Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

5 August 2020

together we will

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
12.30pm - Wednesday 5th August 2020
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21 078	Apologies for Absence	Chair	Verbal	N/A
20/21 079	Declaration of Interests	Chair	Verbal	N/A
20/21 080	Chair's Business	Chair	Verbal	N/A
20/21 081	Key Strategic Issues	Chair	Verbal	N/A
20/21 082	Minutes of Previous Meeting – 1 July 2020	Board Secretary	Paper	4
20/21 083	Board Action Log	Board Secretary	Paper	14
20/21 084	Chief Executive's Report	Chief Executive	Paper	15
20/21 085	Patient Story	Chief Nurse	Video	N/A
20/21 086	Maternity Service Presentation	Director of Nursing & Midwifery – Women's and Children's Division	Presentation	N/A
Performance & Improvement				
20/21 087	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Deputy Medical Director, Interim Director of Workforce and Chief Nurse	Paper	19
20/21 088	Pandemic Impact on Performance Trajectories	Chief Operating Officer	Paper	38
20/21 089	Cancer Pathways – Cheshire & Merseyside	Chief Operating Officer	Paper	44
20/21 090	Month 3 Finance Report 2020/21	Chief Finance Officer	Paper	48
20/21 091	Sickness Absence Report	Chief Executive	Paper	71
20/21 092	COVID-19 Recovery & Reset Update	Director of Strategy & Partnership	Presentation	N/A
20/21 093	2021-2026 Our Strategy...*Improving the health of the communities we serve*	Director of Strategy & Partnership	Presentation	N/A
Governance				
20/21 094	Review of Undertakings Report	Interim Director of Corporate Affairs	Paper	76
20/21 095	Acuity and Dependency Review January / February 2019/2020	Chief Nurse	Paper	85

20/21 096	Health & Safety Quarterly Update	Chief Nurse	Paper	93
20/21 097	Learning from Deaths: Annual Summary Report	Deputy Medical Director	Paper	100
20/21 098	Legionella Sampling	Chief Operating Officer	Paper	112
20/21 099	Change Programme Summary, Delivery & Assurance	External Programme Assurance	Paper	115
20/21 100	Report of Safety Management Assurance Committee	Chair of Safety Management Assurance Committee	Paper	140
20/21 101	Report of Workforce Assurance Committee	Chair of Workforce Assurance Committee	Paper	142
20/21 102	Report of Quality Committee	Chair of Quality Committee	Paper	145
20/21 103	Report of Trust Management Board	Chief Executive	Paper	147
20/21 104	Communications and Engagement Monthly Report	Director of Communications & Engagement	Paper	150
Standing Items				
20/21 105	Any Other Business	Chair	Verbal	N/A
20/21 106	Date of Next Meeting – 2 September 2020	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

1 JULY 2020

VIRTUAL MEETING VIA MICROSOFT TEAMS

Present

Sir David Henshaw	Chair
Steve Igoe	Non-Executive Director
John Sullivan	Non-Executive Director
Chris Clarkson	Non-Executive Director
Sue Lorimer	Non-Executive Director
John Coakley	Non-Executive Director
Janelle Holmes	Chief Executive
Claire Wilson	Chief Finance Officer
Dr Nicola Stevenson	Medical Director
Matthew Swanborough	Director of Strategy and Partnerships
Hazel Richards	Chief Nurse
Anthony Middleton	Chief Operating Officer

In attendance

Paul Buckingham	Interim Director of Corporate Affairs
Sally Sykes	Director of Communications & Engagement
Colm Byrne	HR Consultant
Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Joe Gibson	External Programme Assurance*
Alistair Leinster	Divisional Director*
Angela Tindall	Public Governor

Apologies

Mrs Jayne Coulson	Non-Executive Director

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 20-21/057	**Apologies for Absence** Noted as above.	
BM 20-21/058	**Declarations of Interest** There were no Declarations of Interest.	
BM 20-21/059	**Chair's Business** The Chair opened the meeting and advised of a change to the order of the agenda with the Change Programme report being brought forward to the beginning of the agenda.	
BM 20-21/060	**Key Strategic Issues** There were no key strategic issues to report. ***The Board noted that there were no items to report in addition to the subjects included on the agenda.***	

Reference	Minute	Action
BM 20-21/061	**Minutes of Previous Meeting** The Minutes of the meeting held on 3 June 2020 were reviewed by the Board. In response to a question from Mrs S Lorimer, regarding minute ref 20-21/039, the Chief Executive clarified that, while there had been an earlier peak in COVID numbers, Wirral was not an outlier in terms of overall COVID numbers. Subject to this amendment, the Board approved the minutes as a true and accurate record.	
BM 20-21/062	**Action Log** The Board reviewed the Action Log and noted that there were no outstanding actions that exceeded the scheduled completion date.	
BM 20-21/063	**Chief Executive's Report** The Chief Executive presented a report which included the following subject areas: • CQC Action Plan • COVID-19 Outbreaks and Recovery • Hospital Upgrade Programme (Urgent Care) • Trust Strategy 2021-2026 • Senior Manager Appointments • Network Issues • Serious Incidents and RIDDOR updates • BAME Staff Members • Role of Boards during the Pandemic Emergency • NHS Providers – Annual Conference & Exhibition 2020 • Clatterbridge Cancer Centre. She briefed the Board on the content of the report and advised that an action plan in response to the 'Should Do' recommendations in the CQC Inspection Report had been submitted to the CQC on 30 June 2020. She noted that progress against the action plan would be assessed through 'confirm and challenge' meetings with Divisions with outcomes reported via Quality Committee to the Board. In response to a question from Mrs S Lorimer, the Chief Executive explained the content of a table included in the COVID-19 Outbreaks and Recovery section of the report and advised that figures in the right hand column demonstrated significant improvement over the five-week period. In response to a follow up question from Mr C Clarkson, the Chief Executive advised that details of readmissions were included in the daily situation report. The Chief Executive briefed the Board on recent senior manager appointments and noted that Mrs H Marks had completed her engagement with the Trust on 30 June 2020. She provided an overview of the recruitment process for a replacement Director of Workforce and advised that interviews for shortlisted candidates were scheduled to be held on 15 July 2020. She then referred the Board to page 4 of the report and noted internet performance problems experienced by the Trust during the period 5-14 June 2020. She advised that a temporary solution was in place but noted ongoing	

Reference	Minute	Action
	work to review options for a more resilient solution. The Chief Executive concluded her report by briefing the Board on the Trust's response to correspondence received from the National Guardian's Office and NHS England / Improvement during June 2020 regarding Black and Minority Ethnic (BAME) staff in the context of COVID-19. She noted the support being provided to relevant staff and advised that the Trust was working to ensure that all BAME staff complete a COVID-19 risk assessment by mid-July 2020. In response to a question from Mr J Sullivan, who queried the voluntary nature of staff risk assessments, the Chief Executive advised that the approach to risk assessments was a national NHS position, rather than a local decision, but noted that the Trust would encourage all staff to complete the risk assessment. She also noted that progress with staff risk assessments would be incorporated in the daily situation report. In response to a question from Mr S Igoe, regarding appointment of an Interim Chief Information Officer, the Chief Finance Officer advised that Mr P Young, who had recently completed a review of contract arrangements with Cerner, would be supporting Mr C Mason in progressing ongoing contractual negotiations. The Chair advised that a recent briefing he had received from Mr Young had enhanced confidence that meaningful progress with negotiations would be made. ***The Board of Directors:*** • ***Received and noted the Chief Executive's Report.***	
BM 20-21/064	**Change Programme – Summary, Delivery & Assurance** Mr J Gibson presented a report which detailed the current status of the Change Programme. He briefed the Board on the content of the report and provided an overview of the scope of the Programme, as considered at a Programme Board meeting held on 17 June 2020, and noted links to programmes governed by the Healthy Wirral initiative as set out in the graphic on page 87 of the meeting pack. Mr J Gibson then referred the Board to page 88 and page 89 of the meeting pack and provided an overview of both the governance and delivery ratings for the programme. He noted the impact on ratings of suspension of the programme in response to the COVID-19 pandemic which necessitated a focus on recovery. He advised that good progress was being made following resumption of the Programme and noted that, in relation to the Outpatients programme, issues relating to the separation of responsibilities between the programme and operational managers had now been resolved. Mr J Gibson then introduced Mr A Leinster who delivered a presentation to update the Board on progress with the Outpatients Improvement Programme which covered the following: • What has been achieved? • How it feels for Patients and Clinicians • Challenges going Forward	

Reference	Minute	Action
	Mr A Leinster noted in particular the production of guidance for clinicians for running effective telephone clinics and provided an overview of arrangements for video and telephone attendances. He noted that positive feedback had been received from both patients and clinicians on the revised arrangements. The Chair thanked Mr J Gibson and Mr A Leinster for their reports and noted that it was good to see progress being made on resumption of the Programme. ***The Board of Directors:*** • ***Received and noted the Change Programme – Summary, Delivery & Assurance report.*** *Mr J Gibson and Mr A Leinster left the meeting.*	
BM 20-21/065	**Quality & Performance Dashboard and Exception Reports** The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard for their respective areas. The Chief Operating Officer provided an overview of performance against the A&E 4-hour standard and noted that, while Type 1 attendance numbers had almost returned to normal, attendance at the Walk-In Centre was significantly reduced at circa 20% of pre-COVID levels. The Chief Operating Officer then briefed the Board on performance against Referral to Treatment (RTT) and Cancer standards and, with regard to the latter, noted the categorisation of patients for prioritisation purposes in accordance with nationally defined categories. With regard to the Cancer 2-week wait standard, he noted that, while performance levels had recovered in May and June 2020, the significant downturn in performance during April 2020 meant that the standard for Quarter 1 had not been achieved. In response to a question from Mr J Sullivan, regarding future elective capacity, the Chief Operating Officer provided an overview of regionally coordinated modelling and advised that the Trust's modelling, informed by outcomes of risk assessments, suggested capacity of circa 50%. He noted the benefit from the Trust's Clatterbridge site. In response to a follow up question, the Chief Operating Officer advised that the Spire facility would have limited beneficial impact on capacity and noted limitations such as overnight cover on the Murrayfield site. In response to a question from the Chair, regarding potential use of Nightingale facilities for cancer patients, the Chief Executive advised that Sir S Stephens had iterated support for use of the Nightingale facility in London for cancer diagnostics. She noted that work was currently ongoing to identify potential sites for use in Cheshire and Merseyside. Dr J Coakley, commented on the reduction in 2-week wait referrals and noted his concerns that the reduction was associated with patient concerns in relation to the COVID-19 situation. The Medical Director and the Chief Nurse then briefed the Board on performance in their respective areas and the Chief Nurse advised the Board of an incidence of MRSA in May 2020. She noted mitigating actions being taken which included the retraining of Critical Care staff in aseptic techniques. The Chief Nurse referred the Board to the metrics for Safeguarding training and advised that training had now recommenced. She noted limitations on numbers for Level 3 training, which necessitated face to	

Reference	Minute	Action
	face delivery and forecast that Level 1 and Level 2 compliance would be achieved by the end of Quarter 2 with Level 3 compliance being achieved by the end of Quarter 3. The Medical Director advised that reduced activity had resulted in a positive increase in research and provided an overview of current research activities. Mr C Byrne briefed the Board on performance against the Workforce indicators and noted in particular the level of sickness absence. He advised that a small proportion of absences resulted from track and trace activities and provided a breakdown of COVID-related and non-COVID related absence levels. He then noted that the Workforce Assurance Committee planned to undertake a 'deep dive' on absence rates in the Hotel Services and Estates departments. In response to questions from the Chair, Mr C Byrne advised that pre-COVID work on a pilot programme run by First Care had not been as successful as hoped and noted resistance from staff side colleagues and an inability to link to the Electronic Staff Record (ESR) as limiting factors. He noted that a report on outcomes from the pilot was scheduled for review by the Finance, Business & Performance Assurance Committee in August 2020. The Chief Operating Officer provided an overview of relevant management and supervisory arrangements and noted ongoing work to address gaps in facilities management to ensure an effective management grip. The Chair noted the impact of Hotel Services and Estates-related absences on the Trust's overall absence levels and requested that the Board be presented with an assurance report on this subject at the next meeting. The Chief Executive agreed that a report should be provided and commented on the need for a range of options, including outsourcing, to be examined. The Chief Nurse referred the Board to the metrics for staff turnover and noted a current vacancy level of circa 17% for Band 5 nurses. She advised of her work with the Chief Finance Officer to prepare proposals to address this situation which would be reviewed by the Executive Team prior to consideration by the Finance, Business & Performance Assurance Committee. Mr S Igoe commented on national plans to increase the nursing workforce which he noted would take 3-5 years to produce results. On a positive note, he advised that apprentice schemes would be outside the student number cap. ***The Board of Directors:*** • ***Received and noted the Quality & Performance Dashboard, together with associated Exception Reports, for the period to 31 May 2020.***	**AM**
BM 20-21/066	**Month 2 Finance Report** The Chief Finance Officer presented a report which detailed the Trust's financial position as at 31 May 2020. She briefed the Board on the content of the report and noted that the Trust had delivered a break-even position in-line with NHS Improvement expectations. The Chief Finance noted key headlines in the Month 2 position as follows: • Overall, operational pay and non-pay expenditure was below plan with the underspend offset by costs incurred for COVID-19 of £1.8m (£1m pay	

Reference	Minute	Action
	and £0.8m non-pay). • The Trust had a net increase in expenditure of £0.1m in month 2 and has assumed additional 'top-up' income to offset. The net position was driven by costs of managing COVID-19 offset by underspends relating to significantly reduced bed occupancy. • Cash balances at 31 May 2020 were £44.5m and reflected the accelerated cash payments made to providers in Quarter 1 to support the liquidity position. The Chief Finance Officer referred the Board to s4 of the report and provided an overview of an Income & Expenditure bridge which detailed a reconciliation of movements in the Month 2 position including the impact of COVID-19 costs. She noted the positives in delivering a break-even position with a relatively modest top-up value of £0.1m. The Chief Finance Officer advised that national guidance for financial management arrangements from Month 5 had yet to be published, but anticipated that there would be a continuation of current block arrangements. She also commented on the potential for a greater degree of system involvement in decision-making. The Chair noted that the subject of a Wirral health economy budget had been discussed during a recent health economy Chairs and Chief Executives meeting. ***The Board of Directors:*** • ***Received and noted the Month 2 Finance Report***	
BM 20-21/067	**COVID-19 Recovery and Reset Update** The Director of Strategy & Partnerships delivered a presentation on the COVID-19 Recovery and Reset Plan which covered the following subject areas: • Key Principles and Aspects of the Plan • Stage 2 - Stabilisation Aspect • Stage 2 - Operational Delivery Aspect • Stage 2 - Clinical and Service Change Aspect • Stage 2 - Patients, Families and Communities Aspect • Stage 2 - Workforce and Wellbeing Aspect • Stage 2 - Strategic Estates and Environment Aspect • Stage 2 - Leadership and Governance Aspect • Stage 2 - Financial Management Aspect • Managing the Hospital Environment • Stage 2 - Environmental Safety Mr J Sullivan referred to the Workforce and Wellbeing Aspect and noted the briefing earlier in the meeting from the Chief Nurse on the level of Band 5 nurse vacancies. He advised that if a sickness absence rate of 7% was assumed, and absences for annual leave were taken into account, then circa 30% of this section of the workforce would be unavailable. He queried whether there should be a recruitment and retention programme for this area. The Chief Nurse acknowledged these comments and assured the Board that, while not reflected in the slide set, there was a significant amount of work being undertaken in this area as she had referenced earlier in the meeting.	

Reference	Minute	Action
	Mr S Igoe queried whether there was a role for Safety Management Assurance Committee with regards to seeking assurance that the Trust was 're-opening in a safe manner. He also queried whether there would be a sign-off process to certify that spaces were safe for reoccupation and noted the employer's duty in relation to the vulnerable status of staff members who may be currently shielding. The Chief Nurse noted the roles of the Environmental Safety Group and the PPE Group and suggested that the subject could be discussed in greater detail at the next Safety Management Assurance Committee meeting on 2 July 2020. The Chief Executive noted that coordination of restart activities would be informed by outcomes of divisional risk assessments and provided an overview of the approach. The Medical Director assured the Board that any clinically vulnerable staff would have a risk assessment in relation to any potential return to site. ***The Board of Directors:*** • ***Received and noted the COVID-19 Recovery and Reset Update***	
BM 20-21/068	**Preparation for Capital Planning – Hospital Campus** Board members noted that the presentation on Capital Planning had been withdrawn from the agenda.	
BM 20-21/069	**Interim Governance Arrangements (Meetings)** The Interim Director of Corporate Affairs presented a report which detailed outcomes from a review of Interim Governance Arrangements together with proposed arrangements for the period 1 July – 30 September 2020. He briefed the Board on the content of the report and noted the rationale for the proposed arrangements detailed at Appendix 1 of the report. Mr S Igoe acknowledged that the practice of virtual meetings was going to be the norm for some time to come and supported the proposal to restart meetings that had been suspended as part of the initial arrangements. ***The Board of Directors:*** • ***Received the report and approved the proposed arrangements for meetings for the period 1 July – 30 September 2020 as set out in Appendix 1 of the report.***	
BM 20-21/070	**Financial Governance Arrangements** The Chief Finance Officer presented a report seeking approval for continuation of the temporary financial governance arrangements originally approved by the Board of Directors on 1 April 2020. She briefed the Board on the content of the report and noted that details of the national financial regime from 1 August 2020 had yet to be published. She advised that the Trust may need to make changes to internal budgets, reporting arrangements and financial governance processes when details become known but, in the interim, she recommended continuation of the current financial governance arrangements through to 30 September 2020. The Chief Finance Officer advised that she hoped to be in a position to provide a report to the Board on the national financial regime post-1 August	**CW**

Reference	Minute	Action
	2020 at the next Board of Directors meeting. ***The Board of Directors:*** • ***Received the report and approved continuation of the temporary financial governance arrangements set out in the report until 30 September 2020.***	
BM 20-21/071	**Board Assurance Framework** The Chief Executive presented the Board Assurance Framework for review by the Board and advised that there had been no changes to risk scores since the last review by the Board on 6 May 2020. She noted that amendments to BAF content since the previous review were identified in bold blue font. In response to comments from Mr S Igoe, regarding the need to document risk appetite, the Chief Nurse noted work on a Risk Management Strategy which would incorporate arrangements for documenting and reviewing risk appetite. The Interim Director of Corporate Affairs noted the 'Assurance Rating' column for each BAF entry and advised of the need for relevant Committees to resume the practice of allocating an assurance rating. ***The Board of Directors:*** • ***Noted the updates to content and approved the Board Assurance Framework as presented.***	
BM 20-21/072	**Report of Finance, Business & Performance Assurance Committee** Mrs S Lorimer presented a report which detailed business conducted during a meeting of the Finance, Business & Performance Assurance Committee held on 25 June 2020. She briefed the Board on the content of the report, noting that the majority of subjects had been considered as part of various reports earlier in the meeting. She then referred the Board to s7 of the report and noted the Committee's consideration of a potential risk relating to the revenue consequences of any capital funding allocated for COVID-19-related developments. She advised that the Committee had agreed that this matter should be incorporated under Principal Risk 3 in the next iteration of the Board Assurance Framework. ***The Board of Directors:*** • ***Received and noted the report of the Finance, Business & Performance Assurance Committee***	
BM 20-21/073	**Report of Workforce Assurance Committee** Mr J Sullivan presented a report which detailed business conducted during a meeting of the Workforce Assurance Committee held on 26 June 2020. He briefed the Board on the content of the report and advised that the Committee had encouraged the use of benchmarking health and wellbeing activities. He noted that there appeared to be a management reluctance to seek best practice. Mr J Sullivan then referred the Board to s7 of the report	

Reference	Minute	Action
	and noted the Committee's endorsement of the aim to achieve 100% completion of Health Risk Assessments. Mr J Sullivan referred the Board to s2 of the report and noted the Committee's consideration of Staff Attendance levels. He suggested that consideration may need to be given to an adjustment to the target absence rate as a result of the impact of COVID-19 and noted a potential positive impact on attendance levels as a result of home working arrangements. He also expressed frustration at the lack of an IT solution for absence management. The Chief Finance Officer advised that the Trust was currently reviewing a potential electronic solution with a system demonstration scheduled for week commencing 6 July 2020. The Chief Executive advised that the Executive Team had been vocal on the need for an electronic solution but did not agree that the COVID-included absence level of circa 6.5% should be viewed as a normal level of absence. Mr C Clarkson acknowledged this comment but advised of the need to plan for longer term COVID implications on staffing levels. The Medical Director queried Mr Sullivan's comments on a reluctance to seek best practice. Mr J Sullivan advised that time appeared to be invested in developing internal solutions rather than working others and adopting existing solutions. The Chief Executive advised that the Executive Team did not recognise a reluctance to seek best practice. ***The Board of Directors:*** • ***Received and noted the report of the Workforce Assurance Committee***	
BM 20-21/074	**Report of Trust Management Board** The Chief Executive provided a report of business conducted during a Trust Management Board meeting held on 23 June 2020 which included the following subject areas: • Operational Performance Update • Finance Update • Non COVID-19 Divisional Updates • Trust Strategy 2021-2026 • Divisional Accountability and Performance Framework • Reset and Recovery • Outline Business Case for Digital Dictation • Bed Modelling Update • COVID-19 Testing Update • Review of Complaints She briefed the Board on the content of the report and noted in particular the introduction of a Divisional Accountability and Performance Framework as referenced at s6 of the report. She advised that practical application of the Framework would be tested during Divisional Performance Reviews in August 2020. ***The Board of Directors:***	

Reference	Minute	Action
	• ***Received and noted the report of the Trust Management Board.***	
BM 20-21/075	**Communications Monthly Report** The Director of Communications & Engagement presented a report which provided an update on activity in the areas of; staff engagement, media and social media, charitable fundraising and stakeholder relations. She briefed the Board on the content of the report and noted the resumption of Charitable Funds Committee meetings with the next meeting scheduled to be held on 29 July 2020. She also noted work in preparation for 2020 Staff Survey and work to support development of the Trust Strategy. With regard to charitable funds, Mrs S Lorimer queried whether the Charitable Funds Committee would be provided with a view from the Executive Team on the allocation of additional funding, including the 'Captain Tom' funding. The Chief Finance Officer advised of work to assess options for suggested use of funds derived from a 'staff ideas board' and noted that Executive reviewed proposals would be presented to the Charitable Funds Committee for approval. She also advised that details of the parameters for use of the 'Captain Tom' funding would reported to the Committee. With regard to restrictions on funding, the Medical Director noted that the Wirral Globe had specified that monies generated through their fundraising activity should be allocated for developments which benefitted staff rather than patients. ***The Board of Directors:*** • ***Received and noted the Communications & Engagement monthly report.***	
BM 20-21/076	**Any Other Business** The Chair invited comments on the effectiveness of the meeting and there was general agreement that the virtual arrangements had worked well. In response to comments from Mrs S Lorimer, regarding reintroduction of the Patient Story, the Chief Executive agreed to consider how this practice could be resumed.	
BM 20-21/077	**Date of next Meeting** The next Board of Directors meeting would be held on Wednesday, 5 August 2020, commencing at 12.30pm.	

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Chair

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Date

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

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 01.07.20						
1	BM 20-21/065	The Chair noted the impact of Hotel Services and Estates-related absences on the Trust's overall absence levels and requested that the Board be presented with an assurance report on this subject at the next meeting.	**AM**	Sickness Absence Report included on the agenda for the meeting on 5 August 2020.	5 August 2020	Action complete
2	BM 20-21/065	The Chief Finance Officer advised that she hoped to be in a position to provide a report to the Board on the national financial regime post-1 August 2020 at the next Board of Directors meeting.	**CW**		5 August 2020	
Date of Meeting 03.06.20						
1	BM 20-21/049	Progress report against the IPC Board Assurance Framework to be presented to the Board of Directors.	**HR**		November 2020	
Date of Meeting 04.03.20						
1	BM 19-20/237	Discussion at future Board meeting regarding internal productivity to support financial sustainability	**CW**		July 2020	April '20 – agreed to defer until Q2 following stabilisation of COVID activities.
Date of Meeting 29.01.20						
2	BM 19-20/214	Report outlining opportunities for inclusion in the Estate master plan to ensure full utilisation of hospital sites	**MS**	Report on preparation for capital planning across Hospital Campuses reviewed by Board on 1 July 2020.	October 2020	Action complete

Board of Directors	
Agenda Item	20/21 084
Title of Report	Chief Executive's Report
Date of Meeting	5 August 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 July 2020.

Serious Incidents

In June 2020, one serious incident was declared. The case related to a patient who following re-admission died unexpectedly. The incident was referred to the Coroner to establish cause of death. A review has been initiated to identify any learning and will be reported via the Trust governance arrangements.

RIDDOR Update

There were no RIDDOR reportable incidents in June

BAME Staff Members and Risk Assessments

Risk Assessments- Progress

The National Chief Operating Officer, Chief People Officer and Medical Director for Primary Care wrote to the system on 24 June 2020 with clear instruction: *'All employers need to make significant progress in deploying risk assessments within the next two weeks and complete them – at least for all staff in at-risk groups – within four weeks.*

In this letter, NHS primary and secondary care were also asked to publish risk assessment deployment metrics and make them immediately available to all staff.

NHSE/I set up a Risk Assessment Delivery Unit to monitor central data capture process and to provide intensive support with nominated leads from the regions to accelerate risk assessment processes and share good practice. All employers were asked to make urgent progress in deploying risk assessments within two weeks of the letter ,and completing them for all staff in 'at risk' groups within four weeks.

NHS organisations have been asked to publish a range of metrics until fully compliant. The information is to be made available to all staff either via the intranet, all staff briefings or similar. We are also required to ensure this data becomes part of our Board Assurance Framework.

On Friday 24 July 2020 the figures for WUTH were:

		09/07	17/07	24/7
1	Have you offered a risk assessment to all staff?	Yes	Yes	Yes
2	What % of all your staff have you risk assessed?	59.41%	72.2%	75.12%
3	What % of risk assessments have been completed for staff who are known to be 'at-risk', with mitigating steps agreed where necessary?	68.12%	79.94%	81.62%
4	What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?	74.67%	91.61%	93.6%

WUTH is above the national average in each of the three categories of risk assessments and in the % of risk assessments carried out on BAME staff, we sit above the regional average of 88%.

The Trust has a robust process in place for reviewing risk assessments with an Occupational Health medical consultant reviewing them and supporting higher risk members of staff. Divisions are responsible for ensuring they make a 100% target.

Shielders Return To Work

Shielders are able to return from the 1 August 2010. In preparation for this, all shielders have been asked to complete a full Health Risk Assessment (HRA) form. OH are reviewing all forms and ensuring actions are adequate and safe and speaking with the employee and line manager if necessary especially those at high risk – taking into account mental health and wellbeing.

All shielders have been sent a letter from me informing them of the new guidance, signposting them to sources of support and asking them to contact their line manager to discuss what arrangements need to be put in place prior to their return. To support this the OD team are making a short video that will take shielders on a virtual tour around the hospital, demonstrating the dedicated staff access points, the process for entering the hospital, what Covid secure offices and clinical areas look like, and providing general reassurance to staff who may be struggling to envisage how the workplace might look under new restrictions.

The Trust is participating in a C&M wide group (via the HR Deputy network) looking at the feasibility and issues raised by agile and home working as we recognise this may need to be a feature of how we work in the future, particularly if we experience a second surge.

2020 Flu Plan

The Trust is now working on developing this year's flu action plan. Over this coming week we will be talking to key internal stakeholders to finalise the approach. Given the restrictions that Covid-19 has placed upon us we will be unable to support drop- in clinics and roaming vaccinators this year. Instead:

- Divisions will be asked to nominate a vaccinator for each ward/area who will need to be trained and be responsible for vaccinating staff in their own area

- OH will vaccinate staff in corporate departments by running appointment based clinics – some additional support from peer vaccinators may be required as in previous years and we will need to set up an electronic booking system

More peer vaccinators than in previous years are likely to need training, but this raises capacity issues and we are mindful of the discussions needed with operational teams before this is agreed. Our expectation is that nationally, there will be a target set for 100% compliance.

Access to NHS Staff COVID-19 Test Results

The Trust has received guidance to make it clear who can access the database that holds the results of staff Covid-19 tests. Staff may test positive or negative. They may need to take further action following their result such as self-isolation or returning/continuing to work.

We can ask staff if they have been tested (and if so the result of the test) but employees do not have to disclose the result, unless this impacts on their working ability (e.g. if they need to self-isolate for 7 days the employer will need to make plans to manage their absence). If there is a possibility coronavirus was contracted in the workplace it would require the employer to report this to the Health and Safety Executive (as part of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995)). Once the samples are tested, the results are recorded in a database called the local Integrated Clinical Environment (ICE) database. This enables clinicians to access results to help provide individual care for their

patients, which may include clinical interventions or planning next steps. Access to ICE is strictly controlled by the use of Smartcards or username/password functionality and fully audited to ensure access is legitimate and necessary. The ICE database **must only** be accessed for clinical reasons by those caring for the patient. It **must not** be accessed by non-clinical staff such as HR or Occupational Health departments. Trusts CEO or Board level Directors should be clear about this guidance.

Doctors and dentists Pay Review

For doctors and dentists, in response to the report of the Review Body on Doctors' and Dentists' remuneration (DDRB), the government has today announced a general 2.8 per cent uplift in pay for consultants, SAS doctors, general dental practitioners, salaried GPs and salaried primary care dentists.

This uplift doesn't include doctors and dentists in training, as they are currently still within a multi-year pay deal agreed with the BMA JDC last year.

We expect that the pay will be uplifted in September's payroll, along with a payment of arrears backdated to April 2020.

The government has not provided any additional funding to any part of the public sector as part of this pay deal, and it is our understanding that NHSEI's financial planning assumes 2 per cent pay awards (other than for the multi-year deals already agreed). The ministerial statement advises that there will be reprioritisation of spending within the NHS Long Term Plan, and we have spoken to NHSEI to urgently request clarity on how the recommendations in the DDRB report are going to be funded for employers. I have been assured by NHSEI that they understand the need for clarity on this matter and will respond soon, and I will update you on this when I can.

CPD Monies

An initial 50% CPD payment was made to us in April 2020 through the Learning & Development Agreement (LDA). The remaining 50% of the 2020/21 allocation will be released via the LDA in November 2020 following a HEE review of our investment plan.

Covid-19 and IPC Update

Since mandatory reporting of all nosocomial COVID started in June we have reported 3 cases after day 8 of admission and 1 case after day 14, resulting RCA investigations are reviewed at the weekly Hospital onset infection review meeting chaired by the DIPC, we currently have no outbreaks involving staff or patients.

We are no longer an outlier in the Northwest for incidences of Clostridium difficile and we continue to remain below monthly target; we have recently reported 1 MRSA bacteraemia (2 since April), the post infection review has taken place and the Division are leading on delivering the resulting action plan.

Board of Directors	
Agenda Item	20/21 087
Title of Report	Quality Performance Dashboard and Exception Reports
Date of Meeting	5 August 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 June 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 50 indicators that are reported for June (excluding Use of Resources):

- 15 are currently off-target or failing to meet performance thresholds
- 25 of the indicators are on-target
- 10 do not have an identified threshold or are not rated

Please note during the current Covid-19 pandemic a number of metrics have been suspended from national reporting, and departments within the Trust have been focused on operational priorities over some internal reporting. Where the information is still available and reported within the Trust it has been included.

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

4. Next Steps

WUTH remains committed to attaining standards through 2020-21.

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 June 2020.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

July 2020
Upated 23-07-20

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	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	0.14	0.04		0.04	0.09	0.13	0.13	0.13	0.32	0.31	0.17	0.21	0.21	0.20	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	91.9%	94.6%	94.6%	96.1%	94.9%	94.1%	97.5%	98.7%	98.0%	97.7%	97.7%	97.5%	97.4%	97.5%	
	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	96.8%	97.7%	97.6%	97.6%	97.1%	97.8%	97.3%	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.7%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	95.5%	97.2%	95.0%	97.0%	96.5%	95.7%	95.1%	95.2%	97.0%	96.9%	National reporting ceased	National reporting ceased	National reporting ceased		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	4	3	1	0	5	4	5	5	4	4	3	4	1	8	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	0	0	0	0	0	2	0	0	0	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	≤88 WUTH maximum from 2019-20 retained, equating to max 7.3 per month	SOF	11	5	6	7	8	6	7	4	4	3	6	5	5	16	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 77 for financial year 2020-21, equating to max 6.4 per month	WUTH	2	5	7	2	5	6	6	8	9	1	7	4	6	17	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	0	1	0	0	0	0	1	0	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	98%	99%	100%	99%	100%	100%	99%	100%	100%	100%	100%	99%	99%	99.4%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	0	0	0	1	0	1	0	0	2	0	2	4	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	98%	98%	96%	98%	99%	99%	99%	96%	96%	96%	96%	91%	95%	94%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	93.7%	93.6%	92.9%	93.6%	92.4%	91.2%	91.2%	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	84%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	90.7%	90.4%	90.3%	91.2%	88.3%	85.5%	84.9%	84.4%	85.0%	82.81%	81%	71%	72%	75%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	91.5%	92.3%	90.3%	89.98%	87.46%	88.09%	89.66%	89.53%	86.67%	79.94%	51%	20%	19%	19%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.63%	94.51%	94.40%	94.38%	94.33%	94.14%	94.10%	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.25%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	94.49%	94.07%	93.96%	94.25%	93.99%	93.82%	93.87%	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.94%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.85%	0.68%	2.03%	1.21%	0.86%	0.77%	0.86%	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	0.67%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	10.5%	9.5%	10.6%	10.9%	11.0%	11.3%	11.3%	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.1%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	7.4	7.3	7.7	7.5	7.7	7.6	7.55	7.9	7.7	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		

Quality Performance Dashboard

July 2020
Upated 23-07-20

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	90.0%	93.0%	92.0%	96.0%	97.8%	97.2%	97.5%	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	95.5%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH								96%	94%	95%	93%	98%	97%	95.9%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	18.7%	20.2%	17.9%	18.8%	17.2%	17.1%	19.3%	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	19.9%	
	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	403	383	410	431	443	441	444	446	448	383	174	209	210	210	
	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	171	171	203	193	199	200	217	204	195	118	51	66	53	53	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.1	3.5	3.5	3.5	4.0	3.6	4.6	3.4	3.6	3.9	3.5	3.4	3.5	3.5	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.5	4.6	4.6	5.1	4.8	5.0	5.2	5.1	5.2	6.7	4.8	3.4	3.6	3.9	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	1130	1126	1130	1092	1118	1057	1080	1115	1006	827	667	870	941	826	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	10	11	9	15	10	13	11	16	16	23	6	2	1	3	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	85.5%	88.5%	85.3%	81.0%	82.9%	81.0%	77.3%	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	68.8%	

Quality Performance Dashboard

July 2020
Upated 23-07-20

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	17	16	24	23	17	26	10	10	14	4	2	0	2	4	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	91%	91%	92%	88%	87%	84%	87%	85%	80%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	10%	12%	12%	11%	11%	10%	11%	10%	11%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	96%	98%	97%	96%	97%	96%	97%	97%	97%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	31%	38%	34%	30%	33%	29%	27%	27%	27%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	95%	95%	94%	94%	94%	94%	94.5%	94.1%	95.0%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	99%	93%	92%	92%	91%	94.8%	99%	97%	98%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	CN	≥25%	WUTH	44%	29%	24%	23%	22%	22%	33%	22%	20%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		

Quality Performance Dashboard

July 2020
Upated 23-07-20

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2020-21	SOF	83.5%	81.9%	79.9%	75.6%	72.7%	70.8%	72.1%	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.0%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	1	0	1	33	95	40	24	21	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	54	76	108	210	170	366	431	198	76	80	148	84	82	105	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	80.12%	80.06%	79.89%	79.59%	79.03%	78.09%	78.10%	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	43.29%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	25,733	24,733	24,846	24,721	24,368	23,597	23,233	22,988	23,207	22,350	21,284	21,288	21,383	21,383	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	0	0	0	0	0	0	0	0	0	15	56	200	413	413	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.5%	99.2%	98.3%	99.1%	99.5%	99.2%	99.1%	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	55.5%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	94.0%	94.0%	93.3%	94.3%	95.0%	93.7%	94.4%	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	88.7%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	93.3%	–	–	93.8%	–	–	94.4%	–	–	93.4%	–	–	–		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	97.1%	96.7%	97.3%	96.5%	96.7%	97.0%	97.1%	97.2%	96.9%	98.5%	100.0%	98.3%	96.2%	98.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	96.8%	–	–	96.8%	–	–	96.9%	–	–	97.6%	–	–	–		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	86.3%	85.7%	89.9%	87.8%	85.0%	87.5%	85.9%	85.9%	85.9%	86.0%	87.4%	86.2%	83.2%	85.6%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	86.5%	–	–	88.0%	–	–	86.1%	–	–	85.9%	–	–	–		
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	TBC	WUTH	180	178	184	166	193	195	148	186	160	125	74	99	119	97	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	TBC	WUTH	15	17	22	15	31	13	10	8	16	14	7	8	15	10	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	88%	100%	91.3%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	1	2	2	4	3	0	3	0	1	0	1	5	2	

Quality Performance Dashboard

July 2020
Upated 23-07-20

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	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) - retained	National	48	50	37	50	56	48	41	55	49	117	328	181	150	659	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	82.1%	83.6%	83.4%	82.7%	83.8%	81.4%	80.9%	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	77.9%	

	Indicator	Objective	Director	Threshold	Set by	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020/21	Trend
Use of Resources	I&E Performance (monthly)		CFO	On Plan	WUTH	-0.098	-0.825	-1.498	1.468	0.088	-0.488	-9.543	-0.668	-2.929	2.377	0.00	0.00	-0.001	-0.001	
	I&E Performance Variance to Plan (monthly)		CFO	On Plan	WUTH	0.914	-0.828	-1.106	1.972	-1.507	-1.638	-8.755	-1.818	-2.445	-0.589	0.00	0.00	-0.001	-0.001	
	NHSI Risk Rating		CFO	On Plan	NHSI	3	3	3	3	3	3	3	4	4	4	2	2	2	2	
	CIP Performance (FYF)		CFO	On Plan	WUTH	-5.2%	-4.1%	-7.2%	-5.0%	-10.6%	-11.5%	-11.4%	-18.1%	-18.1%	-17.7%	0.0%	0.0%	0.0%	0.0%	
	NHSI Agency Ceiling Performance (monthly)		CFO	NHSI cap	NHSI	-15.6%	-46.4%	-8.2%	-24.3%	-24.7%	1.8%	-8.4%	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	21.0%	
	Cash - liquidity days		CFO	NHSI metric	WUTH	-15.9	-16.5	-17.4	-15.0	-14.6	-10.9	-14.1	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.2	
	Capital Programme (cumulative)		CFO	On Plan	WUTH	28.0%	14.7%	19.8%	64.2%	61.7%	57.2%	54.4%	53.8%	50.7%	74.8%	134.4%	129.5%	81.2%	81.2%	

(*) Updated Metrics

Effective: Nutrition & Hydration - MUST completed within 24 hours of admission

Metric Change

New metric

(**) Updated Thresholds

Safe : Gram negative bacteraemia infections

Threshold Change

Annual maximum set at 77 for 2020/21, equating to a maximum 6.4 per month

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 2

WUTH Quality Dashboard Exception Report Template as at July 2020

Safe Domain

Pressure Ulcers – hospital acquired category 3 and above

Executive Lead: Chief Nurse

Performance Issue:
WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above. There were two reported pressure ulcers in April 2020 and a further two cases in June 2020.

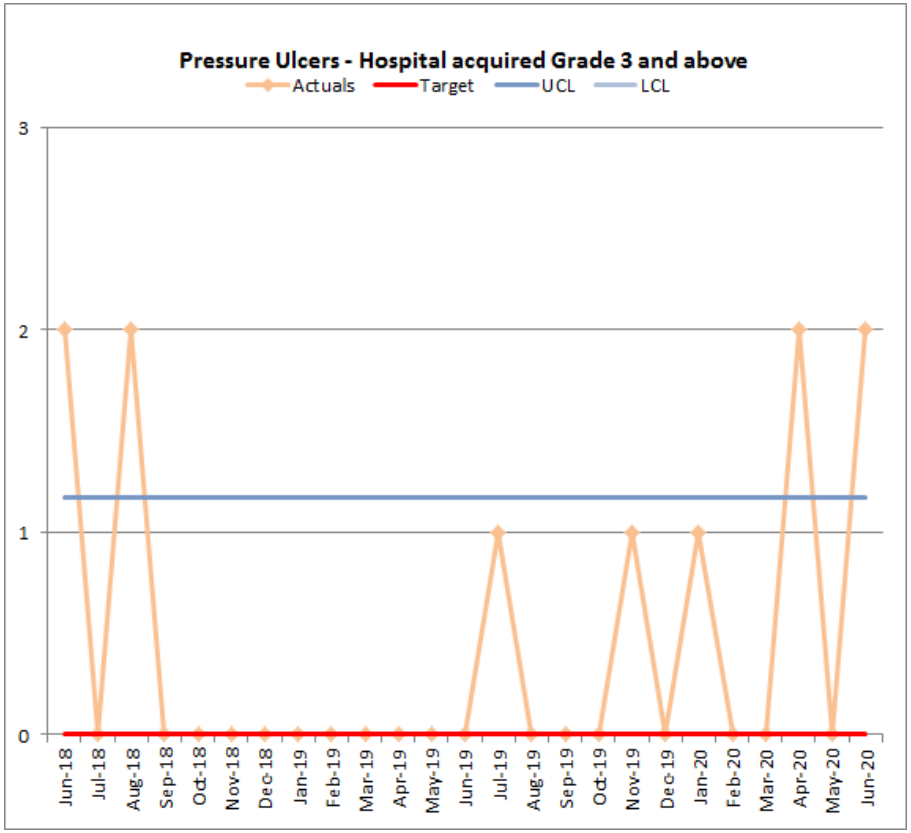
Action:
Root Cause Analysis has been undertaken of the two hospital acquired (HA) category 3 pressure ulcers reported in June 2020. The actions required to address the themes identified align with two of the current priorities detailed within the 2020/2021 Tissue Viability Action Plan.

- To review of the availability of pressure relieving mattresses and associated contract to ensure products are available and meet patient requirements.
- To review of the electronic patient record templates to ensure there is the ability to document assessment, care planning, management and validation of wounds to the required standard.

These actions remain on target to be complete by the end of quarter 3. Along with the tissue viability education plan commenced in quarter 1 2020, this will ensure staff have the skills, competence and appropriate products to care for patients at risk of pressure damage resulting in a reduction in HA pressure ulcers.

Expected Impact:

The Trust will see a reduction in hospital acquired pressure ulcers



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Although regularly achieved, performance against this standard has been deteriorating and is at 71.6% for June 2020.

Action:

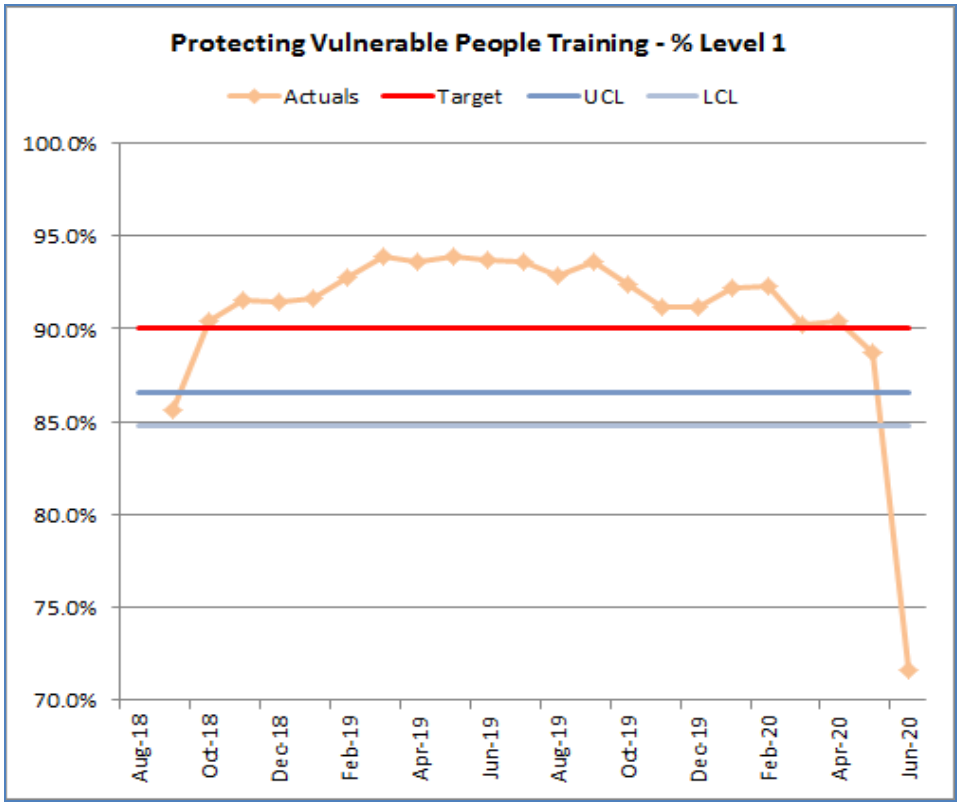
Compliance and trajectories are monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance was also reported in the Safeguarding Performance Report last presented at PSQB in May 2020.

In March 2020 all mandatory training was suspended temporarily due to the COVID 19 pandemic which has had a detrimental impact on the compliance levels. Training has now recommenced across the divisions for eLearning.

PVP level 1 is completed via the intranet and can be accessed by staff at any time. The Trust remains on target with its agreed trajectory to meet compliance by the end of quarter 2.

Expected Impact:

PVP level 1 training compliance will increase month on month expecting to achieve the Trust target by the end of quarter 2.



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 June similar to May at 71.84%.

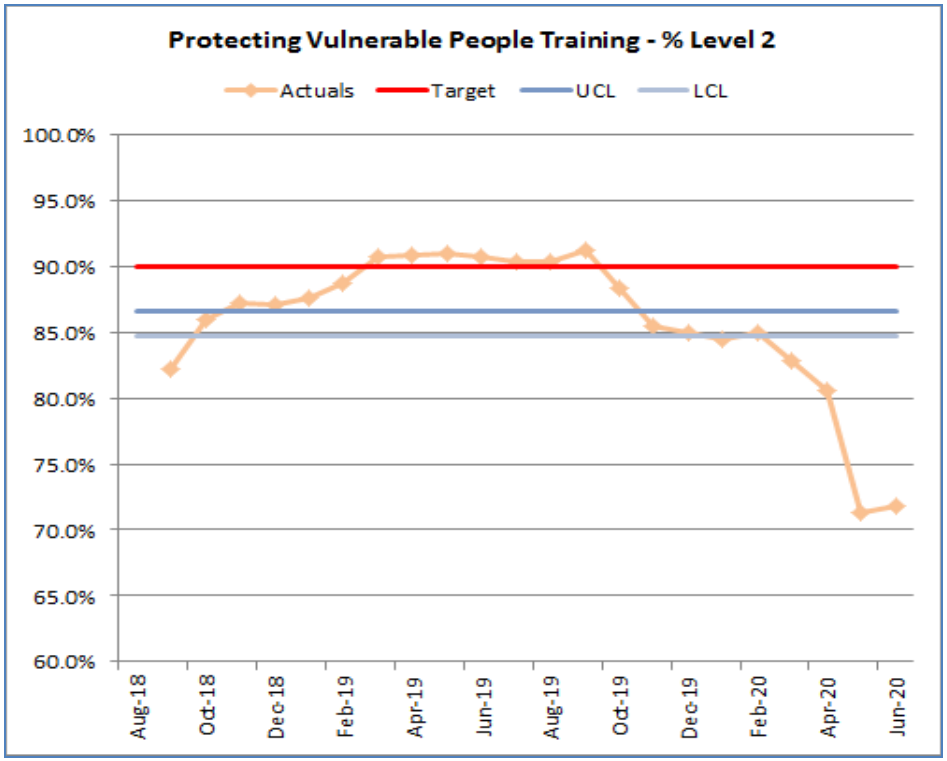
Action:
Compliance is monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance was also reported in the Safeguarding Performance Report last presented at PSQB in May 2020.

In March 2020 all mandatory training was suspended temporarily due to the COVID 19 pandemic which has had a detrimental impact on the compliance levels. Training has now recommenced across the divisions for eLearning.

PVP level 2 is completed via the intranet and can be accessed by staff at any time. The Trust is on target with its agreed trajectory to achieve the agreed compliance by the end of quarter 2.

Expected Impact:

PVP level 2 training compliance will increase month on month expecting to achieve the Trust target by the end of quarter 2.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead:
Chief Nurse

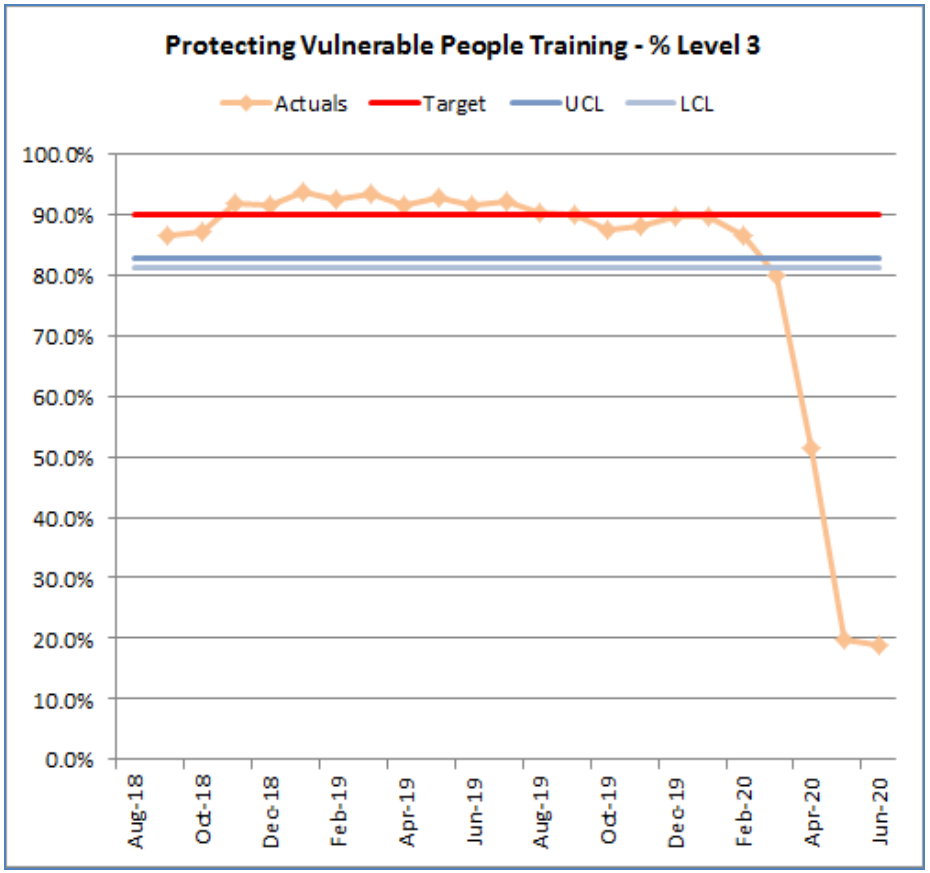
Performance Issue:
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has not been achieved since August 2019, with June being similar to May at 18.96%.

Action:
The impact of pausing mandatory training has continued to result in the deterioration of PVP level 3 compliance in June 2020. PVP level 3 training face to face sessions have been recommenced from June 2020 ensuring enough capacity is available for the Trust to achieve the agreed compliance by the end of quarter 3. In addition an E-Learning package has been launched from July 2020 to increase the opportunities for staff to complete the training in alternative ways.

Divisional compliance and trajectories are monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance was also reported in the Safeguarding Performance Report last presented at PSQB in May 2020. A review of PVP level 3 compliance undertaken in July 2020 identifies the Trust is currently above the agreed trajectory on target to meet the agreed compliance by the end of quarter 3.

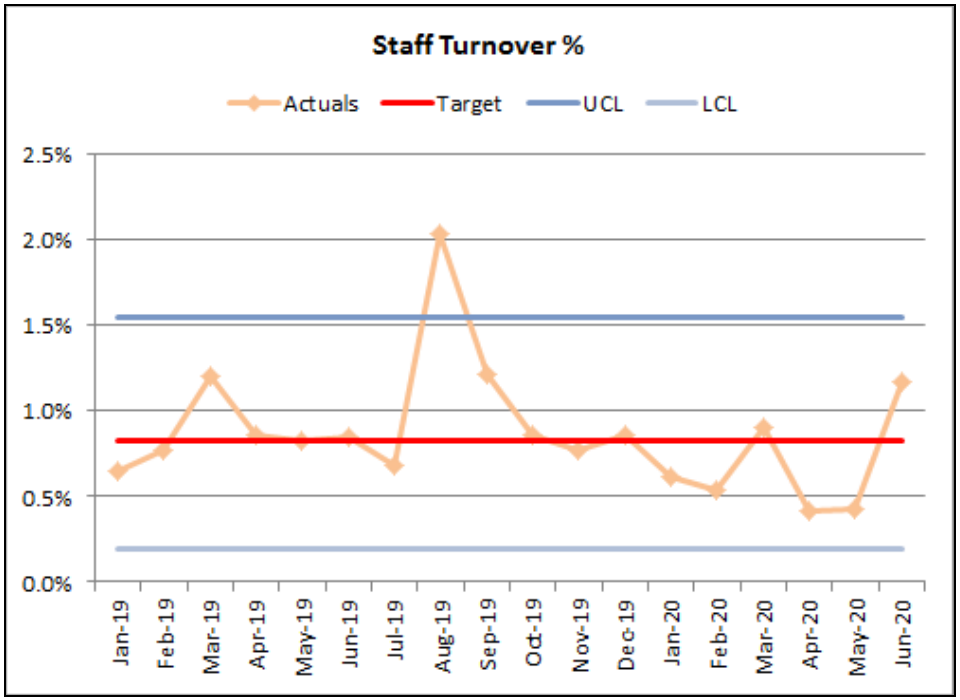
Expected Impact:

PVP level 3 training compliance will increase month on month expecting to achieve the Trust target by the end of quarter 3.



Staff turnover % (in month rate)

Executive Lead: Director of HR / OD
Performance Issue: WUTH has an internal target set at a maximum 10% turnover of staff, this equates to a maximum rate of 0.83% monthly. The June 2020 in-month rate increased to 1.17%, making the rolling 12-month rate 11.1%.
Action: Some staff who had secured alternative employment in February and March 2020 were asked to extend their notice periods at WUTH due to the Covid pandemic. They are now moving on, hence the lower turnover in April and May 2020 and the sudden increase in June 2020.
Expected Impact: This anomaly should correct itself in future months and return to a more stable picture as reset and recovery processes are applied.



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 June 2020 at 19.5%.

Action:

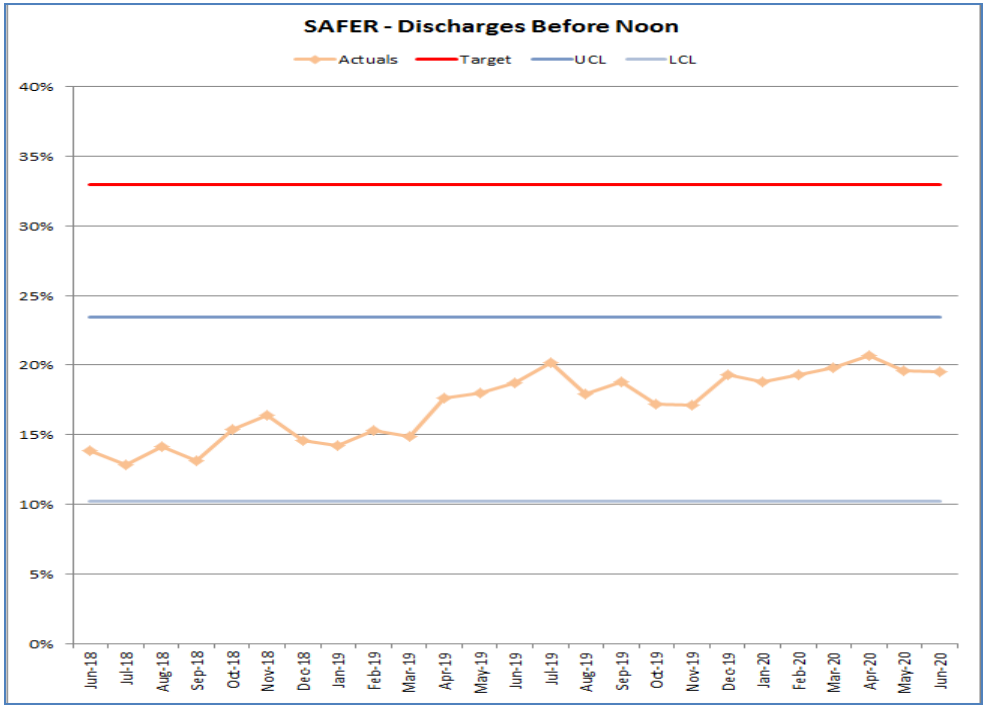
Non-elective admissions have continued to steadily increase and, as a result, we have seen an increase in bed occupancy this month. The number of discharges before noon remains below target.

Increasing discharges before noon is a key focus of the quality improvement work due to commence in first week of August on 2 exemplar wards in Medicine, followed by 2 exemplar wards in Surgery and is one of the outcome measures on the improvement dashboard.

Community and social care teams' increased capacity is supporting improved flow for patients being discharged with support.

Expected Impact:

A key objective of the recovery and reset will be to ensure this rate is built upon.



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 had 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. Numbers continue to be lowered from the joint efforts across the economy to free up capacity for Covid-19 patients. At the end of June the number of inpatients over 7 days was at 210 and the number over 21 days at 53.

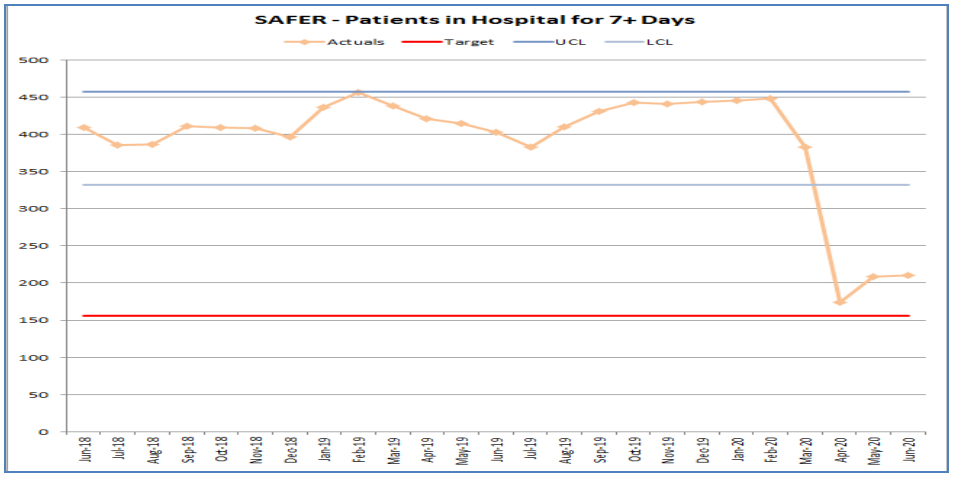
Action:

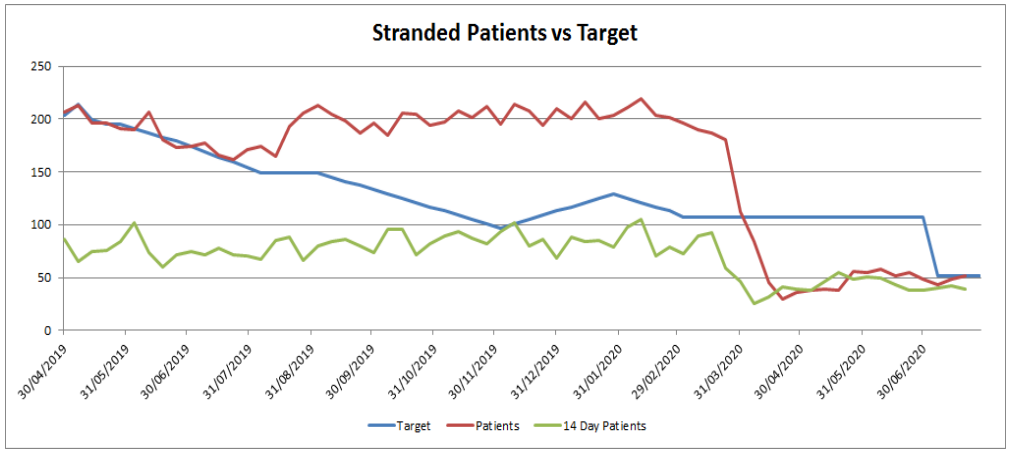
The clinical and operational teams continue with their twice weekly long length of stay reviews to reduce delays for patients and expedite readiness for discharge to sustain the current position. Quality improvement work on 4 wards will commence next week standardising MDT Board Rounds and developing Criteria Led Discharge. Progress on reducing LoS and bed occupancy at ward level will be monitored via an improvement dashboard.

ECIST is supporting this at ward level to embed the improvements for long term sustainability.

Expected Impact:

Revised national standards and trajectories are yet to be published, but the system remains focused on at least maintaining this position.





Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

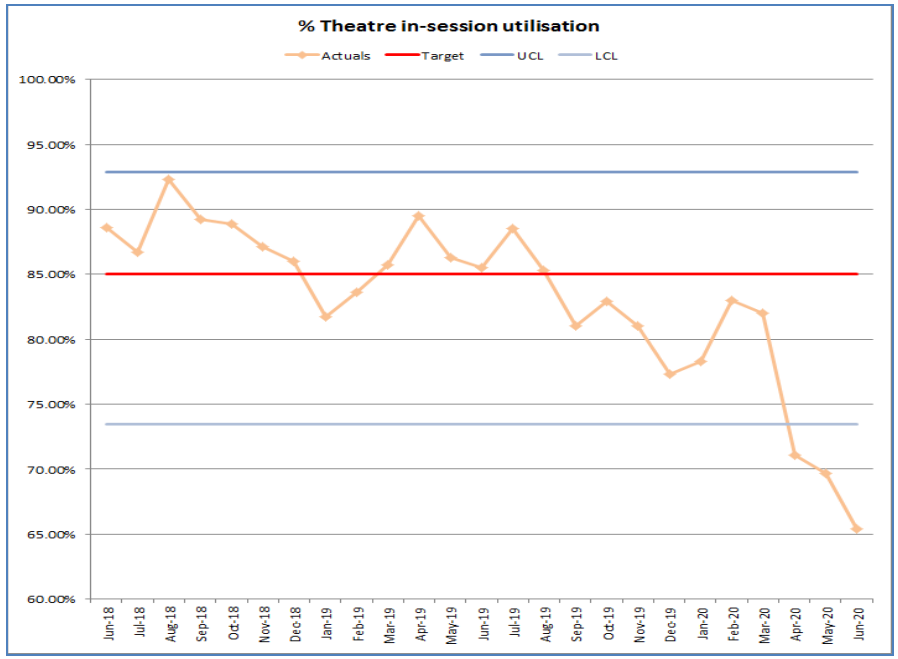
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. With the support of the theatre transformation programme this was regularly achieved from March 2019. However since August performance has deteriorated, largely due to the cancellation of elective activity resulting from pressures with non-elective patient flow. This was further affected by the further cessation of elective activity from March due to Covid-19. The rate for June was 65.4%.

Action:

Theatres are now increasing demand and booking ahead for up to 6 weeks as the elective restart program commences. Utilisation is expected to increase significantly from August and will continue to do so through the remainder of the year. In addition a review of the cleaning of theatres is under way with IPC which is expected to increase utilization further.

Expected Impact:

As plans to increase elective activity increases there may need to be a reassessment of baseline as increased cleaning and PPE processes impact on efficiency.



Caring Domain

Same sex accommodation breaches

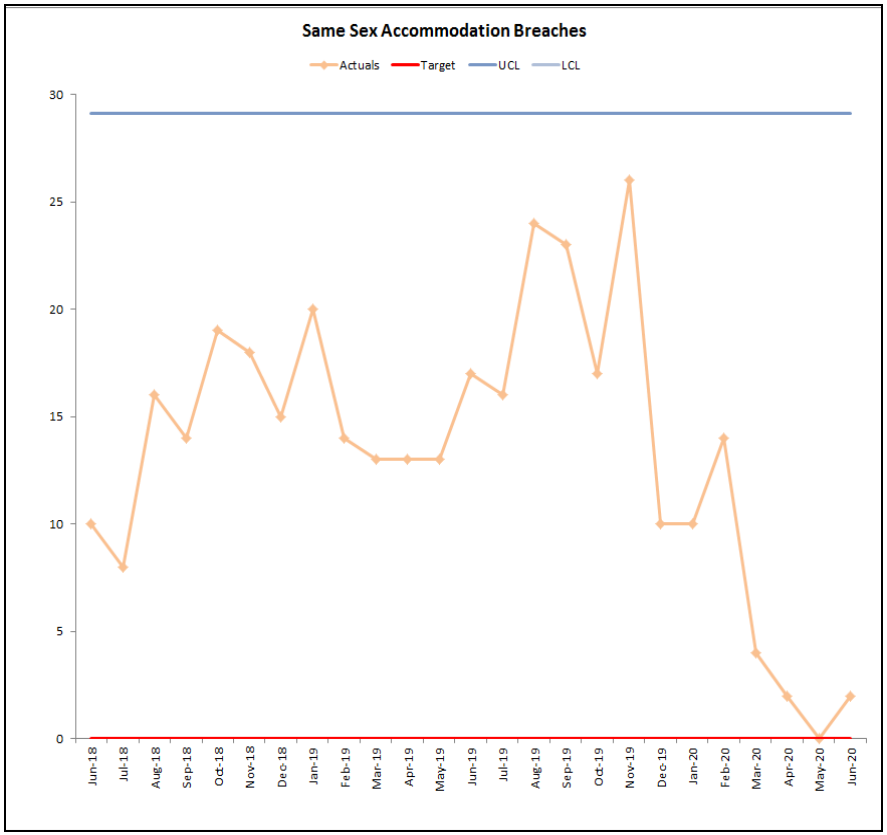
Executive Lead:
Chief Nurse

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 changed in 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 – there were 2 such breaches in June.

Action:
The need to ensure that critical care beds are available has reinforced the need for timely discharges to the wards. This is overseen by the Bed Management Team, with any issues being escalated to the Capacity Command Meetings. Unfortunately 2 breaches occurred for patients awaiting transfer from ITU to surgical beds during the change of function and cleaning of COVID wards. The ward changes were required to support the availability silver wards capacity (COVID free) to enable the restart of the elective programme. There are no further anticipated changes to ward categorisation (Ward colours) thus reducing the risk of further single sex breaches.

Bed occupancy at Arrowe Park is currently remains <70%, so there are no breaches expected.

Expected Impact:
There will be no same sex accommodation breaches



Responsive Domain

Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has a trajectory agreed with NHSI for 2020-21 to maintain at 80% of patients waiting on incomplete Referral to Treatment pathways to be under 18 weeks. June 2020 was 43.29% with July position currently at 40.21%

To date currently there are 667 patients that are waiting more than 52 weeks on RTT pathways and had not yet commenced treatment at 28 July 2020.

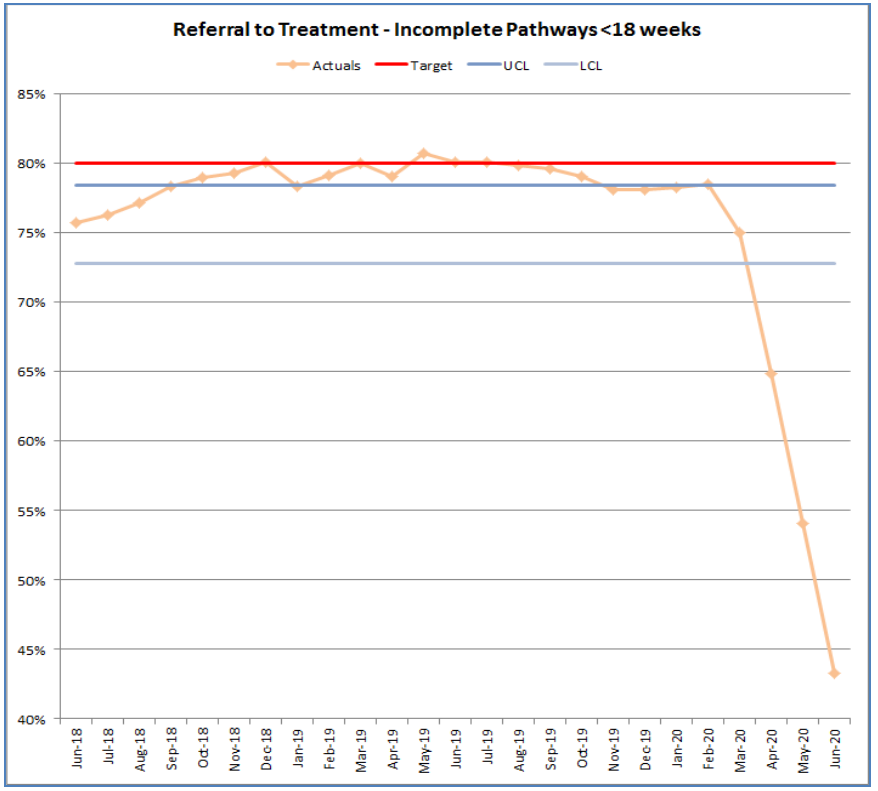
Action:
The deterioration is directly attributable to the cessation of routine elective activity in response to the Covid-19 situation.

The restart of activity is continuing and a plan is in place to increase pace to achieve trajectories of 50% day case, 60% IP and 80% OP. IS usage remains low and is under review.

Harm reviews are being undertaken for all 52 weeks waiters.

Expected Impact:

Waiting list size will continue to grow along with the number of breaches increasing whilst activity levels are sub pre-covid19.



Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

Performance Issue:

There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks.

The position at the end of June 2020 was an improved 74.9%, still affected by the ongoing national directive to release some capacity to cope with the Covid-19 pandemic.

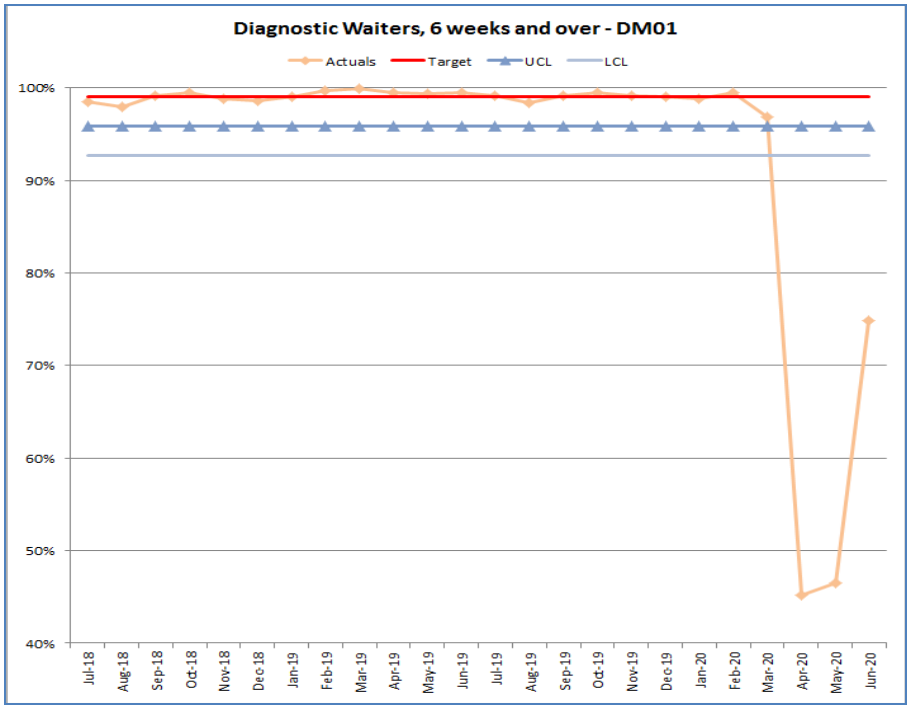
Action:

The recovery for June has commenced in diagnostic waits, capacity and demand is being reviewed in line with reset plans with mitigations in place to increase capacity

Diagnostic support for non-urgent elective and outpatient activities will be factored into the overall reset and recovery.

Expected Impact:

The details of the plan and performance trajectory will be shared with the Board once final reset and recovery plans are finalised.



Well-led Domain

Appraisal compliance %

Executive Lead: Director of HR / OD

Performance Issue:

WUTH has a target set at a minimum 88% of staff to have had an appraisal within the expected timeframes. The 88% standard has not been achieved since March 2019, with June 2020 at 77.9%. Although no Division is currently achieving the standard, Medicine and Surgery are both very close at the end of July at 86.95% and 87.8% respectively.

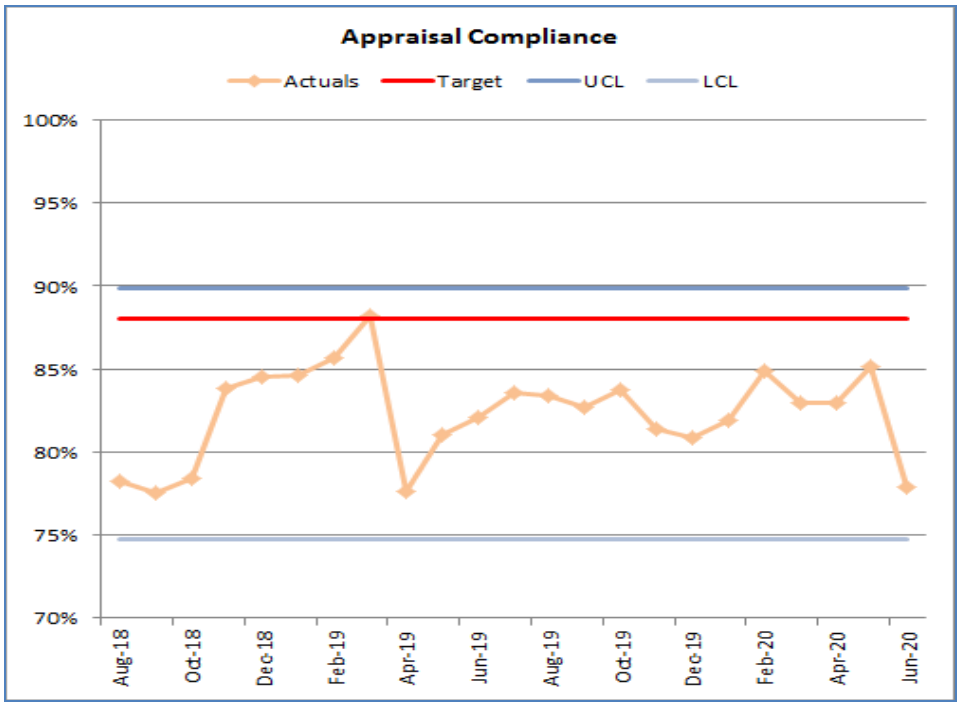
Action:

Appraisals for all medical staff have been suspended nationally until September 2020 which will have an impact on appraisal compliance rates.

Managers and staff receive alerts via ESR email notifications. Heads of department with particularly low compliance rates are alerted and assurance on action requested. Recent communication issued to all staff that appraisal can be done via Microsoft Teams, with working from home not a barrier, though Covid pandemic activity has reduced management time and opportunity to appraise staff. This will be corrected under Trust plans to reset and recover.

Expected Impact:

An increase in overall compliance is expected as the Trust moves into the recovery period. This will now become a focus again and compliance will steadily increase towards achieving the trust standard of 88% by the end of 2020.



Board of Directors	
Agenda Item	20/21 088
Title of Report	Pandemic Impact on Performance Trajectories (Planned Care)
Date of Meeting	5 August 2020
Author	Anthony Middleton, Chief Operating Officer
Accountable Executive	Anthony Middleton, Chief Operating Officer
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**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

This paper provides details on how the Trust is commencing a safe and effective restarting of planned care activities, and the expected impact upon delivery of key access standards during 2020/21.

2. Risk Assessments

All Divisions have completed a detailed risk assessment for each specialty and/or function, which was signed off at Triumvirate level with summary “heat maps” presented to the Chief

Executive officer and Chief Operating officer on the 2 July 2020. In turn this was collated into an overall Trust "heat map" shown in Appendix 1.

The assessments provided a number of questions around the clinical aspects of model provision, for instance self isolation of patient timescales, swabbing processes for staff or the level of PPE to be deployed in the theatre environment. All these questions were considered and determined by CAG, and have been operationalised for the restart.

The assessments also drew attention to key workforce constraints, specifically consultant anesthetists and theatre staff. The medical director, chief nurse and chief operating officer held a number of meetings with the respective leads to understand the issues and provide support to resolution.

3. Operational Model

3.1 Clinical Prioritisation

When national guidance instructed the cessation of all non-urgent planned activities from mid-march, it set out a clinical classification which should be applied to all patients on waiting lists and any new additions:

Code	Clinical Prioritisation Criteria
P1	Operation needed within 24 hours
P2	Operation needed with 4 weeks
P3	Operation can be delayed for up to 3 months
P4	Operation can be delayed for more than 3 months

As the restart gathers momentum it is critical that the same approach to classification is maintained and that a return to previous prioritisation processes is avoided. This is receiving increased focus within Divisions as it is recognised that the operational model for booking moving to a centralised function, with Divisions "seconding" support to the central team will remove localised control.

The centralisation of the booking function has been agreed as the most effective way to ensure theatre capacity is allocated based upon overall access standard risks across specialties.

3.2 Theatre Polling Range

It is the intention to move rapidly to a 6 week polling range across theatres and achieving lockdown of lists much sooner than pre-covid arrangements. It is recognised that at present the SOP for theatre staffing allows lockdown to only 4 weeks, which is out of synch with consultants at 6 and also presents a risk to late notification changes meaning cancellation or low throughput sessions. Given the need for patients to self-isolate in advance of surgery, the earlier notification they receive of an absolute date for surgery the greater the chance they have to prepare.

Throughout the COVID period, booking timescales have fallen due to as low as 2 weeks due to staffing, patient and environmental concerns which has seen an increase in sessional cancellations but bookings are now underway to poll out to the end of August, and then maintain that 6 week range.

3.3 Theatre Throughput

The Trust has examined its processing time around the increased regimes of donning & doffing PPE, deep cleaning and anesthesia and this would suggest that in session utilisation would reduce to 50%. This is not out of synch with other C&M Trust's assessments and is being used at the basis for current bookings, however, a proposal spearheaded by the Surgical Division is being actively considered by CAG which looks to a different approach to the level of PPE being deployed in the Clatterbridge theatres based upon the site's exposure to COVID and the steps taken to test patients in advance of elective surgery. This proposal could see actual operating time to increase to 85% as was the case pre-covid.

3.4 Performance Management

Routine performance reporting is being adapted to encompass "new" critical information such as the "P" codes to ensure administrative processes are robust, as well as prompt and insightful harm reviews for any breach of standard. The increased emphasis on these requirements for all clinical and operational teams to comply with has been discussed and endorsed by the Medical Director, Chief Nurse and Chief Operating Officer and is being communicated and tested out through the next round of Divisional reviews.

4. Access Performance Trajectories

4.1 Cancer

4.1.1. Two Week Waits

It is expected that during Quarter 2 performance against this standard will return to compliance in line with pre-covid levels.

4.1.2 62 Day Standard

The table below details the expected delivery of standard by tumour site and quarter for 2020/21, with an overall Trust level % performance forecast against the 85% standard.
The key to the RAG rating is:

Green = Delivery of national Standard

Amber = Delivery in line with Pre-Covid performance

Red = Reduced delivery as backlog is cleared

Tumour Site	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Breast				
Haematology				
Lung				
Gynaecology				
Other				
Skin				
Head & Neck				
Upper GI				
Colorectal				
Urology				

Trust Total	86%	70%	85%	86%

4.2 Referral to Treatment (RTT)

4.2.1 Time to Clear – Priority Order

All available capacity is being allocated to those patients in clinical priority order, although clearly individual specialties have differing sized waiting lists and theatre staffing teams can also by specialised. This means that delivery against the priorities will not be uniform, although solutions for additional capacity focused on outlying areas is being pursued.

The table below forecasts as what point in the year specialties will be able to deliver against the priority timescale as business as usual and therefore move on to addressing the next priority.

Specialty	P2	P3
Anaesthetics	July 2020	July 2020
Breast Surgery	July 2020	July 2020
Colorectal	July 2020	July 2020
ENT	July 2020	July 2020
General Surgery	July 2020	August 2020
Gynaecology	July 2020	August 2020
Orthopaedics	August 2020	September 2020
Oral & Maxillofacial	August 2020	October 2020
Urology	July 2020	October 2020
Upper GI	August 2020	November 2020
Ophthalmology	August 2020	March 2021

4.2.2 RTT Performance (% under 18 weeks)

The combination of significantly reduced elective activity, reduced referrals and reduced outpatient activity over the past few months has seen a sharp decline in RTT % performance although the overall waiting list has remained relatively static.

It is forecast that the overall performance level is likely to bottom out at 40% by the end of July 2020 and then as the restart gathers momentum there will be a very small recovery of only around 1% per month. This is fully expected given that whilst overall activities will increase it, it will not be at the same level as pre-covid and activity through theatres will be targeted at those patients whose pathway should be complete with 18 weeks.

There is however, an expectation that non admitted RTT performance will improve offsetting any further deterioration.

4.2.3 52 weeks waiters

Since April the number of 52 week waiters (P4 classified patients) is increasing month on month by circa 200 patients. Whilst harm reviews provide a level of assurance that the patient is managed safely it does little to address the deterioration against this standard pro-actively.

Therefore as part of the restart the Trust will move to clinically review any patient who reaches 45 weeks in their pathway and determine whether their “P code” needs to be amended. Should a patient need to be expedited at this point then there will be sufficient time to book the patients treatment date before the 52 week backstop.

5. Conclusion

The performance trajectories for non-urgent elective activities presents a situation where recovery of waiting times will take a considerable period of time to complete, and there still remains a risk of further impact should a second wave of COVID 19 materialise.

It should be noted that at this stage of the recover planning timescales this position is largely in line with that of other general acute trust providers across the country.

The Trust now has greater clarity of the activity it can safely provide through core capacity and is exploring solutions to increase its activity to at least that of pre-covid levels in the long term, and a greater level in the short term to address backlogs.

Internally there is an emphasis on quantifying the appetite and scale of additional activity that could be done outside of normal core hours using existing staff, or at the local independent sector provider, albeit the latter is often reliant on the same workforce.

Regionally there is a work stream looking at how mutual aid could be provided, either through the pooling of waiting lists across Trusts or where pockets of excess specialty capacity could be offered up to address inequalities

6. Summary

The Board is asked to recognise the plan that has been developed, the impact that it will have on key access standards and the work that is underway to mitigate the loss of activity.

It is proposed that a further update is brought to the board at a future date to demonstrate progress.

Trust Heat Map – Planned Care

Summary Trust Risk Heat Map RAYG Rating						
Specialty	Patient Care /Experience/ Harm	Workforce	Performance / RTT/ Targets	Financial	Environmental	Strategic objectives/ Priorities of specialty /Division
AHP outpatient	Yellow 3x2=6	Amber 3 x 3 =9	Yellow 2 x 3 = 6	Green 1 x 1 = 1	Red 4x4=16	Amber 3 x 3 =9
Breast	Green 2 x 2 = 4	Green 2 x 2 = 4	Amber 2 x 4 = 8	Green 2 x 2 = 4	Amber 3 x 4 = 12	Green 2 x 2 = 4
Cardiology	Amber 4 x 3 = 12	Amber 3 x 3 =9	Red 5x3=15	Amber 3 x 3 =9	Amber 3 x 3 =9	Yellow 3x2=6
Chronic Pain	Amber 4 x 3 = 12	Red 5 x 4 = 20	Red 5x3=15	Green 3 x 1 = 3	Yellow 4 x 1 = 4	Amber 4 x 2 = 8
Community Paediatrics (Neuro Dev, Continuing Care)	Amber 3 x 3 =9	Green 2 x 2 = 4	Red 5x3=15	Green 2 x 2 = 4	Green 2 x 2 = 4	Green 2 x 2 = 4
CT	Yellow 2x3=6	Amber 4 x 3 = 12	Red 5x3 =15	Amber 4 x 2 = 8	Amber 4 x 3 = 12	Amber 3 x 3 =9
Dermatology	Amber 3 x 3 =9	Green 3 x 1 = 3	Red 5x3 =15	Yellow 3x2=6	Amber 3 x 3 =9	Amber 3 x 3 =9
Dexa	Amber 3 x 3 =9	Green 1 x 1 = 1	Red 5x3 =15	Green 1 x 1 = 1	Green 1 x 1 = 1	Amber 3 x 3 =9
Diabetes / Endocrinology	Green 3 x 1 = 3	Green 3 x 1 = 3	Green 1x3=3	Green 3 x 1 = 3	Green 3 x 1 = 3	Yellow 3x2=6
DME and Stroke	Amber 3 x 3 =9	Amber 3 x 3 =9	Green 1x3=3	Yellow 3x2=6	Yellow 3x2=6	Amber 3 x 3 =9
Endoscopy	Red 4x4=16	Amber 3 x 3 =9	Red 5x4 = 20	Amber 3 x 3 =9	Amber 4 x 3 = 12	Amber 4 x 3 = 12
ENT	Yellow 2x3=6	Yellow 2x3=6	Red 5x4 = 20	Yellow 3x2=6	Yellow 3x2=6	Amber 3x3=9
Gastroenterology	Amber 4 x 3 = 12	Red 4x4=16	Red 5x3 =15	Amber 4 x 3 = 12	Green 3 x 1 = 3	Amber 3 x 3 =9
General Surgery	Red 5x3 =15	Amber 3x3 = 9	Red 5x4 = 20	Amber 3x3 = 9	Amber 4x3 = 12	Amber 4x3 = 12
Gynaecology (inc Gynae Oncology, Regional Endometriosis)	Red 3 x 5 = 15	Yellow 2 x 3 = 6	Red 5x4 = 20	Green 2 x 2 = 4	Red 3 x 5 = 15	Amber 3 x 3 =9
Haematology	Green 3 x 1 = 3	Amber 3 x 3 =9	Amber 3 x 4 = 12	Amber 3 x 3 =9	Amber 3 x 3 =9	Yellow 3x2=6
IR	Red 5x3 =15	Green 1 x 1 = 1	Amber 4 x 3 = 12	Green 1 x 1 = 1	Red 5x3 =15	Amber 3 x 3 =9
MR	Green 1x1=1	Amber 4 x 3 = 12	Green 1 x 3 = 3	Amber 4 x 2 = 8	Green 1x1=1	Amber 3 x 3 =9
Nephrology	Green 3 x 1 = 3	Amber 3 x 3 =9	Green 1 x 3 = 3	Amber 3 x 3 =9	Amber 3 x 3 =9	Yellow 3x2=6
OMFS	Amber 4x3=12	Amber 4x2=8	Red 5 x 4 = 20	Amber 4x2=8	Amber 4x2=8	Yellow 4x1=4
Ophthalmology	Amber 3x4=12	Amber 4x2=8	Red 5x3 =15	Amber 4x3=12	Amber 4x3=12	Amber 4x2=8
Orthodontics	Amber 4x2=8	Green 2x1=2	Green 1 x 3 = 3	Green 4x1=4	Amber 4x2=8	Green 4x1=4
Orthopaedic	Red 5 x 4 = 20	Red 5 x 3 = 15	Red 5 x 4 = 20	Green 1 x 1 = 1	Amber 5 x 2 = 10	Amber 5 x 2 = 10
Outpatients	Amber 3 x 3 =9	Green 1x3=3	Amber 3 x 3 =9	Green 1x3=3	Amber 4 x 3 = 12	Green 1x3=3
Paediatric Audiovestibular Medicine, Adult Audiology	Amber 3 x 3 =9	Green 2 x 2 = 4	Amber 3 x 3 =9	Green 2 x 2 = 4	Red 3 x 5 = 15	Green 2 x 2 = 4
Palliative Care	Yellow 3x2=6	Amber 3 x 3 =9	Green 1x3=3	Yellow 3x2=6	Yellow 3x2=6	Green 2x1=2
Respiratory	Amber 4 x 3 = 12	Amber 3 x 3 =9	Red 5 x 4 = 20	Yellow 3x2=6	Amber 4x3=12	Yellow 3x2=6
Rheumatology	Amber 4 x 3 = 12	Amber 4 x 3 = 12	Red 5 x 3 = 15	Amber 3 x 3 =9	Yellow 3x2=6	Yellow 3x2=6
Theatres	Amber 4 x 2 = 8	Red 5 x 4 = 20	Red 5 x 4 = 20	Amber 4 x 2 = 8	Amber 4 x 2 = 8	Amber 4 x 2 = 8
Trauma	Green 1 x 2 = 2	Green 1 x 2 = 2	Amber 3 x 4 = 12	Green 1 x 1 = 1	Green 1 x 1 = 1	Green 1 x 1 = 1
Urology	Amber 3x3=9	Yellow 3x2=6	Red 5 x 4 = 20	Yellow 3x2=6	Amber 3x3=9	Yellow 3x2=6
US	Green 1x1=1	Green 1 x 1 = 1	Red 5 x 3 = 15	Green 1 x 1 = 1	Green 1 x 1 = 1	Amber 3 x 3 =9

Board of Directors	
Agenda Item	20/21 089
Title of Report	Cancer Pathways – Cheshire & Merseyside
Date of Meeting	5 August 2020
Author	Anthony Middleton, Chief Operating Officer
Accountable Executive	Anthony Middleton, Chief Operating Officer
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**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The purpose of this paper is to inform the board of the increasing number of cancer patients across Cheshire and Merseyside and the actions being taken locally and collectively to redress.

2. Background

On the 30th June the Cheshire & Merseyside (C&M) Cancer Alliance wrote to all Trust Chairs, Trust Chief Executives and CCG accountable officers to raise that across C&M there was the highest number of patient on cancer pathways waiting more than 104 days in England per 100k population and the second highest number of patients waiting more than 62 days.

The cancer Alliance drew attention to the increase in numbers since the start of the COVID-19 pandemic citing a 663% increase in over 104 day numbers, and a 410% increase for over 62 day patient numbers..

It was specifically requested that boards be sighted on the local and regional performance, which is set out below.

3. Regional Position

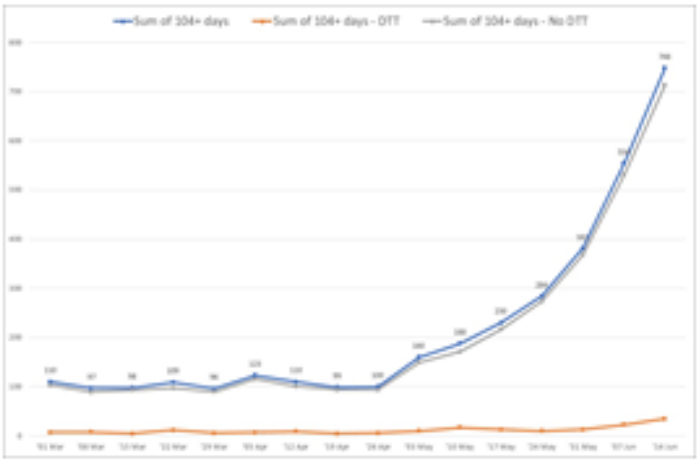
The tables below demonstrate the aggregate increase in patient numbers and also provides the split by provider. It should be noted that the data presented only identifies the current live waiting list position and does not account for patient pathways which pass across more than one provider.

For example a urology referral starting at Aintree before being referred for robotic surgery at Wirral would show as a long waiter at Wirral, even though the pathway may have been delayed at the referring organisation.

Cancer waits >104 days

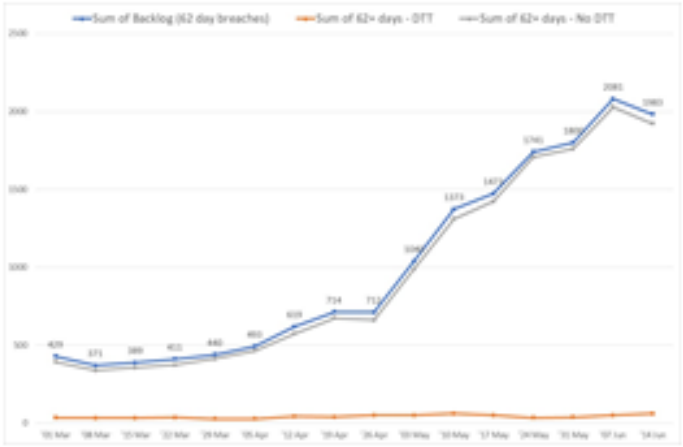
Cheshire & Merseyside Cancer Alliance

The number of patients waiting over 104 days has risen by 663%



Trust	104+ Day Waiters
Countess Of Chester	119
East Cheshire	42
Mid Cheshire	112
Liverpool University Hospitals	239
Southport and Ormskirk	5
St Helens and Knowsley	50
Warrington And Halton	44
Wirral University	111
Bridgewater	0
Clatterbridge Cancer Centre	5
Liverpool Heart and Chest	1
Liverpool Womens	20
Walton Centre	0
CMCA	748

The number of patients waiting over 62 days has risen by 410%



Trust	62+ Day Waiters
Countess Of Chester	284
East Cheshire	132
Mid Cheshire	242
Liverpool University Hospitals	641
Southport and Ormskirk	66
St Helens and Knowsley	113
Warrington And Halton	167
Wirral University	282
Bridgewater	7
Clatterbridge Cancer Centre	18
Liverpool Heart and Chest	1
Liverpool Womens	30
Walton Centre	0
CMCA	1983

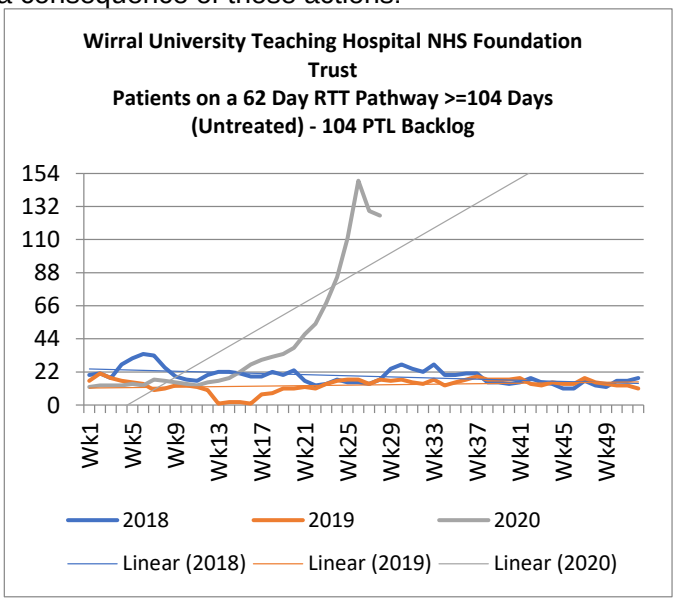
4. Action

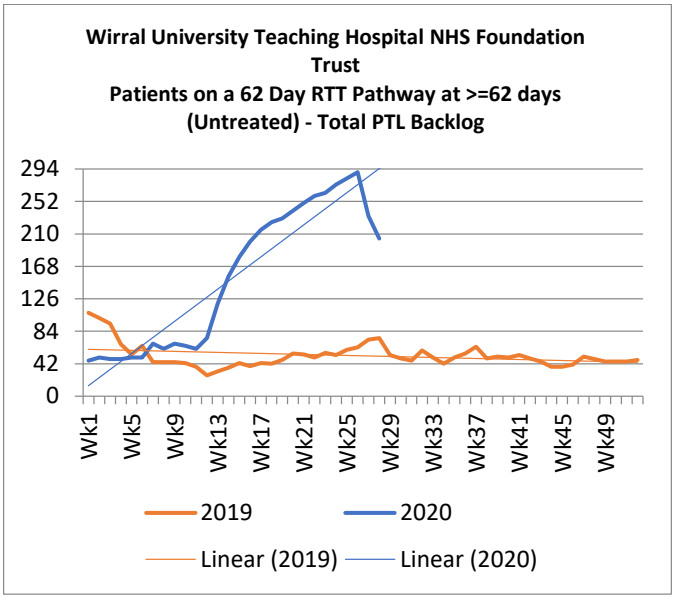
At the outset of the COVID-19 pandemic national guidance was released instructing clinical review of all patients whether they are cancer or non-cancer with a judgement taken on how long those patients could safely wait for assessment, diagnostics or surgery. The most urgent cases continued to be treated throughout the pandemic but pathways were elongated for those that could wait.

As part of the recovery and reset that all providers have commenced, activities for non-urgent cases are now being reinstated and it is expected that numbers will reduce.

The Trust, as detailed in a separate paper also presented to the Board of Directors this month has set out the scale of the restart and the impact on performance trajectories that can be expected.

However, the tables below demonstrate how those numbers are already beginning to reduce as a consequence of those actions:





The improvements seen above are primarily down to the activities within the Trust, however, the Trust is routinely sharing patient level waiting lists, and capacity availability with the cancer alliance so that the long standing single patient targeting list employed across C&M allows choice to patients and clinicians.

5. Conclusion

The Trust has a good track record of delivery of cancer standards in recent years, and has continued to deliver cancer activity for the most urgent cases during the peak of the pandemic. As services increasingly restart the focus will be on using capacity for those patients requiring most urgent treatment, and during quarter 2 of 2020/21 the Trust expects to tackle the backlog created by the pandemic. It is forecast that during Qtr 3 the Trust will be in a position which delivers the standards to the levels seen pre-covid.

The Trust is committed participant to the alliance and is working to provide mutual aid where possible.

6. Recommendations

The Board is asked to note the progress made to redress the increased cancer waiting list and recognise the regional efforts being taken to address inequalities.

Board of Directors	
Agenda Item	20/21 090
Title of Report	Month 3 Finance Report 2020/21
Date of Meeting	5 August 2020
Authors	Shahida Mohammed
Accountable Executive	Claire Wilson Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 3 Finance Report 2020/21

Contents

- The overall Mth 3 performance position is break-even, this is in-line with NHSI's expectations and reflects the new financial infrastructure support provided to organisations to support the national response to the COVID-19 pandemic.

- The in-month position includes:
  - "Income guarantee support" to offset the reduced activity presenting in the Trust during June of £9.0m.
  - Revenue costs incurred in responding to COVID-19 locally of (c£1.1m).
  - "additional top-up" funding of c£0.4m

- All costs incurred in relation to the management of COVID-19 are included in the overall Trust position and 'top up' income is then provided for any ***net*** increase to expenditure.

- The Trust has seen a ***net*** increase in expenditure in month 3 of £0.4m and has therefore included additional "top up" income to offset this. This ***net*** position is driven by a technical adjustment in relation to PDC dividends paid for quarter 1 and has arisen following further guidance released in July from NHSI affecting those Trusts that are converting previous loans (borrowings) to PDC.

- The operational underspend (excluding COVID-19 costs) has been driven by a significant reduction in non-COVID-19 patients presenting to the Trust, including the national suspension of the elective programme (this ended mid-June). Variable costs associated with this routine activity i.e. drugs, clinical consumables, outsourcing and premium staff costs have all decreased from previous levels.

- Cash balances at the end of June 2020 were £41.9m; this reflects the accelerated cash payments made to providers for M1-4 to support the liquidity position. NHSI have committed to supporting the cash position for all providers through to October 2020. This arrangement will then be reviewed in conjunction with the overall financial infrastructure for the NHS for the remainder of 2020/21.

- The Trust's formal cost improvements/efficiencies program has been "paused" to enable it to focus on responding to the pandemic, this is in line with the removal of the national efficiency requirement by NHSI. However, productivity improvements that have been made to support the COVID-19 response are being developed further and the Trust are working with the Healthy Wirral system partners on areas which can further support system capacity as part of the phase 3 recovery reset.

- The finance regime post 31st July 2020 has not yet been confirmed but guidance is expected imminently. It is anticipated that current arrangements will continue until at least the end of August 2020. An update will be provided if any further clarification is received before the meeting.

- On 17th March 2020, the operational planning process for 2020/21 was suspended and NHSE/I announced amended financial arrangements for the initial period between 1 April and 31 July 2020, to enable the NHS to respond to COVID-19.

- A key part of these changes included moving to a nationally determined monthly 'block contract' payment and where necessary 'top-up' payment designed to cover costs.

- The base period for the payments is the average of the Mth 8 – Mth 10 (19/20), activity. A national top-up payment will be allocated to providers to reflect the difference between the actual costs and income guaranteed. Providers are required to ensure that robust financial governance arrangements are in place and that financial grip is maintained.

- The aim of this proposal is to free-up the maximum possible inpatient and critical care capacity and to remove routine burdens. This also includes the cancellation of all non-urgent elective activity for a period of 3 months (this ended mid-June).

- In 2019/20, all costs incurred in relation to the management of COVID-19 were funded directly by NHSI. However, following the change in the financial infrastructure for 2020/21, all on-going COVID-19 costs will now be included in the overall Trust position and 'top up' income will then be provided for any net increase to expenditure.

- All organisations are expected to demonstrate clear governance arrangements are in place for approval and all costs are properly accounted for through the period. Audits will be undertaken to ensure appropriate accounting rigour is applied.

For information, Appendix 1 details changes made in-year changes to the initial financial plan which has a net zero impact.

3. Dashboard, overview and Risks

3.1 Mth 3 Performance Dashboard

		Current Period			Year to date		
		Budget	Actual	Variance	Budget	Actual	Variance
I&E Performance (£'000)	On Plan	0	0	0	0	0	0
NHSI UoR rating	On Plan		2	2		2	2
NHSI Agency Ceiling Performance (£'000)	NHSI cap	656	477	179	1,967	1,554	412
Capital spend (£'000)	On Plan	1,426	773	(653)	2,218	1,800	(418)

3.2 Risk summary

Risk 1 - Operational Management of the position

- Management of the operational position to understand the marginal impact of cost increases as activity beings to resume. This is being reviewed by analysing actual pay costs compared to bed occupancy and LOS to understand the impact step-changes in activity.
- Ensuring all revenue COVID-19 -19 spend is accurately recorded, this is reviewed as part of the monthly reporting cycle and analysed in detail, and assumptions are "stress tested" internally. The reported position is submitted to NHSI where national and regional finance teams perform analytical reviews and reasonableness test for all COVID-19 costs as part of the overall assurance process.

Risk 2 – Cash

- Formal confirmation has been received that the Trust overall cash position will be supported from Mth 1 – Mth 4. This position will be reviewed, and further guidance as to the financial regime from August onwards is due imminently.

Risk 3 – Capital Expenditure

- Divisions submitted refined Capital plans and risk assessed schemes for approval at the end of May 2020 and this has enabled a revised capital programme for the year to be agreed. In year delivery of this programme will be overseen by the newly established Capital Management Group (CMG).
- Ensuring prior approval is received on all COVID-19 19 capital spend, regular dialogue is held with NHSI to ensure the Trust is on the "front-foot" and costs identified are approved prior to schemes commencing.
- The Trust has submitted a bid to NHSI via the Cheshire and Merseyside hospital cell to support its preparation for the phase 3 COVID-19 response over winter. The outcome of this bid is currently not known and will require significant work to deliver in time for winter.

4. Financial performance

4.1 Income and expenditure

For the period April to July 2020, the Trust has a guaranteed monthly income allocation which has been set nationally based upon the Trust's average expenditure run rate for November 2019 to January 2020. Where the impact of COVID-19 results in a net increase in expenditure, this will be funded via a 'top up' payment.

For June (month 3) although, the Trust has delivered a "break-even" position overall as expected by NHSI, "additional" top up funding has been required of c£0.4m. This entirely relates to the impact of dividend charges following the national conversion of previous Trust borrowings to PDC. NHSI are cited on the impact of this and have advised all Trust's to recover this costs via the "additional" top up route.
Excluding this, the overall Trust position is "break-even", this reflects the net impact of underspends relating to reduced activity levels offset by £1.1m of incremental expenditure related to the management of COVID-19.

COVID-19 costs reduced during June compared to costs incurred in May, mainly in pay expenditure due to a decrease in the utilisation of nurse bank staff and the conclusion of the fixed term contracts with final year junior medical staff. The reduction in non-pay costs incurred mainly relates to clinical supplies costs and drugs. Going forward, operational costs to support "routine" activity are expected to increase, particularly as the planned activity program is recommenced.

The operational underspend (excluding COVID-19 costs) has been driven by a significant reduction in non-COVID-19 patients presenting to the Trust, including a suspension of the elective programme (as noted previously). Variable costs associated with this routine activity i.e. drugs, clinical consumables, outsourcing and premium staff costs have all decreased from previous levels.

An analysis of this is provided in Table 1 below.

Table 2: Financial position for the period ending 30th June 2020

Month 3 Financial Position	Budget (Mth 3)	Actual (Mth 3)	Variance	Year To Date Budget	Year To Date Actual	Variance	M2	M3	Mvt
NHS income from patient care activity	27,599	18,546	(9,054)	82,798	50,421	(32,377)	(11,314)	(9,054)	2,260
Income Guarantee	0	8,958	8,958	0	32,157	32,157	11,274	8,958	(2,316)
National Top-up	2,562	2,562	0	7,686	7,688	2	0	0	0
Non NHS income from patient care	457	340	(118)	1,372	1,009	(362)	(110)	(118)	(8)
Other income	2,584	2,139	(445)	7,776	6,503	(1,273)	(448)	(445)	3
Total Income	**33,203**	**32,544**	**(658)**	**99,632**	**97,779**	**(1,854)**	(598)	(658)	(60)
Employee expenses	(22,419)	(21,844)	575	(67,287)	(65,549)	1,738	505	575	70
Operating expenses	(10,357)	(9,270)	1,087	(31,068)	(27,368)	3,699	1,425	1,087	(338)
Covid 19 costs	0	(1,087)	(1,087)	0	(4,441)	(4,441)	(1,796)	(1,087)	709
Total expenditure	**(32,777)**	**(32,201)**	**575**	**(98,354)**	**(97,357)**	**997**	134	575	441
Non Operating Expenses	(426)	(723)	(297)	(1,278)	(989)	289	296	(297)	(593)
Actual Surplus / (deficit)	**0**	**(380)**	**(380)**	**0**	**(567)**	**(567)**	**(168)**	**(380)**	**(212)**
Reverse capital donations / grants I&E impact	0	14	14	0	60	60	23	14	(10)
Surplus/(deficit)	**0**	**(367)**	**(367)**	**0**	**(507)**	**(507)**	**(145)**	**(367)**	**(222)**
Additional "top up" required	0	367	367	0	508	508	145	367	222
Adjusted Surplus/(deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Financial performance

The Mth 3 income position includes:

- **Income guarantee** – the impact of the block agreement of £9.0m received from WUTH commissioners to provide income certainty given impact of COVID-19 and loss of elective activity.
- **National top up** – payment made to support additional expenditure above the income guarantee calculated based upon 2019/20 run rate of £2.6m.
- **Additional top up** – required in Mth 3 of (c£0.4m) ensuring a "break-even" position was delivered.

Operational pay costs excluding COVID-19 are c£0.6m below plan; this predominantly reflects the reduced need of non-core staff in clinical areas which are driving lower agency and WLI payments.

Operating non pay costs expenditure, excluding costs associated with COVID-19 are c£1.0m underspent, this predominantly relates to reduced clinical supplies and drugs costs. Expenditure increased slightly in June mainly in drug costs reflecting the increases seen in operational activity.

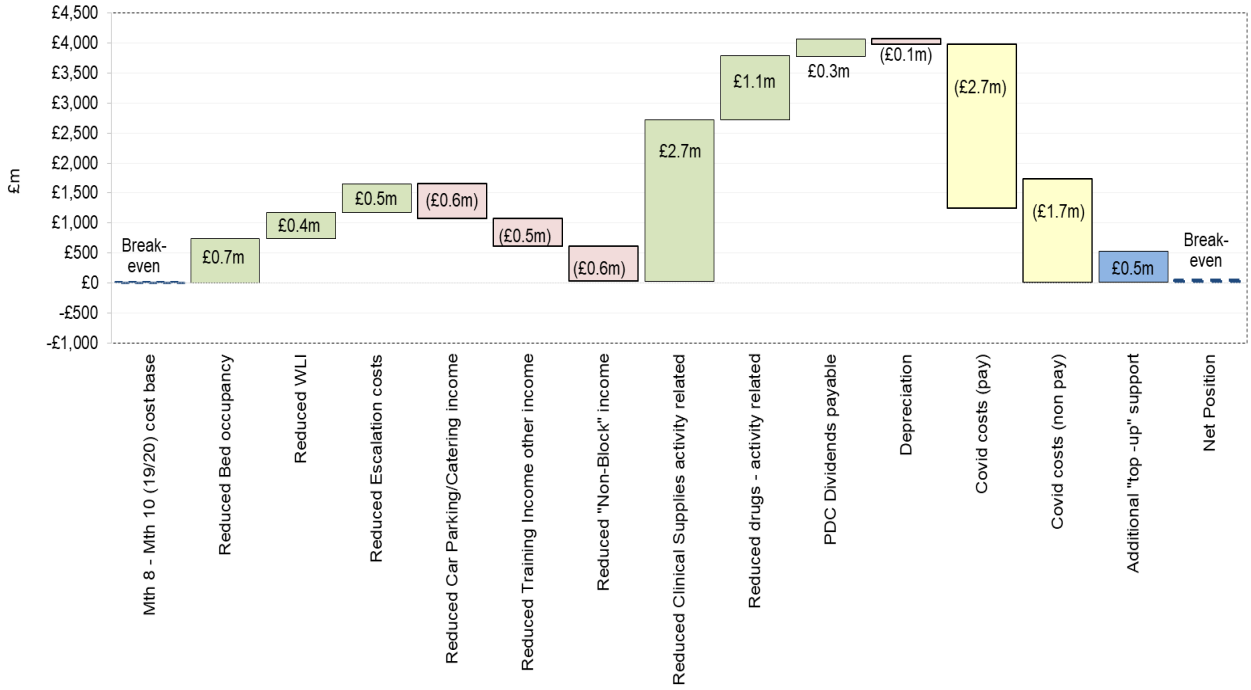
Agency staff costs in June were (c£0.5m), of this (£0.3m) was in medical staff, (c£0.1m) in Pharmacy and nursing, and (c£0.1m) in NHS Infrastructure.

- The improvement in the clinical income position from Mth 3 reflects the increase in emergency care activity in both A&E attendances and NEL spells.
- Operational pay costs in Mth 3 have largely remained consistent with the May spend.
- Non pay costs associated with clinical supplies and drugs increased in June compared to May, reflecting the increase in A&E and NEL activity.
- Costs associated with managing the demand of COVID-19 decreased in June mainly in pay.

In total, c£1.1m was incurred on COVID-19 related activities; this is detailed in Section 5 of this report.

The bridge chart below details the reconciliation of movements in the actual Mth 3 position including the impact of COVID-19 costs.

4. Financial performance



4.2 Income

At the end of June 2020, the Trust overall income position is below plan by (c£1.3m), as the clinical income position is supported by the "block" agreement the under recovery predominately reflects shortfalls in non-contract income below 2019/20 run rate, such as private patients, car parking, and catering. Table 3 below provides a detailed analysis by point of delivery.

Table 3: Income analysis for the period ending 30th June 2020

	Current month			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income from patient care activity						
Elective & Daycase	3,940	1,253	(2,687)	11,821	2,566	(9,255)
Elective excess bed days	303	(2)	(305)	908	161	(747)
Non-elective	3,632	3,049	(583)	10,897	8,172	(2,725)
Non-elective Non Emergency	434	351	(83)	1,302	1,169	(133)
Non-elective excess bed days	1,300	224	(1,076)	3,900	1,556	(2,344)
A&E	7,595	6,424	(1,171)	22,784	16,656	(6,128)
Outpatients	25,001	19,653	(5,348)	75,002	39,657	(35,346)
Diagnostic imaging	2,764	1,564	(1,200)	8,291	2,638	(5,653)
Maternity	535	488	(47)	1,606	1,405	(201)
Non PbR						
HCD						
CQUINs						
National Top up						
Income Guarantee						
Total NHS Clincial Income	45,504	33,003	(12,501)	136,511	73,979	(62,533)
Other patient care income						
Non-NHS: private patients & overseas						
Injury cost recovery scheme						
Total income from patient care activities						
Other operating income						
Total income						

	Current month			Year to date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Elective & Daycase	4,281	958	(3,323)	12,842	1,976	(10,866)
Elective excess bed days	83	(0)	(84)	250	62	(188)
Non-elective	8,487	6,975	(1,512)	25,460	19,050	(6,410)
Non-elective Non Emergency	986	893	(92)	2,957	2,891	(66)
Non-elective excess bed days	357	59	(298)	1,070	416	(654)
A&E	1,286	1,056	(230)	3,858	2,738	(1,120)
Outpatients	3,056	1,815	(1,241)	9,168	4,001	(5,167)
Diagnostic imaging	189	106	(84)	568	171	(397)
Maternity	483	462	(22)	1,450	1,312	(138)
Non PbR	7,185	5,173	(2,013)	21,556	14,918	(6,638)
HCD	1,299	1,095	(204)	3,897	2,966	(931)
CQUINs	190	190	0	570	570	0
National Top up	2,562	2,562	0	7,686	7,831	145
Income Guarantee	0	8,958	8,958	0	32,129	32,129
Total income from patient care (SLAM)	30,444	30,301	(143)	91,332	91,030	(301)
Other patient care income	89	438	349	267	617	350
Non-NHS: private patients & overseas	13	(0)	(14)	40	2	(38)
Injury cost recovery scheme	72	30	(42)	217	133	(84)
Total income from patient care activities	30,619	30,769	150	91,856	91,782	(74)
Other operating income	2,584	2,138	(446)	7,776	6,504	(1,272)
Total income	33,203	32,907	(296)	99,632	98,287	(1,346)

4. Financial performance

Key points are as follows:

- Overall patient-related income is below plan by c£1.3m.
- Based on the "block" arrangements in place for clinical income, the Trust position has been supported by £9.0m in June.
- Operationally activity performance was:

  - A&E activity is at 85% of the previous run rate (average attendances in June were 213 per day, the pre – Covid expected number was 253 per day). This is however an increase of 7% (13 attendances per day) from May.
  - NEL activity is at 84% of expected levels, this is a slight improvement from the May position
  - EL/DC activity has improved by 5% from May. It is now 68% below 19/20 levels.
  - Births were broadly as planned
  - Neonatal cot days have decreased progressively over quarter 1, some of this will be due to managing social distancing measures, therefore reducing cot capacity.
  - Direct Access Radiology/Pathology have increased from the May position
  - Rehab. bed days improved in month; however remain below the previous run rate
  - Other operating income includes shortfalls in car parking and catering income.

4.3 Expenditure

4.3.1 Overall pay expenditure (including COVID-19) for the period ending 30th June 2020

Overall pay costs were below plan by c£0.2m in June and by £1.0m YTD.

The table below details pay costs by staff group.

Table 4: Pay costs by staff type (including COVID-19)

STAFF GROUP	MONTH 3 (£'000)			CUMULATIVE (£'000)		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL / FORECAST	VARIANCE
CONSULTANTS	3,638	3,686	(48)	10,708	10,783	(75)
OTHER MEDICAL	2,491	2,447	44	7,679	7,817	(139)
TOTAL MEDICAL	**6,129**	**6,133**	**(4)**	**18,386**	**18,600**	**(214)**
NURSING & MIDWIFERY	6,056	6,121	(65)	18,321	18,528	(207)
CLINICAL SUPPORT WORKERS	2,294	2,370	(76)	6,891	6,952	(61)
TOTAL NURSING	**8,350**	**8,491**	**(141)**	**25,212**	**25,480**	**(268)**
AHP'S, SCIENTIFIC & TECH	2,928	3,068	(139)	8,830	9,029	(200)
ADMIN & CLERICAL & OTHER	5,012	4,977	35	14,859	15,140	(281)
TOTAL OTHER	**7,941**	**8,045**	**(104)**	**31,629**	**32,214**	**(481)**
OVERALL TOTAL	**22,419**	**22,668**	**(249)**	**75,228**	**76,294**	**(962)**

4. Financial performance

The overspend on Consultants and nursing staff costs from the previous run-rate (budget), predominantly reflects increased costs associated responding to the Covid 19 pandemic.

Part of the increase in nursing and admin & clerical staff costs is also due to the commencement of staff into previously vacant substantive posts, which was outside of the calculation of the base period by NHSI in the development of the budget.

Table 5 below details pay costs by category for June (incl. COVID-19 costs).

Table 5: Pay analysis by type

Pay costs excluding costs associated with COVID-19 is detailed in the table 6 below.

Pay analysis (inc Covid)	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	(251,404)	(19,988)	(20,985)	(997)	(59,993)	(62,342)	(2,349)
Bank	(4,729)	(1,061)	(725)	336	(3,183)	(2,634)	549
Medical bank	(5,092)	(625)	(393)	233	(1,876)	(1,459)	417
Agency	(4,857)	(655)	(476)	179	(1,966)	(1,553)	412
Apprenticeship Levy	(1,026)	(90)	(89)	1	(269)	(261)	8
Total	(267,108)	(22,419)	(22,668)	(249)	(67,287)	(68,249)	(962)

Table 6 – Operational pay costs (excluding COVID-19)

STAFF GROUP	MONTH 3 (£'000) BUDGET	MONTH 3 (£'000) ACTUAL	MONTH 3 (£'000) VARIANCE	CUMULATIVE (£'000) BUDGET	CUMULATIVE (£'000) ACTUAL / FORECAST	CUMULATIVE (£'000) VARIANCE
CONSULTANTS	3,638	3,562	76	10,708	10,393	315
OTHER MEDICAL	2,491	2,368	123	7,679	7,354	324
TOTAL MEDICAL	**6,129**	**5,929**	**200**	**18,386**	**17,747**	**639**
NURSING & MIDWIFERY	6,056	6,004	52	18,321	18,028	294
CLINICAL SUPPORT WORKERS	2,294	2,142	152	6,891	6,279	612
TOTAL NURSING	**8,350**	**8,146**	**204**	**25,212**	**24,307**	**905**
AHP'S, SCIENTIFIC & TECH	2,928	2,881	47	8,830	8,698	131
ADMIN & CLERICAL & OTHER	5,012	4,888	124	14,859	14,796	63
TOTAL OTHER	**7,941**	**7,769**	**171**	**31,629**	**31,264**	**194**
OVERALL TOTAL	**22,419**	**21,844**	**575**	**75,228**	**73,318**	**1,738**

Key points are as follows:

- Non-core costs such as bank and agency for medical and nursing staff groups have reduced substantially due to reduction in non-COVID-19 activity.
- Given the pause on the non-emergency elective programme, WLI were only undertaken in Respiratory Medicine which is to directly support the additional cover required for supporting the Trust COVID-19 response.
- The reduction in the attendances in A&E and non-elective patients eliminated the need for any escalation areas to be open in June; this is reflected in the above position.

4.3.2 Non pay

Table 8: Non-pay analysis (excluding COVID-19 costs)

Non pay expenditure, excluding depreciation, is below plan by c£1.1m in June, and £3.7m YTD.

Non Pay Analysis (exc Covid)	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	(34,958)	(3,007)	(2,259)	748	(9,022)	(6,639)	2,382
Supplies and services - general	(5,158)	(445)	(333)	111	(1,334)	(1,022)	312
Drugs	(24,690)	(1,951)	(1,743)	208	(5,852)	(4,792)	1,060
Purchase of HealthCare - Non NHS Bodies	(8,153)	(618)	(507)	111	(1,854)	(1,643)	210
CNST	(13,235)	(1,070)	(1,119)	(49)	(3,210)	(3,358)	(148)
Consultancy	(474)	(69)	0	69	(206)	(0)	205
Other	(25,991)	(2,365)	(2,494)	(129)	(7,091)	(7,311)	(220)
Total	(112,659)	(9,524)	(8,456)	1,068	(28,569)	(24,766)	3,803
Depreciation	(11,644)	(833)	(814)	19	(2,499)	(2,602)	(103)
Total	(124,303)	(10,357)	(9,270)	1,087	(31,068)	(27,368)	3,699

Key points are as follows:

- The main driver of the underspend is reduced clinical supplies costs of c£0.9m in mth and £2.7m YTD, a direct correlation to the reduced/paused elective programme.
- Drug costs are also reduced which is consistent with activity position.
- The "Other" category above incorporates a number of areas, including energy, and interpreter fees.

4.5 2020/21 Forecast Outturn to July 2020

NHSI have asked organisations to forecast the position to July 2020, (this is the initial period of the "block" arrangement and national support). The main aim of the exercise is to understand the "most likely" value of "additional" top-up needed.

Table 9 below details the "additional" top up funding required.

The following assumptions are included in the forecast position:

- Emergency activity increases to 85% of the previous levels, currently the position is 80%
- EL/DC activity recommences from July 2020, with Theatre utilisation initially at 50% of capacity.
- COVID-19 revenue spend in July will be consistent with costs incurred in June.

Based on the above as shown in Table 9 below, "additional" top-up funding of c£0.7m will be needed to the end of July 2020.

This is a slight reduction from the forecast presented in June and reflects two key components:

- The impact of the technical adjustment regarding the dividend payments on borrowing converted to PDC.

4. Financial performance

- Reduced costs of Covid, reflecting the consistently reduced number of cases in the Trust over June and July.

4. Financial performance

Table 9 – Forecast outturn to July 2020

	April Budget £m	April Actual £m	April Variance £m	May Budget £m	May Actual £m	May Variance £m	June Budget £m	June Actual £m	June Variance £m	July Budget £m	July Forecast £m	July Variance £m	Mth 1- Mth 4 Budget £m	Mth 1-Mth 4 Actual £m	Variance £m
Clinical Income (including PSF)	-30,448	-30,293	-155	-30,448	-30,292	-156	-30,448	-30,298	-150	-30,448	-30,298	-150	-121,791	-121,179	**-612**
Additional Top up	0	0	0	0	-145	145	0	-367	367	0	-202	202	0	-714	**714**
Divisional Clinical Income	-171	-106	-64	-171	-178	7	-171	-105	-66	-171	-105	-66	-684	-494	**-190**
Other income	-2,557	-2,178	-378	-2,636	-2,188	-448	-2,584	-2,138	-446	-2,584	-2,138	-446	-10,360	-8,642	**-1,718**
Total Income	**-33,176**	**-32,578**	**-598**	**-33,254**	**-32,802**	**-452**	**-33,203**	**-32,907**	**-295**	**-33,202**	**-32,742**	**-460**	**-132,835**	**-131,029**	**-1,806**
Consultant	3,535	3,410	**125**	3,535	3,687	**-152**	3,638	3,686	**-48**	3,569	3,695	**-125**	14,277	14,478	**-201**
Other Medical	2,592	2,626	**-33**	2,596	2,745	**-150**	2,491	2,447	**44**	2,555	2,453	**102**	10,233	10,270	**-37**
Nursing	8,429	8,412	**17**	8,433	8,577	**-144**	8,350	8,491	**-141**	8,402	8,502	**-100**	33,614	33,982	**-368**
Other Clinical Staff	4,705	4,799	**-94**	4,774	4,887	**-113**	4,713	4,974	**-260**	4,730	4,974	**-243**	18,923	19,634	**-711**
Other Staff	3,132	3,301	**-168**	3,136	3,138	**-2**	3,227	3,071	**156**	3,164	3,071	**94**	12,660	12,580	**80**
Total Pay	**22,394**	**22,547**	**-153**	**22,474**	**23,034**	**-560**	**22,419**	**22,668**	**-249**	**22,420**	**22,694**	**-274**	**89,707**	**90,944**	**-1,236**
Clinical Supplies	2,983	2,357	626	3,031	2,804	227	3,007	2,189	818	3,007	2,233	775	12,029	9,583	**2,446**
General Supplies	445	597	-153	445	129	316	445	383	61	445	391	53	1,778	1,501	**277**
Drugs	1,951	1,660	291	1,951	1,460	491	1,951	1,742	208	1,951	1,777	173	7,803	6,639	**1,163**
Purchase of Healthcare - non nhs bodies	642	687	-45	594	497	97	618	511	106	618	522	96	2,472	2,216	**255**
Purchase of Healthcare - NHS bodies	520	515	5	530	519	12	525	535	-10	525	546	-21	2,101	2,115	**-15**
CNST	1,070	1,119	-49	1,070	1,119	-49	1,070	1,119	-49	1,070	1,153	-83	4,280	4,511	**-231**
Consultancy	69	38	31	69	-38	106	69	0	69	69	0	69	274	0	**274**
Other	2,677	2,941	-264	2,665	3,172	-506	2,673	3,056	-383	2,672	3,117	-445	10,687	12,285	**-1,599**
Total Non Pay	**10,356**	**9,914**	**442**	**10,355**	**9,661**	**693**	**10,357**	**9,537**	**820**	**10,356**	**9,739**	**617**	**41,423**	**38,851**	**2,573**
Non Operating Expenditure	426	138	288	426	128	298	426	723	-297	426	330	96	1,704	1,319	**385**
Non Operating (Net)	**426**	**138**	**288**	**426**	**128**	**298**	**426**	**723**	**-297**	**426**	**330**	**96**	**1,704**	**1,319**	**385**
Total	**0**	**21**	**-21**	**0**	**21**	**-21**	**0**	**21**	**-21**	**0**	**21**	**-21**	**0**	**84**	**-84**
Reverse capital donations / grants I&E	**0**	**21**	**-21**	**0**	**21**	**-21**	**0**	**21**	**-21**	**0**	**21**	**-21**	0	84	**-84**
Adjusted financial performance including PSF	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**

4.6. Costs incurred to manage the local response to COVID-19 -19

4.6.1 COVID-19 revenue costs

From 1st April 2020, revenue costs incurred as part of the on-going response are not funded separately as they were in 2019/20, instead all costs are included in the overall Trust position and a top up payment made to cover any additional ***net*** costs incurred. During June 2020, an additional £1.1m costs for both pay and non-pay have been incurred. The YTD spend is £4.5m. The revenue cost impact of COVID-19 is collected and submitted to NHSI as part of routine monthly reporting to allow national cost tracking.

For the purposes of ascertaining COVID-19 costs, NHSI have issued detailed guidance as to the "allowable" cost that can be assigned.

.

This means organisations should ***include*** the following:

- The costs of specific COVID-19 policies, directives or nationally approved business cases. This includes the costs of workforce initiatives put in place to enable the expansion of services to deal with the expected increase in demand as a result of COVID-19 (Paragraph 3.1);
- Costs that are a consequence of policies relating to COVID-19 but don't directly relate to the treatment of COVID-19 patients (e.g. paying sick pay at full pay for all staff)
- Some of the above can be subjective and hence Trusts are required to record assumptions.

Table 9 details pay costs by staff group incurred as part of the response.

Table 9: YTD COVID-19 revenue costs – Pay (£000's)

STAFF GROUP	MTH 1 ACTUAL	MTH 2 ACTUAL	MTH 3 ACTUAL	YTD ('000) ACTUAL
CONSULTANTS	70	195	125	390
OTHER MEDICAL	192	191	79	463
TOTAL MEDICAL	**263**	**386**	**204**	**853**
NURSING & MIDWIFERY	163	220	117	500
CLINICAL SUPPORT WORKERS	154	290	228	672
TOTAL NURSING	**317**	**511**	**345**	**1,173**
AHP'S, SCIENTIFIC & TECH	45	99	186	331
ADMIN & CLERICAL & OTHER	187	93	89	369
TOTAL	**812**	**1,090**	**824**	**2,736**

- During June a further c£0.8m was spent on pay costs, directly associated with COVID-19.
- Other medical staff costs have reduced in June following the conclusion of the fixed term contracts of the final year junior medical staff recruited to support the Trust for an initial 8 week period.

- There was also a decrease in the utilisation of bank staff reflecting the reduced demand
- The pay costs above include staff backfill cost for sickness, and those required to self-isolate.
- Sick pay is paid at full pay (for all staff types); this is consistent with NHSI guidelines.

Table 10 below details non-pay costs

Table 10: YTD COVID-19 revenue costs – Non-pay

Non Pay Analysis (Covid)	June Actual £'000	YTD Actual £'000
Supplies and services - clinical	70	(711)
Supplies and services - general	(50)	(88)
Drugs	1	(70)
Purchase of HealthCare - Non NHS Bodies	(4)	(52)
Other	(285)	(815)
Total	(268)	(1,735)

Non pay costs associated with COVID-19 were c£0.3m in June, YTD the spend is £1.7m. This includes:

- On-going rental costs for the Isolation Pod, currently used for swabbing
- Equipment and consumable costs in relation to increasing ITU capacity
- Personal Protective Equipment (PPE) procured by the trust (in excess of the national push deliveries)
- 'Other' includes, lease cost of dialysis equipment, transport costs, and vehicle hire, and signage needed across the ward areas.

4.6.2 COVID-19 Capital costs

Phase 2/3 Recovery/Reset capital requirements

As discussed in the May report, it will be critical to ensure that the Trust takes appropriate measures to stop the spread of infection as non-COVID-19 activity steps up. Detailed planning work was undertaken to assess the IPC infrastructure changes required in each ward and department to support this and to understand the impact this will have on capacity.

The Trust has submitted a draft plan to the C&M hospital cell in early June, this amounted to c£22.6m.

Further work will be required to understand the revenue implications of any successful schemes and the potential exit plans for once the pandemic is over and waiting lists have been managed down to pre-COVID-19 levels. There has been no confirmation of whether capital resources will be available to support the next phase of the plans.

5. Financial Position

5.1 Statement of Financial Position and Cash Flow Statement

The Statement of Financial Position and Cash Flow statement for the period ending 30th June 2020 is set out in Appendix 2.

5.2 Capital programme 2020/21

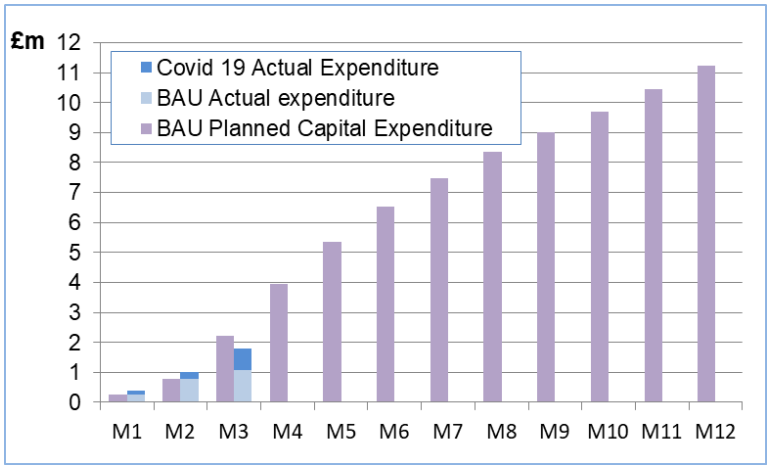
A revised business as usual capital plan of £11.24m has been agreed by the Board of Directors as part of the Cheshire & Merseyside capital envelope.

This plan ***excludes*** COVID-19 response expenditure which is being governed through a national approval process and once approved will be funded through additional Public Dividend Capital (PDC). To date £0.7m has been spent with a full year forecast of £0.9m.

In addition, the Trust has recently re-submitted bids totalling £11.4m to support enhanced IPC requirements and increase clinical capacity at both APH and CGH in response to COVID-19. The outcome of this bid is not yet known. Any approved schemes will be funded through additional PDC.

A detailed analysis of the capital programme to month 3 is set out in Appendix3. Actual YTD capital spend total is £1.8m which largely comprises COVID-19 capital requirements (£0.7m) and schemes brought forward from 2019/20 (£0.8m).

Table 11: Capital expenditure against plan (2020/21)



5.3 Single oversight framework

The table below provides a summary of the Trusts performance against the UoR framework for the period.

- The liquidity rating of 4 remains unchanged from the 2019/20 year end position, reflecting the classification of £83.9m loans as current liabilities pending their repayment in September 2020, funded by additional PDC.

- The capital service capacity metric has improved from a 4 in 2019/20 to a score of 1, due to the year to date break-even position and the cessation of interest charges on borrowings to be repaid in September 2020.
- The month 2 UoR rating is 2 overall. The main driver is the on plan, year to date break-even position under the COVID-19 financial regime.

Table 12: UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-98.2	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.5	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	-21.0%	1
	Overall NHSI UoR rating				**2**

6. Conclusion & Recommendations

At the end of June 2020 (Mth 3), the Trust is reporting a “break-even” position.

This position reflects the £0.4m ***net*** impact of:

- the additional costs relating to COVID-19
- less the reduced expenditure resulting from reduced levels of routine activity undertaken in relation to A&E, emergency and planned care
- the impact of dividend payments following revised guidance from NHSI

The Trust therefore requires “additional” top-up support of c£0.4m (£0.5m cumulatively).

During June 2020, a further £1.1m was spent in managing the pandemic response, increasing the year to date costs to c£4.5m. This includes additional staff backfill costs for sickness, and those required to self-isolate. Non pay costs include equipment and consumables, decontamination, and locally procured PPE. All costs identified as COVID-19 are subject to audit and review by NHSI.

The Trust has been required to forecast its financial position to the end of July 2020. The forecast position to 31st July 2020 is that the Trust will require “additional” top-up funding of £0.7m to ensure a “break-even” position is achieved as the elective programme ramps up over coming weeks.

The finance regime post 31st July 2020 has not yet been confirmed and it is anticipated tht the current regime will continue until the end of August 2020. Securing sufficient capacity to manage winter levels of non-elective demand, future COVID-19 activity and restore at a proportion of the elective programme will be a priority.

A capital investment bid to help the Trust manage the impact of COVID-19 activity on capacity through Phase 2 (restoration) and into Phase 3 (recovery) has been provided to the Hospital Cell for Cheshire and Merseyside in June 2020. Further updates will be provided as feedback is received.

Recommendations

The Board of Directors are asked to note the contents of this report.

Claire Wilson
Chief Finance Officer
August 2020

7. Appendices

Appendix 1

Operational adjustments to the 2020/21 Plan (net zero impact)

The table below details in-year operational adjustments to the initial base plan.

Month 3 Budget Reconciliation	**Breakdown by Budget Type**		
	Income £'000	**Expenditure £'000**	**Deficit £'000**
Base Budget 20/21	99,441	(99,441)	0
Pharmacy PCN Scheme / GPCP Scheme	108	(108)	0
Pharmacy HEE training budget allocation	59	(59)	0
Other minor budget changes	24	(24)	0
M3 Closing Budget	99,632	(99,632)	0
Net Trustwide (Increase)/Reduction	**191**	**(191)**	**0**

7. Appendices

Appendix 2

Statement of Financial Position

Actual as at 31.03.20 £'000		Actual as at 31.05.20 £'000	Actual as at 30.06.20 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	160,923	161,011	88	⇧
14,029	Intangibles	13,837	13,717	(120)	⇩
723	Trade and other non-current receivables	713	696	(17)	⇩
176,244		**175,473**	**175,424**	**(49)**	⇩
	Current assets				
3,991	Inventories	4,200	4,215	15	⇧
24,375	Trade and other receivables	13,257	14,420	1,163	⇧
0	Assets held for sale	0	0	0	⇨
5,931	Cash and cash equivalents	44,466	41,089	(3,377)	⇩
34,297		**61,923**	**59,724**	**(2,199)**	⇩
210,541	**Total assets**	**237,396**	**235,148**	**(2,248)**	⇩
	Current liabilities				
(41,874)	Trade and other payables	(39,828)	(37,885)	1,943	⇧
(3,000)	Other liabilities	(32,101)	(32,055)	46	⇧
(85,234)	Borrowings	(85,273)	(85,292)	(19)	⇩
(2,926)	Provisions	(2,785)	(2,552)	233	⇧
(133,034)		**(159,987)**	**(157,784)**	**2,203**	⇧
(98,737)	**Net current assets/(liabilities)**	**(98,064)**	**(98,060)**	**4**	⇧
77,507	**Total assets less current liabilities**	**77,409**	**77,364**	**(45)**	⇩
	Non-current liabilities				
(2,588)	Other liabilities	(2,570)	(2,561)	9	⇧
(6,274)	Borrowings	(6,263)	(6,258)	5	⇧
(7,304)	Provisions	(7,277)	(7,263)	14	⇧
(16,166)		**(16,110)**	**(16,082)**	**28**	⇧
61,341	**Total assets employed**	**61,299**	**61,282**	**(17)**	⇩
	Financed by Taxpayers' equity				
80,106	Public dividend capital	80,106	80,106	0	⇨
(65,492)	Income and expenditure reserve	(65,534)	(65,551)	(17)	⇩
46,727	Revaluation reserve	46,727	46,727	0	⇨
61,341	**Total taxpayers' equity**	**61,299**	**61,282**	**(17)**	⇩

- Year to date capital additions total £1.8m with the majority of spend relating to COVID-19 response and schemes carried forward from 2019/20.
- Cash and current other liabilities (deferred income) have increased significantly due to the early receipt of NHS Block income under the amended NHSI financial regime implemented in response to COVID-19. These amended contracting arrangements have currently been confirmed until 31 July 2020.
- Current borrowings include £83.9m of DHSC loan which will be repaid in September 2020, funded by receipt of Public Dividend Capital (PDC).

Statement of Cash Flows

	Month Actual £'000	Year to date Actual £'000
Opening cash	**44,466**	**5,931**
Operating activities		
Surplus / (deficit)	(17)	(59)
Net interest accrued	19	65
PDC dividend expense	705	927
Unwinding of discount	(1)	(4)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	706	929
Depreciation and amortisation	814	2,602
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(8)	(8)
Changes in working capital	(3,712)	34,854
Investing activities		
Interest received	0	5
Purchase of non-current (capital) assets [1]	(1,178)	(3,214)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	8	8
Financing activities		
Public dividend capital received	0	0
Net loan funding	0	0
Interest paid	(0)	1
PDC dividend paid	0	0
Finance lease rental payments	(6)	(18)
Total net cash inflow / (outflow)	**(3,377)**	**35,158**
Closing cash	**41,089**	**41,089**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

7. Appendices

Appendix 3

Capital programme 2020/21

	Full Year Budget			Full Year Forecast		YTD	
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual	Distance to Go
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Net depreciation	10,467		10,467	10,467	0	2,617	
Loan repayment	(1,015)		(1,015)	(1,015)	0	0	
Finance lease	(60)		(60)	(60)	0	(15)	
2019/20 funding rolled forward	1,348		1,348	1,348	0	1,348	
Additional external (donations / grant) funding	0	8	8	8	0	0	
Asset disposal proceeds	0		0	0	0	0	
Public Dividend Capital (PDC) - UTC	500		500	500	0	0	
Public Dividend Capital (PDC) - Covid	0	925	925	925	0	0	
Total funding	**11,240**	**933**	**12,173**	**12,173**	**0**	**3,950**	
Expenditure							
Prior year(s) capital commitments	3,526		3,526	3,612	(86)	822	2,790
Estates	4,383		4,383	4,383	0	44	4,339
Informatics	575		575	575	0	5	570
Medicine and Acute	300		300	300	0	0	300
Clinical Support and Diagnostics	369	22	391	392	(1)	23	369
Surgery	1,363	12	1,375	1,375	0	150	1,225
Women and Children's	0		0	0	0	0	0
Other	0		0	0	0	0	0
Contingency[2]	224	(34)	190	0	190	0	0
UTC / Hospital upgrade programme	500		500	500	0	26	474
Covid-19 response	0	925	925	1,003	(78)	729	274
Donated assets	0	8	8	8	0	0	8
Total expenditure (accruals basis)	**11,240**	**933**	**12,173**	**12,148**	**25**	**1,799**	**10,349**
Capital programme funding less expenditure	**0**	**0**	**0**	**25**	**(25)**	**2,151**	
Capital expenditure	11,240	933	12,173	12,148		1,799	
NBV asset disposals	0		0	0		0	
Donated assets	0	(8)	(8)	(8)		0	
CDEL impact	**11,240**	**925**	**12,165**	**12,140**		**1,799**	

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.
[2] Funding is transferred as business cases are approved.

Board of Directors	
Agenda Item	20/21 091
Title of Report	Sickness Absence Report
Date of Meeting	5 August 2020
Author	Jacqui Grice, Interim Director of Workforce
Accountable Executive	Jacqui Grice, Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Choose an item
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

Sickness

1. Executive Summary

This paper contains the current sickness figures across the Trust and outlines the issues faced in performance managing sickness cases given national restrictions faced under agreements at the Social Partnership Forum.

The purpose of the paper is to keep the Board informed about the nature and extent of sickness absence as well as measures currently being undertaken to challenge ongoing, high levels of sickness absence across the Trust.

2. Background

Historically, WUTH has struggled to increase its attendance rate above 95% and its sickness rates are consistently higher than 5%, making it one of the worst performers in the North West Region. The in-month attendance for June 2020 was 93.49%. The rate excluding Covid-19 absences was 95.01%.

Rates of absence had improved prior to February 2020, but have increased during the pandemic, and the Trust, alongside other Liverpool hospitals are showing the highest rates of sickness, (including Covid -19 related illness) in Cheshire & Merseyside. This is consistent with higher rates of infection amongst the general population. We have staff who have been on sick leave for longer periods of time than might be expected from the Covid-19 infection. This suggests they may be suffering anxiety after the event, their immune system may be struggling to recover, or they need closer support and monitoring to understand why they have been unable to return to work.

This paper identifies the steps that have been taken and continue to be taken by managers supported by the HR Services Team in an attempt to improve matters. It also outlines a new approach for dealing with those members of staff with long term sick records (over 30 days).

3. Key Issues/Gaps in Assurance

The Trust releases data to the Regional team who send out comparative information on a weekly and monthly basis to all Trusts. This information is taken from our Central Absence Line spreadsheet and there is on-going reconciliation with ESR. There is an ongoing reconciliation performed with ESR. The Trust is currently working through approximately 200 anomalies between the two systems and these anomalies relate to:

- Return to work dates that have been input to ESR and not reported to the Central Absence Team (overstating our Infographic figure)

and

- Absences that have been recorded directly on ESR not reported to the central absence team (understating our Infographic figure)

This volume of anomalies is proving challenging to manage and there are gaps in reported figures, hence the need to look at automated systems and training for staff. The NW Regional team is mindful of data anomalies at several Trusts, nevertheless, we are an outlier.

Infographic figures that come from the Central Absence Line data are shown in yellow below. If we were to use ESR to report the figures they would look like the green figures below. The reality is somewhere between the two. A recent report issued to the interim Director of Workforce (week commencing 20 July 2020) showed sickness figures excluding Covid-19 at 6.42%.

	Total No of Staff Absent Due to Sickness or Isolation	Total No of Staff Absent Due to Covid-19
CAL Spreadsheet	897	489
Current Regional Rates	14.1%	7.7%
ESR Data	749	373
Predicted Regional Rates	11.8%	5.9%

Prior to Covid-19, the Trust placed a focus on Estates & Facilities as they had shown absence rates in excess of 7%.

Glen Adams, Director of Estates & Facilities presented to the Workforce Assurance Committee in May 2019, outlining some of the issues faced by staff in this staff group. He focused on demographics, IT literacy, pay, and the work undertaken.

Since then the Director of Estates and Facilities has worked closely with HR to focus on staff with the worst sickness records in the directorate. Prior to Covid-19, no fewer than 6 contracts had been terminated on ill health grounds and 2 further meetings are scheduled with Occupational Health advice confirming that ill health grounds apply.

During those meetings, and a deep dive into the sickness data, it was noted that Estates and Facilities have a high percentage of Band 2 staff and sickness at this grade is particularly high across the Trust.

Band 2	
Division	**Rolling Absence FTE %**
408 Clinical Support Division	8.62%
408 Corporate Support Division	6.83%
408 Estates & Hotel Services Division	8.79%
408 Medical and Acute Specialities Division	9.17%
408 Surgery Division	8.93%
408 Women and Children's Division	11.96%

In addition to the deep dive into Estates & Facilities the Interim Director of Workforce has reviewed current sickness figures and reasons across all areas and staff groups in Trust. She has reviewed the levels of sickness per division, by age group and by reasons for sickness.

It is clear that the focus needs to be on all areas, not just Estates & Facilities.

If we look at existing, open ended sickness across all staff grades, the Trust has lost over 32,300 days.

The top reasons for sickness are:

- Anxiety, stress, depression and other psychiatric illness
- Colds, coughs, influenza
- Chest & respiratory
- MSK and back problems (in addition we have circa 17 staff with fractures – information is being gathered to review training and health and safety practices)

Data on sickness over 30 days shows that there are a range of staff on sick leave for lengthy periods of time with these conditions. It is not exclusive to portering, domestics and catering. There are as many significant periods of absence in Clinical Support, Medical & Acute, Surgery, Women & Children and a number of Corporate teams.

Whilst many staff have a return to work plan, 143 staff do not due to a lack of HR and managerial focus during Covid-19. The teams are gradually returning to BAU and this is flagged as a priority.

The Trust offers a range of support to staff including fast access to physiotherapy, a comprehensive EAP, and during the pandemic staff have been able to access additional counselling to help them remain at work and deal with the mental health issues that Covid-19 has triggered. Despite this many staff are absent for longer than expected periods of time. Clearly the levels of available support will need to be reviewed to understand if it is sufficient in respect of quantity and quality.

At a national meeting of the Social Partnership Forum (SPF) last week, it was decided that whilst Trusts could re-start progress with a range of ER cases (disciplinary, grievance and similar), we could not re-commence sickness warnings and sanctions. This decision makes active performance management of these cases more difficult, but not impossible.

This approach whilst understandable, as the NHS is mindful of the toll the pandemic has taken on NHS staff, was not welcome, and given the national pressure to reduce sickness that will no doubt reappear in the autumn, WUTH needs to work closely with staff side to agree a pragmatic approach.

4. Next Steps

At present there are over 170 staff with current absences in excess of 30 days. A significant number of staff have absences in excess of 6 months. The Interim Director of Workforce plans to meet with the Chair of Staff Side to discuss the appetite for holding virtual or face to face sickness clinics to review the Top 100 highest sickness records across the Trust.

The plan would then be to hold meetings with the senior leaders from each Division, their absent staff, OH and staff side. These clinics will take a forensic look at current sickness and determine what steps and support are required to bring the member of staff back to work and to ensure all parties have clear expectations of a way forward.

These clinics will give leaders the tools to both support their staff where adjustments may be required to get staff back to work, strengthen health and wellbeing support where appropriate, particularly for mental health and MSK conditions, and implement robust performance management if that is not already in place. Once the SPF agree that Trust can performance manage sickness and return to normal, the approach is likely to lead to more ill-health retirements or potential contract termination. In the intervening period, the clinics will be held as a mechanism for support, ensuring each person reviewed has the clinical assistance and focus needed to ensure they return to health in line with the expectations in the national NHS People Plan.

In addition, a focus is being placed on all Band 2 sickness absences contained in the table at paragraph 3. Discussions will focus not just on sickness, but teams will look at patterns within those areas such as hotspots with poor local management, low appraisal rates, and a history of low score son the NHS staff surveys. This will enable us to take a holistic approach to improving the working lives of our staff.

Staff that are on sick leave as a result of fractures will be reviewed to ascertain if there are hotspots within given teams and if so, a review of manual handling and other training will be carried out.

5. Conclusion

A target of 95% attendance remains a challenge given the present SPF stance; however, with a focus on the staff suffering from conditions outlined in the next steps, significant progress is achievable. Across the country we are aware that other Trusts are reporting concerns in anxiety, depression and stress as a result of Covid-19, and we have been advised to expect a renewed focus on Health & Wellbeing in the NHS People Plan, due for imminent publication.

6. Recommendations

This report is for question/discussion and noting. Any further suggestions and guidance in relation to the items outline in the next steps are very welcome.

Board of Directors	
Agenda Item	20/21 094
Title of Report	Review of Enforcement Undertakings
Date of Meeting	5 August 2020
Author(s)	Paul Buckingham, Interim Director of Corporate Affairs
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR3, PR6
Level of Assurance • **Positive** • **Gap(s)**	
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 Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Purpose of the Report

The purpose of the report is to advise the Board of Directors of revised enforcement undertakings issued by NHS Improvement on 24 July 2020.

2. Background

Enforcement undertakings under Section 106 of the Health & Social Care Act 2012 were originally applied to the Trust on 5 August 2015. An additional licence condition under S111 of the Health & Social Care Act 2012 was subsequently imposed on 7 August 2015. Both the undertakings and the additional licence condition related to:

- The need for the Trust to secure delivery of services on a financially sustainable basis; and
- The need for the Trust to ensure compliance with the A&E four hour target on a sustainable basis.

Revised enforcement undertakings, which superseded the undertakings applied in August 2015, were issued by NHS Improvement on 23 March 2018. The issues set out in the revised undertakings continued to relate to financial sustainability and sustainable performance against the A&E four hour target.

There have been no subsequent amendments to the additional licence condition and the condition originally imposed on 7 August 2015 remains extant.

3. Current Situation

Further revised enforcement undertakings, which supersede the undertakings applied in March 2018, were issued by NHS Improvement on 24 July 2020. A copy of the undertakings document is included for reference at Annex A to this report.

The breaches which form the basis for the undertakings continue to relate to financial sustainability and sustainable delivery of the A&E four hour target. However, the undertakings for the Trust have been refreshed and can be summarised as follows:

1. The Licensee will take all reasonable steps to deliver its services on a financially sustainable basis, including implementation of a financial recovery plan
2. The Licensee will take all reasonable steps to deliver A&E services on a sustainable basis, including delivery of relevant sections of the Urgent & Emergency Care Improvement Plan agreed at A&E Delivery Board
3. The Licensee will implement a formal Trust Board development programme, to include 360-degree feedback for all members of the Board, for completion by March 2021
4. Where interim support financing or planned term support financing is provided, the Licensee will comply with any terms and conditions which attach to the financing
5. The Licensee will comply with any spending approvals processes that are deemed necessary by NHS Improvement
6. The Licensee will provide regular reports on its progress in meeting the undertakings and will attend meetings to discuss its progress in meeting these undertakings. These meetings will be the Wirral System Improvement Board.

With regard to a Board development programme, the Board had originally planned to complete such a programme in 2019/20 and commissioned support from NHS Providers to facilitate delivery of the programme. This programme was curtailed, and there has been a significant turnover of Executive Directors in the intervening period. Consequently, it is intended to re-commission NHS Providers to deliver the original programme in full during the period September 2020 to March 2021. Board members

will need to commit individually and collectively to full participation in order to maximise benefits of the development programme.

Board members will note that s6.3 of the undertakings document requires that the Licensee will provide NHS Improvement with the assurance relied on by its Board in relation to its progress in delivering these undertakings. Consequently, the Board will need to determine how it plans to generate such assurance. It is suggested that the assurance should be in a form that facilitates focused periodic review by the Board, as opposed to the inclusion of relevant details across a range of Board reports. To this end, the Board should consider use of a consolidated 'Review of Progress against Undertakings' report to be reviewed by the Board on a two-monthly cycle commencing in September 2020.

4. Conclusion

The basis for the enforcement undertakings remains unchanged from the factors leading to issue of the original undertakings in 2015 i.e. financial sustainability and sustainable delivery of the A&E four hour target. However, the actions detailed in the refreshed enforcement undertakings issued on 24 July 2020 provide both the Trust and NHS Improvement with a current basis for the measurement of progress. Use of the Wirral System Improvement Board as the primary means for reporting and monitoring progress should be considered as a positive development in that it ensures the participation and involvement of the external stakeholders who will be integral to effective plans to achieve both financial sustainability and sustainable delivery of the A&E four hour target.

5. Recommendations

The Board of Directors is recommended to:

- Formally endorse the revised enforcement undertakings dated 24 July 2020 included at Annex A to the report.
- Agree participation in a NHS Providers-facilitated Board Development programme
- Agree to receive a Review of Progress against Undertakings report on a two-monthly cycle commencing September 2020.

NHS England and NHS Improvement – North West
Regatta Place
Brunswick Business Park
Summers Road
Liverpool
L3 4BL

Tel: 07876 869449

Email: dlevy1@nhs.net

Date 24 July 2020

LICENSEE

Wirral University Teaching Hospital NHS Foundation Trust ("the Licensee")
Arrowe Park Hospital
Arrowe Park Road
Upton
CH49 5PE

Any reference to "NHS Improvement" or "NHS England and NHS Improvement" in these undertakings is to be taken as a reference to Monitor.

BACKGROUND

On 28 March 2018 NHS Improvement accepted enforcement undertakings from the Licensee under section 106 of the Health and Social Care Act 2012 ("the Act"), having had reasonable grounds to suspect that the Licensee was providing healthcare services for the purposes of the NHS in breach of the conditions of its licence.

The Licensee has not fully complied with the 2018 enforcement undertakings. The undertakings that remain in effect are deemed to be no longer effective as a means of securing compliance due to the passage of time and intervening events.

In place of the 2018 enforcement undertakings, NHS Improvement has decided to accept from the Licensee the enforcement undertakings specified below. These undertakings supersede the 2018 undertakings, which cease to have effect from the date of these undertakings.

DECISION

Based on the grounds set out below, and having regard to its Enforcement Guidance, NHS Improvement has decided to accept from the Licensee the enforcement undertakings specified below, pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").

GROUNDS

1. Licence

The Licensee is the holder of a licence granted under section 87 of the Act.

BREACHES

2. Financial Sustainability

2.1 NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence: FT4(5)(a),(d) and (f), and CoS3(1).

2.2 In particular, the Licensee:

2.2.1 accepted a control total for 2019/20 that required the delivery of a challenging CIP target. By August 2019 the Licensee indicated that it was unlikely to meet these targets and at the year end the Licensee's deficit exceeded its agreed control total by £9 million (excluding Provider Stability Funding, Financial Recovery Funding and Marginal Rate Emergency Tariff funds);

2.2.2 currently has a Use of Resources rating of 3, which is the trigger level for concern under current NHS Oversight Framework. The forecast for 2020/21 is that the rating will remain at 3;

2.2.3 received an external audit report for 2019/20 annual accounts with a statement of material uncertainty related to going concern, reflecting the deficit position and continuing need for cash support in 2020/21;

2.2.4 has a Care Quality Commission overall rating of 'requires improvement', including the domains of 'well-led' and 'use of resources', and has an action plan to respond.

2.3 The matters set out above demonstrate a failure of governance and financial management by the Licensee, including, in particular:

2.3.1 a failure by the Licensee to adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

(a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern;

2.3.2 a failure to establish and effectively implement systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); and

(c) to identify and manage (including through forward plans), material risks to compliance with the Conditions of its Licence.

3 A&E Performance

3.1 NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following condition of its licence: FT4(5)(c).

3.2 In particular;

3.2.2 the Licensee submitted A&E trajectories for 2018/19 and 2019/20 linked to Sustainability and Transformation Funding (STF). These forecast incremental improvement for four-hour A&E performance from 76% in 2018/19 to 95% for 2019/20. Although the Licensee had demonstrated some improvement between April 2019 and June 2019, this was not sustained, and performance dropped continuously and by February 2020 performance against the four-hour standard was 80%.;

3.2.3 The Licensee exceeded 60- minute ambulance handover times for around 80 patients per month for the period April 2019 to January 2020.

3.2.4 the Licensee failed to make necessary improvements to Transfers of Care during 2019/20. In February 2020 there were 189 patients with a length of stay over 21 days in February 2020.

3.3 These failures demonstrate a failure of governance arrangements, in particular:

3.3.2 a failure to establish and effectively implement systems and/or processes:

3.3.2.1 to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.

4 Need for Action

NHS Improvement believes that the action which the Licensee has undertaken to take pursuant to the undertaking recorded here is action to secure that the breaches in question do not continue or recur.

5 Appropriateness of Undertakings

In considering the appropriateness of accepting in this case the undertakings set out below, NHS Improvement has considered the matters set out in its Enforcement Guidance.

UNDERTAKINGS

The Licensee has agreed to give, and NHS Improvement has agreed to accept, the following undertakings, pursuant to section 106 of the Act:

1 Finance

1.1 The Licensee will take all reasonable steps to achieve an understanding of the drivers of its deficit, improve its financial position and minimise its external funding requirement. The Licensee will take all reasonable steps to deliver its services on a financially sustainable basis, including but not limited to the actions outlined below:

1.1.1 intaking all reasonable measures to contribute to the local health economy delivering its financial trajectory, the Licensee will develop and implement a financial recovery plan that details actions to be taken with clear timelines and accountability;

1.1.2 as evidence of continuing effective financial decision-making and control, the Licensee will provide NHS England and Improvement with relevant internal audit reports, addressing matters of financial governance, for the duration of these undertakings, including reports on the exercise of financial controls in accordance with Standing Financial Instructions and the accurate reporting in finance papers to Board and relevant committees;

1.1.3 the Licensee will provide NHS England and Improvement with assurance concerning the engagement of operational managers in financial governance and its Cost Improvement Programme;

1.1.4 the Licensee will provide NHS England and Improvement with evidence of progress against its CQC action plan on those areas pertaining to financial governance and use of resources;

1.1.5 The Licensee will demonstrate that it has adequate capacity and capability in place to deliver the financial plans; and

1.1.6 The Licensee will keep the plans under review and agree necessary amendments with NHS Improvement.

2 A&E Performance

2.1 The Licensee will take all reasonable steps to achieve an understanding of the drivers of its performance against the A&E four-hour wait target and delayed transfers of care targets, and to deliver A&E services on a sustainable basis that meets the trajectory agreed as part of STF funding, including but not limited to the actions outlined below:

2.1.1 the Licensee will provide evidence that it has taken all reasonable steps within its control to deliver the relevant sections of the Urgent and Emergency Care Improvement Plan agreed at A&E Delivery Board;

2.1.2 the Licensee will actively participate in keeping the Urgent and Emergency Care Improvement Plan and its delivery under review through the A&E Delivery Board;

2.1.3 the Licensee will demonstrate that it has worked constructively as part of the Wirral Healthcare system to implement and sustain an urgent care pathway which meets NHS Constitutional Standards.

2.2 Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraphs 2.1.1 and 2.1.2 above, whether identified by the Licensee or another party, the Licensee will notify NHS Improvement as soon as practicable and update and resubmit the Urgent and Emergency Care Improvement Plan within a timeframe to be agreed with NHS England and Improvement.

3 Board Development

3.1 The Licensee will implement a formal Trust Board development programme. The programme shall include individual 360-degree feedback for all members of the Board and should be completed by March 2021 and the results shared with NHS England and Improvement.

4 Distressed Funding

4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health and Social Care to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.

4.2 The Licensee will comply with any reporting requests made by NHS England and NHS Improvement in relation to any financing provided or to be provided to the Licensee by the Secretary of State for Health and Social Care pursuant to section 40 of the NHS Act 2006.

5 Spending Approvals

The Licensee will comply with any spending approvals processes that are deemed necessary by NHS Improvement.

6 Reporting

6.1 The Licensee will provide regular reports to NHS England and Improvement on its progress in meeting the undertakings set out above and will attend meetings, or, if NHS England and Improvement stipulates, conference calls, as required, to discuss its progress in meeting these undertakings.

6.2 These meetings will be the Wirral System Improvement Board, chaired by a Regional Medical Director from NHS England and Improvement, and take place once a month unless NHS England and Improvement otherwise stipulates, at a time and place specified, and with attendees confirmed, by NHS England and Improvement.

6.3 The Licensee will provide NHS England and Improvement with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.

6.4 The Licensee will comply with any additional reporting or information requests made by NHS England and Improvement.

THE UNDERTAKINGS SET OUT ABOVE ARE WITHOUT PREJUDICE TO THE REQUIREMENT ON THE LICENSEE TO ENSURE THAT IT IS COMPLIANT WITH ALL THE CONDITIONS OF ITS LICENCE INCLUDING THOSE CONDITIONS RELATING TO:

- **COMPLIANCE WITH THE HEALTH CARE STANDARDS BINDING ON THE LICENSEE; AND**
- **COMPLIANCE WITH ALL REQUIREMENTS CONCERNING QUALITY OF CARE.**

ANY FAILURE TO COMPLY WITH THE ABOVE UNDERTAKINGS WILL RENDER THE LICENSEE LIABLE TO FURTHER FORMAL ACTION BY NHS ENGLAND AND NHS IMPROVEMENT. THIS COULD INCLUDE THE IMPOSITION OF DISCRETIONARY REQUIREMENTS UNDER SECTION 105 OF THE ACT IN RESPECT OF THE BREACH IN RESPECT OF WHICH THE UNDERTAKINGS WERE GIVEN AND/OR REVOCATION OF THE LICENCE PURSUANT TO SECTION 89 OF THE ACT.

WHERE NHS ENGLAND AND NHS IMPROVEMENT IS SATISFIED THAT THE LICENSEE HAS GIVEN INACCURATE, MISLEADING OR INCOMPLETE INFORMATION IN RELATION TO THE UNDERTAKINGS: (i) NHS ENGLAND AND NHS IMPROVEMENT MAY TREAT THE LICENSEE AS HAVING FAILED TO COMPLY WITH THE UNDERTAKINGS; AND (ii) IF NHS ENGLAND AND NHS IMPROVEMENT DECIDES SO TO TREAT THE LICENSEE, NHS ENGLAND AND NHS IMPROVEMENT MUST BY NOTICE REVOKE ANY COMPLIANCE CERTIFICATE GIVEN TO THE LICENSEE IN RESPECT OF COMPLIANCE WITH THE RELEVANT UNDERTAKING.

LICENSEE

Signed

Dated

NHS IMPROVEMENT

Signed

Dated

24/07/2020

Dr David Levy
Regional Medical Director (North West)

Wirral University Teaching Hospital
NHS Foundation Trust

May 2020

Acuity and dependency review

January / February 2020.

Board of Directors	
Agenda Item	20/21 095
Title of Report	Acuity and dependency review January / February 2019/2020.
Date of Meeting	5 August 2020
Author	Tracy Fennell, Deputy Chief Nurse. Johanna Ashworth–Jones, Senior Analyst, Corporate Nursing.
Accountable Executive	Hazel Richards, Chief Nurse and Director of Infection Prevention and Control (DIPC).
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,3,4,6.
Level of Assurance • **Positive** • **Gap(s)**	Positives. • The Trust has continually fulfilled its requirements to undertake 6 monthly acuity and dependency reviews. • The Trust uses the approved tool Safer Nursing Care Tool (SNCT) to undertake acuity and dependency reviews as recommended by National Quality Board / NHSI. Gaps. • The Trust had to pause the completion of the establishment review to enable the Trust to provide emergency response to the COVID-19 pandemic. • The 6 monthly establishment's review that will conclude in November 2020 will require an additional element that takes into account an escalation plan for COVID–19.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The purpose of this paper is to provide the Board of Directors with an overview of the 6 monthly acuity and dependency review undertaken in January / February 2020. The paper will provide assurance that the Trust has completed the required six monthly acuity and dependency study used to support establishment reviews, as outlined in the NHS Improvement (NHSI) Developing Workforce Safeguards document (2018). The paper notes that the establishment review which follows on from the acuity and dependency review was paused immediately following the 21 day acuity and dependency study period in March 2020 due to the Trust being required to respond to the COVID- 19 pandemic.

The standard operating procedure for establishment reviews normally requires a validation exercise to be completed at the end of the acuity and dependency study. Senior nurse leaders then are able to use the validated data set to undertake a triangulation process exercising professional judgement alongside patient quality and patient experience metrics to agree safe staffing establishments.

These metrics are open to secondary scrutiny during confirm and challenge processes with the Deputy Chief Nurse prior to approval by the Chief Nurse. Due to the decision to pause the validation and establishment review process in its entirety the Trust should be cautious about creating judgement on the outcomes of the Quarter 4 acuity and dependency review.

In response, the establishment review process has been revised to ensure daily immediate secondary validation is completed by a second senior nurse (matron or associate director of nursing). The outcome of this change will enable a more reliable data source to be utilised for scrutiny should the Trust be required to cease the acuity and dependency study to provide emergency response to any future unanticipated pressures.

The Trust commenced the second required 2020 six monthly acuity and dependency study with secondary immediate validation in July 2020 to support the establishment reviews due to conclude in November 2020. Outcomes of the full establishment review will be presented to the Board of Directors in December 2020.

2. Background

In 2018 NHSI released the Developing Workforce Safeguards document outlining recommendations that Trusts make safe, sustainable workforce decisions utilising agreed principles building on previous guidance from the 2016 National Quality Board (NQB) recommendations.

It was agreed that Trusts' compliance would be assessed annually to ensure they were using a 'triangulated approach' to deciding staffing requirements as described in NQB's guidance. This approach should combine evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time, based on patients' needs, acuity, dependency and risks. The document highlights the requirement to undertake six monthly establishment reviews supported by a six monthly acuity and dependency study, utilising a recognised acuity tool such as the Shelford Safer Care Nursing Tool (SNCT).

3. Quarter 4, 2019/2020 Position

In January / February 2020 the Trust commenced the standard 21 day paper-based exercise to assess the acuity and dependency of patients on every adult ward across the Trust. The review was undertaken daily by the ward manager against agreed criteria as set out in the recognised Shelford Safer Care Nursing Tool. The establishment review standard operating procedure outlines the requirement for the data to be validated by the Quality Matron and Associate Director of Nursing at the conclusion of the acuity and dependency data collection. A secondary validation is then required by the Corporate Nursing Team prior to commencement of the establishment review process.

The validated acuity and dependency data set is then used to support senior nursing decision making exercising professional judgement alongside a triangulation exercise against a number of other areas such as:

- Quality KPIs.
- Patient experience data.
- Incidents / serious incidents.
- Operational requirements.
- Environmental factors.
- Skill mix.

Senior nursing teams use their professional judgement in collaboration with finance and operational colleagues to agree the safe establishment for each area for the forthcoming six months. These decisions are reviewed in a confirm and challenge process with the Deputy Chief Nurse prior to sign off by the Chief Nurse and Chief Finance Officer.

4. Gaps / Key Risks

Due to the Trust supporting the national emergency response to the COVID- 19 pandemic, the establishment review process was paused following the conclusion of the acuity and dependency study in March 2020. This resulted in the required validation process being incomplete. Due to the inability to conclude the validation and establishment review process in its entirety, the Trust should be cautious about creating judgement or making any decisions based on the outcomes of the January / February 2020 acuity and dependency review. The un-validated acuity and dependency results are included for noting in Appendix 1.

In response, the establishment review process has been revised to ensure daily immediate secondary validation is completed by a second senior nurse (matron or associate director of nursing). The outcome of this change will enable a more reliable data source to be utilised for scrutiny, should the Trust be required to pause the acuity and dependency study to provide emergency response to any future unanticipated pressures.

5. Safe Staffing Requirements during the COVID -19 Pandemic

In response to the COVID-19 pandemic, the Trust has had to adapt quickly, upskilling and redeploying staff to ensure staff are competent and available to meet the daily changing demand. These adapted staffing models in some areas required staffing models to be used that are outside of current agreed establishments. Due to the impact of reducing bed numbers to enable social distancing measures and an increase in registered nurses in COVID areas to support requirements to apply additional PPE and nurse patients in side rooms this has enhanced patient to registered nurse ratios in many areas. The impact of ward closures has also significantly reduced the Trusts requirement to use temporary staffing to ensure wards are staffed safety,

To ensure the safety of staff and patients, associate directors of nursing lead a staffing review with ward managers and matrons each morning. Mitigations for unplanned absence and changes in operational pressures / changes in staffing requirements are addressed and authorised by the matron rostered to manage staffing on that day. The outputs of this and any staff moves / changes are recorded in the Trust's Safe Staffing Oversight Tracker (SSOT). Where solutions cannot be found, the safe staffing escalation policy is enacted to ensure adequate arrangements are made immediately and senior nurse leaders are alerted to support an organisational across division response to any emerging risks.

In the changing landscape is recognised current ward establishment models are unlikely to meet the requirements of a healthcare system with COVID-19 pressures. WUTH has been required to change its bed base on a number of wards to ensure social distancing is achievable. In response, base wards will have a full establishment review as expected concluding in November 2020 to ensure staffing establishments and skill mix are appropriate to meet the needs of each area. The outputs of the establishment review will be reported to the Patient Safety Quality Board (PSQB) on behalf of the Quality Committee in November 2020 and to the Board of Directors in December 2020.

6. Recommendations

The Board of Directors is asked to:

- Note the contents of paper.
- Accept the assurance the Trust has met its requirement to complete a 6 monthly acuity and dependency audit using a recognised tool.
- Note that the Trust will be undertaking a full establishment review of all wards in line with the Trust's escalation plan to meet the requirements of the COVID- 19 response. These will inform the required staffing models the Trust will adopt for the following 6 months during the recovery phase of the COVID-19 pandemic.

7. Conclusion

The Trust has fulfilled its requirement to complete the regular six monthly acuity and dependency audits using a recognised tool as outlined in the recommendations in the Developing Workforce Safeguards document (2018 NHSI). Due to the Trust supporting the national emergency response to the COVID-19 pandemic, the acuity and dependency validation and establishment review was paused following the conclusion of the acuity and dependency study in March 2020. Due to the inability to accomplish the validation and establishment review process in its entirety, the Trust should be cautious about creating judgement or make any decisions based on the outcomes of the Quarter 4 acuity and dependency review.

The establishment review process has since been revised to ensure daily immediate secondary validation is completed by a second senior nurse (Matron or Associate Director of Nursing). The outcome of this change will enable a more reliable data source to be utilised for scrutiny should the Trust be required to cease the acuity and dependency study to provide an emergency response to any future unanticipated pressures. The Trust commenced the revised 6 monthly acuity and dependency study in July 2020 to support the forthcoming Quarter 3, 2020/2021 establishment reviews. Outcomes of the full establishment review will be presented to the Board of Directors in December 2020.

Appendix 1
Safer Nursing Care Tool
https://f8b25bbf-32a1-4285-85ff-765caead1e42.filesusr.com/ugd/9e8d1e_8c97751992ce4b249d00d6a0fad26daa.pdf

BOX 1. SUMMARY OF SNCT CLASSIFICATIONS

Level	Descriptor
0	Patients requiring hospitalisation whose needs are met by normal ward care
1(a)	Acutely ill patients needing intervention or who are unstable with a greater potential to deteriorate
1(b)	Patients who are stable, but depend on nursing care to meet most or all of the activities of daily living
2	Patients who can be managed within clearly identified and designated beds and resources with the required expertise and staffing level or may require transfer to a dedicated Level 2 facility/unit
3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs

Appendix 2
Results of the acuity and dependency review undertaken February 2020

Division	Ward	Establishment excluding house keeper and ward clerk	**Jul 2019** Shelford	**Feb 2020** Shelford
Surgical	10	28.03	31.48	21.8
Surgical	11	38.96	33.5	37.4
Surgical	12	20.63	17.57	9.28
Surgical	WAFFU	18.67	11.57	11.82
Surgical	M2Ortho	22.21	No data	15.54
Surgical	14 colorectal	43.44	39.67	42.92
Surgical	SEU / 17	43.86	38.18	38.94
Surgical	18	40.8	37	38.58
Surgical	20	39.37	32.49	34.83
Medical	24	32.1	41.2	35.4
Medical	25	40.15	32.5	29.9
Medical	26	39.05	42.68	49.5
Medical	30	36.24	32.11	33.31
Medical	32 & CCU	64.35	57.32	60.78
Medical	33	36.18	41.9	41.5
Medical	36	48.36	51.95	49.63
Medical	37 & 38	68.12	68.32	69.48
Medical	21	40.48	42.68	43.75
Medical	22	39.26	42.45	50.47
Medical	23	41.26	36.49	39.93
Medical	27	38.89	No data	38.24
Medical	CRC	38.71	50.4	48.27
Medical	M1 rehab	40.84	No Data	51.09
Medical	EDRU	15.76	No Data	12.58
Medical	AMU	42.25	No Data	26.62
Medical	MSSW	32.69	No Data	23.49

Health and Safety Management Quarter 1 report

Board

Board of Directors	
Agenda Item	20/21 096
Title of Report	Health and Safety Management Quarter 1 update
Date of Meeting	5 August 2020
Author(s)	Jacqueline Robinson, Associate Director Quality Governance
Accountable Executive	Hazel Richards, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Safety
Level of Assurance • **Positive** • **Gap(s)**	Positive with some Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

Outlined within this report is an overview of Quarter 1 2020 Health and Safety performance and assurance activities.

In March 2020 NHS England declared COVID-19 a level 4 incident. As a result of COVID-19 many 'business as usual' governance processes that could be safely stepped down were suspended in order to respond to the higher risk of COVID-19 and ensure appropriate arrangements were in place to ensure safety and wellbeing to ensure the risk of transmission was reduced.

In relation to actions outstanding relating to H&S team activity a review was undertaken and work re-prioritised with all non-priority issues being placed on a recovery plan so as to ensure important work streams are not lost and in order to ensure these are picked up when pressures created by COVID-19 subside.

Priority activities such as incident investigations; responding to risk and progressing the actions within the CQC action plan following their inspection have continued.

This paper therefore provides the Board with an overview of Health and Safety work undertaken during the COVID-19 pandemic; other priority activities and Health and safety performance and progress currently underway to ensure that the Health and Safety improvement plan and business as usual is re-initiated.

2. Update on activity undertaken as a result of COVID-19

As required in a level 4 National incident, the Trust initiated and retain their EPRR incident co-ordination functions and therefore a Bronze, Silver, Gold command system was established in March 2020 in order to discuss, monitor and escalate issues the pandemic presented. Ensuring effective Health and Safety management and staff wellbeing were one of the key priorities.

Groups feeding into this structure were established and key risk issues such as monitoring PPE stocks, Ward Status (Red, Amber , Purple, White, Green), Wearing of PPE, Face Fit Testing, Oxygen Supply due to increased demand and a range of other issues communicated up and through the communication structure and in some cases into regional and national command structures.

Several sub- groups were also established reporting to Bronze command which include:

- The Respiratory Protective Equipment (RPE) meeting to monitor RPE stock levels and arrangements for Fit Testing of staff.
- A PPE group was established to monitor the supply and demand of all PPE
- The Environmental Group was established in order to support the Trust wide Lockdown plan and to develop an Environmental COVID-19 risk assessment pro-forma
- A weekly Human Resources / Staff Side meeting was set up in order to ensure appropriate consultation with staff side occurred

Daily communication updates regarding COVID-19 arrangements have been developed and continue to be distributed to ensure all staff are kept up to date on changes within the workplace and a specific COVID-19 section was placed on the Intranet which has detailed information available

As the focus was on responding to COVID-19 and the command and control structure introduced a higher than usual communication and assurance mechanisms, a number of the standard governance committees could safely be suspended, including the Health and Safety Committee.
However as Staffside were represented at a number of groups, the requirements of the Safety Representatives and Safety Committees Regulations 1977 (as amended) were still met.

Some of the key areas of work activity within the Trust in response to the pandemic and associated guidance published by PHE, the HSE and NHS Employers are described below:

- Development of an Individual COVID-19 Risk Assessment to ensure ALL Trust staff are assessed in relation to individual risk of COVID-19

- Development of an Environmental COVID-19 risk assessment to ensure all departments comply with 2 m social distancing wherever possible and have appropriate controls to reduce the risk of COVID-19 transmission within the workplace
- Development of a draft Home Worker Policy to provide guidance on control measures required to ensure staff can work from home safely and a checklist linked to the existing home working risk assessment
- Development of additional Health & Wellbeing support
- Development of recommended PPE for COVID-19 by Infection Control to instruct all staff on the appropriate PPE required within the wards and clinical areas of the Trust.
- Implementing a command and escalation system
- Developing a Track and Trace SOP by Occupational Health and key stakeholders
- Development of a Lockdown plan for APH to reduce the risk of transmission of COVID-19
- Carried out several detailed Investigations to review incident; identify learning and ensure appropriate control measures are identified and implemented to reduce likelihood of recurrence, two specifically relating to COVID-19
- Developing RIDDOR reporting and Investigation SOP's to ensure incidents are reported externally to the HSE and further investigation is carried out when required

2.1 COVID-19 Events meeting the requirement to report under RIDDOR

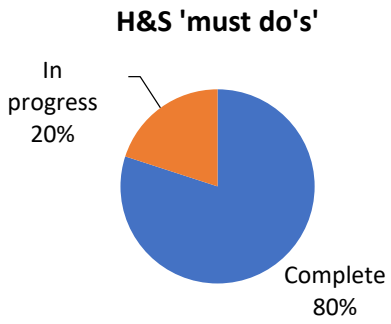
In quarter 1 there were three incidents that were considered to meet the HSE's definition of RIDDOR reportable. After following agreed Trust procedures these were subsequently reported to the HSE at the beginning of July.

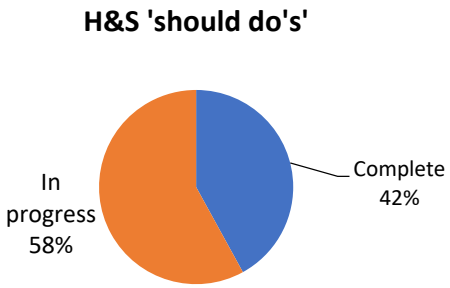
3. CQC action plan

The Care Quality Commission (CQC) published its report on Tuesday 31st March 2020 following the CQC inspection carried out at the Trust on 8-10 October 2019, 15-17 October 2019 and 12-14 November 2019.

During the visit the CQC inspected urgent and emergency services, medical care, surgery, children's and young people's services, out patients and diagnostic services provided from Arrowe Park Hospital and medical care at Clatterbridge hospital.

The CQC identified 5 "must do" actions with a further 5 "should do" actions pertaining to Health & Safety.





The following Trust-wide key actions have been completed:-

- Review of Trusts processes for electrical safety checks on both clinical and non-clinical portable appliances undertaken. A Standard operating process has been developed and circulated to all areas to ensure managers their responsibilities and actions to be taken to ensure these checks are undertaken and are able to clearly articulate the process.
- Audit and risk assessment for safe oxygen storage developed

All other actions are local actions for specific departments.

4. Health and Safety activity and performance during quarter 1 (non COVID-19)

The Health and Safety Committee was re-established in June. The Quarter 1 dashboard is attached in Appendix 1. Key performance indicators demonstrate:

- 2 RIDDOR reportable incidents, both resulting in over seven day absences from work. The monthly average of reportable events is lower than the previous year which is encouraging and both these events were reported to the HSE within the correct timescale;
- There have been a total of 5 new claims received which equates to a monthly average of 1.25 which is below the previous year's monthly average of 3.08;
- Despite COVID-19 mandatory training figures for Health and Safety was maintained:-
  - H&S Level 1 91.47%
  - Moving & Handling 91.79%
  - M&H Practical (currently on-line people handling course due to COVID-19) 80.70%

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

The Trust level performance dashboard continues to develop as more data sources become available and PPE audits and oxygen storage audits have recently been added.

Divisional dashboards and exception reports are in place and being utilised by all Divisions, providing greater transparency across the Trust on Health and Safety performance.

5. Next Steps

Following the re-initiation of the Health and Safety Management Committee the work programme is being reviewed and reset. Key deliverables over the next quarter include:-

- Establish H&S Dashboard for Corporate support services
- Complete H&S associated actions from CQC action plan
- Review of ISO45001 standards and undertake assurance activities to ensure actions have been embedded
- Review all H&S policies and ensure they are up-to-date.
- Complete and circulate Trust legal register for Divisional updates
- Identify key areas and establish H&S audit plan
- Recruit additional Health and Safety advisor to provide capacity to support Estates and Facilities team in managing H&S requirements and deliver against the Trusts H&S improvement plan.

6. Conclusion

Significant work has been undertaken to establish a framework by which Health and Safety can be effectively managed. Whilst Health and Safety management has been prioritized in supporting the COVID-19 response all high priority and statutory requirements have been maintained.

There remains significant work to be undertaken, particularly with the additional requirements of managing the COVID-19 risk over the near future, however there has been a significant shift in engagement and momentum has been maintained.

7. Recommendations

The Board are asked to note the significant improvement in Health and Safety management arrangements with engagement and commitment from across the Trust and the next steps identified.

APPENDIX 1 **Trust Wide (Data correct as of 01/07/2020)**

Total no. non-clinical safety incidents				
	2019/20		**2020/21 (ytd)**	**Increase/ Decrease**
No reported (monthly average)	1970 (164.16)		265 (88.3)	↓
% incidents managed in Ulysses within Trust Timescale	59%		78%	↑
RIDDOR incident				
	2019/20		**2020/21**	**Increase/ Decrease**
No reported 2018/19	24 (2)		2 (0.66)	↓
% reported within timescale	75%		100%	↑

EL & PL Claims				
	2019/20		**2020/21 (average per month)**	**Increase/ Decrease**
No. new claims received	37 (3.08)		5 (1.25)	↓

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

Near Miss/ Non-compliance	
No. of near miss incidents reported	184
No. of near miss incidents investigated	
No. of non-compliances investigated	

H&S Interventions	
No. of informal advice *(corrective actions)*	**0**
No.of letters of recognition	**0**
No. notice of urgent action	**0**
No. of suspension notices	**0**
No. of duty of care notices	2

Operational H&S Risk

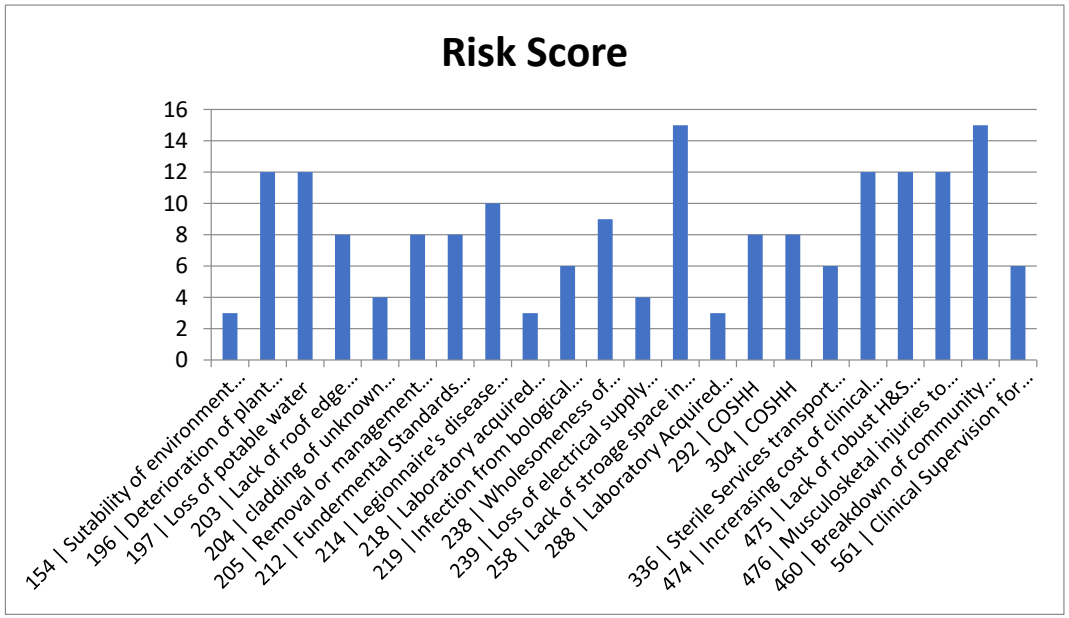
H&S Assurance activity	
No. of inspections	**0**
No.of audits	**0**
No. of investigations	**4**
No. of process reviews	0
No. of Senior team H&S Tours –	0

H&S Communication & Consultation (Trust wide)	
No. of HSM Committees	1
No.of SMA Committees	1
No. of H&S Comms	63
No. of Policies reviewed	2

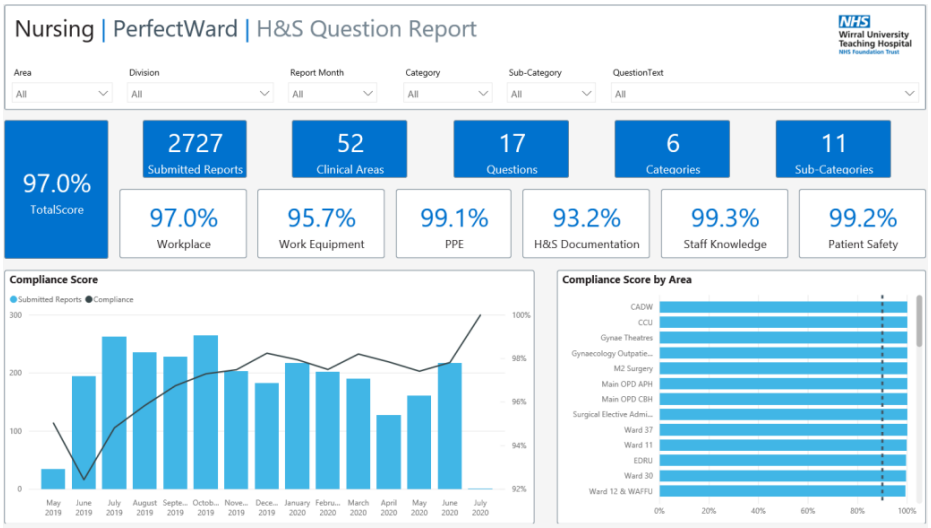
Training and attendance at Trust H&S meetings	
% Divisional attendance	100%
% attendance	100%
% Compliance Mandatory Training	
• H&S Level 1	91.47%
• Moving & Handling	91.79%
• M&H Practical	80.70%

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

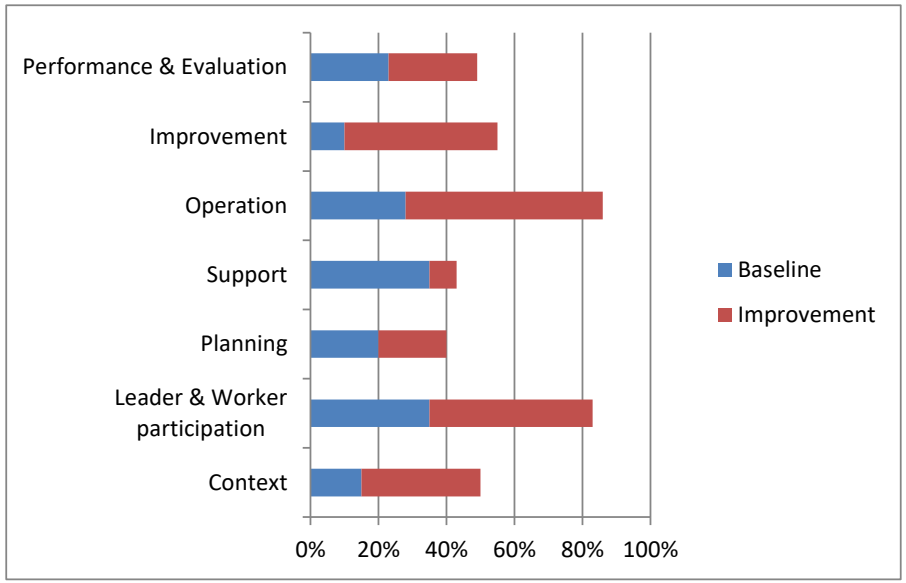
Most frequently reported H&S incidents



Perfect ward



Gap Analysis Status – July 2020



Board of Directors	
Agenda Item	20/21 097
Title of Report	Learning from Deaths - Annual Summary Report
Date of Meeting	5 August 2020
Author	Dr Mike Ellard, Deputy Medical Director
Accountable Executive	Dr Nicola Stevenson, Executive Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 4 Catastrophic failure in standards of safety and care
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	Yes

1. Executive Summary

The Annual Summary Report seeks to bring together the progress to date and work undertaken through 2019/20, to highlight the key learning themes and outline the plans to further enhance the agenda through 2020/21.

Key points to note are:-

- The average HSMR for 19/20 was within the expected range at 105.24
- SHMI at the end of March was 103.38 and also within the expected range. However prior to this there had been a steady rise which is likely directly related to a sudden decrease in the number of discharges (the denominator on which SHMI and expected deaths are determined) and expected deaths with no change to the observed number of deaths in April 2018.
- Within the last 12 months there have been a number of new alerts, with the CEO receiving notice on one (cardiac dysrhythmias). A review identified that 21 of the 24 cardiac dysrhythmias could have been coded more appropriately
- 52% of inpatient deaths have had a PMR in 2019/20 compared to 36% in 2018/19
- The number of higher level reviews (SJR / SI framework) has increased from 35 in 2018/19 to 84 in 2019/20 (24 were attributed to the first 24 COVID deaths).

2. Background

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

CQC's recommendations were translated into seven national workstreams and the Learning from Deaths framework was published in March 2015. The Learning from Deaths framework placed a number of new requirements on trusts:

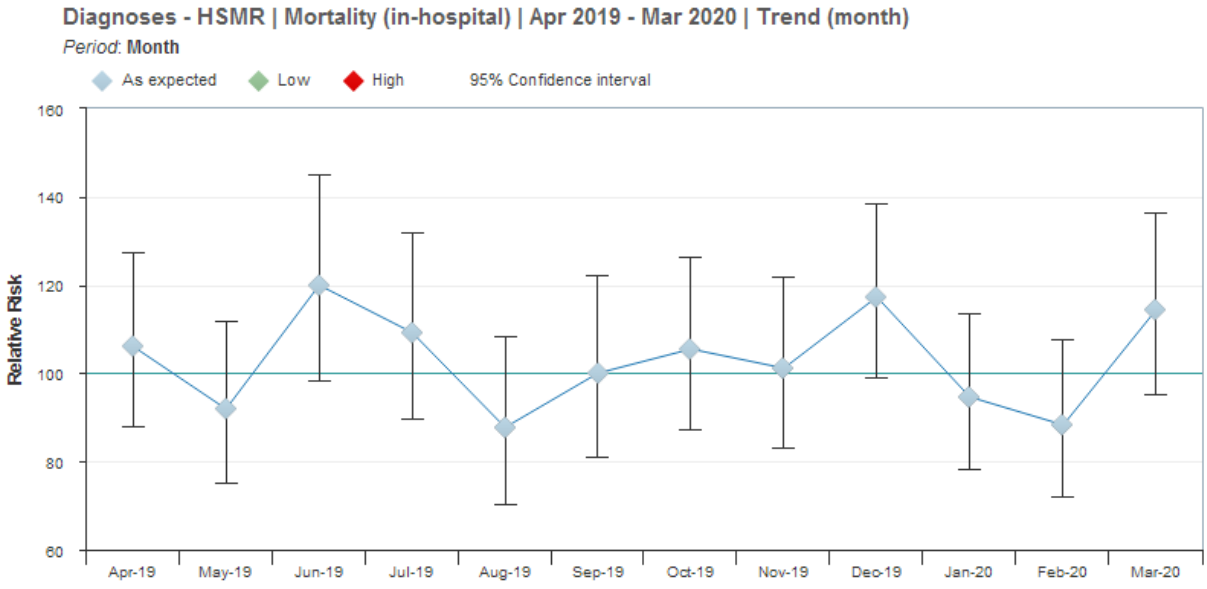
- From **April 2017** onwards, **collect** new quarterly information on deaths, reviews, investigations and resulting quality improvement (specified information required).
- By **September 2017**, publish an **updated policy** on how the trust responds to and learns from the deaths of patients in its care.
- From **Q3 2017** onwards, **publish** information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (specified information required).
- From **June 2018**, **publish** an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

3. Key Issues/Gaps in Assurance

3.1 Wirral university Teaching Hospitals (WUTH) Mortality

There are two national mortality indexes for the hospital: Firstly HSMR-hospital standardised mortality ratio - this measures 85% of in-patient deaths adjusted for palliative care, social deprivation and admission history. It is a more timely mortality index.

Graph 1 illustrates the monthly mortality trend between April 2019 and March 2020 for the whole Trust (HSMR) and it currently is 112.2 for March 20. COVID deaths which were first reported at WUTH on 15th March 2020, and there were 24 up to and including 31st March 2020, are excluded from HSMR and SHMI data nationally.

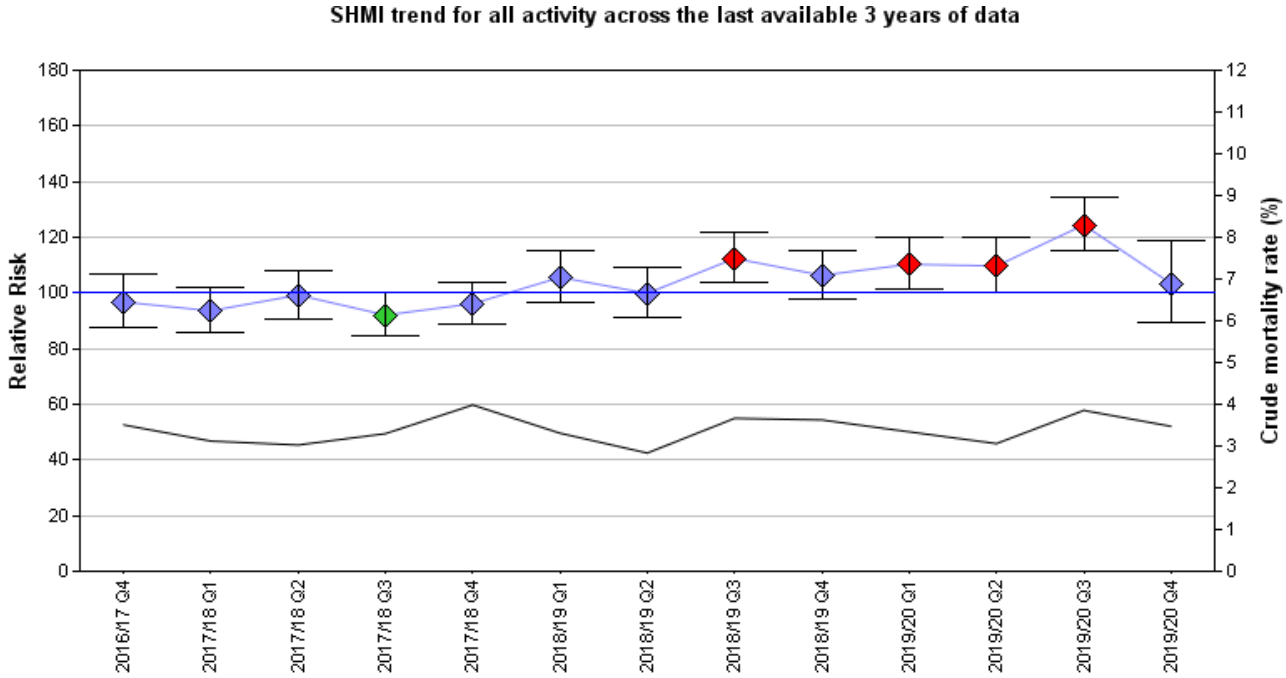


Secondly SHMI – Standardised Hospital Mortality Index – this measures all deaths in the hospital and those occurring within 30 days of discharge.

Graph 2 illustrates SHMI quarterly data from Q4 2015/16 to Qtr4 2019/20. Until Q3 2018/19 the Trust was within the expected range.

The number of discharges (the denominator on which SHMI and expected deaths are determined) decreased by 10% with no change to the observed number of deaths in April 2018. The SHMI rate continued to increase as the 18-19 data became included in the rolling 12 month analyses each successive quarter.

However, the most recent SHMI for Q4 shows it to be the lowest since Q2 2018-19, the reason for this drop is as yet to be determined.



3.2``Dr Foster

Within the last 12 months there have been a number of new alerts, with the CEO receiving notice on one (cardiac dysrhythmias). This was reviewed and 21 of the 24 cardiac dysrhythmias could have been coded more appropriately. All deaths that carry a negative CUSSUM alert are reviewed by the weekly mortality review group prior to the external data submission for accuracy.

Further details of performance by quarter are included at Appendix 1 of this report.

3.3 Primary Mortality Reviews (PMR) and Structured Judgement Review (SJR)

There have been 1,542 deaths in 2019/20 (vs 1,423 in the previous year) and 24 of these were COVID positive. 802 (52%) have had a PMR compared to 522 (36%) in 2018/19. PMR Q4 figures cannot be compared with other Q1-3 as reviews were suspended nationally in March 2020 due to COVID. Q4 deaths can be reviewed up until the end of the subsequent quarter and the trust were advised only on the 15th March that they could do so. The number of higher level reviews (SJR / SI framework) has increased from 35 in 2018/19 to 88 in 2019/20 (24 were attributed to the first 24 COVID deaths).

Total Number of Deaths subject to review (01/04/19-31/03/20)	Primary Mortality Reviews	Higher level reviews escalated from PMR screening	Higher level reviews escalated directly from other sources	Total Deaths considered potentially avoidable
1542	802	47	41	2

Avoidable Death Assessment Score	Score 1 Definitely Avoidable	Score 2 Strong evidence avoidable	Score 3 Possibly Avoidable >50:50	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoid ability	Score 6 Definitely not avoidable
	0	2	0	3	3	52

3.4 Coroners Inquests

There have been 40 inpatient deaths referred to the coroner.

21 Inquests were concluded this year.

12 cases were discontinued following receipt of a natural cause of death.
5 cases were heard at inquest by the Coroner but no Trust staff were asked to attend to give evidence.
4 cases involving Trust staff were heard during this past year and required attendance by Trust staff to give evidence at the Coroner's Court no criticisms of care provided by the Trust were made.

The Coroner issued no Regulation 28 reports to the Trust last year.

3.5 Maternity, Neonatal and Paediatric Mortality Review

Deaths within these services, with the exception of gynaecology, are subject to robust external scrutiny and review processes.

The Perinatal Mortality Review Tool (PMRT) process was implemented in January 2019 and all deaths since December 2018 have been reviewed using the PMRT review process. All relevant cases have a multidisciplinary review which includes peers and reports are submitted to the national perinatal institute. In 2019/20 there has been 15 stillbirths and 3 neonatal deaths, all of which have been reviewed using the PMRT. There were no cases of substandard care or care likely to have affected outcome. However, lessons for learning within the speciality included documentation of carbon monoxide levels, extending smoking cessation support of family members when the mother is a non-smoker and to include an algorithm for concealed pregnancy in the Unborn policy

There have been 4 maternal deaths which have all been reported to MBRACE for investigation. Three were indirect causes and 1 direct cause (booked at WUTH and delivered at Sheffield teaching hospitals). MBRACE do not give direct feedback on individual cases and the annual report will be awaited for any conclusions.

3.6 Learning Disability

Since September 2019 WUTH have had a member of the safeguarding team trained to do Learning Disability Mortality Reviews (LeDeR) and they also now conduct reviews for the local system and region. In 2019/20 there were 5 patients with learning difficulties who died. All deaths have an external national review led by the University of Bristol team. Following the appointment of our own LeDeR reviewer 3 of these have been reviewed internally for the first time. The first 2 predate the appointment of the reviewer.

System wide joint LeDeR reviews have taken place with CWP (1 case)

3.7 Engagement with Families and Carers

The Learning from Deaths Guidance set clear expectations for how NHS Trusts should engage meaningfully and compassionately with bereaved families and carers prior to and following a death.

In July 2018 additional guidance to support the work with bereaved families was published by the National Quality Board. The guidance was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in investigations, as well as with voluntary sector organisations.

In 2019/20 any concerns raised have been escalated to SJR. There were two cases. One review identified communication issues at ward level and the other case related to concerns with primary care and this has been escalated to the CCG.

New concerns will be raised through the medical examiner role.

3.8 Learning identified; actions taken in response, and an assessment of the impact of actions taken

Learning	Actions Implemented	Impact
Delay in discharging frail and elderly patients often results in their deterioration.	Also identified during GIRFT and “avoidance of deconditioning” is part of implementation action plan	In progress
Specialty reviews to report into trust mortality processes	Endoscopy, Surgery and Haematology providing reports	Increased percentage of higher level reviews noted
Improve Quality of Admission Diagnoses	Any CUSUM alerts are reviewed within the Mortality Review Group Speciality diagnoses folders	Ongoing
Improve Communication with system partners on DNCPR	Millenium solution for documentation in place	GP now will receive copy of DNCPR in addition to primary copy being with patient
Bereavement / Carer feedback not assured	Bereavement team escalated to Dep MD concerns and now to be superseded by medical examiner program	Full compliance with medical examiner standards
Warfarin drug interaction	Comms to all medical staff re INR on all patients at time of admission	In progress
Nosocomial patient to patient COVID transmission	COVID bed management policy with no step down from red ward areas	In progress
The use of vasopressors for maintaining blood pressure if fluid replacement insufficient	Critical Care learning via audit meeting	In progress
Consider sepsis early as a differential diagnosis with prompt commencement of antibiotics	Shared learning through safety summit and comms	In progress

3.9 Sharing learning from deaths

Divisions and Clinical Services share learning from Deaths internally through their local Divisional arrangements e.g. good practice meetings/ specialty meetings etc. Mechanisms for sharing lessons learnt across the Trust include Safety Bites Bulletins; Monthly Safety Summits and through the Trust Governance arrangements. Sharing also occurs across the system through regional networks such as NW Coast and the Wirral System Clinical Advisory Group.

At present however divisional / clinical services reviews are not included in quarterly or annual learning from deaths papers.

3.10 Medical Examiner

Recently an external, experienced lead medical examiner has been appointed. Dr. P Iyer starts on 16th July 2020 and will provide 2 full days per week from 19th July 2020. In addition, one WUTH consultant has completed the first phase of training and is eligible to start and two further consultants are doing their initial training. We then should have 7 PAs of medical examiner which is in line with the recommended level (10 PAs per 3,000 IP and ED deaths). The supporting officers are to be interviewed and there are 3 applicants.

At the time of writing this report WUTH is the first acute trust in Cheshire and Merseyside to have implemented the medical examiner role. The lead medical examiner will provide separate assurance reports to the Patient Safety Quality Board (PSQB).

4. Conclusion

The number of primary mortality reviews has increased significantly in 2020. There has been a significant rise in Q4 of SJRs performed and returned within 28 days. A robust LeDeR process is now in place. A weekly mortality review group has been implemented to monitor timely SJR returns and disseminate prompt learning.

A number of medical examiners have been appointed with a lead identified, becoming the first acute trust in Cheshire and Merseyside to do so.

Recommendations from last year's report have been either completed or remain ongoing for monitoring impact.

5. Next Steps

1. New DNCPR documentation is to be embedded across the healthcare system
2. The CQC in their assessment of acute services at WUTH were critical that deaths were not reviewed in a timely fashion. To address this, the mortality review group will meet weekly and all concerns raised through PMR and other sources will be escalated to it for assigning a SJR lead and the monitoring of returns (28 day deadline).
3. The mortality policy has been updated to include the role of the medical examiner and the changes to the mortality review group and has been provided for approval
4. The mortality review group will also collate themes appearing from reviews and extract learning points. The membership of the group is from all clinical divisions so that they can disseminate back to their relevant governance forums. In addition learning will be shared via the patient safety newsletter. Individual feedback will also be given, if necessary, through clinical line management / supervision structures.
5. Themes and trends arising in the learning from deaths process will be shared in the weekly Serious Incident Review process, Monthly safety summits and, where appropriate, externally to relevant clinical governance forums

6. Recommendations

The Board of Directors are asked to note the contents and progress described within the paper.

Wirral University Teaching Hospital
NHS Foundation Trust

Learning From Deaths 2019/20

Table 1: Mortality Review Figures for 2019/20					
2019-20	Total number of Adult In-patients Deaths	Reviewed using Screening tool	Escalated to SJR from Screening & Completed	Cases escalated direct to SJR (inc. SI/ Rapid Review)	Total reviewed
Q1 2019/20	366	291 (80%)	19 (7%)	2	277 (76%)
Q2 2019/20	336	231 (69%)	8 (4%)	4	209 (62%)
Q3 2019/20	352	145 (41%)	14 (11%)	4	163 (46%)
Q4 2019/20	488	135 (28%)	6 (4%)	31	172 (35%)

Table 1 (Narrative): Qtr 1-4 - A total of 53% of reviews (combined total for screening and SJR) has been completed across the year 2019/20. Qtr 3 and Qtr 4 saw a reduction in the number PMR's, with an increase of SJR's in Qtr 4 as a result of a Trust decision to undertake SJR's for COVID-19 deaths.

Number of SJR's completed April 19 to 31 March 2020 = 77

- Escalated from screening tool: 41 (6%)
- Escalated directly to SJR following automatic criteria: 43 (2%)

Table 2: Learning Disability Mortality Review Progress				
2019-20	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care	Referred to LeDeR
Q1 2019/20	3	1	None identified	1
Q2 2019/20	1	1	None identified	1
Q3 2019/20	0	0	None identified	0
Q4 2019/20	1	0		1

Table 2 (Narrative): Identified learning - if there is repeated failure to complete a procedure Best Interest documentation should be completed.

Table 3: W&C's						
2019-20	Total No. of Maternal Deaths	No. reviewed using Mbrrace Tool	Total No. of Neonatal Deaths	No. reviewed using Perinatal Mortality	Still Births (From 22 weeks)	No. reviewed using Perinatal Mortality Review Tool
Q1 2019/20	3	(3)	0	0	(3)	(6)
Q2 2019/20	0	(3)	0	0	(3)	(6)
Q3 2019/20	0	0	2	2	7	7
Q4 2019/20	1	In progress	1	1	2	2

Table 3 (Narrative): Identified learning - maternal deaths - 1 intrapartum death - placenta percreta transferred to Sheffield for delivery. No coronoial or MMBRACE report available. 2 antenatal still births. Care issue in 1 relating to induction of labour medicaltion dosage amd resulting in BBA with PPH. Other SB care issue of intrapartum monitoring of twin 1 at 23 weeks. Neither case would have affected outcome. Neonatal case - ex utero transfer, no care issues.

Table 4: SJR reviews undertaken within the quarter have indicated the following levels of care provided:-

Score 1		Score 2		Score 3		Score 4		Score 5		Total Number of deaths considered more likely than not due to problems in care. (From SJR and other Investigations)	
Very Poor Care		Poor Care		Adequate Care		Good Care		Excellent Care			
Q1 19/20	0	Q1 19/20	0	Q1 19/20	2	Q1 19/20	6	Q1 19/20	0	Q1 19/20	0
Q2 19/20	0	Q2 19/20	1	Q2 19/20	3	Q2 19/20	4	Q2 19/20	0	Q2 19/20	0
Q3 19/20	2	Q3 19/20	0	Q3 19/20	2	Q3 19/20	6	Q3 19/20	0	Q3 19/20	0
Q4 19/20	0	Q4 19/20	5	Q4 19/20	8	Q4 19/20	13	Q4 19/20	6	Q4 19/20	2

Table 4: 26 SJRs were performed on initial COVID deaths. 2 were deemed avoidable-nosocomial infections on a non COVID ward in initial pandemic

Table 5 - Quarter 4 2019/20 Mortality Review Learning Themes & Breakdown

Quarter 4 2019/20		
Theme	Care issue	Positive
Good care no learning points		107
End of Life Planning	9	0
Communication / Documentation (staff)	3	0
Communication patients/ relatives	3	0
Incorrect/ incomplete entry on death certificate	3	0
Resuscition/ DNACPR	2	0
Monitoring / response to deterioration	3	0
MCA/DOLS assessment	2	0
Lost opportunity to identify patient in last 12 months of life at previous admission	1	0
Diagnosis not correctly recorded	1	0
Inappropriate admission	1	0
Inappropriate transfer / place of care	2	0
Inappropriate/ Inadequate/ Delayed discharge	3	0
Inappropriate/ inadequate treatment	1	0

Good care no learning points has consistently been in the top three learning themes over the last 2 years

- Action plan in development to ensure diagnosis is correctly recorded and coded.

- Other learning points identified are linked to Trustwide improvement programmes and governance arrangements

e.g.
- Deteriorating patients
- Resuscitation/ DNACPR
- End of life care
- Safeguarding
- Delays in discharge introduce risks

Sharing Lessons Learnt

All cases with learning will be sent to the Divisional AMD's to disseminate through local Governance arrangements

Where Trust improvement programmes are in place information will be cascaded to programme leads to ensure learning is captured within action plans

The Safety Summit and subsequent Safety Bites Bulletin contiues to be utilised to disseminate learning throughout the Trust

Medical Examiner Update

Following national suspension of all learning form deaths programmes on 25th March 2020, the regional examiner requested all acute trusts in NW resume implementation on 12th June. Recruitment to the medical examiner and officer roles have taken place with a lead examiner (external) appointed and internally 1 consultant has completed initial training and 2 more are doing initial training. A GP has also expressed an interest to date. Within the bereavement team 3 have completed initial training and applied to become officers. The first deaths to be reviewed using the medical examiner are anticpated from 16th July

Figure 2 - HSMR Rolling 12 Month

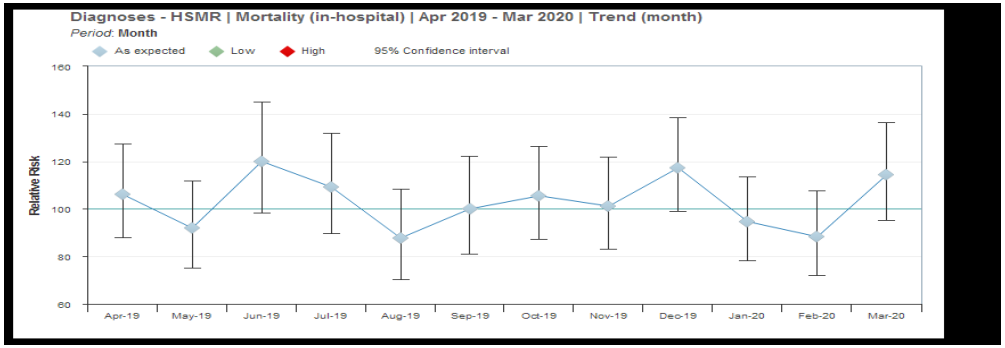


Table 3: Dr Foster Relative risk & CUSUM alerts - Rolling Month (Feb 19-Jan 20)	
Alerts (Diagnosis)	Deficiency & other anaemia; Sprains & Strains; Cardiac Dysrythmias; Fluid & electrolyte disorders; Intestinal infection; Occlusion or stenosis of precerebral arteries and Residual codes
Alerts (procedures)	High cost drugs; Miscellaneous operations; Therapeutic operations on larynx

Table 4: Dr Foster Metrics - Rolling month (vs region acute non specialist)				
Dr Foster Metrics	Oct 18-Sep 19	Nov 18 - Oct 19	Dec 18 to Nov 19	Feb 19-Jan 20
Crude Rate (HSMR)	3.3 vs 3.2	3.7 vs 3.2	3.6 vs 3.3	3.45 vs 3.09
Palliative care code deaths	52.6	58	51.9	47.94
Palliative care coding (%)	2.9 vs 3.0%	3.4 vs 3.0%	3.2 vs 2.5%	2.41
SHMI	110.99			112.69

Table 5: Dr Foster Alerts

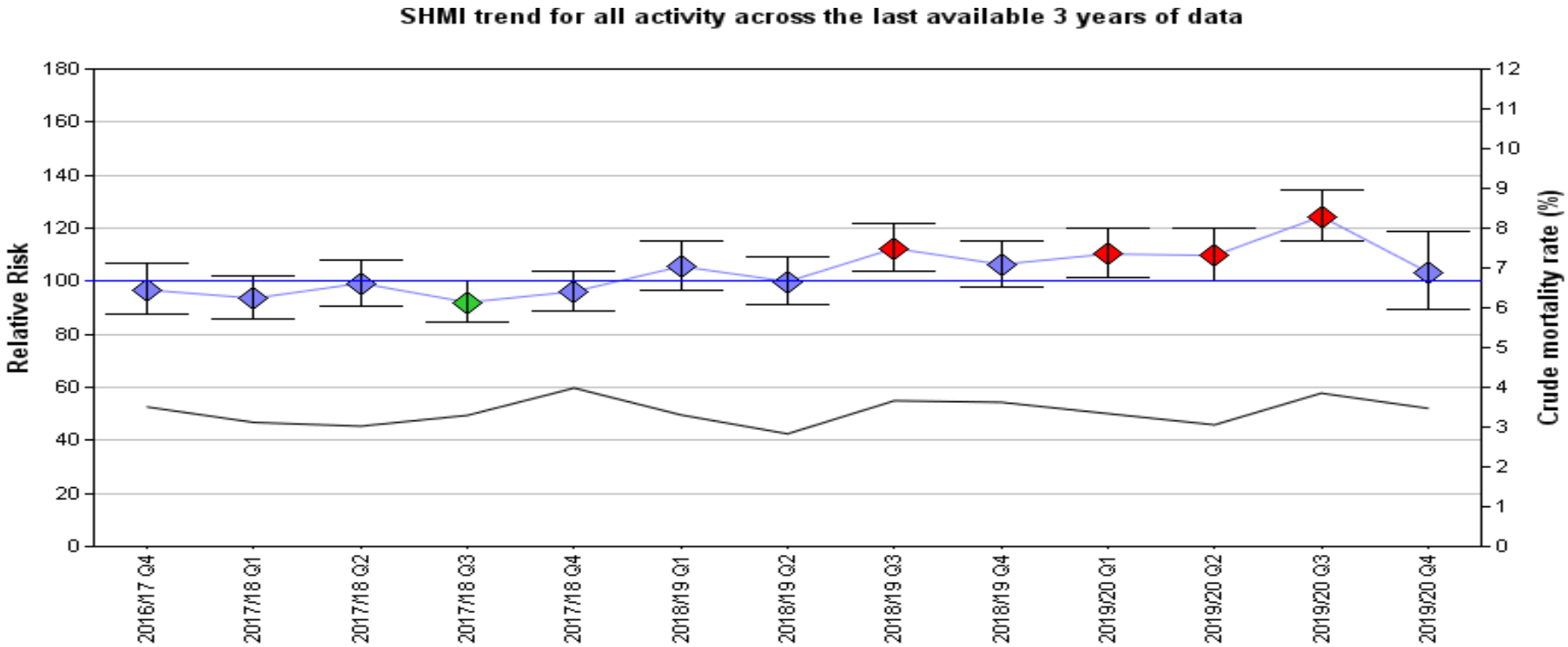
Time Period	Alerts	Q4 12 month Obs vs expected	12 month Observed Q3	Change	
Feb 19-Jan 20	Cardiac Dysrthmias	18 v 12.2	24	↓	
Feb 19-Jan 20	Fluid and Electrolyte	25 v 14.9	25	↔	
Feb 19-Jan 20	Anaemia	17 v 9.5	22	↓	
Feb 19-Jan 20	Sprains and Strains	1 v 0.2	2	↓	
Feb 19-Jan 20	Pre-cerebral Occlusion	1 v 0	1	↔	
Feb 19-Jan 20	Intestinal Infection	26 v 15.8	23	↑	
Feb 19-Jan 20	Residual Codes	32 v 12.1	7.8	↑	new

Dr Foster Overview

The most recent Dr Foster Data released June 2020 (for year ending Jan 20) reported 6 continued negative CUSUM alerts for diagnosis at admission. One previous noted negative (Nutritional deficiency) no longer has a negative alert. Unclassified Residual Codes in March increased from 7.8 to 32 creating a new alert.

Palliative care mortality coding remains one of the highest for acute trusts in Northwest. Crude mortality rate has shown a further quarterly decrease from 3.6 to 3.45. SHMI is now reported monthly, whereas previously it was quarterly. Having gone above expected (the last quarterly figure) it has returned to within the expected range for March 2020

SHMI trend for up to end of Q4 19-20



Board of Directors	
Agenda Item	20/21 098
Title of Report	Legionella Sampling
Date of Meeting	5 August 2020
Author	Anthony Middleton, Chief Operating Officer
Accountable Executive	Anthony Middleton, Chief Operating Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Quality and Safety of Care
Level of Assurance • **Positive** • **Gap(s)**	Gaps in Assurance
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The purpose of this report is to inform the board of two separate incidents of raised legionella levels identified through routine testing; the actions taken to maintain quality and safety of care, and to provide assurance of the systems in place.

2. Background

Legionnaires' disease is a serious pneumonia caused by the Legionella bacteria in which people can become infected after inhalation of water droplets from a contaminated water source.

The following factors have been found to influence the colonisation and growth of legionella:

- Water temperature between 20ºC and 45ºC will promote growth
- Areas of poor flow
- Biofilms within water systems that harbor and provide favorable conditions for legionella to grow

The water systems in the Trust buildings were designed to achieve 50ºC, however NHS estates and Health & Safety Executive technical guidance on legionnaires disease released after the construct of the buildings recommends that where water systems are not able to achieve 55ºC then microbial monitoring is routinely undertaken.

The Trust has a risk based routine testing regime which ensures that all areas over an 18 month period is tested at outlets in those departments/wards furthest away from the plant (i.e. most likely coolest point), with more frequent testing undertaken in areas of the estate known to have the coolest water temperatures as they are the furthest or highest from the plant, or the pipework design and layout creates poor flow. To compliment the testing of water temperatures there is a continual regime of flushing low use outlets in wards and departments undertaken by local teams, and by the Estates teams for areas not in use.

The Trust maintains governance of these issues through the water safety group, which reports through the Infection Prevention and Control group and in turn to the Patient Safety & Quality Group.

3. Incidents

3.1 Ward 20

As part of routine testing an alert was issued on Saturday 23rd May 2020 pointing to high legionella readings from water samples taken from Ward 20. Upon receipt of this information steps were taken to apply filters to outlets on the ward to mitigate the risk and an exceptional meeting of the water safety group was convened for the 28th May whilst awaiting the absolute test results which routinely follow 3 to 4 days later. Following the meeting on the 28th the Chief Nurse, who is also the Trusts Director of Infection Prevention and Control (DIPC) was alerted to the incident for the first time.

The Chief Nurse / DIPC took immediate action with other Executive colleagues to instigate the “outbreak framework” and steps were taken to close Ward 20, with an alternative ward opened to accommodate patients and staff, and asked for a formal incident and investigation to begin.

All patients were clinically reviewed and no symptoms associated with Legionnaires were identified.

The water safety group also provided information that since the start of the COVID-19 pandemic overall monthly water usage on the Arrowe Park site had fallen by circa 3,000,000 litres (16%) and this reduced flow may have been a factor in the raised levels. On this basis the Chief Operating Officer instructed that an extraordinary testing of all areas should be commenced immediately.

The situation on the ward was assessed and it was decided to accelerate the planned pipework refit which was part of the 2020/21 capital programme. These works were completed, the system has been strenuously tested and is running at temperatures well in excess of guidelines and the ward re-opened on the 6th July.

3.2 Ward 33

Late on the on the 25th June as part of the exceptional testing programme raised levels were alerted to the Trust in relation to sampling taken on Ward 33. On this occasion the escalation of

the preliminary results was immediate and the Chief Nurse and COO convened a meeting of consultant physicians and microbiologists, IPC, and Estates staff

Steps were taken to mitigate the risk overnight by the fitting of filters, deployment of portable handwashing stations and the closure of some outlets. . A further instigation of the “outbreak framework” for ward 33 was made.

Again, all patients were clinically reviewed and no symptoms associated with Legionnaires were identified.

The following morning after a robust assessment of operational pressures was made it was decided to close Ward 33 and commence the same programme of refit as per ward 20. Similarly the refit was already planned within the 20/21 capital programme as both of these wards were recognised as the top 2 risks in relation to water temperature control.

The refit programme is underway and the expectation is that the ward can re-open by mid-August.

4. Conclusion

The action taken in both incidents was robust and there is no evidence of any patient harm.

There are concerns in the first incident that escalation was not timely enough and where reduced water flow was recognised, which may have been a factor in raised levels in those areas of greatest risk this did not trigger any remedial measures. It is recognised that in the second incident escalation was rapid and would suggest lessons learnt.

However, there is confidence that the areas known to have been the greatest risks were part of the prioritised capital programme and have now been addressed, and there has been no further alert to raised levels from the exceptional testing process which is now complete.

These issues have raised awareness that the governance around water safety issues is held a relatively low level and reports through a number of layers before it reaches a group overseen by Executive team. Therefore a decision to change the construct of the water safety group to include Executive membership has been actioned and the reporting line for the water safety group has been amended with assurance provided to the Safety Management assurance committee (SMAC).

Furthermore the Executive team have commissioned an independent assessment by the company who provides water safety management to NHS property services in the North West during August.

The scope of the review includes compliance with legislation, documentation, safety systems and effectiveness, qualification and training of key personnel and contracted advisors.

The recommendations of the review will be considered at the end of August and reported through to SMAC

5. Recommendations

The board is asked to note the robust response to the incidents and be assured that steps have been taken to improve governance.

A further update on the commissioned review and subsequent actions will be provided to the Board via the safety management assurance committee.

Board of Directors	
Agenda Item	20/21 099
Title of Report	Change Programme Summary, Delivery & Assurance
Date of Meeting	5 August 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

PROGRAMME SUMMARY

1. Overview

At the Programme Board of 15th July 2020 the members received full update presentations on the priority programmes of Outpatients and Flow. Other main items included an update on the re-launch of the Patient Portal initiative, the approach to 'Digital Dictation Plus' and the introduction of the Trust-developed Theatre Scheduling System. The Programme Board also received the assurance evidence and that evidence (coupled with attendance at most programme meetings) forms the basis, as usual, of this assurance report to the Board of Directors. The scope of the programme **(slide 2)** has been updated to make explicit the four 'Digital Enabling Projects' (which the Board requested be tracked for assurance purposes).

PROGRAMME STATUS

In terms of the overall ratings assessments **(see slides 3 and 4)**, there has been a significant improvement, compared to June, in the assurance evidence for delivery of the portfolio; however, the number of red ratings for governance are at a level last seen in late 2018. For the avoidance of doubt, in assurance terms, the 'governance' rating concerns itself with: clarity, leadership, teamwork and engagement.

1.1. Governance Ratings

Five of the eleven 'live' programmes are green rated for governance, with two attracting an amber rating, and four are red rated; 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 there are six programmes green rated for delivery – this is largely due to the creation of newly base-lined plans approved by exception report – while three are amber rated and two are red rated. For the sake of clarity, 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 Outpatients. The metrics for the Outpatients project are shown at **slide 6**.
2.2 Flow. The metrics for the Flow project are shown at **slides 7 and 8**.

2.3 Perioperative. Metrics for Perioperative Medicine will be appearing again following the update to the Programme Board on 19th August 2020.

3. Service Improvement Team

It is understood that a new operating model for the Service Improvement Team will be received by the Programme Board at its meeting of 19th August 2020.

The team has seen further turnover during the past 8 months but in a positive vein (given the recent investment in skills and capabilities): two members joined the Hospital Upgrade Programme, one has been seconded to clinical governance in the Trust and, more recently, another has been appointed to a leading role on the Healthy Wirral programme. This will leave three core members with three new arrivals (July and August) against the current establishment of nine. Therefore, the priority programmes will need to be carefully guided (by the SRO and programme steering groups) through this transitional phase for the team.

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 presented at the Programme Board meeting (the membership of which includes a non-executive director) held on Wednesday 15th July 2020.

5. Assurance Focus

In aggregate, the assurance ratings for the top three priority projects - namely Flow, Perioperative Care and Outpatients - carry much greater weight than the other eight 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 three 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.

Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

External Programme Assurance
July 2020

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V2.6_10 Jul 20_JG

Wirral University Teaching Hospital NHS
NHS Foundation Trust

P Priority Project

Digital Enabling Project

WUTH Trust Board of Directors

Strategy & Partnerships
Matthew Swanborough

Programme Board – CEO Chair
Janelle Holmes

Clinical Advisory Group
Nikki Stevenson / Hazel Richards

Patient Flow & Outpatients
SRO – Anthony Middleton

- P Front Door — **Lead: Shaun Brown**
- P Back Door — **Lead: Shaun Brown**
- P Capacity Management — **Lead: Shaun Brown**
- ED One Patient Record

Operational Transformation
SRO – Anthony Middleton

- P Perioperative — **Lead: Paul McNulty**
- Theatre Scheduling
- P Outpatients — **Lead: Alistair Leinster**
- OP One Patient Record
- *Enabling Technology* Patient Portal — **Lead: Natalie Park**
- Digital Dictation Plus

Hospital Upgrade Programme
SRO – Matthew Swanborough

- Workforce
- Design
- Clinical Service Delivery
- Management / Finance
- Communications / Engagement

Workforce Planning
SRO – TBD

- WRaPT (Pilot) — **Lead: Ann Lucas**

Linked to programmes governed by

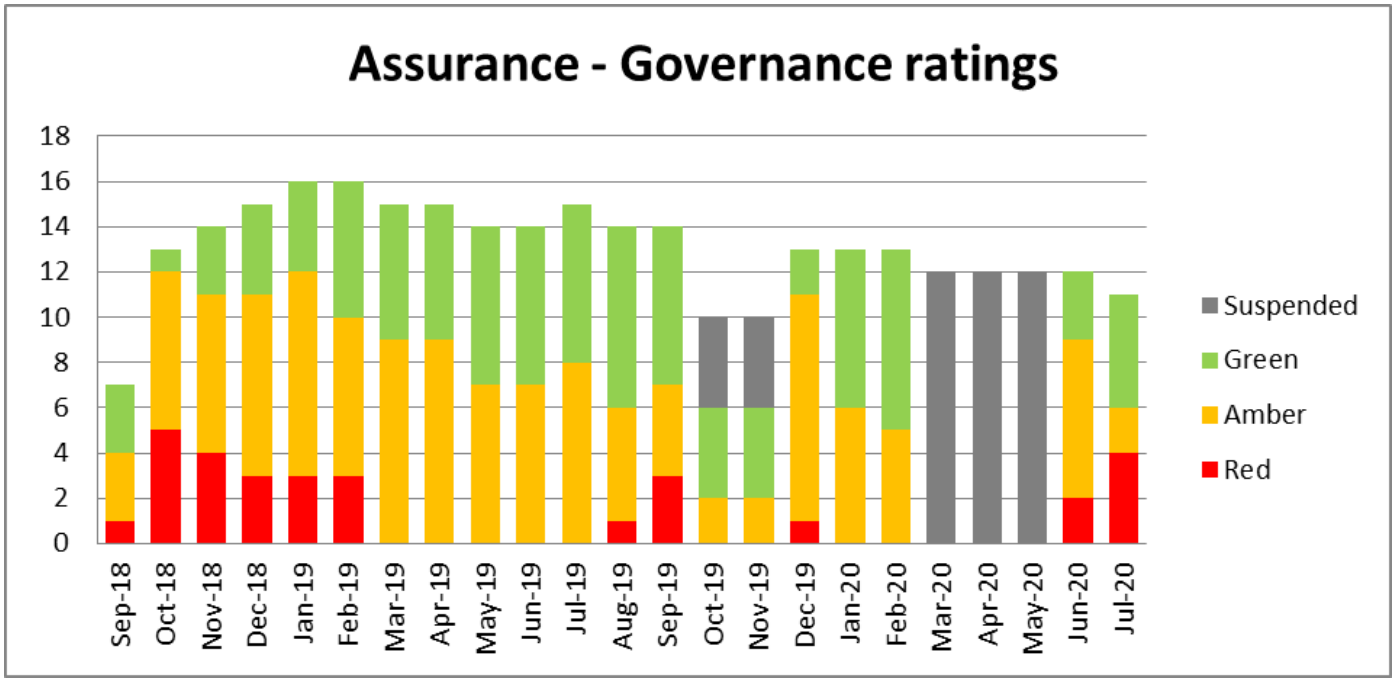
Healthy Wirral

- Medicines Optimisation
- Continuing Health Care
- Planned Care
- Unscheduled Care
- Back Office

Change Programme Assurance Report - Trust Board Report - July 2020

J Gibson – External Assurance

Wirral University Teaching Hospital NHS Foundation Trust



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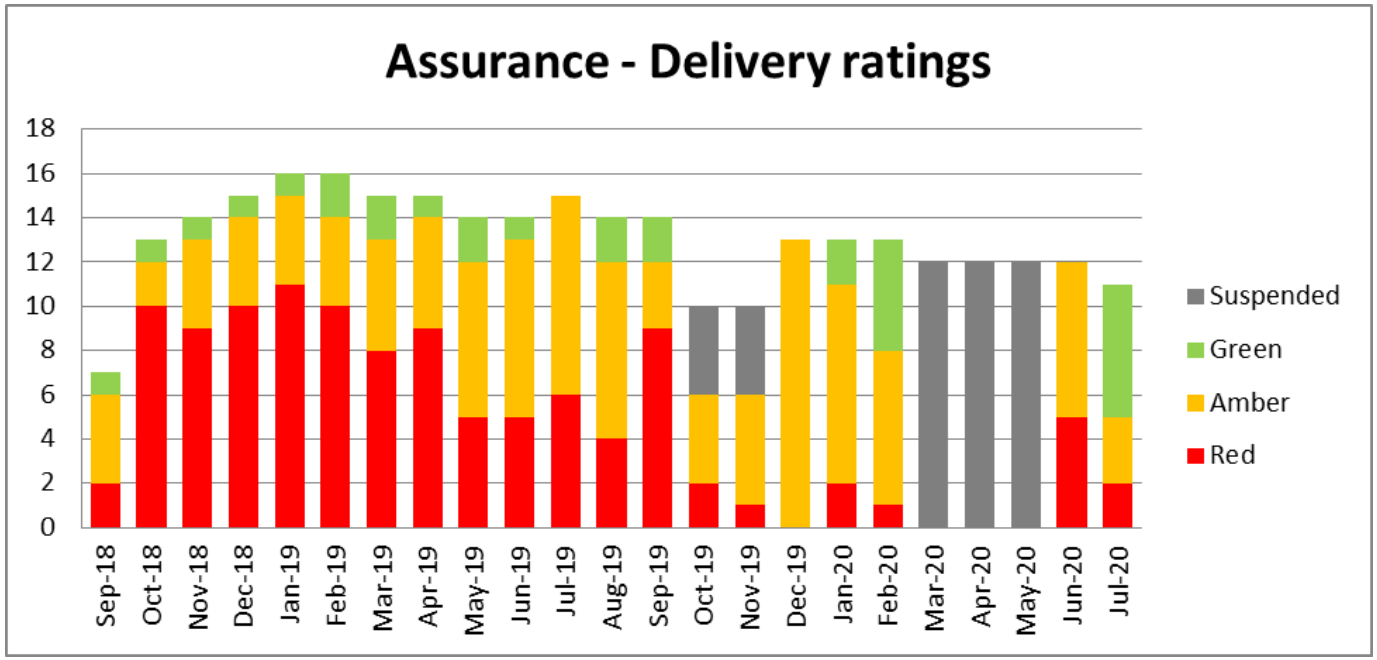
Change Programme Assurance Report - Trust Board Report - July 2020

J Gibson – External Assurance

Wirral University Teaching Hospital NHS Foundation Trust



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Priority Projects Metrics

Senior Responsible Owners

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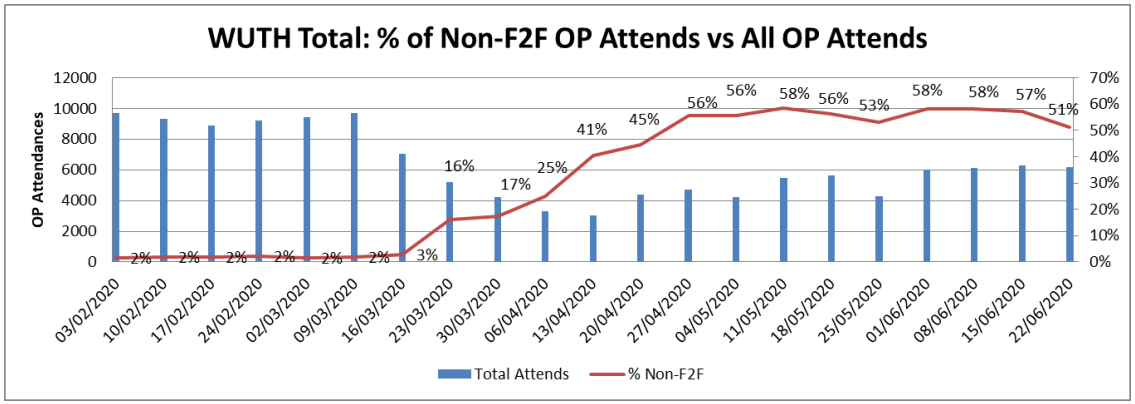
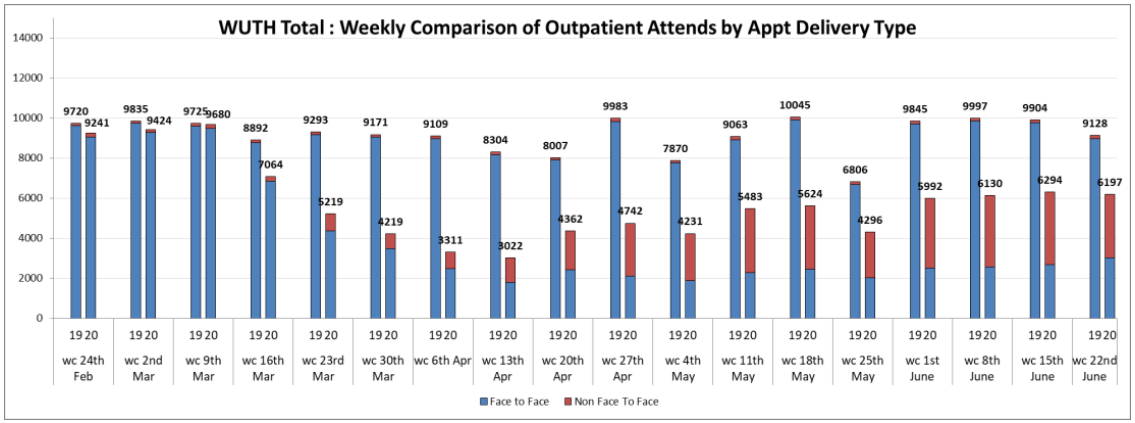
Outpatient Metrics – Programme Board 15 Jul 20
Non-face to face as % of total: overall

Wirral University Teaching Hospital
NHS Foundation Trust





Trust Level Narrative:

Overall OP activity average approx 6150 attns per week in June vs 9700 previous year (63% or previous activity levels). Medicine seen to deliver 95% of previous year's activity, with lower levels in DCS, W&C and Surgery.

% Non-F2F variable by week, with levels in June broadly maintaining levels seen in May. Variation seen across Divisions, with highest proportion of non-F2F seen in DCS and Medicine.

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Flow Metrics – Programme Board 15 Jul 20

Wirral University Teaching Hospital
NHS Foundation Trust

Patient Flow Improvement Group Reporting Meeting - July 2020											
	ID	Description	Reporting Period	Period Target	Jun-20	May-20	Apr-20		YTD Target	YTD Performance	YTD Variance
Patient Flow											
	1	Bed Occupancy	Jun-20	93%	**82.8%**	78.8%	67.9%		93%	**76.5%**	-16.5%
	2	Time spent in A&E (Minutes)	Jun-20	240	**167**	153	184		240	**168**	-72
	3	Average current in-patient LOS (Closed Spells)	Jun-20	TBC	4.69	4.69	6.94		TBC	5.30	
			Week Commencing	Target	30/06/20	23/06/20	16/06/20		09/06/20	02/06/20	26/05/20
	4	Total Number of Long Stay Patients - >=21 days	30/06/2020	52	48	55	52		58	55	56

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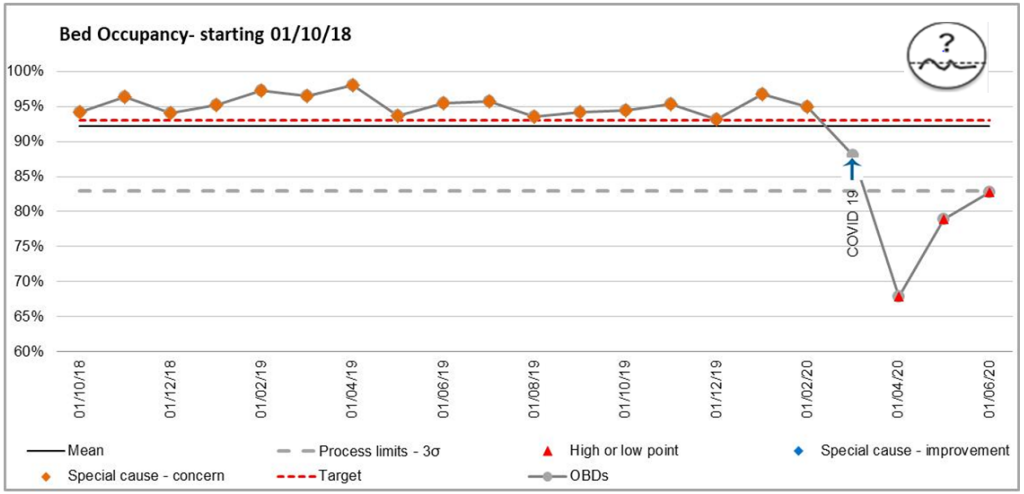
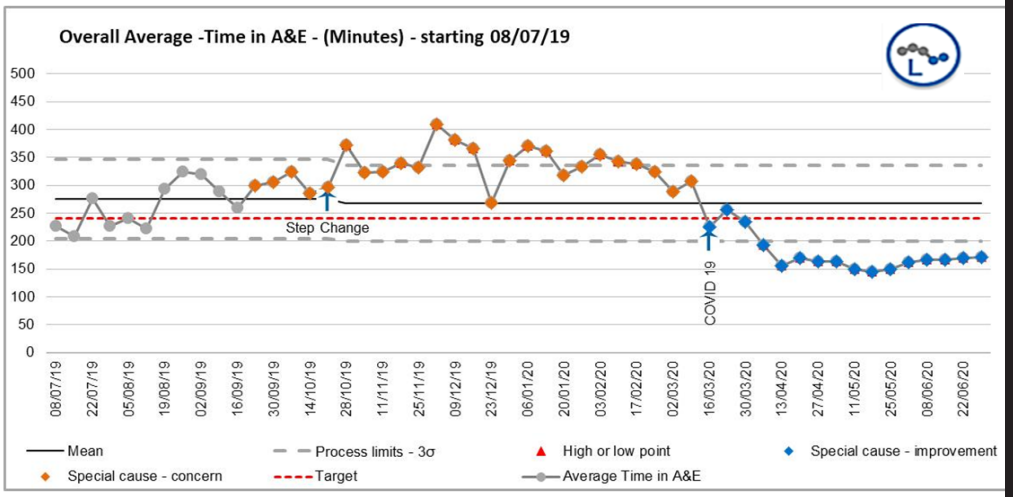
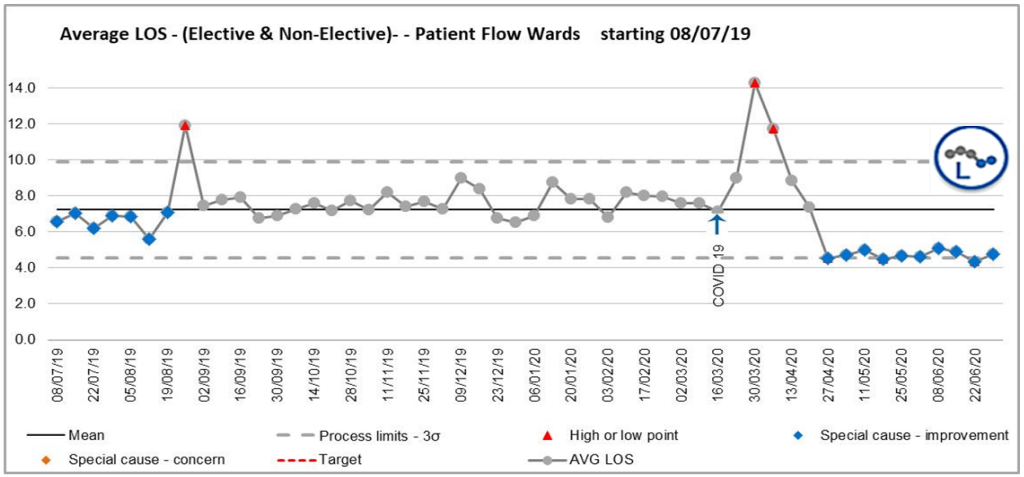
Patient Flow Improvement Group

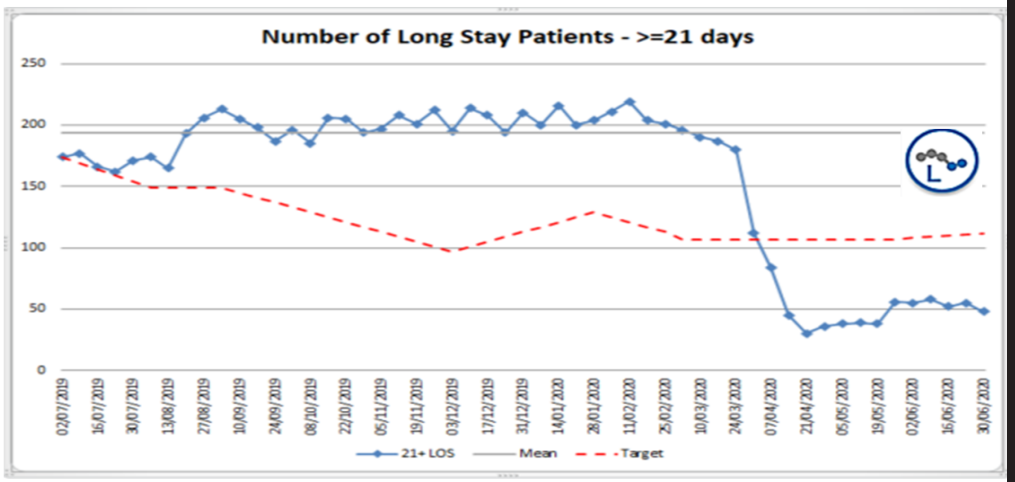
Reporting Meeting - June 2020

NHS Wirral University Teaching Hospital NHS Foundation Trust









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Programme Assurance Ratings

Joe Gibson
15 July 2020

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Amber	Delivery	Amber

- The significant measure of '21day + LoS' for the Flow Programme, following the actions taken by the health & social care system to manage and mitigate the COVID-19 emergency, has continued to maintain a positive trajectory below (48 reported at 30 Jun 20) the revised period target of 52.
- The project now reports (Programme Board 15 July) the lowest number of stranded patients in North West region and is in the top 5 Trusts in England (previously in the bottom 5 Trusts in England). The challenge now will be to sustain these improvements – the revised thresholds and successful delivery - as part of a new paradigm for the Wirral H&SC system.
- **The 'Capacity Management' system, launched 9 March 2020, is currently delivering an 82% accurate picture of the Trust position; the system needs to be 100% accurate. A review of the bed bureau working model, as well as continuing accuracy checks, are the key activities of the project to drive performance.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Green

- The revised PID v0.5 dated 4 Mar 20, including an extensive schedule of benefits and measures, remains extant.
- The Perioperative Medicine Steering Group delivered a presentation of the new Theatre Scheduling System to the Programme Board on 15 July outlining the improvements made and future plans for future development of the system which was created 'in-house'.
- **The project continues to be clinically led and well governed. The revised plan is on track at the time of reporting .**

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Amber	Delivery	Green

- **Overall Progress:** The Outpatients programme was re-focussed (Programme Board on 18th March) to deliver, at pace, radical solutions to keep patients away from the hospital sites by providing outpatients services by alternative (remote) means; the use of these digital options has now stabilised in a overall range risen impressively (phone and video) from 1% in Feb 20 to a **current level of achievement in the range 51-58% Non Face-to-Face (for 9 weeks to 22 June 2020) against an activity level of 63% compared to June 2019.**

- **Compliance and Exceptions:** The programme team has now been working with 27 specialties, across 4 divisions, to identify clinical exceptions that would admit a face-to-face consultation to occur. As reported to the Programme Board on 15 Jul 20, 19 specialties have identified 'clinical exceptions where face-to-face (is) necessary have been quantified and signed off by (the) Division'. For 8 specialties this identification and Divisional sign off remains a work in progress.

- **One Patient Record:** The programme states that there will be a single patient record which will replace paper case notes in Outpatients. As reported to the Programme Board on 15 Jul 20, of 26 specialties where this applies, 6 specialties are stated as being rated as 100% (green) with 'no case notes required'; the remaining 20 specialties are in a range between 20-90% rated.

- **Target:** The programme target for overall delivery by remote means (PID 2 Jul 20, Workbook 7 Jul 20) remains at 50% Non face-to-face. A more ambitious target could now be considered. This target should be a weighted aggregate of the levels set by Divisions and mediated by the Operational leadership and Clinical Advisory Group.

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Workforce Planning - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Ann Lucas	Joe Roberts	Design	Red	Red

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. **2. & 3.** There are revised ToRs of the 'Workforce Planning Group' with minutes of a meeting to 28 Feb 20 and an update to the WAC on 21 Jan 20. **4.** There is some evidence of continuing stakeholder engagement (including e-mail exchanges on divisional priorities during Feb 20), 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 has been tracked to w/c 16 Mar 20 and this shows that several important tasks from Nov 19 - Jan 20 are not completed. **7.** There is now evidence of a Workforce Dashboard (Trust Level) dated 22 May 19 but no explicit link to programme metrics or start dates attached; 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 16 Mar 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.	TBD											

Front Door - Programme Assurance Update – 10 July 2020

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

Independent Assurance Statement

1. Scope is defined by PID v10 dated 3 Mar 20 (benefits matrix was to have been populated by 30 Apr 20). This is supplemented by a 'Front Door Project Post-COVID Re-Start' (PowerPoint) uploaded on 6 Jun 20 stating benefits have been agreed. **2. & 3.** There is a ToR, Issue v3.0 dated 7 Jan 20 and evidence relating to team meetings up to 27 Feb 20; more recent evidence of meetings is required to show team working and governance, it is understood meetings are planned for 16 and 17 July. **4.** There is an extensive list of stakeholders and the 'Front Door Stakeholder Engagement Log', uploaded 6 Jul 20, provides further evidence. There is extensive 'as is' (state) process mapping. **5.** A EA/QIA v1 has been drafted for the Front Door AU re-design and will await sign-off once there is more clarity on the future design. **6.** There is a detailed project plan - in the workbook v11 updated to w/c 6 Jul 20 - the exception report to the June Programme Board 're-baselined' the schedule; however, there are 10 actions open from Jun 20 for which the status is not clear. **7.** The 'Benefits Tracking Tool' shows the ED improvement Plan aiming to deliver benefits by 1 Jul 20 but some baselines are still 'TBD'; the rest of the benefits are to be delivered by 1 Jan 21 but around 50% of these currently lack baseline data. **8. & 9.** Of the 6 risks raised on the register: 3 were last reviewed in Dec 19, 2 in May 20 and 1 in Jul 20. **Most recent assurance evidence submitted 6 Jul 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 – 10 July 2020

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

Independent Assurance Statement

1. The PID, v0.11 dated 13 Feb 20, remains extant as uploaded to SharePoint. The new draft 'Sustain and Review' phase document v0.4 dated 15 May 20 introduces an expanded table of metrics (from 4 to 7) 4 of which require baselines to be established. This is supplemented by a (PowerPoint) Scoping presentation dated 27 May 20**. 2 & 3.** Evidence of CapMan project team meetings is uploaded to 6 Jul 20. The 'Divisional Sign Off' process, including commitments, was completed in full ahead of implementation on 9 Mar 20. **4.** There is now a revised Comms Plan for Phase 2, uploaded on 7 Jul 20, with a raft of actions planned for 'mid' and 'late' July 2020. The action plan should now be tracked to show completion of these tasks. **5.** EA has been drafted and QIA signed-off. **6.** The Capacity Management Project Plan was last updated to show the status of actions to w/c 6 Jul 20 and shows the plan to be largely on track. **7.** As described above, metrics for the 7 benefits are still being developed and none has a target implementation date. **8 & 9.** There is a risk register as part of the workbook and the one remaining risk was transferred to the risk log on 22 Jun 20. There is now a total of 8 recorded issues with owners and status. **Most recent assurance evidence submitted 8 Jul 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 – 10 July 2020

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

Independent Assurance Statement

1. The PID v9.0 dated 4 Feb 20 defines the project; the objectives extend to 31 Mar 21. This is supplemented by a 'Post-COVID Re-Start Plan' (PowerPoint) dated 8 Jun 20. **2. & 3.** The ToR for the Project Team is version 1.0 dated 27 Nov 19. There is evidence of project team meetings, supported by an Action Log, to 25 Jun 20. **4.** There is evidence of stakeholder engagement and guidance, including a 'Flagship Ward' plan extending to the end of September 2020. A Comms Plan for the project would provide further evidence of planned engagement. **5.** There are EA/QIA drafted awaiting sign-off. **6.** The project plan - in the workbook dated 3 Jul 20 - is in draft with numerous tasks to be assigned dates (current actions extend to w/c 20 Jul 20). **7.** There is a 'Benefits Tracking Tool' within the workbook, giving 4 key metrics - Board Rounds & Huddles, Ready for Discharge, Criteria Led Discharge, and Long Length of Stay Reviews - however, work is needed to complete targets, target improvement dates and baselines. The key 21day LoS (Long Stay Patients) target has been achieved as a result of health economy COVID measures (trending at 50 against <100 target at 30 Jun 20). Definition and attainment (and sustainability) of all metrics should now be the planning focus. **8. & 9.** There is a risk register with 1 open risk last reviewed on 1 Jul 20. There are no recorded issues. **Most recent assurance evidence submitted 6 Jul 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 – 10 July 2020

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

Independent Assurance Statement

1. PID v0.5 dated 18 Jun 20 has been uploaded. There are 8 benefit types described with associated metrics but precise targets with dates and baselines remain to be established. The last milestone dates mentioned in the PID are for 'Go Live' April/May 2020, followed by 12 months sustainability to April 2021. **2.** The Project Lead and Programme Manager held an 'Ad Hoc' meeting on 8 Jul 20. There is an action log for meetings with three actions arising from the meeting of 8 Jul 20. There is no other recent (since Jan 20) evidence of meeting (agendas, notes, papers, minutes). **6.** The project plan uploaded 8 Jul 20 shows a 6 month delay to the 'Trauma Documentation' build. **8 & 9.** There is a populated risk register, with two risks, and the 'date of last review' is 7 Mar 20. There is one issue recorded. **Most recent assurance evidence submitted 8 Jul 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														
2.3a	**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 – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Emma Danton	Implementation	Green	Green

Independent Assurance Statement

1. The revised PID v0.5 dated 4 Mar 20, including a schedule of benefits and measures, has been signed-off by the Proj. Steering Group. The Exception Report and Re-start Plan (post-COVID) was approved by the Programme Board in June 2020. **2.** As well as the Steering Group meeting there is 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 30 Jun 20. **4.** There is a Comms Plan dated 19 Feb 20 which covers wide stakeholder engagement both with the programme an individual work streams through 2020. The plan is now supplemented by a Comms tracker uploaded 7 Jul 20; evidence of Comms deliverables should be uploaded as supporting evidence. **5.** The QIA was revalidated in Oct 19. **6.** The project plan is on track, has an impressive level of detail - the exception report having been endorsed by Programme Board in June 2020 (establishing a new baseline). There is also evidence of new baselines and planning for 'Preop Triage' and 'Three Phase Recovery'. **7.** The Benefits Tracking Tool details benefits across 8 categories with some BI work remaining to establish baselines, mainly post phase one. **8 & 9.** Risks ands issues are now logged in the workbook and are updated to 7 Jul 20. **Most recent assurance evidence submitted 7 Jul 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.	Anthony Middleton		●	●	●	●	●		●	●	●	●

Theatre Scheduling - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Lynn Tarpey	Emma Danton	Design	Red	Green

Independent Assurance Statement

1. The Theatre Scheduling PID v0.2 dated 27 Feb 20 on the document control sheet (named v3) uploaded but is yet to be approved by a governance forum. **2.** There is evidence of a 'Theatre Scheduling System' Action Log with entries from 6 May 20 (many overdue for delivery in May 20) but no other record of meetings since Feb 20. **6.** There is a Theatre Scheduling workbook v1.2 uploaded on 3 Jul 20 and this shows post-implementation activities will complete in Nov 20. Phase 2 planning has commenced and the scoping exercise is due to complete w/c 6 Jul 20. **8 & 9.** The risk register for the project shows 3 risks closed and 1 transferred to the Issues Log. The one remaining risk was reviewed on 3 Jul 20. The Issues Log shows 9 issues closed while one remains open. **Most recent assurance evidence submitted 3 Jul 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.	Anthony Middleton											

Outpatients Improvement - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Clare Jefferson	Implementation	Amber	Green

Independent Assurance Statement

1. The DRAFT PID v3.0 dated 2 Jul 20 (under review by Prog. Lead and Clinical Lead) will need to be agreed by the programme and, subsequently, the Programme Board. Agreement of the benefits, post COVID-19 changes, will be pivotal to defining the programme. **2.&3.** An Outpatients Transformation Project Team ToR is in place at v2.0, authorised 10 Jun 20, with evidence of meetings to 29 Jun 20 and an Action Log uploaded on 5 Jul 20 (1 action overdue, 6 due 10 Jul 20 and 4 due by 31 Jul 20). **4.** The 'Outpatients Comms Plan', 10 Jun 20, describes the comms approach but needs to be tracked (RAG rated for progress); there is also evidence of engagement through the recent 'Clinical Feedback' and 'Patient Feedback' exercises. **5.** There is a need for a revised QIA/EA to be raised after the rapid (COVID-19 driven) changes; draft EA/QIA have been prepared and await sign-off. **6.** The project workbook, uploaded 7 Jul 20, shows the project plan on track - a new baseline was established post the exception report to June 20 Prog. Board, with the project due to complete Mar 21. **7.** The Benefit Tracking Tool describes two benefits (both to be ratified in new PID) with benefit tracking in a separate folder. **8 and 9.** There is a populated risk register, with 9 live risks, last updated to 29 Jun 20. There are 2 closed issues and 1 open. **Most recent assurance evidence submitted 7 Jul 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.	Anthony Middleton											

DIGITAL ENABLEMENT: Outpatients - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Nickee Smyth	Clare Jefferson	Design	Green	Green

Independent Assurance Statement

1. A PID v2.0 dated 3 Jul 20 is in evidence for 'Outpatient One Patient Record' and is reported as signed off by the Project Lead; 'high level benefits' are identified in the PID. 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 has evidence of meetings to 3 Jul 20 and also the agenda of OTSG on 9 Jun 20. An 'Action Log' tracks task completion, with 1 action overdue, 2 action due on the 7 Jul and the remaining 5 actions due to complete on 17 Jul 20. **6.** The workbook has been uploaded, at 3 Jul 20, and is updated to w/c 29 Jun 20; it shows the plan largely on track with a final closure date of Apr 21. **8 & 9.** The workbook has a risk register, with all 9 live risks reviewed to 1 Jul 20. One project issue has been closed and one remains live, raised on 1 Jul 20. **Most recent assurance evidence submitted 3 Jul 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.	Anthony Middleton		●	●					●		●	●

Patient Portal - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Natalie Park	Emma Danton	Design	Green	Amber

Independent Assurance Statement

1. The PID v1.0 dated 28 May 20 has been signed-off as approved at Programme Board, May 20. This is supplemented by presentations on the 'Outline Approach' and 'Programme Board Scoping'. **2.** There is evidence of the initial Working Group meeting on 10 Jun 20. **3.** The ToRs for the Working Group are in evidence with authorisation and review dates. there is evidence of project Working Groups meetings to 24 Jun 20 (and preparation for the meeting of 8 Jul 20) together with an Action Tracker. **4.** The Comms and Engagement plan has been produced and has been updated to 25 Jun 20 along with a template for 'Specialty Design Proposals'. There is also comprehensive evidence of comms and engagement deliverables that have been issued including a briefing pack that has gone out to divisions**. 5.** The draft EQIA and QIA have been drafted and await sign-off. **6.** There is a comprehensive project plan which shows that the activities and tasks are largely on track (some minor updates required on tasks to the 'left of the line'). **7.** The Benefits Tracking Tool details benefits across 8 categories under 3 domains; most targets to be defined through early project design phase. The Portal Audit Data, to 29 Jun 20, shows some progress but well below the target set. **8 & 9. Ten r**isks have been updated to 3 Jul 20 and there are also 4 issues logged in the workbook. **Most recent assurance evidence submitted 3 Jul 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	**Patient Portal**	The aim of this project is to: Increasing the number of patients who are registered for the portal Increasing the number of services/specialties that are actively promoting the portal to their patients Introducing some new functionality that will allow patients to input into the portal, where appropriate Ensure there are sustainable management and governance processes in place	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Digital Dictation Plus - Programme Assurance Update – 10 July 2020

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Natalie Park	Emma Danton	Design	Green	Green

Independent Assurance Statement

1. The Digital Dictation Business Case v0.3, is labelled as 'approved by TMB on 22 Jun 20'. There is a draft PID, v0.1 dated 22 Jun 20, and a position statement dated 6 Jul 20 summarising the current status of the project. **2.** There is evidence of project meetings and discussions to 6 Jul 20 and a ToR for the project group. **6.** There is a Digital Dictation workbook uploaded to SharePoint on 7 Jul 20 and the project plan has been updated to w/c 29 Jun 20. **8 & 9.** The risk register for the project shows the date of last review for the two risks raised as 29 Jun 20. There are two recorded issues. **Most recent assurance evidence submitted 7 Jul 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 Plus**	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	Anthony Middleton											

BOARD OF DIRECTORS	
Agenda Item	20/21 100
Title of Report	Report of the Safety Management Assurance Committee
Date of Meeting	5 August 2020
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Hazel Richards, Chief Nurse
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
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 Safety Management Assurance Committee

This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee held on 2 July 2020.

1. Introduction

This was the first meeting of the Committee following the easing of lockdown restrictions and the return to a new normal. The Committee received a number of reports and these are covered briefly in the following sections of the report.

2. Health & Safety Update Report

The Committee was briefed on a number of safety incidents over recent months. A specific issue occurred in relation to a patient becoming trapped in the end section of a bed. The patient was supported until they could be released and the Committee was assured by a range of actions initiated by the Trust to prevent this sort of issue occurring in the future.

The Committee discussed a range of matters surrounding Personal Protective Equipment (PPE) and the System response during the pandemic. Whilst it was clear that this was an uncomfortable experience due to the national control exercised during the peak of the crisis, the Committee was assured that there were now significant national stocks of PPE and, in particular, enhanced learning in relation to using different versions of masks.

In this new normal the Committee spent some time discussing the Trust's 'Working from Home' policies. It was accepted that there is more work to do in terms of supporting staff in this hybrid work model and noted that Executive Directors were sighted on the issues and working with staff to mitigate risks. It was agreed that, whilst there was some assurance from this, the matter would be raised with Divisional Directors through the command structure. Discussion then centred on wellbeing support for staff and it was confirmed to the Committee that a number of mechanisms are being used to support staff and, in particular, the provision of mental health support.

3. Reporting of COVID-19 under Revised RIDDOR Guidance

The Committee was advised that before 2 April 2020 under RIDDOR regulations it was never a requirement for the Health and Social Care sector to report exposure of viruses or diseases to Health Care workers where that virus is present in the community. However, on 2 April 2020, the Health and Safety Executive (HSE) issued new guidance requiring such incidents to be reported under RIDDOR. Further guidance was provided in May 2020, in particular clarifying Dangerous Occurrences and work related deaths due to exposure to a biological agent. The report detailed a number of such incidents and the circumstances behind them .These were reported as required as RIDDOR incidents. The Committee was assured that the Trust continues to monitor Occupational Health reports to identify any events which may now be reportable under this new regime and to continue to revise systems and processes in response to continuing COVID-19 guidance.

4. Legionella Update

The Committee was updated on recent Legionella sampling. An incidence of high counts of legionella on ward 20 was formally investigated and the Committee informed of the remedial work undertaken alongside the further work on cleaning and preparing the ward for usage from 13 July 2020. An increased testing programme was initiated and by the end of July 2020 all areas will have been tested. An independent review of all water safety matters has been commissioned by the Trust and it was agreed that a detailed report would be presented to the Committee at its next meeting.

Steve Igoe
Chair, Safety Management Assurance Committee

Board of Directors	
Agenda Item	20/21 101
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	5 August 2020
Author	John Sullivan, Non-Executive Director
Accountable Executive	Jacqui Grice, Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Choose an item
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Chair's business

The meeting took place on Tuesday 28 July 2020 via Microsoft Teams. The normal agenda was resumed. Presenters of papers were requested to concentrate on 3 or 4 key points from their paper and thereby leave adequate time for Committee scrutiny. The Committee welcomed Jacqui Grice, the new interim Executive Director of Workforce.

2. Health & Well Being Update

Health and Well Being interventions and support have been rapidly increased during the Covid 19 Pandemic.

The Committee requested measures of the impact of the support on Trust staff and also more definition of how the many elements of the Health & Well Being support programmes are aligned with the Trust's Health and Well Being Strategy. Work on the latter has been interrupted

by the pandemic and the Committee agreed that this was an important piece of strategic thinking and needs to be completed and agreed as soon as practicable.

3. Workforce dashboard

KPIs were reviewed and the Committee were assured by the clear presentation of the information within the dashboard.

The divisional deep dives on absence trends indicate particular issues with the Trust's Band 2 population attendance. Further investigation is required.

Attention was drawn the reported cluster of Covid 19 cases in Cheshire & Mersey and the 44,000 nursing vacancies in England. The latter shows the size of the challenge with nursing recruitment and retention in the short / medium term.

4. Workforce / OD Update

The Committee received a report from the Acting Deputy Director of Workforce which described the comparative instability of the HR team currently. There are a number of interim and temporary appointments and a number of people deputising in their next level roles. The Staff Absence line is now primarily manned by recent reassignments of people thereby freeing up HR Managers time. The Workforce / HR teams now have the following priorities:

- Sickness Absence reduction
- Reduction in the grievance / disciplinary case load backlog
- Safely returning shielding staff to work

The committee requested that KPIs be displayed at WAC for grievance and disciplinary case processes.

5. Health Risk Assessments

Some good progress on the drive to completion, however some way to go. BAME population is > 94% complete.

6. Flu Plan 2020

The Committee were informed of the planned improvements in the Trust's flu vaccination programme. These include vaccinators in each area and a drive to maximise take up to reduce pandemic risks.

7. NHS Staff Survey results 2019 and looking forward to Staff Survey 2020

The committee formally received the delayed report from the 2019 staff survey results. The report had been delayed by the Covid 19 pandemic. The 2019 staff survey results have shown improvement, but there are 8 of the overall themes that are still below the national average.

8. Reports received by the Workforce Assurance Committee

The Communications and Engagement Monthly Report and the Diversity and Inclusion Summary Update Report were received. The Committee were assured that the required Diversity & Inclusion reporting has been completed and an annual report is scheduled for WAC in September.

9. Safe Staffing Assurances, Position Statement and Response

The report highlighted a number of positive developments regarding safe staffing, these included:

- MIAA reported the Trust as having substantial assurance for safe staffing processes in 2019
- The Trust has a number of processes that review and record patient quality indicators, incidents and patient experience metrics against staffing data to identify emerging risks
- The Trust continually fulfils its duty to undertake 6 monthly establishment reviews in line with National Quality Board / NHSI Guidance using recognised acuity and dependency tools

The reporting frequency of safe staffing data to the Trust Board of Directors is a gap and will move to monthly reporting from September 2020.

10. Board Assurance Framework

The Committee were reluctant to provide assurance ratings at the meeting for each of the PR2 Risk Vectors. In particular, the Primary Risk Treatments require updating in advance. However, it was agreed that the Committee full time members will form a view on assurance ratings before the next meeting.

11. Items for the Risk Register

The planned and unplanned people and organisational changes in the Workforce / HR team were noted as a new current risk

12. Recommendations to the Board of Directors

- To note the Covid 19 related staff health and wellbeing activities and the future need to measure their effectiveness and plan for their sustainability
- To note the remaining completion gap for staff risk assessments
- To note the Band 2 staff attendance trends across the Trust
- To note the reports received at this committee

13. Next Meeting

Tuesday 22 September 2020, 1.00 - 3.00 pm, via Microsoft Teams

Subject:	Proceedings of the Quality Committee	**Date:** 5.8.2020	
Prepared By:	Dr J Coakley, Non-Executive Director		
Approved By:	Dr J Coakley, Non-Executive Director		
Presented By:	Dr J Coakley, Non-Executive Director		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**
Risks/Issues			
Indicate the risks or issues created or mitigated through the report			
Financial	**None identified**		
Patient Impact	**Potential risk to quality or safety of care:** • **Litigation** • **Cancer Patient Survey** • **Reports on Duty of Candour, Deteriorating Patient and Learning from Deaths received**		
Staff Impact	**None identified**		
Services	**None identified**		
Reputational/ Regulatory	**CQC action plan** **Review of BAF process approved**		
Committees/groups where this item has been presented before			
N/A			

Executive Summary

The Quality Committee met on 29th July 2020. This paper summarises the proceedings.

Litigation Report

There has been an encouraging drop in claims. NEDs on the committee requested that the Board be notified of high value claims in advance of resolution. There was also discussion about the fact that approximately half of the claims were not associated with an incident report. This will be monitored prospectively, to encourage clinicians to report incidents that might lead to a claim. It was however recognised that many claims do not arise from reportable incidents.
The committee noted this progress and approved.

Cancer Patient Survey

This showed improvement against previous reports. The main issue of concern (performance slightly below national average) was in urology, although it was recognised that this is a regional service and many of the concerns relate to interaction with local primary care which is of course beyond the remit of this Trust. There has been an improvement in discussions about participating in cancer research, but the figure of 30% is still below where we would like it to be. The impact of the move of the CCC on this issue is yet to be seen.

Duty of Candour

Compliance with the requirements was noted in a comprehensive and detailed report.

Deteriorating Patient

The report on the management of deteriorating patients was noted. The major concerns were with compliance with early warning scoring and escalation of concerns. These issues are being addressed.

Learning from Deaths

There has been very good progress in learning. Meetings now occur weekly to ensure compliance with reviews. There had been a jump in SHMI towards the end of last year but this has now resolved and returned to expected values. Over half of deaths have had a primary review compared to 36% last year. SJRs have increased from 35 to 84, with only two cases where death was judged avoidable.

CQC Action Plan

In response to the CQC report received in March 2020, an action plan has been drawn up in response to the 'must dos' and 'should dos'. Since the inspection almost the majority of actions are either completed or on track. Three actions remain overdue, namely those to reduce delays in ED (team interactions), storage of oxygen cylinders and portable appliance testing. Progress will be monitored by this committee and the Board of Directors.

Serious Incidents & Duty of Candour

A summary of recent SIs and completed investigations was received and noted. SIs have been stable at about four per month over the last six months, but with only one in the previous month. Eight recently completed SI investigations were reviewed and approved. Duty of candour has been carried out and learning disseminated across the Trust.
Nine new claims have been received and were noted by the committee.
The investigation into a serious incident from January 2020 (hepatobiliary surgery) was reviewed and approved.

Review of BAF

The committee agreed that the BAF relating to Quality Committee's aspects of infection control should be reviewed and re-presented to the next Quality Committee meeting.

Summarised and drafted by the Quality Committee Chair John Coakley 29th July 2020

BOARD OF DIRECTORS	
Agenda Item	20/21 103
Title of Report	Report of the Trust Management Board [TMB]
Date of Meeting	5 August 2020
Author	Janelle Holmes, Chief Executive
Accountable Executive Director	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	
Data Quality Rating	
FOI status	Chairs report may be disclosed in full
Equality Impact Assessment Undertaken	

The Committee met on 30th July 2020 via Microsoft Teams. A summary of the topics covered is provided below:

1. **Performance Update**

The Quality Performance Dashboard was presented to TMB by the Interim Deputy Chief Operating Officer.

A review of thresholds by the appropriate Executive Director is underway, where tolerances have changed or have been impacted by COVID-19 response.

TMB received a report on the Four Hour Performance Review from the Head of Urgent Care, including a detailed action plan. All actions were noted as on track for completion by end of August.

Cancer performance was reviewed against recovery trajectory, which remains on track for recovery at aggregate level. Further work is underway to clearly define recovery timescales at tumour group level.

Referral To Treatment [RTT] performance has been severely impacted by the cessation of all non-urgent elective activity and is having a marked effect on waiting times. The total waiting list size is being maintained due to strong outpatient performance and a reduction in referrals, but the number of patients over 18 week is also rising exponentially.

Urgent elective activities are being managed in line with national directive.

2. Finance Update

TMB received an update from the Chief Finance Officer on Month 3. The Trust has achieved a breakeven position. An additional £400K of expenditure was offset by additional top up income. The financial position was similar to previous months during the COVID-19 pandemic. Month 4 will be the last month when formal arrangements for COVID-19 are in place, comprising block payments and top-up. Clarity on the position from 1st August 2020 is awaited. Contributions from 1st October 2020 are expected to move to an incentivised activity-based approach.

A further £1.5M capital is expected to support backlog maintenance and prioritisation of A&E capital works

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3. Reset & Recovery (Planned Care)

TMB received a report on Reset & Recovery (Planned Care) from the Head of Business Improvement, who highlighted the heat map for all specialities against planned care prioritisation, diagnosis, 52 weeks and cancer. The report also highlighted workforce constraints; in particular theatre staff, however, significant progress, in booking out to 6 weeks of core theatre sessions in line with 6-4-2 lockdown, has been made.

Theatre throughput is comparable with other trusts at around 50% of normal activity, although Surgery Division is reviewing ways to increase this further.

In terms of performance trajectories, during Q2 cancer is expected to return to pre COVID-19 levels of 85% minimum. The Trust's aggregate performance will meet the cancer standard for 62 days, however this is an aggregate and some tumour sites will be below target with individual recovery plans in place.

Harm reviews are underway for all 52 week wait patients, the number of whom has increased to 676. Patients are being booked in line with clinical prioritisation (P1 – P4) not length of wait, although long waiters are being reprioritised as part of the standard tracking processes.

The use of independent sector support to improve capacity remains under review, however remains limited due to the requirements to move staff and equipment form the main site.

The new NICE guidance which recommends the removal of the need for two week isolation should have a positive impact on activity.

The use of UV light cleaning technology, which is due to be launched imminently, once staff training is complete, will have a positive impact on theatre throughput as it will reduce cleaning times between patients.

4. Winter Planning/Capacity

TMB received a report on Winter Planning & Capacity from the Interim Deputy Chief Operating Officer. This is a requirement for all trusts. Wirral University Teaching Hospital [WUTH] and Wirral System are in the process of compiling a whole system plan.

WUTH has highlighted a possible reduction in T2A beds in the community, based on the Venn bed modelling recommendations, which could have a significant impact on WUTH. This will be monitored, and signed off, via the Healthy Wirral programme.

A report is in progress on maximising the Clatterbridge site for elective procedures.

5. Trust Strategy

TMB signed off the Trust strategy for onward review by Board of Directors

6. Reset & Recovery

The paper presented to TMB outlined the Stage 2 progress & Stage 3 plan. All actions remain on track. Divisions are in the process of developing their own plans. The Director of Strategy offered support in the development of these plans if required.

Janelle Holmes
CEO
July 2020

Board of Directors	
Agenda Item	20/21 104
Title of Report	Communications and Engagement Monthly Report
Date of Meeting	5th August 2020
Author	Sally Sykes, Director of Communications and Engagement
Accountable Executive	Jacqui Grice, Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The Board members are asked to note this report on activity since its last meeting in the areas of staff engagement, media and social media, charitable fundraising and stakeholder relations.

2. Background

This is the report of the Director of Communications and Engagement providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe.

3. Key Issues/Gaps in Assurance

Whilst some data are verifiable, the Trust currently does not have a media evaluation agreement in place. The Director has raised this with NHSE/I in the North West and is seeking to procure a suitable system under an existing procurement framework.

Staff engagement is measured in the annual NHS Staff Survey and does provide a robust benchmark for both year on year changes and comparisons with other Trusts. NHSE have confirmed the survey will take place as planned in September 2020.

Charitable fundraising is measured by the funds raised, but is also a significant factor in staff engagement in both staff involvement in fundraising and benefitting from funds raised for staff and patient wellbeing.

There is separate assurance of charity activities provided through the Board committee for charitable fundraising and there is an annual report for the charity. Assurance is also provided through accountabilities and returns to the Charity Commission. The charity committee next meets 7th August 2020.

4. Conclusion

There has been a significant amount of activity in support of the Trust's objectives and the Board are asked to note the progress in the report.

5. Recommendations - None

Report of the Director of Communications and Engagement

Campaigns, media, social media, internal communications, staff engagement and stakeholder relations

Campaigns

- The primary focus has been on the site lockdown arrangements and communicating these to staff, patients and visitors. Patient and visitor leaflets on our expectations of them when visiting the hospitals were produced and are being used to ensure effective infection prevention and control.

- The key messages were reinforced and the context explained in an exclusive interview with the Wirral Globe with Hazel Richards, Chief Nurse

- We launched phase 2 of the Capacity Management campaign, which is an internal campaign for staff. It is aimed at embedding 'Cap Man' across the Trust. It has appeared in the bulletin and on social media. Capacity Management is aimed at ensuring that the right patients are allocated to the right bed, first time

- We highlighted the Keep Wirral Well partnership campaign to the public in relation to COVID-19 and have scheduled social media posts. The Keep Wirral Well campaign is also part of the local authority and their Public Health Director's response to containing or preventing local outbreaks.
  Keep Wirral Well

- We have launched the six-week Keep it SIMPLE campaign for Infection Prevention and Control. This is an internal campaign aimed at improving IPC and will be covered in the coming weeks in the bulletin and social media.

- We produced our own materials to celebrate the 72nd birthday of the NHS and amplified the national materials. Our Twitter posts in this campaign for the Trust reached 27.2k people.

Media

The team has continued to produce proactive news stories from the wealth of positive work being done by staff, volunteers and fundraisers.

- As mentioned earlier, we placed an exclusive interview with Chief Nurse Hazel Richards, who was interviewed by the Wirral Globe about why visiting restrictions remain in place in our hospitals to keep patients and staff safe. Hazel also thanked staff and the people of The Wirral for their amazing support during the pandemic. Chief Nurse interview

  A press release about tablet computers helping a Wirral Hospital patient was featured in the Wirral Globe:
  https://www.wirralglobe.co.uk/news/18533217.252792155/

- Results of the National Cancer Patient Experience Survey showed improvements at WUTH and a press release was covered in the Wirral Globe.
  https://www.wirralglobe.co.uk/news/18549434.cancer-patients-score-hospitals-average/

- A six-year-old boy with a rare condition raised £14,000 for the COVID-19 appeal at WUTH and his valiant efforts were featured on BBC North West Tonight

- 'Health trust rated '8.2 out of 10' by patients' –was the headline locally when there was also a further national CQC survey covering inpatient experiences - with positive results for the Trust. .WUTH CQC National Inpatient survey results

- WUTH doctor, Dr Mehran Asgari was presented with an international award to recognise his work to transform services for patients and reduce admissions with the fainting condition syncope - Award for Dr Asgari

Media statements

- As part of communications preparedness during the recent (contained and small scale, as reported to the Board in the CEO's report in July) outbreak of COVID-19 in the Trust, we agreed a joint statement with the Community Trust (whose staff were affected) and with PHE.

Internal Communications and staff engagement

- We produced three or more staff Bulletins a week with important information on PPE, clinical guidance, staff wellbeing and support; and charity updates.

- We are preparing for the 2020 staff survey, which will run in September 2020. We expect to appoint a contractor in the next couple of weeks. We are taking part in a pilot for the NHS People Pulse, which is a 'temperature check' product that NHS People has created for trusts to share in free of charge until January 2021.

https://www.wuth.nhs.uk/media/15316/wuth-nhs-people-pulse-faqs.pdf

- We continue to highlight the need for social distancing and important initiatives like all staff completing their role-based health risk assessment, which was made mandatory following discussion at last month's Board. We supported the roll out of all hospital staff wearing surgical masks and all patients attending hospital wearing face coverings or masks.

- The 'lockdown' of Arrowe Park Hospital to reduce entrances and exits and to minimise staff and patients' cross traffic flows was implemented and communicated. The next phase is ID badge access control and this is being communicated to staff who are renewing their badges where necessary.

- We built on our new ways of working to communicate with Leaders and enhance executive visibility (a CQC action plan item) via MS Teams and relayed a session in the lecture theatre with Janelle Holmes, CEO and the Exec team to 43 leaders and managers on July 21, with a summary and video playback sent afterwards to 500 senior leaders. Nikki Stevenson and Anthony Middleton led the sessions focusing on reset and recovery.

- We resumed our 'From the Board' summaries with a communication to staff covering the July 2020 meeting.

Charity

- We have are approaching £75,000 in donations for the local COVID-19 support appeal. These will be added to the promised £80,000 and £50,000 allocations from The NHS Charities Together fundraising – with more to be confirmed later. Proposals are being developed to invest in staff wellbeing and welfare.

- As covered in the media section, our top fundraiser is 6 year old Will Ritchie, and #willsmarathonmonth has featured on BBC North West and widely in local press. Our head of fundraising, Victoria Burrows was also interviewed by the BBC.

- We came to the end of the privilege of being one hospitals selected for free food for frontline staff via 'Salute the NHS' mobilised by McLaren's founder and former chair Ron Dennis CBE and Nigel Harris of Absolute Taste. We will report more fully to the Charity Committee but initial estimates put this in kind donation value at £0.5m approx.

- The scheme was stepped down nationally at the end of July and we have sent our heartfelt thanks for all the provisions that literally kept our frontline staff going during the times when they could not leave the wards.

Stakeholders

- We continue to work with our system partners in Wirral and our CEO takes part in a regular update for local MPs with Wirral MBC.

- We have asked for staff to nominate colleagues for the national COVID-19 honours and for the NHS Parliamentary awards.

- We worked with local partners on responding to the outbreak and in sharing their materials to 'Keep Wirral Well'.

- We are developing our relationship with local Healthwatch and are sharing information and campaigns in a mutually supportive way. We are currently in discussions with them about their new patient ratings product to rate experiences in hospitals.

Sally Sykes
Director of Communications and Engagement
30 July 2020