in-month largely to support transformation and governance. It is anticipated this spend will reduce in future months and is offset by vacancies in these areas.
- The “Other” category above incorporates a number of areas, including energy, interpreter fees, Divisional restructure implications, re-branding costs etc. There are over/under spends across a number of categories, all areas of discretionary spend are reviewed in detail at the monthly scrutiny panel the position includes the benefit of c£0.3m in relation to a non-recurrent energy rebate.

2.6 CIP Performance

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	Fully Developed £k	Variance £k	In Progress £k	Total £k	Variance £k
Transformation										
Patient Flow	Antony Middleton	603	520	(83)	1,500	1,417	(83)	0	1,417	(83)
Theatre Productivity	Antony Middleton	332	207	(125)	1,000	555	(445)	320	875	(125)
Outpatients	Antony Middleton	396	396	0	1,000	1,000	0	0	1,000	0
Demand Management	Antony Middleton	45	0	(45)	500	0	(500)	500	500	0
Digital	Paul Charnley	3	7	4	123	33	(90)	90	123	(0)
Sub total - transformation		**1,379**	**1,129**	**(249)**	**4,123**	**3,006**	**(1,117)**	**909**	**3,915**	**(208)**
Quipp & Cross cutting workstreams										
Workforce	Helen Marks / Tracy Fennell	333	175	(158)	1,500	319	(1,181)	852	1,171	(329)
CNST	Antony Middleton	0	0	0	653	590	(63)	0	590	(63)
GDE	Paul Charnley	70	70	0	500	500	0	0	500	0
Endoscopy	Antony Middleton	0	0	0	150	0	(150)	13	13	(138)
Meds Management	Pippa Roberts	175	191	16	568	540	(28)	29	569	1
Procurement	Karen Edge	120	156	37	526	399	(126)	44	443	(83)
Tactical and transactional										
Divisional and Departmental	Divisional Directors	1,777	2,189	412	5,161	4,495	(666)	530	5,025	(136)
Total		**3,853**	**3,911**	**57**	**13,181**	**9,849**	**(3,332)**	**2,377**	**12,225**	**(955)**

- The overall CIP planned to be delivered as at the end of Mth 5 of £3.9m has been achieved.
- Transformational productivity schemes are all below plan with the exception of outpatients, but are mitigated financially in the divisional financial performance from the divisional allocation of the growth reserve.
- Workforce schemes – the nursing e-rostering scheme has been reviewed/agreed with further work ongoing to assess the non ward savings. Work is ongoing on the medical workforce scheme particularly in the Medicine division and will be shortly finalised. Any shortfall that materialises will be reallocated to the divisions for in- year mitigation.
- Priorities have been agreed for the Digital scheme and will deliver recurrently from 2020, slippage in year has been returned to the Divisions for additional BAU.
- Cross-cutting medicines management and procurement schemes continue to marginally over-deliver as at Mth 5.
- The BAU schemes continue to over-perform, this includes a significant amount of non-recurrent vacancy mitigation particularly in the Corporate Division.
- The “in- progress” schemes are monitored on a weekly basis by the Exec. Directors, in addition to reducing the “unidentified gap”.

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%	-18.1	4	-17.4	4	-30.4	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	0.1	4	-0.7	4	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-3.4%	4	-4.6%	4	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-1.2%	3	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	0.0%	1	23.0%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has overspent against the agency cap. Approximately 50% of this £0.3m relates to 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 has adopted an alternative model (which went live on 8 July) so that VAT will no longer be incurred. The remaining pressure relates to consultant costs in 'difficult to recruit posts'. This should reduce going forward as the Trust has recently recruited 7.00 WTE consultants substantively.
- The *Distance from financial plan* metric is currently above plan as a result of the year to date EBITDA position.
- The month 4 UoR rating is 3 overall, which matches the 2019/20 plan UoR rating of 3.

4. Forecast

As discussed at the previous Board meeting a full month by month forecast to the end of the year has been completed and was presented to FBPAC at its meeting on the 26th September.

Based on the year to date position and assumptions made by the Divisions on delivery of activity targets and deployment of resources, the forecast outturn as at Month 4 is a deficit of (£10.0m)

The table below details the outturn position by quarter.

Financial Position (£k)	Q1 Variance	Q2 Variance	Q3 Variance	Q4 Variance	FYF Variance
Income from patient care activity	*1,335*	*110*	*(407)*	*(289)*	*749*
Other income	66	(36)	27	11	*68*
Total Income	1,401	74	(380)	(278)	817
Employee expenses	(739)	(1,678)	(1,898)	(1,601)	*(5,916)*
Operating expenses	(622)	(1,067)	(1,421)	(1,775)	*(4,885)*
Total expenditure	(1,361)	(2,745)	(3,319)	(3,376)	(10,801)
Operating surplus / (deficit)	**40**	**(2,671)**	**(3,699)**	**(3,654)**	**(9,984)**
Non Operating Expenses	8	(13)	18	18	*31*
Actual surplus/(deficit)	**48**	**(2,684)**	**(3,681)**	**(3,636)**	**(9,953)**

The above forecast position includes:

- Repayment of the “accelerated” support from Wirral CCG - £1.4m.
- Includes PSF/FRF payments for Q2, Q3 & Q4 of £10.6m (Q1 was achieved following support received from Wirral CCG as above)
- Assumes all CQUIN targets are achieved - £3.7m.
- Assumes the closure of Wd 24, in-line with the Business Case to fund the step down facility opened in November 2018 on the Clatterbridge site, reduction in cost of (£0.7m).
- Does not assume any additional cost implications to manage “Winter”
- Does not include the implications of the legal action taken for the Junior Medical workforce contracts.

The main areas contributing to the deficit position can be analysed as “unplanned” items, and in-year “operational” pressures:

Unplanned Pressures	£m	Notes
Depreciation charges (RICS change)	(1.2)	Amendments to asset valuation instructions issues by Royal College of Chartered Surveyors
Medical Locums VAT	(0.3)	This was not known when the plan was set, this has been mitigated from July 2019
Asceptics Unit closure/PY charges	(0.3)	The closure of the Unit was unplanned and unexpected and is expected to resolve fully from September.
18/19 costs	(0.1)	This relates to Theatre Loan kits, and the timing of receipting of items, the process has been tightened going forward
Clinical Supplier (Future Op. Model)	(0.3)	This reflects the expected benefit estimated for the Trust of the "purchasing power" from moving to the central purchasing "hubs". This has not transpired to offset the "top slice" of tariff
TOTAL	**(2.2)**	

"Operational" pressures contributing to the deficit are detailed below:

Operational Pressures	£m	Notes
Clinical Supplies - Surgery	(0.3)	Activity related and usage
Drugs - Surgery activity related	(0.2)	Patient acuity
MSK	(0.5)	Implications of delivering operational standards and patients exercising "choice" in relation to Orthopaedic care.
Revenue impact of Capital schemes	(0.1)	Cath. Lab refurbishment
Clinical Pay Pressures - Med. Staff	(4.1)	Net impact of medical pressures, including WLI, junior medical shortfalls in the rota, cover for vacancies
Clinical Pay Pressures - Escalation areas/ED	(1.5)	Costs of Ward 1 and managing ED to ensure there are no "corridor waits"
Clinical Pay Pressures - Nursing	(1.2)	Increased sickness, patient acuity, WLI sessions
Clinical Pay Pressures - Other	(0.4)	Pressures in Clinical Support areas, mainly Pharmacy and Physio.
Hotel Sevices pay pressures	(0.3)	Sickness, and introduction of "hot" meals at lunchtime
Staff Restructure costs	(0.4)	Exec. approved
Clinical Income	0.5	Mainly in Obstetrics and excess bed days
Energy credit	0.4	Non recurrent benefit
Corporate pay underspends	1.5	This reflects the number of expected vacant posts in Corporate areas during 19/20
Business Case slippage - Medicine	1.1	AMU and Bed Management, pending business case approval
Undelivered CIP	(2.3)	Detailed below
TOTAL	**(7.7)**	

- 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 of c£3.0m. This was expected to be mitigated by Corporate vacancies of c£1.3m, and continuing nursing pay underspends. Corporate vacancies have materialised as forecast above.
  However although nursing costs are not overspent overall, the expected level of underspend has not occurred due to an increase in the "fill" rate of NHSP bank which at Q1 18/19 was 57% and is at Q1 19/20 was 71%. Sickness rates in some areas have increased, resulting in an increase in clinical support worker costs and additionally escalation areas have been opened to support patient flow
- The forecast does take account of the favourable August junior doctor rotation, and the commencement of 7.00 WTE Consultants, some of whom had previously been covered by premium locum/agency spend.
- CIP Delivery (schemes risk rated as red and amber), the main areas of shortfall are in the cross-cutting/transformation schemes.

Actions to reduce the deficit:

- Delivery of CIP forecast shortfall - c£2.3
- Benefit of 1-2-1 activity redirected to WUTH c£0.4m
- Welsh activity for Surgery (pending confirmation of funding from Wales) c£0.3m
- Reduce MSK Physio. contacts to deliver performance standards only

Assuming the above mitigations are delivered, this would reduce the deficit to (c£6.9m)

Actions to reduce this further would require assessment of risk as they would relate to clinical cost reduction.

The original plan set at the beginning of the year, assumed no additional cash support in 19/20 would be required. However based on the current forecast deficit, there will be a requirement to request additional cash support in November. The forecast cash position is closely monitored to ensure there is sufficient notice to engage effectively with DHSC/NHSI.

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 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.
- The Trust's borrowings arrangement with DHSC is such that the Trust is expected to borrow to match deficits. The Board is asked to approve above-plan borrowing of £4.0m in November 2019, and further draw-downs as required within the DHSC deficit limit, to maintain ongoing liquidity in 2019/20. The final draw-down relating to 2019/20 is forecast to occur in quarter one of 2020/21.
- 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.
- Following the reinstatement of the Trust original Capital spend plan of £9.1m, the capital program has been reassessed and a forecast of £7.6m advised to NHSI.
- Due to the lead time involved in the delivery of the Car Park Scheme, this will be deferred to 2020/21. NHSI have advised that they are currently not aware of any capital programme restrictions in going forward that would prevent this scheme being in-

cluded in 2020/21, although new controls for capital may be developed. As the Trust is funding this internally the Trust will have to manage its working cash balances appropriately across 2019/20 and year end to ensure there is sufficient resource available for this in 2020/21.

- Of the remaining programme minor adjustments have been made, which have been approved by FPBAC.

6. Conclusion

Although the Trust delivered the financial plan for Qtr1 with the non-recurrent accelerated support of c£1.4m received from Wirral CCG. During July and August the position deteriorated by a further (£1.9m). The Trust continues to face operational challenges, mainly in resourcing capacity to maintain flow, which has continued in Mth 5. The Trust has had a favourable increase in the number of WTE junior doctor following the recent (August) rotation. This will reduce the medical bank pressure going forward. It has to be noted the Trust nursing vacancies has reduced compared to 18/19, in addition to improved "fill" rates by NHSP. Both of which will support safe staffing models in clinical areas are achieved. However high sickness rates in certain key areas is impacting the position.

The Operational teams supported by the Executive Directors are proactively managing expenditure, activity performance and the delivery of the CIP plan. The weekly vacancy panel is reviewing non-clinical vacancies.

Exceptional items such as the impact of VAT on medical locums and depreciation have impacted the position (c£0.8m) year to date; the VAT impact has been eliminated from July 2019.

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 5 position was delivered and plans are progressing through the various CIP milestones. These meetings are chaired by the Chief Executive.

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

The Trust is fully engaged with the Wirral System to support, develop, progress and delivery of the finance recovery plan for the "Place". The Trust has been transparent with the other partners as to the financial position and challenges facing the Trust.

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

Karen Edge
Acting Director of Finance
October 2019

Board of Directors	
Agenda Item	15
Title of Report	Draft Workforce Strategy 2019-22
Date of Meeting	2nd October 2019
Author	Helen Marks, Executive Director of Workforce
Accountable Executive	Helen Marks, Executive Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Gold - externally validate
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The draft People Strategy 2019-22 is the 3 year roadmap that informs, describes and guides the many activities that will shape, build and sustain the Trust's workforce.

The successful implementation of our People Strategy is critical to every aspect of the Trust's ambition to deliver the best quality and safest care to the communities we serve and to drive the improvement needed to achieve this.

Our People Strategy 2019-2022 has been carefully designed to reflect national and regional direction for the future of the NHS's workforce and embraces our Trust's values and behaviours. It is divided into six interdependent building blocks that will underpin our future success and make our Trust a great place to work.

The delivery of the Strategy will impact on every one of our 6000+ Trust workforce and that delivery will be monitored and assured by the Trust's Board of Directors represented through our Workforce Assurance Committee.

2. Background

The 2018 rating by the Care Quality Commission as “Requires Improvement” , 2018 national staff survey findings and the implications of the NHS Interim People Plan and the Cheshire and Mersey workforce strategy underpin the Trusts workforce strategy.

The People Strategy 2019 – 2022 sets out a clear approach for the Trust to become a great place to work. It also articulates the organisation’s commitment and ambition to secure and retain a high performing workforce which continuously delivers the best care that can be provided. The strategy identifies the Trust’s people priorities for the next three years.

In order to achieve the Trust’s vision and ambitions over the coming years we need an engaged workforce who are ambassadors for the Trust and are empowered to take ownership for the continual improvement in their services. Our ultimate aim is to create and provide a healthy and vibrant environment for all staff to work in, and work towards being recognised as, not only the employer of choice, but an excellent employer.

3. People Strategy

The People Strategy is based around 6 building blocks that aim to address the key workforce challenges and sets out the steps that will be taken. The Building Blocks are:

1. Culture and Values
2. Leadership and Management Development at every level
3. Engagement and creating the employee voice
4. Recruitment, retentions and creating a sustainable workforce
5. Securing the Health and wellbeing of the workforce
6. Promoting Inclusion

4. Next Steps

The strategy is underpinned by the comprehensive OD plan that was developed last year. However, the OD plan will now be reviewed to ensure that it includes clear metrics to monitor progress and the delivery of the strategy. The implementation of the strategy will be tracked through the existing workforce governance arrangements.

5. Recommendations

Trust Board is asked to:

- Agree the draft People Strategy
- Note that the existing OD plan will now be reviewed
- Agree that implementation of the strategy will be monitored through the existing workforce governance arrangements i.e. Workforce Assurance Committee

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

...create a great place to work

People Strategy

2019-2022

Contents

Executive Summary

John Sullivan
Non-Executive Director & Chair of Workforce Assurance Committee

Wirral University Teaching Hospital NHS Foundation Trust's ambitious patient centred vision and forward strategy will be delivered by its people. The Trust's People Strategy is the three year roadmap that informs, describes and guides the many activities that will shape, build and sustain the Trust's workforce through 2019 to 2022 and beyond. The successful implementation of our People Strategy is critical to every aspect of the Trust's ambition to deliver the best quality and safest care to the communities we serve.

Our People Strategy 2019-2022 has been carefully designed to reflect national and regional direction for the future of the NHS workforce and embraces our Trust's values and behaviours. It is divided into six interdependent building blocks that will underpin our future success and make our Trust a great place to work.

The delivery of our People Strategy 2019-2022 will impact on every one of our 6000+ Trust workforce and that delivery will be monitored and assured by the Trust's Board of Directors represented through our Workforce Assurance Committee.

Introduction and Purpose

To achieve our ambition for the Trust to be “a great place to work” we have developed a workforce strategy for 2019 - 2022. The strategy sets out a clear approach for the Trust to become a great place to work. It also articulates the organisation’s commitment and ambition to secure and retain a high performing workforce which continuously delivers the best care that can be provided.

The strategy identifies the Trust’s people priorities for the next three years which underpin the Trust’s vision and objectives on its improvement journey to become outstanding.

This strategy complements the following documents:

- Quality Strategy
- Communication & engagement Strategy
- Nursing, Midwifery & AHP Recruitment & Retention Strategy
- Equality and inclusion strategy
- Volunteer strategy

In order to achieve our vision and ambitions over the coming years we need an engaged workforce who are ambassadors for the Trust and are empowered to take ownership for the continual improvement in their services. Our ultimate aim is to create and provide a healthy and vibrant environment for all staff to work in, and work towards being recognised as, not only the employer of choice, but an excellent employer.

The strategy also supports the NHS long term plan, Interim NHS People Plan and the Cheshire and Mersey workforce strategy.

Setting the Context

Our Trust

Wirral University Teaching Hospital employs approximately 6000 members of staff and is the largest employer on the Wirral. The hospital is split between two sites, Arrowe Park and Clatterbridge and provides a range of services. The Trust also has additional services at St Catherine's Hospital, Victoria Central Hospital and Microbiology in Bromborough.

WUTH had been at the centre of a difficult period late 2017 and had been subject to negative attention by our regulators as well as national, regional and local media. The uncertainty caused in 2017 -2018 subsequently led to leadership changes. These changes established a new Chair, Chief Executive and a number of new executive directors.

The Care Quality Commission (CQC) inspection report dated 13th July 2018 rated the Trust as 'Requires Improvement'. The Trust is due to be re-inspected in autumn 2019.

Quick facts*

WUTH workforce profile:

Gender:		Age:	
Female	5027	<20	47
Male	1363	21 – 30	1130
		31 – 40	1518
		41 – 50	1497
		51 – 60	1622
		61 – 70	554
Total	6390	>71	22

WUTH workforce attendance:

94.07% of staff attended work during July 2019

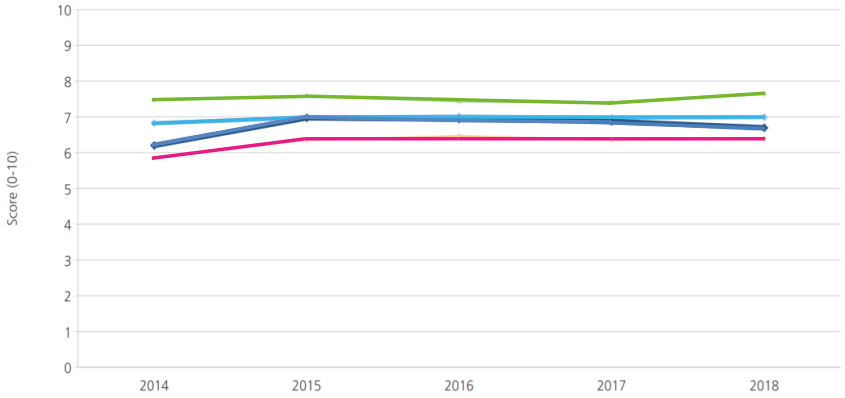
WUTH vacancy rates:

All staff	7.20%	Consultant	9.24%
Registered Nursing & Midwifery	9.57%	Allied Health Professionals	2.65%

*** Based on September 2019 data unless otherwise stated**

National Staff Survey 2018

The results from the 2018 NHS Staff Survey are outlined below. Whilst the findings were disappointing it did identify some 'green shoots', particularly in relation to equality and diversity. The Trust also experienced an increase in the number of staff who took part in the survey.



WUTH score	6.2	7.0	6.9	6.9	6.7
Best acute score	7.5	7.6	7.4	7.4	7.6
Average acute score	6.8	7.0	7.0	7.0	7.0
Worst acute score	5.9	6.4	6.5	6.4	6.4

In addition to the NHS Staff Survey, WUTH received disappointing feedback from a Medical Engagement survey (undertaken in March 2017). The concerns raised in the survey highlighted a perception of 'disconnect' between medical staff and management.

Our Vision

Underpinning our Vision are our Values and Behaviours

caring for everyone

Acting with kindness, compassion and empathy with everyone.

Being friendly, welcoming approachable and remembering the simple things like a greeting and a smile.

Being considerate of the needs of others.

Listening to ideas, opinions, thoughts and feelings of others.

Taking personal responsibility and accountablility for the care that you deliver.

embracing teamwork

Working within and accross teams to provide the best possible quality of care and experience of our patients, families, carers and colleagues.

Communicating effectively within teams.

Recognising the value of everyone's role, contribution, skills and abilities.

Supporting colleagues within the team when needed.

Engaging in opportunities to develop and grow the team.

respect for all

Being honest and open, including honesty about what we can and cannot do.

Being polite and professional with everyone, introducing ourselves by name, saying please and thank you.

Listening to patients, families and colleagues.

Respecting cultural and individual differences.

Ensuring we treat everyone

committed to improvement

Activley seeking new ways of working to enable improvement.

Working together to improve our services for our patients, families and carers.

Taking personal responsibility and ownership of things that need to improve.

Being positively receptive to change and improvement.

National and Regional Context

NHS Long Term Plan

In January 2019 the NHS published its 'Long Term Plan' which detailed the ambitious ten year vision for healthcare in England. The plan set out new models in which there are a greater focus on prevention and health inequalities, improving the quality of care and health outcomes across all the major health conditions and where technology plays a significant role in transforming services.

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

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

- **Making the NHS the best place to work** – Making the NHS an employer of excellence – valuing, supporting, developing and investing in our people

- **Improving the leadership culture –** Positive, compassionate and improvement focused leadership creates the culture that delivers better care. Improving the leadership culture nationally and locally

- **Prioritise urgent action on nursing shortages –** There are shortages across a wide range of NHS staff groups. However, the most urgent challenge is the current shortage of nurses. We need to act now to address this

- **Develop a workforce to deliver 21st century care –** To grow and transform a workforce with a varied skill mix, new types of roles and different ways of working

- **Develop a new operating model for the workforce** – To continue to work collaboratively being clear what needs to be done locally, regionally and nationally with people planning activities undertaken by the local integrated care system

- **Developing the full People Plan** – taking immediate action in 2019/20 while a full five year plan is being developed

EU Exit

Following the triggering of Article 50 on the 29 March 2017, the UK has for the past two years (plus any extension) been engaged in negotiations to establish a withdrawal agreement and framework for a future relationship with the EU before the point of the UK's exit from the EU on 31 October 2019. This continues to be a concern for the NHS in relation to the supply of the workforce.

In August 2018 WUTH took part in a pilot arranged by the Home Office which allowed for the organisation's existing EU workforce to register for UK citizenship. The Trust currently has 142 EU nationals, of which 37 took part in the pilot.

As the implications of the exit from the EU unfold the organisation will need to continuously review the landscape and take action accordingly.

Cheshire and Merseyside Workforce Strategy 2019-2024

Health and social care services need to change to provide a safe and sustainable system that is fit for the future. The three priority areas for the Health and Care Partnership are:

- Delivering care more efficiently
- Improving the quality of care
- Improving the health and care of the population

To achieve these priorities there needs to be a change in the way the system works. This means having new teams and new roles that work across organisations boundaries. Many staff will work outside of hospitals, in communities where people live and work.

The Cheshire and Merseyside strategy aims to recruit people into health and care roles, making careers attractive and encouraging a wider range of people to consider working within this sector. It sets out a commitment to retain highly skilled and dedicated staff, by enabling flexible careers and new ways of working, having

supportive employment models and ensuring that organisations across the system have the right skills, competencies and equipment to allow staff to do their jobs. It acknowledges that our employees are supported by a huge number of unpaid volunteers and carers and that plans will be put in place to help ensure that they too are appropriately developed and trained.

The Building Blocks for success

Our people are our greatest asset and are fundamental to the success of the Trust. A high performing workplace is characterised by commitment, creativity, innovation, flexibility and productivity. We want to create an organisation where people not only choose to work for us but want to stay and build their careers. The diagram below identifies some of the key features of a good employer:

In order to achieve this goal we need to establish the foundations that will pave the way for the Trust. Therefore, there will be six building blocks that the organisation will focus on over the coming three years as detailed below:

Building Block One

Culture and values, the way we do things around here

Values and Behaviours

Culture is probably best described as shared values and behaviours that create "the way we do things around here". Therefore, culture is important as it has the most significant influence on the way our people behave. There is a wealth of evidence highlighting the links between culture and performance and it has been demonstrated that patient satisfaction is highest in trusts where there is a clearly articulated vision and clear objectives establishing priorities for improvement. Characteristics of high performing cultures include staff 'living the values of the organisation, accountability and team-working".

Following a consultation process with over 2000 staff, patients and members of the public, the Trust launched its new vision, values and behaviours as described in page 7 on 1st July 2019.

The values and behaviours will form part of our everyday practices and the delivery of care. The values and behaviours will be fundamental in our HR processes such as induction, our contribution framework, recruitment, reward and recognition and will be the platform for the 'way we do things' around the organisation.

Every ward and department will be expected to sign a pledge that is clearly displayed demonstrating publicly their commitment to the Trusts values and behaviours.

In addition, the Trust is linking with a local University to develop a series of scenarios in animation form that bring to life the values and behaviour. These pieces of animation can be used for team discussions as well as being used for training.

Values based recruitment

Over the coming months work will be undertaken by the recruitment team and the HR business partners to implement values based recruitment to ensure that we are

recruiting individuals whose values and behaviours are aligned with the Trust's. All recruitment panels will be required to shape their questioning around the values and behaviours in addition to exploring a candidate's skills and experience. In some positions the recruitment process will involve practical scenario situations.

In 2020 the Trust will be seeking to extend our links with universities to be part of the student recruitment to ensure that we are recruiting students with the values of the organisation from an early point.

Creating High Performance Environment

Creating a high performance environment is fundamental for any organisation. Detailed below are some of the key success factors that the Trust is seeking to replicate within the organisation:

- **Training and developing together**: wherever possible creating the opportunities for multidisciplinary teams to learn and develop together
- **Working on the fundamentals**: getting the basics right with regular and constant feedback, coaching and reflection
- **Developing skill acquisition**; allowing teams to grow and acquire new skills
- **Goal setting**; being clear about what needs to be achieved and regularly monitoring to track progress towards the required goals
- **Setting the vision**: describing the ambition and celebrating wins and success
- **Developing a strong sense of trust**: trust is developed and maintained not just with leaders but between teams and team members
- **Everyone's voice matters**: everyone has a valuable contribution to make and their input should be encouraged and listened to

Contributory Framework

Accountability goes hand in hand with empowerment. It is vital that our staff are supported to give their best and make an effective contribution to the goals of the Trust but are willing to take personal ownership and responsibility for their behaviour and outcomes. Whilst the Trust has various systems in place for appraisal and performance assessment, attention needs to focus on assessing, evaluating and providing feedback to individuals. The Trust needs to design and implement an employee contribution framework which will support a quality performance driven culture.

The employee contributory framework will ensure that there is a clear link between the Trust's strategic goals and objectives and individual objectives and that the performance review defines their individual contribution towards the Trust's strategic direction. In addition the reviews will foster engagement to share ideas around

service improvement, personal development and to identify talent for the Trust's talent pipeline processes.

Coaching

To support the work around the employee contributory framework we will be focusing on the development of coaching and coaching conversations. A coaching culture can be described as one where 'coaching is the predominant style of managing and working together and where the focus is to improve the people'. We will be equipping our managers with the tools to engage in the right coaching conversation with their staff to empower them to feel able to make decisions and changes within their areas.

The Trust will continue to build and develop a register of trained coaches that can be accessed by any employee across the organisation wishing to receive coaching.

Induction

In 2019 the Trust will have a refreshed induction programme and policy which will be more focused on the vision, values and behaviours and the engagement of our new employees. It will detail how we support our staff throughout their employment journey with us. It will have greater emphasis on meeting the executive and senior teams from an earlier point in their careers with the Trust. The induction programme is one of the central planks in setting the relationship and the culture with our new starters.

Team working

"Team based working is vital for high quality care, continually improving and compassionate patient care and for staff wellbeing." (Professor Michael West 2016). Team work is also one of the Trust's core values. A number of interventions will be progressed over the next 12 months and include the introduction of:

- Team Positivity Ratio scale that has been developed to measure the balance of positivity to negativity in teams
- Ensuring that there are team objectives and goals in place
- Exploring the feasibility of all teams having at least one time out each year to focus on team building as well as focusing on any service improvements
- Securing team identity and ensuring that team members understand clearly their roles and the roles of other team members, so there is no ambiguity about who is responsible and accountable for what tasks

- Exploring and implementing different ways for teams to learn together

Just Culture

Just culture is a culture of trust, learning and accountability. In the event of an incident, a restorative just culture asks: ‘who are hurt, what do they need, and whose obligation is it to meet that need?’ It doesn’t dwell on blame, violation of the rules and consequences. Instead, it gathers from those affected by an incident and collaborates to collectively address the harms, in a way that is respectful to all parties. It holds people accountable by looking forward to what must be done to repair, to heal and to prevent the incident occurring again.

Merseycare NHS Trust explains that they began to address their culture in 2016:

“We had a significant number of disciplinary cases and associated suspensions. This was problematic for safe service delivery and seriously affected the health and wellbeing of colleagues. Between, 2016-2017 one of the four clinical divisions saw 64% reduction in disciplinary cases. This has a positive impact on many costs, as well as on morale and, crucially, continuity of care.”

The Trust will be introducing the principles of Just Culture over 2019-2020.

Building Block Two

Leadership and management development at entry level

Developing compassionate leaders

Our leaders will play a powerful role in delivering the Trust's vision, values, behaviours and strategy. Professor Michael West, Senior Fellow at Kings Fund is clear that "What our leaders pay attention to, what they monitor, what they reward, what they talk about, communicates to staff what it is that's valued in the organisation" and impacts on an organisation's culture. There is also strong evidence that shows the links between how employees are managed and the quality of care patients experience (Boorman Review. 2009).

Therefore, it is imperative that our leaders embody compassion in their leadership styles and behaviours. The Trust has committed to ensuring that compassionate leaders are developed at every level with a range of programmes and development opportunities from the Board right across the Trust.

The Trust has developed a top leader's programme for band 7's and above. This is a 12 month programme which also involves the attendees developing quality improvement skills to apply to local and organisational improvement projects. It is envisaged that a number of 'think tanks' will form, made up from the attendees on the course to be support for each other but also to act as reference groups for the Trust. The top leaders programme will be externally evaluated through the Trust's internal auditors in 2021 to assess impact and success.

Talent Pipeline

WUTH has also been successful in securing a place on the Shadow Board programme and therefore those attendees finishing the top leaders programme will continue to become shadow board members and will be viewed by the Trust as its future talent pool.

As part of the contributory framework described in page 11, a talent pipeline matrix will be developed, in order for managers to identify talent and to ensure that they are directed to the appropriate leadership programmes.

Medical Leadership

Medical leadership is vital in delivering high-quality healthcare. Since September 2018 the Trust has had in place a leadership programme, which has been developed

with the GMC, for new consultants and associate specialists. Arrangements will be made in 2020 to evaluate the success of the programme and to review any areas that need improving.

The Trust is also seeking to develop an introduction to leadership for our junior doctors as part of their educational programme which will incorporate the values and behaviours of WUTH and what leadership means to our Trust.

Peer Leadership

In 2018 the Trust introduced a range of initiatives such as 'ward accreditation'. This enables the organisation to have a clear view of the areas that are excelling and those areas that require further support and development.

To assist with that support the Trust will be creating peer-based development for leaders. Peer leadership enables learning with and from each other by sharing what has worked, and what has not worked so well. Areas that require support will be given a peer leader from a high achieving ward.

Management Development

In addition to the leadership programmes at every level a suite of practical good people management courses will be available across the trust dealing with subjects from handling disciplinary and grievances to budgets and resources. A nine day programme has been developed for new managers to provide them with an introduction as to what needs to be in their tool box of skills. Individuals wishing to move into leadership and management roles will need to be able to demonstrate they have undertaken leadership and management development before they can be considered for these positions.

A management portal will be developed so managers have access to tools, advice and aides all in one place to assist them to the delivery of good people management practices.

Building Block Three

Engagement, creating the employee voice

Staff Engagement

To achieve our ambition for WUTH to be recognised as “the best place to work” with a highly engaged and high performing workforce, staff engagement will be a major cornerstone. Engagement should not just be viewed as improving communication but creating the conditions whereby our employees can:

- be fully engaged in delivering the best possible care to patients
- be at the heart of decision making and feel empowered with a voice, autonomy and freedom to shape not only their own services but the way the Trust operates
- be high performing teams where good practice is shared and celebrated.

Engagement has to underpin all our activities and will require changes in style, attitude and behaviour throughout the organisation that encourage and support staff to contribute. From a leadership perspective again it is recognised that a key role of leaders needs to be consulting staff and learning from them. These behaviours need to be embedded into the fabric of the organisation through role modelling, visibility of our executive team and senior managers listening to our staff.

WUTH recognises that as one of the largest employers in the area it employs generations of family members across the Trust. Therefore, one of our key engagement initiatives is to build on the theme of being a family Trust.

The Trust has begun to put in place a number of interventions. For example weekly In Touch staff communications and monthly magazine, big debates with frontline staff, as well as undertaking consultation and engagement events around the shaping of our vision, values, behaviours and strategy.

With our ‘together’ brand the organisation is keen to generate a sense of pride within our teams. Therefore, recognising and celebrating not only success but the good work our teams do every day.

A particular theme that the Trust is keen to address is behaviour which may be perceived or experienced as bullying or harassment. In May 2018 we took a snap shot of all grievances lodged between April 2018 to April 2019 which contained an element of bullying and harassment allegations. We found that these cases could be quite complex and, although bullying was a feature in some, the abiding theme in most cases was a failure amongst colleagues to respect each other. In partnership, the recognised Trade Unions and the HR Services Team has formed a Respect at

Work Group which has now drafted an initial action plan to take a number of issues forward.

Further work needs to be undertaken to explore the different methods for engaging our workforce such as a staff app and tools to undertake pulse checks on the NHS Staff Survey themes (along with others as appropriate) rather than just engaging with them on an annual basis. Therefore, a two year engagement strategy and implementation plan will be developed.

NHS Staff Survey

WUTH's response rate in the NHS Staff Survey was 45% in 2018. The Trust is working towards moving the response rate to being one of the best Trusts (Chesterfield Royal Hospital NHS Foundation Trust response rate for 2018 was 71%). This will be through understanding the barriers to staff completing the forms, providing time for the questionnaire to be completed and encouraging staff to complete the questionnaires by rewarding them.

Medical engagement

The Trust undertook a medical engagement survey (MES) in 2017, the results of which were disappointing. Since then work has been undertaken to actively engage with the medical body through a number of routes, in particular strategy days, big debate etc. The NHS Staff Survey showed encouraging signs of improvement for the medical body. It is planned that there will be a systematic assessment of medical engagement through the MES on a 2 yearly basis in order to create benchmarking as well as understanding the appetite for service transformation and redesign.

The next MES took place in August 2019 with the results being available in October 2019. Actions from the survey will be progressed through the existing workforce governance arrangements.

Freedom to Speak Up

The Trust has had Freedom to Speak Up Guardians (FTSUG) in place since 2015. There are currently two FTSUG in post. The Respect At Work Group referred to earlier in the document has highlighted the need to strengthen Freedom to speak up service over the next 12 months.

Building Block Four

Recruitment, retention and planning for a sustainable workforce

Recruitment

In recent months the Trust has commenced different recruitment methods such as open days, use of social media, attending career fairs, etc. The organisation has also simplified recruitment processes through the implementation of TRAC. The TRAC recruitment system is an e-recruitment system that has been designed to meet the needs of public sector organisations, particularly the NHS.

However, further work needs to be taken forward to ensure that we continually engage with individuals from when they become potential candidates right through to when they start in post. The relationship between the individual and the organisation needs to build from the very point they first engage with the Trust.

We will develop schemes to facilitate recruiting talent through work experience, apprenticeships, employer funded bursaries, scholarships, internships and graduates. We will also provide routes for **all** staff groups to ensure there are clear career paths that enable the organisation to 'grow our own' using national training schemes. In addition we will support schemes which give those with less advantages access to work experience and training, such as Prince's Trust and leavers from care, to encourage school age children to consider careers in healthcare.

Over the next three years the Trust will build a career library on the website of videos of our own staff talking about their specific role i.e. band 5 nurse in the emergency department and what it is like to work for the Trust from their perspective. Members of the public and our staff will be able to access this career library. These videos can also be used a career events etc.

International Recruitment

The NHS interim People Plan outlines the need to attract nurses from abroad. The Trust will be exploring options over the next 12 months such as Earn, Learn and Return (which enables overseas clinical staff to come to the NHS for 3 years and then return to their home country) to understand the most cost effective and best way forward for the organisation.

New roles

Ensuring that we have the right numbers, skills, capabilities and resilience across the Trust will be the foundation of everything we want to achieve. We need to ensure that we are able to resource teams to the right level to enable the delivery of safe care, whilst ensuring we are as productive as we can be. This will be critical to all our staff feeling supported and being able to give patients safe care.

The national prediction is that the NHS will need an additional 190,000 healthcare staff by 2027. The Trust will develop longer-term plans for the use of new and alternative roles to tackle skills shortages. This will include the use of new roles such as Nurse Associates, Advanced Clinical Practitioners, Medical Team Assistants (MTA), Physician Associates and Computer Scientists as technology plays an increasing part in the delivery of care.

The introduction of any new role within the Trust needs to be researched, planned, understood, communicated and evaluated in order that there is a clear understanding of the role and how it fits with existing teams and functions.

Volunteers and work experience

In September 2018 the Trust Board agreed to a two year volunteer strategy. This set out an ambition to double the number of registered volunteers in a variety of areas. The strategy detailed a range of initiatives including attracting individuals to undertake work experience within the Trust to raise the profile of the range of roles that exist within the organisation.

We will build closer links between work experience and apprenticeship opportunities as a way into work for people from our local communities.

Apprenticeships

We aim to develop our apprenticeship schemes to provide maximum opportunities, particularly in roles within Estate and Facilities. Our ambition is to have over 2.3% of the workforce on apprenticeship schemes each year and 20 staff within certain areas of our Estates and Facilities Division on apprenticeship programmes. The Trust will also explore the use of its levy across the local health and social care system to create opportunities.

Links with schools, college and universities

Over the past twelve months the Trust has built links with local primary, secondary schools and colleges, in order to raise awareness of the organisation and to discuss the different roles within the Trust. As part of our people strategy we will be looking to cement these connections through open day events, taster days for college students and being part of school and college events.

We will be fostering stronger relationships with a number of universities across the North West to raise the profile of the Trust and to maximise our future supply chain. In addition we will work with our local universities to facilitate a relationship with future students from the very start of their training journey.

Retention

Whilst our recruitment campaigns as described above have been successful the Trust has to ensure that it can retain its workforce.

Given our challenges in resourcing our teams to the levels needed, we have to get a better understanding of what will make people stay with us to reduce the number of vacancies we need to fill. Retaining as many of our staff as possible will be an important foundation for delivering our plans, especially as 50% of our employees who will be with us over the next ten years are already here.

As described on page 14 we need to develop compassionate leaders who are not only skilled at motivating and inspiring teams but also have good people management practices.

We need to provide opportunities for flexible working where appropriate, recognising the needs of different generations, from millennials to those who are nearing retirement. This will mean more accommodating approaches to people working less than full time, different shift pattern lengths, a degree of choice in the run up to retirement, and also looking at the use of technology to support options such as homeworking and enabling staff to work more flexibly, recognising their caring responsibilities.

We need to put in place methods that facilitate the gathering of intelligence about what motivates our people, in particular why people join and leave our organisation (including via exit interviews) and what the needs of different generations are. We

will develop mechanisms to identify our early flight risks to put actions in place to prevent them from leaving.

Career development

We are aware that some of our staff exit the organisation for career progression. Therefore, we need to support individuals to design their ideal career pathway to achieve their full potential and career aspirations. By facilitating flexible career pathways we will enable staff to continue to work and move across Trust.

We will offer confidential career development conversations. This will allow staff to discuss and identify any potential opportunities at the Trust and the support that can be offered to them.

The Trust will provide alternative routes and support for clinical staff to develop their careers by pursuing teaching, research and leadership opportunities. We will also formalise clear career paths and development and support to specialty and associate specialist (SAS) doctors who are an important part of the medical team,

Education and Development opportunities

If we are to achieve our vision and ambitions we need to make sure that our workforce has the best education and development opportunities. We already have a strong reputation for the training we provide, in particular for junior doctors. Our aim is to ensure all our staff have access to the education, training and development to assist them both retain and expand their skills. We plan to roll out our clinical simulation plans to strengthen education and practice to meet the needs of the organisation and curriculums for learners.

Over the past 12 months we have undertaken a considerable amount of work around our mandatory and role specific training, ensuring that every member of staff has a training record as well as having a focus on e-learning packages. We are aware that our compliance rates in the last twelve months range from 75 to 90% for the core mandatory programmes. However, there is still more we need to do to ensure we create a strong culture of continuous learning and provide consistently high quality education and training in more flexible and innovative ways to improve access and develop improvement capability across the Trust

To support our education and development agenda we want to provide a range of options that will include employer funded bursaries, scholarships, sabbaticals, secondments, specialist qualifications or stretch projects.

In early 2019 a comprehensive review of the Trust's educational offerings was undertaken to ensure that they are fit for purpose. There were a number of findings in particular the need to build on the practice educator roles across the Trust, Actions are being tracked through the education governance routes.

Reward and Recognition

There needs to be a clear link between the culture we want to create and the behaviours we want to reward, recognise and promote. Equally, it is important that we reward and recognise the work and effort of the staff. Over the coming months a menu will be developed detailing a range of reward and recognition initiatives which will be shaped by the recent engagement work with our staff.

The menu will include such things as supporting individuals in education and development opportunities, showcasing individuals or teams on good practice, assisting teams to apply for external awards as well as creating opportunities to celebrate together all the good work the Trust delivers. Further work will be undertaken directly with our staff to explore other ways in which the Trust could reward and recognise them.

We will also be exploring a range of staff discount schemes that feature discounts in gym membership, cafes and restaurants, MOT services etc..

These initiatives will build on the organisation's annual staff award ceremony (which will be expanded year on year) and the Trust's long service event that recognises individuals with 25 and 40 years' service. There are also plans to introduce a new 'WUTH Alumni' forum for retired and previous employees to use and get together.

Workforce Planning

A key component of the Trust gaining workforce sustainability is the organisation's ability to undertake long term workforce planning that connects finance, activity and workforce. Workforce planning allows the organisation to intelligently plan the workforce and forecast strategic workforce movements in relation to transformational changes. Our workforce plans need to identify changes such as creation of new roles, extension of skill mixing and the educational requirements in response to changes in patient pathways and service redesign.

The Trust has established a workforce planning project which has included the introduction of the Workforce Repository and Planning Tool (WRaPT). The WRaPT tool supports strategic workforce planning for health and social care. The tool will

enable the collection, analysis and modelling of workforce information and has been developed jointly with Health Education England and Lancashire Healthcare.

The tool has been piloted within the Women's & Children division. The arrangement is for Women' & Children to be the first division to have a fully developed workforce plan which can be used as template for the other divisions, with a view that the Trust will have a comprehensive five year workforce plan within the next 18 months.

To sustain workforce planning skills the Trust will be developing workforce planning training for managers across the organisation though a series of workshops. The development of workforce planning competencies will be a core component in the delivery of transformational projects going forward.

Drive for efficiency and productivity

In the earlier part of 2019 the Trust undertook a review of its medical staffing processes in order to ensure our rotas, rosters and job plans are implemented and used to best effective through the use of technology. Over the next 12 months we will be implementing the recommendations of that review as well as building synergies between the various roster teams (including nursing e-roster team) by bringing them all under one function.

Building Block Five

Securing the health and wellbeing of the workforce

The Trust recognises the need to ensure that our staff are well at work in order to deliver effective, quality care for patients. It is more important than ever that we create a working environment that encourages and enables our staff to lead healthy lives and make choices that support positive wellbeing. As a Trust we employ nearly 95% of our staff from the local communities of Wirral. Therefore, when we discuss the local population's health determinants, in many cases we are talking about our own staff and their families. This means that our health and wellbeing plans have to include addressing those health challenges such as smoking, obesity etc.

Physical health wellbeing

The Trust will be putting in place a range of initiatives over the next 12 months that will assist and support our staff physical health. These will include the following:

- Fast track physiotherapy through the Trust's MSK services
- Regular well men clinics
- Menopause support programme
- Weight management advice
- Smoking cessation
- Establishing sport and physical activity groups such as Yoga, Tai Chai and Pilates

Mental health wellbeing

According to the charity Mind, approximately one in four people in the UK will experience a mental health problem in their lifetime. This means that in our Trust alone around 1500 staff will experience a mental health problem at any one time. Therefore, it is vital that the organisation has in place a range of support over the next two years which will include:

- All managers having mental health first aid training as well mental health awareness as part of their core management skills
- Introduction of a 24/7 employee assistance programme
- Befriending service
- MacMillan carers support cafés
- Books on prescription
- Alcohol and substance misuse support
- Resilience and relaxation workshops
- Self-referral retreats

- Awareness raising for managers and others about staff who may be experiencing domestic abuse.

Financial Wellbeing

Whilst physical and mental health wellbeing is high on the Trust's agenda, financial wellbeing is becoming increasingly significant. Money worries can affect all staff across our workforce and have an impact upon their attendance at work. Therefore, financial wellbeing is an important part of the health and wellbeing plan.

The employee assistance programme, introduced in September 2019, is associated with the debt charity 'StepChange' and can make direct referrals on behalf of any one of our employees requiring their assistance. Over the coming twelve months the Trust will also be exploring other external financial support organisations that our workforce would be able to utilise.

Environmental wellbeing

The environments where staff work have an impact on their health and wellbeing. Therefore, it is important that conditions are created that are positive and support staff to keep well. We want our working environments to be free from bullying and harassment, that staff feel able to speak up and that their input is encouraged and valued. We also want to ensure that staff are able to take necessary rests from their busy working environments.

Included within this part of the health and wellbeing plan will be the following initiatives:-

- Respect at work training for all staff across the Trust
- Appropriate rest areas where staff can take refreshments
- Ensuring showering facilities are available
- Ensuring healthy food options are available
- Creating a relaxation area within the library that all staff can use

Communication will play a key role in raising the profile of the agenda and a communication plan will be developed to underpin this work.

Occupational Health

The work of occupational health has changed considerably over the years with common mental health problems on the increase and now dominating work-related ill health. Therefore, there is a need for occupational health to have a greater focus on employee wellbeing and be the engine room for the Trust's health and wellbeing agenda.

The starting point for creating such an engine room is for the organisation to undertake a comprehensive review of our existing resource within the next six months. This will provide a baseline for the organisation to work from over the following year to change the existing occupational health function into one of a health and wellbeing department.

Attendance at work

The Trust has seen an increase in sickness absence over the past twelve months. During 2018, a new attendance policy has been produced in partnership with our staff side colleagues. The policy focuses on supporting and improving our workforce attendance. It also introduces the 'Bradford Factor' as a methodology for determining sickness absence. Training for managers on the new policy will be rolled out from July 2019.

The Trust recognises that managers need support to manage attendance. Therefore, from August 2019 the organisation will be engaging the services of an external sickness absence solution to undertake a pilot in Estates and Facilities department over the next six months.

Building Block Six

Promoting inclusion

Our vision is to create an environment for patients and staff where the principles of equality legislation are fully embraced and where people feel respected, valued and treated with dignity. Our aim is to ensure that our services are accessible to all members of our community and that they are delivered equally regardless of any differences and that our staffing reflects the communities we serve.

Detailed below are some of the key priorities the Trust will be taking forward over the next 3 years:

- Building a diverse workforce
- Robust equality monitoring in place across all HR activities e.g. recruitment, training and development to deal with bias (conscience and unconscious)
- Developing an external reference group made up of stakeholders from the communities we serve to assist with the development and progression of the Equality Delivery System (EDS2)
- Ensure our staff have access to training in order to raise awareness
- Inclusive leadership that promotes inclusion
- Introduction of reverse mentoring
- The continual development of staff network groups to offer additional opportunities for staff within certain protected characteristics to share their views
- Links local and national initiatives to enhance further development and support for staff including NHS Leadership programmes such as Stepping Up and Ready Now development programmes for Black, Asian and Minority Ethnic (BAME) staff and the government's Disability Confident Scheme.
- Annual conferences to raise awareness on specific equality and inclusion topics e.g transgender and non-binary
- Undertake external best standard accreditations such as Navajo and Mindfulness
- Review and address issues through Public Sector Equality reporting, gender and equality analysis and equal pay audits

What Will Success Look Like….

The strategy is underpinned by the comprehensive OD plan that was developed last year. However, the OD plan will now be reviewed to ensure that it includes clear metrics to monitor progress and the delivery of the strategy.

Governance

The delivery of the strategy will be driven through the workforce steering group. The workforce steering group will provide assurance to the board through the workforce assurance committee. A number of working groups will report through to the workforce steering group and these are listed below:

- Education Governance group
- Medical Education group
- Nursing, Midwifery & AHP recruitment and retention working group
- Respect at Work group

The delivery of the strategy will be reviewed thoroughly by the Workforce Assurance Committee

Trust Board of Directors	
Agenda Item	16
Title of Report:	Flu Plan 2019-20
Date of Meeting:	2nd October 2019
Author:	Ann Lucas, Deputy Director of Workforce Intelligence
Accountable Executive:	Helen Marks, Executive Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document includes FOI exempt information
Equality Analysis completed Yes/No **If yes, please attach completed form.**	

1. Executive Summary

1.1 The purpose of this paper is to present the Trust's Occupational Health Department (OHD) flu plan for the 2019/20 campaign, to ensure delivery of the CQUIN (Commissioning for Quality and Innovation) 80% target which is needed to secure the £583k payment to WUTH.

1.2 The 2019/20 action plan is attached as appendix 1 and details the progress to date and the key milestones throughout the campaign.

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

2. Background

2.1 On 17 September all NHS Chief Executives received a joint letter form NHS Improvement (NHSI) and NHS England (NHSE) asking the Trust to tell them how they plan to ensure that all frontline staff are offered the flu vaccine and how it will achieve the highest possible level of vaccine coverage this winter. The letter states that in 2018/19 provider organisations saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff. The ambition is to improve on this for 2019/20. It points out Board and ward leadership are critically important to promote vaccination to staff, providing visibility and transparency.

2.2 NHSI and NHSE also point out those healthcare workers with direct patient contact need to be vaccinated because:

- Flu contributes to unnecessary morbidity and mortality in vulnerable patients
- Up to 50% of confirmed influenza infections are asymptomatic but nevertheless may pass on the virus to vulnerable patients and colleagues
- Flu related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence
- Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated

2.3 Last year's flu campaign results, validated by NHS England, shows Wirral University Teaching Hospital vaccinated 84.5% of front line (patient facing) and was fourth highest on the North West. This year's campaign, led by the OHD as in previous years, will aim to build on last year's success.

2.4 The CQUIN attached to the staff flu vaccination rate requires 80% of front line healthcare workers to have received their flu vaccination between 01 September 2019 and 28 February 2020. However, the attached plan aims for 85% of front time staff to be vaccinated. Exclusions are:

- Staff working in an office with no patient contact (office staff with regular patient contact are included in the target)
- Social care workers
- Staff out of the Trust for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)

If the 80% target is not achieved it will mean a loss of income for the Trust of £583k.

3. Key Issues

3.1 The 2019/20 Flu plan is shown in appendix 1. Given the high level of importance that the Trust is placing on this campaign, the Chief Executive and the Acting Director of Nursing and

Midwifery will also be trained as vaccinators and play an active role in delivery of this year's target.

3.2 Due to the small number of OH nurses in the department and the number of people to be vaccinated, a number of other vaccinators have also been identified within the Trust (peer vaccinators) to support the campaign. As in previous years this will be supplemented by some bank workers.

3.3 A slightly different approach is being taken this year with peer vaccinators being made responsible for a specific ward/area to ensure a more focused approach. All senior nurses will be trained - in addition to the Chief Executive and Acting Chief Nurse, Divisional Directors of Nursing, Matrons, Infection control team, Safe Guarding team and some Community nurses will all be trained as vaccinators. Matrons will be made responsible for ensuring staff in their own areas have been vaccinated. At least one vaccinator will be identified in each clinical area.

3.4 As in previous years the aim will be to vaccinate as many people as possible in the first few weeks of the campaign. However, this will be made more difficult this year by the vaccine delivery arriving in three separate batches over three months. The three deliveries are expected as follows:

- w/e - Friday 27/09/2019 2,520 vac's
- w/e - Friday 18/10/2019 2,160 vac's
- w/e - Friday 01/11/2019 2,520 vac's

Attempts are being made to get the later scheduled deliveries earlier.

Front line clinical staff will have to be prioritised in the early weeks of the campaign.

3.5 Communications and the OHD and senior nurses within the Trust will work closely with all concerned on the details for flu communications across the Trust. Staff will start to see more information in the coming weeks and will continue throughout the campaign.

3.6 Staff side representatives have been involved with the planning process and are fully supportive of the campaign.

3.7 Once the campaign starts a weekly update with be provided to the Executive Director of Workforce for update to the executive team. This will include the percentage of front line staff who have been vaccinated to date, compared with the same period last year – by division and staff group.

3.8 This year's campaign will ensure all vaccinators have greater awareness of, and appropriately use, the 'opt out forms'. Any staff members who choose not to have the vaccine will be asked to sign an 'opt out' form. Getting opt out forms signed is one of the lessons learned from last year and has been incorporated into this year's plan.

4. Conclusion

4.1 The action plan that has been developed supports the delivery of the 2019/20 flu target and will be supported by robust communications for the duration of the campaign.

5. Next Steps

- Deliver the attached plan
- Provide weekly updates on numbers of people vaccinated against target

6. Recommendations

6.1 The Board is asked to note the attached plan and contents of this report.

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

	Milestone	Action	Person Accountable	Start/Completion date	Comments	Status
1	**Flu vaccination, ordering, storing and monitoring of stock during the campaign**	Vaccine ordered and approximate date for delivery known	SH	Completed	Order confirmed and vaccine will arrive in three stages rather than one as in previous years due to late updates about the strain of the vaccine by the WHO. The three deliveries are expected as follows: w/e - Fri 27/09/2019 2,520 vac's w/e - Fri 18/10/2019 2,160 vac's w/e - Fri 01/11/2019 2,520 vac's	Done
		Confirmation that vaccine is on site	SH/JR	w/e- Fri 27/09/2019 2,520 vac's expected w/e - Fri 18/10/2019 2,160 vac's expected w/e - Fri 01/11/2019 2,520 vac's expected	Awaiting delivery	Not yet due – no expected delays
		Sign off Patient Group Directive (PGD) & Written Instruction – at Pharmacy Non-Medical Prescribing (NMP) meeting	SH/JR	Fri 06.09.19	Clarity needed about whether non-Trust employees can be vaccinated under the PGD/Written Instruction Narrative letter included – i.e. the consent narrative	Done
		Horizon scan for PHE updates and escalate any potential risks	J TG	Immediately and throughout the duration of the flu campaign	Group email being put together for any required communication	In progress

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		Stock take to inform additional stock order	SH/JR	To commence on delivery date w/e Fri 27.09.19 and last for duration of campaign	It is anticipated there will be adequate stock across the deliveries but note stock includes vac's for Clatterbridge Cancer Centre with whom WUTH holds an SLA Unlikely to have the option of ordering additional stock Includes 10 egg free vaccines Priority will be given to front clinical staff initially - main entrance hub at APH will not be opened until second delivery received	
		Identify a place for the vaccine to be stored through the campaign and notify all concerned	TF/SH/JR	Fri 06.09.19	Second floor feed store - will be used for ward and department vaccinators Pharmacy department will be used - for hub and roaming vaccinators	Done
		Stock received and secured safely within the Pharmacy department	PR	To commence on delivery date w/e Fri 27.09.19 and last for duration of campaign	Pharmacy will hold main stock and decant to feed store as needed to give 24/7 access	Not yet due – no expected delays
		Monitoring of stock to account for it safe custody	PR	To commence on delivery date w/e Fri 27.09.19 and last for duration of campaign	A daily check will be undertaken by pharmacy staff -resident pharmacists can be contacted in event of urgent need.	Not yet due – no expected delays
		Lead on the preparation and approval of the Consent, Opt Out and	SH/JR	Fri 20.09.19		Not yet due – no expected delays

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		'Vaccinated Elsewhere' forms and ensure they are ready for use and distributed to wards, flu clinics and peer vaccinators etc. Ensure a plentiful stock of forms is held on the shelf in feed room and in the hub Produce flow chart to explain what needs to happen with all of the forms so they are processed and input correctly and in a timely manner Put a check list in place for what needs to be collected with the vaccine and understand where ward based anaphylaxis kit is located	 EB EB LP			
2	**Recruitment and training of adequate number of peer vaccinators to support campaign**	Agree training dates, content and booking system for peer vaccinators Immunisation training – core competency and inactivated vac proof of certification needed prior to anaphylaxis training Anaphylaxis – WUTH video	SH/TF AE AE	Fri 13.09.19	**Note: Vaccinators must be CPR compliance prior to training** 3 dates with 8 sessions agreed	Done

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		(e-learning) and face to face with session with AE PGD – signed to confirm understanding of content and give consent CPR training – ensure MT CPR is up-to-date 'See one do one' training – it is a prerequisite identified in the e-learning that all vaccinators will receive practical training in vaccine administration	 JB TF/JB JB		AEv in Pharmacy will support and advise if needed	
		Communicate training dates to peer vaccinators	JB/LP	Fri 13.09.19		Done
		Identify and agree who will be peer vaccinators/the number of vaccinations they are each expected to carry out/ the area they are responsible for in terms of getting staff vaccinated – ensuring non-wards areas and corporate services staff who have patient contact are covered	JB/LP	Fri 13.09.19	Peer vaccinators to include: CEO/Chief Nurse/Medical Director/All ward managers/DDN's/Matrons/AND's/IPC team/Safe Guarding team/Community nurses At least one vaccinator to be identified in each clinical area Vaccinators data base has been created and will be kept up-to-date throughout campaign	Done
		Identify any staff awaiting return to work with	CB /HRBPs	Fri 20.09.19	List of names to be sent to LP	Not yet due – no expected

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		reasonable adjustments who may be suited to be peer vaccinators				delays
3	**Staffing for flu campaign**	Book bank nurses to support flu clinics and agree shifts times and dates with them Jeanette to organise and ensure they are properly trained and Sally/June to book and authorise	SH/JR/JB	To commence w/e Fri 13.09.19 and ongoing throughout campaign		In progress
		Arrange and set up of general flu clinics in APH Information Hub/Induction sessions/CBH OH Department/APH & CBH Restaurants/Other areas Jeanette to organise and to prioritise clinical staff first – to be done working with Sally/June during some protected office time based in Occy health Department	SH/JR/JB	To commence w/e Fri 13.09.19 and ongoing throughout campaign	LP will help and advice based on the number of peer vaccinators available in the Trust and the areas they will be responsible for	In progress
4	**Communications plan**	Agree and deliver flu communications plan Jeanette to feed with local information and updates	MB JB	Commence w/e 30.08.19 and continue throughout campaign	Comms has started w/e 30.08.19	In progress

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		Update website with current year information Jeanette to feed with local information and updates	MB JB	Fri 20.09.19 Commence w/e 20.09.19 and continue throughout campaign		In progress In progress
5	**Reporting of statistics**	Identify the number of front facing staff who have regular patient contact and therefore count towards the target percentage for reporting purposes	EB	Wed 18.09.19		Not yet due – no expected delays
		Input flu data to ESR/Cohort/PHE portal and produce weekly update reports for Executive Team	EB	Commence w/e 04.10.19 and continue throughout campaign	Weekly updates – by division and staff group - including comparison figures for the same week last year, to be sent to Executive Director of Workforce and Deputy Director of Workforce Intelligence for weekly reporting to CEO and Exec Team	Not yet due – no expected delays
		Reconcile the number of vaccines used to the number of forms received and input to the portal to ensure all are recorded and reported to PHE	EB	Commence w/e 04.10.19 and continue throughout campaign		Not yet due – no expected delays
6	**Record of cost**	Record all consumables used including bank staff and any overtime costs to identify cost pressure and report to finance	EB	To commence 05.08.19 and ongoing throughout campaign	Copy to be sent to Deputy Director of Workforce Intelligence at end of campaign	In progress

Appendix 1 2019-2020 WUTH Flu Action Plan – updated version as at 17.09.19

		department				
7	**Public Assurance**	Board to agree percentage target to aim for – suggested 85% of front line healthcare workers vaccinated	AL	Wed 02.10.19	Suggested 85% (last year achieved 84.5%) agreed by Exec's	Not yet due – no expected delays
		Board to receive a campaign evaluation report including final data, challenges, success and lessons learnt	AL	February 2020		Not yet due – no expected delays
		Board Campion for Flu to be agreed	AL	Wed 02.10.19	Exec's agreed HM – Board to ratify	Not yet due – no expected delays
		All board members to receive flu vac and ensure publicised	JB/MB	Mon 31.09.19		Not yet due – no expected delays
		Staff side representatives to be consulted and regularly updated on the plan	CB/HRBPs	Starting in August and throughout duration of the campaign		In progress

Board of Directors	
Agenda Item	17
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	2nd October 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 Programme Board confirmed - at its meeting of 18 September 2019 – that the 'Hospital Upgrade Programme' now forms part of the scope, as agreed by the 4 September Trust Board, and will be subject to the assurance framework. The 'World Class Administration of Patient Services' project will bring it's Project Initiation Document to the October programme Board whereupon it will be introduced to the scope.

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 altered:

1.1. Governance Ratings

There has been deterioration with one project moving from green to amber rated and two projects shifting from amber to red rating, based upon the SharePoint evidence. SROs should act 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 marked decline, to the tune of five projects moving from amber to red rating; the evidence suggests that the reasons are discrete to each project as opposed to any overall driving effect. By way of reminder, amber rating remains indicative of substantive issues albeit considered within the competency of the project team to resolve. The areas for attention are the definition and realisation of benefits and robust tracking of milestone plans and risk.

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 was completed, as previously reported, over the four days of the

29 July and 13-15 August. Appendix 1 refers to the new structure and arrival dates for the six newly appointed staff have been agreed as shown. The new complement will be complete by 2 Dec 19 and, thereafter, all staff will be undergoing a one week intensive training course to qualify in 'Managing Successful Programmes' (MSP). However, the remaining team members and project teams continue to work hard to mitigate any impact and the overall maintenance of the governance ratings is indicative of their hard work.

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 18th September 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.

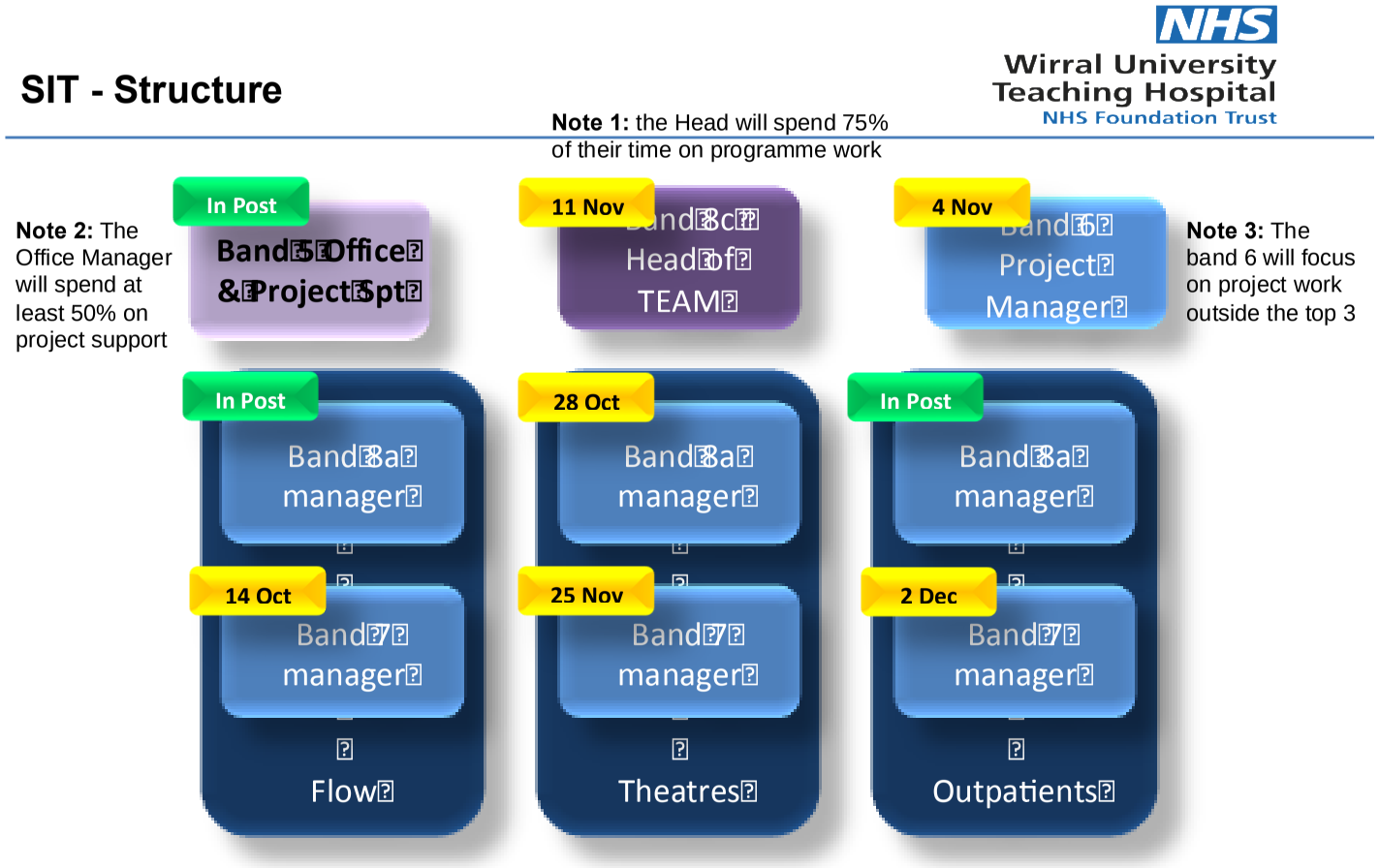
The first page (slide **10**) of the Change Programme Assurance Report provides a summary of each of the 3 Priority Projects and highlights key issues and progress.

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



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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**

Hospital Upgrade Programme
SRO – Anthony Middleton

Pipeline 'Themes'

- Programme Management
- Financial Management
- Communications & Engagement
- People
- Care Pathways
- Building

Digital
SRO - Nikki Stevenson

- GDE Meds Management **Lead: Pippa Roberts**
- GDE Device Integration **Lead: TBD**
- GDE Image Management **Lead: TBD**
- GDE Patient Portal **Lead: Mr David Rowlands**

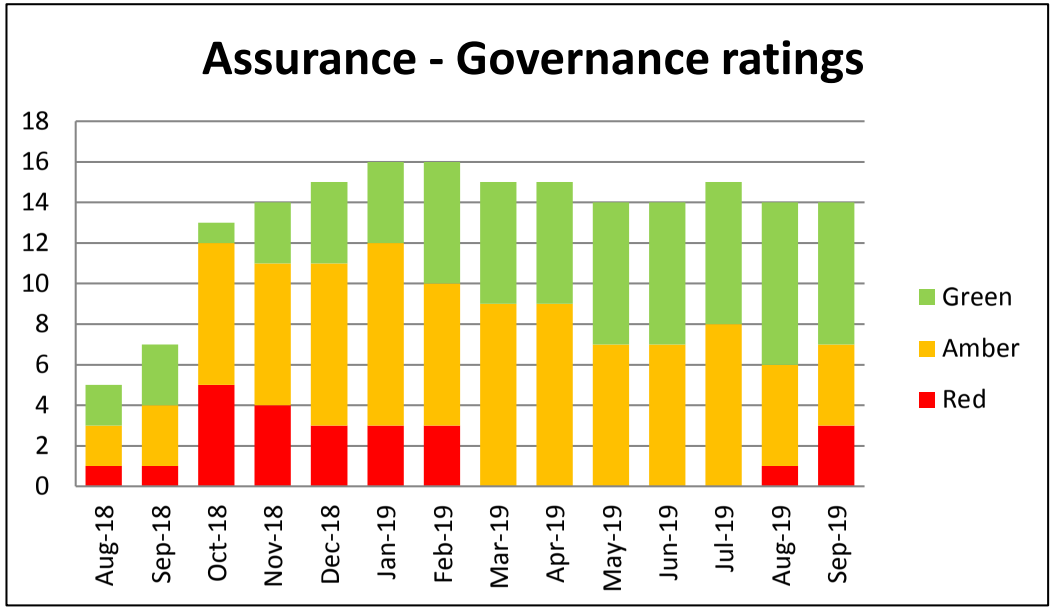
Partnerships (GDE Enabled)
SROs - per programme

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

Change Programme Assurance Report - Trust Board Report - September 2019

S Brimble – Office Manager & Project Support

Wirral University Teaching Hospital
NHS Foundation Trust



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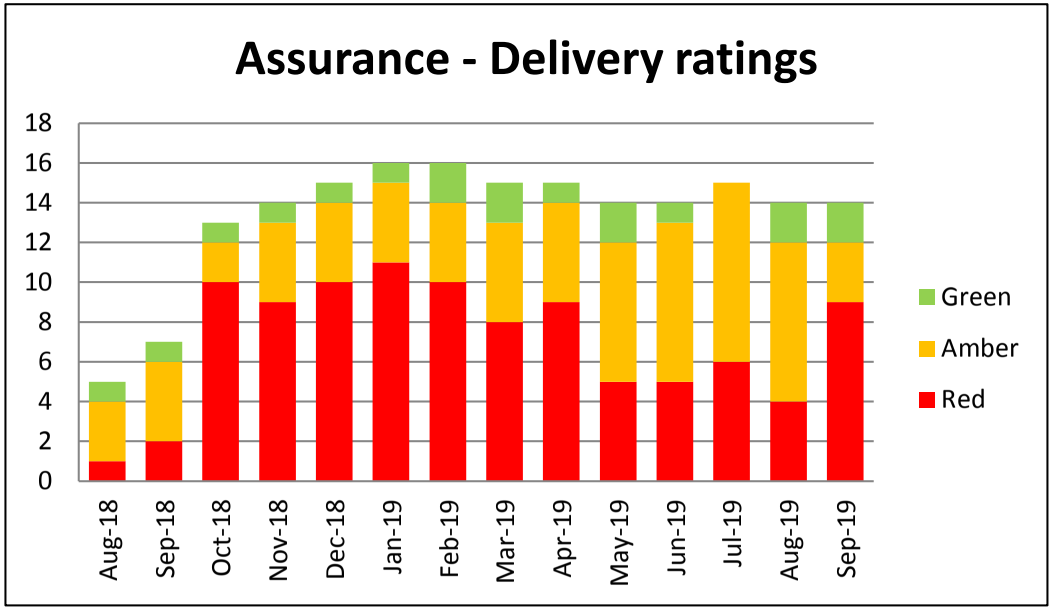
Change Programme Assurance Report - Trust Board Report - September 2019

S Brimble – Office Manager & 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 – August 2019
Programme Lead – Nikki Stevenson

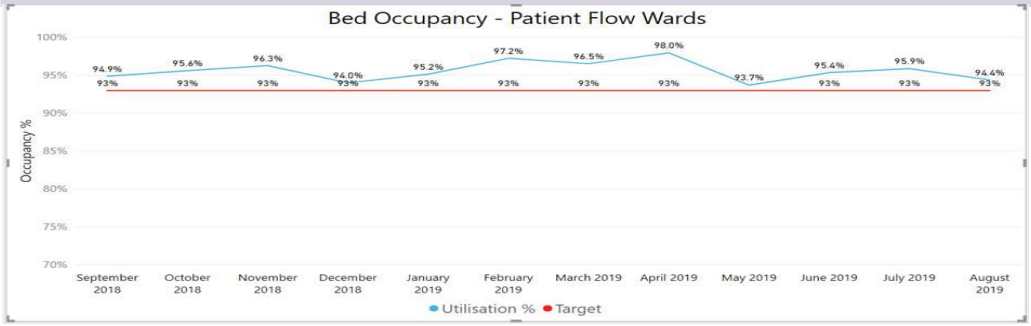
Overall Governance	Overall Delivery	Plan to Turn Green
Amber	Amber	Assessment Review: Regular project meetings in place, milestone plan to be updated and KPIs to be developed.
Green	Red	Ward Based Care/Transformation of Discharges: Restructure programme, update mile stone plans and KPIS. Take corrective action supported by ECIST. Command Centre: milestone plan to be updated, expected benefits and metrics to be confirmed.

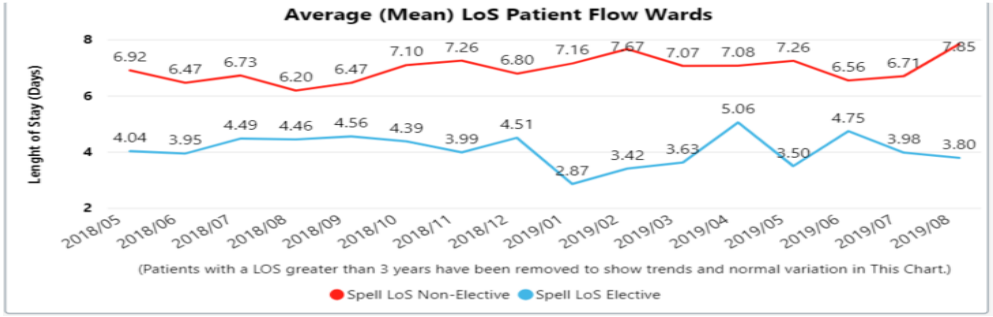
3 things you need to know

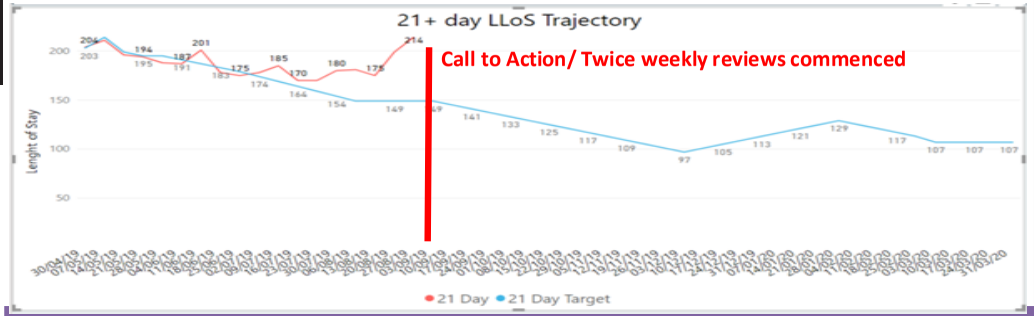
Urgent system response to decrease 21 day + LOS patient numbers supported by ECIST. Twice weekly LOS reviews, daily 'Call to Action' senior leads meeting for highest LOS patients and daily system teleconference with Community Trust and CCG.

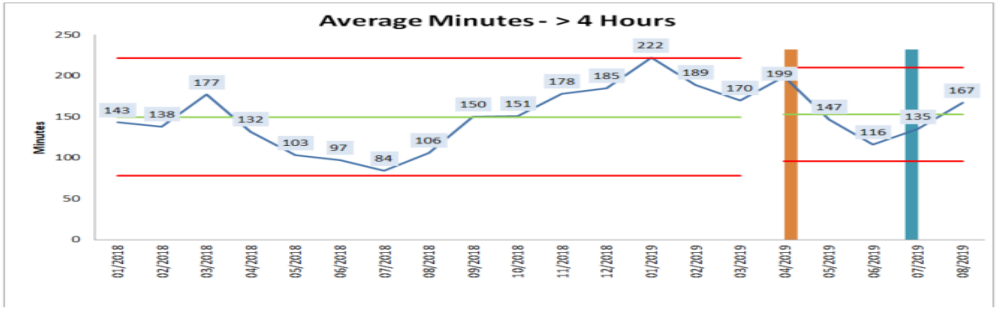
Cerner are unable to support the Trust's request for 'Go Live' with the Capacity Management System in Nov 2019 & there have been concerns raised regarding the Trust's operational readiness to Go Live. Calderdale visit planned on 24th September to see Capacity Management in use. 'Go Live' date of the 9th March 2020 has now been confirmed. Launchpoint 'Go Live' remains on 18th Nov 2019.

Acute nursing business case being presented at TMB September which will improve nursing cover within UMAC









Escalation

Long stay (21 day +) patients
Corridor care

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

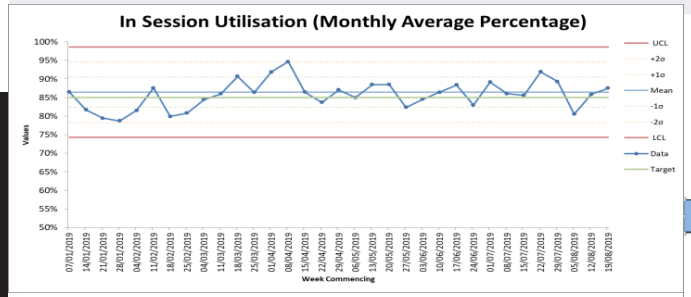
Four things you need to know

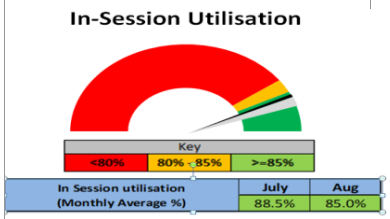
Main Focus: Three phase recovery options have been presented to the Executive Team with a decision approved in principle.

Theatre Scheduling System design specification has been used to develop a scheduling system in-house using Power BI and is currently being tested prior to parallel running with the existing approach before going live.

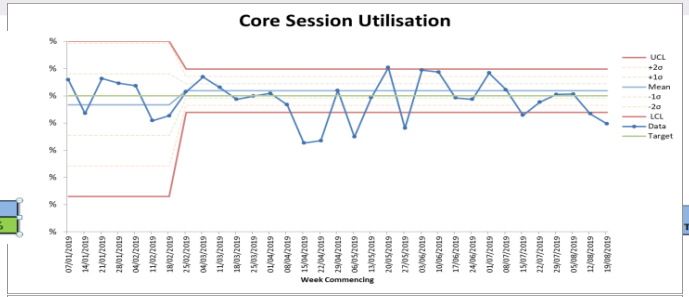
Pre-op has moved from SEAL to OPD with a further plan to move Colorectal School to CGH.

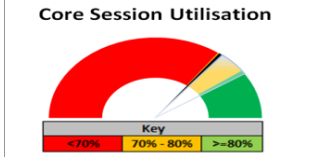
KPI performance as expected for August due to annual leave, with greatest reason for dropped sessions is consultant leave as teams not been able to backfill.



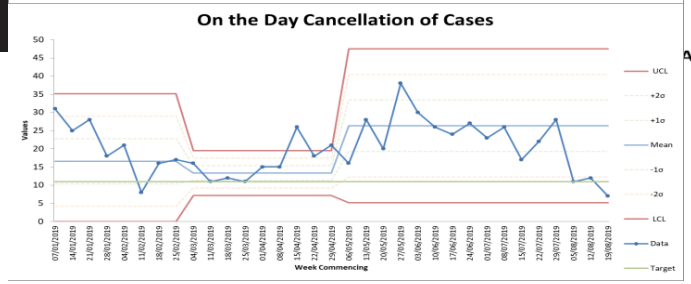


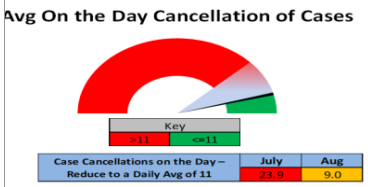
In Session utilisation (Monthly Average %)	July	Aug
	88.5%	85.0%



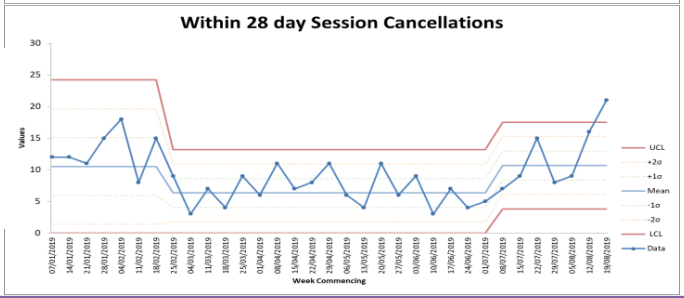


Core session utilisation Target 80% of 52 week capacity	July	Aug
	80.5%	70.5%





Case Cancellations on the Day – Reduce to a Daily Avg of 11	July	Aug
	23.9	9.0



Late Cancellation of Sessions

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

April	37
May	33
June	23
July	42
August	53

Escalation

The increase in medical outliers and use of escalation areas will negative impact two KPI's specifically, In session and On the Day Cancellations due to lack of beds post operatively

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

Overall Governance	Overall Delivery	Plan to turn green
Green	Green	N/A

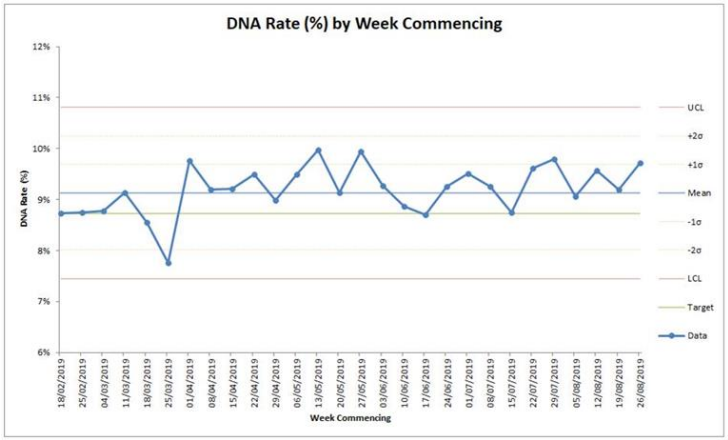
Things you need to know

The Future of Wirral Outpatients Engagement Workshop with DDs, DMs and Clinical Leads has been scheduled for the 18th October at 12:30pm-3pm in the Boardroom. 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.

A pilot of advice and guidance agreed in principle for Gynaecology to work with one of the PCNs on the Wirral, to be included in the showcasing of Outpatients Improvement workshop.

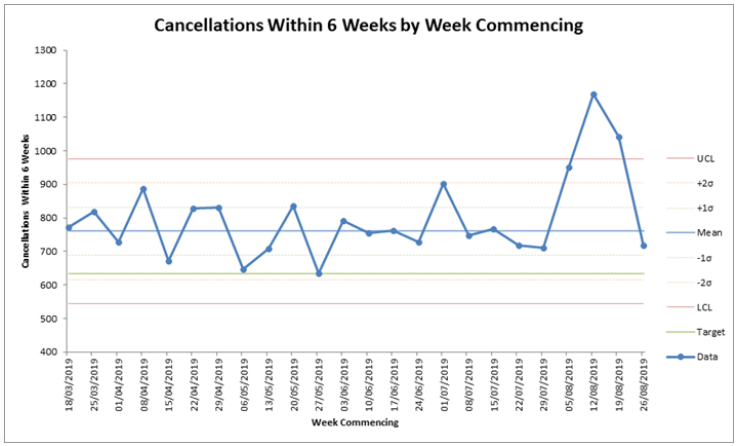
Current delivery of outpatient activity levels now meeting overall contract plan.

DNAs



Currently all DNAs reported – to be modified to just show 'Follow ups'

Cancellations



Activity

	18/19 YTD	19/20 YTD	Variance	% Var
New	28448	29527	1079	3.8%
FU	55892	56477	585	1.0%
Op Proc	12855	14159	1304	10.1%
Total	**97195**	**100163**	**2968**	**3.1%**

Activity vs plan graphs in development

Escalation

Nil

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Programme Assurance Ratings

Joe Gibson
18 September 2019

together we will

wuth.nhs.uk

Change Programme Assurance Report - Trust Board Report - September 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'** there is a ' A 'Ward Based Care Milestone Plan' updated to 6 Sep 19; activity lines past due date show a number of delays. Benefits and measures are covered in the spreadsheet 'Flow Metrics - 3 Sep 19' - 21day + LoS is now in excess of 30% above target.
- For he **'Command Centre'** evidence of widespread stakeholder engagement with clinical groups is thin; a more compelling communications and engagement effort (see Plans from May 19) will be required.
- **'Transformation of Discharge Services'** has a 'TDS Internal Plan' updated to Jul, with significant delays (in excess of 2-3 months) with no revised plan to deliver this element.
- For the '**Assessment Review (Medical)'** the milestone plan has been updated to 19 Aug 19; there are some delays to key milestones. There is now evidence of measurement of one KPI - UMAC Clinical Criteria Audit - but the link to the benefits defined in the PID (or baseline/target information) is not clear.

Perioperative Medicine Improvement	Governance		Delivery	

- As previously stated, the **'Perioperative Medicine Improvement**' programme has evidence of wider stakeholder engagement uploaded but this ceases (8 Jul 19) with the May-July Divisional Newsletter; more recent evidence is required. A communications plan is now available but is not being tracked.
- The revised plan, dated 1 Aug 19 - as re-baselined by means of an Exception Report to the May Programme Board - is showing some delays across a range of milestones.
- KPIs are developed in the PID; the performance has deteriorated on key measures during July and August and so a red rating has been applied.
- Evidence in place concerning risk and issue management; however, 'date of last review' at 4 June 19.

Outpatients Improvement	Governance		Delivery	

- For the **'Outpatients Improvement'** there was a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan - Apr 19 but this shows no signs of being actively tracked and is now out of date.
- A detailed Gantt chart has now been produced, uploaded 10 Sep 19, to cover 2019/20 following approval of the revised PID; the tracking is not up to date across work streams with undefined delays.
- The main KPI, achievement of plan, is reported as showing a year-on-year increase. However, additional KPIs are being developed to introduce further transformational change.

Workforce Planning - Programme Assurance Update – 18 September 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a revised PID v0.2 dated 16 Mar 19 has been drafted with benefits described; however, there are no benefits start dates or metrics identified (that could lead to estimated financial benefits). **2. & 3.** There is now some evidence of regular meetings with divisions up to 12 Aug 19 in terms of diary invitations but no recent minutes or notes of project team meetings. **4.** There is now evidence of some stakeholder engagement in the form of engagement events in Oct/Nov 18 but further evidence of engagement through 2019 is required. **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 a trackable Gantt chart; however, there is an absence of evidence on SharePoint to support the milestone delivery (e.g. Review PILOT and assess lessons learnt; future states modelled - completed April 19). **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 but not reviewed for 3 months, 7 Jun 19 - the RAID Log also records the 1 live issue. **Most recent assurance evidence submitted 15 Aug 19.**

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

Ward Based Care for Earlier Discharges - Programme Assurance Update – 18 September 2019

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

Independent Assurance Statement

1. ECIST providing 3 months support to flow and producing an operational plan. Therefore, the group has decided to amend/approve the PID and TOR taking into account this new operational plan. Proposed new structure, reporting & governance arrangement are drafted and waiting for approval at PFIG on 12 Sep 19. **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 5 Sep 19 are in evidence. **4.** Extensive evidence of stakeholder engagement submitted up to 2 Aug 19, including 'Ward Performance Posters' to 22 Jul 19. **5.** EA/QIA are now completed. **6.** A 'Ward Based Care Milestone Plan' updated to 6 Sep 19; activity lines past due date show a number of delays. **7.** 'Benefits and Measures': these are covered in the spreadsheet 'Flow Metrics - 3 Sep 19' - 21day + LoS is now in excess of 30% above target. **8 & 9.** There is now evidence of risk and issue management in the form of a RAID Log with risks reviewed up to 5 Sep 19. **Most recent assurance evidence submitted 8 Sep 19.**

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

Command Centre - Programme Assurance Update – 18 September 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 v0.5 dated 26 Jul 19, lacks metrics by which benefits will be measured and these are in the process of being developed. The business case for 'Capacity Management Devices' dated 12 Aug 19 was approved at the interim PFIG 12/08/19; however, issues around storage/charging are yet to be resolved. **2. & 3.** Evidence of documented project meetings is available up to the action log updates post the meeting of 30 Aug 19 and ToRs are also in evidence. **4.** Evidence of widespread stakeholder engagement with clinical groups is thin; a more compelling communications and engagement effort (see Plans from May 19) will be required. **5.** EA has been drafted and QIA signed-off. **6.** The new Command Centre Project Plan has been updated to 9 Aug. 19 shows a number of delays of 2 to 3 months. **7.** As described above, there are no metrics as yet for the benefits to be measured. **8 & 9** There is a RAID Log showing the date of risks last reviewed as 30 Aug 19. **Most recent assurance evidence submitted 14 Aug 19.**

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

Transformation of Discharge Services - Programme Assurance Update – 18 September 2019

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

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'. There is also now a 'Long Stay Review SOP' uploaded on 8 Jul 19. **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	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 – 18 September 2019

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

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. This is supplemented by the 'Assessment Redesign Scope' initiation slides uploaded on 22 Aug 19. **2.** Project Team names are now complete on this dashboard. **3.** Evidence of meetings to Jul 19 with status reports (some meetings being postponed); agendas would benefit from having the date of the meeting on the document. **4.** There is a Communications Plan dated 5 Jul 19 which will need tracking to assure delivery; many actions and surveys planned for May/Jun 19 should have evidence of completion. **5.** EA/QIA signed off, 6 Aug 19. **6.** The milestone plan has been updated to 19 Aug 19; there are some delays to key milestones. **7.** There is now evidence of measurement of one KPI - UMAC Clinical Criteria Audit - but the link to the benefits defined in the PID (or baseline/target information) is not clear. **8.** and **9.** Risks and issues are featured in a RAID Log and were reviewed up to 23 Aug 19. **Most recent assurance evidence submitted 6 Sep 19.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.4	**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 – 18 September 2019

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

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 6 Aug 19; an action log is now in place to assist governance. **4.** There is evidence of wider stakeholder engagement uploaded but this ceases (8 Jul 19) with the May-July Divisional Newsletter; more recent evidence is required. A communications plan is now available but is not being tracked. **5.** The QIA has now been revalidated. **6.** The revised plan, dated 1 Aug 19 - as re-baselined by means of an Exception Report to the May Programme Board - is showing some delays across a range of milestones. **7.** KPIs are developed in the PID; the performance has deteriorated on key measures during July and August and so a red rating has been applied**. 8 and 9.** Evidence in place concerning risk and issue management; however, 'date of last review' at 4 June 19. **Most recent assurance evidence submitted 10 Sep 19.**

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

Outpatients Improvement - Programme Assurance Update - 18 September 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	TBC	Implementation	Green	Green

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 2 Sep 19. **4.** There was a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan - Apr 19 but this shows no signs of being actively tracked and is now out of date. **5.** The signed QIA has been submitted. **6.** A detailed Gantt chart has now been produced, uploaded 10 Sep 19, to cover 2019/20 following approval of the revised PID; the tracking is not up to date across workstreams with undefined delays. **7.** The main KPI, achievement of plan, is reported as a 3% year-on-year increase. However, additional KPIs are being developed to introduce further transformational change. **8 and 9.** There is a comprehensive RAID Log in evidence with risks and issues last uploaded on 9 Sep 19. **Most recent assurance evidence submitted 10 Sep 19.**

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

Diagnostics Demand Management - Programme Assurance Update - 18 September 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 6 Sep 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, updated 6 Sep 19, on which tasks have been updated and which shows delays to some milestones. **7.** There is now benefit reporting against two metrics (compared to the six detailed in the PID) and one is green, the other amber rated; the CIP target is being reported as on track. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 14 Aug 19. **Most recent assurance evidence submitted 6 Sep 19.**

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

Digital: GDE Medicines Management – Programme Assurance Update – 18 September 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 VTE meetings available to 28 Jun 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. Pharma Outcomes PP v1 20190702 uploaded 13 Aug 19. **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 v22, 24 May 19; risks reviewed 27 Mar 19. **Most recent assurance evidence received 10 Jul 19.**

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

Digital: GDE Device Integration – Programme Assurance Update – 18 September 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Gaynor Westray	Michelle Murray	Implementation	Red	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	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 - 18 September 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Nikki Stevenson	Michelle Murray	Implementation	Red	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 8 Jul 19.**

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

Digital: GDE Patient Portal - Programme Assurance Update - 18 September 2019

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

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	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 – 18 September 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	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	Natalia Armes	**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 - 18 September 2019

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

Independent Assurance Statement

1. PIDs have now been uploaded for: HW AMR (draft), HW MOCH (draft), HW Pan Mersey (draft), Mental Health, and HW Stoma; eTCP, were updated and uploaded 14 Aug 19. Some of these PIDs are only partially complete with benefits either partly defined or cross-referred to the GDE SoPB. **2.** Notes of Healthy Wirral Meetings and Highlight Reports are available up to Aug 19, including the 'Medicines Optimisation Programme Board' up to Jul 19. **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 now a detailed milestone plan, v3 uploaded 15 Aug 19, with some workstream dates remain to be decided. **7.** Benefits are shown in a range of reports, uploaded to Sep 19, covering: Adalimumab Biosimilar; Biosimilar Uptake; Etanercept Biosimilars; Infliximab Biosimilars; Lucentis Data; Rituximab Biosimilars. Lost opportunities numbers are shown but overall benefits (numbers) unclear. **8 and 9.** There is a monthly risk and issues log in place and updated to Sep 19 (although it is in non-standard format) with 'date of last review' as Aug 19. **Most recent assurance evidence submitted 6 Sep 19.**

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

WWC Alliance: Pathology - Programme Assurance Update - 18 September 2019

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

Independent Assurance Statement

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

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Collaboration - Wirral West Cheshire Alliance														
6.4	**Pathology**	For WUTH and COCH to form a joint pathology service across the two Trusts which will deliver against indicative NHSI savings targets, provide operational benefits, reduce a number of current operational risks and position both Trusts for future broader regional collaboration.	Karen Edge	**As agreed at the Programme Board on 17 April 2019: assurance ratings suspended pending a decision on project initiation**										

Board of Directors

Subject:	Agenda Item 18 Proceedings of the Trust Management Board held 26.09.2019	**Date:** 2nd October 2019	
Prepared By:	Andrea Leather – Board Secretary		
Approved By:	Janelle Holmes, Chief Executive		
Presented By:	Janelle Holmes, Chief Executive		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**Risk associated with non-delivery of financial control total based on M5 outturn.**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care – exposure to infection, VTE assessment and attendance management.**
Staff Impact	**Attendance management and appraisal compliance 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 26/9/2019. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors.

2. Divisional Updates

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

(i) Surgery – cross divisional working groups established to map flow in relation to the Third Stage Recovery project. Tender for Intestinal Failure Services published – Trust to consider submission of a bid and identify next steps including resources required to support service.

(ii) Women & Children's – pilot of new neurodevelopmental pathway started in Community Paeds in collaboration with WCT, CWP and the CCG. The evaluation of the pilot is expected during December. Commissioners to consider interim additional funding to support increasing demand on the Perinatal Mental Health Service, with a view to scoping the service across the health economy.

(iii) Diagnostics and Clinical Support – tender submitted for community Orthoses and Wigs – outcome expected end of October 2019. Following a deep dive regarding MSK service and a review of Key Performance Indicators (KPI's) underway. IT to provide an impact assessment regarding ongoing PAC's issues for all Divisions and provide options to

address eg possible roll-out of Carestream.

(iv) Medical & Acute – 'Call to action' process instigated in response to deterioration of long length of stay performance. Report to next TMB outlining learning from the process and measures to be implemented to address internal and system wide approach. Divisional recruitment day planned for November/December.

(v) Estates & facilities - minor works programme underway and work has commenced on Ward 36, updates to be provided to TMB. It was noted that the Trust is an exemplary site for water services following a recent Drinking Water Inspectorate (DWI) inspection on both Arrowe Park and Clatterbridge sites.

3. Quality and Performance Dashboard

- TMB received the revised Quality Performance Dashboard covering the 12 months ended 31st August 2019.
- There are currently 21/57 indicators outside tolerance.
- TMB noted the progress to date and the number of indicators that were now seeing improvement and/or coming under control

4. Infection Prevention Control (IPC) Improvement Actions Update

- TMB received the progress against plan for IPC.
- A survey of hand hygiene dispenses on both Arrowe Park and Clatterbridge is underway to ensure compliance with IPC guidance.
- A summary of the works started was provided for Wards 36 and 22.
- It was noted that the number of *Clostridium difficile* cases had significantly reduced in quarter 2 – 13 reported, overall total is 42 – it was acknowledged that this reflects the hard work undertaken and the challenges the organisation has to sustain this level of performance.

5. First Care sickness Absence Management Pilot

- TMB received the first set of data collected by the First Care pilot in estates and hotel services. Future reports will be provided to the Workforce Assurance Committee to monitor progress against any actions identified.
- Divisional triumvirates to review differential data produced from ESR – consider options to address issues and establish short and long term solution, to be reviewed at Divisional Performance Reviews.
- TMB requested a comparison of sickness absence during the last 6 months to highlight any gaps in data.

6. Workforce Reviews – Emergency Department (ED) Medical Staffing

- TMB considered the recommendations outlined in the report based on benchmarking undertaken against other ED's to ensure safe medical cover.
- TMB supported the next steps and the development of an action plan.
- TMB instructed the Divisions to align the rate of pay with that of other Trusts and implement across the Trust.

7. Workforce Reviews – Emergency Department (ED) Nurse Staffing

- TMB considered the recommendations outlined in the report based on benchmarking and ECIST report on ED nurse staffing.
- It was agreed to trial proposed changes to shift patterns ahead of full rollout, seeking staff views – what works well and suggestions for any concerns.
- TMB supported the next steps.
- Finance business partners to provide support to identify any related costs pressures.

8. M5 Financial Position

- TMB received and noted the financial position for the end of month 5.
- Members noted the underlying deficit position against plan of (£3.3m) and the key components relating to pay - agency spend on consultants, cover for junior medical vacancies and bank costs for nursing.
- TMB noted the financial breakdown for each Division.
- Members noted that if the Trust was unable to achieve a "break-even" position and therefore not able to access the 'control total' funding of £12m this would significantly impact the 2020/21 budget.

9. Business Cases

A. <u>Capacity Management Handheld Devices for Porters</u>

- Assurance provided that a risk impact assessment completed and appropriate arrangements would be in place regarding other functions such as security and charging of devices, workforce related matters.
- TMB reviewed the business case and approved option 1 – cost £14,583. The purchase of items would be deferred until certainty was established of the go live dated of Capacity Manage, currently scheduled for March 2020.

B. <u>Acute Medicine Nursing Establishment Investment</u>

- TMB reviewed the business case for acute medicine nursing establishment.
- TMB recommendation to Finance, Business, Performance Assurance Committee (FBPAC) is to approve option 2 staffing model.

C. <u>Endoscopy – expanding nursing workforce</u>

- TMB considered the business case and supported in principle.
- TMB requested a separate business case for the capacity and demand of the core service – to be considered at TMB in December 2019.

D. <u>Bed Management Review</u>

- TMB reviewed the business case outlining an effective capacity management system.
- TMB recommendation to Finance, Business, Performance Assurance Committee (FBPAC) to approve option 3 to fund the current overspend and expand the staffing model. FBPAC to consider the business case at its November meeting.

E. <u>Replacement of Cardiac Catheter Lab</u>

- TMB reviewed the business case options for the replacement of the cardiac catheter lab.
- It was noted the possible opportunity to capitalise the £100,000 revenue expenditure for a portable lab directly related to the need to complete works enabling the implementation and reduce cost (weekend working, etc).
- TMB recommendation to Board of Directors to approve the proposal to replace the catheter lab.

<u>Note:</u> This proposal is in line with the 2019/20 capital programme approved by the Board of Directors. FBPAC considered the business case at its September meeting with a recommendation to approve by the Board.

F. <u>Three Phase Recovery</u>

- TMB reviewed the business case for the development of a three stage recovery area.
- TMB recommendation to Board of Directors to approve the proposal to implement scheme 4 the three stage recovery area to ensure a sustainable future model of perioperative care.

<u>Note:</u> This proposal is in line with the revised 2019/20 capital programme approved by FBPAC at the September 2019 meeting. FBPAC considered the business case with a

recommendation to approve by the Board.

G. <u>Braun Containers</u>

- TMB reviewed the business case and approved option 2 to replace broken lids and bases. The cost pressure arising is c£25k.
- The managed service contract component to be included to be built into the budget setting process for 2020/21.

10. Chair's Reports

- The following Chair reports were received and reviewed by TMB:
  - Patient Safety & Quality Board Report – 12/9/19
  - Risk Management Committee Report – 10/9/19
  - Workforce Steering Group – 22/8/19
  - Finance & Performance Group 20/8/19

11. TMB approved the Terms of Reference for the Clinical Procurement & New Procedures Group.

12. TMB noted the update regarding Cheshire & Merseyside Pathology Network Collaboration.

13. TMB note the update relating to a No Deal EU Exit

Written and summarised on behalf of the Chief Executive by:
Andrea Leather, Board Secretary
30th September 2019

Board of Directors

Subject:	Proceedings of the Quality Committee	**Date:** 24.09.2019	
Prepared By:	Dr J Coakley, Non-Executive Director		
Approved By:	Dr J Coakley, Non-Executive Director		
Presented By:	Dr J Coakley, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**None identified**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care:** • **Exposure to infection and infection control indicators including hand hygiene (beyond trajectory level for C.diff)** • **Quality dashboard improving but not yet completely reassuring** • **CQC plan on track**
Staff Impact	**None identified**
Services	**None identified**
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.** **CQC Insight Tool improved – still some areas for improvement**
Committees/groups where this item has been presented before	
N/A	

Executive Summary

Executive Summary

- The Quality Committee met on 24th September 2019. This paper summarises the proceedings.

Serious Incidents & Duty of Candour

- There was only one incident in August and none in September to date. Committee reviewed two recent investigations. There have been no never events for over twelve months

Infection Prevention and Control Report

- We continue to experience challenges with Clostridium *difficile*, although there has been an improving trend over the last two months. The Committee was not minded to adjust the BAF at this stage, but will reconsider at our next meeting providing the encouraging reduction persists.

CQC Action Plan Report

- The Committee took account of the progress report and are satisfied.

Overall Quality Performance

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

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

- The Committee discussed the current performance against standards. Some ward areas are showing improvement, but concern was expressed at the shortfall in the 'organisation and management' domains across ward areas. Further work will be done urgently to determine why this is so and how it can be addressed.

Summarised and drafted by the Quality Committee Chair by:
John Coakley 25th September 2019

BOARD OF DIRECTORS	
Agenda Item	20
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	4 October 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 September 2019

This report provides a summary of the work of the FBPAC which met on the 24th September 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. Month 5 Finance Report

The committee received the Month 5 Finance report. The key points noted were the year to date deficit of (£7.2m), this being (£1.9m) worse 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

(£3.3m) worse than plan and the adverse performance has been driven primarily by the costs of covering consultant and junior doctor vacancies, the additional depreciation charges as a result of RICS guidance and the VAT impact of the medical locum supply and the costs of sickness and escalation capacity affecting nursing pay. Income performance is balanced to plan and some under-performance in elective activity has been offset by higher excess beddays and maternity income.

The committee discussed the reasons for the financial overspends, particularly the deterioration in the Month 5 performance. It was discussed the impact of operational flow and long length of stay on elective performance and escalation costs. The Trust was receiving support with this issue from ECIST and system partners. The costs of agency and locum spend for medical staff was a concern and the action plan to address this needs to be developed further.

The Committee reviewed the Forecast report which detailed a forecast outturn position of (c£10m) deficit, excluding the impact of foregone PSF/FRF of (c£10.6m). The forecast assumes the planned bed closures in October and no additional spend for winter. The forecast assumes a gap in CIP delivery of £2.3m which if delivered and further mitigation on income achieved would deliver a forecast of (c£6.9m). As a result of the forecast deficit, additional cash support would be required and early discussions were being had with the central team.

The Chair advised the committee was not accepting of the forecast and further discussion would be required at Board.

The Trust delivered £3.9m against a plan of £3.9m CIP YTD. Significant progress was noted against the Trust target of £13.2m with £12.6m of schemes identified.

Cash at £2.6m was favourable to plan. The capital spend year to date totalled £1.7m with a forecast of £7.5m.

2. Capital Programme

The Acting Director of Finance presented an update on the Capital programme which had been refreshed mid-year following changes to the available resource limit, emerging risks and developments in respect of planned schemes. The programme would deliver spend of c£7.6m and the key changes included IT, Clatterbridge clinical development no longer proceeding and a proposed Theatres and A&E scheme.

The Committee accepted the proposed changes for recommendation to the Board.

The Committee reviewed the Cath Lab Replacement and the Three Phase Recovery (Theatres) Business cases and would recommend approval to the Board.

3. Cerner Contract Update

The committee received an update from Gary Evans (IT Systems Improvement Lead) which highlighted the following risks in terms of CERNER contract price increases for 2020/21 onwards.

- Core Contract payment profile £0.5m
- Discount removal following CoCH decision on shared instance £0.4m
- Population Health payment profile £0.4m
- Increase in Concurrent Users charges £0.3m

Legal advice was being sought over the CoCH contract change and the Trust was challenging the increase on a number of fronts including value for money, service delivery and management of resources. A further update on the negotiations would be provided at the Trust Board.

4. Quality Performance Dashboard

The Chief Operating Officer presented the 'responsive' element of the Quality performance dashboard. The key areas discussed were the deterioration of A&E performance and Ambulance turnaround times affected by the flow pressures and long length of stay increases. The 12 hour breach recorded related to changes in the recording of mental health patient breaches. System

responses to operational flow are being deployed focussing on front door demand, streaming and discharge processes.

5. 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 addition, the Committee received a report on Cyber Security in relation to risk PR 5: Major disruptive incident which gave positive assurance.

The assurance ratings based on the identified risks were considered by the Chair and were updated.

6. Renewal of Trust Insurances

The Board Secretary presented a report of the renewal of Trust insurances. The requirement for this 'top up' insurance was questioned by the Chair in light of the reducing distinction between FT's and non FT's. The Board Secretary gave feedback on benchmarking from local Trusts where the insurances were in place. It was agreed this would be discussed further outside of the meeting with the input of the Audit Chair, Steve Igoe and after seeking advice from NHSI.

7. Medical Workforce Contract

The Committee received a report with regard to an emerging risk following employment tribunal claims for holiday pay from 4 junior doctors undertaking locum shifts. A legal strategy was being developed and the Workforce Assurance Committee were overseeing remedial actions. The likely risk is predicted to be c£250k.

8. Other items

The committee received and noted reports in regard to:

- The Long Term Plan submission
- The Reference Cost submission
- STP Pathology Collaboration
- Report of the Finance Performance Group

9. Items of the Risk Register

- Financial risks in respect of the CERNER contract and Medical Bank contracts of employment
- Spend of c£16m-£18m on premium medical staff pay

10. Recommendations to the Board

- To note the concerns with regard to the forecast, the non-achievement of the financial control total and subsequent loss of central funding.
- Approval of the revised Capital Programme
- Approval of the Cath Lab Replacement and Three Stage Recovery capital business cases

BOARD OF DIRECTORS	
Agenda Item	21
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	2 October 2019
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	PR2
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The tenth meeting took place on Wednesday 25th September 2019.

2. Key Agenda Discussions

2(a) Chair's Business

The Chair highlighted two workforce priorities to the Committee. Firstly the continuing concern at Trust Board with the deteriorating trend in sickness absence and the quantity of Medical staffing expenditure.

The Committee noted that there were no deputies in attendance for Operations or Medical Executives absences. It was agreed that this would be discussed with the relevant executives outside the meeting.

It was proposed and agreed that the Communications and Engagement Strategy paper would be postponed pending further work.

2(b) Staff Story

The committee welcomed Ms Annie Cooper who is a WUTH volunteer of 7 years standing. Ms Cooper described the job satisfaction she gets from her role and her frustrations with car parking complaints and inappropriate use of the Trust's wheelchairs. Ms Cooper also highlighted the great work done by volunteers in the End of Life Team.

The committee warmly thanked Ms Cooper for her contributions and insights.

2(c) Draft Workforce Strategy

The committee expressed its thanks and support for the Workforce Strategy and recommended its acceptance to the Trust Board. It was also suggested that the current Workforce KPIs be explicitly linked to the building blocks and success factors of the Workforce Strategy.

2(d) Communications Dashboard

The Communications and Engagement dashboards were presented for July and August. The committee endorsed the 1 page snapshot reports. The members of WAC thought the information was clear and understandable.

2(e) Workforce Intelligence & KPI review

Recommendations for a more comprehensive and analytical workforce information report were presented to the committee.

The three Board level Workforce KPIs of attendance, appraisals and turnover will remain but will be supplemented in future by a detailed monthly report on attendance management.

The remaining workforce KPIs will be replaced at the committee by more BAF risk based detailed 'deep dives' including benchmarking (model hospital) and deeper analyses of issues.

Future areas of focus will include Medical Staffing, Respect at Work cases and themes, staff turnover and measures of staff engagement.

The recommendations were supported and it was suggested that productivity measures for hospital services be developed and eventually included.

2(f) NHSI Lessons to improve Staff Disciplinary practices.

Nine good practice recommendations from NHSI have been accepted and will be implemented at WUTH. A paper will be presented to the WUTH Trust Board for information and support.

2(g) Medical Workforce Contracts -- historical issues

Historical poor HR practice and management, particularly a failure to adopt the advice of H.M. Govt following an ECJ ruling in 2006, has resulted in the Trust being vulnerable to litigation and significant, unexpected costs.

A full paper will be presented to the Board of Directors on Wednesday 2nd October 2019.

In the meantime the committee supports the urgent introduction of the Casual Workers Agreement and the requirement that all relevant staff must sign it before any further work can be offered to them.

The committee acknowledges that the implementation of this new agreement may result in some resistance and that this may have some operational implications. The committee also supported the suggestion of internal audit undertaking a complete review.

2(h) Attendance Management -- First Care Pilot Implementation Update

The first set of monthly data collected by the First Care pilot project in the Facilities & Estates areas was presented.

There are some absence data differences between First Care and the WUTH ESR system. It will be 3 months before we can reliably report on the impacts the First Care Pilot is having in Estates & Facilities. The Committee welcomed the data presented to date and will receive monthly updates on the pilot.

Although the pilot is experiencing some teething problems in its implementation phase, it is on track and is providing managers, HR and the Exec Director of Workforce with live data on sickness absence through a live portal.

2(i) Recruitment Process Review Audit (by MIAA)

The MIAA led audit covered recruitment and selection processes to ensure that vacancies were consistently filled and followed adequate processes in line with Trust policy and employment law. The audit found a good system of internal control designed to meet the system objectives, and that controls were generally being applied consistently. The level of assurance given was Substantial Assurance.

2(j) Flu Plan Update

The Trust's Occupational Health Department (OHD) flu plan for the 2019/20 campaign was presented and approved. Delivery of the CQUIN (Commissioning for Quality and Innovation) 80% target -- needed to secure the £583k payment was noted.

The action plan that has been developed supports the delivery of the 2019/20 flu vaccination target and will be supported by robust communications for the duration of the campaign.

There are some delivery delays with the vaccine supply this season and the Trust's vaccination programme will be approximately 1 month behind last year's timetable.

2(k) Board Assurance Framework

The Workforce Assurance Committee completed:

a) a review of the risks delegated to it by the Board
b) consideration of the BAF assurances and mitigating actions

c) an updated assurance rating for each of the risk vectors (as defined in the guidance notes provided).

2(l) Update from the Workforce Steering Group -- Chair's report

The Chair's Report of the Workforce Steering Group meeting held 22nd August 2019 was received by the committee.

The issue of securing adequate medical leadership representation at the Group's meetings was discussed.

3. Recommendations to the Board of Directors

To note the contents of this report and the revised timescale for assurance feedback from the Attendance Management First Care pilot in Facilities & Estates.

4. Next Meeting

27th November 2019

BOARD OF DIRECTORS	
Agenda Item	22
Title of Report	Report of the Audit Committee
Date of Meeting	2 October 2019
Author	Steve Igoe, Audit Chair
Accountable Executive Director	Karen Edge, Acting Director of Finance
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Audit Committee
Data Quality Rating	
FOI status	Chairs report may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The Committee met on 25 September 2019 and received a full update on a range of matters. The Committee welcomed John Fry as a public Governor to the meeting.

2. Key Agenda Discussions

In terms of matters arising from previous meetings good progress had been made with only 3 items outstanding of which one is due for review at the November 2019 meeting, one will be discussed with the Board imminently regarding Self-assessment and one is actively being followed up.

Internal Audit

The internal auditors MIAA updated the Committee on the outcomes of recent internal audit reviews. The outcomes being as follows:

Safe Nurse Staffing Levels – Substantial Assurance

Managing Conflicts of Interest – N/A. This was an advisory piece. The latest guidance on this would appear to be practically unworkable requiring such confirmations from everyone above Band 7. As a result the Committee asked for a plan to seek such confirmations on a basis that is risk based and proportionate. The Committee will review and endorse or otherwise the plan in due course, however, what will come from this is a control system that is workable and capable of implementation rather than one which is doomed to failure from its inception.

Activity Data Capture (VTE, MUST, Pressure Ulcers and Falls) – Limited Assurance. The Committee felt the management responses to this report were vague and weak in terms of action to resolve the matters being raised and has asked for a more detailed response confirming actions taken for the next meeting.

Management of Complaints - Moderate Assurance. There is work to do on resolving this issue and the Committee were briefed on a new system due to come on stream to review complaints, escalate as necessary and share learning from issues. The Committee will receive a further report in due course on the operation of the system.

Follow-up Report – Good progress is being made to resolve and close out previous issues raised by Auditors. MIAA confirmed good engagement by the Executive on this and as a result a positive outcome.

Counter Fraud

The regular update was received from the Counter Fraud Specialist. Work is on track and in terms of the various plan areas:

Inform and Involve
Prevent and Deter
Hold to Account
Strategic Governance

These are all “green” rated. This rating is consistent with the Self-Assessment Review Tool (SRT) submitted on 30 April 2019.

External Audit

Grant Thornton presented their regular update on sectoral issues to the Committee. A summary was provided in relation to the finalisation of the 2018/19 work and a draft timetable provided for 2019/20. The Committee asked finance colleagues to produce an integrated timetable covering both the External Audit key dates and the Trust’s own key deadlines.

Financial Assurance Report

The Committee was updated particularly in relation to Losses and Special Payments. Further information was requested in relation to personal injury claims and their management and the losses incurred by the Trust as a result of medical equipment being taken. This latter item being flagged due to the reporting of the loss of a wound pump with a value of £6,000 when a patient “absconded”. There was no evidence presented of any attempt by the Trust or any other authorities to recover this valuable asset.

Financial Systems

A report was produced providing positive assurance on the operation and delivery of the "outsourced" financial systems of the Trust via the NEP Consortium. A further report will be produced later in the year for the reliance of both the Trust and External Audit to assist in the completion and audit of the financial statements.

Risk Management

The Director of Quality and Governance presented a brief report on the proceedings of the Risk Management Committee (RMC). He confirmed the positive progress in terms of Infection, Prevention and Control and in particular the management of the recent C Diff Outbreak. He confirmed the continuing challenges as a result of an ageing infrastructure, but expanded on the ongoing plans to mitigate this risk. The Committee also discussed BREXIT preparedness recognising that this is being managed system wide. The risk management systems and processes are due for review by MIAA as part of their Risk Maturity Review. The Committee acknowledged that assurance had been provided to RMC that the Trust has self-assessed against the NHS England's Emergency Preparedness, Resilience & Response (EPRR) Core Standards during Q2 (2018-19) and demonstrated substantial compliance and considered to EPRR Annual Report 2018/19.

Escalation

There were no items specifically identified to escalate either to the Board or for the Risk Register.

"In camera" Meeting

As usual the NED's had the opportunity to meet with representatives of both External Audit and Internal Audit without members of the Executive being present. There were no issues raised by either party.

3. Next Meeting

The next Audit Committee meeting will be held on 27 November 2019.

BOARD OF DIRECTORS (Public)	
Agenda Item	23
Title of Report	CQC Action Plan Progress Update
Date of Meeting	2 October 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 26TH SEPTEMBER, 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:

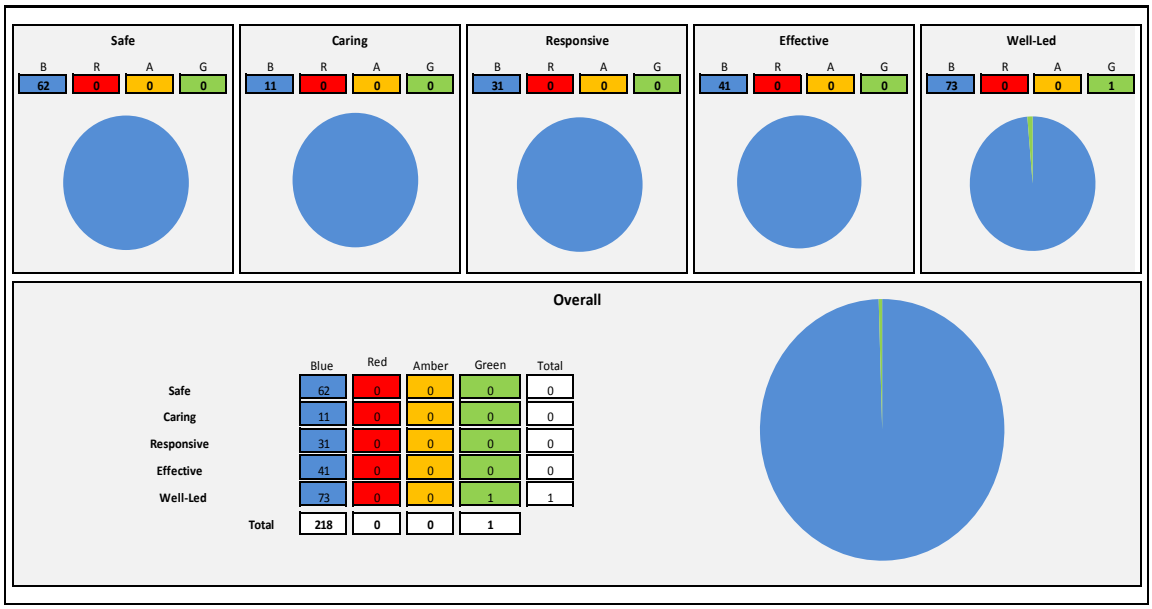
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

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.**

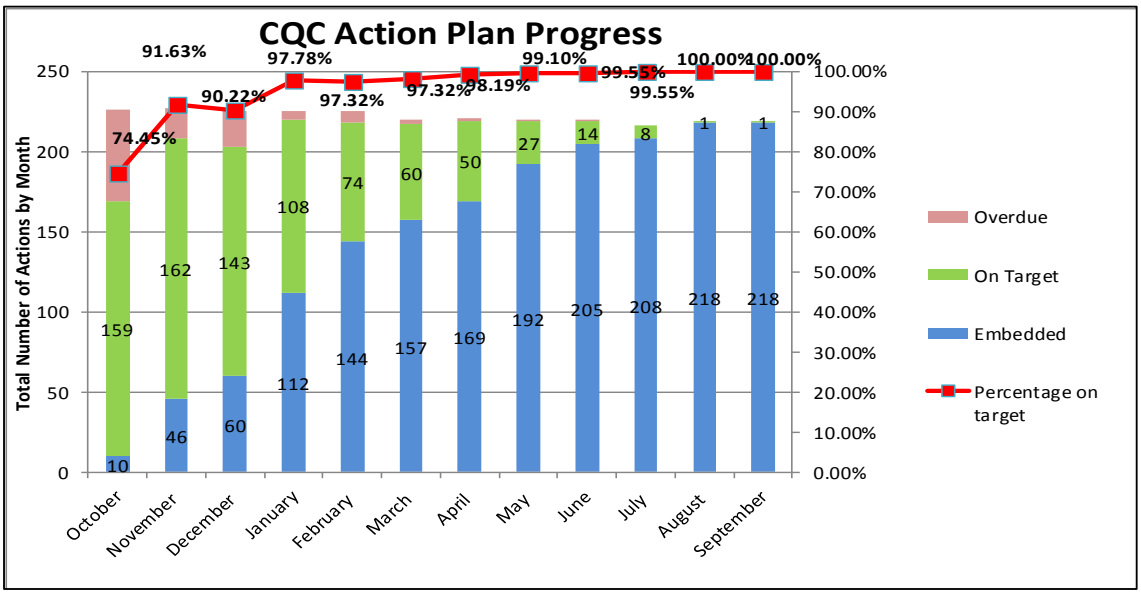
The delivery of the quality improvement action plan is reviewed monthly and performance is reported through to the Board at each formal meeting.

4.0 CQC Action Plan Progress – 26th September 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. All 219 actions have been completed and 218 of these actions have been fully embedded and rated as Blue. The 1 Green action relates to a delay in launching the patient experience strategy and is due to nursing priorities necessarily being focused upon the prevention and control of infections and managing patient flow. The acting Chief Nurse recognises that there is some delay in launching the strategy; although this is purposeful in order to allow him to consult more widely on the strategy.

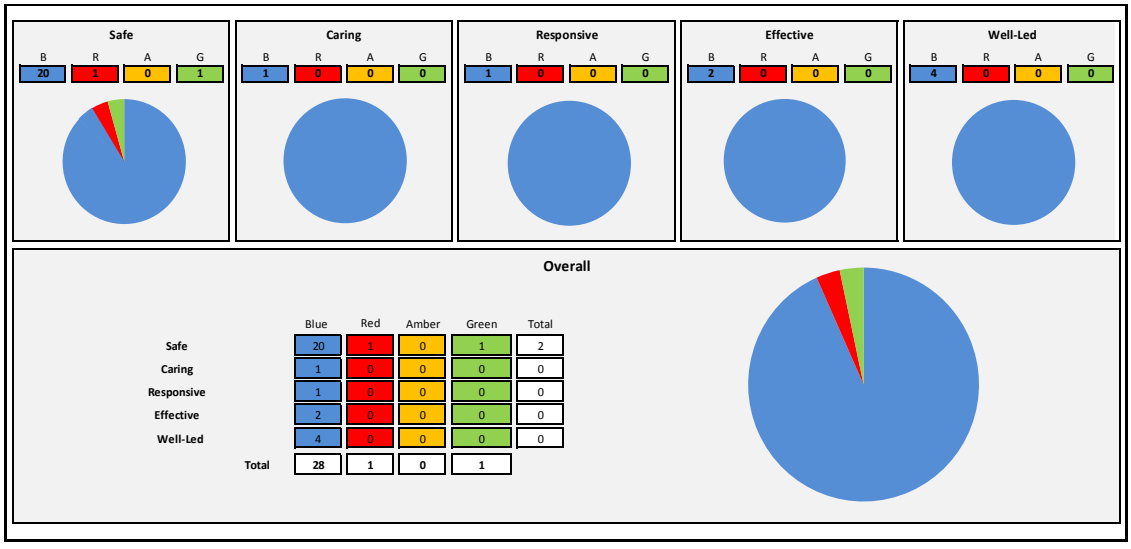


	Blue	Red	Amber	Green	Total
Safe	62	0	0	0	0
Caring	11	0	0	0	0
Responsive	31	0	0	0	0
Effective	41	0	0	0	0
Well-Led	73	0	0	1	1
Total	218	0	0	1	

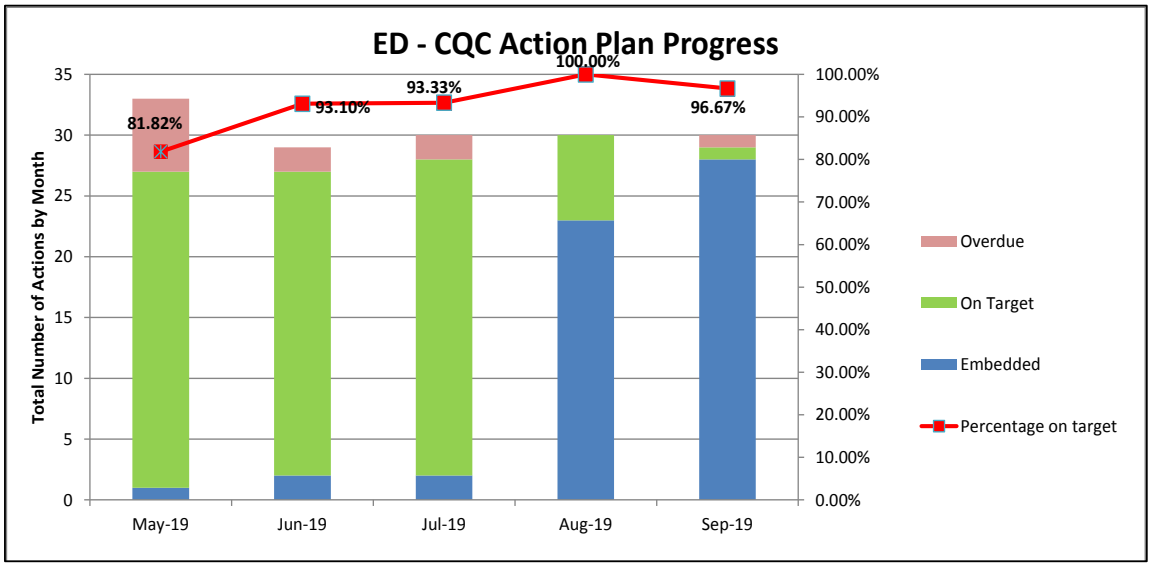


4.1 CQC Urgent Care Actions

The graphs below summarise the current position of the Emergency Department CQC action plan. There are 0 overdue action and one 'at risk' items for this reporting period.



Embedded - (3 months plus compliance)
Completed
On track
At Risk



5. EXCEPTIONS

The Urgent Care at risk action (RED Rated) relates to the use of *'Corridor Care'.* Although the Trust achieved a period of zero *Corridor Care* usage in the early summer, it has again used *Corridor Care* in August and September, although at significantly reduced levels (90% reduction from peak usage) – see **Annex A (i).**.

The action relating to compliance with the RCPCH recommended staffing levels for paediatric trained nurses within ED is set for completion by the target of 30 September. The Division have agreed an appropriate management approach for this action and it is expected that this will be completed before the end of September wherein this action will be concluded, subject to the necessary approvals.

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

Number	Core Service e.g. Trustwide / Corporate Medical Care, Etc.	Core Service	"Must Do / Should Do" Actions	CQC Regulation	Workstreams	Action	Director Lead	Operational Lead	Due Date	Completed Date	Comments	RAG
227	**CQC ED visit Treatment of disease, disorder or injury Care was not always person centred and did not always meet individual needs. Staff did not always make reasonable adjustments to the service to meet individual needs**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	10 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Cease routinely treating patients in corridors (except for mass casualty events or extreme and unpredictable surges in demand for urgent care)	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**24.09.19** - Although use of corridors has fallen significantly from 2018 (90% reduction and is for a shorter period) - Corridor care is being used at low levels on a regular basis. **12.08.19** - Increase in capacity within majors. Winter planning creating additional 40 beds. **11.06.2019** - How confident in PFIG programme that this will be delivered by September 19 **02/05/2019**: Interim arrangements have been put in place to support the flow of patients through the unit, however long term sustainable change will be achieved through delivery of patient flow improvement programme outcome **11.06.2019** - RCA has had a positive impact but this has been flagged as a risk ACTION: Graph to show improvement trajectories	
256	**Paediatric ED and APLS/PLS actions**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	15 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Ensure the availability of paediatric trained nurses in the Paediatric ED complies with RCPCH recommended staffing levels	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**26.09.09** The Divisional triumvirate have agreed approach to management of this action. Details of management plan will be available before the 30/09/19 **12.08.19** - Awaiting agreed response to aco this issue form ED and W&C **11.06.2019** It was requested that ED staff make a decision on agreed way forward and devise an implementation plan **21.05.2019** - Clarification sought via CQC. Challenge not accepted. CQC confirmed that the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (June 2018) apply and as such the Emergency Department must ensure that it has 2 RSCN's on duty at all times (irrespective of the opening times of the Paediatric ED).	

ANNEX B (Embedded actions in September 2019)

Number	Core Service e.g. Trustwide / Corporate Medical Care, Etc.	Core Service	"Must Do / Should Do" Actions	CQC Regulation	Workstreams	Action	Director Lead	Operational Lead	Due Date	Completed Date	Comments	RAG
236	**Deliver improvements in triage responsiveness**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	19 – Person Centred Care, 12 – Safe Care and Treatment	Safe	All GP referrals to go to go directly to speciality assessment facilities not ED unless required ED resuss	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**24.09.19** - SOP agreed by all specialities. Implementation and PDSA commenced 2.09.19. Action completed **12.08.19** - NHSI improvement working on streaming models all will be in place for end of September. Agreed to extend target date for completion to 30 September 2019 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. Update **23.07.19** SOP and Data collection has been agreed. 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.	

											11.06.19 - SOP/Data. Confirm meeting has taken place and agreed outcomes. Being picked up as part of PFIG - Receive feedback following PFIG meeting 11th June 19. Orthopaedic/MENT/Max Fax/ Ophthalmology. Follow up meeting due end of June 19 to agree inter professional standards and GP referrals remains part of that. Divisional Triumvirates are meeting up to discuss resolution proposals for Orthopaedics specifically. KS to provide a report and provide as evidence Arrangements agreed for Medicine & Acute assessment areas. Conclusion required for Surgery and Women's & Children's. 21.05.2019 - AMD meeting to be arranged take place to discuss way forward. To be escalated to Executive Medical Director.

237	**Streaming**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	20 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Integrate streaming process for community trust	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**23.09.19** -PDSA process place for operational streaming of by CT. **12.08.19** - NHSI improvement working on streaming models all will be in place for end of September. Agreed to extend target date for completion to 30 September 2019. Update **23.07.19** 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 **11.06.19** - we have a process agreed for integration across the health economy. Model ratified end of June, implementation end of July 19. Agreed an extension. Delivery of action involves complex engagement with a number of stakeholders **21.05.19** - Chair and CEO are participating in local health economy process review with the intention that this will come under the jurisdiction of WUTH and ED governance going forward. Exact timing of transfer of responsibilities uncertain and therefore potential risk of slippage.	

238	**Streaming**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	21 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Establish the convention for streaming governance to be a standing agenda item on ED Governance meeting	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/04/2019	30/04/2019	**24.09.19** - Streaming Governance established as standard agenda item for ED governance meeting **08.08.19 -** Require copy of ED governance meeting agenda to include standing agenda item **11.06.19** Joint meeting - agenda and minutes as evidence June/July 19 Complete subject to verification. Evidence requested.	
250	**Medical staffing in Emergency Department**		Should Do	35 – Person Centred Care, 12 – Safe Care and Treatment	Safe	Develop and approve long term medical workforce plan for ED	Executive Medical Director/ Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/05/2019	11/06/2019	**26.09.19** - Workforce review signed off by TMB ref TMB19-20/088 **12.08.19** - Awaiting evidence of plan sign-off **21.04.19** - CESR Business case 5 year workforce plan to be signed off at DMT 24.05.2019	
258	**Paediatric ED and APLS/PLS actions**	Urgent And Emergency Care (Acute & Medical Division)	Should Do	16 – Person Centred Care, 12 – Safe Care and Treatment	Well Led	Deliver training to all ED Shift leaders in APLS	Executive Medical Director / Chief Operating Officer	Medicine and Acute Divisional Triumvirate	30/09/2019		**24.09.19** - All ED Shift leaders have completed APLS training **12.08.19** - Deadline extended to 30 September 2019 **11.06.19** - Agreement to change date and extend action until final staff member has received training Due date reviewed and extended to take account of availability of training courses. **21.05.19** - 6 out of 7 ED Shift Leaders booked on to APLS by July 19 with the remaining Shift Leader booked on in September 19.	

Board of Directors	
Agenda Item	24
Title of Report	2020 Schedule of meetings
Date of Meeting	2nd October 2019
Author	Andrea Leather, Board Secretary
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Choose an item
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The 2020 schedule of meetings encompasses Board, assurance meetings and the management meetings that report into Trust Management Board (TMB). Where possible I have tried to hold Assurance Committees that have similar members, particularly in relation to NED's attendance trying to combine the frequency of visiting the Trust.

For the majority of the year the Board meetings will be held on the first Wednesday of the month with the following exceptions:

January 2020 – due to a number of factors this will be held as per the 2019 schedule on the last Wednesday of the month, 29th January 2020.

February 2020 – there will be no Board meeting this month due to the timing of the January meeting.

May 2020* – will require an additional meeting to sign off the Annual Report & Accounts (based on the 2019 guidance the deadline for submission is likely to be Wednesday 27th May 2020) therefore it is proposed to hold the meeting on Tuesday 26th May as single agenda item.

*Due to the importance of both Audit Committee and Board towards the end of May, can you please confirm attendance as we need to ensure both meetings are quorate.

There is a possibility that Finance, Business, Performance & Assurance (FBPAC) currently scheduled for 23rd January 2020 may be required to be rearranged, this will be dependent on the timeframe for submission of the annual plan.

Note: Safety Management Assurance Committee is a time limited meeting and therefore has only been scheduled until end of quarter 1.

2. Next Steps

Following approval, the finalised schedule will be circulated along with timings and venue details, where possible calendar invites by the PA who supports the meeting.

3. Recommendations

The Board of Directors is asked to:

- approve the 2020 schedule of meetings

Schedule of Meetings 2020

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan	BH			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S	SAFETY MAN CTTE	AUDIT CTTE / W'FORCE CTTE	CHAR FUNDS CTTE TMB	*FIN BUS PERFORM / Q&S CTTE		S	S			BOARD		
Feb	S	S						S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW CoG	PROG BOARD	2 x DIVISION PERFORM REVIEW	SAFETY MAN CTTE	S	S			RESERVED DAY	TMB		S		
March	S			BOARD			S	S		CLINICAL CARE STEERING GROUP		RISK MAN CTTE	PAT SAFE & QUAL BOARD	S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		SAFETY MAN CTTE	FIN BUS PERFORM / Q&S CTTE	W'FORCE CTTE	TMB	S	S		
April	BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD	BH	S	S	BH	2 x DIVISION PERFORM REVIEW CoG	PROG BOARD AUDIT CTTE	0 x DIVISION PERFORM REVIEW		S	S		RESERVED DAY	TMB	SAFETY MAN CTTE		S	S					
May		S	S			BOARD		BH	S	S		RISK MAN CTTE	PROG BOARD	PAT SAFE & QUAL BOARD		S	S	SAFETY MAN CTTEE	2 x DIVISION PERFORM REVIEW	W'FORCE CTTE / AUDIT CTTE (conf with Ex Audit)	2 x DIVISION PERFORM REVIEW	FIN BUS PERFORM / Q&S CTTE	S	S	BH	BOARD (am)		TMB		S	S
June			BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		SAFETY MAN CTTEE			RESERVED DAY	S	S			
July	BOARD			S	S						S	S		RISK MAN CTTE CoG	PROG BOARD	PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	FIN BUS PERFORM / Q&S CTTE	2 x DIVISION PERFORM REVIEW		S	S		W'FORCE CTTE / CHAR FUNDS CTTE	TMB		
Aug	S	S		S	BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S			PROG BOARD	TMB		S	S						S	S	BH
Sept		BOARD			S	S		RISK MAN CTTE / CLINICAL CARE ST GROUP		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW	RESERVED DAY	S	S		FIN BUS PERFORM / Q&S CTTE	AUDIT CTTE / W'FORCE CTTE			S	S		TMB	AMM	
Oct			S	S			BOARD			S	S			RISK MAN CTTE		PAT SAFE & QUAL BOARD	S	S	CoG	2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW		S	S		CHAR FUNDS CTTE	CoG & BOARD AWAY DAY	TMB		S
Nov	S			BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S		2 x DIVISION PERFORM REVIEW	PROG BOARD	2 x DIVISION PERFORM REVIEW	RESERVED DAY	S	S		FIN BUS PERFORM / Q&S CTTE	AUDIT CTTE / W'FORCE CTTE	TMB		S	S		
Dec		BOARD			S	S		RISK MAN CTTE		PAT SAFE & QUAL BOARD		S	S			PROG BOARD	TMB		S	S					BH	S	S	BH			