Wirral University Teaching Hospital NHS Foundation Trust

Public Board of Directors

4th March 2020

together we will

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors

9am - Wednesday 4th March 2020
The Board Room, Education Centre

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
19/20 026	Apologies for Absence	Chair	Verbal	N/A
19/20 027	Declaration of Interests	Chair	Verbal	N/A
19/20 028	Chair's Business	Chair	Verbal	N/A
19/20 029	Key Strategic Issues	Chair	Verbal	N/A
19/20 030	Minutes of Previous Meeting – 29.1.2020	Board Secretary	Paper	4
19/20 031	Board Action Log	Board Secretary	Paper	16
19/20 032	Chief Executive's Report	Chief Executive	Paper	17
Quality and Safety				
19/20 033	Patient Story	Head of Patient Experience	Verbal	N/A
Performance & Improvement				
19/20 034	Month 10 Finance Report	Chief Finance Officer	Paper	21
19/20 035	Financial Planning and Capital Programme Update	Chief Finance officer	Paper	39
19/20 036	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce, Director of Quality & Governance and Chief Nurse	Paper	51
Workforce				
19/20 037	Annual NHS Staff Survey 2019 Results	Director of Workforce	Paper	74
19/20 038	'Deep Dive' into the Trust Sickness Absence	Director of Workforce	Presentation	N/A
Governance				
19/20 039	Change Programme Summary, Delivery & Assurance	Joe Gibson	Paper	80
19/20 040	Report of Trust Management Board	Chief Executive	Paper	107

19/20 041	Report of Finance Business Performance & Assurance Committee	Chair of Report of Finance Business Performance & Assurance Committee	Paper	111
19/20 042	Report of Safety Management Assurance Committee	Chair of Safety Management Assurance Committee	Paper	114
19/20 043	Board Assurance Framework	Board Secretary	Paper	116
Standing Items				
19/20 044	Any Other Business	Chair	Verbal	N/A
19/20 045	Date of Next Meeting – 1.4.2020	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

29th JANUARY 2020

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Chair
Chris Clarkson	Non-Executive Director
John Coakley	Non-Executive Director
Claire Wilson	Chief Finance Officer
Janelle Holmes	Chief Executive
Helen Marks	Director of Workforce
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Dr Nicola Stevenson	Medical Director
Matthew Swanborough	Director of Strategy and Partnerships
Steve Igoe	Non-Executive Director
Hazel Richards	Chief Nurse
Paul Moore	Director of Quality & Governance (Non voting)

In attendance

Andrea Leather	Board Secretary [Minutes]
Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Paul Charnley	Director of IT and Information
Mike Ellard*	Deputy Medical Director
Jenny Wood*	Head of Service Improvement Team
Steve Evans*	Public Governor
Angela Tindall*	Public Governor
Jane Kearley*	Member of the Public
Stuart Bateman*	Patient Story
Linda Bateman*	Patient Story
Sue Milling-Kelly*	Patient Experience Team
Lyndsay Young	Communications & Marketing Officer

Apologies

Sue Lorimer	Non-Executive Director
Jayne Coulson	Non-Executive Director
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

Reference	Minute	Action
BM 19-20/207	**Apologies for Absence** Noted as above.	
BM 19-20/208	**Declarations of Interest** There were no Declarations of Interest.	
BM 19-20/209	**Chair's Business** The Chair welcomed all those present to the Board of Directors meeting and extended a warm welcome to Hazel Richards, Chief Nurse and Claire Wilson, Chief Finance Officer who joined the Trust earlier in January 2020. In opening the meeting, the Chair informed the Board of Directors that the majority of key issues would be captured within items already contained on the agenda.	

Reference	Minute	Action
	Martin Wakeley has been appointed as the Senior Responsible Officer for the Healthy Wirral Programme. Martin will take responsibility for the leadership and operational delivery of the Healthy Wirral Plan, working in conjunction with Wirral NHS providers and Wirral CCG.	
BM 19-20/210	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Chief Finance Officer** – informed the Board of the successful recruitment process for the Deputy Chief Finance officer. **Chief Operating Officer** – apprised the Board that at the recent Overview & Scrutiny Committee focus was now on the quality aspects of the Grove Discharge Unit. **Director of IT & Information –** meeting arranged to discuss Cerner contract and an update would be provided at a future Board meeting. **Mr John Sullivan – Non-Executive Director** – apprised the Board of the Shadow Board that had taken place earlier in the week. All participants contributed to the discussion with some insightful questions and challenge made. It was positive to observe participants thinking about what they wanted see as 'Directors' on the Shadow Board. Participants extended an invitation to Non Executive Directors to attend future Shadow Board meetings. **Directory of Strategy and Partnerships** – apprised the Board of the engagement workshops underway to support the development of the Trust's Organisational Strategy and the timelines for approval. Planning guidance for the 2020/21 Operational Plan is expected imminently from NHS England/Improvement. Work is underway with Wirral Borough Council regarding social values. ***The Board noted that although some members did not have updates there were a number of topics already covered within agenda items.***	
BM 19-20/211	**Board of Directors** **Minutes** The Minutes of the Board of Directors meeting held on 4 December 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 19-20/212	**Chief Executives' Report** A number of key headlines, contained within the written report, were highlighted for Board members; including: • System meetings including Cheshire & Merseyside Health and Care Partnership and C&M Pathology Network	

Reference	Minute	Action
	• National Emergency Laparotomy Audit (NELA) • CQC National Maternity Survey 2019 results • Sentinel Stroke National Audit Programme (SSNAP) 2019 Acute Organisational Audit • Serious Incidents and RIDDOR updates. To provide further context, the Chief Executive expanded on a number of the items contained within the report. The recruitment process for the Chief Officer, Cheshire & Merseyside Health and Care Partnership is currently underway. The Board was assured that the 5 Serious Incidents and 1 RIDDOR reportable incident are all being fully investigated and reported to the Quality Committee and Health & Safety Committee respectively. ***The Board noted the Chief Executive's Report.***	
BM 19-20/213	**Patient Story** The Board were joined by Stuart and Linda Bateman who appraised the Board of Directors of his journey having been diagnosed with cancer. Stuart described having a very active life, from numerous holidays to running major marathons [Boston, Athens, New York] and cycling 30 miles as light exercise. He explained that he was anxious about attending the Trust due to a poor experience at another organisation. But his story reflected the kindness shown by all staff at WUTH and Clatterbridge Cancer Centre and his gratitude of the support, compassion and care received. In particular, Stuart expressed thanks to his surgeon, Mr Nambirajan, and a young nurse on Ward 20. Stuart highlighted the continued after care he was receiving. The Board thanked Stuart for sharing his experience and wished her well with her ongoing treatment. ***The Board noted the feedback received from Stuart and Linda Bateman.***	
BM 19-20/214	**Infection Prevention Control (IPC) Update** The Board were provided a progress report showing an update on the mandatory infections reported to Public Health England (PHE), the Trusts performance against National HCAI objectives, local objectives and the quality indicators reportable to Wirral CCG. A summary of performance in relation to MRSA, *Clostridium difficile (CDI),* Norovirus and gram-negative bloodstream infections. The Board were advised that current national ambition was to deliver a 25% reduction of all 3 healthcare associated gram-negative blood stream infection by 2021-2022 with 50% by 2023-2024. The Trust Quality Performance Report is to be updated to reflect this change. Current performance for E-coli bacteraemia shows 41 reported cases against an annual target of 42 and therefore actions to address the risk of non compliance were identified and support by the Board.	

Reference	Minute	Action
	The IPC team are developing a Three Year Strategy and Delivery Plan to be reported to the Quality Committee. The Board were assured that although Health Care Acquired Infections (HCAI's) remain a significant challenge, the incidences of CDI continue to be under the monthly trajectory. The introduction of the Three Year Strategy will ensure a proactive delivery plan is devised and will be an integral element of the Estates Strategy. It was reported that Influenza detection had started earlier than in previous seasons with 437 confirmed cases between October – December, compared with 66 cases the previous year. The Chief Nurse advised that the number of cases had now seen a reduction. Chair of Quality Committee reported the detailed discussions that had taken place at the recent meeting in relation to infection prevention control and the correlation with the ongoing estates works and future plans. ***The Board noted the actions taken to manage infection prevention control and the development of the Three Year IPC Strategy.***	**HR**
BM 19-20/215	**Health & Safety Quarterly Report** The report outlined an overview of Quarter 3 2019/20 Health & Safety performance and assurance activities, together with an update on progress against the Health & Safety action plan. Work continues in building a framework by which health and safety can be effectively managed in line with ISO45001. The implementation of new processes has slowed in Q3 to allow time for those arrangements implemented in quarter 2 to be embedded. Improvements continue to be seen with regard to reducing EL/PL and RIDDOR reportable incidents, however during winter it is anticipated the Trust may see an increase next quarter due to winter conditions leading to high instances of slips, trips and falls. If we maintain the current trajectory of EL/PL claims it is anticipated non-clinical claims could reduce by 35% compared with the previous year. The next meeting of the Safety Management Assurance Committee is to consider the legal risk register that is being developed. An objective identified in the Quality Strategy for 2019/20 was the achievement of at least Bronze level ROSPA award, the submission is being prepared for completion by the 31st January 2020. The Director of Quality & Governance informed the Board that the Division of Diagnostic and Clinical Support has commissioned the services of a Dangerous Goods Safety Advisor (DGSA), who is reviewing the security plan and risk assessments developed by the Trust. He will attend the lab to undertake an audit, which will inform an annual report. Chair of the Safety Management Assurance Committee congratulated the team for the significant progress made within a short period of time and the continued improvement trajectory.	

Reference	Minute	Action
	The Board noted the quarter 3 performance, the significant and rapid improvements made and the performance measures now available.	
BM 19-20/216	**Learning from deaths quarterly report** The quarterly learning from deaths report was presented providing the Board of Directors with an update against compliance and the wider mortality agenda. Progress continues in further developing the mortality review process to ensure the opportunity for learning in optimised. The utilising of Ulysses Safeguard has supported the process, and the number of PMRs being undertaken is 66% in Quarter 2. The number of Structured Judgement Review's (SRJs) undertaken has decreased slightly and 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. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital, the Trust is currently rated SHMI Band 2 'as expected' mortality rate. The introduction of a medical examiner office is currently being developed and the Deputy Medical Director is meeting with the Regional Medical Examiner and the Senior Coroner for Liverpool to ensure the system introduced at WUTH complies with expectations of NHSE. ***The Board noted the Learning from deaths quarterly report and the improvements made to ensure the process is optimised.***	
BM 19-20/217	**Month 9 Finance Report** The Chief Finance Officer apprised the Board of the summary financial position at the end of Month 9. The Trust reported an actual deficit of £11.8m versus planned deficit of £3.7m. Therefore for quarter 3 the Trust has been unable to access PSF/FRF monies of £3.8m. The key headlines for Month 9 include: • Month 9 deficit of (£1.7m) vs planned deficit of (£0.8m), being (£0.9m) worse than plan. • YTD, income has exceeded plan by (£0.2m). Elective and Daycase activity is worse than plan reflecting in year trend, however, ophthalmology, gynaecology and excess bed days is higher than plan. Non-PbR is below plan (£0.2m) mainly due to lower than plan Critical Care activity. • In month, pay is exceeded plan by (£0.7m), with a YTD overspend of (£4.9m). Medical and Nursing pressures continue as a result of gaps and escalation capacity. • In month, non-pay is worse than plan by (£0.7m), with a year to date overspend of (£1.4m). This includes clinical supplies, outsourcing and general supplies linked to activity. • CIP delivered £7.9m YTD, (c£1.1m) below plan. • Cash is £3.3m, (£0.2m) above plan.	

Reference	Minute	Action
	• Capital is behind the revised plan by £3.5m as a result of slippage on a number of schemes. However, this is expected to be recovered in the final quarter. The Chief Finance Officer provided an update regarding the organisations approach to financial recovery and a summary of the works being undertaken by PA Consulting. It was noted that NHS England/Improvement understand the approach being undertaken by the Trust and had emphasised the importance that the Trust and therefore the wider health economy deliver the forecast. This view was reiterated and supported by the Board. The Board were apprised of the up-front phasing of commissioner payments to support costs incurred in advance of system wide transformation plans being implemented. It was noted that these payments had been repaid in quarter 3. The Board were assured that although there are delays to the delivery of detailed capital plans that may present risks of potential capital underspend at year end, it is expected the Trust will deliver against plan. The capital position including flexibility to bring forward schemes is actively managed through monthly divisional performance meetings and via the Finance and Performance Group. ***The Board noted the Month 9 finance performance and the steps being undertaken to address the financial position both internally and the wider health economy.***	
BM 19-20/218	**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 57 indicators with established targets or thresholds 22 are currently off-target or not currently meeting performance thresholds. The lead Director for a range of indicators provided a brief synopsis of the issues and actions being taken: • 4 hour A&E – demand has seen an increase of 7% and mirrors that of the national picture and is exacerbated by Norovirus and Influenza. This combined with winter pressures and above average long length of stay, performance continues to be challenging. It was recognised that the system Winter Plan developed earlier in the year has not materialised. The Command Centre is in place with support of partners and meet twice a day. The internal focus continues on two key areas of improving the numbers streamed away from ED and to improve processes at Ward and the integrated discharge team to expedite issue preventing discharge. • 12 hour breaches – Chief Operating Officer reported a significant increase of breaches due to increased demand. Patient assessments are undertaken on a regular basis to ensure patient safety during this time. • The ability to achieve the RTT trajectory remains a primary concern as it is impacted by the urgent care pressures and therefore the vast majority of Orthopaedic procedures have been transferred to the Clatterbridge site to mitigate the loss of activity due to urgent care bed pressures. Although performance is below trajectory within month, the indicator is expected to	

Reference	Minute	Action
	achieve target by quarter end as reported to the regulator. The introduction of the 3 stage recovery plan during February should support improvement on Arrowe Park site. • Mortality: SHMI and HSMR data are within the expected range and performance is being monitored via Quality Committee. The data is triangulated to inform the 'learning from deaths' information. • Staff attendance continues to cause concern and is not seeing improvement, in spite of the number of actions implemented. There is variation across the organisation with a number of areas achieving the Trust target such as Corporate and Diagnostic and Clinical support, the areas that lack local leadership show higher instances of absence. The 'Attendance Team' continue to work with managers offering support and advice and ensuring ESR is up to date. The Board were reminded of the procedures introduced to address performance and are being closely monitored at the Workforce Assurance Committee. • Overall, the Safe Domain reported largely in the green. • Investigations of reported serious incidents are ongoing to identify the root cause and contributory factors. Duty of candour undertaken for each case. • The Trust continues to work with the Local Research Network in recruiting patients to the National Institute for Health Research studies. • Appraisal completion continues to be monitored. The Community Trust has provided analysis of 'front door' activity which shows the non complex streaming and the increase of complex streaming into the Trust. Due to the complexity of patient pathways and the number of providers a meeting has been arranged to tailor the clinical models with emphasis on the patient. The A&E Board will establish the vision for 'urgent care' being under one management and address the levers to ensure an effective system. The Board recognised the increase in demand and the challenges this generated for the Trust and the internal measures such as continuing assessment of capacity on the Clatterbridge site along with reinvigorating the daily Board Rounds and Safety Huddles. Underpinning the measures already being implemented, is the work underway regarding the clinical service strategies to include bed modelling and establishment of an estate master plan to ensure the estate is being fully utilised. A report outlining opportunities to be discussed at a future meeting. A detailed review of attendance management is to be completed over the next four weeks. The Board expressed concern as too the continued non compliance of the attendance indicator and requested a report to the next meeting highlighting the themes and detailing the next steps to include sanctions that could be implemented. The measures introduced and planned to address attendance management performance were supported by the Workforce Assurance Committee and should provide greater clarity of areas of concern whilst ensuring staff are being supported in returning to work with the most appropriate help and support. ***The Board noted the current performance against the indicators to the end of December 2019.***	**MS** **HM**

Reference	Minute	Action
BM 19-20/219	**Length of Stay Progress Update** The Board were provided with a progress update on the initiatives to reduce length of stay (LoS) within the Trust. The update detailed the focused work across each of the 4 work streams to optimise LoS and reduce the number of long stay 21+ day patients within the acute bed base. The report also provided a brief overview of future initiatives being supported by ECIST to expand the focus. It was recognised that, nationally Long Length of Stay (LLoS) ie patients with a length of stay 21+ days performance is a concern. Discussions both at national and local level are considering how best performance could be improved. This includes the NHS being asked to increase general and acute beds during 2020 by 3000 – 5000 and ensure community and social care services are in place to deal with the increased demand. Collaboration across the system with clear lines of responsibility will be required to improve current performance which can be defined in three main areas; rehabilitation, external and internal barriers. An outline of each of the four internal work streams was provided including the objectives and metrics: • Roll-out of daily Board Rounds and Huddles across all wards • Improving Discharge Processes (initial focus on fast-track process) • Therapy led and Criteria-led Discharge • Optimisation of Cerner Millennium to support discharge. Board discussion emphasised the unrealistic national target and therefore the continuing difficulties experienced by the Trust to address performance, primarily due to the increased demand and lack of system accountability. This culminated with 'pj' paralysis clearly highlights the need to strengthen communications for patients, families and staff, stressing the risk of harm for patients remaining in hospital long term. ***The Board noted the report and supported the approaches being undertaken.***	
BM 19-20/220	**Change Programme Summary, Delivery & Assurance** Jenny Wood, Head of Service Improvement Team apprised the Board of progress and modifications regarding the Change Programme. In summary these included: • Review of Patient Flow ratings which have attracted 'Amber' ratings as the re-scoping exercise concludes. • Hospital Upgrade Programme and new proposals for Workforce Transformation will have assurance ratings applied – timing to be advised by the Programme Board. • Pathology, under the auspices of the Wirral West Cheshire Alliance, has been removed from the programme as it is not a 'live' programme. • The ratings now include 'World Class Administration of Patient Administration' and the 'Digital Enabling' projects supporting the 3 priority programmes.	

Reference	Minute	Action
	The governance ratings are improving again following the hiatus in the flow programme assurance. Evidence on SharePoint in the 3 weeks since the ratings were compiled, shows further improvement in the trend. Delivery ratings are improving gradually, with no red ratings for the first time since the assurance framework was initiated in August 2018. Again, work now available on SharePoint shows significant improvement in development of plans during January. The Board acknowledged the need for the programme teams to augment their 'Vision' with a compelling 'narrative' expressed in graphical form to describe – for all stakeholders – what the destination is, what will good look like. It is hoped that the current consultancy support in the Trust will help to 'flesh out' the portfolio of major change programmes that should be running, at pace, to achieve the desired end state. Following discussion it was agreed that the next report would provide a focus on 1 or 2 work streams. ***The Board noted the Change Programme summery, delivery and assurance report.***	
BM 19-20/221	**Report of Trust Management Board** The Chief Executive provided a report of the Trust Management Board meetings on 19th December 2019 and 21st January 2020 summarising those items not already discussed earlier in the meeting: • Divisional updates • Delivering Financial Improvement • Decommissioning of Services provided to Clatterbridge Cancer Centre • Endoscopy Capacity & Demand Summary Report. • Annual Operational Plan 2020/21 • Critical Care bed reconfiguration. ***The Board noted the reports of the Trust Management Board.***	
BM 19-20/222	**Quality Committee** Dr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the Quality Committee, held on 23rd January 2020 which covered: • Falls and dementia • Serious Incidents and Duty of Candour • Infection Prevention & Control • Quality Strategy • Overall Quality Performance. The Committee expressed concern that the rationale why a patient may have been prescribed a sedative, initiated in primary care and are of long-standing was to be fed back to the CCG. It was acknowledged that acute setting is not one in which cessation of these drugs should be contemplated.	

Reference	Minute	Action
	The Board was assured that appropriate measures are in place to support the possibility when you mobilise patients an increase in falls was to be expected, although reporting of such incidents currently remains static. ***The Board noted the report of the Quality Committee.***	
BM 19-20/223	**Finance, Business, Performance and Assurance Committee** Mr Chris Clarkson, Non-Executive Director, provided a report of the key aspects from the recent Finance, Business, Performance and Assurance Committee, held on 23rd January which covered: • Month 9 finance report • Review of Waiting List Initiative approval process • Financial Recovery Plan • Quality Performance Dashboard • Board Assurance Framework • Internal Audit Reports - Procurement Processes and Key Financial Systems and Financial Reporting • Chairs report of the Finance Performance Group Whilst there were no new risks to report to the Board, the Committee stressed the importance of the work to support financial recovery must be maintained. ***The Board noted the Finance, Business, Performance and Assurance Committee report.***	
BM 19-20/224	**Report of the Charitable Funds Committee** Dr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the Charitable Funds Committee, held on 22nd January 2020 which covered: • Head of Fundraising Report • Finance report (including the Annual Report & Accounts 2019/20) • Governance and compliance matters • Royal Voluntary Service • Arrowe Park Hospital League of Friends The Board was advised that that following a meeting with RVS Deputy Chief Executive the issues surrounding the release of accumulated funds to the Charity have been resolved. As a result £205k will now be released to the Patient Wish Fund. The significant progress to date was recognised by the Board, as Corporate Trustee. Board members agreed to attend the Summer Ball, details to be circulated and the Medical Director to co-ordinate. ***The Board noted the Charitable Funds Committee report and approved the Annual Report & Accounts 2019/20.***	

Reference	Minute	Action
BM 19-20/225	**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 21st January 2020 which covered: • Workforce KPI's • Workforce Planning Update • WISE Ward Accreditation Programme Update • Nursing and Midwifery Recruitment and Retention Strategy and Implementation Plan • Leading Indicators and Productivity measures • Board Assurance Framework • Chairs Report of the Workforce Steering Group The Nursing & Midwifery strategy to encompass Care Support Workers and other Allied Health Professionals. Opportunity for Care Support Workers to undertake the 'care certificate' is being considered and a report to be provided to a future WAC meeting. The Committee recommended and subsequently the Board agreed that 'staff stories' presented to the Board was to be on a quarterly basis and should be structured and aligned with the key strategic objectives with the possibility of using serious incidents as a source of lessons learned. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 19-20/226	**Report of Safety Management Assurance Committee** Mr Steve Igoe, Non-Executive Director, apprised the Board of the key aspects from the recent Safety Management Assurance Committee, held on 13th January 2020 which covered: • Good progress resolving outstanding actions • Health & Safety Dashboard – • Divisional H&S dashboard • ROSPA submission • Analysis on violence and aggression incidents • Chairs report of Health & Safety Committee A cross disciplinary (clinical and non clinical) group established to review the analysis of violence and aggression incidents, with a view to providing advice and guidance for consideration at a future meeting. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 19-20/227	**Report of Audit Committee** Mr Steve Igoe, Non-Executive Director, apprised the Board of the key aspects from the recent Audit Committee, held on 10th December 2019 and 13th January 2020 which covered: • Internal Audit Reports including the good progress to date in resolving	

Reference	Minute	Action
	outstanding actions • Review of losses and special payments • Internal Audit Memorandum of Understanding with MIAA • Review of the tender waiver history • Approved the annual review process to be used as a form of assurance for the Board as part of the year end regulatory reporting process. • Counter Fraud update • IPC data check revealed that mandatory data historically submitted was not accurate. A new verification system is now in place which is designed to minimise the occurrence in the future of any such issues. • Draft Internal Audit plan for 2020/21 • Plan for the external Audit of the Trust's financial statements for year ended 31 March 2020 and quality account • Review of accounting policies • Committee work plan for 2020/21 The areas of escalation were: **i.** External audit process for 2020/21 and in particular the significant increase in proposed fee for this year only as the last year of a 5 year (2+3) contract. **ii.** The approval of the Trust in entering into the MIAA MOU for the continuing provision of Internal Audit Services. **iii.** The Breach of policy in terms of receipt of a gift by ED staff in the form of vouchers. **iv.** Significant reduction (one third) in number of single tender waivers requested. ***The Board noted the report of the Audit Committee and the requirement to undertake a tender process for the external audit services beyond 2020/21.***	
BM 19-20/228	**Any Other Business** Whilst there was no other business to report, the Board were assured that actions implemented and embedded are beginning to show improved performance across the organisation. The last 18 months has been creating an environment for sustainability and the Trust is now moving into the next stage of its improvement journey.	
BM 19-20/229	**Date of next Meeting** Wednesday 4th March 2020.	

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Chair

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Date

Board of Directors Action Log
Updated – 29th January 2020
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 29.01.20						
1	BM 19-20/214	IPC Three Year Strategy & Delivery Plan to be presented to Quality Committee	**HR**	**Complete**	March '20	Schedule for discussion at Quality Committee May '20
2	BM 19-20/214	Report outlining opportunities for inclusion in the Estate master plan to ensure full utilisation of hospital sites	**MS**		October '20	
3		Sickness absence 'Deep dive' highlighting themes and next steps to address compliance	**HM**	**Complete** – see agenda item BM 19-20 038	March '20	

Board of Directors	
Agenda Item	19/20 032
Title of Report	Chief Executive's Report
Date of Meeting	4.3.2020
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 January 2019.

Internal

Serious Incidents

In January 2020 five serious incidents were declared. Two cases related to complications of surgery/diagnostic procedure, one involved diagnostic delay and two relating to care. Full investigations are underway and will be monitored and reported via the Quality Committee.

RIDDOR Update

The Trust reviewed two RIDDOR reportable incidents at the Serious Incident panel during January 2020. These involved a back injury sustained following unpredictable patient movement whilst handling; and a needle stick injury.

Full investigations are currently in progress and these will be monitored at the Quality and Safety Management Assurance Committees.

Achievements

Congratulations to Ward M1 at Clatterbridge who have achieved Level 3 (Green) as part of the WISE (Wirral, Individual, Safe Care, Every time) ward accreditation process, having been rated on their delivery of care across a number of domains.

This is a fabulous achievement for the ward, showing their commitment to continuous improvement and delivery of outstanding patient care.

Strategic Framework Development

The Trust commenced the development of the 2020-25 Strategy, with a series of staff and stakeholder workshops. The four workshops were attended by over 100 staff and stakeholders from across the Wirral health system and focused on the development of the strategic goals and priorities for the next five years.

Following these workshops, the Strategy Team, with the support of the NHS Transformation Unit, are developing the Trust Strategy document, for approval by the Board and Council of Governors in Spring 2020.

Operational Plan 2020/21

In early February 2020, the NHS National Operational Planning Guidance was released, setting out the national priorities and expectations for systems and acute trusts. This includes a focus on system working and alignment to STP planning, a requirement to improve access to A&E and flow across hospitals, a need to reduce bed occupancy levels to 92% and minor tariff uplift for systems.

Prior to the release of the National Guidance, the Trust commenced the development of the Operational Plan for 2020/21. This Plan sets out the activity, capacity, quality, workforce and financial requirements and plans for the Trust over the coming financial year. The Plan also aligns the Healthy Wirral and Cheshire and Merseyside Health and Care Partnership 5 year plans, moving the Trust towards greater system working and service integration over the coming financial year.

The Trust is aiming to submit a first draft of the plan to regulators in early March 2020, with a final version of the plan being submitted in late April 2020, following Board approval.

Regional & Local

Coronavirus Update

As part of the national response to Coronavirus (COVID-19), the Trust has established a COVID-19 coordination service and patient pod at Arrowe Park Hospital. This service works in conjunction with the NHS 111 to provide a pathway for patients attending the hospital with suspected Coronavirus, which includes a receiving unit for patients (known as a pod), a priority access line to NHS 111 and a diagnostic sampling service.

The Trust is working with NHS England and other local NHS providers to monitor the use of the COVID -19 coordination service at Arrowe Park Hospital and results from diagnostic sampling undertaken.

In addition, the Trust was chosen to provide an isolation facility for repatriated UK citizens from Wuhan, China. We hosted 94 guests for 2 weeks who were all subsequently negative for Coronavirus. This programme provided a blueprint for excellent partnership working with Wirral NHS colleagues, the Local Authority, emergency services, regional and national NHS services, and Public Health England.

Subsequently, the national teams decided that we should host passengers from the Diamond Princess cruise ship. We are currently, in conjunction with our partners, providing care for 31 guests.

System meetings

Following the appointment of Mr Martin Wakeley as Senior Responsible Officer for the Healthy Wirral Programme in January 2020, Mr Wakeley has undertaken a stocktake of the Healthy Wirral Programme and Plan, with his findings being presented to Partner Chairs and Chief Executives in February 2020.

Following the release of this report, Mr Martin Wakeley will work to revise the programme governance arrangements and prioritisation of the workstreams, in conjunction with Healthy Wirral Partner organisations.

Cheshire & Merseyside Health and Care Partnership

The Cheshire and Merseyside Health and Care Partnership has recently released its five year strategic plan, which focuses on collaboration across providers, integration of services, financial sustainability and improving health outcomes for the population.

Dr Jackie Bene has been appointed Chief Officer for the Partnership and will commence in May 2020. Dr Bene will work with Trusts and CCGs to implement the five year strategic plan as well as the formation of Integrated Care Systems (ICS) across Cheshire and Merseyside.

National

UKAS inspection in Microbiology

In November 2019, Microbiology was inspected against the requirements of ISO15189:2012 as part of the regular annual inspection, and accreditation was maintained. The inspection assesses '***How effectively the results of quality assurance / quality control techniques such as proficiency testing, inter laboratory comparisons are used to reduce the risk of providing incorrect test results'.***

The feedback received was positive and identified a number of key strengths:

- Internal audit programme
- Change control process
- Competent and knowledgeable staff in assigned roles
- Excellent staff mix
- Commitment to ongoing quality improvement
- Acceptance testing, Internal Quality Control (IQC) and External Quality Assurance (EQA).

Janelle Holmes
Chief Executive
March 2020

Board of Directors	
Agenda Item	19/20 034
Title of Report	Month 10 Finance Report
Date of Meeting	04.03.2020
Authors	Shahida Mohammed, Acting Deputy Director of Finance
Accountable Executive	Claire Wilson, Chief Finance Officer
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 10 Finance Report 2019/20

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1. Executive summary

For the period ending 31st January 2020, the Trust's operational financial performance was a deficit of (£16.2m) against a deficit plan of (£2.5m); an adverse variance of (c£13.7m). However, this position is marginally (£150k) better than previously forecasted.

In month, (January 2020) the Trust reported an operational deficit of (£0.6m) against a surplus plan of £1.2m, an adverse performance of (c£1.8m).

Based on the current financial position and the continued operational pressures over the winter period, the Trust is anticipating an operational deficit at year end of (£9.0m), and a resulting loss of £8.2m of PSF/FRF. The overall year-end position is therefore forecasted to bea defict of (£17.2m) which has been shared formally with NHS Improvement.

The following summary details the Trust's operational financial performance during January (Month 10).

1.1 Key Headlines

- The key components of the quarterly and monthly position are set out in Table 1 below:

Table 1: Key components of financial position

	Qtr1 £m	Qtr2 £m	Qtr3 £m	Mth 10 £m	YTD £m
Depreciation	(0.3)	(0.3)	(0.3)	(0.1)	(1.0)
VAT (medical locums)	(0.3)	(0)	0	0	(0.3)
Aseptic Unit - closure	(0.2)	(0)	(0.1)	0	(0.3)
Divisional Restructure	(0.1)	0	(0.2)	0	(0.3)
18/19 Costs	(0.1)	(0)	(0.1)	0	(0.2)
Pay Pressures	(0.4)	(1.8)	(2.6)	(0.5)	(5.3)
Income	1.4	2.6	(3.9)	0.6	0.7
PSF/FRF	0.0	0.0	(3.8)	(1.5)	(5.3)
Non Pay Pressures	0	(0.3)	(1.1)	(0.3)	(1.7)
TOTAL	**0**	**0**	**(11.9)**	**(1.8)**	**(13.7)**

- Net operational pay costs exceeded plan by a further (c£0.5m) in January, increasing the year to date overspend to (c£5.3m). The drivers of the pay position are multi-faceted; unplanned additional bed capacity to maintain safety and patient flow, nurse bank costs increased due to increased sickness, improved shift "fill" rates, the commencement of nursing staff into substantive posts which were previously vacant, continued medical staff pressures and support to operational demand in ED and staffing of escalation beds.

- Non pay costs exceeded plan by (c£0.3m), this mainly relates to general clinical supplies linked to activity. This position is expected to improve in the final quarter of the year as the impact of additional controls on non-essential costs take effect.

- Operationally patient-related income is broadly in-line with plan. This position includes the application of local contract terms agreed during the planning process, the over performance predominantly reflects "one-off" national allocations for winter pressures.

- Elective and Daycase activity has underperformed over recent months as a result of the impact of system wide bed pressures and bed closures associated with Flu and Novovirus. The position reflects a year end contract performance agreement for this area; this is benefiting the position by c£0.9m.

- Cash balances at the end of January 2020 were £2.7m, which was £0.7m below plan.

- Cost improvements/efficiencies delivered YTD amount to c£8.9m, although this is below plan by (c£1.5m), the position is ahead of previous years. Going forward work continues in the divisions to identify further cost improvement opportunities, which will be consolidated within the overall Trust Financial Improvement Plan for 2019/20, and 2020/21.

- Capital spend to January 2020 is behind the revised plan by £3.1m as a result of slippage on a number of schemes. However, this is expected to be recovered in the final quarter of the year as prioritiy schemes from 2020/21 are brought forward to manage emerging risks. The Trust therefore continues to forecast in line with its plan. This currently excludes the impact of any PDC allocations notified in February 2020, which are still being discussed with NHSI colleagues.

- The Trust delivered a UoR rating of 4, reflecting the year to date deficit, including the loss of the PSF allocation in quarter 3.

2. Background

The Control Total issued by NHSI to the Trust for 2019/20 is a “breakeven” position. Delivery of this would enable the Trust to access £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 included a CIP requirement of £13.2m.

The plan to deliver a “breakeven” position has been profiled to reflect the expected trajectory in income recovery and the anticipated delivery of cost reductions, Cost Improvement Plans (CIPs) and transformational schemes during the year.

For information, Appendix 1 sets out a number of financial plan changes made during the year which have a net zero impact.

3. Financial Performance

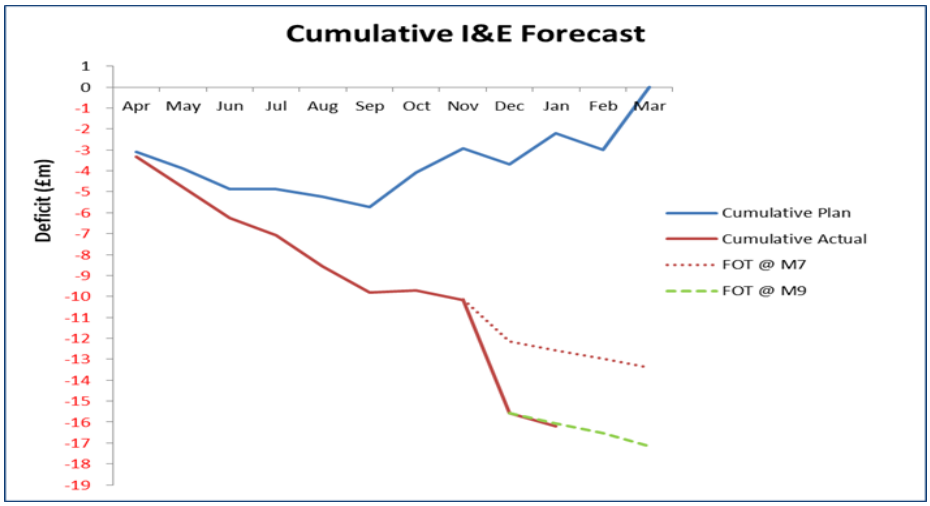
3.1 Income and expenditure

Due to the continued and increased operational pressures in the Trust, in January the financial position is showing an operational overspend of (c£0.6m). The cumulative impact of this is an actual deficit of (£16.2m), against a planned deficit of (£2.5m), therefore (£13.7m) worse than plan. An analysis of this is provided in Table 2 below.

Table 2: Financial position for the period ending 31st January 2020

Month 10 Financial Position	Budget (Mth 10)	Actual (Mth 10)	Variance	Year To Date Budget	Year To Date Actual	Variance	M10 Forecast Variance (Mth 10)	Actual Variance (Mth 10)	Variance
NHS income from patient care activity	27,689	28,150	461	269,392	270,242	850	509	461	(48)
Non NHS income from patient care	509	450	(59)	4,707	4,186	(520)	(28)	(59)	(31)
PSF/FRF/MRET	1,985	524	(1,462)	14,838	9,619	(5,219)	(1,461)	(1,462)	(1)
Other income	2,410	2,621	211	23,981	24,454	473	(44)	211	255
Total Income	32,592	31,744	(848)	312,918	308,501	(4,417)	(1,024)	(848)	176
Employee expenses	(21,144)	(21,714)	(570)	(213,797)	(219,875)	(6,078)	(679)	(570)	109
Operating expenses	(9,939)	(10,325)	(385)	(98,322)	(101,457)	(3,135)	(271)	(385)	(114)
Total expenditure	(31,083)	(32,038)	(955)	(312,119)	(321,332)	(9,213)	(950)	(955)	(5)
Non Operating Expenses	(359)	(373)	(14)	(3,529)	(3,531)	(2)	1	(14)	(15)
Actual Surplus / (deficit)	**1,150**	**(668)**	**(1,818)**	**(2,730)**	**(16,362)**	**(13,632)**	**(1,973)**	**(1,818)**	**155**
Reverse capital donations / grants I&E impact	21	21	0	208	152	(56)	*0*	*0*	*0*
Surplus/(deficit) incl. PSF/FRF (Q1 & Q2)	**1,171**	**(647)**	**(1,818)**	**(2,522)**	**(16,210)**	**(13,688)**	**(1,973)**	**(1,818)**	**155**

- The graph below shows the cumulative financial position against plan, together with the current forecast. The actual month 10 operational position was marginally, £0.2m better than had been forecast but the year end forecast remains at (£17.2m) deficit. The adverse movement from the mth 7 forecast previously expected is £4.4m which relates to the PSF lost at Quarter 3.



- As shown in the table above, the expenditure position for January was slightly better than forecast. Whilst the loss of PSF in quarter 3 and 4 has had an impact on the reported position, the operational performance actually saw a marginal improvement. The key factors within this were bank nursing and substantive medical staffing which was lower than anticipated. Sickness rates in some areas have improved, however specialing for patient acuity has remained static.

- Actual agency staff costs in January were (c£0.7m), of this (£0.5m) was in medical staff, and the balance relates to Pharmacy and nursing.

- Non pay costs exceeded plan in January due to increased general supplies costs, which are activity related. This position is expected to improve in the final quarter of the year as the impact of additional controls on non-essential costs take effect. All non-stock orders are now approved by Divisional or Executive Directors.

- Weekly "scrutiny panels" lead by the HR & Finance Executive Directors continue to review both clinical and non-clinical vacancies. In addition, any Medical locum costs are escalated to the Medical Director for approval.

- As previously reported, the position includes £0.3m relating to locum VAT costs in quarter 1 which have now been mitigated going forward. A further pressure of £1.0m in the year to date (£1.2m for the year) relating to changes to valuation guidance issued by the Royal Institute of Chartered Surveyors were not incorporated into the opening plan. Although this is a national issue, NHSI has maintained the view that this is a matter for individual trusts to manage and mitigate locally.

3.2 Income

At the end of January 2020, overall patient-related income was below plan by (c£4.4m) ((£0.8m) in month). Table 3 below provides a detailed analysis by point of delivery.

Table 3: Income analysis for the period ending 31st January 2020

	Activity						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	4,234	4,156	(78)	41,949	40,339	(1,610)	4,646	4,636	(10)	46,453	44,789	(1,664)
Elective	615	485	(130)	6,320	5,368	(952)	2,258	2,060	(198)	22,856	21,328	(1,529)
Daycase	3,619	3,671	52	35,629	34,971	(658)	2,388	2,576	188	23,597	23,461	(136)
Elective excess bed days	287	375	88	2,811	3,088	277	78	106	28	766	814	48
Non-elective	3,995	3,622	(372)	38,215	36,392	(1,822)	8,774	8,812	38	83,272	83,122	(149)
Non-elective Non Emergency	461	423	(38)	4,322	4,332	10	1,017	946	(72)	9,457	9,568	112
Non-elective excess bed days	1,111	1,427	316	10,511	13,084	2,573	302	358	56	2,856	3,471	615
A&E	6,930	7,215	285	71,824	76,091	4,267	1,193	1,110	(83)	12,362	12,449	86
Outpatients	26,118	26,499	381	255,497	252,798	(2,699)	3,123	3,144	21	30,443	30,519	75
Diagnostic imaging	2,465	3,180	715	24,307	28,028	3,721	181	191	9	1,813	1,844	31
Maternity	528	488	(40)	4,961	5,183	222	472	488	16	4,518	4,589	71
Non PbR							6,583	7,036	453	65,097	66,500	1,403
HCD							1,443	1,443	(0)	13,109	13,109	(0)
CQUINs							186	186	0	1,861	1,862	1
Other							0		0			0
PSF/FRF/MRET							1,985	524	(1,462)	14,838	9,619	(5,219)
Total NHS Clincial Income	46,128	47,386	1,257	454,396	459,336	4,939	29,983	28,979	(1,004)	286,846	282,255	(4,591)
Other patient care income							80	62	(18)	800	884	84
Non-NHS: private patients & overseas							30	19	(11)	401	264	(136)
Injury cost recovery scheme							89	68	(21)	891	648	(242)
Total income from patient care activities							30,182	29,128	(1,054)	288,937	284,052	(4,885)
Other operating income							2,410	2,616	206	23,981	24,435	453
Total income							32,592	31,744	(848)	312,918	308,486	(4,431)

- Overall patient-related income (excluding PSF/FRF) exceeds plan by £0.6m.
- PSF/FRF is showing a deficit against plan of (£5.2m). This relates to PSF/FRF loss in Q3 and anticipated loss for M10 due to not achieving the Trusts control total
- Elective performance has deteriorated in month 10 due to operational pressures. The main areas of cumulative underperformance continue to be ENT, Oral Surgery, Colorectal Surgery, Upper GI Surgery, Urology and T&O. These are offset by over performances within Ophthalmology & Gynaecology. The MSK Orthopaedic under performance has been offset by additional work undertaken by the sub-contractor through patient choice.
- Although NEL activity is below plan, the Trust continues to have a large proportion of long LOS patients. The position has been mitigated by the contractual agreement; cumulatively this is benefiting the position by c£3.9m.
- Non Elective Excess Bed Days is cumulative higher than plan mainly in Respiratory Medicine, Trauma and Orthopaedics and Upper GI Surgery.
- Outpatients with Wirral CCG have cumulatively over performed by £0.5m. This has been adjusted within the position to reflect the "block" arrangement.
- The year to date Maternity performance includes £0.2m relating to One to One midwifery patient transfers, this occurred in Mth 5.
- Neonatal activity is based on a "block" for 2019/20; this has benefitted the position by c£0.9m.
- Non PbR is above plan by £0.2m. The main area of over performance is DA Pathology this is offset by under performances in critical care and PbR exclusions. Winter support funding of £0.4m is included in the Mth 10 position (50% of the total value available), and c£0.1m of BCF slippage funding.
- Cumulatively the position reflects the year to date benefit of the NEL "block" of £3.9m, and the "year-end" agreement with Wirral CCG, of c£0.9m for Elective and Daycase activity only.

3.3 Pay

Pay costs exceed plan by (£0.6m) in month, increasing the cumulative overspend to (£6.1m).

The table below details pay costs by staff group. Appendix 2 provides ana analysis of the monthly spend by staff group.

Table 4: Pay expenditure for the period ending 31st January 2020

STAFF GROUP	MONTH 10 (£'000)			CUMMULATIVE (£'000) ACTUAL /		
	BUDGET	ACTUAL	VARIANCE	BUDGET	FORECAST	VARIANCE
CONSULTANTS	3,314	3,488	(174)	33,449	36,338	(2,890)
OTHER MEDICAL	2,323	2,489	(166)	23,600	25,154	(1,554)
TOTAL MEDICAL	**5,637**	**5,976**	**(340)**	**57,049**	**61,492**	**(4,444)**
NURSING & MIDWIFERY	5,974	5,969	5	60,527	59,696	831
CLINICAL SUPPORT WORKERS	1,971	2,281	(309)	19,955	22,410	(2,455)
TOTAL NURSING	**7,945**	**8,250**	**(304)**	**80,482**	**82,106**	**(1,624)**
AHP'S, SCIENTIFIC & TECH	2,803	2,831	(28)	27,906	28,207	(301)
ADMIN & CLERICAL & OTHER	4,758	4,656	102	48,360	48,069	291
TOTAL SUPPORT STAFF	**7,562**	**7,487**	**74**	**76,266**	**76,277**	**(10)**
TOTAL	**21,144**	**21,714**	**(£570)**	**213,797**	**219,875**	**(£6,078)**

- 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 Waiting List Initiatives (WLIs). The agency consultant 'hotlist' as is reviewed monthly to monitor progress and explore alternative staffing models where appropriate to mitigate the premium cost.

- Other medical pressures reflect shortfalls in the trainee grades; although the "gap" has reduced following the recent rotation.

- Although nursing and midwifery is underspent in the year to date, the in month position is balanced, this reflects 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 enhanced 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£0.7m) of undelivered CIP in relation to workforce schemes, including medical staffing, non-ward based nursing and e-rostering.

- Table 5 below details pay costs by category for January and cumulatively.

Table 5: Pay analysis by type

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	(250,375)	(20,186)	(19,251)	936	(203,901)	(195,526)	8,376
Bank	(257)	(20)	(1,073)	(1,053)	(218)	(9,906)	(9,688)
Medical bank	(3,124)	(250)	(612)	(362)	(2,637)	(6,231)	(3,593)
Agency	(1,171)	(604)	(691)	(88)	(6,207)	(7,372)	(1,165)
Apprenticeship Levy	(1,000)	(83)	(87)	(3)	(833)	(841)	(7)
Total	(255,926)	(21,144)	(21,714)	(570)	(213,797)	(219,875)	(6,078)

- 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.
- Agency costs exceed the NHSI cap by (c£1.2m) as at the end of January. 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). The remaining pressure predominately relates to consultant costs in 'difficult to recruit posts'.
- A "deep dive" into the Medical pay costs was undertaken earlier in the year, at the requested by the Finance Business Performance and Assurance Committee (FBPAC) the action plan is being progressed.

Waiting List Initiatives (WLIs): Detailed below is the spend incurred on WLI sessions by Division.

Table 6: WLIs by Division

Inpatients	No. of Sessions	No. of patients	Total Costs (£)
Surgery	466	1,202	257,204
Medicine	509	2,768	267,465
W&C	7	22	3,945
Clinical Support	4	14	2,113
TOTAL	**986**	**4,006**	**530,727**

Outpatients	No. of Sessions	No. of patients	Total Costs (£)
Surgery	817	6,884	445,117
Medicine	219	1,614	98,790
W&C	195	644	105,882
Clinical Support	49	468	27,612
TOTAL	**1,280**	**9,610**	**677,399**

- The combined year to date actual costs for both inpatients and outpatients is (c£1.2m). The budget available to manage WLI requirements to deliver national cancer standards to Mth 10 is £0.4m, therefore an overspend of (c£0.8m).
- On average, c£0.1m is spent on WLI on a monthly basis.
- The main specialities in Surgery where WLI have been undertaken are Urology and Colo-rectal to deliver 62 day cancer standards.
- Within Medicine, additional sessions have been needed to ensure delivery of key access waiting time standards in Gastro, Endoscopy and Dermatology.
- Additional Breast outpatients sessions have been undertaken 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

Table 7 below details the £1.3m of costs incurred in the year to date relating to unfunded areas and the utilisation of escalation beds.

Table 7: Unfunded areas and 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 1-10) £000	Actual cost of medical staff (Mth 1-10) £000	Staffing source (agency/bank/ locum)	Total Expenditure (Mth1-10) £000
Reverse Cohort Area	12 trolleys	From 1st May 2019 (as and when required)	2 .00 wte Nurses 2.00 wte CSW 24/7	529	117	Combination of bank/agency	646
Ward 26	4 beds	Used for Medical outliers throughout 19/20 when needed	1 .00 wte Nurses 1.00 wte CSW	37	0	Bank	37
Ward 36	2 beds	Used for Medical outliers throughout 19/20 when needed	1 wte CSW	61	0	Bank	61
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)	293	109	Bank	402
Fluid Room	2 trolleys 2 lounge chairs	July 2019 (Mon - Friday)	1.00 wte Band 6 Nurse	38	0	Transfer of substantive staff	38
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)	110	*0*	Combination of bank/agency	110
TOTAL				**1068**	**226**		**1294**

- Ward 26, 36, 1 and 54 are recognised escalation areas, earlier in the year they were only used on an ad-hoc basis, however recently they have been open continuously to manage patient flow.

- 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 cover is provided by planned use of NHS Professionals (NHSP), which are deployed in the Emergency Department (ED) should RCA not be needed. NHSP costs are incurred to ensure safe staffing levels are maintained. As part of the support provided by NHSE over Winter, the Trust secured c£0.6m funding; this has been profiled in the income position from December.

3.4 Non pay

Table 8: Non-pay analysis

Non pay expenditure, excluding depreciation, exceeds plan by (c£2.5m) year to date, the in-month position is an over spend of (c£0.3m).

Non Pay Analysis	Annual Budget £'000	Current period Budget £'000	Current period Actual £'000	Current period Variance £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
Supplies and services - clinical	(34,067)	(2,810)	(2,989)	(178)	(28,526)	(29,108)	(582)
Supplies and services - general	(4,519)	(392)	(448)	(57)	(3,757)	(4,097)	(339)
Drugs	(23,622)	(2,079)	(1,960)	118	(19,674)	(19,408)	266
Purchase of HealthCare - Non NHS Bodies	(7,438)	(610)	(479)	131	(6,219)	(6,709)	(489)
CNST	(12,921)	(1,079)	(1,079)	(0)	(10,763)	(10,763)	(0)
Consultancy	(0)	(0)	(119)	(119)	(0)	(445)	(445)
Other	(25,905)	(2,184)	(2,400)	(215)	(21,736)	(22,600)	(864)
Total	(108,472)	(9,153)	(9,473)	(320)	(90,675)	(93,130)	(2,455)
Depreciation	(9,219)	(787)	(852)	(65)	(7,646)	(8,327)	(680)
Total	(117,692)	(9,939)	(10,325)	(385)	(98,322)	(101,457)	(3,135)

- Clinical supplies costs cumulatively are showing a pressure and largely reflect increased activity and acuity in key specialities. The savings associated with the national procurement changes are not being fully delivered and represent a pressure of c£0.3m YTD.
- Purchase of healthcare non-NHS overspend relates to outsourcing costs with sub-contractors to manage waiting times as part of the MSK service. 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.

3.5 CIP Performance

The overall CIP delivered as at the end of Mth 10 is below plan by (£1.5m), a further deterioration of (c£0.3m) from the Mth 9 position. At Mth 10 there is a current projected year end shortfall of (£1.5m); this is included in the year end position. It should be noted that £2.5m of the CIP forecasted to be delivered in year is **non-recurrent**.

Table 9: CIP Performance

Year ending 31 March 2020	YTD			In Year Forecast					
Division	NHSI Plan £k	Actual £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	In Progress £k	Total £k	Variance £k
Medical And Acute	3,403	2,770	(633)	4,357	3,422	(935)	96	3,518	(839)
Surgery	2,483	1,970	(513)	3,037	2,430	(608)	169	2,599	(439)
Womens & Children	1,068	932	(136)	1,326	1,104	(222)	47	1,150	(176)
Clinical Support	1,127	836	(291)	1,560	1,021	(540)	160	1,181	(379)
Corporate Services	1,445	1,490	**45**	1,829	1,759	(70)	9	1,768	(61)
Estates & Hotel Services	865	923	**58**	1,071	1,067	(4)	3	1,070	(1)
Central	0	0	**0**	0	0	**0**	0	0	**0**
Total	**10,390**	**8,920**	(1,470)	**13,181**	**10,802**	(2,379)	**485**	**11,286**	(1,894)

- The underperformance is largely driven by the non-delivery of the workforce schemes mainly medical staffing and the increased profile during the latter part of the year.
- Although the Theatre productivity shortfall is mitigated financially in the Divisional position, the position reported here reflects performance against KPI's developed as part of the work stream.

4. Use of Resources

4.1 Single oversight framework

Table 10: UoR rating (financial) - summary table

	Metric	Description	Weighting %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	Liquidity (days)	Days of operating costs held in cash-equivalent forms	20%	-23.9	4	-28.0	4	-30.4	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	2.0	2	-1.1	4	2.5	2
Financial efficiency	I&E margin (%)	Underlying performance: I&E deficit / total revenue	20%	-0.8%	3	-5.2%	4	0.0%	2
Financial controls	Distance from financial plan (%)	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-4.4%	4	0.0%	1
	Agency spend (%)	Distance of agency spend against cap	20%	0.0%	1	19.0%	2	0.0%	1
	Overall NHSI UoR Rating				2		4		2

UoR rating summary

- Although the Trust has cumulatively overspent against the agency cap by (£1.2m). This is partly due to the 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. In month the Trust's spend on agency staff was within the cap value.
- The Distance from financial plan metric is currently below plan as a result of the year to date EBITDA position.
- The month 10 UoR rating is 4 overall, this is below the 2019/20 plan UoR rating of 3. The main driver is the year to date deficit including the shortfall in the achievement of the PSF allocation for quarter 3.

5. Forecast

Financial Forecast Outturn

For both December and January the Trust has achieved it revised forecast financial position. This does provide assurance and certainty that the outturn position of an operational deficit of (£9.0m) as discussed previously at the January Board meeting will be achieved. A number of deficit mitigation schemes have been identified by the Exective team and are being progressed throughout quarter 4.

This position has also been formally notified to Regulators in Month 10 (January) in-line with the requiremesnts of the NHSI protocol for adjusting the Trusts outturn position, which includes the completion of the Board Assurance Statement.

The table below details the components of the outturn position.

WUTH 2019/20 Forecast outturn	£m	Notes
Extraordinary Items	(2.7)	Depreciation (£1.2m), VAT cost of Medical staff(£0.3m), closure of Aseptics Unit (£0.3m), 18/19 costs (£0.2m), departmental restructures (£0.5m), FOM (£0.3m)
Shortfall in CIP	(3.0)	Forecast shortfall from target of £13.2m
Medical Staff	(2.2)	Net of Corporate pay underspend (£1.5m)
Escalation areas/ED	(1.9)	Manage corridor waits, and impact of escalation areas remaining open
Anticipated Ward closure	(0.8)	Unable to be closed as planned due to operational need
MSK	(0.5)	Impact of outsourcing
Other pay pressures	(0.3)	Facilities staff
Non Pay Pressures	(0.2)	Clinical supplies activity related
OPERATIONAL FORECAST OUTTURN	**(11.5)**	
Additional cost improvements challenge for Qtr 4	***2.5***	*Qtr 4 Mitigations*
TARGET OPERATIONAL DEFICIT	***(9.0)***	
Loss of PSF/FRF Q3 & Q4	(8.2)	
ADJUSTED FORECAST OUTTUIRN	**(17.2)**	

The above forecast position includes:

- Includes Ward 24 remaining open, this was initially planned to close in November 2019, in-line with the Business Case to fund the step down facility opened in November 2018 on the Clatterbridge site, reduction in cost of (£0.8m). Due to the continued operational pressures this will not be achieved in 2019/20.
- Includes additional cost implications to manage seasonal pressures based on the current demand on services and most likely demands over the remaining year. The position includes additional winter funding received from NHSE of £0.6m.
- Better Care Fund (BCF) monies have also been received from system slippage of c£0.2m and have been included above.
- The impact of reduced EL/DC activity based on performance in this category over recent months and projected over quarter 4, the Trust has agreed a "year-end" performance position with Wirral CCG, and this is included in the above position.
- Delivery of further cost improvements of £2.5m, areas of improvement have been identified and progressed. The schemes will be closely monitored; although some of

the initiatives are non-recurrent, longer term recovery actions are also being explored. This is subject to a separate item on the agenda.

- The original plan set at the beginning of the year assumed no additional cash support in 2019/20 would be required. However, based on the current forecast deficit, there will be a requirement to request additional cash support. The forecast cash position is closely monitored to ensure there is sufficient notice to engage effectively with DHSC/NHSI.

Risks

- Further deterioration in costs as a result of operational pressures, with escalation capacity being fully utilised to maintain patient safety.
- Additional deficit mitigation schemes need to have a significant impact with a relativley short lead in time. Executive leads have been identified for each project to ensure strong leadership and robust plans.

The above risks are currently being closely monitored and additional resource and support has been identified to ensure the current forecast for 2019/20 is achieved and to support development of the wider cost improvement plans in 2020/21.

6. Risks and Mitigations

Risk 1 - Operational Management of the position

- Management of agency/locum 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 is managed in light of the operational pressures, and the quality standards are delivered.
- Detailed “line by line” review of the forecast position as at Mth 10, to ensure any unforeseen pressures are managed during the “winter” period.
- The weekly executive led vacancy “scrutiny” panel review and all roles, prior to advertisement, exploring alternative methods of service delivery.
- Monthly review of Divisional performance is undertaken by the Executive Directors as well as a more detailed review by the Chief Finance officer.
- Additional external Consultancy support has been commissioned to ensure Financial Improvement plan during quarter 4 is delivered and support the Trust into 2020/21.
- Further conversations are currently underway with Wirral CCG in order to provide certainty/stability as to the year-end outturn position against the contract.

Risk 2 – Cash

- As the initial plan has not been delivered, additional loan funding has been required 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.

Risk 3 – Capital Expenditure

- As at the 31st January the year to date Capital spend position is (c£3.0m), work is currently underway to bring forward planned capital schemes from 2020/21 where possible to utilise the funding. The position is being pro-actively managed on a weekly basis, to ensure the schemes are being mobilised during February and March to deliver the plan.

7. Conclusion and Recommendations

At the end of January 2020, the Trust is reporting an operational deficit of (£16.2m), against a plan of (£2.5m), a variance of (£13.7m); this includes the loss of (£3.8m) PSF/FRF monies for quarter 3.

The CCG supported the gradual ramp up of system wide transformation plans by profiling £4.0m of its contractual payment into quarter 1 and 2 to support costs incurred by the Trust in the first half of the year. This payment was phased out during quarter 3 as planned.

The Trusts position reflects the continued operational challenges facing the Trust, mainly in resourcing capacity to maintain flow, which has continued during December. Despite the multi-faceted approach in managing operational costs, the Trust does not anticipate the control total target of "break-even" for 2019/20 will be achieved.

The forecast outturn position is an operational deficit of (c£9.0m) and a loss of (c£8.2m) PSF/FRF funding; therefore the reported outturn position will be a deficit of (£17.2m). This has been discussed in detail with Wirral System partners and also with NHSI/E as part of the overall System Financial Recovery. This is an improvement of c£2.5m from the projected outturn position following the identification of a number of mitigation schemes.

It has to be noted that within this position there remains some risks which have been set out in section 5 above and are being actively managed by the executive team.

Reccomendation

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

Claire Wilson
Chief Finance Officer
February 2020

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 10 Budget Reconciliation	Breakdown by Budget Type		
	Income £'000	**Expenditure £'000**	**Deficit £'000**
Base Budget 19/20	311,919	(314,649)	(2,730)
CIP - Increase Clinical Income Oral Surgery	125	(125)	0
Extra Day adjustment value	(147)	147	0
NNU Block adjustment	58	(58)	0
PbR excluded drugs, devices & bloods adjustment	25	(25)	0
Welsh Ophthalmology DC	55	(55)	0
Non Recurrent Income Targets	775	(775)	0
Realignments (inc CIP)	108	(108)	0
M10 Closing Budget	312,918	(315,648)	(2,730)
Net Trustwide (Increase)/Reduction	**999**	**(999)**	**0**

Monthly pay cost analysis by staff group

Medical Staffing			
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)
Mth 6	5,875	6,339	(£464)
Mth 7	5,676	6,220	(£544)
Mth 8	5,636	6,100	(£464)
Mth 9	5,639	6,086	(£447)
Mth 10	5,637	5,976	(£340)
TOTAL	57,049	61,492	(£4,444)

Nursing & CSW			
Period	£m Budget	£m Actual	£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)
Mth 6	7,991	8,057	(£67)
Mth 7	7,969	8,223	(£254)
Mth 8	7,818	8,199	(£381)
Mth 9	7,961	8,189	(£228)
Mth 10	7,945	8,250	(£304)
TOTAL	80,482	82,106	(£1,624)

AHP's (Scientific & Tech) and A&C/Other			
Period	£m Budget	£m Actual	£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)
Mth 6	7,496	7,630	(£133)
Mth 7	7,486	7,628	(£141)
Mth 8	7,619	7,850	(£231)
Mth 9	7,477	7,523	(£46)
Mth 10	7,562	7,487	£74
TOTAL	76,266	76,277	(£10)

Note:

- Includes substantive and temporary staffing costs
- 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.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors

2020/21 Financial Plan and Capital Update

Claire Wilson
Chief Finance Officer

4 March 2020

together we will

wuth.nhs.uk

Summary

Wirral University Teaching Hospital NHS Foundation Trust

- **Financial planning for 2020/21**
- The Trust is forecasting a £17.1m deficit for 2019/20. This includes a loss of £8m Provider Sustainability Funding (PSF) as the Trust has not been able to deliver in line with its control total for the year.
- The position in 2019/20 has included a number of non-recurrent measures which have supported the achievement of the position in year but need to be taken into account in the 2020/21 baseline.
- The Trusts financial trajectory target set by NHS Improvement for 2020/21 is £9.9m, this would enable it to receive £9.9m of PSF funding to report a break even position.
- The continued run rate pressures and impact of increased bed capacity requirements mean that the Trust is not able to deliver a plan in line with this trajectory and will therefore not have access to the £9.9m PSF funding.
- The overall draft financial plan for 2020/21 is for a £27.7m deficit. This is a £12.3m adverse movement from the Long Term Financial Model position submitted in November 2019. This movement relates to two specific items.
    - £6.3m loss of MRET funding (held centrally instead)
    - £6m estimate for the impact of the new requirement to reduce bed occupancy to 92%

- This paper provides an update on the assumptions made in the draft plan which, subject to Board of Director approval, is due to be submitted to NHS Improvement on Thursday 5th March 2020.
- Further work on bed capacity and configuration modelling is underway and this will enable enhancements to be made to the staffing cost models.
- The report also provides a update on the draft capital plan for 2020/21 which is set at c.£13m.
- The Trusts plan is being submitted in the context of the overall Wirral system and a breakdown of each organisations positon is contained within the report
- **Recommendations**
- The Board of Directors are asked to approve the plan for submission to NHS Improvement on 5th March 2020.
- It should be noted that there is still a level of risk in the position, especially the delivery of a 3.7% CIP for the year and no contingency.
- Potential mitigations/upsides which are not included in the plan are as follows:
    - Part year effect slippage on opening of new bed capacity
    - Review of future liability provision associated with Frontis under-occupancy subsidy (currently on balance sheet at c. £5m)

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Draft Financial Plan

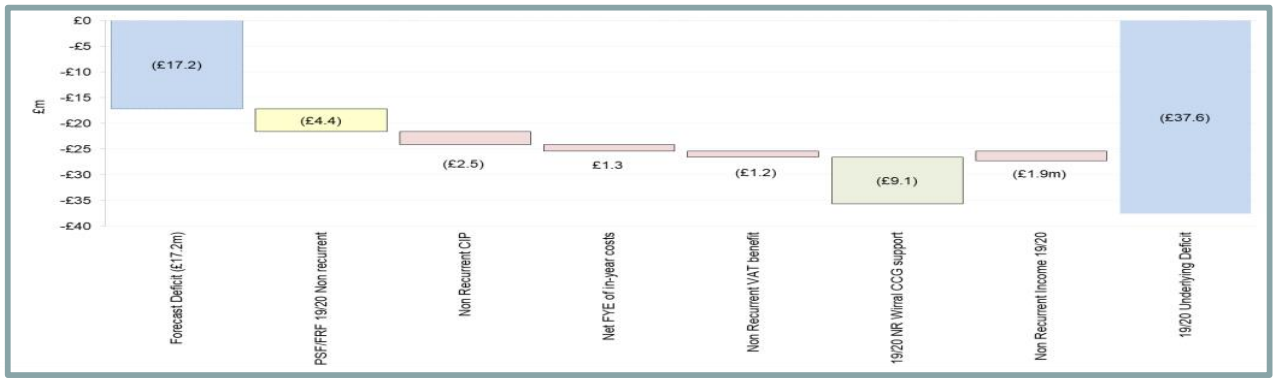
a. 2019/20

- The Trust is forecasting a £17.1m deficit for 2019/20. This includes a loss of £8m Provider Sustainability Funding (PSF) as the Trust has not been able to deliver in line with its control total for the year.
- The position in 2019/20 has included a number of non-recurrent measures which have supported the achievement of the position in year but need to be taken into account in the 2020/21 baseline.
- Allowing for these adjustments, the Trusts underlying financial position for 2019/20 is estimated to be a £37.6m deficit. The bridge chart below provides an analysis of the underlying position.
- This position includes the impact of non-recurrent CIP and technical adjustments which currently form part of our year end forecast. It also excludes income received from the CCG which is still considered to be non-recurrent until contract negotiations are concluded. [An assumption on this income is then added back in building up the 2020/21 as described in section c].

b. Planning Assumptions for 2020/21

- The Trust has made the following assumptions in relation to the 2020/21 draft financial plan:
  - 2019/20 exit run rate of £37.6m deficit
  - A CIP of £13.9m is delivered in full.
  - Stranded costs associated with the move of Clatterbridge Centre for Oncology are managed on a risk share basis over more than one year.
  - Contract negotiations are ongoing in line with national timelines, it is assumed that commissioning contracting principles are consistent with 2019/20.
  - No costs have been included in relation to the NHS response to COVID 19 as it is assumed that the impact would be funded centrally.
  - It is assumed that any costs associated with extended quarantine facilities on the Arrow Park site are fully funded by the Department of Health.

Chart 1: 2019/20 underlying financial position (exit run rate)



C. 2019/20 Financial Plan

- The Trusts financial trajectory target set by NHS Improvement for 2020/21 is £9.9m, this would enable it to receive £9.9m of PSF funding to report a break even position.
- The continued run rate pressures and impact of increased bed capacity requirements mean that the Trust is not able to deliver a plan in line with this trajectory and will therefore not have access to the £9.9m PSF funding.
- Table 1 provides an analysis of the movement from the 2019/20 underlying financial position to the 2020/21 opening plan given current planning assumptions.
- This includes an estimate of the impact of a move to 92% bed occupancy which was a new requirement in the planning guidance issued in January 2020.
- Bed capacity and configuration work is still ongoing, however, it is clear that the Trust is currently unable to move to the required 92% occupancy with reductions in length of stay alone.
- A high level cost estimate of this for an estimated 60 additional beds is estimated to be:
    - £3m of costs in the existing run rate in relation to escalation capacity already open
    - £3m additional costs associated with a requirement for further capacity
- The additional costs associated with bed occupancy is a key change from the position submitted in November 2020 and as such will be subject to regulatory scrutiny.

Table 1: Bridge from 2019/20 run rate to 2020/21 plan

	£m
Forecast Outturn 19/20	**(17.2)**
Underlying Deficit:	
Less FRF/PSF 19/20	(4.4)
Non rec income	(1.9)
Non Recurrent VAT	(1.2)
Net FYE of in-year costs	(1.3)
19/20 NR Wirral CCG contractual support	(9.1)
Non rec CIP in 19/20	(2.5)
Recurrent Opening deficit in 20/21	**(37.6)**
Tariff uplift	5.4
Inflationary cost pressures	(10.4)
Cost pressures -including Cerner and loss of CCC contribution	(5.6)
Approved business Cases	(1.3)
Additional Depreciation	(0.7)
PDC adjustment	0.9
Additional cost to deliver 92% bed occupancy	(3.0)
loss of MRET funding	(6.3)
Growth delivered at no additional cost	3.0
CIP at 3.9%	14.4
assumed CCG support as per 19/20 contract	9.6
Closing Deficit in 20/21	**(31.6)**
Further Mitigations required	
Run rate mitigations required	3.0
Review of Non Pay costs/Balance sheet	1.0
Adjusted Deficit	**(27.6)**

d. 2020/21 Income

- Income assumptions have been triangulated with Wirral CCG and an initial assumption made that contracts will be at similar levels to 2019/20.
- However, contract negotiations have yet to be concluded and there remain a number of areas for agreement which may shift income & costs between provider and commissioner. Given that assumptions have been made consistently on both sides, any changes will not impact upon the bottom line for the system.
- Issues to be addressed are identified as being:
    - Treatment of growth funding
    - Tariff uplift to be applied above national levels
    - Marginal Rate Emergency Tariff review
    - Bed capacity funding
    - Status of non-recurrent top up paid in 2019/20 by CCG to WUFT
- Discussions with Specialist Commissioning have not yet concluded and assumptions have been made in the position which may present a risk if not agreed. Two key issues identified at this stage are:
    - The Trust has not recognised the Specialist Commissioners QIPP target as detailed plans have not yet been provided.
    - It is assumed that £888k non-recurrent NNICU funding continues into 2020/21.
- The impact of a £6.3m loss of national MRET funding has been included as the Trust will no longer receive this national funding as it is now subject to sign up to financial trajectory, which the Trust in able to do.

e. 2020/21 Summary Income and Expenditure

- The overall draft financial plan for 2020/21 is for a £27.7m deficit.
- This is a £12.3m adverse movement from the Long Term Financial Model position submitted in November 2019. This movement relates to two specific items.
    - £6.3m loss of MRET funding (held centrally instead)
    - £6m estimate for the impact of the new requirement to reduce bed occupancy to 92%
- Table 1 below provides a summary of this position compared to the 2019/20 forecast out-turn.

Table 1: 2020/21 Summary Income and Expenditure

Statement of comprehensive income	Forecast Outturn	Plan
	31/03/2020	31/03/2021
	£000	£000
Operating income from patient care activiti	331,185	338,633
Other operating income	39,707	26,976
Employee expenses	(262,229)	(267,359)
Operating expenses excluding employee expenses	(121,815)	(122,649)
OPERATING SURPLUS/(DEFICIT)	**(13,152)**	**(24,399)**
FINANCE COSTS		
Finance income	130	120
Finance expense	(2,216)	(811)
PDC dividends payable/refundable	(2,085)	(2,588)
NET FINANCE COSTS	**(4,171)**	**(3,279)**
Other gains/(losses) including disposal of assets	(43)	0
Share of profit/(loss) of associates/joint ventures	0	0
Gains/(losses) from transfers by absorptio	0	0
Movements in fair value of investments, inv	0	0
Corporation tax expense	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(17,366)**	**(27,678)**

f. Efficiency savings and CIP

(i) Healthy Wirral Financial Recovery Plan

- Healthy Wirral partners have embarked upon a refresh of their system wide plans and governance in order to focus on delivery of priority projects that will deliver enhanced reductions in expenditure across the system and act as the precursor of a 3-year financial recovery plan (FRP).

- Revised management arrangements have been implemented in addition to a refreshed Programme Delivery Unit (PDU) which will coordinate system wide plans by collating and coordinating all CIP and QIPP plans from a single PMO repository (PM3) which will reduce duplication and enhance system wide scrutiny and support.

    - The system partners have agreed to focus their energies on the following areas of work.
    - To establish a system wide medicine management process under the leadership of a single director of pharmacy services.
    - To revise the management of CHC and associated services, adopting best practice from other systems nationally
    - To align demand and capacity for planned care services across the system in order to reduce additional expenditure incurred by providers in needing to fund additional capacity.

- In addition to the above, additional system wide opportunities will be considered that reflect the outputs of the Carter report and other areas as they are discovered.

(ii) Hospital Productivity Programme

- In recognition of the Trusts significant underlying deficit, the Trust is targeting £14.4m (3.7%) of productivity efficiencies in 2020/21 in order to support sustainability and deliver a step change in the Trust run rate into 2021/22.

- We have recognised that this will be a challenge and will require detailed schemes to be in place and delivering from April 2020. The Trust has therefore commissioned PA Consulting to provide additional capacity and expertise to support divisional teams until the end of March 2020. Slippage on schemes starting remains a key risk which will need to be managed.

- At the end of February 2020, the Trust is 8 weeks into a 12 week programme of work with PA consulting to develop the 2020/21 programme. Intensive work is ongoing to ensure that the gap is fully identified by 31st March 2020.

- To date, £10.3m of opportunities have been identified towards the 13.9m target, a 25% confidence weighting is in place given the current level of plan detail. The key focus for the Trust now is to complete the detailed PID plans to ensure that cash is released by 1 April 2020. The Executive team is taking steps to ensure that this is a priority for scheme leads over the next 4 weeks.

- Table 2 overleaf provides summary of the latest Trust Cost Improvement Plan.

Table 2: Draft 2020/21 CIP as at end February 2020.

NHS Wirral University Teaching Hospital NHS Foundation Trust

Financial Recovery Plan
Week 8: CIP opportunities tracker summary (by Programme)

WUTH Number of Cost Improvement Schemes by Stage

STATUS:

			Stage													
			S0 (#)	S0 (£)	S0 (FTE)	S1 (#)	S1 (£)	S1 (FTE)	S2 (#)	S2 (£)	S2 (FTE)	S3	S4	S5	#	£
Divs.	Divisional Projects	Pay	3	£453,000	13.80	44	£1,421,000	4.50								
		Non-Pay	1			61	£655,700								127	£ 2,673,700
		Income				18	£144,000									
Transformation	Patient Flow	Pay				1										
		Non-Pay													1	£ -
		Income														
	Theatres	Pay				3	£302,000									
		Non-Pay				1	£575,000								4	£ 877,000
		Income														
	Outpatients	Pay				2	£1,085,000									
		Non-Pay													2	£ 1,085,000
		Income														
	World Class Patient Admin	Pay	4	£870,000	21.75	5										
		Non-Pay													9	£ 870,000
		Income														
Cross-cutting	Workforce - Medical	Pay	2	£280,000		8	£1,561,944	13.00								
		Non-Pay													10	£ 1,841,944
		Income														
	Workforce - Nursing	Pay	4	£357,000		4	£542,000									
		Non-Pay													8	£ 899,000
		Income														
	Workforce - Other	Pay				3										
		Non-Pay													3	£ -
		Income														
	Purchasing	Pay														
		Non-Pay				134	£884,173		2	£23,000					136	£ 907,173
		Income														
	Meds Management	Pay														
		Non-Pay	4	£438,000		8	£262,000								12	£ 700,000
		Income														
	CNST	Pay														
		Non-Pay				1	£480,000								1	£ 480,000
		Income														
	Totals (Unweighted)		18	£ 2,398,000	35.55	293	£ 7,912,817	17.5	£ 2.00			£ -	£ -	£ -	*313*	*£ 10,333,817*
	Confidence weighting			25%			25%		50%			75%	100%	100%		
	Weighted for confidence			£ 599,500			£ 1,978,204		£ 1			£ -	£ -	£ -		£ 2,577,705

Key:

S0 – Initial benchmarking/review indicates a potential opportunity
S1 – Idea creation
S2 – Scheme scoping
S3 – Scheme development
S4 – Scheme implementation
S5 – Benefits realisation

See last slide for further detail on the stages and gates

g. Cash flow Plan

- The results of the Trusts cash flow modelling for 2020/21 are set out in the Statement of Cash Flows in Table 3. Cash balances fall to £1.973m at the end of the year from an opening balance of £3.45m.

- The Trust has transacted the expected conversion of debt into PDC **on** the 1st April 2020 as set out in the planning guidance. This is therefore **not** reflected in the opening PDC value. The Trust has estimated the level of PDC interest using the current 'average' methodology and the resulting benefit has been used to offset other inflationary pressures above tariff. This provides a benefit to the Trust of £900k in year given that the PDC charge will only be half the full amount in the first year. This methodology is being checked for accuracy with NHS Improvement.

Table 3: Statement of Cash Flows

Statement of cash flows	Plan 31/03/2021 Year Ending £'000
Cash flows from operating activities	
Operating surplus/(deficit)	**(24,657)**
Non-cash income and expense:	
Depreciation and amortisation	**12,420**
Amortisation of PFI credit	**(108)**
(Increase)/decrease in receivables	**(3)**
Increase/(decrease) in provisions	**(141)**
Net cash generated from/(used in) operations	**(12,489)**
Cash flows from investing activities	
Interest received	**121**
Purchase of intangible assets	**(656)**
Purchase of property, plant and equipment and investment property	**(12,653)**
Net cash generated from/(used in) investing activities	**(13,188)**
Cash flows from financing activities	
Public dividend capital received	**80,384**
Loans from Department of Health and Social Care - received	**27,800**
Loans from Department of Health and Social Care - repaid	**(80,901)**
Capital element of lease rental payments	**(60)**
Interest paid	**(624)**
Interest element on leases	**(144)**
PDC dividend (paid)/refunded	**(2,259)**
Net cash generated from/(used in) financing activities	**24,196**
Increase/(decrease) in cash and cash equivalents	**(1,481)**
Cash and cash equivalents at start of period	**3,454**
Cash and cash equivalents at end of period	**1,973**

h. 2020/21 Capital Plan

- The Trusts draft capital programme for 2020/21 totals £12.96m and is summarised in Table 4.
- The Trust has a significant level of backlog maintenance and essential infrastructure requirements and has therefore undertaken a detailed capital planning process to ensure that key risks are being addressed with the limited resources available.
- Included within the programme is a £500k PDC drawdown against the capital allocation for the Wirral Hospital Upgrade Programme. This is to support key enabling works to be undertaken during the year.
- The Trust is assuming that the impact of new accounting guidance in relation to leases (IFRS 16) will be funded centrally in accordance with planning guidance. A more detailed review of the impact of this will be undertaken at the next Audit Committee.
- Schemes have been prioritised using ratings set out in the Trusts risk register which is regularly reviewed as part of the Trusts internal governance processes. Schemes with a risk rating of 15 or above are recommended for approval.
- 'Other' schemes totalling £1.9m are still being discussed and further work is ongoing in order to assess priority items from schemes currently rated at 12 or above on the risk register.

Table 4: Draft Capital Programme

2020/21 Capital Programme	Total £k
Schemes brought forward from 2019/20	1,274
Car Park (APH)	1,800
Essential refurbishment works	1,200
Estates - fire alarms & detection	912
Estates - medical gas infrastructure	1,109
Estates - other schemes	1,501
Clinical Support & Diagnostics	769
Informatics	535
Surgery	755
Other	1,885
Urgent Treatment Centre	500
Impact of IFRS 16 - New leases in year	722
Total Expenditure	**12,962**
Funded by:	
Depreciation	12,420
less: Depreciation - Donated and IFRS 16 Assets	(1,893)
less: Loan repayments	(1,015)
Capital element of finance lease payments	(60)
2019/20 funding carried forward	2,288
PDC Drawdown - Urgent Treatment centre	500
Central funding of IFRS 16 in year impact	722
Total Funding	**12,962**

Wirral system – summary of draft plan submissions (1)

The table below summarises the income and expenditure plan along with distance from trajectory for each organisation within Wirral in comparison to that originally submitted at the beginning of December 2019.

Operating Plan (Draft)			
Surplus / (Deficit) excluding FRF	**Plan 03/12/19**	**Plan 02/03/20**	**Movement**
WUTH	(15,120)	(27,402)	(12,282)
WCT	44	(582)	(626)
WCCG	(11,137)	(21,932)	(10,795)
Total Surplus / Deficit (excl FRF)	**(26,213)**	**(49,916)**	**(23,703)**
Trajectory (excl FRF):			
WUTH (adjusted for MRET @£6,282k pa)	(9,940)	(15,584)	(5,644)
WCT	-	36	36
WCCG	2,590	2,590	-
Total Trajectory	**(7,350)**	**(12,958)**	**(5,608)**
Distance from Trajectory:			
WUTH	(5,180)	(11,818)	(6,638)
WCT	44	(618)	(662)
WCCG	(13,727)	(24,522)	(10,795)
Total Distance from Trajectory	**(18,863)**	**(36,958)**	**(18,095)**

To note: FRF @ £9.3m for WUTH is not available in 20/21 due to distance from trajectory

The table below summarises the savings plans included within the income and expenditure plan above. This has increased by £9.8m to offset a number of increased pressures since the last submission.

CIP/QIPP Savings Plan £	Plan 03/12/19	Plan 03/02/20	Movement
WUTH	13,323	14,423	1,100
WCT	1,559	1,600	41
WCCG	6,305	8,305	2,000
Total	21,187	24,328	3,141

CIP/QIPP Savings Plan %	Plan 03/12/19	Plan 03/02/20	Movement
WUTH	3.5%	3.7%	0.3%
WCT	2.1%	2.1%	0.0%
WCCG	3.9%	1.3%	-2.6%
Total	**3.5%**	**4.0%**	**0.5%**

Wirral system – summary of draft plan submissions (2)

There are a number of additional pressures that have been identified since the November submission which has resulted in additional savings being required to meet the original deficit submitted in early December, this a very challenging target and the additional challenge will be supported by Healthy Wirral System Programmes (see below for further information).

The System was asked in February to improve on its distance from trajectory by £7.5m, however given the additional pressures that have materialised along with the additional savings now planned this stretch target of £7.5m will be difficult to achieve and has not been factored in to the plans at this stage.

The table below highlights a number of additional pressures that are now included within the current plans:

Organisation	£,000	Comments
WCT	**600**	no funding for AFC pay increases for local govt contracts
WCCG	4,500	additional CHC & Prescribing costs
	2,500	brokerage/pay back of non rec mitigations in 19/20
	600	Population Health/ Cerner
	2,810	HCP top slice
	385	Additional contingency required to meet 0.5% (per planning guidance)
Total WCCG	**10,795**	
WUTH	6,282	Loss of MRET
	6,000	Costs to deliver 92% occupancy
Total WUTH	**12,282**	
Grand Total	**23,677**	

Recommendation

Wirral University Teaching Hospital NHS Foundation Trust

- The Board of Directors are asked to approve the plan for submission to NHS Improvement on 5th March 2020.
- It should be noted that there is still a level of risk in the position, especially the delivery of a 3.7% CIP for the year and no contingency.
- Potential mitigations/upsides which are not included in the plan are as follows:
  - Part year effect slippage on opening of new bed capacity
  - Review of future liability provision associated with Frontis under-occupancy subsidy (currently on balance sheet at c. £5m)

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Board of Directors	
Agenda Item	19/20 036
Title of Report	Quality Performance Dashboard
Date of Meeting	4.3.2020
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 January 2020.

2. Background

The Quality 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 December (excluding Use of Resources):

- 25 are currently off-target or failing to meet performance thresholds
- 24 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.

Appendix 2 details the indicators that are not meeting the required standards within month in an exception report, excluding finance indicators which are covered in the separate finance report. The report includes a brief description of the Issue, the remedial Action and expected Impact.

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 January 2020.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

February 2020
updated 19-02-20

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2019/20	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.17	0.14	0.13	0.18	0.22	0.09	0.09	0.09	0.18	0.04	0.13	0.13	0.08	0.12	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit (audit sample size 150)	Safe, high quality care	MD	≥95%	WUTH	89.9%	95.0%	98.7%	96.2%	86.0%	91.9%	94.6%	94.6%	96.1%	94.9%	94.1%	97.5%	98.7%	94.5%	
	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	96.6%	96.8%	96.9%	96.4%	96.3%	96.8%	97.7%	97.6%	97.6%	97.1%	97.8%	97.3%	97.8%	97.2%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	95.5%	97.1%	96.4%	96.5%	95.7%	95.5%	97.2%	95.0%	97.0%	96.5%	95.7%	95.1%	95.2%	95.9%	
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	2	4	2	1	1	4	3	1	0	5	4	5	5	29	
	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clostridium Difficile (healthcare associated)	Safe, high quality care	CN	≤88 for WUTH financial year 2019-20, as per mthly maximum threshold	SOF	7	10	5	19	9	11	5	6	4	4	4	7	4	73	
	E.Coli infections	Safe, high quality care	CN	≤42 pa (max 3 per month)	WUTH	3	4	2	6	2	2	5	7	2	5	6	6	8	49	
	CPE Colonisations/Infections	Safe, high quality care	CN	To be split	WUTH	10	6	5	12	9	8	5	9	7	13	5	1	8	8	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	2	0	0	0	0	0	0	0	0	1	0	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	83%	99%	99%	98%	91%	98%	99%	100%	99%	100%	100%	99%	100%	100%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	0	0	0	0	1	0	0	0	1	0	1	3	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH		98%	99%	99%	99%	98%	98%	96%	98%	99%	99%	99%	96%	98%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	91.6%	92.8%	93.9%	93.6%	93.9%	93.7%	93.6%	92.9%	93.6%	92.4%	91.2%	91.2%	92.2%	92.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	87.6%	88.7%	90.7%	90.9%	91.0%	90.7%	90.4%	90.3%	91.2%	88.3%	85.5%	84.9%	84.4%	84.4%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	93.6%	92.6%	93.5%	91.4%	92.8%	91.5%	92.3%	90.3%	89.98%	87.46%	88.09%	89.66%	89.53%	89.53%	
	Attendance % (in-month rate) (*)	Safe, high quality care	DHR	≥95%	SOF	94.28%	94.38%	94.74%	94.84%	94.91%	94.49%	94.07%	93.96%	94.25%	93.99%	93.82%	93.87%	94.40%	94.26%	
	Staff turnover % (in-month rate) (* & **)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.65%	0.77%	1.20%	0.86%	0.83%	0.85%	0.68%	2.03%	1.21%	0.86%	0.77%	0.86%	0.62%	0.62%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	7.3	7.2	7.2	7.2	7.2	7.4	7.3	7.7	7.5	7.7	7.6	7.55	7.9	7.51	

Quality Performance Dashboard

February 2020
updated 19-02-20

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2019/20	Trend
Effective	SHMI	Safe, high quality care	MD	Band to be 'as expected' or 'lower than expected'	SOF	104.92	106.06	107.45	107.81	107.34	108.51	110.06	110.33	110.99	–	–	–	–	As expected	
	HSMR	Safe, high quality care	MD	≤100	SOF	98	99	99.00	100.1	99.4	100.3	102.2	102.2	102.4	–	–	–	–	102.2	
	Mortality Reviews Completed. Monthly reporting finalised 3 months later	Safe, high quality care	MD	≥75%	WUTH	86%	71%	56%	76%	78%	68%	75%	63%	44%	44%	32%	32%	26%	67.3%	
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	83%	81%	94%	92.0%	95.0%	90.0%	93.0%	92.0%	96.0%	97.8%	97.2%	97.5%	98.3%	94.9%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	14.2%	15.3%	14.9%	16.4%	12.8%	15.7%	18.8%	16.1%	16.9%	16.4%	15.9%	17.9%	17.2%	16.4%	
	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	437	457	438	421	415	403	383	410	431	443	441	444	446	424	
	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	203	193	194	208	207	202	202	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	2.7	4.0	3.6	4.2	3.2	4.1	3.5	3.5	3.5	4.0	3.6	4.6	3.5	3.8	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.7	4.9	4.7	5.1	4.9	4.5	4.6	4.6	5.1	4.8	5.0	5.2	5.1	4.9	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	903	788	914	871	970	884	887	872	813	860	846	807	810	862	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	10	16	14	11	14	10	11	9	15	10	13	11	16	12	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	81.7%	83.6%	85.7%	89.5%	86.3%	85.5%	88.5%	85.3%	81.0%	82.9%	81.0%	77.3%	78.3%	83.7%	

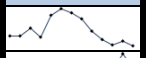
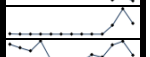
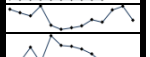
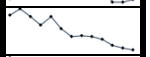
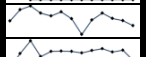
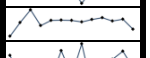
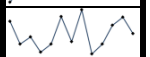
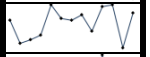
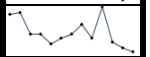
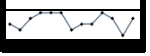
Quality Performance Dashboard

February 2020
updated 19-02-20

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2019/20	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	20	14	13	13	13	17	16	24	23	17	26	10	10	169	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	85%	87%	87%	87%	89%	91%	91%	92%	88%	87%	84%	87%	85%	88%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	11%	11%	13%	9%	11%	10%	12%	12%	11%	11%	10%	11%	10%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	98%	97%	97%	98%	97%	96%	98%	97%	96%	97%	96%	97%	97%	97%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	19%	15%	13%	19%	22%	31%	38%	34%	30%	33%	29%	27%	27%	29%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	95%	94%	95%	94%	94%	95%	95%	94%	94%	94%	94%	94.5%	94.1%	94%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	99%	98%	96%	94%	97%	99%	93%	92%	92%	91%	94.8%	99%	97%	94.8%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	CN	≥25%	WUTH	27%	36%	44%	25%	29%	44%	29%	24%	23%	22%	22%	33%	22%	27%	

Quality Performance Dashboard

February 2020
updated 19-02-20

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	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	74.0%	74.0%	76.7%	73.6%	81.1%	83.5%	81.9%	79.9%	75.6%	72.7%	70.8%	72.1%	70.5%	70.5%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	2	0	0	0	0	0	0	1	0	1	33	95	40	170	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	379	323	273	437	118	54	76	108	210	170	366	431	198	217	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2019-20	SOF	78.32%	79.12%	80.00%	79.04%	80.72%	80.12%	80.06%	79.89%	79.59%	79.03%	78.09%	78.10%	78.26%	78.26%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 24,735 by March 2020	National	27,506	28,367	27,309	26,223	27,317	25,733	24,733	24,846	24,721	24,368	23,597	23,233	22,988	22,988	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2019-20	National	28	19	0	0	0	0	0	0	0	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.1%	99.7%	99.9%	99.5%	99.3%	99.5%	99.2%	98.3%	99.1%	99.5%	99.2%	99.1%	98.8%	99.1%	
	Cancer Waiting Times - 2 week referrals (latest month provisional)	Safe, high quality care	COO	≥93%	National	87.8%	93.1%	98.1%	91.9%	94.0%	94.0%	94.0%	93.3%	94.3%	95.0%	93.7%	94.4%	90.5%	93.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (latest month provisional)	Safe, high quality care	COO	≥96%	National	97.1%	96.7%	96.8%	96.5%	96.7%	97.1%	96.7%	97.3%	96.5%	96.7%	97.0%	97.1%	96.9%	96.8%	
	Cancer Waiting Times - 62 days to treatment (latest month provisional)	Safe, high quality care	COO	≥85%	SOF	85.4%	86.5%	85.8%	85.3%	87.9%	86.3%	85.7%	89.9%	87.8%	85.0%	87.5%	85.9%	81.7%	86.3%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	TBC	WUTH	178	153	157	162	195	180	178	184	166	193	195	148	186	179	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	TBC	WUTH	27	28	17	17	12	15	17	22	15	31	13	10	8	16	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	2	1	3	4	4	4	1	2	2	4	3	0	3	3	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

February 2020
updated 19-02-20

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	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%	100.0%	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY19/20 (ave min 59 per month until year total achieved)	National	43	41	59	32	31	48	50	37	50	56	44	43	53	444	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	84.6%	85.7%	88.2%	77.6%	81.1%	82.1%	83.6%	83.4%	82.7%	83.8%	81.4%	80.9%	81.9%	81.9%	

	Indicator	Objective	Director	Threshold	Set by	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2019/20	Trend
Use of Resources	I&E Performance		CFO	On Plan	WUTH	-1.755	-4.037	-5.402	-3.340	-1.458	-0.098	-0.825	-1.498	1.468	0.088	-0.488	-9.543	0.406	-15.288	
	I&E Performance (Variance to Plan)		CFO	On Plan	WUTH	-1.002	-1.338	-4.690	-0.237	-0.630	0.914	-0.828	-1.106	1.972	-1.507	-1.638	-8.755	-0.744	-12.559	
	NHSI Risk Rating		CFO	On Plan	NHSI	3	3	3	3	3	3	3	3	3	3	3	3	4	4	
	CIP Forecast		CFO	On Plan	WUTH	-13.9%	-13.5%	-13.0%	-6.0%	-6.8%	-5.2%	-4.1%	-7.2%	-5.0%	-10.6%	-11.5%	-11.4%	-18.1%	-18.1%	
	NHSI Agency Ceiling Performance		CFO	NHSI cap	NHSI	11.9%	-22.1%	-44.0%	-19.5%	-26.8%	-15.6%	-46.4%	-8.2%	-24.3%	-24.7%	1.8%	-8.4%	-14.4%	-14.4%	
	Cash - liquidity days		CFO	NHSI metric	WUTH	-12.9	-12.8	-20.9	-14.0	-21.3	-15.9	-16.5	-17.4	-15.0	-14.6	-10.9	-14.1	-28.0	-28.0	
	Capital Programme		CFO	On Plan	WUTH	62.3%	56.6%	12.2%	52.1%	31.0%	28.0%	14.7%	19.8%	64.2%	61.7%	57.2%	54.4%	53.8%	53.8%	

(*) Updated Metrics

Safe: Attendance %

Safe: Staff turnover %

Metric Change

Reported % now in-month attendance, previously reporting the rolling 12-month rate

Reported % now in-month turnover rate, previously reporting the rolling 12-month rate

(**) Updated Thresholds

Safe: Staff turnover %

Threshold Change

To support in-month rate reporting, the annual maximum 10% standard is reflected in a maximum 0.83% per month.

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 2

WUTH Quality Dashboard Exception Report Template as at January 2020

Safe Domain

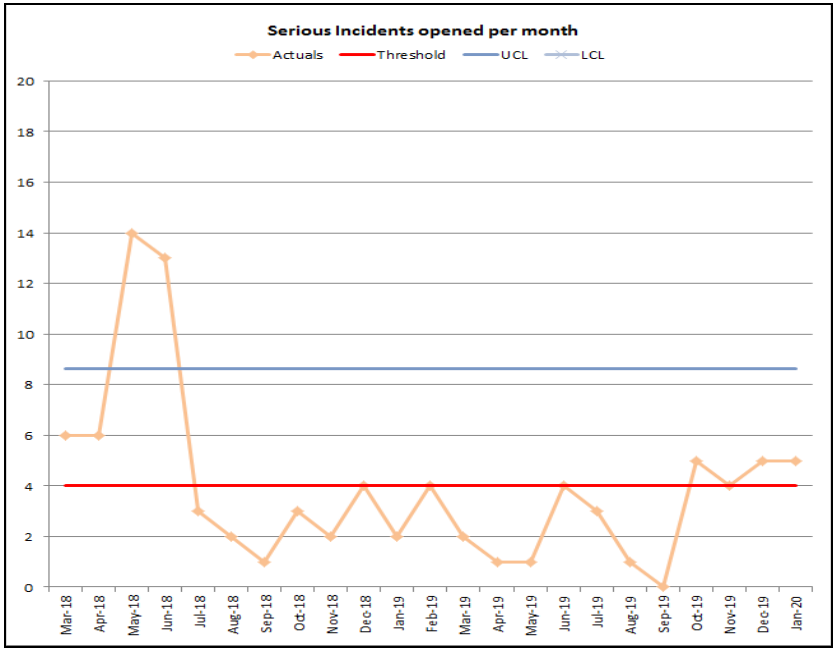
Serious Incidents

Executive Lead: Director of Quality & Governance

Performance Issue:

WUTH has a standard to minimise serious incidents, with a threshold of no more than 4 in any one month (no more than 48 in 12 months). In the current year to date the Trust remains on track to achieve, as per the Quality Strategy, at least 10% reduction compared to 2018/19 baselines (n=29/48). However, in January 2020 there were five cases that crossed the threshold for reporting as serious incidents.

The cases declared were: (i) damage to the common bile duct during laparoscopic cholecystectomy (rare complication); (ii) an unexpected death (cause not yet known) associated with a reaction to an intravenous medicine administered as part of a diagnostic procedure; (iii) an erroneous CT scan report which delayed emergency surgery to repair a perforated bowel; (iv) a case of aspiration pneumonia; and (v) a baby born in a poor clinical condition associated with a prolonged foetal bradycardia.



Action:
Each incident is currently undergoing investigation to identify the root cause and contributory factors; analysis for any commonalities and other factors.

In depth analysis of root causes and contributory factors for incidents declared as Serious Incidents over the previous 12 months will be available for presentation in April, to identify any gaps in embedding learning.

Expected Impact:
Uncertain, subject to close monitoring of implementation of learning and action.

E.Coli infections

Executive Lead: Chief Nurse

Performance Issue:

WUTH has an internal threshold set for a maximum 42 cases in 2019-20, with an indicative monthly tolerance of a maximum 3 in any one month. In January there were 8 cases reported, a further increase on recent months.

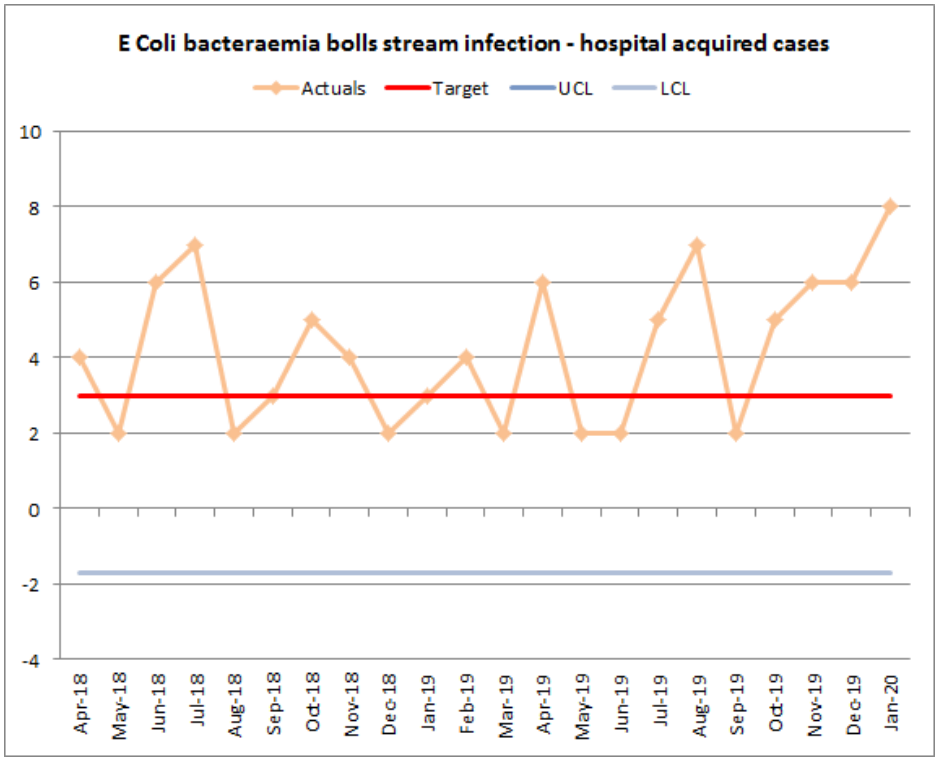
The cumulative number to the end of January is 49 cases, so beyond the maximum for the year by 7

Action:

- Review of the investigation tool to pull out themes in order to develop action plans to address lessons learnt.
- Divisions to report by exception at their monthly IPC meeting.
- Divisions to share their lessons learnt with other Divisions at the monthly IPC meeting with evidence of the completion of action plans..
- Enhanced monitoring via IPCG introduced.

Expected Impact:

Trust wide learning of investigations will promote best practice to promote prevention.



Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been deteriorating and not achieved since September 2019, with January at 84.4%.

Action:

Protecting Vulnerable People (PVP) level 2 is an online e-learning package only.

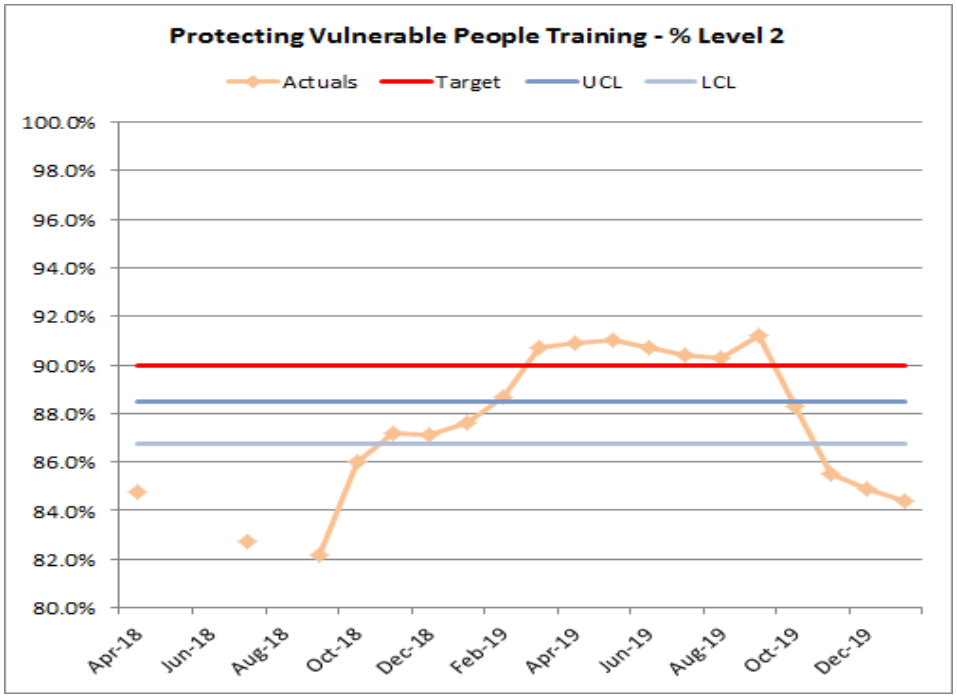
Concerns regarding the decline in compliance were raised at the Safeguarding Assurance Group meeting on the 11th February 2020. This decline was escalated to all the divisions to request that staff are encouraged and supported to complete this training as soon as possible in order to reach and sustain the required compliance.

The compliance of training will be monitored by the ward managers on a monthly basis, with the matrons and ADN having overview and challenge will be provided for those who become non–compliant.

Non-compliance will also be reflected and recorded within the individual staff member's appraisal.

Expected Impact:

It is anticipated that there should be an increase in compliance if the overview of PVP training is maintained by the managers/matrons and Associate Director of Nursing.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

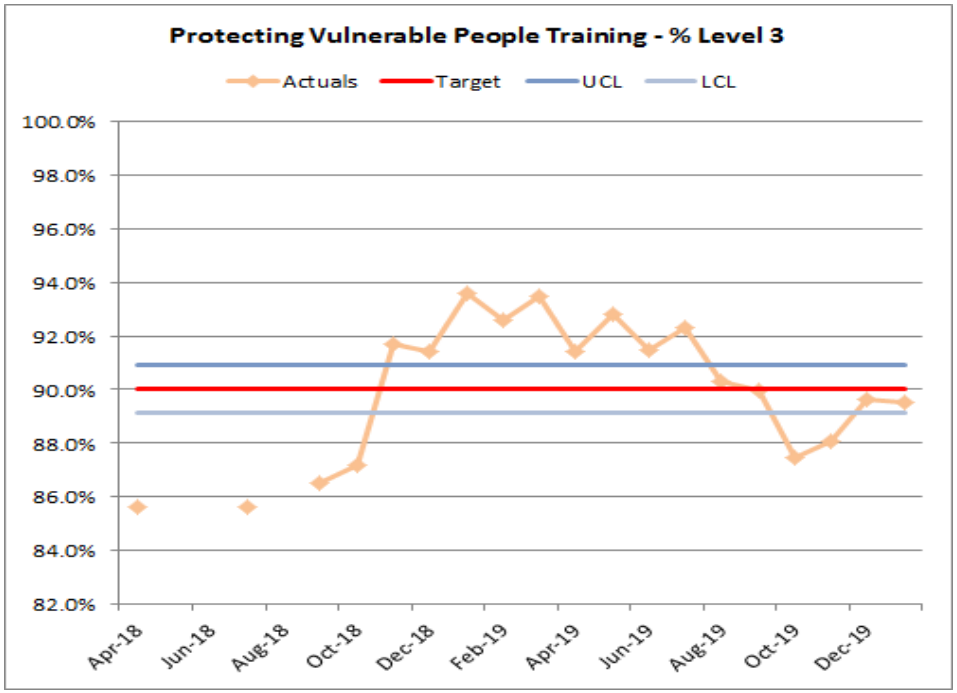
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has not been achieved since August 2019, with January just short of the threshold at 89.53%.

Action:

Concerns regarding the decline in compliance were raised at the Safeguarding Assurance Group meeting on the 11th February 2020. This decline was escalated to all the divisions to request that staff are encouraged and supported to complete this training as soon as possible in order to reach and sustain the required compliance.
The compliance of training will be monitored by the ward managers on a monthly basis, with the matrons and ADN having overview and challenge will be provided for those who become non–compliant.
Non-compliance will also be reflected and recorded within the individual staff member's appraisal.

Expected Impact:

It is anticipated that there should be an increase in compliance if the overview of PVP training is maintained by the managers/matrons and Associate Director of Nursing.



Effective Domain

SAFER bundle: % of discharges taking place before noon

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. This standard is consistently not achieved, with the average for 2019-20 at 16.4%.

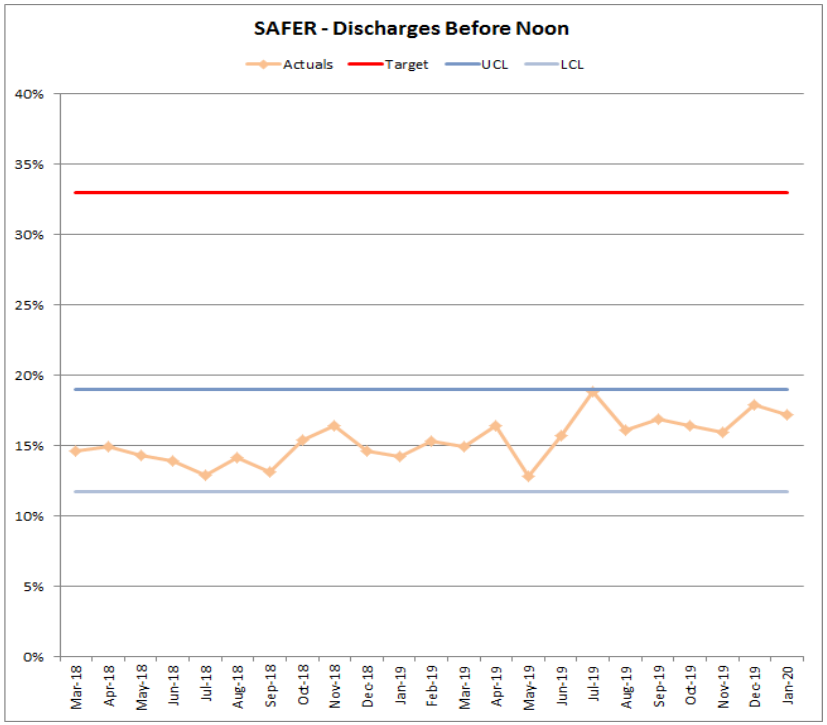
Action:

The Back Door workstream from Patient Flow Information Group (PFIG) continues to focus on improving Board Round form and function via roll out of the `Perfect Board Round' programme. The roll-out is on track for completion by end of February for all Medical and Surgical wards.

This programme will be supported by the re-focussed Long Length of Stay Reviews which are being led by the senior Divisional Triumvirate supported by the System Lead for Discharge.

Expected Impact:

Although it is not expected that the 33% target will be attained in the current financial year, a staged increase is expected following roll out of the Perfect Board Round and re-focussed Long Length of Stay reviews.



SAFER bundle: average number of patients in hospital for 7 days or more and 21 days or more

Executive Lead:

Medical Director / Chief Operating Officer

Performance Issue:

A WUTH target has been set to reduce the number of patients in hospital for seven days or more to a maximum 156, and for 21 days or more to a maximum 107. The numbers remain considerably above this target, with an average of 7 days or more at 446, and the number at 21+ days at 202 at the end of January.

Action:

- Refocus weekly long length of stay reviews to ensure Divisional oversight and ownership of patient 21+ days.
- 6 week pilot agreed with Surgery, led by senior triumvirate. Executive weekly progress update to be provided and Medicine & Acute exploring similar pilot.

All work supported by ECIST team.

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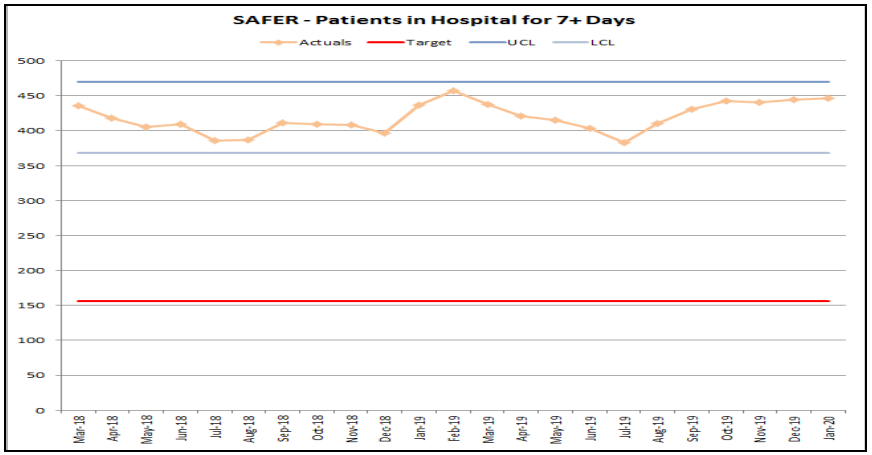
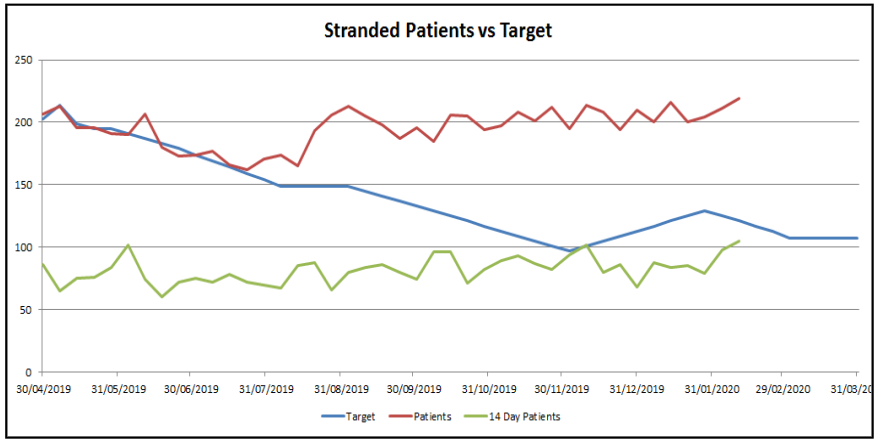
Expected Impact:

Following the revised national guidance, our target has been adjusted to reduce the number of 21+ day patients initially to 171 and subsequently to 107 by March 2021.





Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. With the support of the theatre transformation programme this was regularly achieved from March 2019. However since August performance has deteriorated, largely due to the cancellation of elective activity resulting from pressures with non-elective patient flow. January has improved slightly at 78.3% as the level of outliers decline.

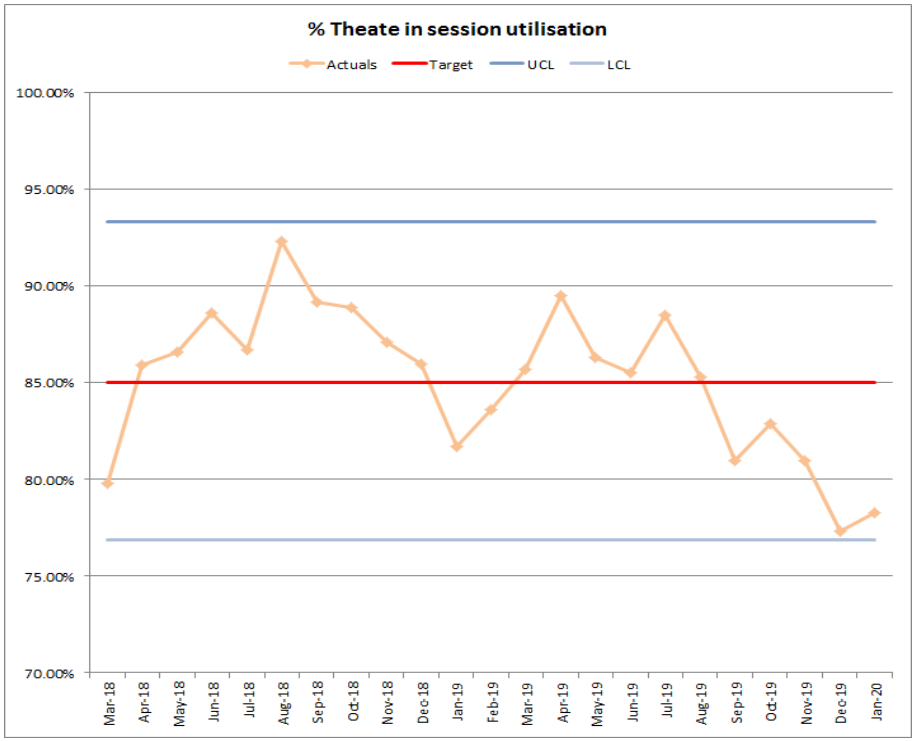
The driver behind the reduced performance is largely CGH lists as a result of moving list at relatively short notice from APH and not being able to then fill the list when located at CGH. This action saves cancelling all patients on the list if it was kept at APH.

Action:

- Continue to maintain core session utilisation.
- Continue with the movement of sessions from APH, but at least 1 week in advance to ensure lists are fully utilised
- Review under utilised specialties with the view to adding on a additional case if list starts >15 mins late and finished >30mins early.

Expected Impact:

It is expected that utilisation rates and overall volumes of elective activity will be improved from mid February**.**



Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

A national standard is set that providers should not have mixed-sex accommodation, except where it is the overall best interests of the patient or reflects personal choice. Patients in our 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. The national rules on calculating breach times have changed wef January 2020, with the hours of 22.00 to 07.00 no longer being included in line with NICE guidance that patients should not transfer wards between these times.

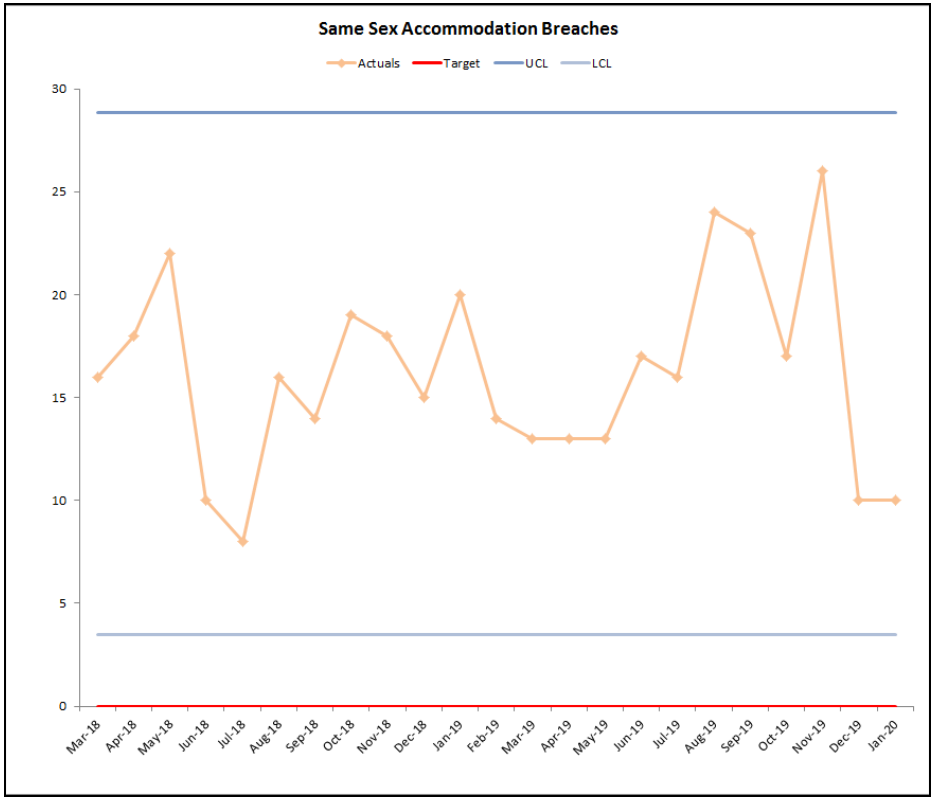
WUTH breaches of the guidelines are largely in relation to patients waiting more than 24 hours for transfer from critical care areas to general wards – under the new time rules there were 10 such breaches in January.

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

Action:

- Ensure definite discharges are highlighted at every bed meeting
- Ensure full review of any patient who is not admitted within 4 hours of needing a critical care bed
- All patients who are delayed discharges have privacy and dignity documentation completed daily, to ensure all clinical and psychological needs are met. 10 patients are audited monthly to ensure this is happening.
- Capacity and demand of department has been modelled , bed re configuration
- Capacity manager for roll out March 2020.

Expected Impact:
That every patient who needs a Critical Care beds gets one in a timely manner. That every patient has a very positive stay and understands the reason for their delayed discharge.



FFT recommend rate: ED

Executive Lead: Chief Nurse

Performance Issue:

A WUTH target is set at a minimum 95% recommend rate. The January rate of 85% is a downturn again after the improvement seen in December.

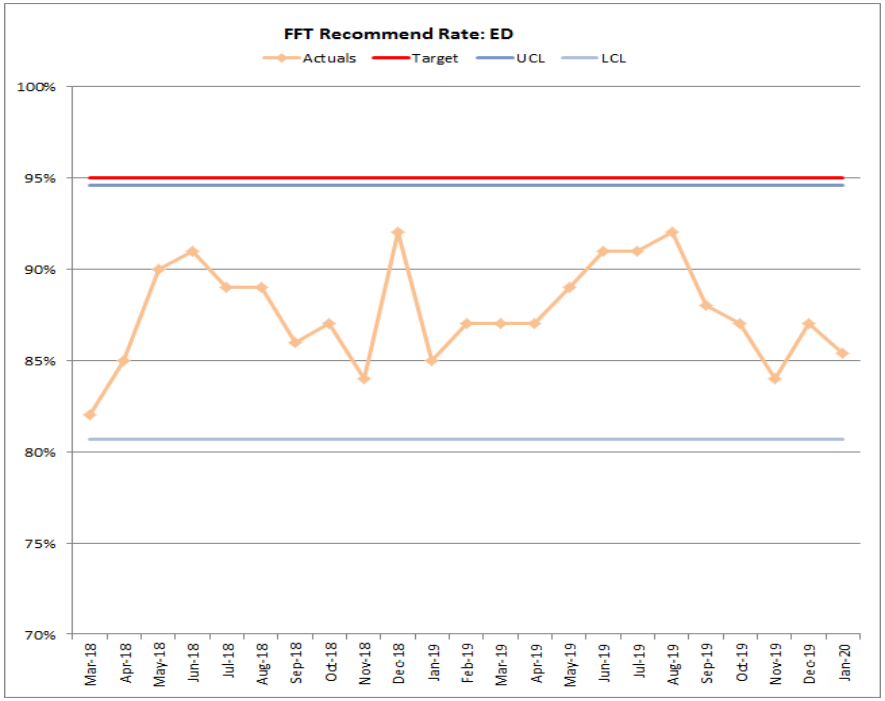
Action:

The latest available data in the NHS England portal September indicates the average National and regional recommend rate to be 84% compared with WUTH at 85% in January. There are no new themes identified this month themes continue to be waiting times, being informed of delays and some staff attitude. Deterioration unfortunately is a consequence an overcrowded department with extensive waiting times where patient experience is compromised. In order to improve address the issues the department regularly puts out tannoy messages to keep the patients fully up to date with expected waiting times. Support has been sought from Age concern who supplies volunteers in to support with comfort checks, nutrition and hydration. The provision of hot meals is being explored for the department, along with in house volunteers to also provide support. The corporate team provides additional support in times of severe overcrowding with apologies and tea and toast rounds and comfort checks. Communication has remained a consistent theme, the ED matron is raising awareness at staff huddles ensuring all members of the Multi-disciplinary team are aware to keep optimum levels of communication with all patients. Additional profile beds have been purchased for long stay patients to ensure patients are not spending excessive lengths of time on trollies and are more comfortable.

Trolley area now has bedside tables and chairs for patients with long lengths of stay to sit out. The Department is monitoring safety and experience of patients via a specialised audit recently developed on Perfect Ward

Expected Impact:

Increased response rates for FFT. Improved patient awareness.



FFT response rate: ED

Executive Lead:

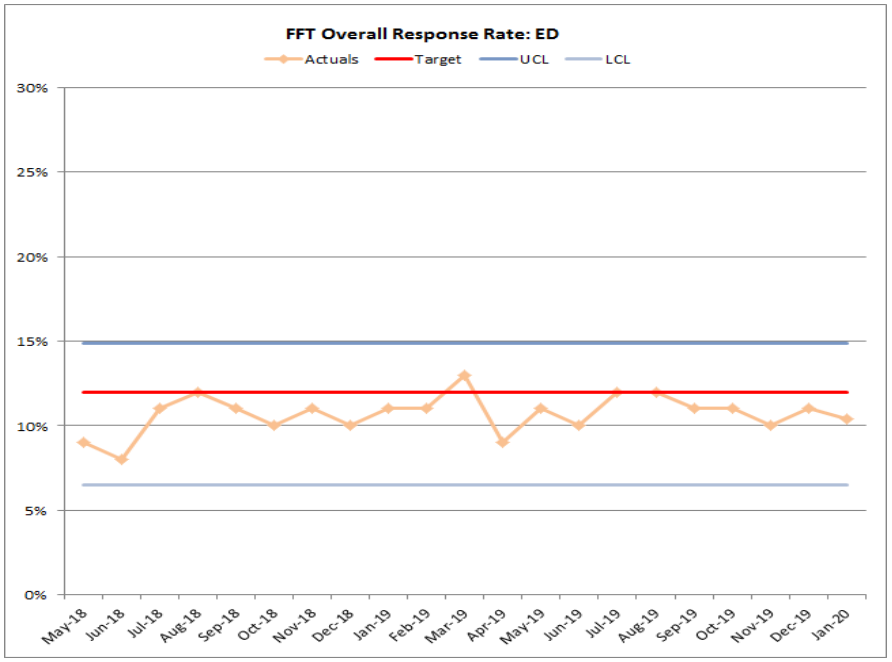
Chief Nurse

Performance Issue:

A WUTH target is set at a minimum 12% response rate for ED. This has not been achieved since August, with January at 10%.

Action:
The department FFT feedback is currently completed via a text messaging service this text service is being advertised so patients are aware they will be receiving this text and how we would welcome feedback to improve the department. New FFT standards live from April 2020 will give greater opportunities to seek feedback in a plethora of ways thus increasing the response rates. The Divisional Nurse Director has met with the communications team to ensure ED is included in the new FFT communications campaign**.**

Expected Impact:
Increased response rates for FFT. Improved patient awareness.



FFT recommend rate: Outpatients

Executive Lead: Chief Nurse

Performance Issue:

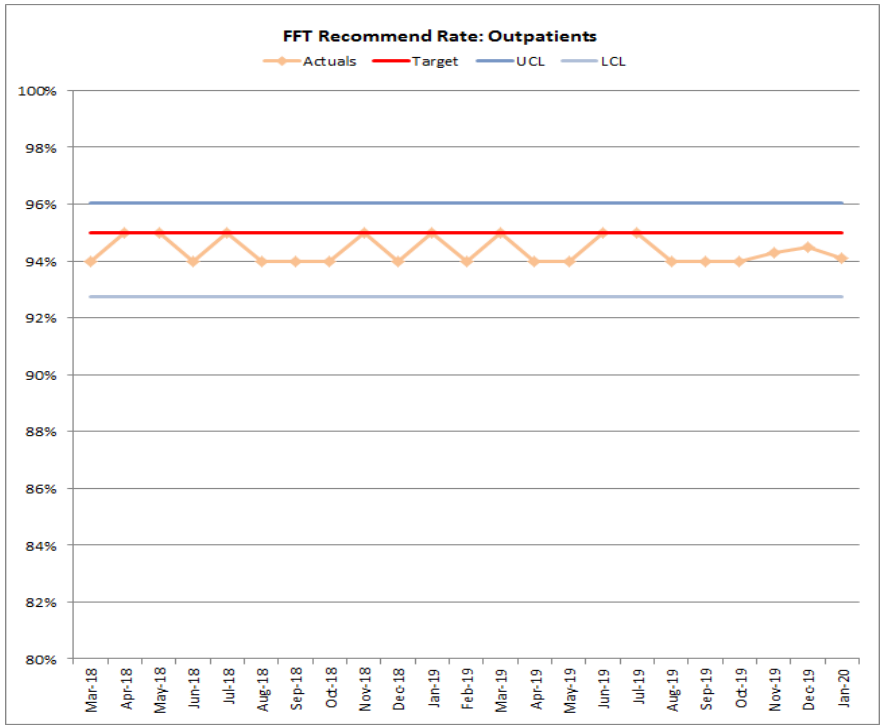
A WUTH target is set at a minimum 95% recommend rate. At 94.1% January has seen a slight deterioration following the improvement of previous months.

Action:

- This result includes all outpatient departments in WUTH. A meeting is being arranged for all department leads to ensure continuity of information and to explore opportunities to improve patient experience and response and recommend rate
- Information leaflets/posters are being explored with the communication team to explain the text messaging service to patients
- All feedback is discussed by general OPD manager and issue/concerns/compliments are discussed with the relevant person.

Expected Impact:

To see an improvement in the recommend rate with all areas improving patient experiences in the clinic environment.



Responsive Domain

4-hour Accident and Emergency Target (including Arrowe Park Walk in Centre)

Executive Lead: Chief Operating Officer

Performance Issue:
The Trust has a recovery trajectory agreed with NHSI for 2019-20 for the 4-hour Urgent Care Standard. Performance continues to be considerably below this, with January at 70.48% against a trajectory target of 90.5%.

In addition there were 40 patients in January that waited longer than 12 hours in ED from decision to admit to actual admission ('12 hour trolley wait').

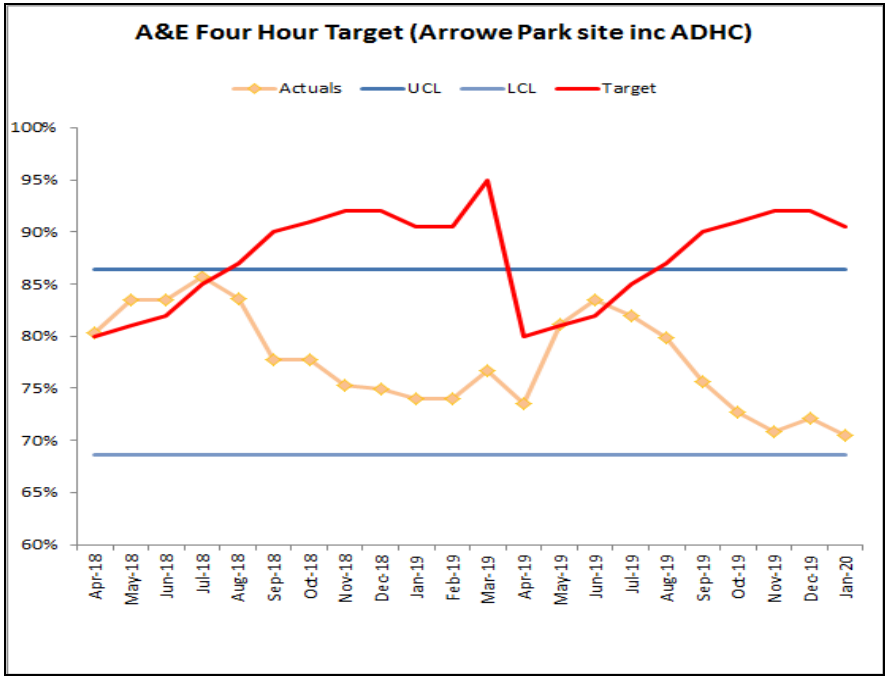
Action:

- Front Door workstream- focusing on improving utilisation of trollies and chairs in all assessment areas and maximising appropriate admissions to assessment areas.
- Back Door workstream- focusing on 'Perfect Board round' roll-out and implementation of criteria led discharge.
- Capacity manager roll out workstream.
- Bed modelling numbers are complete, a Trust wide workshop will be held early March to look at reconfiguration

Expected Impact:
Roll out of PFIG key initiative expected to leads to improved performance against a number of deliverables including:

- % utilisation of trollies and chairs.
- % utilisation of assessment area admissions.
- % Same Day Emergency Care (SDEC) admissions.
- Number of ≥21 day LOS inpatients.
- Number of weekend discharges.
- Number of discharges before 12pm.

Performance trajectories against these KPIs currently being developed via PFIG.



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 not been achieved since July, with January at 78.26%. Urgent care pressures continue to impact on RTT performance as does the ability to deliver agreed activity plans.

There are 3 elements to performance standards relating to elective activity with % RTT seen as the lowest priority.

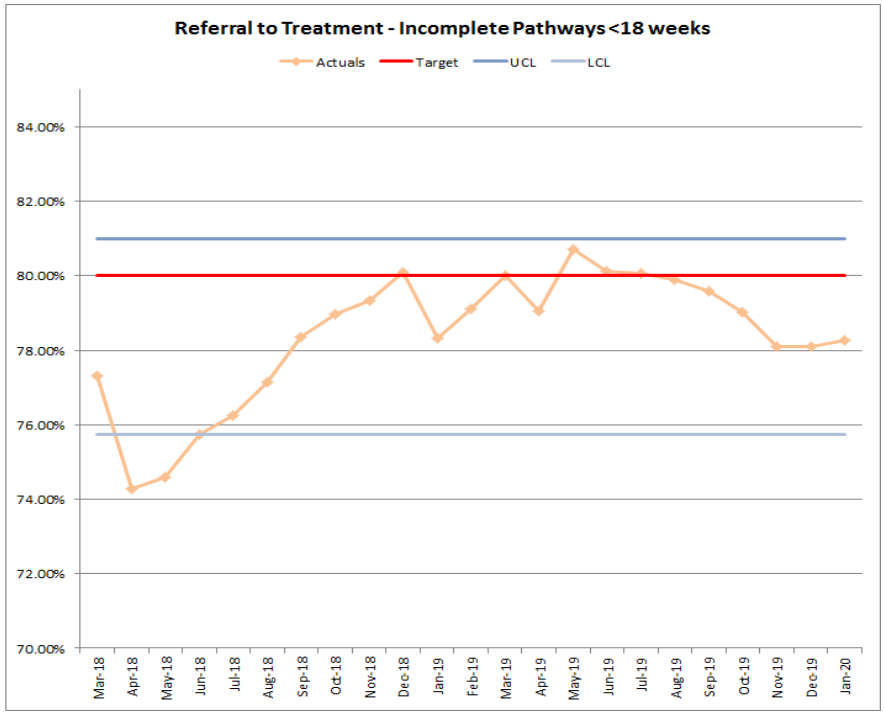
Action:

Activity has been transferred to Clatterbridge and the 3rd stage recovery project will mitigate the need for a day case ward on the Clatterbridge site.

A de-escalation plan other compromised wards being used for urgent care provision is being locked down.

Expected Impact:

The Trust is ahead of plan on total waiting list size and has sustained zero 52 week objectives. The 3rd standard of 80% is expected to be delivered subject to urgent care pressures.



Diagnostic Waiters 6 weeks and over

Executive Lead:

Chief Operating Officer

Performance Issue:

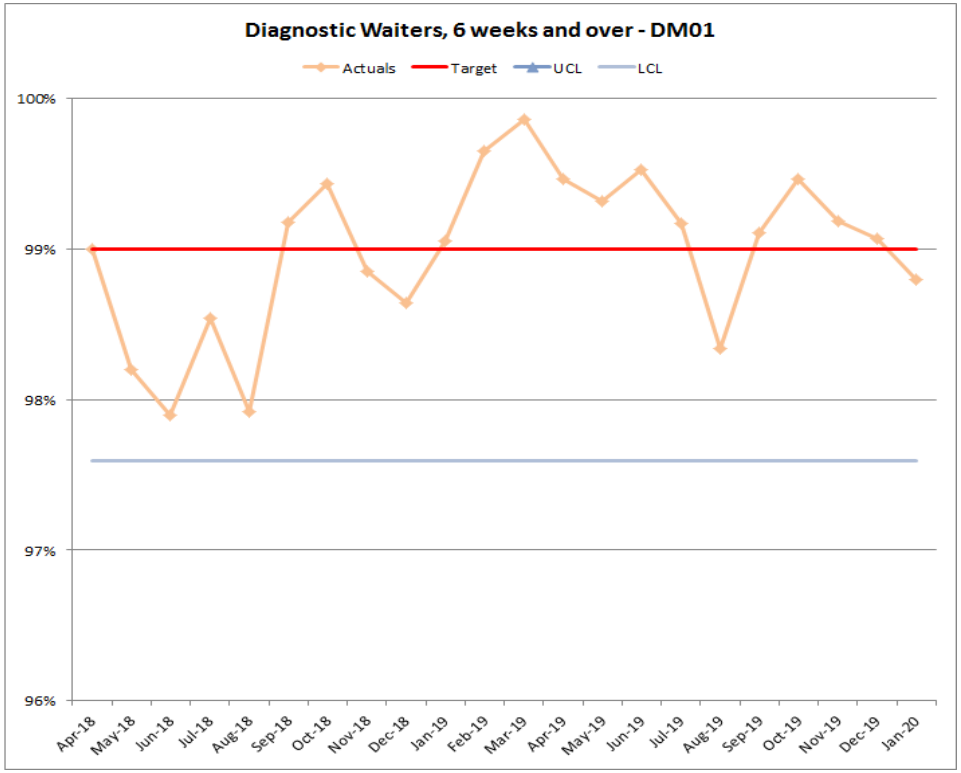
A national standard in support of Referral to Treatment waiting times is that patients should not wait longer than 6 weeks for diagnostic tests. The threshold target is set at a minimum 99% of patients waiting for a subset of investigations at month-end to be 6 weeks or less.

Action:

- *Echo*: Long term recruitment with 3 x preceptors and 2 x advanced roles. Continued use of non-core capacity as interim measure.
- *Cystoscopy*: 2 additional scopes + capital replacement of the washers at CGH. In the interim additional weekend WLI lists.
- *Cardiac CT*: Work with Medicine and Surgery to facilitate additional lists / patients per list in response to 27% increase in demand. Additional lists to be provided as interim solution.

Expected Impact:

- *Echo*: Reduction in breaches to 15 in Feb within increased capacity.
- *Cystoscopy*: plans will enable 5-6 scopes per list increasing capacity by 50% therefore reducing the number of breaches from April.
- *Cardiac CT*: predict 0 breaches in Feb.
- The above actions in total are expected to deliver compliance in February.



Well-led Domain

Number of patients recruited to National Institute for Health Research studies

Executive Lead: Medical Director

Performance Issue:

Following discussions with the Local Research Network, the initial internally set WUTH target of recruiting 500 patients to National Institute for Health Research (NIHR) studies in 2019-20 has been amended to 700 (November '19). The revised trajectory is set at a target 59 per month until the annual 700 is reached.

This has not been achieved in any month this year so far, with 53 recruited in January.

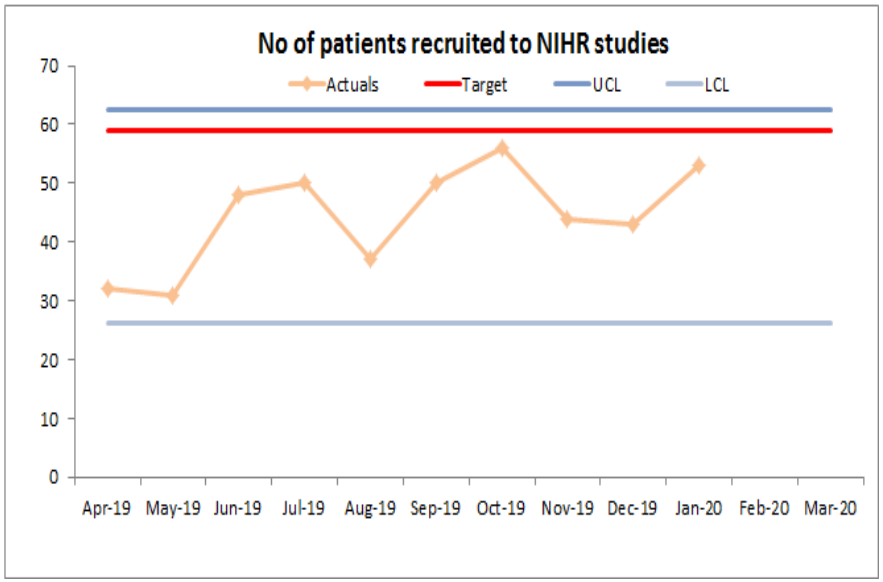
Action:

- To continue to work with the Local Research Network to find, and participate in, high recruiting studies.
- To increase recruitment to studies already open.
- New Research Divisional Leads to take part in NIHR research and
- To encourage more clinicians to participate in research.
- Going forward, in 2020/21 each division will be given its own research recruitment target.
- Appointment of 2 academic consultant posts.

Expected Impact:

Unlikely to achieve the amended target of 700 during 2019-20.

Lack of increase in recruitment could potentially impact on research funding from local research network.



Appraisal compliance %

Executive Lead:

Director of Workforce

Performance Issue:

WUTH has a target set at a minimum 88% of staff to have had an appraisal within the expected timeframes. The 88% standard has not been achieved since March 2019, with January at 81.9%.

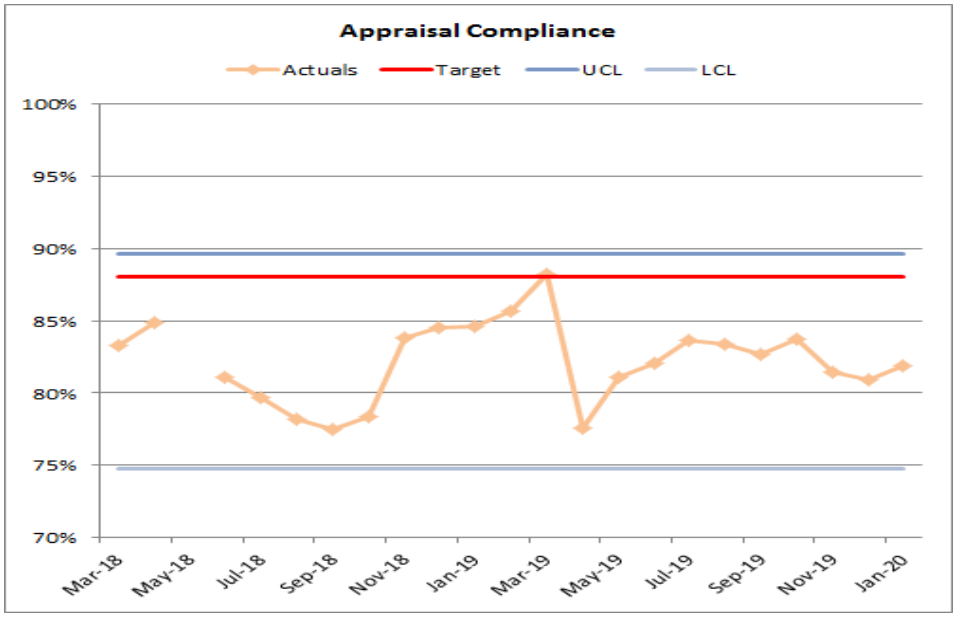
NOTE: Performance at the end of February is 84.73%.

Action:

A focus on Estate and Facilities to identify different ways to ensure appraisals are being conducted promptly and effectively. This will include the development of bespoke simplified appraisal documentation and talent process and team appraisals. This will be available by 1st February 2020.

Appraisal compliance is regularly being tracked through the monthly divisional performance reviews.

Expected Impact:
To achieve the Trust target by the end of quarter 4



Board of Directors	
Agenda Item	19/20 037
Title of Report	Annual NHS Staff Survey 2019 Results
Date of Meeting	4.3.2020
Author	Cathy McKeown, Deputy Director Organisational Development
Accountable Executive	Helen Marks (Executive Director of Workforce)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2 - **Critical shortage of workforce capacity & capability** **Strategic Priority:** I. PEOPLE: Supported empowered workforce II. PERFORMANCE: Consistently deliver financial sustainability and performance standards **Principal Risk**: A critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards.
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Gold - externally validate
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This paper highlights the outcome of the NHS Staff Survey for 2019.

A number of staff engagement events highlighting the results will have already taken place prior to the Board meeting on 4th March 2020.

This paper includes the link below to the full 170 page report and the 18 page Directorate Report. https://www.wuth.nhs.uk/your-wuth/wuth-staff-health-wellbeing/staff-engagement/nhs-staff-survey/staff-survey-results-2019/

2. Background

The NHS Staff Survey, undertaken by independent external organisation, Quality Health, took place between September and November 2019.

Questionnaires were issued to 5941 staff via mixed mode being via email and paper version.

The Trust received 2,265 completed questionnaires yielding a response rate of 38%, which is lower than last year's response of 45%. The median of response rates of 85 acute Trusts was 47%.

The results were under embargo until 18th February 2020 and published after this on the NHS National Co-ordination Centre website and the Trust's website.

3. Findings of the 2019 NHS Staff Survey

The full findings for all Trusts, confirmed by the Survey Coordination Centre, were published on 18th February 2020 and can be found by visiting the link below.
https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/

There are 11 themes within the survey which includes an additional theme of team working. The themes are:

- Equality and Diversity
- Health and Wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment - bullying and harassment
- Safe Environment - violence
- Safety culture
- Staff engagement
- Team working

A set of questions from the staff survey feed into each theme. The number varies between 3 and 9 questions. Of the 11 themes two have shown no change from the 2018 survey and nine have improved.

The following table provides more detail regarding each theme:

Theme	WUTH 2018 score	WUTH 2019 score	2019 National Average	Changes
Equality and Diversity	9.2	9.2	9.0	→ ←
Health and Wellbeing	5.6	5.7	5.9	↑
Immediate Managers	6.4	6.7	6.8	↑
Morale	5.9	6.1	6.1	↑

Quality of Appraisals	5.1	5.4	5.6	
Quality of Care	7.3	7.4	7.5	
Safe Environment Bullying & Harassment	7.7	7.8	7.9	
Safe Environment - Violence	9.4	9.4	9.4	
Safety Culture	6.3	6.5	6.7	
Staff Engagement	6.7	6.8	7.0	
Team working	6.2	6.3	6.6	

There are 102 questions that form the staff survey and from theses, 92 have improved and 10 have declined, with most of the latter by less than 1%.

3.1 Questions with most significant improvement (ie over 5%)

Question #	Question	2019 Change
12d	Reporting violence and aggression at work	Up from 62.8 to 70.0 (7.2% increase)
15c (7)	Grounds for discrimination experienced (Other)	Down from 40.8% to 27.0% (13.8% improvement)
17a	Organisation treats staff involved in an error, near miss or incident fairly	Up from 51.0% to 56.5% (5.5% improvement)
19e	Values of the organisation discussed as part of appraisal	Up from 30.7% to 39.0% (8.3% improvement)
21c	I would recommend the organisation as a place to work	Up from 55.2% to 60.4% (5.2% improvement)
22b	I receive regular updates on patient/service user feedback in my directorate/department	Up from 45.6% to 53.9% (8.3% improvement)

Questions with most significant deterioration: (ie over 5%)

Question #	Question	2019 Change
15c (1)	Experienced discrimination on grounds of ethnicity	Increased from 25.1% to 30.8% (5.7% deterioration)

3.2 National Highlights

The NHS Staff Survey remains the world's largest staff survey and over 569,000 NHS staff responded this year, an increase of 70,000 since 2018.

Following the publication of the 2019 National Staff Survey results on 18th February 2020, Anthony Hassall, (Regional Chief People Officer / Director of Workforce and OD (NW), NHS England/NHS Improvement) has highlighted some of the key national messages. Some of these highlights can be seen in more detail in Appendix 1.

In summary: The 2019 NHS Staff Survey shows improvements across five of the eleven themes, with the highest scores for the last five years in areas including how staff feel about their immediate

managers and indicators of staff morale. The remaining six theme scores have remained at a similar level compared to 2018.

4. Conclusion

Whilst the staff survey results have shown improvement, there are 8 of the overall themes that are still below the national average. There is therefore still much more work to be done and the Organisational Development (OD) Team will therefore focus on the areas for improvement linked to the OD Plan to ensure there are no gaps based on the findings. The key areas in the OD Plan are:

- Leadership
- Values and Behaviours
- Engagement
- Valuing our Workforce
- Learning Organisation
- Healthy Workforce
- Inclusivity

5. Next Steps

The following actions are planned:

- An informative and easy to understand presentation slide deck and social media animation will be created for staff. This will give a top line and easy to digest summary of the results.

- Face-to-face presentations are to be fronted by the Executive team to go through the slide deck with leaders/colleagues. This presentation and slide deck will also be an opportunity to build the recent work around values and behaviours as well the work being undertaken around shaping a new vision for the organisation.

- Divisional Triumvirates and Corporate Heads of Service will receive more detailed information relating to their areas in order for plans to developed to address the issues identified within their areas. These will be monitored via the Divisional Performance Reviews.

- The organisational development team will cross reference the detailed findings with the corporate themes that were shaped last year to identify any gaps, areas of concern and further areas to focus on in 2020.

6. Recommendations

The Board is asked to:

- Note the contents of the report

Appendix 1

2019 National Staff Survey Summary Highlights

Leadership

- Leaders at all levels play an incredibly important role in how it feels to work in the NHS, and evidence shows that compassionate, inclusive leadership leads to improved staff engagement and better patient outcomes. It is encouraging to see a year on year increase in all five of the questions that contribute to the immediate managers theme score since 2015.

- Increase in the quality of appraisals and staff feeling their work is valued by their organisation

- However, staff are telling us they need leaders with humanity, humility and compassion and the NHS People Plan will include a new leadership 'compact', setting out the values and behaviours we expect from NHS leaders.

Growing and retaining our future workforce

- Fewer staff report thinking about leaving their organisation this year compared to 2018. Strong retention action plans need to be in place and the People Plan will describe a further package of measures to make the NHS the best place to work.

- 63% of staff would recommend their organisation as a place to work - a year on year increase since 2017 - and morale and staff engagement scores have also increased.

- 84% of staff report that their organisation acts fairly with regard to career progression/promotion, halting a long-term declining trend.

Health and wellbeing

- 72% of staff agree that they receive the respect they deserve from colleagues at work

- Staff are feeling pressure to work when they are sick with 57% coming to work in the last three months despite not feeling well enough to perform their duties. 92% putting themselves under pressure to come to work.

- 28% report experiencing musculoskeletal problems as a result of work activities, 40% report that they have felt unwell as a result of work-related stress in the last 12 months, rising to 52% for ambulance Trusts.

- 70% of staff agree that their immediate manager takes a positive interest in their individual health and wellbeing, a steady increase since 2015. This is something we need to build on.

Inclusion

- If we're really serious about tackling health inequalities, then it's essential that we reflect that in our culture by ensuring that people in all roles represent the patients and communities we serve. It's encouraging to see the improvements in the WRES data - especially the increase in BME representation at board level - but we have much more to do to make the NHS a fairer and more inclusive employer.

- Despite initial progress in 2016 where BME colleagues reported an improved picture in terms of experiencing bullying and harassment and abuse from the public, we've now seen the picture deteriorate over the past four years to the extent that it is now worse than it was in 2015. We see a

similar picture for white members of staff, but the figures remain lower than reported in the 2015 survey, increasing the gap between the two groups.

- We see a similar picture for staff experiencing harassment, bullying or abuse from staff. Although the 2019 results demonstrate an improvement for BME colleagues, this hasn't meaningfully reduced the gap between them and white staff as the 2019 results demonstrate an improvement in experience for white members of staff. The past couple of years' results show that the disparity of experience between the two groups remains considerably larger than five years ago, something which needs our urgent attention.

- In terms of WDES indicators, overall the results are showing improvement across most indicators for both disabled and not disabled staff, with the improvement greater for the disabled group, reducing the disparity.

- Through the forthcoming NHS People Plan we are committed to making the NHS and care sector the best place to work. This includes ensuring people in all roles across the NHS represent the patients and communities they serve, and this must also mean that people are treated fairly regardless of their race, age, gender or disability.

Bullying and harassment

- No one working in the NHS should be subjected to harassment, bullying or abuse. This isn't something we will compromise on. As well as a moral duty to care for one another and a basic right for staff, a bullying culture has a negative impact on staff and patient care, and leads to high turnover, high sickness and low team productivity.

- 29% of our colleagues report personally having experienced harassment, bullying or abuse at work from patients, relatives or the public in the last 12 months, which has been pretty consistent over the last five years. 12% report experiencing this from managers, although this is decreasing.

- 15% of staff reported experiencing physical violence from patients, their relatives or other members of the public in the previous 12 months (broadly stable over five years), and this rises to 34% and 20% for staff working in ambulance trusts and mental health/learning disability trusts. The Joint Agreement on Offences against emergency workers ensures a more effective investigation process and prosecution of cases when emergency workers are the victim of a crime and sets out the standards victims of these crimes can expect.

Ambulance staff

- Our ambulance trust colleagues have seen improvements to all theme scores from 2018 to 2019, with the largest in the immediate managers theme, quality of appraisals and morale. However, ambulance trusts have the lowest theme scores for 9 out of the 11 themes and significantly so in many of these areas.

- 38% of ambulance staff report often thinking about leaving their organisation, with 19% saying they will do so as soon as they can find another job. We have worked very closely with these colleagues in recent months.

Anthony Hassall (Regional Chief People Officer / Director of Workforce and OD (NW), NHS England/NHS Improvement)

Board of Directors	
Agenda Item	19/20 039
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	4.3.2020
Author	Joe Gibson, External Programme Assurance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Choose an item	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

SUMMARY

1.Overview
The scope (see slide 2) of the Change Programme has remained stable during the past month. The Programme Board meeting of 19 February 2020 was stood down due to a lack of quoracy caused by other operational priorities. However, the comprehensive nature of the papers prepared for the meeting was encouraging. The pipeline programmes - 'Workforce Transformation' and 'Hospital Upgrade Programme' – still remain to have dates agreed for initiation through Programme Board and, thereafter, assurance rating.

Otherwise, the Executive Team continues to direct enhanced focus on the three large priorities within the Change Programme: Patient Flow, Outpatients and Perioperative Care.

The overall ratings assessments (see slides 3 and 4) have changed from the previous month; there has been a significant improvement in governance ratings together with another marked improvement in the assurance evidence for the digital projects albeit there remains room for improvement. Overall, quantification and delivery of benefits across the portfolio remains the defining challenge.

1.1. Governance Ratings
Seven of the thirteen 'live' programmes are green rated for governance – a significant improvement on the last report - with six attracting an amber rating; this is 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 shows two programmes green rated for delivery, nine showing amber for delivery, and two red rated. For the avoidance of doubt, amber ratings remain indicative of substantive issues albeit considered within the competency of the programme/project team to resolve. The areas for attention are, in particular, 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 and Hospital Upgrade Programme
The two staff recruited from the Service Improvement Team into the 'Hospital Upgrade Programme' took up their new roles, full time, on 21st February 2020. The Programme Director has also been released, at least part time, to get the programme up and running. The immediate priorities are: from a governance perspective, and as a matter of urgency, the formation of a Steering Group; on the delivery side, the planning to complete an Outline Business Case (OBC) needs to be fully completed. Assurance rating of the programme will begin at the request of the Programme Board and it is suggested that this be in place for March 2020.

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 was most recently discussed at the Programme Board meeting (the membership of which includes a non-executive director) held on Wednesday 15 January 2020. (the February meeting having been stood down).

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 7 projects. This weighting is true not only in terms of their significance to, and impact upon, the Trust mission in the near term but also the breadth and degree of difficulty of the work involved.

The first two pages (**slides 10 and 11**) of the Change Programme Assurance Report provide a summary of each of the 3 Priority Projects and highlights key issues and progress.

6.Recommendations
The Board of Directors is 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 / Executive Sponsors to direct their projects to further improve confidence in delivery.

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NHS Foundation Trust

Change Programme Summary

External Programme Assurance

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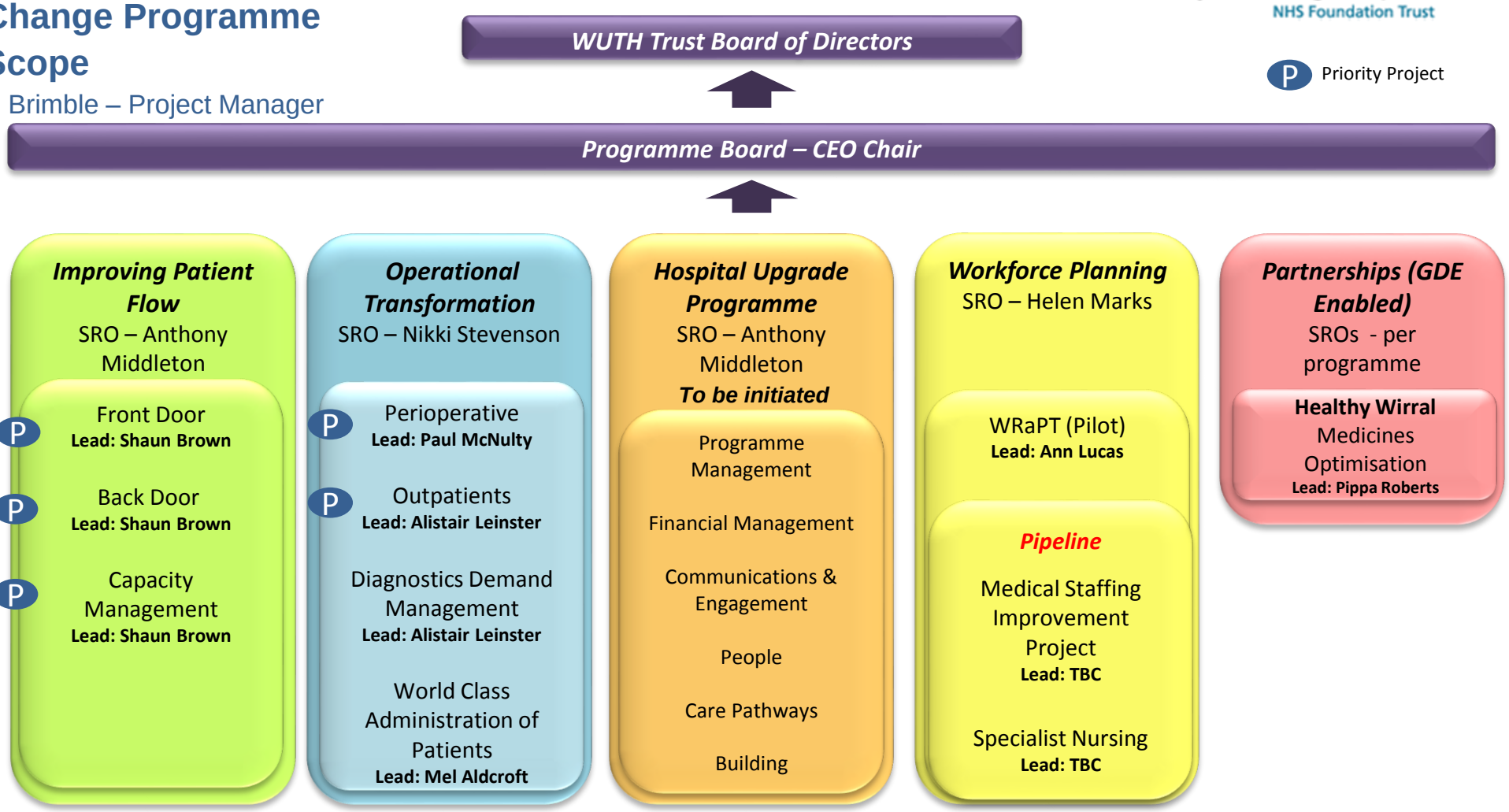
Change Programme Scope

S Brimble – Project Manager

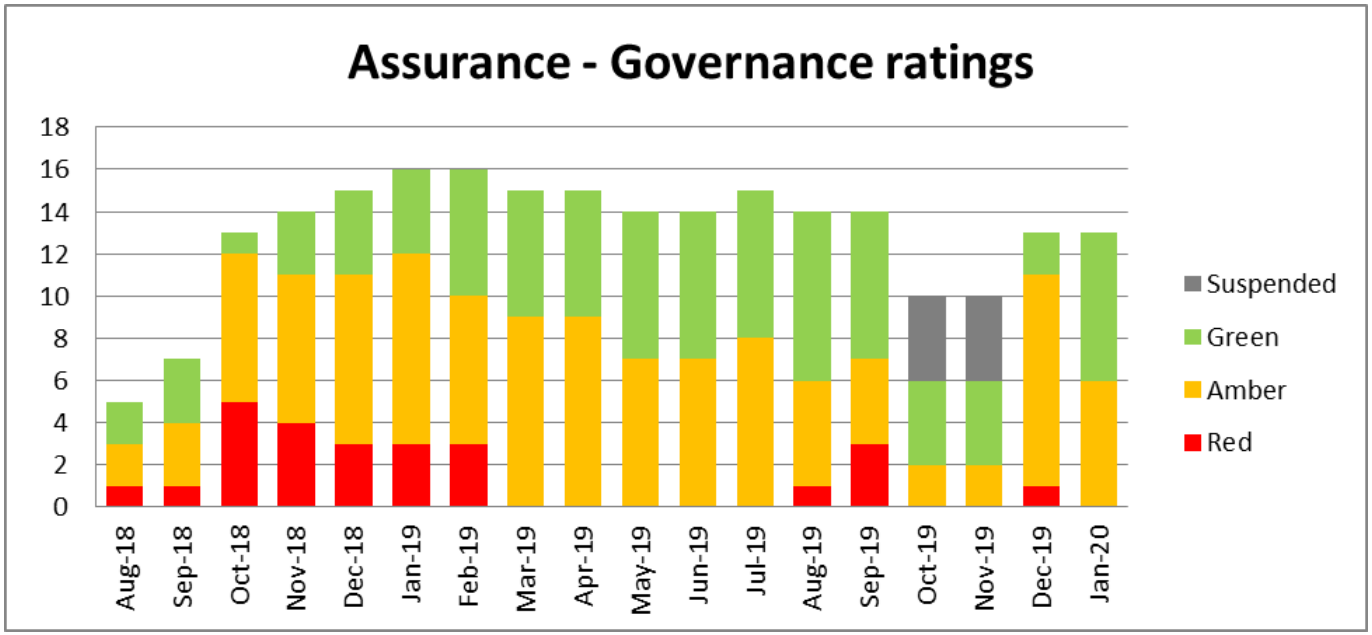
Wirral University Teaching Hospital NHS
NHS Foundation Trust



Change Programme Assurance Report - Trust Board Report - February 2020

S Brimble – Project Manager

Wirral University Teaching Hospital NHS Foundation Trust



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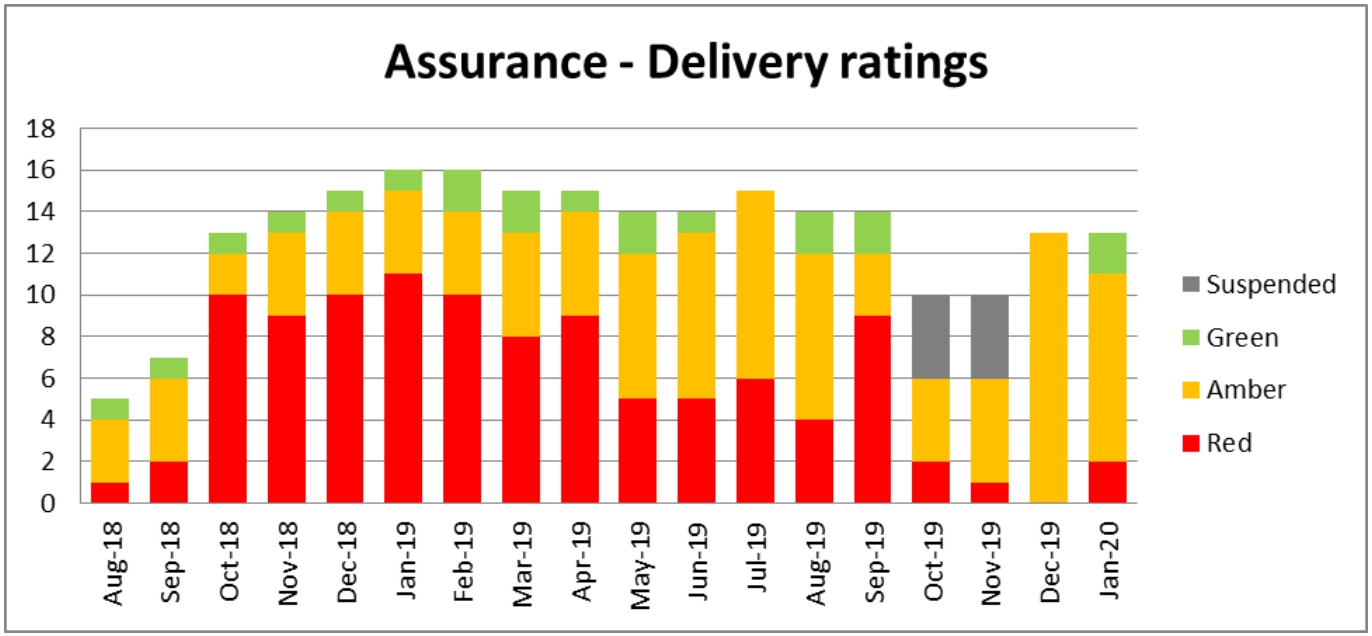
Change Programme Assurance Report - Trust Board Report - February 2020

S Brimble – Project Manager

Wirral University Teaching Hospital NHS Foundation Trust



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Priority Projects Highlight Report - Metrics

Senior Responsible Owners

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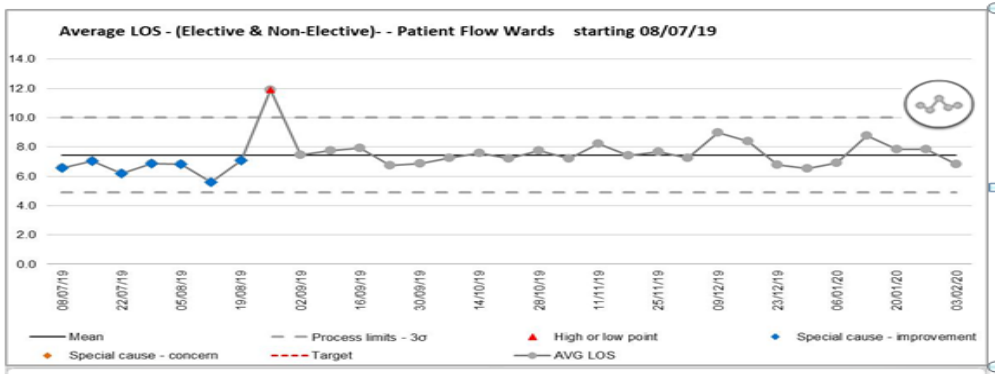
Things you need to know

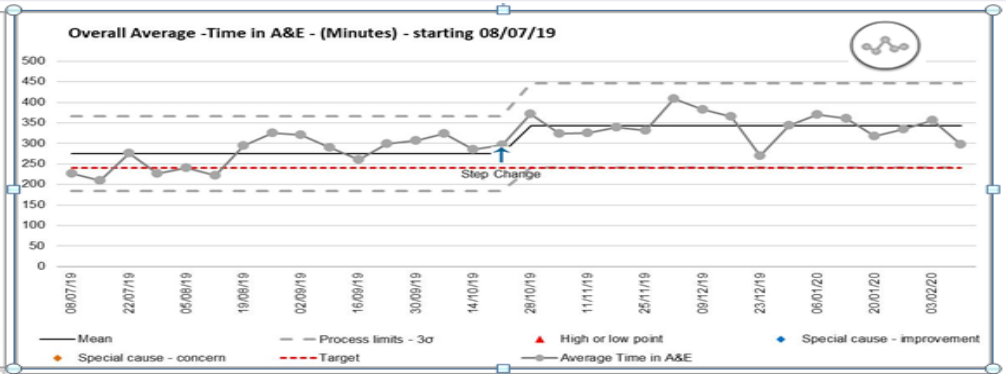
Capacity Management: On track for 'Go Live' on 9th March. Training underway and Trust wide communication circulated. Divisions to ensure all staff access Capacity Management elearning in advance of 'Go Live'. Seeking approval for extraordinary meeting re Capacity Management & LaunchPoint 'Go Live' approval.

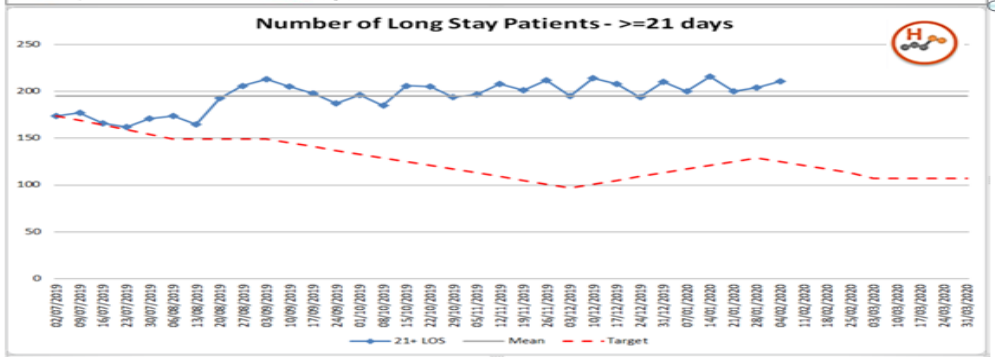
Front Door: 'As is' process maps for Assessment Units have been completed. Majority of benefits for each unit have been agreed and will be signed off at next PFIG.

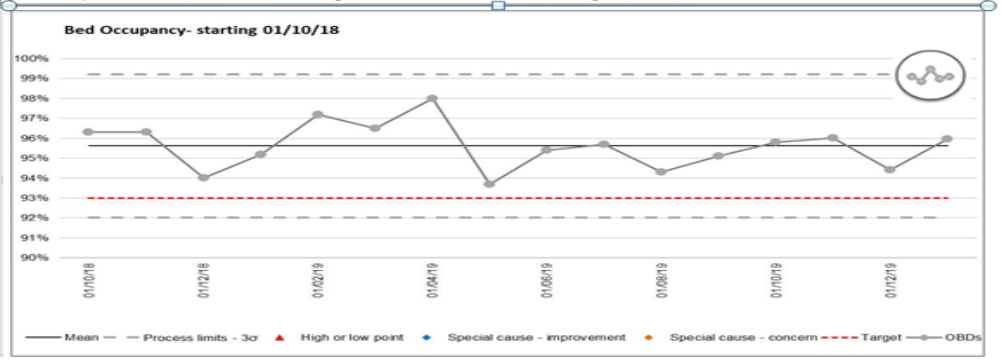
Back Door: Perfect Board Round and huddle rollout on track . FastTrack Improvement Workshop held with the aim of reducing time between FastTrack referral & discharge.

ED One Patient Record: LaunchPoint 'Go Live' planned for 9th March. Training has commenced and is on track.









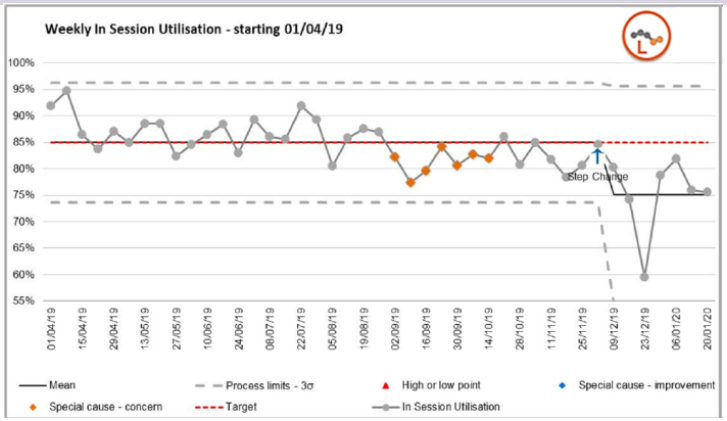
Escalation

Things you need to know

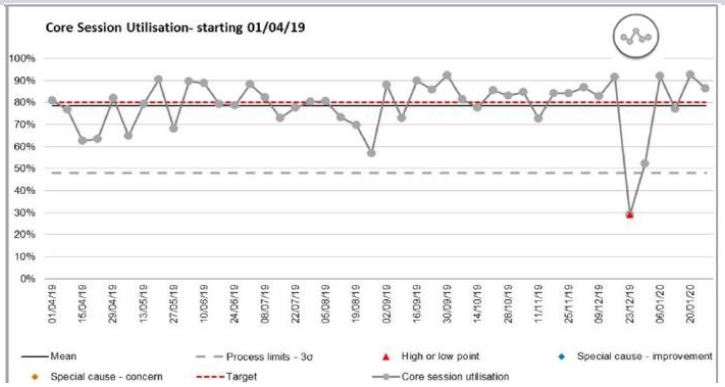
Programme Lead has devised a vision and scope. Throughout January, engagement sessions have been held with operational, medical and nursing staff, patient groups and other stakeholders to verify and develop the vision. We are now in a position to share the PID and Plan for the next 12 months and aims for the next 3-5years

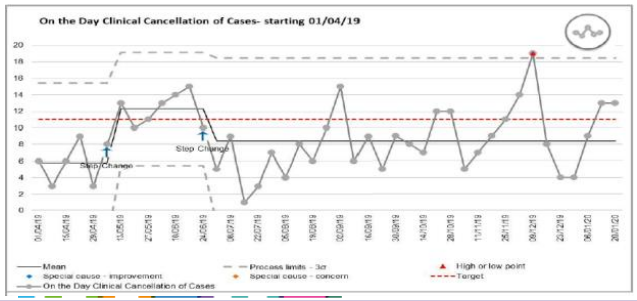
Implementation previously identified initiatives continues including three phase recovery (building work has started) and theatre scheduling system (technical testing complete and final user testing taking place).

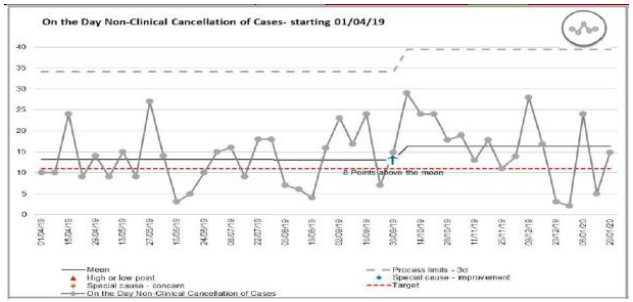
Project teams and steering groups have refreshed their terms of reference, attendee lists and standard agendas to reflect the refreshed scope.

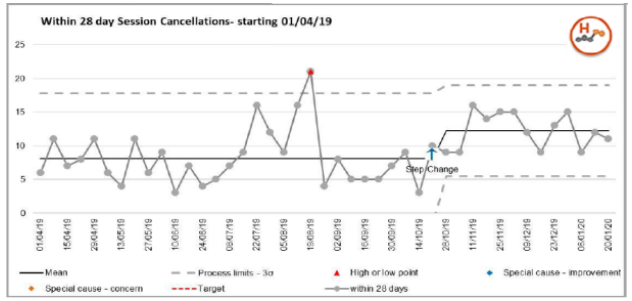


Core sessions remain consistently above target. The decline in performance linked to elective cancellations due to NEL demand (Sept onwards) and compounded by loss of Ward 12 (November onwards) as the Elective Orthopaedic ward









Escalation

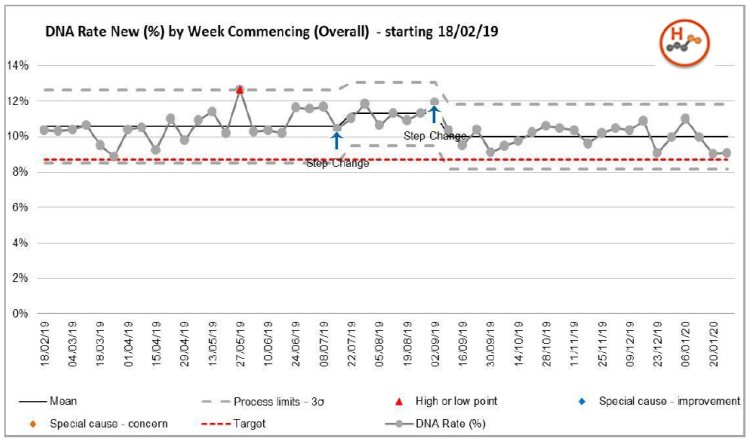
Relocation of Pre-OP from Cardiovascular to Clinic 1 at APH remains an issue and has been flagged by CQC

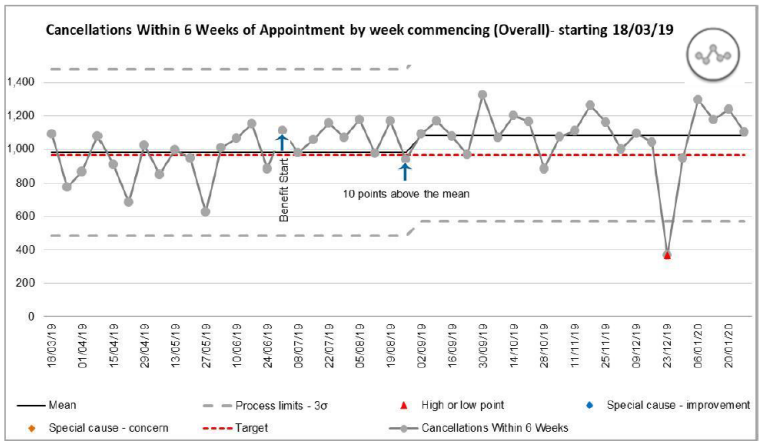
Things you need to know

Outpatient Support: Cancellations within 6-weeks: Medical Staffing issues identified, 2nd workshop scheduled to address end-to-end processes for cancelling clinics.
DNA Rate: Text reminder review in progress and agreement to send an additional reminder for high DNA rate specialties. Patient Access policy implementation planned for March 2020.

21st Century Outpatients: Telephone and virtual clinic SOPs drafted and workshops with DMs initiated. Clarity to be determined on the plans for Health Economy End to End Pathway Redesign Project.

Digital Enablers: Outpatient One Patient Record planning underway for Consultation Event March 2020.





Reporting Meeting - February 2020

Wirral University Teaching Hospital NHS Foundation Trust

	ID	Description	Reporting Period	Period Target	Jan-20	Dec-19	Nov-19	YTD Target	YTD Performance	YTD Variance	System Assurance	SPC Trend
A	Outpatients											
	1	DNA Rate New (%)	Jan-20	8.7%	9.8%	10.3%	10.2%	8.7%	10.5%	1.77%		
	2	DNA Rate Follow-Up (%)	Jan-20	8.3%	8.0%	9.4%	8.3%	8.3%	8.7%	0.38%		
	3	Cancellations Within 6 Weeks by Week Commencing (All)	Jan-20	TBC	5227	4023	4756					
	3a	Cancellations Within 6 Weeks by Week Commencing (Study Leave)	Jan-20	TBC	126	94	167					
	3b	Cancellations Within 6 Weeks by Week Commencing (Annual Leave)	Jan-20	TBC	374	285	353					

Escalation

Programme Assurance Ratings

Joe Gibson
10 January 2020

Change Programme Assurance Report -
Trust Board Report - February 2020 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Green	Delivery	Amber

- For the Flow Programme the key metric '21day + LoS' has been on a plateau of some 200 patients since mid-August 2019. The plans delivered over the following 6 month period have had no significant positive impact on this trend; however, it may be that the improvement actions have prevented the situation from deteriorating further, although no evidence has been presented to support this view. The target remains to achieve a level of 171 by 31 March 2020.

- The Capacity Management (formerly Command Centre) project is approaching it's implementation date of 9 March 2020. The current green ratings reflect a significant amount of planning, communication and engagement on the part of the project team. **A robust sign-off process has been completed by each divisional '3 at the top' and the final 'go live' decision is being managed through the Patient Flow Improvement Group (PFIG).**

Perioperative Medicine Improvement	Governance	Green	Delivery	Amber

- The Vision, Blueprint and comprehensive presentation of the re-scoped programme was prepared for the Programme Board of 19 February; unfortunately, the Programme Board was cancelled due to a lack of quoracy due to other operational priorities. A PID has also been in development and formed part of the evidence pack.

- The re-scoped programme demonstrates some detailed medium to long term planning and has been based upon credible and wide-ranging stakeholder engagement.

- **The next important step for the project team will be to complete the work to profile the realisations of benefits both in terms of quality and sustainability of services.**

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Change Programme Assurance Report -
Trust Board Report - February 2020 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Amber	Delivery	Amber

- The current PID, v2.0 dated 6 Jan 20, has 4 benefits described. However, reduction in DNAs has no proposed improvement level defined albeit the benefit start date is still stated as Sep 19; moreover, there is no evidence of specialty reporting of the increase in number of non face to face appointments (or current baselines).
- An Outpatients Transformation project team is in place at v1.1 (but the ToR Issue date is 'TBC') with evidence of meetings and an Action Log to 6 Jan 20.
- There is also evidence of widespread engagement through the stakeholder event and specialty planning meetings. However, the Steering Group meeting in January discussed the relatively slow pace of planning and adoption in divisions.
- **The project needs to address the definition and ambition of the benefits to be realised and work through a methodology that will secure divisional and speciality commitment to achieve certain thresholds by planned dates.**

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Workforce Planning - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Helen Marks	Ann Lucas	Joe Roberts	Design	Green	Amber

Independent Assurance Statement

1. Project Mandate and PID (v1.0 dated 17 Oct 19) uploaded 6 Nov 19 with benefits described; however, the metrics for measurement of benefits are yet to be defined. A 'DRAFT' scope for a W&C workforce 'plan' (with start date of 17 Jan 19) was uploaded 13 Nov 19. **2. & 3.** There are revised ToRs of the 'Workforce Planning Group' with minutes of a meeting to 9 Dec 19 and an update to the WAC on 21 Jan 20. **4.** There is evidence of continuing stakeholder engagement (including e-mail exchanges on divisional priorities during Jan 20) in the form of a comprehensive slide pack for 'Divisional Workshops' together with 'Stakeholder Analysis', a 'Communications Plan' and engagement with other Trusts - the plan will need to be tracked. **5.** EA/QIA were signed off in May 2019 (although new drafts are now in evidence). **6.** A 'draft' project plan with delays of 4-6 weeks and it's not clear if some actions from Nov 19 - Jan 20 are complete. There is also an update report from 6 Feb 20 giving a 'green' status. **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; however, the benefits profile in the PID has been revised (with metrics to be finalised). **8 & 9.** There is a revised risk register which shows evidence of updates to Dec 19; however, the 'date of last review' column needs to be completed. **Most recent assurance evidence submitted 10 Feb 20.**

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											

Front Door - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Charlotte Wainwright	Implementation	Green	Amber

Independent Assurance Statement

1. The project scope is defined by the PID v0.9 dated 23 Jan 20; six benefits are described. Of those six benefits: the first has yet to have % targets set; the second, third and fourth have proposed targets with baselines TBC by the end of the Initiation Phase; the fifth has yet to have the proposed improvement defined; and the sixth needs to align the proposed improvements with the 3 measures stated. **2. & 3.** There is a ToR, Issue v3.0 dated 7 Jan 20, for the Project Team and slidepacks relating to team meetings up to 9 Jan 20; the comprehensive evidence of team meetings also includes action logs and meeting summaries. **4.** There is an extensive list of stakeholders to be engaged across the Project Team; moreover, the 'Front Door Stakeholder Engagement Log' provides further evidence of engagement. **5.** A EA/QIA v1 has been drafted for the Front Door AU re-design. **6.** There is a detailed project plan - in the workbook v10 uploaded 7 Feb 20 - extending to end May 20 and an associated milestone tracker; these are being actively managed. However, the work on baseline data and process maps has been delayed by 4-6 weeks and needs revised milestones. 7. There is a partially completed 'Benefits Tracking Tool' (see comments on the PID above) within workbook v10; this version does not appear to cover the sixth benefit covering sickness/turnover/morale etc. **8. & 9.** There is an up to date risk register. **Most recent assurance evidence submitted 7 Feb 20.**

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	**Front Door**	Improving the flow of Urgent Care patients by providing the right care, first time, by referring the patient to the right place, first time.	Anthony Middleton											

Capacity Management - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Clare Jefferson	Implementation	Green	Green

Independent Assurance Statement

1. The PID, draft v0.11 dated 31 Dec 19, has now identified benefits and metrics which continue to be further developed. The business case for 'Capacity Management Devices' dated 12 Aug 19 was approved at the interim PFIG 12 Aug 19. **2. & 3.** Evidence of CapMan project team meetings is uploaded to 31 Jan 20. Moreover, the 'Divisional Sign Off' process is well underway. **4.** There is now extensive evidence uploaded of widespread communications and engagement including clinical groups. **5.** EA has been drafted and QIA signed-off. **6.** The Capacity Management Project Plan has now been updated to 7 Feb 20 and all activities are currently showing as broadly on track. **7.** As described above, metrics are still being developed. **8 & 9.** There is now a fully tracked risk register as part of the workbook with risks reviewed up to 6 Dec 19. **Most recent assurance evidence submitted 7 Feb 20.**

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	**Capacity Management**	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.	Anthony Middleton		●	●	●	●	●		●	●	●	●

Back Door - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Jane Hayes-Green	Implementation	Green	Red

Independent Assurance Statement

1. The PID v9.0 dated 4 Feb 20 defines the project; the objectives of the project extend to 31 Mar 21. **2. & 3.** There is a ToR for the Project Team, Version 1.0 dated 27 Nov 19 and shown as approved, and an action log summarising the meetings up to 21 Jan 20. **4.** There is also some evidence of information for stakeholder engagement and this would be assisted, given the nature of the project, by a 'register' of stakeholder engagement. **5.** There are EA/QIA drafted awaiting sign-off**. 6.** The project plan - in the workbook dated 10 Feb 20 - extends to Sep 20 and there is an associated milestone tracker; these are being tracked and currently shows a majority of actions being delivered on time**. 7.** There is a 'Benefits Tracking Tool' within the workbook, giving 4 key metrics with target dates; however, there is still work to be completed to define all metrics fully. The key 21day LoS (Long Stay Patients) target continues to fall short of the desired improvement trajectory, remaining stubbornly above the 200 mark - at time of writing (10 Feb) reported as 238. **8. & 9.** There is now a fully tracked risk register as part of the workbook with all open risks reviewed during Jan 20. **Most recent assurance evidence submitted 10 Feb 20.**

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	**Back Door**	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. 'Better Sooner, Home Faster' - Board Rounds & Huddles; Discharge Pathways; Electronic Fastrack; Therapy Led Discharge; Optimising Discharge	Anthony Middleton											

DIGITAL ENABLEMENT: ED One Patient Record - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Rob Jewsbury	Jane Hayes-Green	Design	**Amber**	**Amber**

Independent Assurance Statement

1. PID v0.4 dated 27 Jan 20 has been uploaded. There are 9 benefit types described with associated metrics but precise targets with dates and baselines remain to be established. **2.** The Project Lead is named as Rob Jewsbury and a project team is identified in the PID. There is an action log for meetings during 2019 but no evidence of meetings in 2020 to date. **6.** The project plan uploaded 3 Feb 20 shows 'Future State Validation' is behind schedule by one month. **8 & 9.** There is a populated risk register but the 'date of last review' needs to be completed for all risks. **Most recent assurance evidence submitted 3 Feb 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														
2.3a	**ED One Patient Record** (Digital Enablement - Outpatients - Separate Folder)	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.	Anthony Middleton		●	●					●		●	●

Perioperative Medicine Improvement – Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Paul McNulty	Emma Danton	Implementation	Green	Amber

Independent Assurance Statement

1. The revised PID v0.2 dated 28 Jan 20, including an extensive schedule of benefits and measures, awaits final sign-off by the Project Group and Programme Board; this is planned to happen by the end of Feb 20. **2.** As well as the Steering Group there is now evidence of a 'Patient Safety and Experience Project Group' and an 'Operational Excellence Project Group'. **3.** The Perioperative Steering Group has ToRs revised in Jan 20 and evidence of meetings up to 4 Feb 20. **4.** There is now extensive evidence of wide stakeholder engagement both with the programme an individual work streams. **5.** The QIA has now been revalidated. **6.** The project plan has an impressive level of detail and projects out to Sep 21. **7.** The Benefits Tracking Tool details benefits across 9 categories with significant BI work remaining to establish baselines. **8 & 9.** Risks ands issues are now logged in the workbook and are updated to the end of Jan 20. **Most recent assurance evidence submitted 4 Feb 20.**

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.	Nikki Stevenson											

Theatre Scheduling - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Lynn Tarpey	Emma Danton	Design	Amber	Red

Independent Assurance Statement

1. The Theatre Scheduling PID v1 dated 31 Dec 19 is uploaded but is yet to be approved and with benefits to be defined. **2.** There is evidence of a 'Theatre Scheduling System' meeting of 8 Jan 20 together with a 'Checkpoint Report' dated 7 Feb 20 (but no evidence of prior meetings). **6.** There is a Theatre Scheduling workbook v1.1 dated 31 Dec 19; the project plan has not been updated since w/c 9 Dec 19 and 4 milestones are shown as red rated in Jan/Feb 20. **8 & 9.** The risks registers for the project shows the date of last review as 6 Feb 20. **Most recent assurance evidence submitted 7 Feb 20.**

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														
3.1a	**Theatre Scheduling** (Digital Enablement - Perioperative Care)	The objective of this project is to implement informatics developments to support operational changes and help streamline and improve theatre processes from pre-op through to recovery and discharge.	Nikki Stevenson											

Outpatients Improvement - Programme Assurance Update - 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Alistair Leinster	Clare Jefferson	Implementation	**Amber**	**Amber**

Independent Assurance Statement

1. There is a PID v2.0 dated 6 Jan 20; for the 4 benefits described: reduction in DNAs has no proposed improvement level defined albeit the benefit start date is given as Sep 19; there is no evidence of specialty reporting of the increase in number of non face to face appointments (or current baselines). **2.&3.** An Outpatients Transformation project team is in place at v1.1 (but the ToR Issue date is 'TBC') with evidence of meetings and an Action Log to 6 Jan 20. **4.** The 'Outpatients Communications Plan' dated Jan 20 describes the comms approach (but is not tracked); there is also evidence of widespread engagement through the stakeholder event and specialty planning meetings. However, the Steering Group meeting in January discussed the relatively slow pace of planning and adoption in divisions**. 5.** The signed QIA has been submitted. **6.** The project workbook has a comprehensive milestone plan extending out to May 2021, this is being tracked and progress is reported as on track. **7.** The Benefit Tracking Tool needs further development. **8 and 9.** There is a fully populated risk register updated to 6 Jan 20. **Most recent assurance evidence submitted 4 Feb 20.**

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.	Nikki Stevenson											

DIGITAL ENABLEMENT: Outpatients - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Nickee Smyth	Clare Jefferson	Design	**Amber**	**Green**

Independent Assurance Statement

1. A PID v0.4 uploaded on 30 Jan 20 for 'Outpatient One Patient Record'; the document refers to 'high level benefits' for which the detail can be found in the project workbook. There is also a 'Decisions and Actions' presentation dated 3 Jan 20. **2.** There is a project team ToR as approved on 31 Jan 20. There is a 'Meeting Log' on SharePoint which refers to an 'Action Log' but no evidence of the Action Log on SharePoint. **6.** A workbook has been uploaded, at 10 Feb 20, and shows all actions on track. **8 & 9.** The workbook has a risk register, with all risks reviewed at 24 Jan 20. **Most recent assurance evidence submitted 12 Feb 20.**

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														
3.2a	**Outpatients One Patient Record** (Digital Enablement - Outpatients Improvement)	The key deliverables from this project are: Removing Case Notes from Outpatients Reducing the amount of paper produced within the Outpatient environment Solutions to make unavoidable paper available electronically.	Nikki Stevenson											

Diagnostics Demand Management - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Alistair Leinster	Alex Warrington	Implementation	Green	Amber

Independent Assurance Statement

1. The project PID, ISSUE v1.0 dated 15 May 19 was approved (as draft version 0.9) at the OTSG 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 meetings log with agendas and action log up to the 'Project Steering Meeting' of 13 Jan 20; moreover, there is a log with the record of attendance to Dec 19. **4.** There is a stakeholder mapping matrix and active measurement of engagement. There is also a register of 'Stakeholder Engagement Actions'. The Comms Plan has been incorporated into the Project Milestone Plan where it is tracked. **5.** A QIA/EA has been drafted and QIA has been signed off on 18 Mar 19. **6.** A comprehensive milestone Gantt chart plan has been developed, updated 10 Jan 2020, on which tasks have been updated and which shows delays to some milestones. **7.** Current CIP 'Actual' savings profile it at some 75% of the 'Projected' savings profile. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 2 Dec 19. **Most recent assurance evidence submitted 14 Jan 20.**

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);	Nikki Stevenson											

World Class Patient Administration - Programme Assurance Update - 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Mel Aldcroft	Emma Danton	Design	**Amber**	**Amber**

Independent Assurance Statement

1. The project PID, v1.1 dated 9 Sep 19, defines the project; improvements and benefit start dates are yet to be defined. The PID is accompanied by a 'Vision', 'Scoping Document' and 'Driver Diagram'. **2.** A project team is defined. **3.** There is evidence of a WCPA project team meeting, with ToR agreed, of 19 Nov 19; there is no record of meetings since but it is understood a meeting is planned during Feb 20. **4.** There is a comprehensive 'Communications and Engagement Plan' dated Jan 2020 uploaded and a draft initial newsletter has been prepared and uploaded on 3 Feb 20. **5.** A QIA/EA has been drafted and signed off on 3 Oct 19. **6.** A comprehensive milestone Gantt chart plan is in place, uploaded 5 Feb 20, and is being tracked albeit the initial sign-off meeting for the PID is delayed by 1 month. **7.** Definitions and benefits, with starts dates, is partially completed in the project PID. **8 and 9.** Risks and issues are recorded; risk register shows the 'date risk last reviewed' as 30 Jan 20. **Most recent assurance evidence submitted 4 Feb 20.**

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														
3.4	**World Class Administration of Patient Services**	This programme aims: To align administrative and clerical functions at WUTH using the Basic, Better, Best approach: Patients administrated safely, timely and correctly Right Person / Right Job / Right Paygrade Governance structure Standardised Working processes	Nikki Stevenson		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Digital Dictation - Programme Assurance Update – 14 February 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Rob Jewsbury	Jane Hayes-Green	Design	**Amber**	**Amber**

Independent Assurance Statement

1. The Digital Dictation PID dated 30 Oct 19 (as amended to v0.2 8 Nov 19) describes the scope and approach with some clarification needed on the proposed benefits. **2.** There is evidence of just one meeting of three key stakeholders on 29 Oct 19; evidence of governance and regular project team meetings is required. **6.** There is a Digital Dictation workbook v1 dated 31 Jan 20. The project plan shows all activities are on track and all milestones currently due have been completed; however, given the nature of the project, there is scant information in the plan concerning the significant communication and engagement required to underpin the desired outcomes. **8 & 9.** The risks register for the project shows the date of last review as 31 Jan 20. **Most recent assurance evidence submitted 6 Feb 20.**

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														
3.4a	**Digital Dictation** (Digital Enablement - WCAP)	Provide a digital diction solution fully integrated with the EPR (Electronic Patient Record) A complete audit trail for transcription processes Standardise current administration processes Enable the monitoring of clinical typing turnaround times Provide the ability to prioritise typing accordingly More efficient ways of working will be identified	Nikki Stevenson											

Healthy Wirral: Medicines Optimisation - Programme Assurance Update - 14 February 2020

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Mike Treharne, DOF CCG	Pippa Roberts	Mel Carrol	Implementation	Green	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. An updated DOAC PID v4 (uploaded 7 Feb 20) has been submitted in evidence as signed off by the Board in Jan 20. **2.** HW MO reports are available up to Feb 20. **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. There is evidence of minutes and action log up to Feb 20. **4.** There is continuing evidence of stakeholder engagement and comms by means of presentations and meetings to Nov 19. **5.** EA/QIA signed off 18 Mar 19. **6.** There is now a detailed milestone plan, dated Feb 20, uploaded; however, some milestones are being reported as delivered late. **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 Feb 20 (although it is in non-standard format) with 'date of last review' as Feb 20. **Most recent assurance evidence submitted 7 Feb 20.**

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

Subject:	Agenda Item 19/20 040 Proceedings of the Trust Management Board held 25.02.2020	**Date:**	4th March 2020
Prepared By:	Andrea Leather – Board Secretary		
Approved By:	Executive Directors		
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 M10 outturn.**			
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care – 4 and 12 hour waits, Long Length of Stay, 18 week Referral to Treatment, maintaining zero 52 week breaches, diagnostic waiters and attendance management.**			
Staff Impact	**Attendance management represent a risk to workforce effectiveness**			
Services	**None identified**			
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.**			

Committees/groups where this item has been presented before

N/A

Executive Summary

1. Executive Summary

The Trust Management Board (TMB) met on 25/02/2020. 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 – maintaining zero 52 week breach continues to be a challenge and is compounded by the bed pressures, particularly day cases. However, the regaining of Ward 12 as the elective orthopaedic ward significantly reduces this risk with all long waiters. Three Phase Recovery works are progressing well, although there has been a minor delay, completion remains on target for April 2020. The clinical pathway for Vascular Orthopaedic injuries has been agreed with Countess of Chester Hospital (CoCH) and has been in place since 24th January 2020. Perioperative Improvement programme Project Initiation Document (PID) is ready for sign off which details the work for Perioperative over the next 12 months and outlines the 3-5 year programme.

(ii) Medical & Acute - Capacity Management on target to 'go live' 9th March 2020 and Trust-wide training programme underway. The same date is planned 'go live' for ED One Patient Record: Launch Point and Nursing documentation. Ward 30 refurbishments work due to start 29th February, logistics for bed management and impact on flow reviewed,

mitigation plans introduced. Backlog maintenance assurance process, including quality impact assessment to be reviewed to ensure senior leadership visibility. Identification of funding available from clinical networks to support future developments eg telemedicine in Stroke to be discussed at future meeting.

A summary of workforce changes were provided.

(iii) Women & Children's - Waiting time for Community Paediatric services remains high due to increases in demand from multiple sources. Pilot of new neurodevelopmental pathway started in collaboration with WCT, CWP and CCG due for completion in December 2019 has now been extended. Certificate of accreditation for 2020 received from British Society for Gynaecological Endoscopy for Endometriosis service. TMB advised that options for 24/7 Children's ED being reviewed, general principles of operating model agreed and paper to be presented to TMB in March. A review of Continuing Care Service with Wirral Community Trust (WCT) underway, due diligence documentation completed and due for presentation at the WCT executive team in February. Update to be provided to TMB in March. Colposcopy Quality Assessment report received, paper to be presented to PSQB.

(iv) Diagnostics and Clinical Support - MSK Contract Performance Notice remains in place and will remain until progress is made relating to waiting times for consultant led specialties. 'Deep Dive' against the original business case assumptions to be presented to TMB to inform service model going forward. Work is underway with 3 Primary Care Networks (PCNs) to develop First Contact Physiotherapist model in MSK to support Primary Care in a way that compliments and is supported by the existing MSK service.

Discussions ongoing with WCT regarding AHP integration between WUTH and WCT, initial focus to support joint rotations and establishing joint management team meetings as well as review of pathways where teams from both organisations interact. Design work commencing with IT regarding the Wirral Remote Ordering and Communications System (WROCS) replacement – business case discussed later in meeting.

(v) Estates & facilities – Report outlining the management of estates capital programme to be provided for March TMB. The Divisional restructure is reaching the final stages and adverts for posts to be published shortly.

3. Quality and Performance Dashboard

- TMB received the revised Quality Performance Dashboard covering the 12 months ended 31st January 2020.
- There are currently 25/57 indicators outside tolerance.
- TMB noted the progress to date, in particular the significant reduction of Serious Incidents compared with the previous year and attendance management improvement across the majority of areas.
- HR business partners reviewing and drafting plans for mandatory training to be implemented April 2020, inclusion of sanctions to be reflected in Trust policy – TMB to consider revised policy.
- Following discussion, TMB requested a report describing how Divisions are managing productivity / efficiency indicators in relation to long length of stay and mandatory standards.
- Priority is being directed at efforts to avoid unnecessary admissions to hospital, reduce overall length of stay with emphasis on long length of stay patients.

4. Infection Prevention Control (IPC) in the built environment update

- TMB received the progress report for IPC.
- *Clostridium difficile* – we have remained under the monthly trajectory since July, resulting in being below our quarterly trajectory for Q2 and 3, however we remain under annual trajectory at this point (73 /88). TMB were advised that the year-end performance may be under trajectory and recognised what a huge achievement this would be, particularly based on the pressures faced by the Trust. There is some uncertainty about this pending position as at 31st March 2020.
- Cleaning spot checks are being undertaken to maintain momentum.
- An update regarding refurbishment work was provided including additional elements agreed in a number of areas. Some
- Tender process for refurbishment works on Ward 30 complete, preliminary scoping of works complete. The work is planned to commence early March and to be concluded by mid May 2020.

5. Bed Modelling

- TMB received a summary report outlining the provisional bed requirements for Surgery and Medicine & Acute. It was accepted that the data should be recalculated based on new national requirement of less than 92% occupancy and take into account seasonality requirements to establish the aggregated requirements.
- A workshop, attended by all Divisions to be arranged within the coming weeks. The workshop to focus on the reconfiguration of the bed base to drive efficiencies and longer term requirements.

6. Cerner Update

- TMB discussed a number of outstanding commercially sensitive matters to be referenced in the letter being prepared and an update to be provided to the Board of Directors at the March meeting.

7. Month 10 Finance Update

- TMB received and noted the financial position for the end of month 10.
- A breakdown by Division was provided to highlight the main areas of concern.
- Work is underway to revise the capital programme to address the slippage in quarter 4, this will encompass bringing forward priority capital schemes from 2020/21 to utilise the funding.
- The CIP includes £2.5m of non-recurrent items, TMB recognised that the programme has not identified WTE ie disestablishment of posts and the impact this has on the Trust run rate increasing month on month.
- The Chief Finance Officer stressed the importance of delivering in line with forecast.

8. Financial Recovery Plan

- TMB were joined by PA Consulting who provided a progress update.
- Analysis and follow-up sessions has identified £9.8m of emerging CIP against a target of £13m and work is underway with Divisions regarding the development of PIDs. TMB recognised that this work needed to be prioritised.
- Divisions to identify non-viable services that may be considered for the 2020/21 on onwards.

9. Investment Process

- TMB were reminded of the investment process in line with the Trust's Standing Financial Instructions (SFI's).
- A number of follow-up actions were agreed:
    - Finance Team to develop a simple one page guide to SFI/approvals/business case process and share widely with appropriate communications.
    - Regular training to be provided to support Divisional / Corporate teams.
    - Compliance and review of cases will be monitored via TMB.

10. 2019 Staff Survey results

- TMB received an overview of the findings for the 2019 staff survey across the 11 themes.
- Of the 11 themes the Trust has improved in the majority and remained the same in two areas.
- The findings have been circulated to Divisions/Corporate departments to inform the development of action plans.
- The OD Strategy is to be reviewed to reflect the feedback.

11. Business Cases

(i) Wirral Remote Ordering and Communications System (WROCS) replacement

- TMB reviewed the business case and considered the options provided, including funding options
- TMB approved the recommendation of option B and acknowledged the implementation date of March 2021.

(ii) Certificate of Eligibility of Specialist Registration (CESR)

- TMB considered the business case and supported in principle.
- TMB requested a separate paper outlining the impact of ED consultant job planning and to reflect the work of the ECIST team.

12. Chair's Reports

- The following Chair reports were received and reviewed by TMB:
    - Patient Safety & Quality Board Report – 13/02/20
    - Risk Management Committee – 11/02/20

Written and summarised on behalf of TMB Chair by:
Andrea Leather, Board Secretary
2nd February 2020

BOARD OF DIRECTORS	
Agenda Item	19/20 041
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	4.3.2020
Author	Sue Lorimer, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
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 23rd January 2020

This report provides a summary of the work of the FBPAC which met on the 27th February 2020. 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 10 Finance Report

Income and Expenditure: The committee received the month 10 finance report noting that the year to date position was a deficit of (£16.2m) against a deficit plan of (£2.5m); an adverse variance of (c£13.7m). However, this position is marginally (£150k) better than previously forecasted and the Trust year end forecast continues to be as previously reported. This position will result in the loss of PSF income in quarters 3 and 4 and mean that the year-end reported

position is expected to be a deficit of £17.4m. The importance of delivering the current forecast was noted together with the additional mitigations being pursued to support this.

Capital plan: The committee asked for assurance on the delivery of the capital expenditure currently being forecast. There was a concern raised that year to date delivery was currently £3.1m short of the revised plan and that this was a recurring issue each year. The CFO and COO have been asked to review processes to ensure that plans can be delivered quickly once approved. The committee noted and approved a number of priority schemes totalling £1.5m which will be brought forward from 2020/21 into 2019/20 to support slippage in other schemes. The schemes brought forward are each rated 15 on the Trust risk register.

2. Financial recovery plan

PA consulting attended the committee to update on the ongoing work to develop the 2020/21 Cost Improvement Plan (CIP). They are currently 7 weeks into a 12 week programme and, to date, 180 schemes have been identified with a total unweighted value of £9.8m. Given that Project Initiation Documentation (PID) is not yet developed, a prudent weighting for delivery had been applied to generate a weighted value of £2.5m. As PIDs are developed in coming weeks, the schemes will move through the maturity levels and the weighted value will increase. The COO explained that divisional management teams are being freed up to focus on this work during March 2020.

It was recognised that sustainability and turnaround was dependent upon not just CIP delivery but also controlling the run rate pressures. The committee asked for assurance that policies were being adhered to and asked that the CFO make arrangements for compliance of workforce processes to be picked up in the 2020/21 audit plan.

The committee asked for assurance that CIP planning and governance work would be aligned to existing teams and structures. The CFO confirmed that this was being addressed by the Executive team as the governance proposals were being developed. The CFO was asked to bring the agreed arrangements to the next meeting of the committee.

£13.3m (3.5%) is clearly a challenging target and successful delivery remains a risk to the Trust, however, all necessary actions are being taken to ensure that a robust plan is in place by the 1st April 2020.

3. Supply of Electricity Procurement

The current contract for the supply of electricity will expire on 31st March 2020. A procurement exercise has taken place to allow new arrangements to be implemented from 1 April 2020 and a paper outlining the process and recommended option was presented to the Committee (included in Appendix 1 for information). It was recommended that the trust procure its supply of electricity for 24 months through the Countess of Chester framework.

As the annual expenditure on Electricity across both sites is circa £1m this decision must also be approved by the Board of Directors. The committee reviewed the proposals and recommends that the contract is let in line with the proposal set out in the paper.

4. Update on 2020/21 Financial Plan and Capital

The Chief Finance Officer provided an update on the current status of the planning and budgeting process at the Trust, including an assessment of the underlying run-rate and impact on the 2020/21 plan. There is still work to do on the plan and run rate mitigations and it was clear that there is still a considerable level of risk in the position. The Executive team has identified financial planning and turnaround as one of two priority areas for the next three months. Arrangements are being made to ensure that divisional teams have the capacity needed to complete the bed configuration planning work required to underpin the position. A further update will be reported to the Board of Directors in its meeting on 4th March 2020.

The draft capital plan was shared with the committee for review before being shared with the Board of Directors. The committee supported the process, however, given the significant size of the programme, asked for assurance that the trust had the capacity to deliver it. The COO outlined steps being taken to provide additional resource in this area.

5. Quality performance dashboard report

Month 10: The Chief Operating Officer presented the month 10 quality performance dashboard report and answered a number of clarification questions in relation to the responsiveness section of the report. It was recognised that ED performance was single biggest issue and a discussion on bed capacity took place.

Urgent Treatment Centre: The committee asked for an update on the Urgent Treatment Centre programme and the COO described progress to date with the project team now in place. It had been recognised that this needed increased focus to deliver the business case in line with NHS Improvement expectations and the Executive team had recently addressed this. The committee asked that an update is provided at the next meeting together with a description of the governance process.

6. Risk Register

It was recognised that the delivery of the financial plan will be a key risk for the Trust in 2020/21 and an assessment on the level and nature of the risk will be required once the plan is finalised.

7. Recommendations to the Board

The Committee recommends that Board of Directors approve:

(i) the supply of electricity through the CoCH framework
(ii) the approval of £1.5m priority capital schemes brought forward form 2020/21 each of which is rated at 15 on the Trust risk register.

BOARD OF DIRECTORS	
Agenda Item	19/20 042
Title of Report	Report of the Safety Management Assurance Committee
Date of Meeting	4.3.2020
Author	Chris Clarkson, Chair
Accountable Executive Director	Paul Moore, Director of Quality & Governance
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 17th February 2020 and received a full update on a range of matters.

2. Key Agenda Discussions

1. Good progress was noted on resolving previous actions

2. The Committee received a report of Health & Safety Management Committee's January meeting and was pleased to see the continued progress being made to improve Health & Safety aspects within the Trust, providing assurance as to the priority being given within the Trust to this important topic.

3. The committee then reviewed the Health & Safety Dashboard and Divisional reports, it was pleasing to see all the Divisions were represented at the meeting and reporting on their individual areas.

4. Whilst there was visible improvement across the board it was clear that further action was needed in the areas of mandatory training compliance, the appropriate disposal of waste and manual handling, if the Trust is to deliver on its Health & Safety commitments. Actions were agreed in the areas of communications and encouraging the completion of mandatory training in order to address these issues.

3. Next Meeting

The next Safety Management Assurance Committee meeting will be held on 24th March 2020.

Board of Directors

Agenda Item	19/20 043
Title of Report	Board Assurance Framework
Date of Meeting	4.3.2020
Author	Andrea Leather, Board Secretary
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	There are gaps with mitigating action.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The attached report includes the following:

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

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

NOTE: All updates have been highlighted and the key risk indicators are based on data as at the end of January 2020.

2. Next steps

The Board of Directors is asked to review and consider:

a) the updated assurances and mitigating actions
b) the assurance rating for each of the risk vectors as provided by the relevant Committee (as defined in the guidance notes provided).
c) Overall risk rating for 'Primary Risk 4' – likelihood reduced to 3 – following stand down of 'outbreak' designation.
d) Overall risk rating for 'Primary Risk 6'
e) the overall risk rating, with a particular focus on those risks where 'negative' assurance ratings have been provided.

3. Recommendations

The Board of Directors is asked to:

- approve amended the risk ratings
- approve assurance rating and updates as detailed in the report.

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

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

How to use the BAF

The key elements of the BAF to be considered are:

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

Key to lead committee assurance ratings:

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

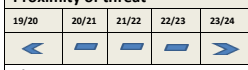
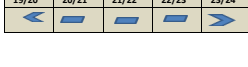
Amber = Inconclusive assurance: the Committee is uncertain that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

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

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

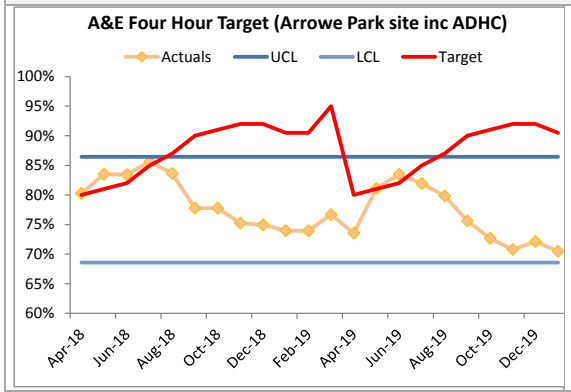
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

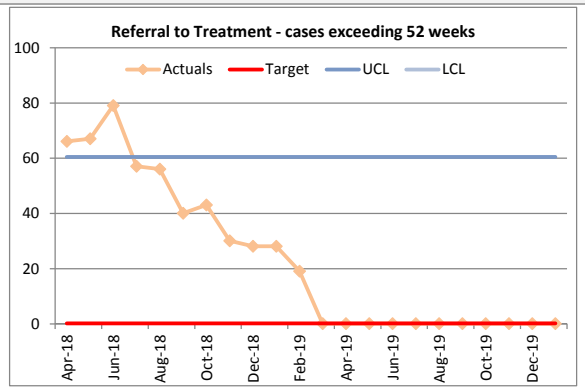
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that overwhelms capacity to deliver care effectively** A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards	**Executive lead**	COO	**Likelihood:**	5. V. Likely	3.Possible	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	4. High		
		Last reviewed	23/01/2020	**Risk rating**	**25. Significant**	**12. High**		
		Last changed	17/02/2020	**Anticipated change**	Intensifying			
Details of change	Updated gaps in control/assurance, plans to improve control/assurance and assurance ratings							

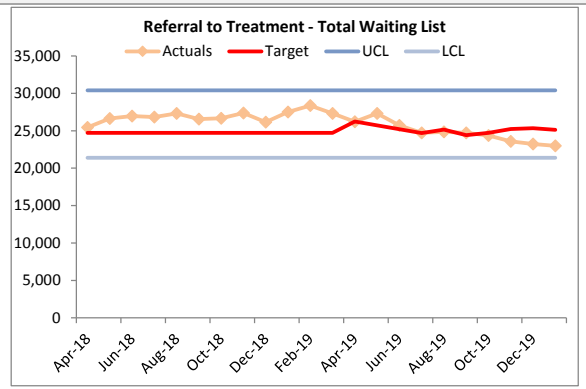
Risk Vector (what might cause this to happen)	**Primary Risk Treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Level & Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Threat: Exponential **growth in demand for care** caused by an ageing population (forecast annual increase in emergency demand of 4-5% per annum); -2% reduced social care funding and increased acuity leading to more admissions & longer length of stay **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Emergency demand & patient flow management arrangements • Winter capacity plan • Access Policy in place • Detailed operational plans agreed annually • Activity based contract and commissioners • Workforce model adjusted for planned activity • ED Streaming • Defined escalation areas (act as flood plane) during periods of exceptional pressure • Discharge procedures • Use of admission avoidance schemes • Use of SHOP model medical review • Ambulatory & Day case care **Contingency controls** • Emergency preparedness (Surge plan) • Expansion into corridor / designated escalation area • Reverse cohort area expansion within A&E footprint implemented • Quality matrons conduct patient safety checks for all patients in corridor/escalation area – reintroduce if required. • Staffing plan for escalation	• Higher than expected length of stay (LOS) • Normalised reliance upon escalation areas during pressure • Insufficient daily discharges to deliver net patient flow • Standards of care in corridors or escalation areas during periods of very high demand and very high bed occupancy • Reliability of SHOP implementation • Optimising patient care when prolonged stay in ED	Patient flow transformation programme **SLT Lead:** COO **Timescales:** As per change programme Introduction of system wide Command Centre during periods of exceptional demand **SLT Lead:** COO **Timescales:** as required ECIST support to guide improvement in patient flow **SLT Lead:** COO **Timescales:** Q4 19/20 Patient rounding in ED through Meds (MSOP) development plan to ensure timely administration of medicines **SLT Lead:** MD **Timescales:** Q4 19/20	**Level 1** • Divisional performance reviews (monthly); • Stranded patient reviews (2 per week) – focus on over 21 days • Overall bed occupancy rate (daily) • Ambulance Handover times (daily) – improved NW Ambulance performance • Command Centre meetings – 2 per day • Appoint system lead for discharge process – Amanda Portillo **Level 2** • Q&P Dashboard (monthly) • PFIG Report to Board (monthly); • Wirral A&E Delivery Board • Programme Board report to Board of Directors (monthly) **Level 3** • CQC improvement oversight; • System Improvement Board • Limited scope external audit – Quality Account 2017/18 • CQC unannounced inspection (March '18) • Contract meetings • MIAA Activity Data Capture – Limited Assurance • Model hospital – data submissions to regulator (monthly / annually)	Internal performance metrics to highlight organisational risk **Action:** A request to be made to review the internal metrics within the 'responsive' domain **Note:** a more comprehensive paper presented to FBPAC Nov '19	Negative
Threat & Opportunity: Operational **failure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort' **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Emergency preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL • Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse • Reliance on Walk-in-Centres / Urgent Care Centre • Urgent Care Board(UCOG & UCEXG) • System partners escalation process	Not within the Trusts sphere of control. In the event of GP practice collapse on Wirral there would likely be surges in demand for secondary care	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** • Reports to TMB **Level 3** • Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); • LHRP Assurance Process • Urgent Care Board (monthly)	Uncertainty re: fragility of general practice in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of General practice in Wirral	Inconclusive
Threat & Opportunity: Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL • Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse • Reliance on Walk-in-Centres / Urgent Care Centre • Urgent Care Board (UCOG & UCEXG) • System partners escalation process	Not within the Trusts sphere of control. In the event of collapse, emergency procedures will govern the response	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing Review Contingency plans **SLT Lead:** COO **Timescales:** Ongoing	**Level 2** • Reports to TMB **Level 3** • Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); • LHRP Assurance Process • Urgent Care Board (monthly)	Uncertainty re: fragility of neighbouring providers in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of neighbouring providers in the Wirral	Positive

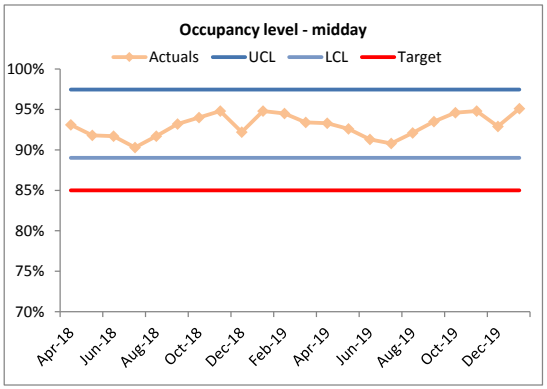
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

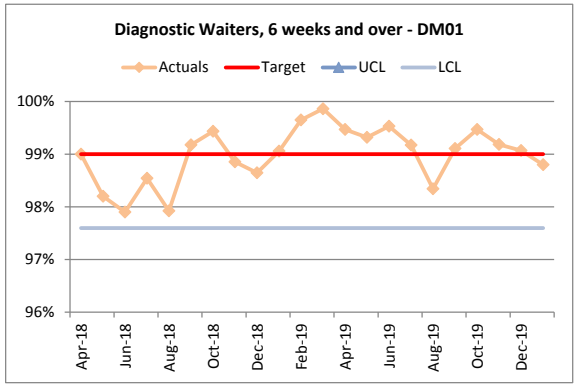
Key risk indicators (KRIs) – Data updated 17/02/20

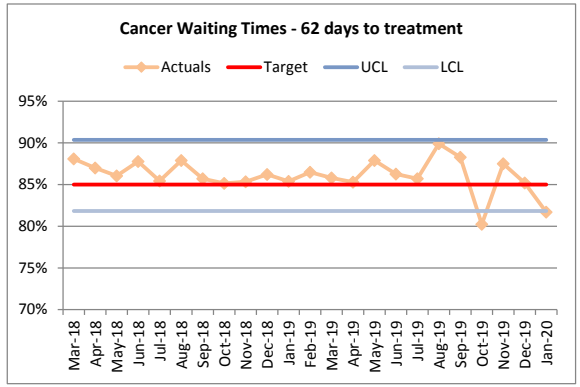




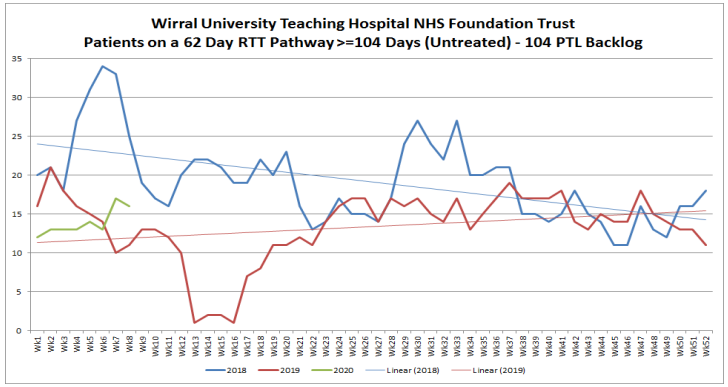








WUTH activity (Admitted, Discharges & Net flow)
To be developed



Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

Strategic priority	I. PEOPLE: Supported empowered workforce II. PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	WAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 2: Critical shortage of workforce capacity & capability** A critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards	**Executive lead**	Dir. HR/Workforce	**Likelihood:**	5. V. likely	3.Possible	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	4. High	4. High		
		Last reviewed	21/01/2020	**Risk rating**	**20. Significant**	**12.High**		
		Last changed	17/02/2020	**Anticipated change**	Intensifying			
Details of change	Updated gaps in control/assurance, plans to improve control/assurance and assurance ratings							

Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Level & Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Demographic changes (including the impact of Brexit and an ageing workforce) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition) resulting in critical workforce gaps in some clinical services	• E-rostering and job planning to support staff deployment • Vacancy management and recruitment systems & processes • TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation • Defined safe medical & nurse staffing levels for all wards & departments/ Safe Staffing Standard Operating Procedure • Temporary staffing approval and recruitment processes with defined authorisation levels • 'No deal' EU Exit Planning Team – incl workforce planning – action cards/ global comms/ EU exit page on intranet • Medical staffing & HR Teams in place • Nursing & Midwifery recruitment & retention strategy • Volunteer strategy • Recruitment campaign (Band 5; CSW; Volunteers) • Ward establishment review • Change in pension rules • Divisional ownership and understanding of workforce issue inc hard to recruit groups • Medical staffing review • Workforce Strategy and Implementation Plan • Vacancy rates for nursing posts monitored through T&F Group • Zero hours - new contracts issued in line with guidance • Introduction of Pension Exchange Policy – in line with BMA guidance	Vacancy rates / high locum use and hard to recruit medical posts	Bed modelling & specialty capacity/ demand review **SLT Lead:** COO **Timescales:** Q4 19/20 (Report to TMB Feb '20)	**Level 1** • Divisional performance reviews – workforce metrics (monthly) • Workforce steering group – all KPI's (monthly) • Safe Staffing Report – recruitment (quarterly) • Finance & Workforce Scrutiny meeting (weekly) • Medical Staffing Steering Group established to consider the Action Plan identified following the Medical Staffing Review. • Nursing & Midwifery Recruitment & Retention Strategy Update (WAC) • Workforce Steering Group – Chair's report • Recruitment & Retention Steering Group report to WSG • Exception reports (QPR) for Attendance, Appraisal and turnover **Level 2** • Workforce Strategy & Plan – Updates provided to WAC • Quality and Performance dashboard- Workforce metrics (monthly); • Report of Workforce Assurance Committee to Board (Monthly); • FBPAC reports (Monthly) • EU exit paper presented to TMB and Chairs report to Board (Feb/ Mar '19) • Workforce Key Performance Indicators (KPI's) – WAC (bi-monthly) **Level 3** • Organisational Development Plan • MIAA Safe Nurse Staffing (Substantial) • MIAA Recruitment Process Review (Substantial) • Medical Staffing Review – outcomes reported to Board	Lack of assurance re: control of locum use. **Action:** Medical Staffing Action Plan, improvements in control report via WSG	Negative
		Lack of control re: recruitment	• Recruitment to be brought back in-house to enable greater control • Project Plan prepared including TUPE transfer of staff • Mitigation plan to ensure team in place to provide continuity of service • Process mapping underway in relation main workstreams and processes within the recruitment service **SLT Lead:** Dir HR **Timescales:** Q4 (due to 6 mth notice)			
		Pension Exchange	Implementation of 'Recycle scheme' with effect from 31.3.20. (approved by RemCom)			
			Recruitment & retention plan outlining opportunities that reflect changing profile of the workforce **SLT Lead:** Dir HR **Timescales:** Q4			
		Zero hour contracts in relation to doctors and employment tribunal claims	• New contracts issued – in line with legal requirements. • Review underway with BMA, Solicitors and JLNC • Wage slips – breakdown provided from Jan 2020 **SLT Lead:** Dir HR **Timescales:** Sept 2019			

Proximity of threat

19/20	20/21	21/22	22/23	23/24
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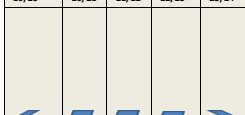
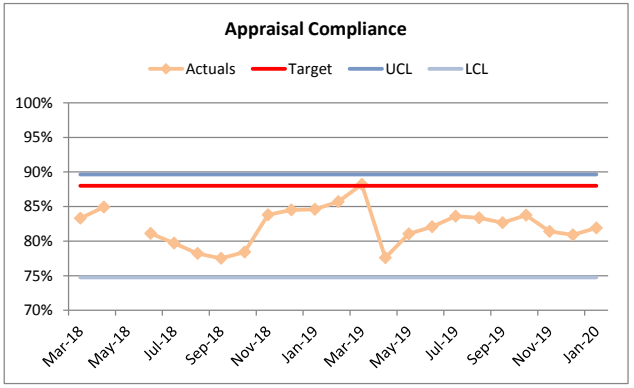
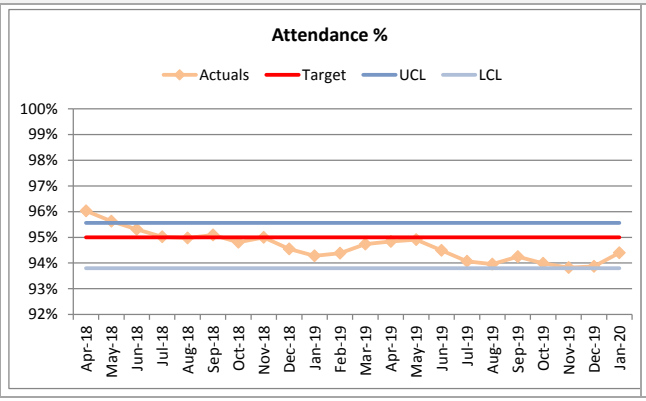
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

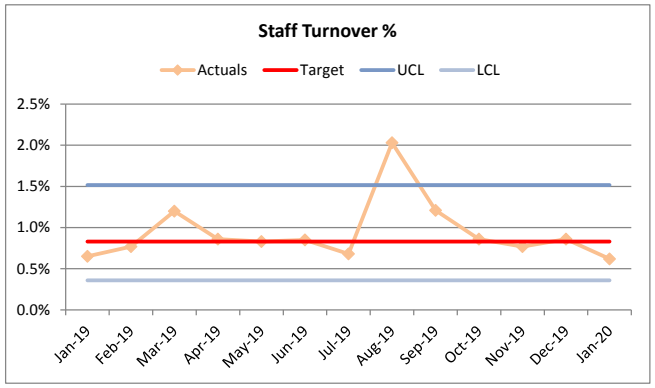
Threat: A failure to acquire or loss of of workforce productivity ***(attendance management)*** arising from a reduction in discretionary effort amongst substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint or workforce fatigue	• Staff Communication bulletin; Schwartz rounds • Divisional action plans from staff survey • Policies (Inc. staff development; appraisal process; sickness and relationships at work policy) • Leadership development programme / Duties of a doctor programme / Shadow Board Programme • Executive & SLT visibility; Big debates; Ask the Exec Team • Divisional staff support networks; Freedom to Speak up Guardians; Occupational Health Support (as required) • Health & Wellbeing team in place • Rewards & recognition i.e. annual staff celebration; cards • Attendance Management procedures • Oversight of OD delivery via Workforce Assurance Committee • Introduction of Health & Well-being Programme and Employee Assistance Programme • Pilot for external sickness management solution	• Unsustainable levels of sickness absence • Gaps in assurance regarding attendance management data	Pilot for External Sickness Management Solution **SLT Lead:** Dir HR **Timescales:** until Jan 2020 Review of Attendance Management Policy underway **SLT Lead:** Dir HR **Timescales:** Q4 2019/20 Review of Attendance Management data in ESR / First care underway **SLT Lead:** Dir HR **Timescales:** Q4 2019/20 Effective manager programme roll-out **SLT Lead**: Dir HR **Timescale:** January '20 – 1st cohort due to complete	**Level 1** • Divisional performance reviews – workforce metrics (monthly) • Workforce Steering Group – all KPI's (monthly) • Regular pulse checks starting June '19 • Establishment of 'Respect' at Work Group (monthly) • Pilot of external sickness management solution – report Sept '19 • Exception Report – Board of Directors (Sept '19) **Level 2** • Workforce/ OD strategy & plan • Quality and Performance dashboard- Workforce metrics (mthly); • Report of Workforce Assurance Committee to Board (Monthly); • Communications & Engagement Strategy (WAC – Nov '19) • Workforce Key Performance Indicators (KPI's) **Level 3** • National Staff Survey (Mar 19); • CQC Report (Mar '18); • Medical engagement survey	None identified	Negative
Proximity of threat 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) • The LHRP co-ordinated response. • Annual Review of EPRR Assurance Statement of Compliance	Limits to the extent contingencies can provide the state required in emergency	Test EPRR arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by end Q4 '20	**Level 2** • Resilience Assurance report to RMC (Mar; Sept 19) • EPRR Assurance Statement of Compliance **Level 3** • Confirm and Challenge by NHS England Regional team and CCGs; • LHRP Assurance Process	None identified	
Threat: Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Induction; Mandatory & role specific training programmes; • Corporate teams provide support and training as required • Exercises to test business continuity and incident management plans including loss of technology • ESR training record • Protected budgets for training & development • Practice educators • **Effectiveness of mandatory training knowledge acquisition in practice**: o 80% of the core 10 mandatory training subjects are available via e-learning. The remaining 20% (2) are practical sessions and therefore need to be face to face. o All Clinical skills programmes are based on national standards and competencies. o Education Review completed	Capacity of practice educators within Divisions to deliver education	Release practice educators from clinical duties to focus on education role **SLT Lead:** HR Dir **Timescales:** By end Q4 '19/20	**Level 1** • Education Review – TMB (Oct '19) **Level 2** • Q&P Dashboard- Mandatory training (monthly); • Report of Workforce Assurance Committee to Board (monthly) • Launch of Values & Behaviours • Workforce Key Performance Indicators (KPI's) (WAC, bi-monthly) **Level 3** • Staff survey (Mar '19)	None identified	Inconclusive

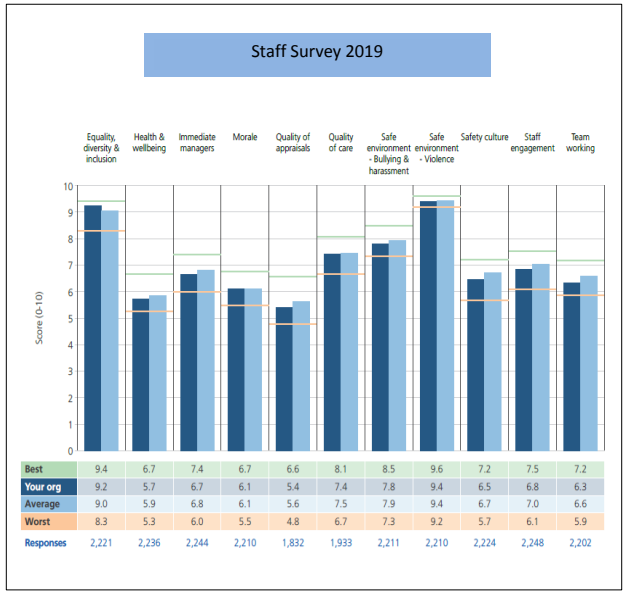
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

Key risk indicators (KRIs) Data updated 17/02/2020



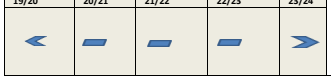


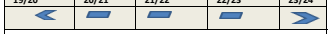
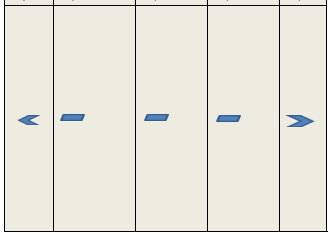




Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

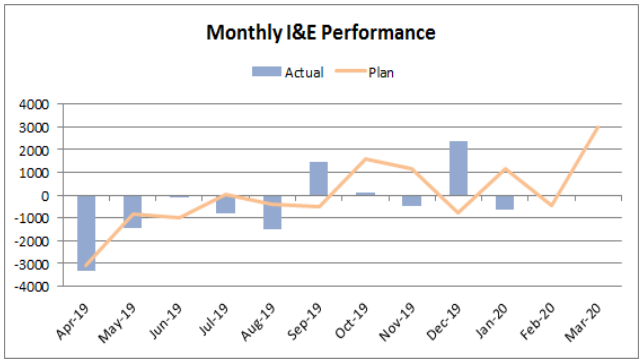
Strategic priority	PERFORMANCE: Consistently deliver financial sustainability and performance standards	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify / Transfer
Principal risk (what could prevent us achieving this strategic priority)	**PR 3: Failure to achieve and/or maintain financial sustainability** Inability to deliver the annual control total resulting in a failure to achieve and maintain financial sustainability.	**Executive lead**	Finance Dir.	**Likelihood:**	4. High	2. Unlikely	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	4. High		
		Last reviewed	23/01/2020	**Risk rating**	**20. Significant**	**8. Medium**		
		Last changed	17/02/2020	**Anticipated change**	Intensifying			
Details of change	Updated primary risk controls, gaps in assurance/plans to improve control and assurances documented							

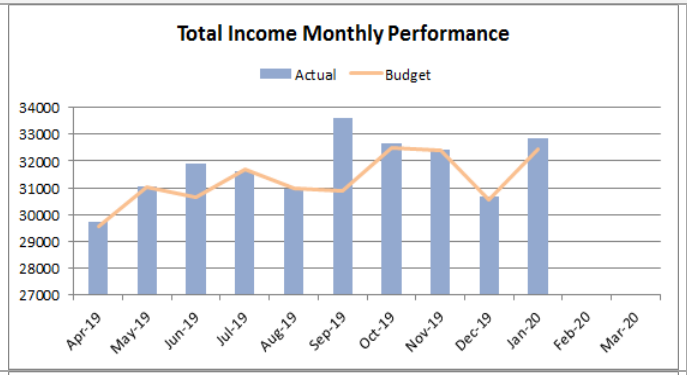
Risk Vector (what might cause this to happen)	**Primary risk controls** (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Increased cost & income volatility as a result of tariff changes; deteriorating condition of clinical estate; dependency on temporary staffing; growth in competition from the private health sector; contract penalties/ fines leading to uneconomic services **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Annual plan, including control total consideration; reduction of underlying financial deficit • Contract terms reduce risk of income volatility as a result of block payment basis for Outpatients and support to underwrite Non-elective variation • SFI's authorisation limit (scheme of delegation) • Core financial control Policies / Procedures • Access to Working Capital support • Budgetary controls/Budget at Ward & Dept level • Training for budget holders • Procurement processes and Team • Risk based annual capital planning process • Embedded service line reporting • Courses throughout the year provided for Budget holders • Introduction of extra-ordinary controls: CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay); Discretionary non-pay sign off escalation; Forecasting review based on issues and interventions • KPI meetings (all Divisions) to drive and improve standards of e-rostering • Development of Regulatory approved System Financial Recovery Plan (FRP)	• Not all budget holders have completed training • Compliance with escalation as per SFI • MTFM not yet agreed • Effectiveness of budget management @Divisional/ Corporate/ Ward/ Dept • Operational productivity impacting adversely on income and expenditure • Robust capacity plan • Job planning and e-roster • Estates Strategy in development • Unbudgeted expenditure, including that related to meet regulatory requirements arising in year without mitigating savings • Decomissioning of services provided to Clatterbridge Cancer Centre (CCC)	Develop & agree MTFM **SLT Lead:** FD **Timescales:** End of Q4 Establishment of a Joint Working Group to oversee decommissioning of services provided to CCC **SLT Lead:** DoS&P **Timescales:** May '20 Development of a Financial Recovery Plan 2019/20 **SLT Lead:** FD **Timescales:** Q4 2019/20	**Level 1** • Divisional risk reports to Risk Committee bi-annually; • E-roster data reviewed at Workforce Steering Group (quarterly) • Weekly CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay) **Level 2** • Finance report presented to Board (monthly) • Significant risk report to RMC (monthly); • Chairs report escalated to FBPAC & Board; • Q&P Dashboard (monthly) • Annual report & Accounts **Level 3** • Internal audit • External audit • Signed contract with WHCC/NHSE • System Finance Report to Board (monthly) • System Financial mitigation plan 2019/20 (submitted Dec '19) • Procurement Processes (MIAA) – Moderate Assurance • Financial Systems Key controls and Financial Reporting (MIAA) – Substantial Assurance • Risk Management Process (MIAA) - Substantial Assurance	None identified	Negative
Threat: Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• CIP planning processes and coordination of delivery • Agreed CIP plans at Divisional and Dept level • Access to Working Capital support • Programme Board • SRO's identified for CIP programme • CIP planning; scoping; approval and initiation process in place with QIA and clinical sign-off • CIP delivery oversight meeting • Healthy Wirral System 5yr Recovery & Sustainability plan developed	• Unidentified CIP in year • Slippage in agreed schemes • Effectiveness of oversight • CIP planning only relates to current financial year • Capacity and capability to drive significant efficiency schemes	• Introduction of CIP challenge and check process to monitor progress against target • Executive leads identified for 2019/20, financial mitigations and PIDs developed. • PA Consulting commissioned to support development of 2020/21 CIP programme. Resources being pulled to develop specific in-house financial turnaround capacity **SLT Lead**: FD **Timescales:** End of Q4 2019/20 Develop & agree Medium Term Finance Model (MTFM) - linked to other Trust Strategies **SLT Lead**: FD **Timescales:** End of Q4	**Level 1** ▪ Divisional reports to Programme Board ▪ CIP Scrutiny Panel (weekly) ▪ **Level 2** ▪ Finance report presented to Board (monthly) ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit/ External audit;	None identified	Negative

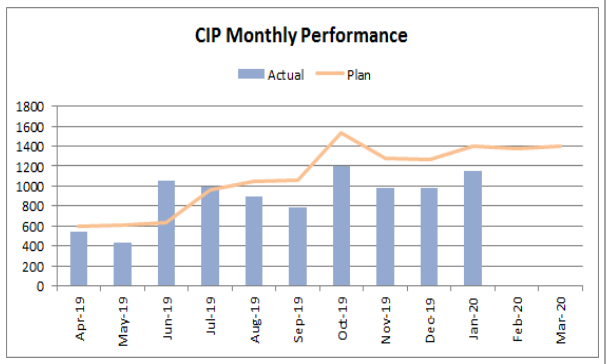
Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Treasury loan process/NHSI Capital approval process. • Planned and preventative maintenance regime in place based on compliance • Reactive maintenance regime to repair immediate issues as they arise with dedicated Budget for Backlog maintenance - circa £1.2 million • Dedicated Capital Budget for improvement works on the Physical Environment- various.	• The condition of the current estate and ageing medical devices presents a significant maintenance and affordability burden in a restrained operations environment • Restrictions on availability of central capital funding • Review and identified area of capital programme that does not impact backlog maintenance – relates to Car Park. • Lack of equipment replacement programme to inform capital programme	Draft Estate Strategy to be developed informed by 6 facet survey **SLT Lead:** COO **Timescales:** Q1 2020 – timeframe revised to align with development of Trust Strategy Medical Devices Procurement Group to review equipment replacement programme **SLT Lead:** Deputy MD **Timescales:** Q4 19/20	**Level 1** • Divisional risk reports to RMC (monthly) • Backlog report presented to RMC -March 19; • Compliance Audit undertaken (every 6mths) **Level 2** • Significant risk report to RMC (monthly) • IPC & Estates Capital Plan (Sept '19) **Level 3** • PLACE audits (annually) • 6 Facet survey – Board of Directors – Aug '19 • Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	Positive
Threat: Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24 	• Specialist H&S advisors & legal team employed • Membership of CNST scheme • H&S policies and procedures/ staff training • Investigation processes; action planning and sharing lessons learnt to reduce likelihood of recurrence • Clinical audit and effectiveness programme • Other insurance policies • Safety Management Strategy	• Maturity of the safety management system is currently at 'emerging' level • Limited monitoring of compliance with H&S requirements • Restricted adaptive capacity • Delayed responses to non-clinical incidents	Re-establishment of H&S Management Committee to oversee compliance with H&S legislation. **SLT Lead:** DoQ&G **Timescales:** Q4 '19/20	**Level 1** ▪ Divisional H&S reports to SMAC (monthly) ▪ H&S Committee report - SMAC (monthly) **Level 2** ▪ H&S report to RMC (6 monthly) ▪ H&S Update and Dashboard (SMAC – monthly) ▪ SIRG receives all claims/ RIDDOR incidents ▪ IR(ME)R Compliance Audit (SMAC Nov '19) **Level 3** ▪ Authorised engineers reports; UKAS ▪ NHSR claims profile; MHRA inspection reports; HSE inspection/ Environmental Health inspections; CQC inspection reports ▪ Independent safety management audit (Arcadis) ▪ Claims Management, MIAA – Substantial Assurance		Inconclusive

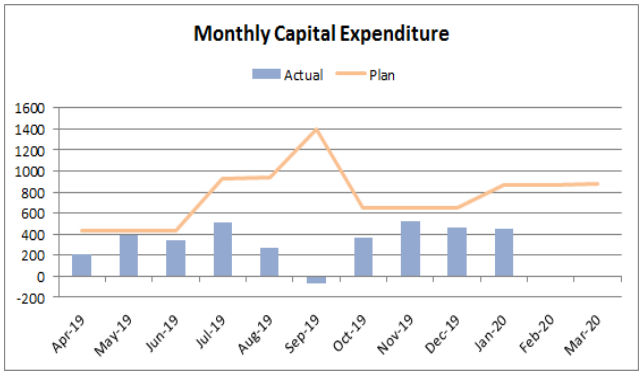
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

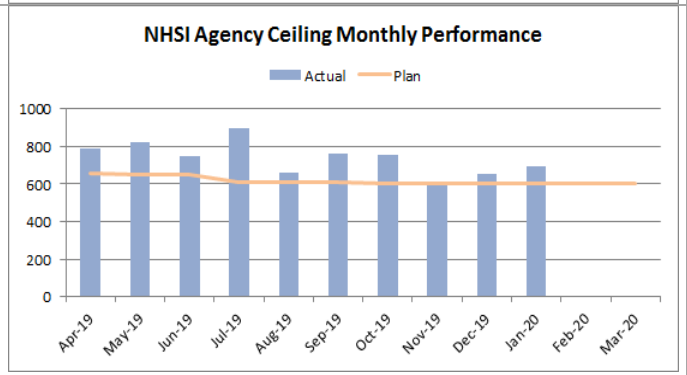
Key risk indicators (KRIs) Data updated 17/02/2020











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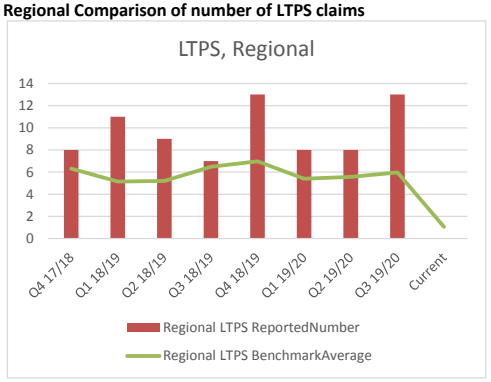
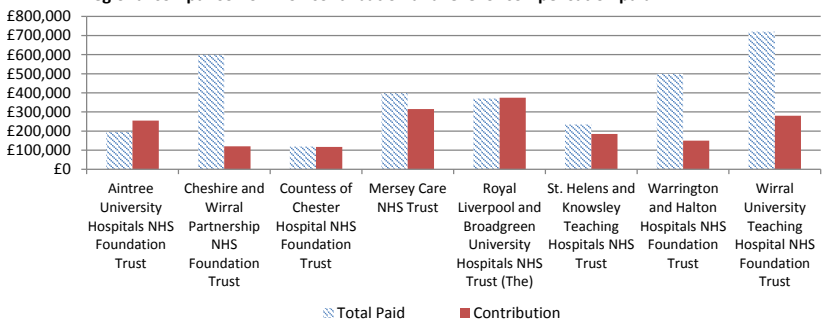
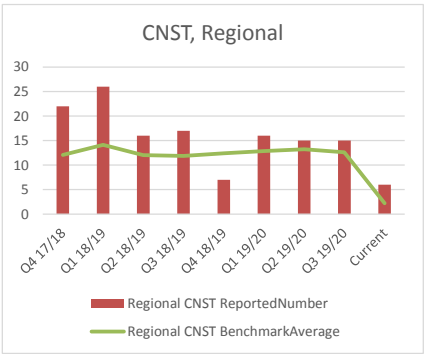
Regional Comparison of number of LTPS claims



Regional comparison of RPST contribution and level of compensation paid



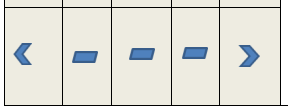
Regional Comparison of number of CNST claims



Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

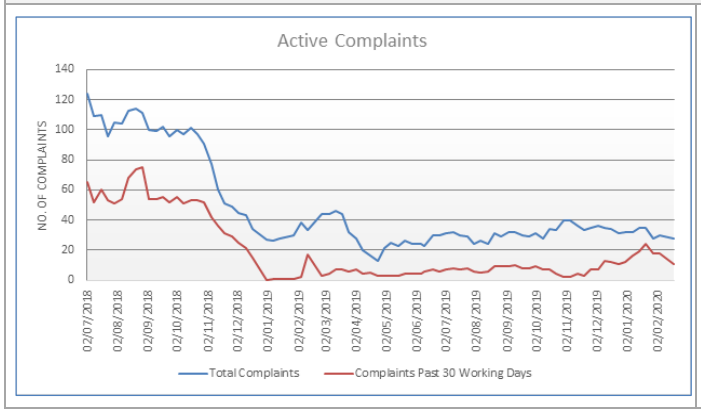
Strategic priority	PATIENTS: Pursuing quality improvement	**Lead Committee**	Quality	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 4: Catastrophic failure in Standards of Care** A Catastrophic failure in standards of safety and quality of patient care across the Trust resulting in multiple incidents of severe, avoidable harm and poor clinical outcome	**Executive lead**	Medical Director / Chief Nurse	**Likelihood:**	3. Possible	3. Possible	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	3.Moderate		
		Last reviewed	23/01/2020	**Risk rating**	**15. Significant**	**9. Medium**		
		Last changed	17/02/2020	**Anticipated change**	Uncertain			
Details of change	Updated risk rating, gaps in control, plans to improve control and assurances documented							

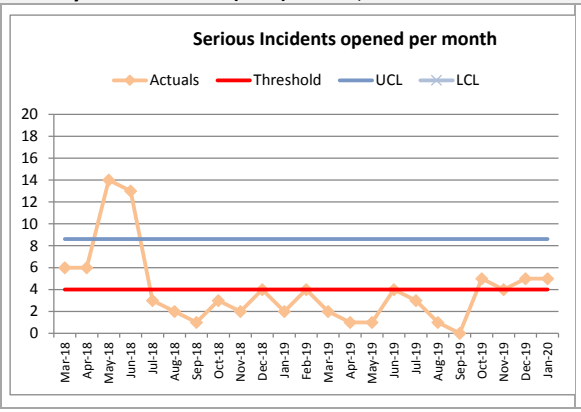
Risk Vector (what might cause this to happen)	**Primary risk treatment** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease (such as pandemic influenza; norovirus; infections resistant to antibiotics) that forces closure to one or more areas of the hospital and/or causes avoidable serious harm or death to service users **NOTE: See also PR1** **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Chief Nurse identified as DIPC • IPC service provided Trust wide by the IPC Team incl. seven day out of hour's on-call service; IPC Programme of work • Infection Prevention & Control policies/ procedures • Staff training • Antibiotic stewardship • Environmental cleaning Procedures / Standards in all areas • Decontamination standards – CSSD; Flu vaccination prog • Strict adherence to single use items • Bed occupancy managed by leads that attempts to minimise risk of cross contamination • Mattress decontamination / disposal & replacement • Robust Infection Prevention Control plan in response to *Clostridium difficile* outbreak, seasonal infections such as flu / Noro Virus • Ward Managers prioritising areas for maintenance works to inform overall Estates Strategy • IPC Action Plan reflects changes in cleaning practice	• The management of Gram-Negative bacteraemia • Level of clinical engagement in IPC • Microbiology capacity for IPC • Bed occupancy levels • Consultant scrutiny of death certification for matters concerning healthcare associated infection	• Isolating or cohorting infectious patients • Enlisting public support to restrict visiting • Daily briefing re: performance against each infection • Estate refurbishment plans as agreed by the Board of Directors • CDI action plan • Gram-Negative improvement plan involving wider health system in Cheshire & Merseyside • Contingency plans for Influenza and winter viruses (tested in December '19)	**Level 1** • Perfect ward/ ward accreditation audits; Divisional reports to IPORT • IPC task & finish group (weekly) to review actions • IPC Standing item on Board agenda (monthly) **Level 2** • IPC Performance Report to Board; IPC-Improvement Plan – PSQB/Quality; Quality • CDI Action Plan (Quality) • Performance Dashboard; Weekly escalation report IPC specific; IPCG/ PSQB oversight • Outbreak meetings stood down with effect from Nov '19 (November Board) • Annual Flu Plan – progress report to WAC and Board • **Level 3** • IPC Improvement plan; MIAA Internal audit reports; PHE reports • Invited Richard Cooke, microbiologist – Alder Hey to review plan • IPC Review MIAA – Limited Assurance • Report IPC data to CCG (CQPD)		Positive
A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including o Monthly Patient Safety & Quality Board (PSQB) with work programme aligned to CQC registration regs o Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems o Clinical audit programme & monitoring arrangements o Clinical staff recruitment, induction, mandatory training, registration & re-validation o Defined safe medical & nurse staffing levels for all wards & departments o Ward assurance/ metrics & accreditation programme o CAS Implementation process o Mortality review policy & process o Real time review of incident reports and complaints handling	• Current levels of mortality review and structured judgement review where these are indicated • Exposure to serious incidents (above trajectory in 2 out of the last 3 months, as at Dec '19)	Appointment of Medical Examiners **SLT Lead:** Deputy MD **Timescales:** April 2020 Actions to address serious incidents exposure are outlined on a case by case basis, and where appropriate are linked to the CDI action plan.	**Level 1** • Perfect ward/ ward accreditation audits (ongoing) • FTT and electronic patient/relative feedback kiosks • Primary Mortality Reviews + structured judgement reviews. Quarterly/Annual Report to Board. • VTE Committee review with clinical lead • All Complaints – Executive sign off **Level 2** • Quality Performance Dashboard (monthly); • PSQB reports (monthly) • Quality Account (annual); • KLOE inspections local inspections; • Serious Incident Review Group (weekly) • Safety Summits (monthly) **Level 3** • CCG oversight of SI's (monthly) • CQC Insight tool(monthly); • Dr Foster updates;	None identified	Positive

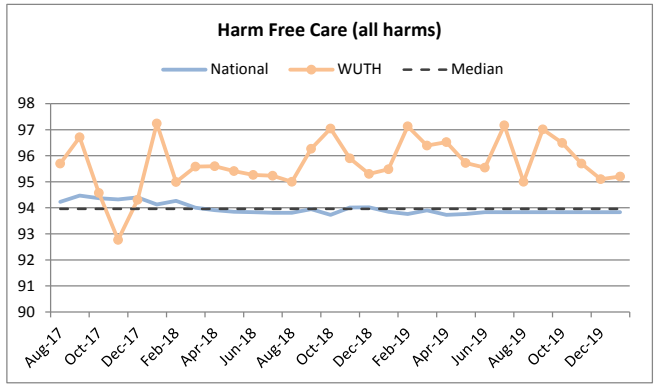
					○ Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission • Triangulation of mortality reviews – patient/carer experience, deaths in ED included			• MIAA SI- significant assurance • MIAA audit re safe staffing: Significant assurance • Patient/ Staff surveys • SHIMI / HSMR data • MIAA Management of Complaints - Moderate Assurance • Report IPC data to CCG (CQPD)		
Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **NOTE: See also PR1** **Proximity of threat** 19/20 20/21 21/22 22/23 23/24 					**Key Measures** - We have the ability to measure metrics shown in the rest of the BAF eg VTE and MUST **Training –** end users are not provided access unless they are trained **Continuous improvement of the EPR** Response to divisions about usability and function	**Extended measures** There are other areas to monitor e.g fluid balance or IVs **Training –** adoption of a new way of training described in paper to WAC which includes regular updates **Innovation –** The way innovations are introduced into the Trusts needs more of a framework to manage priorities, costs and sustainability Unresolved imaging issues following 2018 Cerner update	**Cerner Optimisation –** address specific areas for improved usage (ongoing programme to be reviewed by Digital Board) **SLT Lead:** Dir IT & Info **Timescales:** initial scope by end Q4 19/20 **New Training -** adoption of a new way of training to be resourced and delivered, paper to TMB **SLT Lead:** Dir IT & Info **Timescales:** Dec '19 for case approval, end March '20 for delivery **End user Survey** and benchmark report on end user experience **SLT Lead:** Dir IT & Info Note: delay due to upgrade concerns **Timescales:** Dec '19 Technical solutions being trialled, including the link to the alternative modality purchased (Carestream) - Jan '20 testing in Radiology **SLT Lead:** Dir IT & Info **Timescales:** end of Q4 19/20	**Level 1** • Digital Maturity assessments done as self-assessments with peer review • Competency based assessment of training / knowledge/skills • Perfect Ward assessments of compliance • Optimisation programme to be delivered by IT team • Digital Programme Oversight Committee (DiPSOC) **Level 2** MIAA Audits on use of the system and accuracy of data **Level 3** • GDE audits for milestone payments • HIMSS assessment • MIAA Activity Data Capture (Limited assurance) • Population & Health Management	Currently no mechanism to determine success of training **Action:** **Measure objective** feedback e.g. immediately after training and again later **Introduce tests of knowledge** to see how many people know what they should. Competencies agreed now need to be applied as part of new training regime. **SLT Lead:** Dir IT & Info **Timescales:** Dec '19	Inconclusive

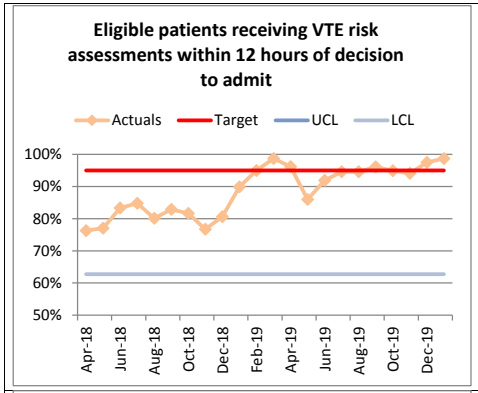
Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

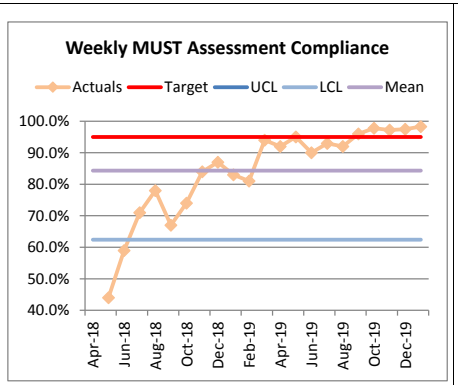
Key risk indicators (KRIs) - Data updated 17/02/2020

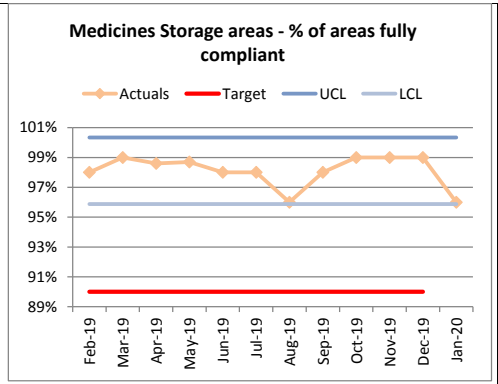


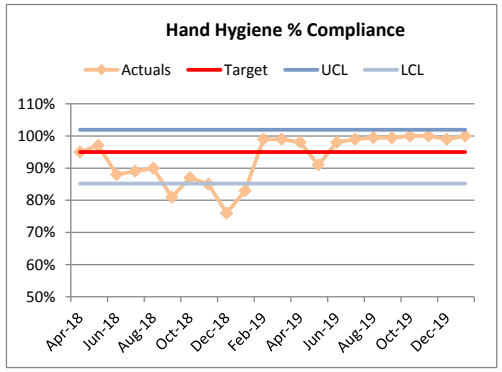


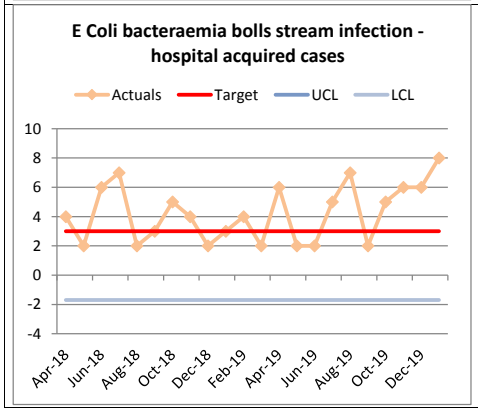


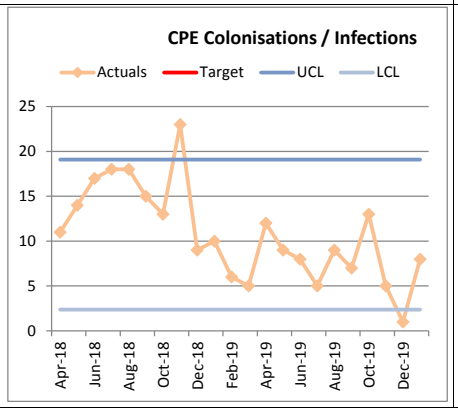


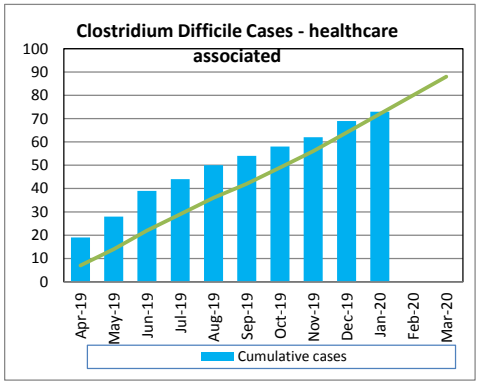


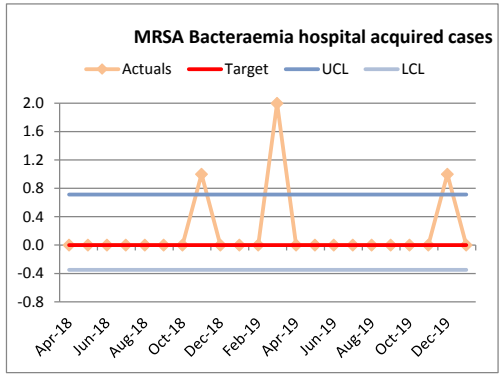












Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

Strategic priority	ALL STRATEGIC OBJECTIVES	**Lead Committee**	FBPAC	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Modify
Principal risk (what could prevent us achieving this strategic priority)	**PR 5: Major disruptive incident (leading to rapid operational instability)** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community	**Executive lead**	COO	**Likelihood:**	3. Possible	1. V. Unlikely	**Risk appetite**	Minimal
		Initial date of assessment	01/04/2019	**Consequence**	5.V. High	5. V. High		
		Last reviewed	23/01/2020	**Risk rating**	**15. Significant**	**5. Med**		
		Last changed	17/02/2020	**Anticipated change**	Intensifying			
Details of change	Updated plans to improve control							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: A large-scale **cyber-attack** that shuts down the IT network and severely limits the availability of essential information for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Data Security Assurance Framework (IGAF) • Fire wall controls • Access controls • VPN access • Anti virus and updates • Mandatory Data Security Training • Business Continuity plans & BIA – Divisional & IT specific • Pilot site unified cyber risk framework	Lack of co-ordination of incident response across region	Implement funded program to co-ordinate cyber security across the Mersey in liaison with NHS(E) **Note:** central funding released October 2019, implementation reviewed by Lancashire/Midlands CSU **SLT Lead:** Dir IT & info **Timescales:** Plan by end of Q4, implementation by end of 2020 Cyber Security briefing for Board of Directors **SLT Lead:** Dir IT & info **Timescales:** By end Q4 '20	**Level 1** • IG & Clinical Coding Group • Cyber Security Progress Report to FBPAC (Sept '19) **Level 2** • Data Security and protection toolkit submission to Board; **Level 3** • Business Continuity Confirm and Challenge NHSE • LHRP Assurance Process • Cyber Essential Scheme Test Specification • National Cyber Essential Certification (Board of Directors – Sept '19)	None	Positive
Threat: A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels • Operational strategies & plans for specific types of major incident (e.g. fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) • Strategic, Tactical, Operational command structure for major incidents • Business Continuity, Emergency Planning & security policies • Power failure action cards • Business Impact assessments • Major incident plan and action cards • 6 Facet survey commissioned. Interim report – August '19 Board.	Deterioration of plant equipment & Fabric of building due to age of estate and availability of funding & extent of work required.	Development of Estates Strategy following receipt of 6 facet survey **SLT Lead:** COO **Timescales:** Q1 2020 – timeframe revised to align with development of Trust Strategy	**Level 1** • EPRR Twice yearly report to RMC **Level 2** • Monthly Significant Risk Report to Risk Committee • EPRR annual report (Sept) • Communication testing (every 6 months) **Level 3** • EPRR Core standards compliance rating (+ve); • Facet survey (May '19) • MIAA Internal audit report – Emergency planning (May 19) • April 2019 notification of NHSE review of EPRR core standards – Rating of "Substantial" assurance received for 2018/19	None	Positive
Threat: A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period **Proximity of threat** 18/19 | 19/20 | 20/21 | 21/22 | 22/23	• CAS alert system – Disruption in supply alerts • Procurement • Account Management • Supplier Assurance • Contingencies – Stock control • 'No deal' EU Exit Planning Team established • SRO & EU Exit lead identified for Exit preparation • Risk assessment and business continuity planning	EU Exit Operational Readiness Guidance identifies a number of actions Trusts must take in preparation for Brexit	EU Exit planning team to review Operational guidance and ensure all actions completed within timescales **SLT Lead:** COO **Timescales:** As determined by Parliament (Review end Q1 '19) **Note:** Prof Keith Willet EU Exit Strategic Commander – instructed Trusts to 'stand down' all EU Exit Planning	**Level 2** • EU Exit paper to TMB (Feb 19) • EU Exit update – standing item TMB • EU Report to Risk Management Committee (Sept '19) • EU Exit preparation update to Board (Mar 19) • EPRR Twice yearly report to RMC (Mar; Sept) • EPRR Annual Report (Sept '19) • EPRR Compliance Statement (Sept '19) **Level 3** ▪ Letter of assurance, DoH		Positive

Key risk indicators (KRIs) Data updated 17/02/2020

EPRR
Confirm and Challenge by NHS England Regional team and CCGs
September 2019:

Full Compliance
Substantial Compliance
Partial Compliance
Not Compliant

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

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

NHS Digital — Estates Returns Information Collection, England - 2018/19
Publication date October 2019

RIDDOR incidents	10
Estates and facilities related incidents	31
Clinical service incidents caused by estates and infrastructure failure	5
Overheating occurrences triggering a risk assessment (No.)	26
Fires recorded	2
False alarms – No call out	32
False alarms – Call out	29

Cyber Security measures

Patching overview	Quantity	Compliance levels (Target 100%)
Desktop patching	4437	80%
Server Patching	229	*26%
Anti Virus		Compliance levels (Target 95%)
Desktop	4437	98%
Server	274	95%

Inactive directory device accounts	July'19	Oct'19	Jan'20
60 days (Notice issues)	345	17	489
90+ days to be disabled	276	100	350
Web filtering			
Access requests authorised	18	32	14
Removable media			0
Additions to the whitelist	0	4	

NHS Information Governance Toolkit — DH Department of Health

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

Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

Strategic priority	PARTNERSHIPS: Improve services through closer integration	**Lead Committee**	Board	**Current risk exposure**		**Tolerable risk**	**Risk Treatment Strategy:**	Seek, Modify, Accept
Principal risk (what could prevent us achieving this strategic priority)	**PR 6: Fundamental loss of stakeholder confidence** Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public	**Executive lead**	CEO	**Likelihood:**	2. Unlikely	1. V. Unlikely	**Risk appetite**	Open
		Initial date of assessment	01/04/2019	**Consequence**	5. V. High	5. V. High		
		Last reviewed	23/01/2020	**Risk rating**	**10. High**	**5. Medium**		
		Last changed	17/02/2020	**Anticipated change**	Uncertain			
Details of change	Updated risk rating, primary risk controls, gaps in control, plans to improve control and assurances documented							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
Threat: Changing regulatory demands (including potential impact of Brexit) or reduced effectiveness of internal controls resulting in failure to make sufficient progress on agreed quality improvement actions; Or widespread instances of non-compliance with regulations and standards **Proximity of threat** 19/20 | 20/21 | 21/22 | 22/23 | 23/24	• Quality & corporate governance & internal control arrangements • Conflicts of interest & whistleblowing management arrangements • Routine oversight of quality governance arrangements & maintenance of positive relationships with regulators • Formal notification process of significant changes (Relationship manager, CQC; Chief Inspector of Hospitals) • Internal KLOE inspections in clinical areas • Exec visibility & visits • Clinical & management audit • Policies and procedures • External oversight from regulators via System Improvement Board • Delivery of all elements of 2018 CQC inspection 'must do and should do's' • Governance & Assurance processes	Compliance:- • Financial sustainability ***(refer to PR3 for action, control and assurances)*** • 2018 CQC rating of 'Requires Improvement' (inc Use of Resources • Patient Flow Management ***(refer to PR1 for action, control and assurances)***	Deliver all elements of 2019 CQC inspection 'must do and should do's' **SLT Lead:** DoQ&G **Timescales:** Dec 2019 Development of System Financial Sustainability Work Programme, aligned to Health Wirral Programme **NOTE:** see PR3 - Development of Regulatory approved System Financial Recovery Plan (FRP) Development of Trust Strategy within Strategic Framework **SLT Lead:** DoS&P **Timescales:** Q4 19/20	**Level 1** • Ward accreditation metrics • Managing Conflicts of Interest – New Policy • Freedom to Speak Up – WAC (bi-monthly) • Freedom to Speak UP – Board (bi-annually) **Level 2** • CQC Action Plan Progress Report (actions identified in action plan 2018 completed) • PSQB Report to Quality Committee • Quality Performance Dashboard **Level 3** • CQC Inspection report 2018 (inc use of Resources) – Requires Improvement • System Improvement Board (NHSI/E) – (bi-monthly) • 6 Facet Survey (Aug 2019) • System Finance Report to Board (monthly) • Board to Board – CCG (bi-annually) • Healthy Wirral Programme Board • Unplanned Care Board (monthly)	None identified	Positive
Threat: Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust	• Communications department to handle media relations • Established relationships with regulators • Trust website & social media presence • Internal communications channels • Continued public & stakeholder engagement utilising a wide range of consultation & communication channels; • Involvement & Engagement Strategy Trust Board • Surveys and Friends and Family Testing • Consultation on proposed strategy and service changes • Development and implementation of Patient Experience Strategy • Communication Strategy (approved November 2019)	Established processes to improve engagement with stakeholders Lack of delivery of Healthy Wirral Plans	Comms / PR Strategy Implementation Plan **SLT Lead:** HR Dir **Timescales:** Q4 2020 Introduction of Patient Experience Strategy Implementation Plan **SLT Lead:** CN **Timescales:** Q4 2020 • Quarterly meeting with Wirral Globe • Introduction of 'Ask Janelle' column in the Wirral Globe – starting February 2020 • Recruitment of Director of Communications – February '20 • Launch of 'Leader In Touch Forum' – February '20 • Governance Framework • Healthy Wirral Plan (5 year Strategy) • Appointment of Independent SRO and Chair to oversee delivery **SLT Lead:** DoS&P **Timescales:** 2025	**Level 1** • Media Analysis (WAC, bi-monthly) • Top Leaders Programme – Media Training • Patient Stories – Board (monthly) • Review of complaints – PSQB (monthly) • Messages from the Board – (monthly) • Patient Experience Implementation Plan – PFEG reporting to PSQB (monthly) • Staff stories – Workforce Assurance Committee (bi-monthly) • National Medical Engagement Survey - Board **Level 2** • Communication / Press statements • Patient Experience Strategy (Oct '19) • Operational Plan (Annual) – submitted to regulators **Level 3** • CQC National patient survey; • FFT recommendation ratings • Healthwatch commentary • OSC commentary • NHS Choices ratings • National In-patient Survey – Board (Nov '19)	None identified	Positive

Proximity of threat								
19/20	20/21			23/24				
←	–	–	–	→	Conflicting priorities, financial pressures and/or ineffective governance resulting in a breakdown of relationships amongst STP partners and an inability to influence further integration of services across acute, primary & social care providers	• Representation on STP Committees • Leadership of STP Planned Delivery • Engagement with STP Partners and Commissioners **SLT Lead:** DoS&P **Timescales:** 2025			

Board Assurance Framework (BAF): 2019/20 (valid as of 17th February 2020)

Key risk indicators (KRIs) Data updated 17/02/2020

Wirral University Teaching Hospital NHS Foundation Trust

CQC overall rating

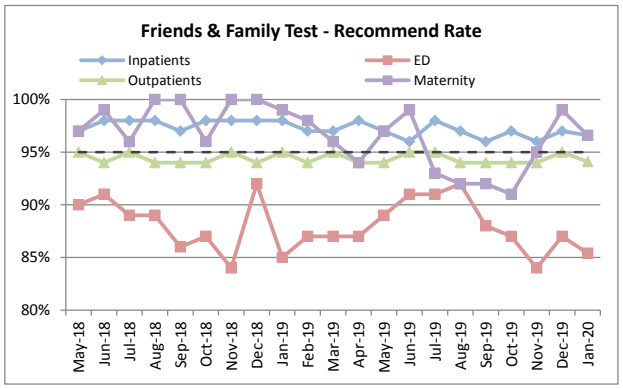
Requires improvement

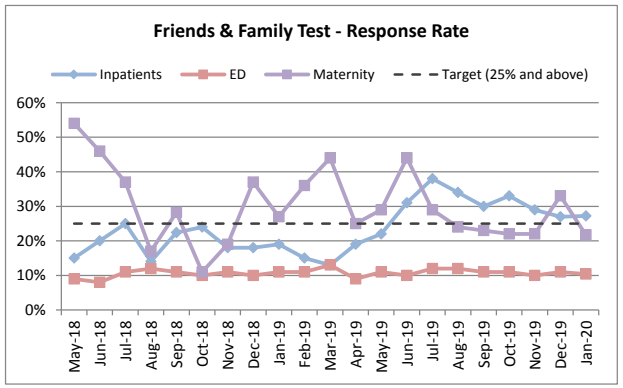
13 July 2018

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

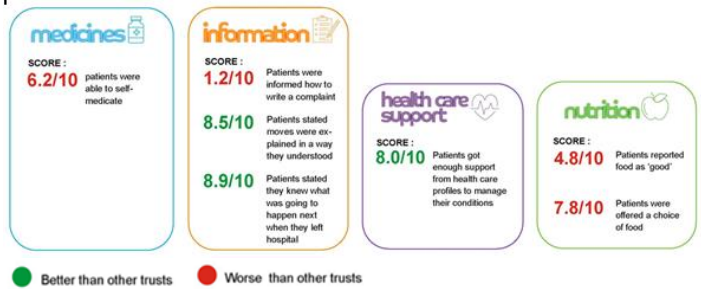
NHS Choices – 17/02/20

	NHS.UK users rating	Care Quality Commission inspection ratings	Recommended by staff	Mortality rate (in hospital and up to 30 days after discharge)	Food: Choice and Quality
Arrowe Park Hospital	197 ratings Rate it yourself	Requires Improvement Visit CQC profile	OK Within expected range with a value of 69%	OK Number of deaths within the expected range	OK 79.69% Within the middle range
Clatterbridge Hospital	44 ratings Rate it yourself	Requires Improvement Visit CQC profile	OK Within expected range with a value of 69%	OK Number of deaths within the expected range	OK 66.11% Within the middle range





National Inpatient Survey Report 2018



Comms & Engagement KPI
To be developed

CQC Maternity Services patient survey – Published Feb 2020

Patient survey	Patient response	Compared with other trusts
Labour and birth	9.1/10	About the same
Staff during labour and birth	8.7/10	About the same
Care in hospital after the birth	8.4/10	About the same