Wirral University Teaching Hospital NHS Foundation Trust

Public Board of Directors

2 September 2020

together we will

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Meeting of the Board of Directors
12.30pm - Wednesday 2nd September 2020
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21 107	Apologies for Absence	Chair	Verbal	N/A
20/21 108	Declaration of Interests	Chair	Verbal	N/A
20/21 109	Chair's Business	Chair	Verbal	N/A
20/21 110	Key Strategic Issues	Chair	Verbal	N/A
20/21 111	Minutes of Previous Meeting – 5 August 2020	Board Secretary	Paper	4
20/21 112	Board Action Log	Board Secretary	Paper	18
20/21 113	Chief Executive's Report	Chief Executive	Paper	19
Performance & Improvement				
20/21 114	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Interim Director of Workforce and Chief Nurse	Paper	22
20/21 115	Month 4 Finance Report 2020/21	Chief Finance Officer	Paper	43
20/21 116	Operational Delivery – Phase 3 Planning Submission	Chief Finance Office, Chief Operating Officer, Interim Director of Workforce, Director of Strategy & Partnerships	Presentation	N/A
20/21 117	Hospital Upgrade Programme	Director of Strategy & Partnerships	Presentation	N/A
Governance				
20/21 118	CQC Compliance and Action Plan Progress Update	Chief Nurse	Paper	65
20/21 119	Maternity & Neonatal Report	Chief Nurse and Associate Medical Director, Women & Children's	Paper	73
20/21 120	Progress Against Enforcement Undertakings	Interim Director of Corporate Affairs	Paper	81
20/21 121	Safeguarding Annual Report 2019 - 2020	Chief Nurse	Paper	85
20/21 122	Change Programme Summary, Delivery & Assurance Theatre Scheduler System	External Programme Assurance Associate Director of Health Care Professions	Paper Presentation	121 N/A

20/21 123	Report of Safety Management Assurance Committee	Chair of Safety Management Assurance Committee	Paper	152
20/21 124	Report of Charitable Funds Committee	Chair of Charitable Funds Committee	Paper	157
20/21 125	Report of Trust Management Board	Chief Executive	Verbal	N/A
20/21 126	Communications and Engagement Monthly Report	Director of Communications & Engagement	Paper	160
20/21 127	NHS People Plan	Interim Director of Workforce	Paper & Presentation	165
Standing Items				
20/21 128	Any Other Business	Chair	Verbal	N/A
20/21 129	Date of Next Meeting – 7 October 2020	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

5 AUGUST 2020

VIRTUAL MEETING VIA MICROSOFT TEAMS

Present

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

In attendance

Mike Ellard	Deputy Medical Director
Paul Buckingham	Interim Director of Corporate Affairs
Sally Sykes	Director of Communications & Engagement
Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Joe Gibson	External Programme Assurance*
Debbie Edwards	Director of Nursing & Midwifery*
Natalie Park	Divisional Director Women & Childrens*
Annemarie Lawrence	Divisional Quality & Safety Specialist*
Angela Tindall	Public Governor
Ann Taylor	Staff Governor

Apologies

Dr Nicola Stevenson	Medical Director
Mr Chris Clarkson	Non-Executive Director
Mrs Jacqui Grice	Interim Director of Workforce
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 20-21/078	**Apologies for Absence** Noted as above.	
BM 20-21/079	**Declarations of Interest** There were no Declarations of Interests.	
BM 20-21/080	**Patient Story** The Board watched a video in which Sophie and her husband Adam described their surrogacy experiences. Just over 10 years ago, Sophie had been diagnosed and treated for cervical cancer, which left her unable to carry a child herself. Part of Sophie's surgery involved preserving her ovaries which meant that surrogacy would be a future option for them both to be parents of their baby. Through a surrogacy charity, they met their surrogate, Jo, and their baby	

Reference	Minute	Action
	Theo was subsequently born at the Seacombe Birth Centre, with strong support and back up from colleagues at Arrowe Park Hospital. Both Sophie and Adam praised the way in which the team provided care and sensitively handled the birth with their special circumstances. They used the experience gained from these special circumstances to work with the teams at the Trust to update the Trust policy for surrogate pregnancies. The couple were full of praise for their midwife, also called Jo, and the way in which they were treated by all the midwives and staff. ***The Board of Directors:*** • ***Received and noted the Patient Story.***	
BM 20-21/081	**Maternity Service Presentation** Ms D Edwards, Director of Nursing & Midwifery, Ms A Lawrence, Divisional Quality & Safety Specialist, and Ms N Park, Divisional Director, delivered a presentation which covered the following subject areas: • Overview of Maternity Service • Cultural Review 2015 • 2020 – Where are we now as a Maternity Service • Internal Stakeholder Scrutiny • External Stakeholder Scrutiny • Maternity Dashboard 2020 • 2019 Outcomes in comparison with other Service Providers The Chair thanked the Maternity Service representatives for an informative and reassuring presentation and asked what arrangements were in place to ensure listening to staff. Ms D Edwards noted the importance of leader visibility for providing opportunities to meet with and listen to staff and advised of other initiatives such as the use of single issue focus groups and staff suggestion boxes. Mr J Sullivan noted that he had been a Board member at the time of the cultural review in 2015 and so fully understood the scale of the challenges which meant that a number of difficult decisions had been taken. He wanted to convey his thanks to the maternity team and say well done for five years of sustained improvement. The Chair endorsed these comments and noted that the outcomes detailed in the presentation provided demonstrable evidence of a high performing team. He asked the Maternity Service representatives to pass on the thanks of the Board to their wider teams. ***The Board of Directors:*** • ***Received and noted the Maternity Service presentation.*** *Ms D Edwards, Ms A Lawrence and Ms N Park left the meeting.*	
BM 20-21/082	**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 noted that digital enabling projects had been incorporated in the programme scope detailed on page 167 of the meeting pack. Mr J Gibson then provided	

Reference	Minute	Action
	an overview of performance against metrics for priority projects and concluded his report by noting the progress summary for the Top 3 priority projects included at page 175 of the report. Mr J Sullivan noted the impact on capacity of Covid-19-related procedures and queried whether the transformation team had Lean methodology skills to improve procedures. The Director of Strategy & Partnerships confirmed that the team had the relevant skills and advised that the design of efficient procedures was a subject of absolute focus. The Chief Nurse acknowledged the need for efficiency but cautioned against the risk of introducing unsafe practices as a result of process re-design. In response to a question from Mrs S Lorimer, who queried whether there was a downward trend in the proportion of non-face to face outpatient attendances, the Chief Operating Officer advised that the level of variation was normal and noted that restart of outpatient activity would involve a proportion of attendances where face to face appointments were necessary. In response to comments from the Chair, the Chief Operating Officer agreed that the Covid-19 pandemic had provided a catalyst for a range of service developments and noted the importance of maintaining the benefits to be derived from such developments. ***The Board of Directors:*** • ***Received and noted the Change Programme – Summary, Delivery & Assurance report.*** *Mr J Gibson left the meeting.*	
BM 20-21/083	**Chair's Business** The Chair briefed the Board on continuing progress on integrated working with partners in the local health economy through meetings involving the Chairs and Chief Executives of partner organisations. He noted in particular the desirability of further developing relationships with the local authority and commented on the potential for appointing a local authority representative as an Associate Non-Executive Director to facilitate participation in Board meetings. The Chair then briefed the Board on matters discussed during a regional teleconference held on 4 August 2020 which had focused on the Phase 3 arrangements set out in correspondence from NHS England / Improvement dated 31 July 2020. He noted that much of the discussion had focused on the requirement to achieve 80% elective capacity levels in September 2020. In response to a question from Dr J Coakley, regarding local authority track and trace arrangements, the Chief Executive provided an overview of the work in Wirral which was being coordinated by the local authority's public health department. Dr J Coakley noted his experience of arrangements in his own local area and there followed a discussion on test and trace arrangements in Greater Manchester and the wider North West region. In response to a question from the Chair, regarding work with care homes, the Chief Executive noted the work of the Community Geriatrician in providing liaison between the Trust and care homes and advised that care homes were being supported with training and infection prevention and control measures through Healthy Wirral arrangements.	

Reference	Minute	Action
	The Board of Directors: • ***Received and noted the verbal briefing.***	
BM 20-21/084	**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.***	
BM 20-21/085	**Minutes of Previous Meeting** The Minutes of the meeting held on 1 July 2020 were agreed as a true and accurate record.	
BM 20-21/086	**Action Log** The Board reviewed the Action Log. The Chief Finance Officer advised that she would brief the Board on developments relating to the national financial regime as part of the Month 3 Finance report agenda item. No other actions had exceeded the scheduled completion dates.	
BM 20-21/087	**Chief Executive's Report** The Chief Executive presented a report which included the following subject areas: • BAME Staff Members and Risk Assessments • Shielding Staff - Return to Work • 2020 Flu Plan • Access to NHS Staff Covid-19 Test Results • Doctors and Dentists Pay Review • Continuing Professional Development (CPD) Monies • Covid-19 and IPC Update • Serious Incidents and RIDDOR updates She briefed the Board on the content of the report and noted in particular that the Trust was achieving higher than national average rates across all categories for completion of Covid-19 related risk assessments. She then provided an overview of ongoing work to develop the Trust's flu vaccination plan for winter 2020/21 and noted the expectation that there would be a national target for 100% vaccination compliance. Mr J Sullivan referred the Board to the IPC Update section of the report and congratulated management on the implementation of successful infection control measures. The Chief Executive acknowledged this comment and noted the positive work being undertaken by Jay Turner-Gardner and the IPC team. ***The Board of Directors:*** • ***Received and noted the Chief Executive's Report.***	

Reference	Minute	Action
BM 20-21/088	**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 Type 1 attendance numbers had been at almost the same level as the previous year for the past three weeks. He noted that capacity in the hospital ensured good patient flow which contributed to the positive performance levels. The Chief Operating Officer advised that, while not included as a metric on the dashboard, there had been no instances of ambulance handovers in excess of 60 minutes during June 2020. The Chief Operating Officer concluded his report by providing an overview of performance against Cancer and Referral to Treatment (RTT) standards. In response to a question from the Chair, the Chief Operating Officer advised that, as of 4 August 2020, there were 667 52-week wait breaches and noted that the level of breaches was currently increasing at approximately 200 per month. He advised that the Trust was identified as an outlier in this respect proportional to overall waiting list size. The Chief Nurse then provided an overview of performance against 'Safe' metrics and noted two instances of Category 3 pressure ulcers in June 2020. She briefed the Board of work in this area and noted a significant increase in the number of patients having pressure ulcers when admitted. The Chief Nurse advised the Board that plans for achieving compliance with safeguarding training remained the same as reported the previous month i.e. Level 2 compliance by the end of Quarter 2 and Level 3 compliance by the end of Quarter 3. The Chief Nurse concluded her report by referring to the 'Caring' metrics and noted that two breaches of the same sex accommodation standard had resulted from changes in ward functionality. In response to a question from Mr J Sullivan, who noted the instances of Category 3 pressure ulcers and queried whether it was possible to look at root causes to establish whether there was any commonality, the Chief Nurse advised of work being undertaken to validate data from January 2020 onwards. She also advised that Tissue Viability had been included in the Internal Audit programme for a review which would test data quality. The Deputy Medical Director completed presentation of the Dashboard by providing an overview of performance against metrics for research activities and VTE risk assessments. ***The Board of Directors:*** • ***Received and noted the Quality & Performance Dashboard, together with associated Exception Reports, for the period to 30 June 2020.***	
BM 20-21/089	**Pandemic Impact on Performance Trajectories** The Chief Operating Officer presented a report which detailed the pandemic impact on performance trajectories for planned care activities. He briefed the Board on the content of the report and noted that the report had been produced prior to receipt of NHS England / Improvement correspondence on Phase 3 arrangements. The Chief Operating Officer referred the Board to s3.1 of the report and provided an overview of the clinical prioritisation criteria applied to patients on waiting lists. He then referred the Board to s4 of the	

Reference	Minute	Action
	report and noted the performance trajectories for both the Cancer 62-day standard and the Referral to Treatment (RTT) standard. With regard to the latter, he noted in particular the extended timescales for Ophthalmology patients and advised that the Trust had secured additional private sector capacity to address this matter. The Chief Operating Officer concluded his report by noting that the Phase 3 arrangements correspondence included revised guidance on theatre arrangements which was likely to increase activity throughput. Consequently, the Trust would review the guidance and re-forecast trajectories accordingly. In response to a question from Mr J Sullivan, regarding statements made in the fourth paragraph of s5, the Chief Operating Officer explained that comments regarding 'appetite' related to the current operating environment which was very intensive and physically challenging for staff. He noted that a revised theatre approach may help in this regard. In response to a follow-up question from Mr J Sullivan, the Chief Operating Officer confirmed that the Trust was complying with national guidance in relation to risk assessments and noted that outputs from risk assessments for surgeons and theatre staff were scheduled for review at the next Clinical Advisory Group meeting. ***The Board of Directors:*** • ***Received and noted the Pandemic Impact on Performance Trajectories report.***	
BM 20-21/090	**Cancer Pathways - Cheshire & Merseyside** The Chief Operating Officer presented a report regarding increasing numbers of cancer patients in Cheshire and Merseyside. He briefed the Board on the content of the report and noted that the Cheshire & Merseyside Cancer Alliance had specifically requested a report to Boards on this subject in a letter dated 30 June 2020. The Chief Operating Officer referred the Board to s4 of the report and noted a positive downturn in the number of patients on both the 62 day and 104 day lists. He assured the Board that the Trust was not currently a regional outlier in these areas. ***The Board of Directors:*** • ***Received and noted the Cancer Pathways report.***	
BM 20-21/091	**Month 3 Finance Report** The Chief Finance Officer presented a report which detailed the Trust's financial position as at 30 June 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 3 position as follows: • Overall, operational pay and non-pay expenditure was below plan with the underspend offset by costs incurred for COVID-19 of £1.1m. • The Trust had a net increase in expenditure of £0.4m in month 3 and has assumed additional 'top-up' income to offset the increase. The net position was driven by a technical adjustment relating to PDC dividends paid during Quarter 1.	

Reference	Minute	Action
	• Cash balances at 30 June 2020 were £41.9m and reflected the accelerated cash payments made to providers in Quarter 1 to support the liquidity position. The Chief Finance Officer noted in particular the additional PDC charges following conversion of loans and advised of the potential longer term implications of this change on financial sustainability. The Chief Finance Officer advised the Board that details of national financial arrangements had been included in of correspondence from NHS England / Improvement on 31 July 2020, which set out actions for the third phase of the NHS response to Covid-19. She noted that the current financial regime would continue in August and September 2020 with a new regime to be introduced from 1 October 2020. She advised that details of the new regime were not yet available but commented on the potential for funding to be linked to demonstration of value for money in the delivery of services e.g. attainment of performance thresholds. The Chief Finance Officer then referred the Board to s5.2 of the report and provided an overview of progress against the Trust's capital programme. She noted that the Trust had recently been advised of two additional capital allocations, each with a value of £1.4m, for addressing critical infrastructure risks (CIR) and enhancing the Accident & Emergency department. She advised that both allocations would need to be spent by 31 March 2021 with an expectation that A&E developments were completed in advance of the winter period. In response to a question from the Chair, who queried whether expenditure could be completed within the required timescales, the Chief Finance Officer acknowledged the challenge but noted current work to assess options and mitigate associated risks. Mr S Igoe noted that there was already slippage against the Capital plan and commented on planned backlog maintenance spend in relation to infection prevention measures. He queried whether a range of 'shovel-ready' projects should be identified for early approval. The Chief Finance Officer advised that expenditure during Quarter 1 had been focused on Covid-19 measures and noted recent establishment of a Capital Management Group which would provide oversight of planned capital expenditure and associated project management arrangements with a view to mitigating the risk of overload during Quarter 4. She acknowledged the suggestion of 'shovel-ready' projects but advised that her preference at present would be delivery of the plan originally approved by the Board. The Chair emphasised the importance of having the right capability and capacity in place for the management and delivery of capital projects and encouraged the commissioning of necessary support as soon as practicable. Mrs S Lorimer endorsed these comments and noted historical difficulties with the delivery of projects. She requested that proposals for both planned capital projects and project support be reported to the Finance, Performance & Business Assurance Committee at its next meeting on 20 August 2020. The Director of Strategy & Partnerships advised that the need for additional project support had been identified by management and noted current discussions with a number of service providers with a view to commissioning appropriate support. ***The Board of Directors:***	

Reference	Minute	Action
	• ***Received and noted the Month 3 Finance Report*** • ***Agreed that proposals for planned capital projects and project support should be reported to the Finance, Performance & Business Assurance Committee on 20 August 2020.***	**CW**
BM 20-21/092	**Sickness Absence Report** The Chief Executive presented a report which detailed current sickness absence figures together with issues faced in performance managing absence cases in the context of national restrictions agreed through the Social Partnership Forum. She briefed the Board on the content of the report and noted an increased focus on sickness absence following the recent appointment of Mrs J Grice as Interim Director of Workforce. Mr J Sullivan welcomed the report but noted a focus on the management of long term absences. He referenced the Bradford Factor (based on the theory that short, frequent, unplanned absences are more disruptive to organisations than longer absences) and suggested that a different approach was required to address short term sickness absence. Mr J Sullivan also noted that anxiety / stress was identified as one of the top reasons for long term absence and queried whether it was feasible to provide access to in-house psychology support. The Chief Executive acknowledged these comments and noted that staff were able to access counselling services with appointments available within a matter of days. She also advised that on-site support was available to staff through the health and wellbeing hubs. Mrs J Coulson commented on the need to ensure that staff who had experienced mental health difficulties were appropriately supported on their return to work. ***The Board of Directors:*** • ***Received and noted the Sickness Absence report.***	
BM 20-21/093	**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 Stage 3 Plan • Stage 2 - Reflections on Delivery • Stage 3 - Covid-19 Stabilisation Aspect • Stage 3 - Operational Delivery Aspect • Stage 3 - Clinical and Service Change Aspect • Stage 3 - Patients, Families and Communities Aspect • Stage 3 - Workforce and Wellbeing Aspect • Stage 3 - Strategic Estates and Environment Aspect • Stage 3 - Leadership and Governance Aspect • Stage 3 - Financial Management Aspect The Director of Strategy & Partnerships noted that content of the plan had been prepared prior to receipt of correspondence from NHS England / Improvement on 31 July 2020, which set out actions for the third phase of the NHS response to Covid-19, and advised that the Trust's plan would be	

Reference	Minute	Action
	reviewed and adjusted where necessary to ensure consistency with national requirements. The Chair noted that the NHS England / Improvement correspondence set out clear expectations in relation to activity levels and he anticipated increased regulatory pressure to achieve the activity requirements. The Chief Executive commented on the challenge of achieving the 80% elective activity level in September 2020 and noted the risk should attainment of performance levels be linked to the financial regime. With regard to regulatory pressure, the Chief Operating Officer noted that weekly calls relating to performance against the A&E four-hour standard had been stood down during the pandemic but advised that weekly calls relating to restart plans had recently been introduced. In response to a question from Dr J Coakley, regarding the recent reduction of the isolation period for elective patients and availability of a 90-minute test, the Chief Operating Officer advised of an increased appetite amongst patients to undergo elective procedures since the reduction. The Associate Medical Director (Women & Children) noted a positive response amongst patients and advised that the availability of a rapid swab made little operational difference. He noted, however, that a negative swab test would help in relation to changed PPE protocols. The Deputy Medical Director commented on the potential implications where there may be different arrangements for out of area patients. ***The Board of Directors:*** • ***Received and noted the COVID-19 Recovery and Reset Update***	
BM 20-21/094	**2021-2026 Our Strategy** The Director of Strategy & Partnerships presented the draft strategy document for approval. He briefed the Board on the background to development of the strategy and noted amendments to the 'Our Challenges' section on page 9 of the draft document following feedback from Non-Executive Directors. The Director of Strategy & Partnerships also noted amendments to the 'How We Will Deliver Our Strategy' section on page 21 of the draft document. Mrs S Lorimer commented on the disparity between the picture of the organisation set out in the draft strategy document and the picture suggested by the Review of Undertakings letter in the next agenda item. She queried whether the starting point for the new strategy was being underestimated. Mrs S Lorimer also queried the omission of references to the Trust's Financial Strategy from the document and suggested that regulators would expect this to be explicitly included. The Chief Executive acknowledged these comments but noted that a five-year plan necessarily needed to be high level to avoid the need for regular review and revision of the overarching document. She advised that the strategy document would be supplemented by annual delivery plans which would clearly set out challenges to be addressed each year. The Director of Communications & Engagement endorsed this view and commented on the need to 'future proof' the strategy document. The Chief Finance Officer advised that she planned to prepare a separate	

Reference	Minute	Action
	Financial Strategy which would incorporate a financial recovery plan. Dr J Coakley acknowledged Mrs S Lorimer's comments but suggested that the financial challenges were already clearly stated in the 'Our Challenges' section of the draft strategy document. The Chair advised that he had some sympathy for the views expressed by Mrs S Lorimer and suggested that there was also a need to emphasise the aim to address challenges from a local health economy perspective. Mrs S Lorimer suggested that plans to produce a separate Financial Strategy should be clearly stated in the draft strategy document. The Chair concluded the discussion by iterating the need to give thought as to how Non-Executive Director support and challenge on delivery of the strategy could be incorporated in between Board meetings to avoid too linear a process. ***The Board of Directors:*** • ***Approved the document 2021-2026 Our Strategy subject to amendments to strengthen content relating to the Trust's Financial Strategy.***	
BM 20-21/095	**Review of Undertakings Report** The Interim Director of Corporate Affairs presented a report which detailed revised enforcement undertakings issued by NHS Improvement on 24 July 2020. He briefed the Board on the content of the report and provided an overview of the revised undertakings as summarised at s3 of the report. The Interim Director of Corporate Affairs noted the requirement to provide NHS Improvement with the assurance relied on by the Board in relation to progress in delivering the undertakings. He suggested that assurance should be provided through Board consideration of a consolidated Progress against Undertakings report on a two-monthly cycle commencing in September 2020. Board members endorsed this suggestion. ***The Board of Directors:*** • ***Formally endorsed the revised enforcement undertakings dated 24 July 2020 included at Annex A to the report.*** • ***Agreed participation in a NHS Providers-facilitated Board Development programme.*** • ***Agreed to receive a Review of Progress against Undertakings report on a two-monthly cycle commencing in September 2020.***	
BM 20-21/096	**Acuity and Dependency Review** The Chief Nurse presented a report which detailed outcomes from an Acuity and Dependency review undertaken during January / February 2020. She briefed the Board on the content of the report and noted the assurance provided that the Trust had met the requirement to complete a six-monthly acuity and dependency audit using a recognised tool. ***The Board of Directors:*** • ***Received the report and noted the assurance provided on***	

Reference	Minute	Action
	compliance with the requirement to complete a six-monthly acuity and dependency audit using a recognised tool. • ***Noted that the Trust will be undertaking a full establishment review of all wards in line with the Trust's escalation plan to meet requirements of the Covid-19 response.***	
BM 20-21/097	**Health and Safety: Quarterly Update** The Chief Nurse presented a report which detailed Health and Safety performance and assurance activities during Quarter 1 2020/21. She briefed the Board on the content of the report and noted that the report had also been reviewed at the most recent meeting of the Safety Management Assurance Committee held on 27 July 2020. The Chief Nurse provided an overview of activity undertaken as a result of the Covid-19 pandemic, as set out at s2 of the report, and noted that meetings of the Health and Safety Committee, which had been suspended as part of the pandemic response, had resumed in June 2020. ***The Board of Directors:*** • ***Received and noted the Health and Safety Quarterly Update report.***	
BM 20-21/098	**Report of Safety Management Assurance Committee** Mr S Igoe presented a report which detailed business conducted during a meeting of the Safety Management Assurance Committee held on 2 July 2020. He briefed the Board on the content of the report and advised that the Committee, and consequently the Board, was far better sighted on Safety Management matters since establishment of the Committee some 12 months earlier. Mr S Igoe advised that the embedding of practice within Divisions was now more evident and noted that the Committee would be looking at the practicalities for transition to a more normalised assurance process. He noted that the resumption of Health & Safety Committee meetings, suspended in response to the Covid-19 pandemic, was a positive development. ***The Board of Directors:*** • ***Received and noted the report of the Safety Management Assurance Committee.***	
BM 20-21/099	**Learning from Deaths: Annual Summary Report** The Deputy Medical Director presented an Annual Summary Report which detailed progress made and work undertaken on Learning from Deaths during 2019/20. He briefed the Board on the content of the report and noted that the process for Learning from Deaths, which had been suspended in March 2020 as a result of the Covid-19 pandemic, had restarted in June 2020. He then referred the Board to s3.1 of the report and provided an overview of the trend change on the Standard Hospital Mortality Index (SHMI). The Deputy Medical Director concluded his report by noting introduction of a Medical Examiner role, as detailed at s3.10 of the report, and advised that the Trust was the first acute trust in Cheshire and	

Reference	Minute	Action
	Merseyside to have implemented the medical examiner role. ***The Board of Directors:*** • ***Received and noted the Learning from Deaths: Annual Summary Report.***	
BM 20-21/100	**Legionella Sampling** The Chief Operating Officer presented a report which advised the Board of two incidences of raised legionella levels identified through routine testing together with details of actions taken to maintain quality and safety of care. He briefed the Board on the content of the report and noted that an independent assessment had been commissioned to review compliance with legislation, documentation, safety systems and training of key personnel. He advised that outcomes from this review would be reported to the Safety Management Assurance Committee. Mr J Sullivan noted factors such as span of control for the Head of Estates and the level of capital investment in infrastructure which would probably not be captured by the review. The Chief Operating Officer noted the composition of the Water Safety Group, in addition to the Head of Estates, but acknowledged the validity of Mr Sullivan's comments relating to infrastructure investment. ***The Board of Directors:*** • ***Received the report and noted both the response to the incidents and the assurance provided on governance improvement measures.***	
BM 20-21/101	**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 28 July 2020. He briefed the Board on the content of the report and noted in particular the Committee's consideration of a report on Health and Wellbeing interventions. He advised that the Committee had requested further information on the impact of such activities on staff and had emphasised the need to ensure that programmes were fully aligned with the Trust's Health and Wellbeing Strategy. Mr J Sullivan advised the Board of a degree of instability for the Human Resources team with a number of vacant positions currently being covered by either acting up arrangements or on a temporary basis. In response to a follow-up question from the Chairman, the Chief Executive advised that the situation was being addressed as a matter of priority. ***The Board of Directors:*** • ***Received and noted the report of the Workforce Assurance Committee***	

Reference	Minute	Action
BM 20-21/102	**Report of Quality Committee** Dr J Coakley presented a report which detailed business conducted during a meeting of the Quality Committee held on 29 July 2020. He briefed the Board on the content of the report and noted in particular that the Committee had received positive assurance on the Trust's level of compliance with Duty of Candour requirements. He also noted the Committee's consideration of a report on the management of deteriorating patients which had identified compliance concerns relating to early warning scoring and the escalation of concerns. He advised that the Committee had been assured that these issues were being addressed. The Chief Nurse advised that the Committee had also considered a Legal Services Annual Report and a report on the Cancer Patient Survey, which had been omitted from the report included in the meeting pack. She noted that the Legal Services Annual Report would be presented to the Board of Directors at the next meeting on 2 September 2020. The Interim Director of Corporate Affairs apologised for the omissions and advised that a copy of the full report would be circulated to Board members following the meeting. ***The Board of Directors:*** • ***Received and noted the report of the Quality Committee***	
BM 20-21/103	**Report of Trust Management Board** The Chief Executive presented a report of business conducted during a Trust Management Board meeting held on 30 July 2020 which included the following subject areas: • Operational Performance Update • Finance Update • Reset and Recovery (Planned Care) • Winter Planning / Capacity • Trust Strategy 2021-2026 • Reset and Recovery She provided the Board with an overview of the report content and noted that all of the subjects had been considered by the Board earlier in the meeting. ***The Board of Directors:*** • ***Received and noted the report of the Trust Management Board.***	
BM 20-21/104	**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 in particular preparations for the 2020 staff survey which is scheduled to commence in September 2020. She also advised of the Trust's participation in a pilot for the NHS People Pulse, a 'temperature check' product designed by NHS People. The Director of Communications & Engagement concluded her report by noting the	

Reference	Minute	Action
	intention to reduce the number of staff bulletins to two per week from week commencing 10 August 2020. The Chairman thanked the Director of Communications & Engagement for her report and noted that the Trust's internal communications had been superb during the Covid-19 pandemic. ***The Board of Directors:*** • ***Received and noted the Communications & Engagement monthly report.***	
BM 20-21/105	**Any Other Business** There were no matters raised as Any Other Business.	
BM 20-21/106	**Date of next Meeting** The next Board of Directors meeting would be held on Wednesday, 2 September 2020, commencing at 12.30pm.	

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Chair

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Date

Board of Directors Action Log
Updated – 5 August 2020
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 05.08.20						
1	BM 20-21/091	**Month 3 Finance Report –** The Board agreed that proposals for planned capital projects and project support should be reported to the Finance, Performance & Business Assurance Committee on 20 August 2020.	**CW**		2 September 2020	
Date of Meeting 01.07.20						
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**	The Chief Finance Officer briefed the Board on developments during the Month 3 Finance Report agenda item on 5 August 2020.	5 August 2020	Action complete
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.

Board of Directors	
Agenda Item	20/21 113
Title of Report	Chief Executive's Report
Date of Meeting	2 September 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 August 2020.

2021-2026 Our Strategy

The draft strategy document was reviewed and approved by the Board subject to a number of amendments as discussed at the meeting. The Director of Strategy & Partnerships subsequently updated the document to include additional detail on the financial challenges facing both the Trust and the Wirral system together with additional details of the Trust's financial strategy and enabling strategies. Validation against the NHS England Strategy Development Guidance was also completed.

The amended document was jointly signed off by the Chair and Chief Executive on 17 August 2020. The document is now subject to a design stage which will be undertaken and completed during September 2020 with an anticipated launch date of 1 October 2020.

Clinical Service Strategies

A total of fourteen clinical service strategy workshops were undertaken during July and August 2020 and outputs from these workshops have been shared with participants prior to wider stakeholder engagement. To date, a further six workshops have been scheduled to take place during September 2020 and this number is expected to increase as colleagues return from annual leave.

Safe Staffing Update

Following a review of safe nurse staffing processes in July 2020, a report presented at Workforce Assurance Committee noted the Trust as having substantial assurance around staffing processes with a good system of internal control that is being applied consistently. The Committee agreed this could be enhanced further by ensuring the Board of Directors has oversight of nurse staffing data monthly from September 2020. The Trust has seen a static band 5 RN vacancy rate of around 16% for a number of years and the Committee remained keen to ensure the Board has oversight of the impact of this on care, safety and patient experience; as well as the negative effect on the retention of nursing staff due to the high number of staff moves required to ensure wards are suitably staffed.

To inform this report availability of a number of metrics and intelligence reports are required to ensure a comprehensive analysis is undertaken. In the current cycle of business the first week of each month finalises data and reports for the previous month. To ensure the Board is able to review a full months evaluation of staffing it has been agreed that the Board of Directors will receive the first report featuring August 2020 staffing position at its meeting on 7 October 2020 and monthly thereafter.

Serious Incidents

In July 2020 four serious incidents were declared. Two related to patient falls, resulting in fractures; one a neonatal death and the fourth attributable to significant weight loss of a patient, whilst an inpatient. Duty of Candour has been undertaken for all incidents, supported by ongoing detailed investigation of the facts.

RIDDOR Update

The Trust submitted a number of RIDDOR reports to the HSE in July. One incident involved a physical assault to a member of staff and a second incident involved a member of staff, who slipped on a recently cleaned floor. The Trust also reported a total of 14 COVID related RIDDOR incidents in July 2020. Board members will recall that the Health and Safety Executive (HSE) issued guidance on 2 April 2020 which required RIDDOR reporting for such incidents as advised in the Safety Management Assurance Committee report to the Board on 5 August 2020.

Board of Directors	
Agenda Item	20/21 114
Title of Report	Quality Performance Dashboard and Exception Reports
Date of Meeting	2 September 2020
Author	WUTH Information Team, Corporate Nursing 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 July 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):

- 19 are currently off-target or failing to meet performance thresholds
- 21 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 July 2020.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

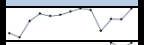
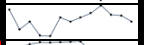
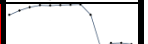
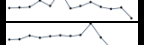
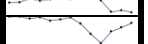
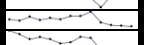
Quality Performance Dashboard

August 2020
Upated 24-08-20

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-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	0.04		0.04	0.09	0.13	0.13	0.13	0.32	0.31	0.17	0.21	0.21	0.20	0.20	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	94.6%	94.6%	96.1%	94.9%	94.1%	97.5%	98.7%	98.0%	97.7%	97.7%	97.5%	97.4%	97.2%	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	97.7%	97.6%	97.6%	97.1%	97.8%	97.3%	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.1%	97.6%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	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	National reporting ceased		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	3	1	0	5	4	5	5	4	4	3	4	1	4	12	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	0	0	0	0	2	0	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	5	6	7	8	6	7	4	4	3	6	5	5	1	17	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 77 for financial year 2020-21, equating to max 6.4 per month	WUTH	5	7	2	5	6	6	8	9	1	7	4	6	8	25	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	1	0	0	0	0	1	0	1	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99%	100%	99%	100%	100%	99%	100%	100%	100%	100%	99%	99%	100%	99.4%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	1	0	0	0	1	0	1	0	0	2	0	2	0	4	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	98%	96%	98%	99%	99%	99%	96%	96%	96%	96%	91%	95%	95%	94%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	93.6%	92.9%	93.6%	92.4%	91.2%	91.2%	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	82%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	90.4%	90.3%	91.2%	88.3%	85.5%	84.9%	84.4%	85.0%	82.81%	81%	71%	72%	74%	74%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	92.3%	90.3%	89.98%	87.46%	88.09%	89.66%	89.53%	86.67%	79.94%	51%	20%	19%	42%	42%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.51%	94.40%	94.38%	94.33%	94.14%	94.10%	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.35%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	94.07%	93.96%	94.25%	93.99%	93.82%	93.87%	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.94%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.68%	2.03%	1.21%	0.86%	0.77%	0.86%	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	0.80%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	9.5%	10.6%	10.9%	11.0%	11.3%	11.3%	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.7%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	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	National reporting suspended		

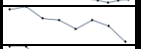
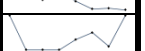
Quality Performance Dashboard

August 2020
Upated 24-08-20

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	93.0%	92.0%	96.0%	97.8%	97.2%	97.5%	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	96.4%	
	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%	98%	96.5%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	20.2%	17.9%	18.8%	17.2%	17.1%	19.3%	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	19.7%	
	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	383	410	431	443	441	444	446	448	383	174	209	210	202	202	
	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	205	193	194	208	207	200	198	108	35	54	48	53	53	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	3.5	3.5	3.5	4.0	3.6	4.6	3.4	3.6	3.9	3.5	3.4	3.5	2.8	3.3	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.6	4.6	5.1	4.8	5.0	5.2	5.1	5.2	6.7	4.8	3.4	3.6	3.3	3.8	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	1126	1130	1092	1118	1057	1080	1115	1006	827	667	870	941	1016	874	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	11	9	15	10	13	11	16	16	23	6	2	1	0	2	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	88.5%	85.3%	81.0%	82.9%	81.0%	77.3%	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	69.4%	

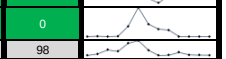
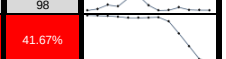
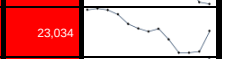
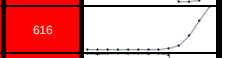
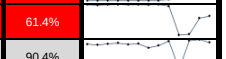
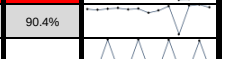
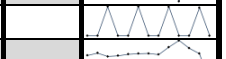
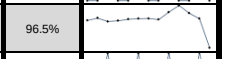
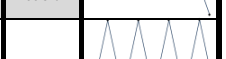
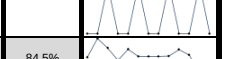
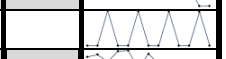
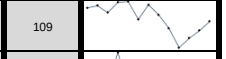
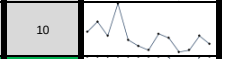
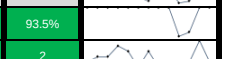
Quality Performance Dashboard

August 2020
Upated 24-08-20

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	16	24	23	17	26	10	10	14	4	2	0	2	3	7	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	91%	92%	88%	87%	84%	87%	85%	80%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	12%	12%	11%	11%	10%	11%	10%	11%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	98%	97%	96%	97%	96%	97%	97%	97%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	38%	34%	30%	33%	29%	27%	27%	27%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	95%	94%	94%	94%	94%	94.5%	94.1%	95.0%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	93%	92%	92%	91%	94.8%	99%	97%	98%	National reporting suspended	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	29%	24%	23%	22%	22%	33%	22%	20%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		

Quality Performance Dashboard

August 2020
Upated 24-08-20

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-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	81.9%	79.9%	75.6%	72.7%	70.8%	72.1%	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	90.4%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	1	0	1	33	95	40	24	21	0	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	76	108	210	170	366	431	198	76	80	148	84	82	78	98	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	80.06%	79.89%	79.59%	79.03%	78.09%	78.10%	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	41.67%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	24,733	24,846	24,721	24,368	23,597	23,233	22,988	23,207	22,350	21,284	21,288	21,383	23,034	23,034	
	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	15	56	200	413	616	616	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.2%	98.3%	99.1%	99.5%	99.2%	99.1%	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	61.4%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	94.0%	93.3%	94.3%	95.0%	93.7%	94.4%	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	90.4%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	–	–	93.8%	–	–	94.4%	–	–	93.4%	–	–	90.2%	–		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	96.7%	97.3%	96.5%	96.7%	97.0%	97.1%	97.2%	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	96.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	–	–	96.8%	–	–	96.9%	–	–	97.6%	–	–	98.6%	–		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	85.7%	89.9%	87.8%	85.0%	87.5%	85.9%	85.9%	85.9%	86.0%	87.4%	86.2%	82.1%	82.2%	84.5%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	–	–	88.0%	–	–	86.1%	–	–	85.9%	–	–	85.3%	–		
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	TBC	WUTH	178	184	166	193	195	148	186	160	125	74	99	119	143	109	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	TBC	WUTH	17	22	15	31	13	10	8	16	14	7	8	15	11	10	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	88%	100%	100%	93.5%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	1	2	2	4	3	0	3	0	1	0	1	5	1	2	

Quality Performance Dashboard

August 2020
Upated 24-08-20

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-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 FY 20/21 (ave min 59 per month until year total achieved) - target retained from 19/20)	National	50	37	50	56	48	41	55	49	117	326	181	151	87	745	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	83.6%	83.4%	82.7%	83.8%	81.4%	80.9%	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	78.4%	78.4%	

	Indicator	Objective	Director	Threshold	Set by	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21	Trend
Use of Resources	I&E Performance (monthly)		CFO	On Plan	WUTH	-0.825	-1.498	1.468	0.088	-0.488	-9.543	-0.668	-2.929	2.377	0.00	0.00	0.00	0.00	0.000	
	I&E Performance Variance to Plan (monthly)		CFO	On Plan	WUTH	-0.828	-1.106	1.972	-1.507	-1.638	-8.755	-1.818	-2.445	-0.589	0.00	0.00	0.00	0.00	0.000	
	NHSI Risk Rating		CFO	On Plan	NHSI	3	3	3	3	3	3	4	4	4	2	2	2	2	2	
	CIP Performance (FYF)		CFO	On Plan	WUTH	-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%	0.0%	
	NHSI Agency Ceiling Performance (monthly)		CFO	NHSI cap	NHSI	-46.4%	-8.2%	-24.3%	-24.7%	1.8%	-8.4%	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	22.0%	
	Cash - liquidity days		CFO	NHSI metric	WUTH	-16.5	-17.4	-15.0	-14.6	-10.9	-14.1	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-98.0	
	Capital Programme (cumulative)		CFO	On Plan	WUTH	14.7%	19.8%	64.2%	61.7%	57.2%	54.4%	53.8%	50.7%	74.8%	134.4%	129.5%	81.2%	65.5%	65.5%	

(*) Updated Metrics

Metric Change

(**) Updated Thresholds

Threshold Change

Wirral University Teaching Hospital NHS Foundation Trust

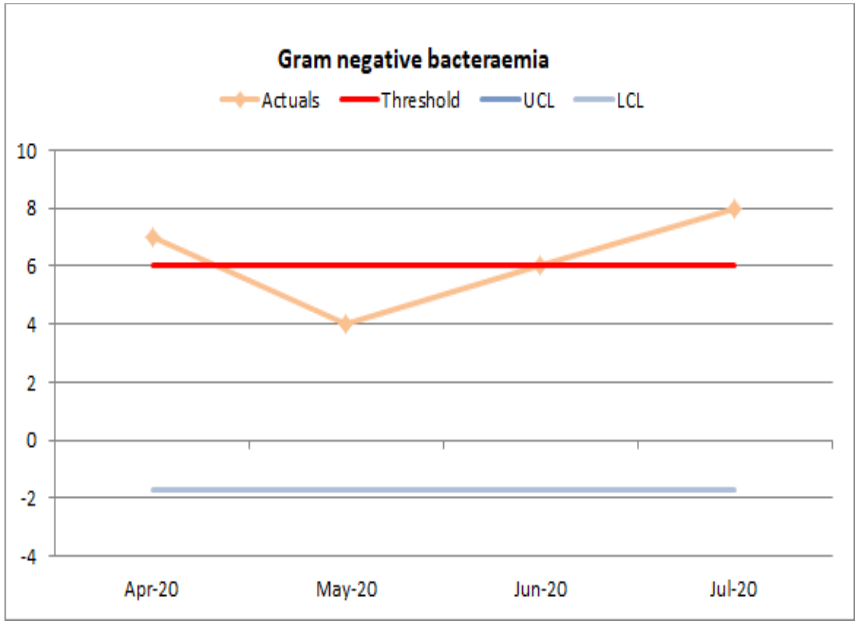
Appendix 2

WUTH Quality Dashboard Exception Report Template as at August 2020

Safe Domain

Gram Negative Bacteraemia

Executive Lead: Chief Nurse
Performance Issue: The current national ambition is to deliver a 25% reduction of healthcare associated Gram-negative -*Escherichia coli (E. coli)*, *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella (Klebsiella* spp.) blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values). To meet this requirement a threshold/maximum of 77 cases is set for 2020-21, equating to an indicative maximum of 6 per month. In July there were 8 cases reported. There has been a reduction of 70% Klebsiella and 25% Pseudomonas bacteraemia when compared to the same period last year, however an increase of 21% for E-coli. Overall there has been a 17% reduction; further improvement is required to meet the national ambition. The cumulative number to the end of July is 25 cases, just above the maximum threshold for that period.
Action: An increased scrutiny of *E-coli* bacteraemia has commenced to look at common themes, the results of these MDT investigations are presented at Divisional IPC meetings where there are discussion in how the resulting action plans are being delivered including the training and education introduced around interventions to reduce incidence. Lessons learnt are shared at local safety huddles and Trust wide at the monthly IPCG.
Expected Impact: Targeted interventions will promote reduction in the instance of *E-coli* bacteraemia which will be reflected in the overall reduction in gram negative bacteraemia to ensure the monthly threshold is not exceeded.



MRSA Bacteraemia – hospital acquired

Executive Lead: Chief Nurse

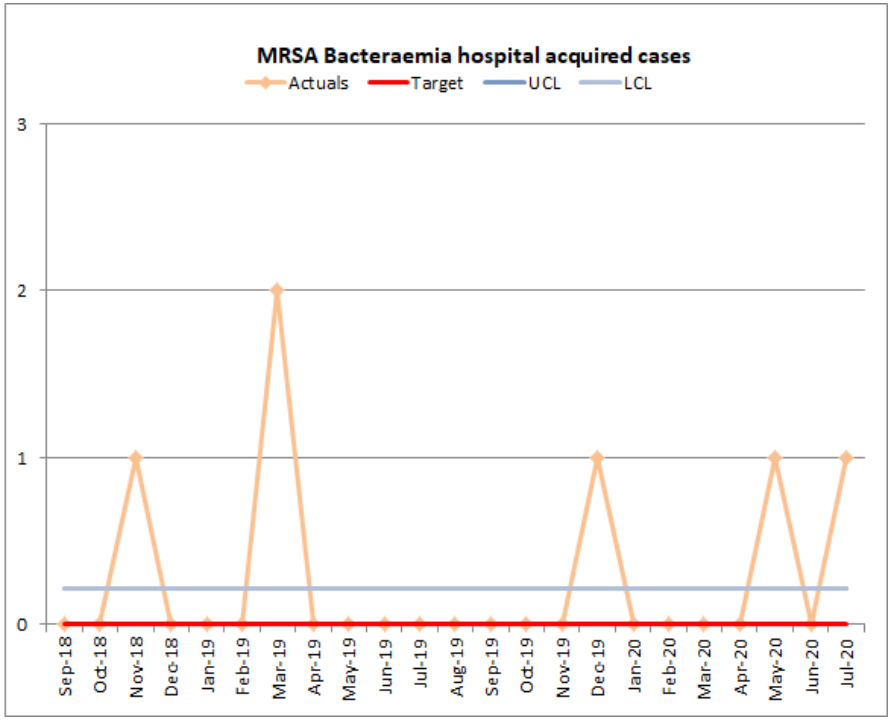
Performance Issue:
The government considers it unacceptable for a patient to acquire an MRSA BSI while receiving care in a healthcare setting. Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. All MRSA blood stream infections are subject to a Post Infection Review (PIR).
WUTH has reported its second MRSA bacteraemia this year in July.

Action:
A Multi-disciplinary PIR was completed as required. The investigation was thorough and proved difficult to determine the definite cause due to multiple factors. The learning outcomes as a result of the investigation were recorded in a MDT action plan, the results of which were presented at the Divisional IPC meeting which prompted discussion on how the actions captured in the plan would be delivered, this included the training and education of the staff in carrying out specific interventions required to avoid further incidence.

The undetermined causative factors are not related to the previous reported incidence.

Lessons learnt have been shared at local safety huddles and Trust wide at the monthly IPCG

Expected Impact:
The learning outcomes will result in a change of practice that is reflected in local policies and the expectation is that this will result in no further MRSA bacteraemia.



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 79.3% for July 2020.

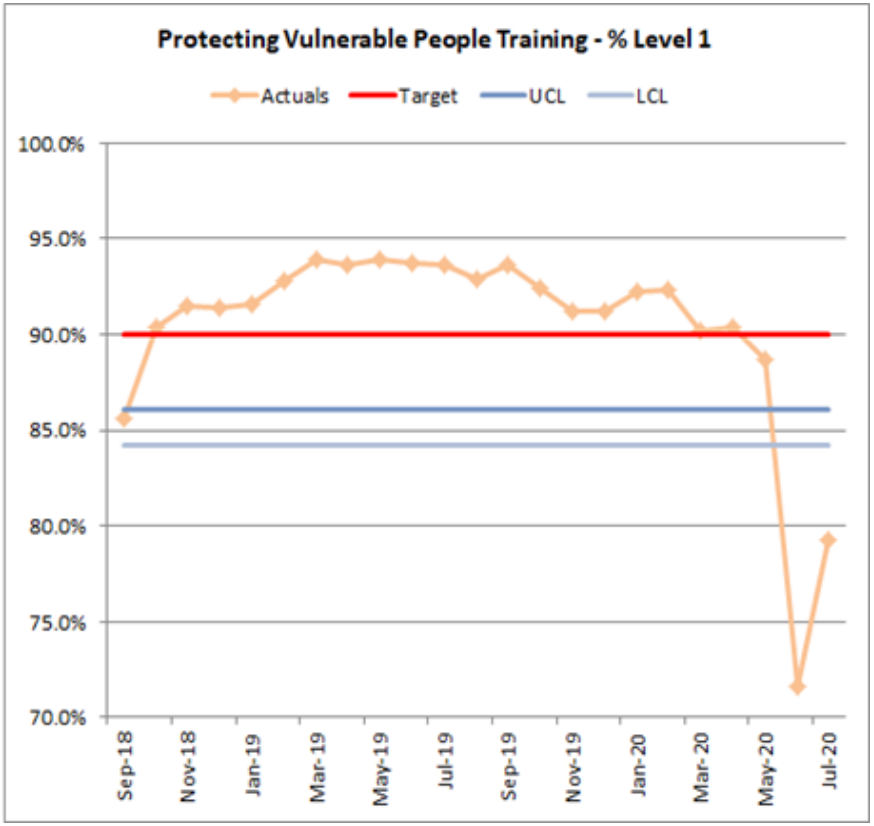
Action:

Compliance and trajectories continued to be 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. PVP level 1 is completed via the intranet and can be accessed by staff at any time. Training has now recommenced across the divisions for eLearning. Increased focus on mandatory training has noted a positive impact on compliance during July 2020 ensuring the Trust remains on target with its agreed trajectory to achieve 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 July increased to 73.5%.

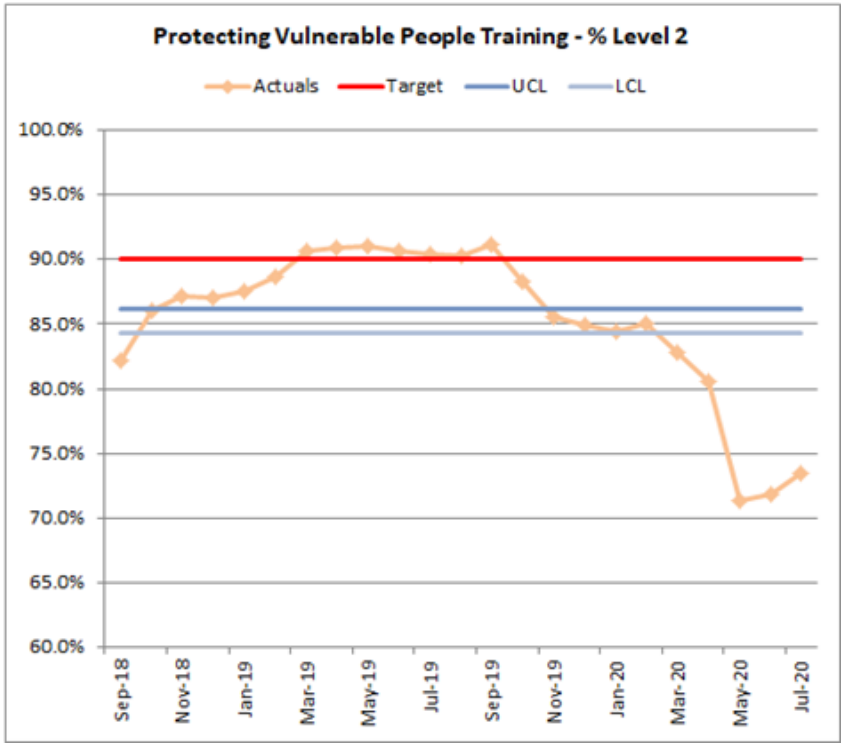
Action:
Compliance is monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance was also reported in the Safeguarding Performance Report last presented at PSQB in May 2020.

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 are completed via the intranet and can be accessed by staff at any time. Areas / teams with non-compliance have increased monitoring to ensure staff access training to ensure the Trust remains on target with its agreed trajectory to achieve 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

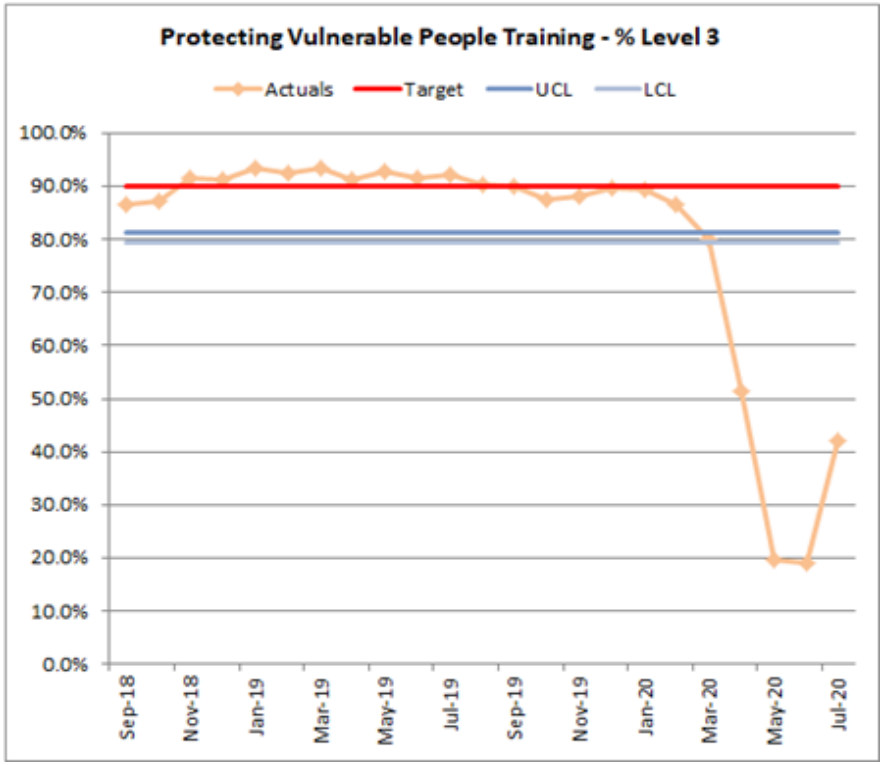
Executive Lead:
Chief Nurse

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 July much improved to 42.0%.

Action:
The pausing of mandatory training during the COVID pandemic 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. These actions have resulted in a 23% increase in compliance during the month of July 2020.

Divisional compliance and trajectories continue to be 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 mid-August 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 attendance % (in-month rate)

Executive Lead: Director of HR / OD

Performance Issue:

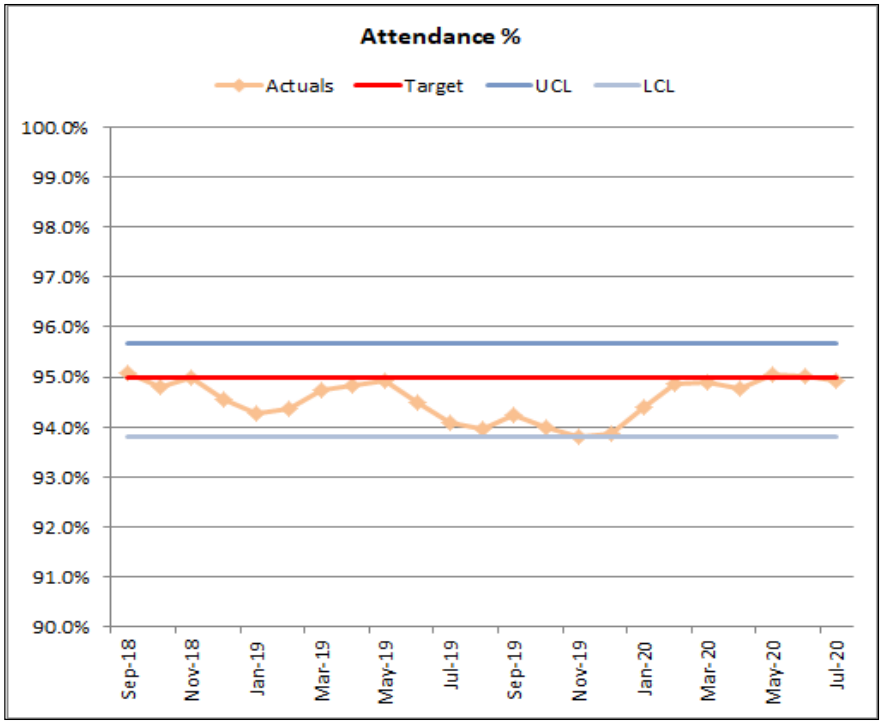
WUTH has a target set at a minimum 95% attendance of staff, with performance against this metric reported as both an in-month rate and a 12-month rolling average. The 95% standard was achieved in May and June 2020, however July was marginally below at 94.92%. The rolling 12-month performance was 94.92%.

Action:

- Data cleansing and central absence reporting line to cease returning to manager self-serve from September and absence team redeployed to focus on telephoning managers of absent staff to ensure all sickness episodes are closed where appropriate
- Top 200 employees targeted to ensure they have a 'plan on a page' to return them to health and to work
- Sickness clinics to be held in September with Chair of Staff Side, HRD/DHRD, Divisional Director and absent member of staff to review their case and agree pertinent actions
- Divisional triumvirates return to weekly review of sickness data and caseloads
- Recruitment of HRBP's to take place immediately to address recent high turnover in this staff group

Expected Impact:

More robust management of sickness absence and improved attendance.



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. July 2020 remained at the rate of 1.17%, with the rolling 12-month rate at 11.7%.

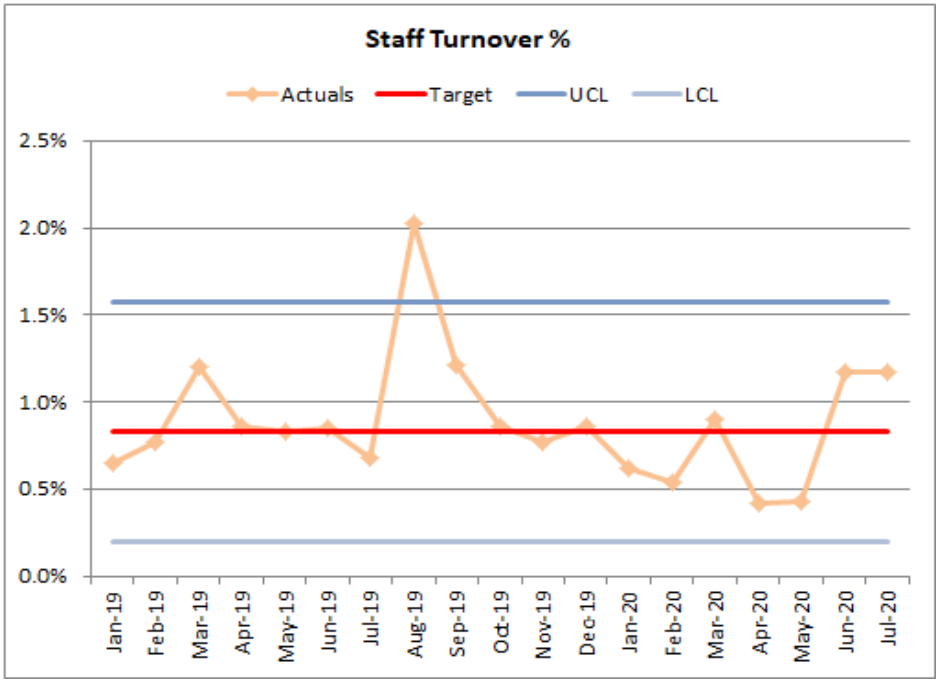
Action:

The trend from March to date is in line with known intelligence that some staff secured alternative employment outside of the Trust in February and March 2020 and there was a general agreement across the Region not to move staff during the peak of the pandemic so notice periods were extended. The peak in June and plateau in July is in line with the timing of staff moving on to the roles they were appointed to during the pandemic.

As BAU picks up more focus will be given to improving retention as was the case prior to the Covid outbreak.

Expected Impact:

This peak should now start to fall as the Trust moves further into its reset and recovery programme.



Effective Domain

SAFER bundle: % of discharges taking place before noon

Executive Lead: Medical Director / Chief Operating Officer

Performance Issue:

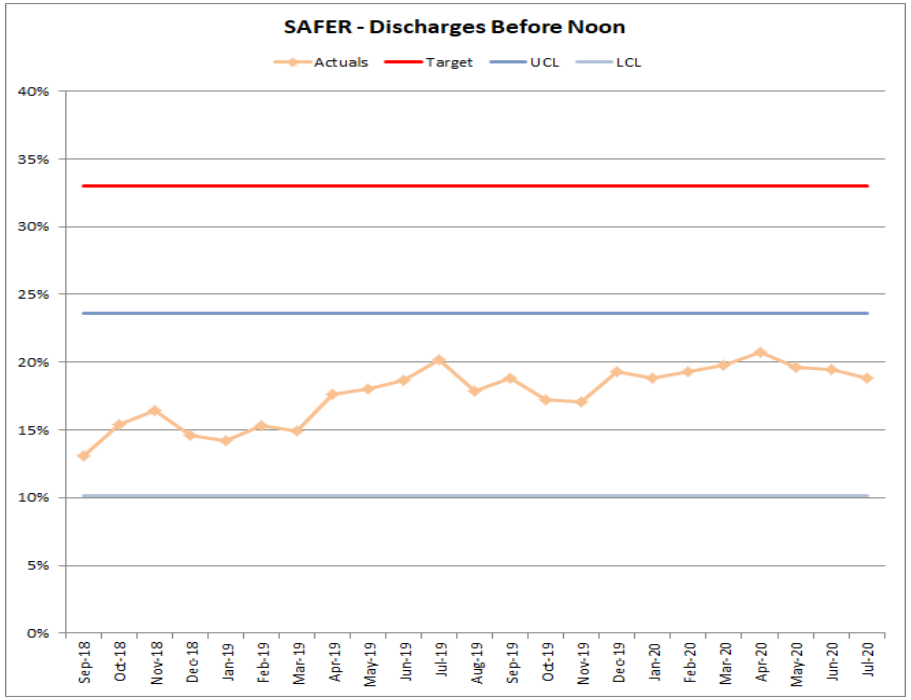
A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. This standard is consistently not achieved, with July 2020 at 18.8%.

Action:
Increasing discharges before noon continues to be a challenge and performance remains below target.

However, from the early results of the improvement work on 2 medical wards we have already seen an increase in the number of patients discharged before midday. This intense focus on early discharge will continue and will be extended as a key part of the improvement work with 2 wards in Surgery this month. This outcome will continue to be monitored via the improvement dashboard.

Unfortunately, delays have been experienced for patients awaiting a negative Covid swab result. However, the process of swabbing patients going home with support is currently under review by the Clinical Advisory Groups and the System Clinical Group (STAC) and removing this requirement will help to mitigate the risk of delay. Work is also ongoing to ensure all patients who no longer meet the criteria to reside in an acute setting are declared for discharge after the twice daily MDT reviews which will ensure early discharge planning.

Expected Impact:
A key objective of the recovery and reset will be to ensure we reach the target of 33% of discharges before 12 midday.



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:

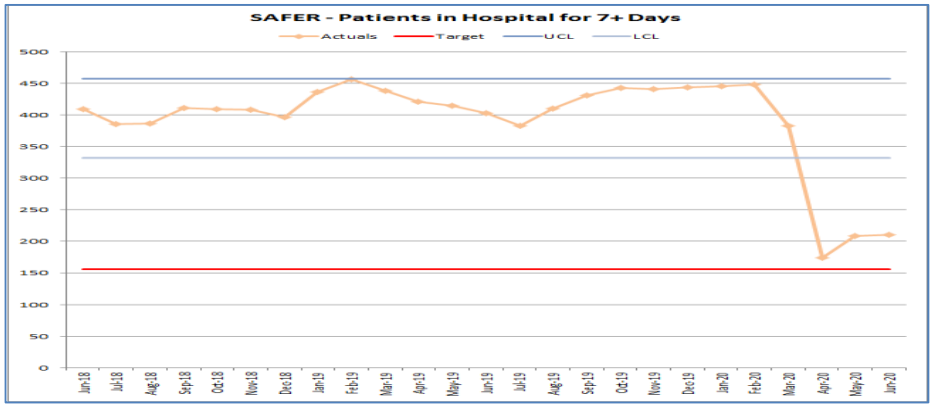
A WUTH target had been set to reduce the number of patients in hospital for seven days or more to a maximum 156, and for 21 days or more to a maximum 107. Whilst the number of 21+ day patients has remained lower than 107 there has been an upward trend in August to 60, above our forecast position of 50 patients but below the tolerance of 90. A steady increase in bed occupancy has correlated with an increase in the number of 7+ day patients to a range of 200-210 which is significantly above the target of 156.

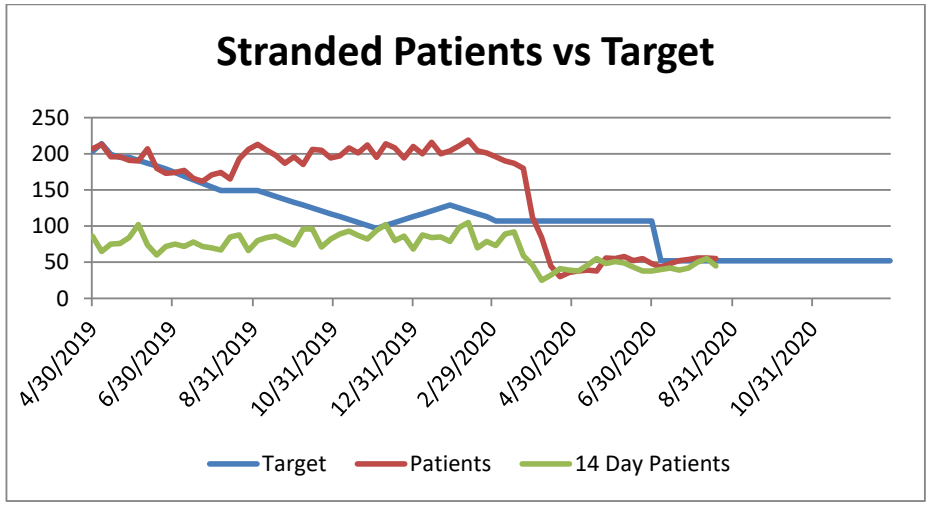
Action:

In addition to the 2 x weekly (Surgery) and 3 x weekly (Medicine) long stay reviews, a Multi-disciplinary Discharge Event will take place ahead of the Bank Holiday weekend to provide a system overview of barriers to discharge and partner involvement to explore care in a non-acute setting. This will be a regular monthly event during winter.
Quality improvement work is progressing well on the 2 Medical wards with standardized MDT Board Rounds and a focus on developing Criteria Led Discharge. As a result, there has been a reduction in the number of 21+ day patients and overall LoS on these wards. Work with 2 Surgical wards will commence after the Bank Holiday weekend.
ECIST and NHSI continue to support 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:

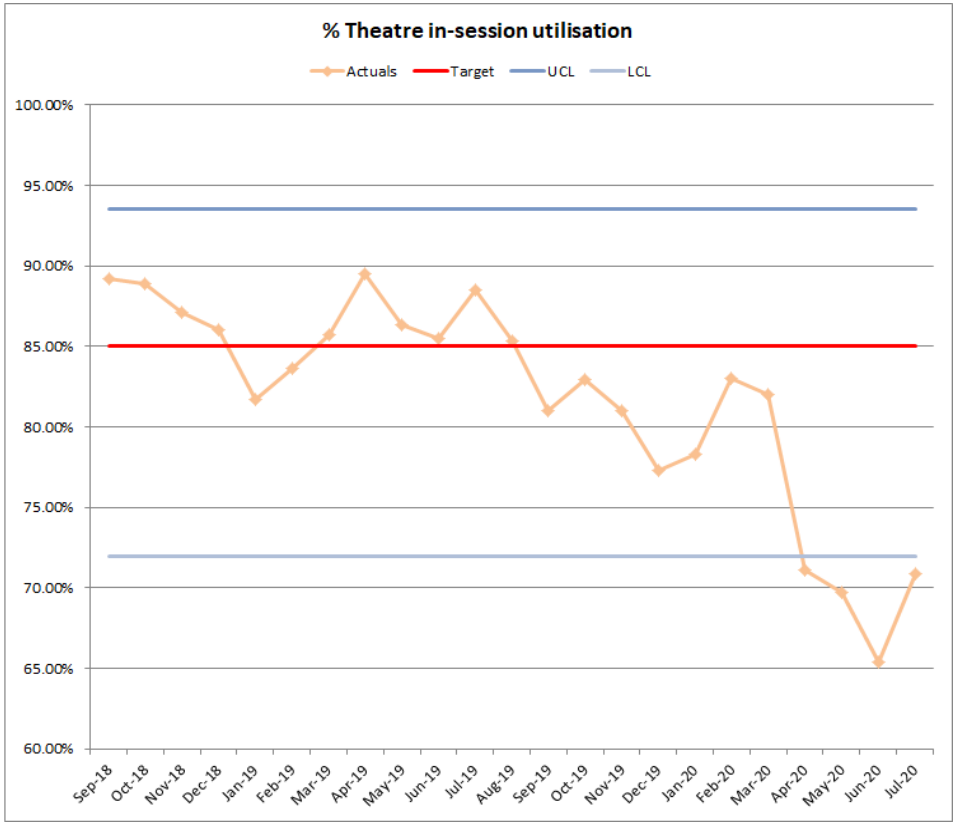
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. With the support of the theatre transformation programme this was regularly achieved from March 2019. However from August 2019 performance deteriorated, largely due to the cancellation of elective activity 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 July was 70.9%.

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 underway with IPC which is expected to increase utilisation further and a reduction in the requirements to use PPE which means more cases will be able to be added to current list.

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

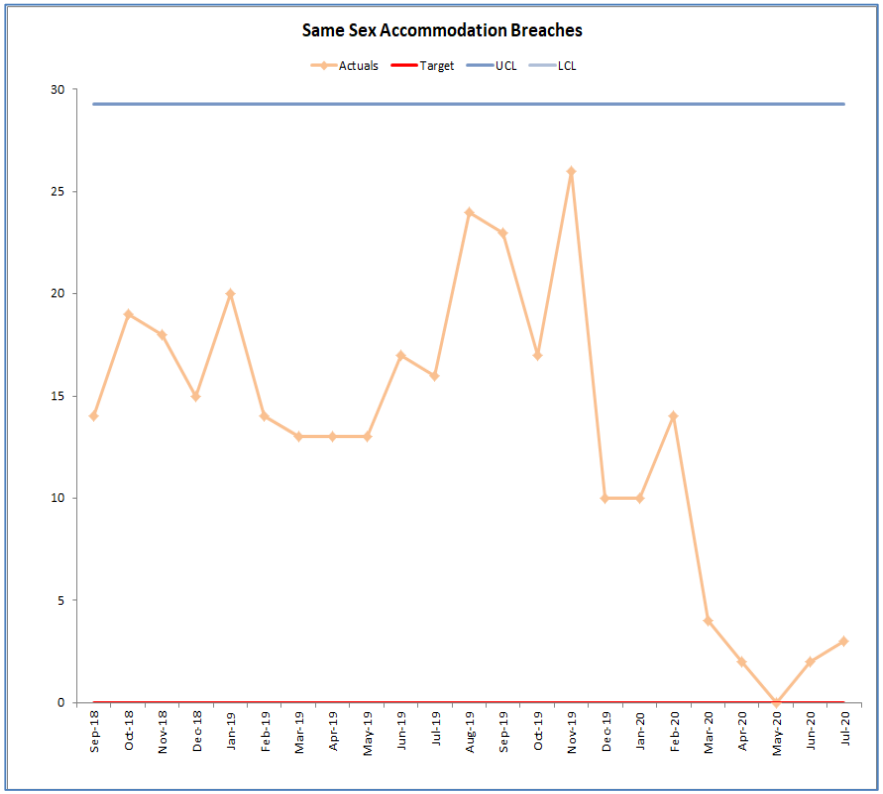
Executive Lead:
Chief Nurse

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 3 such breaches in July.

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 there were 3 breaches in July 2020 due to bed occupancy being at 75% creating pressure (due to the reduced bed base) this pressure was also compounded by the limited availability of side rooms across the Trust. The new Critical Care Step Down policy is currently out for consultation due to be ratified in quarter 3. This policy will enhances the escalation process for delays to ensure appropriate action is enacted quickly thus reducing the number of mixed sex accommodation breaches.

Expected Impact:
There will be a reduction in same sex accommodation breaches.



Responsive Domain

Referral to Treatment – incomplete pathways < 18 weeks

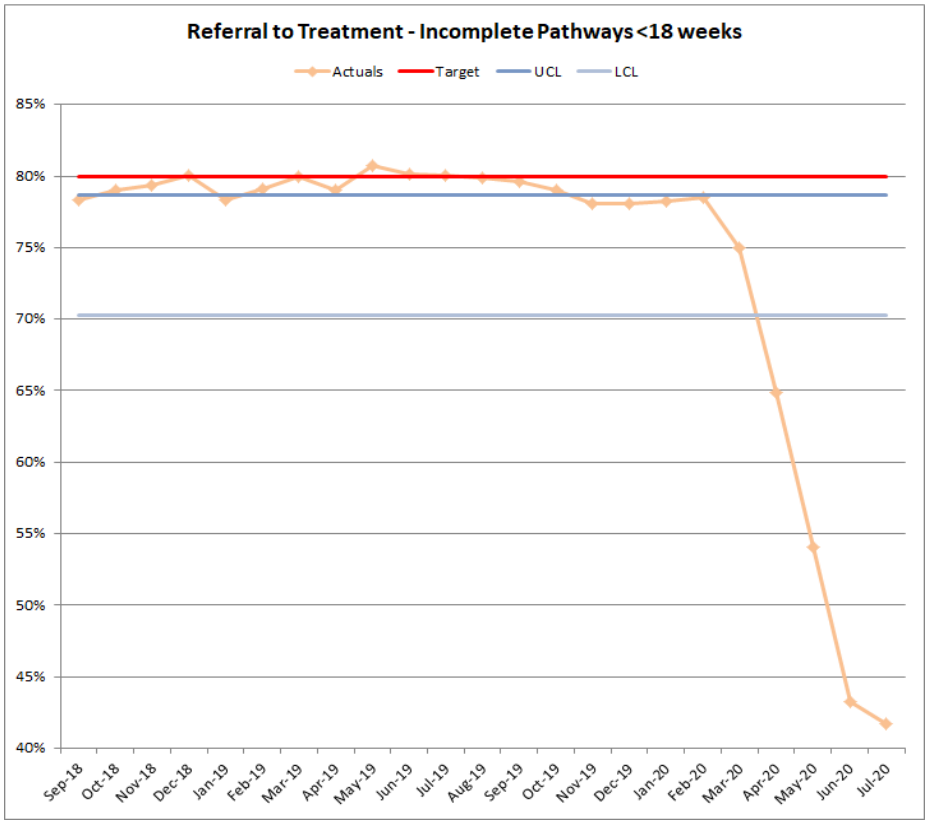
Executive Lead: Chief Operating Officer

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. July 2020 was 41.67%, with the August position currently at 48.14%.
As at the 23rd August there were 717 patients waiting more than 52 weeks on RTT pathways that had not yet commenced treatment, but are being proactively managed.

Action:
The deterioration is directly attributable to the cessation of routine elective activity in response to the Covid-19 situation. Activity targets have been updated to reflect Phase 3 restart targets of 90% against last year's activity.
29,709 appointments have been booked / attended in August to date against a plan of 33,872.
Patients continue to be dated in clinical priority and then referral date order and those patients without a P status need urgent review.
All Divisions are increasing activity and reviewing IPC measures and staffing to increase capacity.

Expected Impact:
Waiting list size and number of breaches will start to decrease once the Trusts activity returns to pre-Covid levels, which we aim to be at 100% by November.



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.

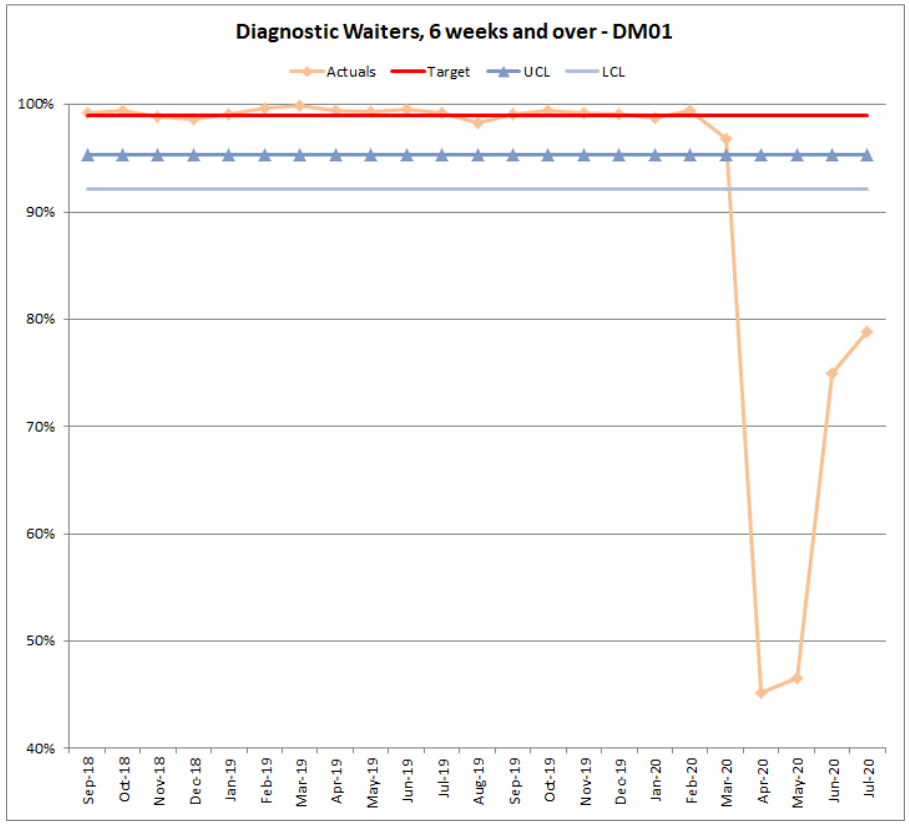
The position at the end of July 2020 was 78.8%, a further improvement from the previous month.

Action:

The recovery in diagnostic waits continues. Capacity and demand is continually reviewed alongside other Divisional reset plans, with mitigations in place to increase capacity. The use of the IS sector has commenced with some CT and MR work being undertaken at Spire. Improvements in endoscopy around cleaning times and use of PPE have been agreed which will also increase capacity.
Additional sessions are being made available with a plan to achieve 100% of last year's activity by October.

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:

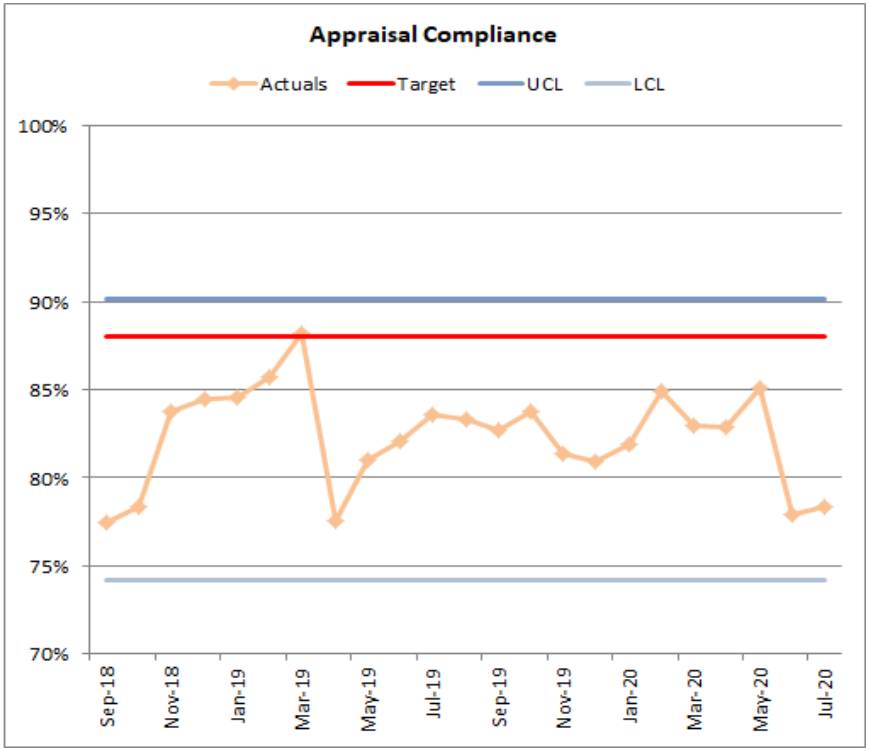
WUTH has a target set at a minimum 88% of staff to have had an appraisal within the expected timeframes. The 88% standard has not been achieved since March 2019, but there has been a 2.8% increase since last month with overall compliance at 81.25%. Surgery is the only division achieving compliance although medicine and Acute Division is marginally below at 87.71%. Compliance in Corporate Services is the lowest performing Division at 63.91% and areas needing to improve as a priority are Informatics and Finance.

Action:

Appraisals for all medical staff have been suspended nationally until September 2020 which will have an impact on appraisal rates. Managers and staff receive compliance alert reports via ESR and individuals through ESR email notifications. Heads of service or departments with particularly low compliance rates are alerted and assurance on action requested. Capacity to undertake appraisals during the pandemic has been restricted. This will be corrected under Trust plans to reset and recover as we return to business as usual. A team appraisal process has been developed and is being tested before roll out.

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	20/21 115
Title of Report	Month 4 Finance Report 2020/21
Date of Meeting	2 September 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 4 Finance Report 2020/21

Contents

- The overall Mth 4 performance position is break-even, this is in-line with NHSI's expectations and reflects the new financial infrastructure provided to organisations to support the national response to the Covid pandemic.

- The in-month position includes:
  - "Income guarantee support" to offset the reduced activity presenting in the Trust during July of £8.3m.
  - Revenue costs incurred in responding to Covid locally of (c£1.6m).
  - "additional top-up" funding of c£0.1m

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

- Overall, at Month 4, operational pay and non-pay expenditure is below plan, this is offset by costs incurred for COVID-19 of £0.9m, on pay and £0.7m in non-pay costs.

- Based on the above position, the Trust has seen a ***net*** increase in expenditure in month 4 of £0.1m and has therefore assumed additional "top up" income to offset this. This ***net*** position is driven by the costs of managing COVID-19 offset by underspends relating to the continued reduced bed occupancy (c. 63%).

- Although activity numbers are increasing steadily, the operational underspend (excluding covid costs) has been driven by the reduction in non-covid patients presenting to the Trust, the year to date position also includes the suspension of the elective programme during quarter 1. This has now resumed albeit impacted by patients required to isolate before surgery and reduced throughput in theatres to ensure adherence to IPC measures. Variable costs associated with this routine activity i.e. drugs, clinical consumables, outsourcing and premium staff costs have all decreased in-line with activity.

- Cash balances at the end of July 2020 were £39.9m; this reflects the accelerated cash payments made to providers to support the liquidity position. NHSI have committed to supporting the cash position for all providers through to October 2020. This arrangement will be reviewed in conjunction with the overall financial infrastructure for the NHS for the remainder of 2020/21. This is discussed further in section 4.7.

- 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.

- Capital spend for 2020/21 can be sub-divided into three key work streams,
  - Operational capital spend - following the re-submission of the draft plan in May which addressed both the slippage of the 2019/20 plan, and the impact of the C&M capital limit on the 2020/21 plan for WUTH, the annual plan is £11.2m. This is detailed in Section 7.
  - Additional national allocations for Critical Infrastructure (£1.4m) and A&E (£1.4m)
  - Capital requirements to support the local response to Covid 19, this is detailed in Section 5.

- 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 4 Performance Dashboard

		Current Period			Year to date		
		Budget	Actual	Variance	Budget	Actual	Variance
I&E Performance (£'000)	On Plan	0	1	1	0	1	1
NHSI UoR rating	On Plan		2	2		2	2
NHSI Agency Ceiling Performance (£'000)	NHSI cap	656	494	162	2,622	2,047	575
Capital spend (£'000)	On Plan	1,732	687	(1,045)	3,948	2,487	(1,461)

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 of step-changes in activity.
- Going forward as part of the Phase 3 recovery and accelerating the return to near-normal levels of non-Covid health services, there is a need to ensuring the Trust is making full use of the capacity available in the 'window of opportunity' between now and winter. This is being progressed through the weekly activity meeting taking place with the Divisional teams and the Chief Operating officer, to both understand activity projections and associated costs and also ensuring trajectories are delivered as outlined in the letter sent to all NHS Organisation in England from NHSI/E on 31st July.
- Ensuring all revenue Covid -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's overall cash position will be supported from Mth 1 – Mth 6. In relation to the position from Mth 7 onwards, this will be determined by the Phase 3 Planning submission due 21st September, and the spend on the Capital programme.

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).
- 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. The Trust has been allocated further specific funding for A&E and critical infrastructure support, schemes have been identified, and the teams are focussed to ensure plans are mobilised through the Capital Management Group.
- The revised capital plan for 2020/21 is dependent upon the delivery of a significant level of estates work and will require careful planning to ensure that operational capacity is not disrupted at key pressure points in the year. This is a key risk to the delivery of the capital programme for the year which is being addressed through identification of additional project planning resource.

4. Financial performance

4.1 Income and expenditure

For the period April to July 2020, the Trust received a guaranteed monthly income allocation which had 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 is funded via a 'top up' payment. Confirmation has been received that this arrangement will continue until 30th September. The arrangements from 1st October are discussed further in section 4.5.

For July (month 4) the Trust has delivered a "break-even" position overall as expected by NHSI, further "additional" top up funding has been required of c£0.1m. Costs incurred in managing Covid have increased from the previous month, despite the reduced number of cases presenting, mainly relating signage in relation to social distancing, IT costs to manage patients remotely, PPE (locally procured mainly Paediatric), and costs in relation to Critical Care such as gas flow analysers.

Excluding COVID-19 costs, the overall underlying operational spend during July 2020 is broadly consistent with the June position, despite activity improving across all points of delivery. This reflects the release of accruals previously held for outsourcing following the receipt of actual activity information.

The operational underspend year to date (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.

Going forward, operational costs to support "routine" activity are expected to increase, particularly as the planned activity program ramps up.

An analysis of this is provided in Table 1 below.

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

Month 4 Financial Position	Budget (Mth 4)	Actual (Mth 4)	Variance	Year To Date Budget	Year To Date Actual	Variance	M3	M4	Mvt
NHS income from patient care activity	27,599	19,232	(8,368)	110,398	69,636	(40,762)	(9,054)	(8,368)	686
Income Guarantee	0	8,279	8,279	0	40,408	40,408	8,958	8,279	(679)
National Top-up	2,562	2,562	0	10,248	10,251	3	0	0	0
Non NHS income from patient care	457	343	(114)	1,829	1,353	(476)	(118)	(114)	3
Other income	2,372	2,258	(114)	10,149	8,761	(1,387)	(445)	(114)	331
Total Income	**32,991**	**32,674**	**(317)**	**132,624**	**130,454**	**(2,170)**	(658)	(317)	341
Employee expenses	(22,207)	(21,581)	626	(89,494)	(87,130)	2,364	575	626	51
Operating expenses	(10,358)	(9,249)	1,109	(41,425)	(36,617)	4,808	1,087	1,109	22
Covid 19 costs	0	(1,589)	(1,589)	0	(6,030)	(6,030)	(1,087)	(1,589)	(502)
Total expenditure	**(32,565)**	**(32,420)**	**145**	**(130,920)**	**(129,777)**	**1,142**	575	145	(430)
Non Operating Expenses	(426)	(308)	118	(1,704)	(1,297)	407	(297)	118	415
Actual Surplus / (deficit)	**0**	**(54)**	**(54)**	**0**	**(621)**	**(621)**	**(380)**	**(54)**	**326**
Reverse capital donations / grants I&E impact	0	(66)	(66)	0	(5)	(5)	14	(66)	(80)
Surplus/(deficit) - Control Total	**0**	**(120)**	**(120)**	**0**	**(626)**	**(626)**	**(366)**	**(120)**	**246**
Additional "top up" required	0	121	121	0	626	626	367	121	(246)
Adjusted Surplus/(deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Financial performance

The Mth 4 income position includes:

- **Income guarantee** – the impact of the block agreement of £8.3m received from WUTH commissioners to provide income certainty given impact of covid 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 4 of (c£0.1m) ensuring a "break-even" position was delivered.

Pay costs (£0.6m below plan): Pay costs in Mth 4 have broadly remained static; this predominantly reflects the reduced need of non-core staff in clinical areas which are driving lower agency and WLI payments.

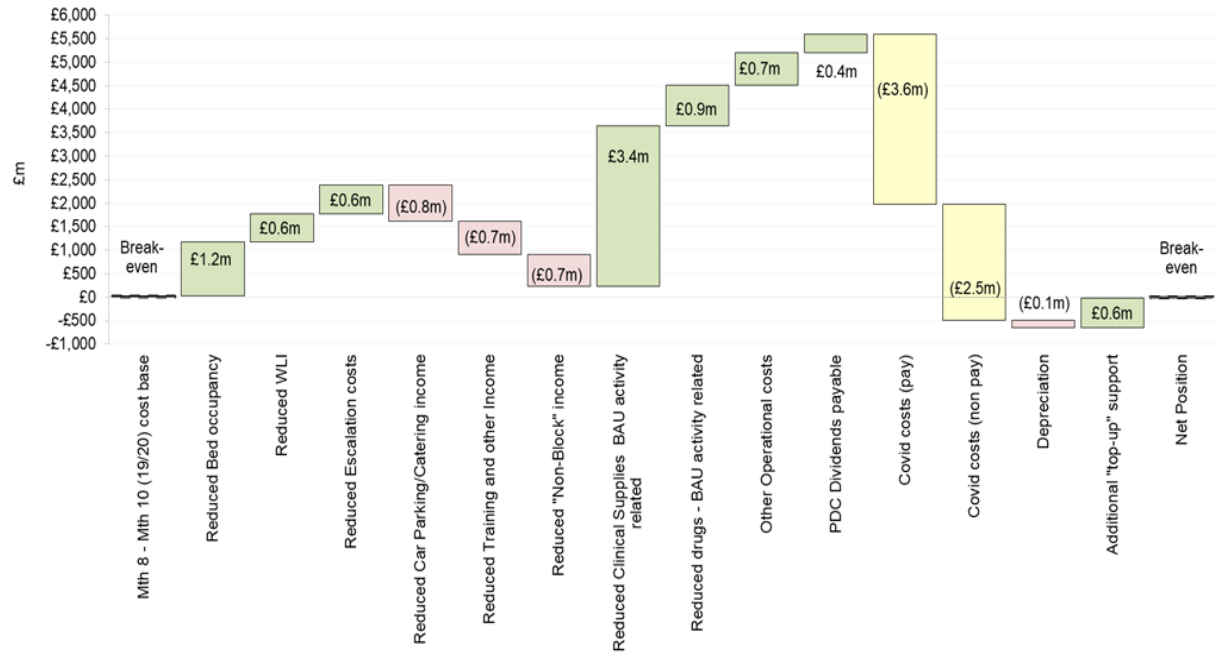
Actual agency staff costs in July were (c£0.5m), of this (£0.3m) was in medical staff, (c£0.1m) in non-allied health professionals and nursing, and (c£0.1m) in NHS Infrastructure.

Non pay costs (£1.1m underspend): Non-pay associated with clinical supplies and drugs increased in July 2020 compared to June, reflecting the increase in activity, however, this was offset by the realignment of costs in relation to outsourcing following the receipt of actual activity information.

Income: The improvement in the clinical income position from last month reflects the increase in activity across all points of delivery including, elective, A&E attendances, NEL spells, and direct access Pathology and Radiology.

COVID-19 costs: In total, c£1.6m was incurred on covid related activities; this is detailed in Section 5 of this report.

The bridge chart below details the reconciliation of movements in the actual Mth 4 position including the impact of covid costs.



4. Financial performance

4.2 Income

At the end of July 2020, the Trust overall income position is below plan by (c£2.2m), 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 31st July 2020

	Current month			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income from patient care activity						
Elective & Daycase	3,940	2,179	(1,761)	15,762	4,745	(11,017)
Elective excess bed days	303	109	(194)	1,211	270	(941)
Non-elective	3,632	3,336	(296)	14,529	11,507	(3,021)
Non-elective Non Emergency	434	411	(23)	1,737	1,580	(157)
Non-elective excess bed days	1,300	(47)	(1,347)	5,200	1,508	(3,692)
A&E	7,595	7,199	(396)	30,378	23,855	(6,523)
Outpatients	25,001	20,302	(4,699)	100,003	59,958	(40,045)
Diagnostic imaging	2,764	2,569	(195)	11,054	5,206	(5,848)
Maternity	535	541	6	2,141	1,946	(195)
Non PbR						
HCD						
CQUINs						
National Top up						
Income Guarantee						
Total NHS Clincial Income	45,504	36,598	(8,906)	182,015	110,576	(71,440)
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	2,245	(2,035)	17,122	4,221	(12,901)
Elective excess bed days	83	30	(53)	333	92	(241)
Non-elective	8,487	4,900	(3,587)	33,946	23,950	(9,997)
Non-elective Non Emergency	986	956	(30)	3,943	3,847	(96)
Non-elective excess bed days	357	(9)	(366)	1,427	407	(1,020)
A&E	1,286	1,206	(80)	5,144	3,944	(1,200)
Outpatients	3,056	1,944	(1,112)	12,224	5,945	(6,279)
Diagnostic imaging	189	180	(9)	757	351	(406)
Maternity	483	511	27	1,933	1,823	(111)
Non PbR	7,185	5,385	(1,801)	28,741	20,303	(8,438)
HCD	1,299	1,924	625	5,196	4,891	(305)
CQUINs	190	190	0	760	760	0
National Top up	2,562	2,682	120	10,248	10,877	629
Income Guarantee	0	8,279	8,279	0	40,408	40,408
Total income from patient care (SLAM)	30,444	30,423	(21)	121,775	121,818	42
Other patient care income	89	79	(10)	356	331	(25)
Non-NHS: private patients & overseas	13	1	(13)	54	3	(51)
Injury cost recovery scheme	72	33	(39)	290	166	(123)
Total income from patient care activities	30,619	30,536	(83)	122,475	122,318	(157)
Other operating income	2,372	2,258	(114)	10,149	8,762	(1,386)
Total income	32,991	32,794	(197)	132,624	131,081	(1,543)

Key points are as follows:

- In Mth 4 the Trust position is supported by the "block" arrangement by a further c£8.3m, increasing the year to date support received to £40.4m.
- This includes the impact of the release of the new Grouper which now includes Covid specific HRG's. This will now map COVID-19 related diagnosis and procedures to the new COVID-19 HRG's. However as there is no national tariff, NHSI have advised all Trust to include this activity at "zero" price and recover the income during mths 1-6 via the retrospective top-up. During quarter 1 the Trust performed 604 Covid related spells which have now mapped to the specific COVID-19 HRG's with zero price, the impact of this is (£2.1m). Excluding this, the income guarantee would be £6.2m in July

  Operationally activity performance was as follows:
  - A&E activity is at 95% of the previous run rate (average attendances in July were 232 per day, the pre – COVID-19 expected number was 245 per day). This represents an increase of 8% (18 attendances per day) from June.
  - NEL activity is at 92% of expected levels, this is an improvement of 8% from the June position
  - EL/DC activity has improved by 23% from June. It is now 45% below 19/20 levels.

- Births were slightly below plan.
- Neonatal cot days have decreased progressively over quarter 1, some of this is due to managing social distancing measures and reduced cot capacity.
- Direct Access Radiology/Pathology have increased significantly from the June 2020 position
- Rehab. bed days are consistent with June 2020, however remain below the previous run rate.

4.3 Expenditure

4.3.1 Overall pay expenditure (including COVID-19) for the period ending 31st July 2020

Overall pay costs were above plan by c£0.2m in July and by (£1.2m) YTD.

The table below details pay costs by staff group.

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

STAFF GROUP	MONTH 4 (£'000)			CUMULATIVE (£'000)		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
CONSULTANTS	3,569	3,593	(24)	14,277	14,376	(99)
OTHER MEDICAL	2,561	2,499	62	10,239	10,316	(77)
TOTAL MEDICAL	**6,130**	**6,092**	**38**	**24,516**	**24,693**	**(176)**
NURSING & MIDWIFERY	6,210	6,020	190	24,531	24,548	(16)
CLINICAL SUPPORT WORKERS	2,297	2,383	(86)	9,188	9,335	(147)
TOTAL NURSING	**8,507**	**8,403**	**104**	**33,719**	**33,883**	**(163)**
AHP'S, SCIENTIFIC & TECH	2,744	2,973	(229)	11,573	12,002	(429)
ADMIN & CLERICAL & OTHER	4,827	4,977	(150)	19,685	20,117	(431)
TOTAL OTHER	**7,570**	**7,950**	**(380)**	**31,259**	**32,119**	**(860)**
OVERALL TOTAL	**22,207**	**22,445**	**(238)**	**89,494**	**90,694**	**(1,200)**

The YTD overspend across all staff groups from the previous run-rate (budget), predominantly reflects increased costs associated responding to the Covid 19 pandemic. The position includes the cost of final year medical students and nursing staff required during April and May.

Part of the increase in clinical support staff, AHP's 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.

The in-month position particularly for nursing staff which is underspent by £c0.2m reflects the reduced requirement of bank staff due to escalation remaining closed and activity not quite at full capacity.

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

Table 5: Pay analysis by type

4. Financial performance

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	(251,174)	(19,771)	(20,477)	(706)	(79,764)	(82,819)	(3,055)
Bank	(4,746)	(1,066)	(865)	201	(4,249)	(3,499)	750
Medical bank	(5,092)	(625)	(537)	89	(2,502)	(1,995)	506
Agency	(4,857)	(655)	(493)	162	(2,621)	(2,046)	575
Apprenticeship Levy	(1,026)	(90)	(74)	16	(359)	(335)	24
Total	(266,894)	(22,207)	(22,445)	(238)	(89,494)	(90,694)	(1,200)

Pay costs excluding the spend associated with Covid is detailed in the table 6 below.

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

STAFF GROUP	MONTH 4 (£'000) BUDGET	MONTH 4 (£'000) ACTUAL	MONTH 4 (£'000) VARIANCE	CUMULATIVE (£'000) BUDGET	CUMULATIVE (£'000) ACTUAL / FORECAST	CUMULATIVE (£'000) VARIANCE
CONSULTANTS	3,569	3,499	70	14,277	13,892	385
OTHER MEDICAL	2,561	2,394	166	10,239	9,749	491
TOTAL MEDICAL	**6,130**	**5,894**	**236**	**24,516**	**23,641**	**875**
NURSING & MIDWIFERY	6,210	5,888	323	24,531	23,915	616
CLINICAL SUPPORT WORKERS	2,297	2,067	230	9,188	8,346	841
TOTAL NURSING	**8,507**	**7,955**	**553**	**33,719**	**32,262**	**1,458**
AHP'S, SCIENTIFIC & TECH	2,744	2,883	(139)	11,573	11,581	(8)
ADMIN & CLERICAL & OTHER	4,827	4,851	(24)	19,685	19,647	39
TOTAL OTHER	**7,570**	**7,733**	**(163)**	**31,259**	**31,227**	**31**
OVERALL TOTAL	**22,207**	**21,581**	**626**	**89,494**	**87,130**	**2,364**

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.
- The increase cost in AHP reflects the commencement of the Community Primary Care Networks and associated additional Pharmacy staff recruited.

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 July, and £4.8m YTD.

4. Financial performance

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	(34,862)	(2,912)	(2,317)	595	(11,934)	(8,956)	2,977
Supplies and services - general	(5,158)	(445)	(323)	121	(1,778)	(1,345)	434
Drugs	(24,690)	(1,951)	(2,138)	(188)	(7,803)	(6,931)	872
Purchase of HealthCare - Non NHS Bodies	(8,248)	(713)	(317)	397	(2,567)	(1,960)	607
CNST	(13,235)	(1,070)	(958)	112	(4,280)	(4,316)	(35)
Consultancy	(474)	(69)	0	69	(274)	(0)	274
Other	(25,993)	(2,366)	(2,304)	62	(9,457)	(9,615)	(158)
Total	(112,661)	(9,525)	(8,357)	1,168	(38,093)	(33,123)	4,971
Depreciation	(11,644)	(833)	(892)	(59)	(3,332)	(3,494)	(162)
Total	(124,305)	(10,358)	(9,249)	1,109	(41,425)	(36,617)	4,808

Key points are as follows:

- The main driver of the underspend is reduced clinical and general supplies costs of c£0.7m in mth and c£3.4m YTD, a direct correlation to the reduced/paused elective programme.
- Drug costs increased in July in-line with increased activity, the year to date position reflects the reduced activity during quarter 1.
- The "Other" category above incorporates a number of areas, including energy, and interpreter fees.

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

4.4.1 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 July 2020, an additional £1.6m costs for both pay and non-pay have been incurred. The YTD spend is £6.1m. 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.

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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.

4. Financial performance

Table 9: YTD Covid revenue costs – Pay (£000's)

STAFF GROUP	MONTH 1 ACTUAL	MONTH 2 ACTUAL	MONTH 3 ACTUAL	MONTH 4 ACTUAL	CUMULATIVE ACTUAL
CONSULTANTS	70	195	125	94	484
OTHER MEDICAL	192	191	79	105	568
TOTAL MEDICAL	**263**	**386**	**204**	**199**	**1,052**
NURSING & MIDWIFERY	163	220	117	132	633
CLINICAL SUPPORT WORKERS	154	290	228	316	988
TOTAL NURSING	**317**	**511**	**345**	**448**	**1,621**
AHP'S, SCIENTIFIC & TECH	45	99	186	90	421
ADMIN & CLERICAL & OTHER	187	121	89	126	523
TOTAL	**812**	**1,118**	**824**	**863**	**3,617**

- During July, a further c£0.9m was spent on pay costs, directly associated with COVID-19.
- Medical staff costs are consistent with June, the main drivers are enhanced shifts completed by Trainee Medics, agency and med bank to support shielding, sickness, and in the Medicine Division to support the respiratory rota and additional sessions from palliative care consultants.
- Nursing costs have increased in month, mainly in nurse bank shifts; given the activity numbers this is currently being reviewed. The year to date position does include expenditure relating to trainee nurses, uplift in nursing wte on Covid wards and additional nurses in ED.
- The increase in administration and clerical costs includes infrastructure staff to support Occupational Health and HR.

Table 10 below details non-pay costs

Table 10: YTD Covid revenue costs – Non-pay

Non Pay Analysis (Covid)	July Actual £'000	YTD Actual £'000
Supplies and services - clinical	(99)	(809)
Supplies and services - general	(28)	(117)
Drugs	(25)	(95)
Purchase of HealthCare - Non NHS Bodies	(6)	(58)
Other	(573)	(1,392)
Total	(731)	(2,471)
Depreciation	0	0
Total	(731)	(2,471)

Non pay costs associated with COVID-19 were c£0.7m in July, YTD the spend is c£2.5m. This includes:

- Equipment and consumable costs in relation to increasing ITU capacity, such as monitors and gas analysers and supporting the remote management of patients.

- Personal Protective Equipment (PPE) procured by the trust (in excess of the national push deliveries) the July position includes PPE for paediatric patients, which is not nationally procured
- 'Other' includes, lease cost of dialysis equipment, transport costs, and vehicle hire, social distancing signage and barriers, minor works, and hotel costs to accommodate staff.
- On-going rental costs for the Isolation Pod, currently used for swabbing

Appendix 2 details Covid related costs incurred by category for both pay and non-pay expenditure.

Detailed pay and non-pay spend

4.4.2 COVID-19 Capital costs

Claims totalling £0.9m in respect of medical and IT equipment purchased in Phase 1 of the Covid-19 response during April and May 2020 have been submitted to NHSI.
In addition, the Trust has approved Covid-19 capital bids totalling £0.1m 'at risk' pending confirmation of additional Phase 2/3 funding.

In response to phase 3 capacity issues, WUTH submitted a draft bid to C&M in early June 2020 totalling £22.6m. Following the release of further guidance from NHSI prioritising those requirements that relate to IPC, this bid was revised to £11.4m as set out in the month 3 finance report to the Board of Directors.

Capital funding discussions in relation to COVID-19 are still ongoing at a national level and it is increasingly unlikely that any further funding will be received for the capacity elements of this bid.

However, the Trust has recently been awarded £1.4m for Urgent and Emergency Care (UEC) and a further £1.4m for Critical Infrastructure Risk (CIR).

The 2020/21 Capital Programme is subject to a separate paper on the agenda.

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.

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, "additional" top-up funding of c£0.7m was estimated to be needed to deliver a "break-even" position. The actual requirement is slightly lower at £0.6m, mainly due to the net effect of the reduced "step up" in the elective programme, and non-patient related Covid costs increasing such as social distancing posters/signage/barriers and infrastructure support costs.

4.6 Funding regime post July 2020 to year end.

Further guidance was released to the NHS on 31st July in relation to the funding regime for the period from August 2020 to March 2021

In essence there are two finance related updates:

- The finance regime to 30th September (for mth 5 and mth 6) has now been confirmed and will be consistent with Mth 1-Mth 4, which in essence comprises of nationally-set block contracts between the Trust and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to support delivery of breakeven positions against reasonable expenditure.
- From 1st October 2020 (Month 7) to 31st March 2020 (Month 12), the funding regime will change. The intention is to move towards a revised financial framework, the simplified arrangements for payment and contracting will be retained but there will be a greater focus on system partnership and the restoration of elective services.
    - Systems will be issued with 'funding envelopes' which are the equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope.
    - There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines.
    - Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

It should also be noted that the 'block payments' will be adjusted depending on delivery against the activity restart goals aimed at accelerating the return of non-COVID-19 health services which include:

- Restoring full operation of all cancer services
- Recovering the maximum elective activity possible making full use of the capacity available.

The performance trajectories are:

4. Financial performance

- Delivering a minimum of 80% of 2019/20 activity for both inpatient electives and for outpatient/daycase procedures, rising to 90% in October 2020
- Achieving 90% of 2019/20 activity levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October 2020.
- Delivering 100% of 2019/20 activity for first outpatient attendances and follow-ups (face to face or virtually) from September 2020through to March 31 2021.

The Trust is working closely with the Divisional teams, Wirral system partners and the Cheshire & Mersey Health and Care Partnership (HCP) to understand the Trust position on this and the associated costs to deliver the additional activity and forecast the financial position to 31st March 2021.

All Cheshire and Merseyside organisations have been asked to submit activity/workforce and associated cost plans to 31st March 2021 to the C&M HCP, who will then triangulate the regional position prior to national submission on 21st September. Given the short timelines to submit this, the detail will be presented to the FPBAC at the next meeting.

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 31st July 2020 is set out in Appendix 2.

5.2 Capital programme 2020/21

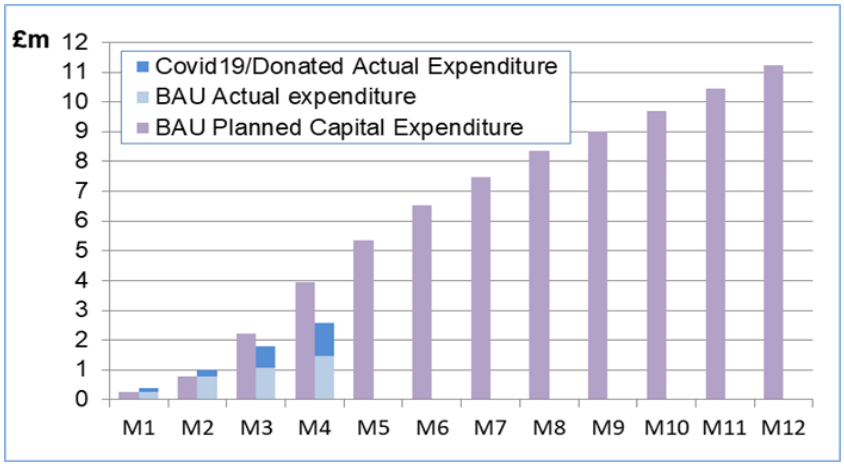
A revised business as usual capital plan of £11.24m has been agreed by the Board of Directors as part of the Cheshire & Merseyside capital envelope.

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 4 is set out in Appendix3. Actual YTD capital spend total is £2.6m which largely comprises COVID-19 capital requirements (£1.0m) and schemes brought forward from 2019/20 (£1.2m).

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 4 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%	-98.0	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.6	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
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-22.0%	1
	Overall NHSI UoR rating				**2**

6. Conclusion & Recommendations

At the end of July 2020 (Mth 4), the Trust is reporting a "break-even" position.

This position includes "*additional"* top up support of c£0.1m for July (c£0.6m cumulatively), this reflects the ***net*** impact of:

- the additional costs relating to COVID-19
- less reduced expenditure incurred due to lower levels of routine activity undertaken in relation to A&E, emergency and planned care, (this has progressively increased from earlier months)
- the impact of dividend payments following revised guidance from NHSI

During July 2020, a further £1.6m was spent in managing the pandemic response, increasing the year to date costs to c£6.1m. This includes additional staff, backfill costs for sickness, and those required to self-isolate. Non pay costs include equipment and consumables, decontamination, locally procured PPE, and social distancing signage and barrier costs. All expenditure identified as COVID-19 is subject to audit and review by NHSI.

The forecast cost position to 31st July 2020 submitted to NHSI estimated "additional" top-up funding of c£0.7m would be needed to deliver a "break-even" position. The actual requirement is slightly lower at £0.6m, mainly due to the reduced "step up" in the elective programme. This is however expected to ramp up over the coming weeks/months.

The finance regime to 30th September has now been confirmed and will be consistent with Mth 1-Mth 4, which in essence comprises of nationally-set block contracts between the Trust and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to support delivery of breakeven positions against reasonable expenditure.

Following the release of further guidance to the NHS on 31st July, from 1st October 2020 (Month 7) the funding regime will change. The intention is to move towards a revised financial framework, the simplified arrangements for payment and contracting will be retained but there will be a greater focus on system partnership and the restoration of elective services.

The Trust is working closely with the local Wirral System and regional colleagues with the HCP to ensure the Trust delivers against the activity trajectories required as well as securing sufficient capacity to manage winter levels of non-elective demand, future COVID-19 activity and restore the stepped improvement of the elective programme will be a priority.

The forecast position post October 2020 will be provided at the next meeting.

Recommendations

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

Claire Wilson
Chief Finance Officer
September 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 4 Budget Reconciliation	Breakdown by Budget Type		
	Income £'000	Expenditure £'000	Net £'000
Base Budget 20/21	132,588	(132,588)	0
Pharmacy PCN Scheme / GPCP Scheme	0	0	0
Pharmacy HEE training budget allocation	0	0	0
Other minor budget changes	36	(36)	0
M4 Closing Budget	132,624	(132,624)	0
Net Trustwide (Increase)/Reduction	**36**	**(36)**	**0**

7. Appendices

Appendix 2

Statement of Financial Position

Actual as at 31.03.20 £'000		Actual as at 30.06.20 £'000	Actual as at 31.07.20 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	161,011	160,999	(12)	⇩
14,029	Intangibles	13,717	13,612	(105)	⇩
723	Trade and other non-current receivables	696	669	(27)	⇩
176,244		**175,424**	**175,280**	**(144)**	⇩
	Current assets				
3,991	Inventories	4,215	3,849	(366)	⇩
24,375	Trade and other receivables	14,420	15,216	796	⇧
0	Assets held for sale	0	0	0	⇨
5,931	Cash and cash equivalents	41,089	39,969	(1,120)	⇩
34,297		**59,724**	**59,034**	**(690)**	⇩
210,541	**Total assets**	**235,148**	**234,314**	**(834)**	⇩
	Current liabilities				
(41,874)	Trade and other payables	(37,885)	(36,615)	1,270	⇧
(3,000)	Other liabilities	(32,055)	(32,253)	(198)	⇩
(85,234)	Borrowings	(85,292)	(85,292)	0	⇨
(2,926)	Provisions	(2,552)	(2,491)	61	⇧
(133,034)		**(157,784)**	**(156,651)**	**1,133**	⇧
(98,737)	**Net current assets/(liabilities)**	**(98,060)**	**(97,617)**	**443**	⇧
77,507	**Total assets less current liabilities**	**77,364**	**77,663**	**299**	⇧
	Non-current liabilities				
(2,588)	Other liabilities	(2,561)	(2,552)	9	⇧
(6,274)	Borrowings	(6,258)	(6,252)	6	⇧
(7,304)	Provisions	(7,263)	(7,234)	29	⇧
(16,166)		**(16,082)**	**(16,038)**	**44**	⇧
61,341	**Total assets employed**	**61,282**	**61,625**	**343**	⇧
	Financed by Taxpayers' equity				
80,106	Public dividend capital	80,106	80,384	278	⇧
(65,492)	Income and expenditure reserve	(65,551)	(65,486)	65	⇧
46,727	Revaluation reserve	46,727	46,727	0	⇨
61,341	**Total taxpayers' equity**	**61,282**	**61,625**	**343**	⇧

- Year to date capital additions total £2.6m 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 September 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	**41,089**	**5,931**
Operating activities		
Surplus / (deficit)	66	6
Net interest accrued	0	66
PDC dividend expense	309	1,236
Unwinding of discount	(1)	(5)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	374	1,303
Depreciation and amortisation	892	3,494
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(88)	(96)
Changes in working capital	(1,967)	32,887
Investing activities		
Interest received	0	5
Purchase of non-current (capital) assets [1]	(693)	(3,907)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	88	96
Financing activities		
Public dividend capital received	279	279
Net loan funding	0	0
Interest paid	0	1
PDC dividend paid	0	0
Finance lease rental payments	(6)	(24)
Total net cash inflow / (outflow)	**(1,120)**	**34,038**
Closing cash	**39,969**	**39,969**

[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							
Total Internally Generated Funding	10,740		10,740	10,740	0	4,817	
PDC (Public Dividend Capital) - UTC	500		500	500	0	0	
PDC - COVID-19	0	925	925	925	0	279	
PDC - Critical Infrastructure Repair	0	1,434	1,434	1,434	0	0	
PDC - Urgent & Emergency Care	0	1,441	1,441	1,441	0	0	
External Funding - donations/grants	0	96	96	96	0	0	
Total funding	**11,240**	**3,896**	**15,136**	**15,136**	**0**	**5,096**	
Expenditure							
Prior year(s) capital commitments	3,526	18	3,544	3,561	(17)	1,259	2,302
Estates	4,383	(34)	4,349	4,383	(34)	0	4,383
Informatics	575		575	575	0	21	554
Medicine and Acute	300		300	300	0	0	300
Clinical Support and Diagnostics	369	22	391	392	(1)	23	369
Surgery	1,363	14	1,377	1,375	2	135	1,240
Women and Children's	0		0	0	0	0	0
Other	0		0	0	0	0	0
Contingency [2]	224	(20)	204	0	204	0	0
UTC / Hospital upgrade programme	500		500	500	0	35	465
COVID-19 response	0	925	925	1,079	(154)	1,015	64
Critical Infrastructure Repair	0	1,434	1,434	1,434	0	0	1,434
Urgent & Emergency Care	0	1,441	1,441	1,441	0	0	1,441
Donated assets	0	96	96	96	0	96	0
Total expenditure (accruals basis)	**11,240**	**3,896**	**15,136**	**15,136**	**0**	**2,584**	**12,552**
Capital programme funding less expenditure	**0**	**0**	**0**	**0**	**0**	**2,512**	
Capital expenditure	11,240	3,896	15,136	15,136		2,584	
NBV asset disposals	0		0	0		0	
Donated assets	0	(96)	(96)	(96)		(96)	
CDEL impact	**11,240**	**3,800**	**15,040**	**15,040**		**2,488**	

[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.

Capital funding

- Capital expenditure is forecast to be comfortably within external funding and internally generated limits for the year.
- Internally generated funding includes brought forward cash.
- During July the Trust has been awarded £1.4m PDC support for Critical Infrastructure Repairs
- A further £1.4m PDC support has also been made available for Urgent & Emergency Care capital works to improve patient flow through A&E in support of winter pressures
- The additional PDC support must be spent in year with the A&E support required to be spent by the end of December.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors

CQC Action Plan -2020

Board of Directors	
Agenda Item	20/21 118
Title of Report	CQC Action Plan 2020 – Quarterly update
Date of Meeting	2 September 2020
Author	Jacqueline Robinson, Associate Director 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**	PR4 Catastrophic failure in standards of safety and care PR6 Fundamental loss of stakeholder confidence
Level of Assurance • **Positive** • **Gap(s)**	The action plan provides assurance that actions have been identified to ensure gaps identified through CQC inspection are being adequately addressed.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

Following the publication of the CQC inspection report on 31 March 20, the Trust has made significant progress in both the response to requirements and recommendations made. Action plans were developed to address the 31 must do's and 76 should do's and 351 actions to support achievement of full compliance and continued improvement identified. The 'should do 'action plan was populated and agreed by the Executives and submitted to the CQC on 30th June.

Scrutiny of progression of the CQC Action Plan has commenced. Confirm and challenge meetings now include progress on the must and should do actions and Divisions have fully engaged.

This paper provides the Board with a quarterly update as to progress against the CQC action plan and highlights:-

- any overdue actions;
- actions at risk

176 actions have been completed, evidence has been provided against 25 actions. There are currently:-

- 2 'must do' actions overdue;
- 3 'must do' actions at risk
- 1 'should do' action at risk.

However progress has been made against all of these actions, and where barriers have been identified these are being addressed.

Patient flow currently is the area which is most at risk. Additionally it should be noted that whilst some Patient flow actions are recorded as completed, and therefore not highlighted in tables, as activity increases these may be at risk**.** Further assurances that they are embedded and effective will be undertaken as hospital activity increases. The Programme Board provides oversight and assurance of the patient flow actions and the Divisional Triumvirates feed updates into the Confirm and Challenge process, however we are currently strengthening Programme Board oversight of progress against CQC actions linked to patient flow.

Next steps are to ensure all actions confirmed as completed have evidence of completion and to undertake assurance activities to confirm that the actions have been embedded and identify mechanisms to confirm that the requirement is now met or the desired improvement made. The Executive team are currently reviewing the Use of Resources report to ensure actions to address are incorporated into the CQC action plan and governance arrangements.

2. Background

a. The CQC inspected the Trust during October and November 2019 and the final report was published on 31 March 2020.

b. The CQC inspection report highlighted 31 'must do's' and 76 'should do' recommendations

c. Divisions; Corporate and Executive teams reviewed the CQC findings and developed action plans to address each must and should do.

   a. The quality improvement action plan (for Must do's) has 122 specific actions/work-plans for implementation on or before 31st March 2021.

   b. The quality improvement action plan (for Should do's) has 229 specific actions/work-plans for implementation on or before 30th April 2021

d. Following review and approval by the Executive team, the 'must do' action plan was submitted to the CQC on 12th May 2020 and the 'should do' action plan was submitted on the 30th June 2020.

e. The CQC Action Plan provides the means of improving control over the risks highlighted following the CQC inspection and, alongside the Trust pre-existing organisational control framework, reduces the risk that ;

   a. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care.

   b. The Trust fails to comply with CQC Registration Regulations and has its certification of registration revoked.

3. Key Issues/Gaps in Assurance

3.1 Delivering improvements

The CQC inspection report was utilised to support the Trusts consideration of which areas we need to improve. In developing the action plan the following areas of consideration were included:-

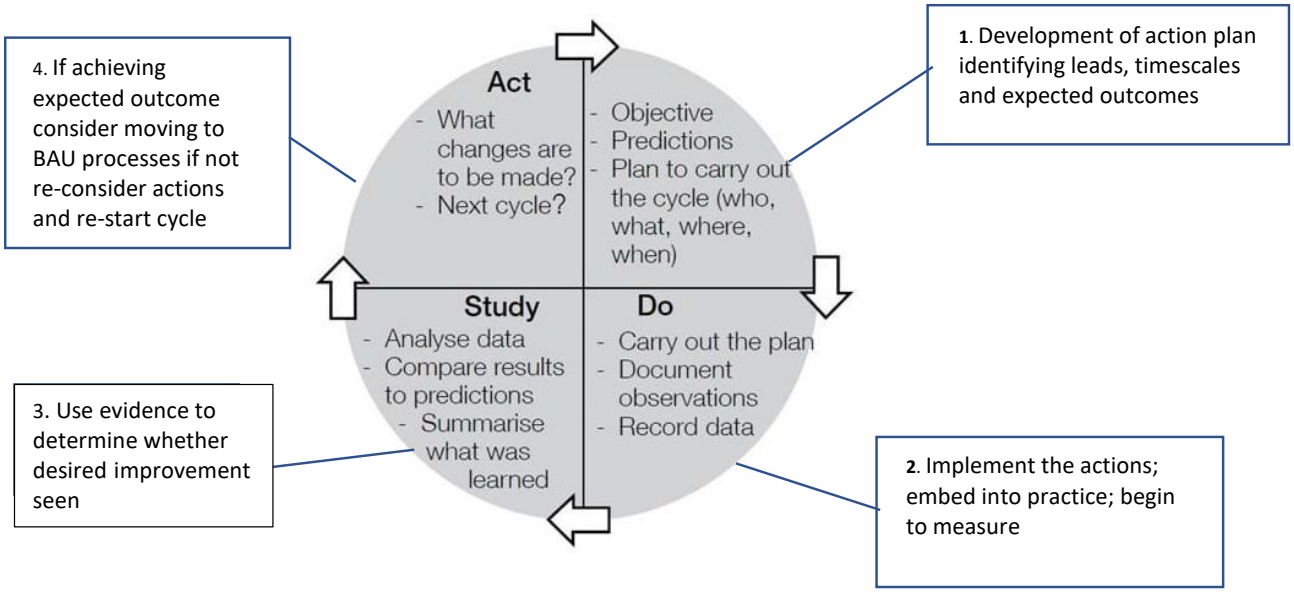
- What was the outcome we hoped to achieve (referencing the CQC must/should do's; regulatory requirements; clinical expertise) i.e. how can we improve safety and quality for our patients
- What changes (actions) will lead to the improvement
- How will we monitor the actions are being implemented
- What resources will we require to make the change

It is recognised that the completion of the identified actions is only one stage in the process of ensuring that that the desired outcome has been achieved and sustained.

3.2 Confirm and Challenge process

Confirm and challenge meetings were established in June 2020 to oversee implementation of the actions identified and ensure mechanisms are in place to provide robust assurances that the actions are embedded and deliver the improvements expected.

The process has been established around a PDSA cycle methodology



Confirm and challenge meetings are held with each Division on a monthly basis and are attended by:-

- Members of the Governance Support Unit
- Divisional Triumvirate
- Deputy Chief Nurse
- Deputy Medical Director
- Operational leads identified in the CQC action plan

Divisions provide evidence against each of their actions appropriate to the stage in the cycle for that particular action.

Members of the 'Confirm and Challenge' meetings will RAG rate each action as follows:-

Embedded	The action has been completed and reviewed; it is embedded and there is evidence that the desired outcome has been consistently met and has been tested.
Completed & Assured	The action is completed and assurance has been given by way of evidence

Completed	Verbal assurances that action has been completed
On track	Action is on track with target date
At risk	Action is at risk of not meeting its target date
Overdue	Action is overdue

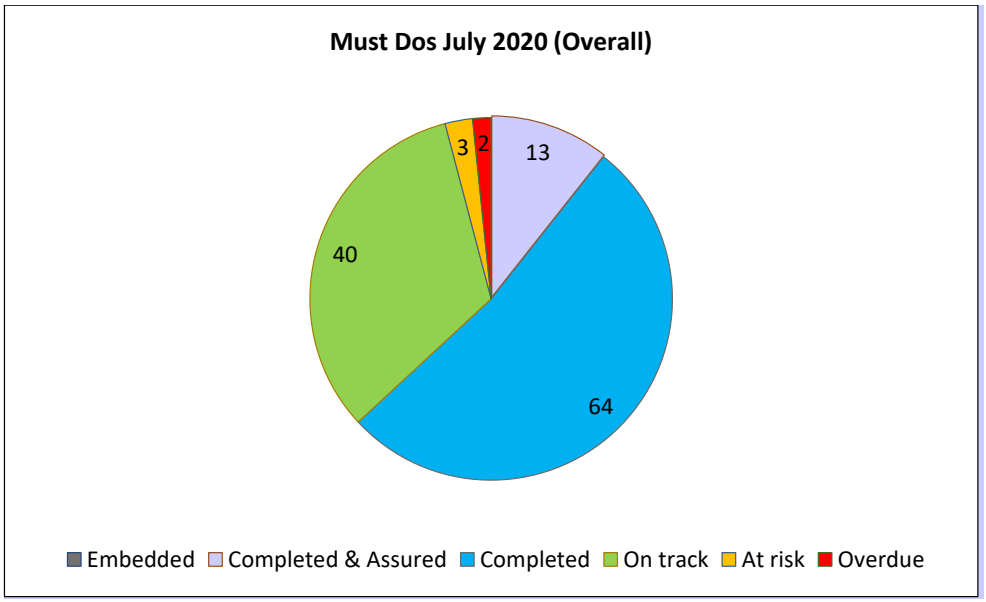
The dashboard and update report is presented to PSQB on a monthly basis, highlighting:-

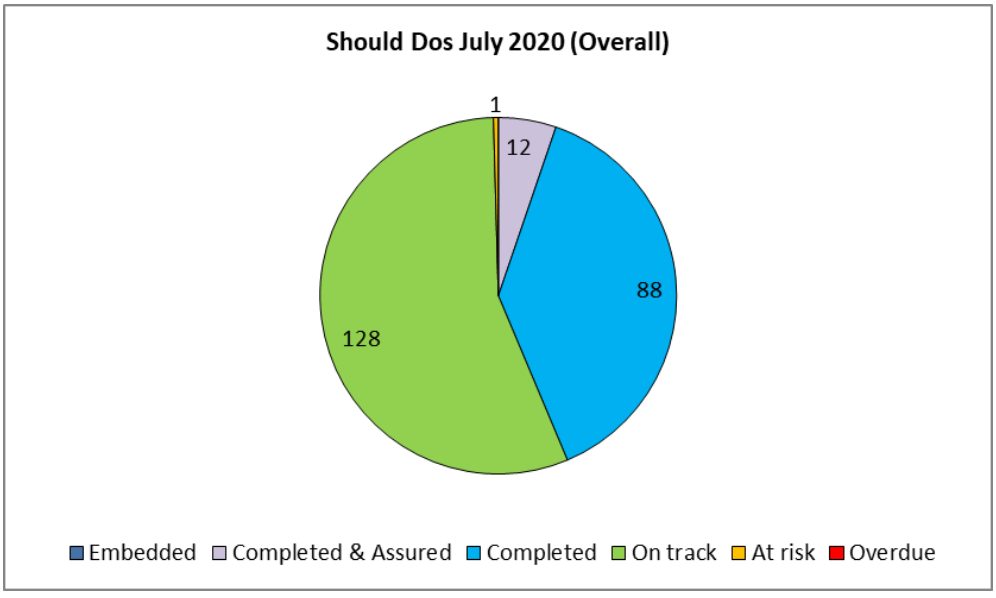
- any overdue actions;
- actions at risk;
- requests for extensions or changes to the actions.

This is supported by a quarterly report presented to PSQB which provides greater detail of the assurances of completion; implementation; the action has been embedded; improvement has been achieved; and the improvement is being sustained.

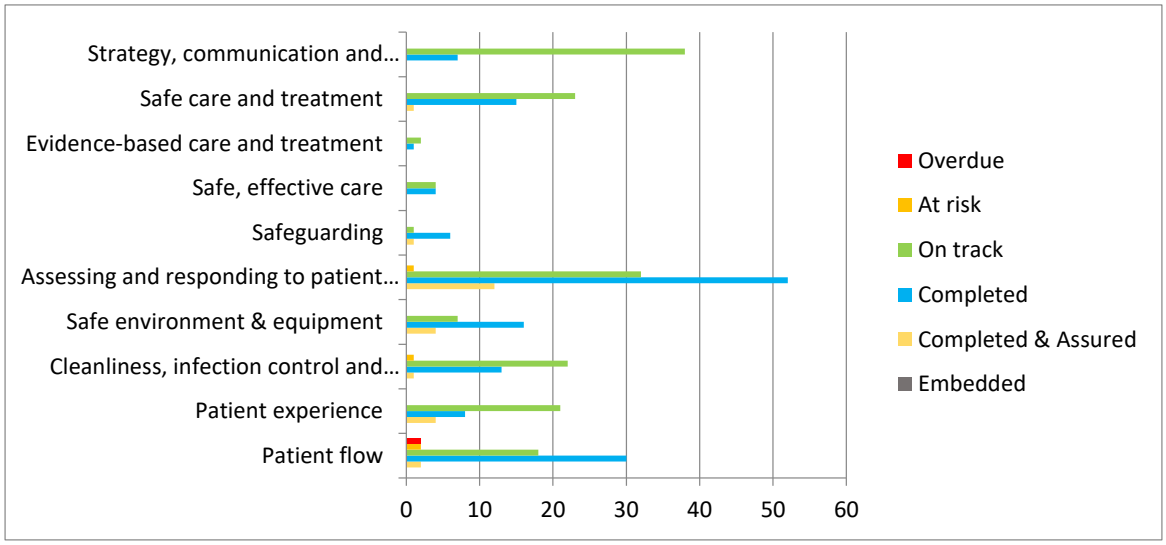
3.3 Current position

The graphs below summarises the current position of the CQC action plan as of 19/08/2020.





Actions have been grouped into key themes as well as CQC domains. Themes are subjectively identified and the crossover between themes is challenging e.g. to separate risk, patient safety and effective care:



Guidance around CQC domains exists so actions can be accurately aligned. These will start to form the basis of the assurance framework for a self-assessment on CQC standards.

Actions overdue

	Date due	Action taken to meet regulation	Related Regulation	Update	Key Theme
Must Do	31/07/20	Divisional Triumvirate to work with IT to make Estimated Discharge Date (EDD) a mandatory field within Cerner Millennium.	The service must implement clear plans, with set timescales and actions, to improve patient's access to care and to achieve their timely discharge from hospital. (Regulation 17)	The division has sought ways to incorporate EDD consistently into Patient records. It is part of ward round prompts to medical staff, handover documentation. Improvements have been seen but compliance recording of the non-mandatory field is underway to confirm – Expected date October. The IT build is for **mandatory / conditional** formatting, prioritisation and timescale from IT but the project is likely to take longer than initially anticipated. Timeframe will be confirmed for	Patient flow
Must Do	31/07/20	AMD to ensure that all Consultants agree and document EDD during ward rounds.			Patient flow

				the next confirm and challenge meeting. The Division is linking with the Wirral Discharge lead to see if an exemplar ward for modelling discharge processes can occur- Position to be confirmed end of September	

The following actions have been identified as at risk

	Date due	Action taken to meet regulation	Related Regulation	Update	Key Theme
Must Do	31/10/20	Trial and evaluation of implementation of ED senior clinician decision rights.	The service must reduce delays in decision to admit times (Regulation 12)	Triumvirate felt that the inter-Professional IP standards were a more appropriate measure to reduce delays in decision to admit –review of action and evidence as to how this meets requirement to be provided - October.	Patient flow
Must Do	31/08/20	Explore viability of bringing key diagnostic tests in-house e.g. **Capsule Endoscopy /** Cardiac MRI. Alongside developing mitigations if not viable	The service must ensure patients have timely access to care and treatment.(Regulation 17)	Cardiac MRI has been explored and not viable. Gastroenterology service is currently limited by capacity – exploring other actions to ensure improvement made – End of September	Patient flow
Must Do	30/09/20	Explore the option of a revised electronic handover	The service must ensure that staff share key information, in line with trust policy, when handing over the care of patients who are medical outliers or moved into escalation areas	The SBAR handover template has been reviewed and its use reinforced to mitigate risk whilst electronic project being completed The request for an electronic template has been initiated, and prioritisation is awaited form IT. The completion of the project is likely to be longer than the period initially thought. Timeframe will be confirmed for the next confirm and challenge meetings.	Assessing and responding to patient risk & safety
Should Do	31/08/20	Finalise plan for potential expansion of the NNU, aligned to the Divisional Strategy and identify Exec lead.	The service should ensure that routine equipment checks are undertaken consistently, the safe storage of supplies within the neonatal area	Initial drawing and plans have been developed, however Tiny Stars appeal which was funding this work has been halted due to COVID-19. The Division is currently reviewing requirements to align with regional approach – timeline	Safe environment & equipment

			and the service continues to work towards meeting the national guidance on minimum cot space.	to be confirmed	

4. Next Steps

- Ensure that there is evidence of completion against all completed actions – 31 September 2020
- Identify actions confirmed as completed May to August and test to confirm that the actions have now been fully embedded – 31 September 2020
- Establish measures to confirm that required improvements are being delivered and include in next quarterly update to Board – December 2020.
- Confirm timeframe for IT build projects.
- Concerns raised within the CQC Use of Resources Report are identified within the Risk Register. A review is being undertaken with Executives to ensure that actions are mapped into the CQC action plan and monitored accordingly – End of September.

5. Conclusion

Following the publication of the CQC inspection report on 31 March 20, the Trust has made significant progress in both the response to requirements and recommendations made. Action plans were developed to address the 31 must do's and 76 should do's and 351 actions to support achievement of full compliance and continued improvement identified.

The assurance framework has been established with all Divisions fully engaged with 'confirm and challenge' meetings. Confirmation has been received from Divisions that 176 actions are complete and evidence of completion is being collected.25 actions have been confirmed as completed and assured.

The impact of the COVID-19 response has had some impact on timescales for completion of actions however the majority are progressing with only 2 currently 'off target'. It is anticipated that COVID-19 has also impacted the speed at which actions could be embedded due to changes in processes during the pandemic.

6. Recommendations

Board is asked to confirm that they are assured regarding progress and are aware of the risks identified.

Board of Directors	
Agenda Item	20/21 119
Title of Report	Overview of Neonatal and Maternity Services (including CNST compliance update) at Wirral Women and Children's Hospital.
Date of Meeting	2 September 2020
Author	Debbie Edwards, Divisional Director of Nursing and Midwifery & Annemarie Lawrence, Quality & Safety Specialist, Women and Children's Division. Hazel Richards, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
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**	PR4 Catastrophic failure in standards of safety and care PR6 Fundamental loss of stakeholder confidence
Level of Assurance Gaps	Significant assurance in most areas of reporting. Recognition of areas requiring further review and improvement. 3 CNST MIS standards are reported as amber rated "on track to achieve".
Purpose of the Paper **Discussion** **Approval** **To Note**	This paper provides further information following the Maternity Services presentation to the Wirral University Teaching Hospital NHS FT Board in August 2020.
Reviewed by Assurance Committee	Has not been reviewed by an assurance committee in its entirety; however the CNST and SI elements have been presented to PSQB and Quality Committee.
Data Quality Rating	Silver
FOI status	Document may be disclosed **in part**.
Equality Impact Assessment Undertaken Yes / No	N/A

1. Executive Summary

Following the publication in 2016 of 'Better Births' (the National Maternity Services Review) maternity services in England have undergone significant transformation. Each STP footprint was required to establish a Local Maternity System (LMS). This afforded the Trust the opportunity to improve and positively transform maternity services. This paper describes the journey of improvement since 2015 that maternity services at WUTH have

undergone, when historical cultural difficulties and a lack of effective leadership within the service resulted in a critical external cultural review of the service.

Following improvements to address the underlying cultural issues and with support from the Executive Team the maternity services progressed from a CQC rating of Requires Improvement to a rating of Good, with work ongoing to realize an Outstanding Rating at the next CQC visit.

The maternity service has improved its overall performance with the implementation of the recommendations within 'Better Births'. Comparison of some key performance indicators with other providers across the North West Coast Strategic Clinical Network is also positive.

This paper provides an overview of maternity and neonatal services and supplements the presentation to the Board of Directors in August 2020. The narrative describes the journey of improvement over the last 5 years whilst acknowledging the challenge of the service achieving full compliance with the Local Maternity System (LMS) deliverables.

2. Background

WUTH provides acute and community Maternity, Neonatal and Children's services to women and their families with a birth rate of approximately 3,200 per year. The W&C Division is committed to providing the highest quality care possible in order to improve outcomes, to reduce inequalities and avoid unwarranted variations in care. We continue to work closely with the Cheshire and Merseyside LMS, North West Coast Strategic Clinical Network and the Cheshire and Merseyside Women's and Children's Partnership and are currently still the only provider in Cheshire & Merseyside providing all 4 place of birth options to pregnant women (obstetric unit, alongside midwifery led unit, free standing midwifery led unit and home birth).

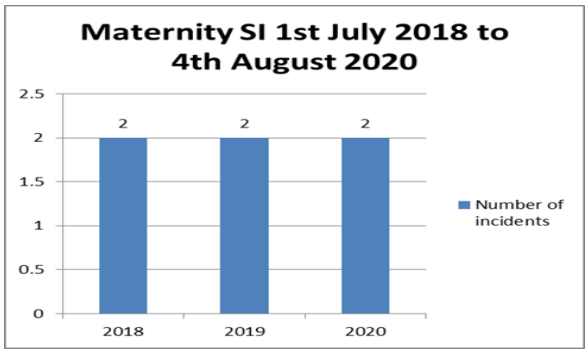
From September 2014 until June 2017 Women & Children's services were part of the Surgical, Women's and Children's (SWAC) Division however, an executive decision to separate W&C Services to a Division in its own right resulted in a clear and enhanced focus on Women's and Children's services, in particular maternity and neonatal services. As a Division we strive to enable our teams to train together to become a high performing team and support the delivery of care that is women and child centered. The values based culture encouraged within the Division promotes innovation, continuous learning and success.

3. National interest – Maternity services.

Over the last 6 years maternity service providers in England have come under scrutiny and criticism where some providers have failed to address areas of poor practice, learnt lessons from incidents nor undertaken appropriate and thorough investigation of serious incidents. Such providers include Morecambe Bay, Guernsey, North Devon, East Kent and more recently Shrewsbury and Telford where mothers and babies have suffered through a lack of appropriate care.

Influencing themes identified from all of these reviews have included: suboptimal leadership, significant cultural issues such as bullying, inadequate staffing, poor governance and a lack of accountability. Negative press is likely to continue into 2021 regarding maternity services, as a review is being undertaken to examine the commissioning and management of One to One Midwives Ltd - an Independent Midwifery Provider based in Wirral who ceased to trade in July 2019.
The need for an open, honest and transparent approach to investigating incidents when things go wrong cannot be under estimated. Effective communication with parents is key to ensuring lessons learnt are shared and embedded so that other families do not experience poor care.

4. Thematic review of all maternity SI's since 2018



A thematic review has been undertaken in 2020 of the SI's involving CTG interpretation. The findings from the review identified no themes and additional assurance was provided on staffing, incident location, communication, root causes and action plans. Both incidents in 2018 were attributable to the One to One Midwifery Ltd and were therefore discounted from the review.

As additional assurance, a request was made to the Strategic Clinical Network for an overview of other provider's maternity STEiS reportable incidents since 2018 and these can be evidenced as follows:

Maternity STEiS Reports by Reporting Organisation	**2018**	**2019**	**2020**
Trust 1	2	3	3
Trust 2		1	
Trust 3		5	2
Trust 4	10	11	10
Trust 5	2	2	1
Trust 6		6	2
Trust 7		1	
Trust 8		1	1
CCG 1	1		
CCG 2			1
CCG 3	1		
Trust 9	3		
Trust 10		1	
Provider 1		2	
Trust 11		5	3
Trust 12		2	2
Trust 13	2	1	3
Trust 14		1	
Wirral University Teaching Hospital NHS Foundation Trust	2	2	2
Grand Total	**21**	**44**	**32**

5. Cheshire & Merseyside Regional Performance

WUTH provide monthly data that informs the regional dashboard from which providers are benchmarked against the national average.

All stillbirths – WUTH is sitting above the North West Coast mean with a 5.59% however this rate includes women who did not have their antenatal care with WUTH, for example one out of area woman who experienced a stillbirth was visiting the area on holiday.

However every stillbirth is reviewed externally using the Perinatal Mortality Review Tool (PMRT) with input from a clinical expert/s from another provider within C&M. This process is open and transparent with any identified lessons learnt shared across the region in the North West Coast Strategic Clinical Network Safety SIG.

Year	No. of stillbirths	No. out of area	No. >37 weeks
2019	15	5	3
2020 (to date)	6	2	0

3rd/4th degree tears – WUTH has the lowest rate of 3rd/4th degree tears in the region which can be attributed to the introduction of the Obstetric Anal Sphincter Injury (OASI) care bundle, a quality improvement project introduced to reduce the rates of perineal tears through use of an evidence-based care bundle.

Babies born by Caesarean Section – WUTH is below the NWC average sitting just above the lower control limit. The rate of caesarean section is consistent and reflects the support provided with vaginal birth after caesarean section (VBAC) and the promotion of normality.

6. Neonatal Services

The Divisional Triumvirate oversees the management of the Neonatal unit which works alongside the maternity service.

C&M Neonatal partnership – discussions are currently ongoing for the development of a partnership for neonatal services with the other two level 3 providers within Cheshire & Merseyside, these are Liverpool Womens Hospital FT & Alder Hey Childrens Hospital FT. This partnership will facilitate pooling of workforce resources to ensure that the neonatal and surgical care needs of all babies are met; maximise the benefits for patient care by better facilitating and encouraging standardised care pathways where appropriate; in effect work as one entity to provide care for neonatal babies and support clinical and financial sustainability.

GIRFT Reviews – discussion will commence in the coming weeks across the North West Neonatal ODN with a review to resetting the programme of reviews.

Network Activity, Capacity & Demand: The North West Neonatal Operational Delivery Network (NODN) captures relevant data in the Neonatal Activity, Capacity & Demand Report (ACD), which is then shared with all service providers on a quarterly basis and subsequently in an annual report.

Overall trends continue to demonstrate an ongoing reduction in the requirement for NICU, HDU & SCBU cots. The annual NODN activity report 2019 / 20 identified that overall there is a surplus of cots in the region which can be broken down into a surplus of 38 cots in total: 6 IC, 15 HD, 17 SC (current cot base = 156).

The Cheshire & Merseyside rates of demand and occupancy are lower than the other two networks – (Lancashire & South Cumbria and Greater Manchester).

Within Cheshire & Merseyside the report evidences that postnatal transfers out of the Network is high (16 babies) but this is decreasing compared to previous years. Transfers out are either Level 2 or 3 babies and include those babies who are from out of area returning to a local hospital eg North Wales babies. There is flexibility with the use of cots within the unit as level 2 babies are sometimes transferred out to a suitable unit providing Level 2 care. This creates capacity for level 3 care when required as this level of care is only available at WUTH and Liverpool Women's Hospital. There are fewer postnatal transfers into C&M from non-NWODN units (15%) and there has been a reduction in North Wales activity (36 fewer babies over 3years = 35%).

WUTH NNU ACD: Overall trends reflect the national picture with a year on year reduction in activity for all dependencies. In-line with the recommendations included as part of the Neonatal Critical Care Transformation Review (2019) all NICUs should, as a minimum, look after at least 100 very low birth weight (VLBW) infants per year and be delivering >2000 intensive care days (Health Resource Group definition, 2016). This further underlines the necessity for this developing partnership.

Despite a reduction in critical care delivery for May 2020, WUTH has seen an increase in neo-natal unit closures (this is when the unit has to close to new admissions), this quarter in comparison to last year. First impressions suggest that these closures could be Covid19 related however further review is required to look for any emerging themes.

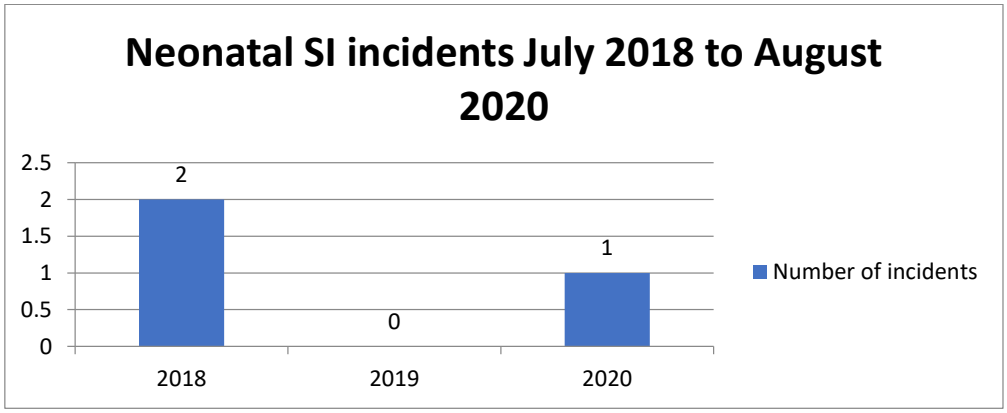
NWNODN Unit closure –

Provider	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	April 20	May 20	June 20	Total Q1
Arrowe Park, Wirral	2	4	2	2	3	3		
Trust 3	1	2	5	0	0	0		
Trust 4	1	6	11	4	9	2		
Trust 6	1	12	13	5	1	0		
Trust 8	13	2	1	6	n/a	n/a		
Trust 11	6	4	21	9	0	0		
Trust 14	0	1	0	0	3	0		
Trust 12	9	2	16	13	1	4		
Cheshire & Merseyside	**33**	**33**	**69**	**39**	**17**	**9**		
Trust 1	15	0	3	7	1	0		
Trust 2	1	0	9	0	0	0		
Trust 3	10	6	16	9	0	0		
Trust 4	1	0	4	0	0	0		
Trust 5	18	13	18	3	2	0		
Trust 6	0	0	4	2	1	0		
Trust 7	0	2	4	0	0	0		
Trust 8	0	6	1	0	0	0		
Greater Manchester	**45**	**27**	**59**	**21**	**4**	**0**		

Trust 1	21	8	5	2	0	0		
Trust 2	12	1	17	2	3	14		
Trust 3	0	0	0	3	0	0		
Trust 4	1	0	4	17	0	0		
Trust 5	0	0	1	0	1	11		
Lancashire & South Cumbria	**34**	**9**	**27**	**24**	**4**	**25**		

Mortality Reviews / clinical incident reviews - All deaths are reviewed using the perinatal mortality review tool (PMRT) in order to standardise the review process across the country. Review panels include external Obstetricians, Neonatologists and Midwives to ensure openness and transparency. A mortality review is also completed and sent to the network for regional sharing of lessons learnt and cases are presented at the Maternity Safety Special Interest group (SIG) and Stillbirth SIG.
All incidents are reviewed weekly at a very well attended MDT comprising of junior doctors, consultants, ANNP's and nursing staff; lessons learnt are disseminated quickly via staff huddles, lessons of the week and stand up solutions (SUS) which is an ideal opportunity for staff to raise an issue but also provide a solution to the problem.

Serious Incidents
There have been 3 serious incidents reported for neonates since 2018, all are investigated in line with our Trust policy and reported through Quality Committee.



5. Next Steps

Continuing with the monthly submission of data to the Regional Maternity Dashboard is important with clear guidance on how this is collated and validated. Given the many regional meetings it is important to ensure consistent representation at the LMS, Strategic Clinical Network, Neonatal ODN and all Special Interest Group meetings across C&M.

Work is continuing to meet compliance with all 10 Standards within CNST Maternity Incentive Scheme which provides each Trust the assurance that safe high quality services are being offered and delivered.

Clinical Negligence Scheme - CNST

Safety is one if not the most important aspect of the delivery of maternity care as obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme's (CNST) biggest area of spend. Now in its third year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts contributions to the CNST. The MIS rewards trusts that meet all ten safety standards designed to improve the delivery of best practice in both Maternity and Neonatal care.

In 2019/20, through the MIS the Trust was compliant with all 10 maternity safety standards and benefited from a reduction of over £500k to the Trusts CNST premium. This demonstrates commitment to the provision of a high quality service and supports the driving down of the Trusts maternity reference costs as we seek to be a financially sustainable organisation.

Board of Directors will sign off the submission to NHSR which was originally due in early September 2020 however at the outset of the Covid19 pandemic the 2020/21 MIS was paused, with submission deferred until 2021. Despite the challenges posed from COVID, work has continued to meet compliance with all ten safety actions.

The ten Safety Actions of the Maternity Incentive Scheme with RAG rated compliance are outlined below:

Safety Action	Update on progress to date	RAG Rating
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	All perinatal mortality cases are reviewed to the required standard using the National Perinatal Mortality Tool (PMRT). 100% of all eligible cases have been completed to date with external clinical representation from across Cheshire & Merseyside engaging and supporting the review process. A quarterly mortality report is submitted to PSQB detailing the outcome of each case.	Compliant
Safety action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?	NHS Digital submits a monthly scorecard that confirms compliance with the submission of MSDS data. WUTH is one of few Trusts nationally to submit data for 11 out of the 11 MSDS required standards to date. WUTH has a plan to ensure its full compliance with the NHS Digital standards by November 2020.	On track to achieve
Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?	The Transitional Care (TC) service is based on Ward 53 – Maternity ward. There is an agreed policy including a clinical pathway that supports the clinical delivery of the service. The Avoiding Term Admissions into Neonatal units (ATAIN) action plan was developed and completed.	Compliant
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Medical workforce has been reviewed with the proportion of Obstetrics & Gynaecology trainees in WUTH responding positively to the protection of post educational/training opportunities. The Neonatal workforce has been reviewed regionally within Cheshire and Merseyside by the Neonatal ODN Lead. Current neonatal staffing is determined by demand and capacity of the Neonatal unit.	Compliant
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A midwifery workforce review is being undertaken in December 2020 by Birthrate+ which specifically looks at acuity and demand within the Maternity service to determine safe staffing levels. The ratio of midwives to births is monitored monthly on the maternity dashboard and is within the agreed ratio recognised nationally. The Division will be compliant in December 2020 following Birthrate+.	On track to achieve
Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle v2?	An improvement plan was developed inclusive of all 5 elements of the Saving Babies Lives care bundle v2. A previous paper was presented to PSQB detailing compliance with this	Compliant

	standard in May 2020. A recent survey across the North West Coast SCN identified WUTH as the only provider currently compliant with all elements of the SBL Care Bundle version 2.	
Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to co-produce local maternity services?	The Divisional Director of Nursing & Midwifery meets monthly with the MVP Chair to discuss service user feedback. Service users are involved in service developments – eg development of an Induction of Labour Suite, development of a Surrogacy policy.	Compliant
Safety action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	A requirement of compliance with this standard was submission of a paper to PSQB / Board with evidence of compliance in July 2020. However, the deadline for this has moved with confirmation of the same awaited from NHSR. However, the following update outlines that to date the Trust is **non-**compliant with this standard at 59%. Work is ongoing to meet compliance before the end of December 2020. Action: To monitor monthly compliance with mandatory training at the W&C Divisional DMB with escalation of any concerns. Further support from the Surgical Division has been requested to improve compliance rate of theatre staff attending the required training.	On track to achieve with support from surgery
Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The membership of Safety Champions has been reviewed with a relaunch of the purpose/reporting mechanism – it is envisaged that the CCG are included in this meeting. Dates for the Trust Safety Champion meetings were put on hold during Covid19 but have since been reintroduced with an updated membership including a Neonatal representative. The Division is compliant with this safety action.	Compliant
Safety action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme(ENS)	The Divisional Clinical Governance Lead works closely with the legal team to ensure all qualifying incidents are reported. However, in April 2020 this process changed and cases are reported to the ENS via the Health and Safety Investigation Board (HSIB) to which the W&C Division report all cases meeting the HSIB criteria. The Division is compliant with this action.	Compliant

6. Conclusion

The cultural review undertaken in 2015/16 and the publication of Better Births has promoted and supported significant improvements in the delivery of safe, high quality maternity and neo natal services at the Trust. Progress with the CNST MIS demonstrates continuous improvement. Further work is needed through the Cheshire & Merseyside Partnership to further improve maternity and neonatal outcomes for women and babies through collaboration. There is a commitment to a transparent and learning culture as we strive towards achieving Outstanding from the CQC and pride and recognition with our staff and patients.

7. Recommendations

The Board of Directors is asked to:

- note the content of the paper
- to acknowledge compliance to date with CNST
- to continue its support of the delivery of Neonatal Services by working in collaboration with the Cheshire & Merseyside Partnership.

Board of Directors	
Agenda Item	20/21 120
Title of Report	Review of Progress against Undertakings
Date of Meeting	2 September 2020
Author(s)	Paul Buckingham, Interim Director of Corporate Affairs
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1, PR3, PR6
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.**	No

1. Purpose of the Report

The purpose of the report is to advise the Board of Directors of progress against the 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 dated 24 July 2020 continue to relate to financial sustainability and sustainable performance against the A&E four hour target.

The Board of Directors formally endorsed the revised undertakings during a meeting held on 5 August 2020 and agreed to review progress against the undertakings on a two monthly cycle commencing in September 2020. Progress against each of the relevant undertakings is detailed in subsequent sections of this report.

3. Financial Sustainability (inc Financial Recovery Plan)

The Trust is operating in an emergency finance regime for 2020/21 which was introduced to support the national response to the COVID-19 pandemic. The Trust has reported a break-even financial position for the first 4 months of 2020/21 which is in line with expectations given the temporary funding mechanisms in place.

While the financial envelopes and detail behind the financial framework for the period from 1 October 2020 is yet to be confirmed, the Trust will be working towards delivery of a break-even position for the remainder of the year, assuming appropriate levels of funding are made available. However, this will be heavily dependent upon the funding made available to the NHS for the next phase of COVID-19, our ability to restore the elective programme and the impact of any further COVID-19 demand surge.

The 2020/21 break-even position (year to date) has enabled our cash position to be protected in this unprecedented year.

The Trust began a significant programme of work supported by PA Consulting in the spring of 2020 in order to support the 2020/21 £14m CIP programme. This work was paused whilst operational focus shifted to the emergency response,but the Trust is now reinstating this work in preparation for 2021/22.

Alongside this, a long term financial plan is currently being developed which will underpin the Trust's financial strategy and recovery plan which is due for completion in Quarter 3 2020/21.

4. Sustainable Delivery of Accident & Emergency Services

The Trust aims to be compliant against the National Constitutional 4 Hour standard of 95%. Whilst the Trust is currently performing in line with comparator organisations, it has not consistently achieved the 95% target over an extended period of time.

A full review of systems and processes has led to the development of a number of improvement workstreams both internally at hospital level and externally at system level.

Internal Actions and Assurance
A range of internal key performance indicators are tracked and managed internally to actively and dynamically support patient flow. In addition, a series of improvement workstreams are in place with delivery managed by the Patient Flow Improvement Group and reported to Programme Board through to Trust Board.

System Actions and Assurance
As achievement of the standard is a recognized indicator of Patient flow performance across the Wirral Health and Social Care System, Executive and System Leadership is in place to deliver system improvements. Reporting is via the System Chair and Chief Executive Group of the Healthy Wirral Partners Board. The Trusts internal improvement plans are mapped through to the Healthy Wirral Programme, which has a dedicated Unscheduled Care workstream. This consists of Pre Hospital Improvement, Hospital Improvement and Discharge / Out of Hospital Care Improvement.

Aligned to this work is the Hospital Upgrade Programme with the completion of the outline Business Case ready for submission later this year. The Programme will support the redevelopment of the onsite Urgent Treatment Centre and Emergency Department, to improve Patient flow, streaming and turnaround.

5. CQC Action Plan

The revised undertakings dated 24 July 2020 specifically state that; *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.* The actions relating to 'Must Do' and 'Should Do' recommendations have been reviewed and there are no recommendations or actions which relate to either financial governance or use of resources.

However, Executive Directors are reviewing the separate Use of Resources report from the CQC inspection to ensure that any identified areas for improvement are incorporated in relevant action plans. A full report on progress against CQC Action Plans is included as a separate agenda item for the Board of Directors meeting on 2 September 2020.

6. Board Development

The Trust had previously commissioned a Board Development programme which was planned to be delivered by NHS Providers during 2019/20. The programme was based on a foundation session incorporating Board observation, a questionnaire and one-to-one interviews with Board members which would then be followed by a series of themed workshops. Unfortunately, only the first two elements of the programme were completed.

The Interim Director of Corporate Affairs is liaising with NHS Providers with a view to the Trust re-commissioning this programme in its entirety. It should be noted that there have been a number of changes in Board composition since the original programme was commenced. This, and the passage of time, the last session was undertaken in June 2019, supports the need to complete the whole programme. Initial engagement with NHS Providers has been based on a programme as follows:

Workshop	Description	Days
Pre-Work	Questionnaire, 1:1 interviews, Board observation and analysis	3.5
1	Developing an effective and compassionate unitary Board	1
2	Courageous Conversations, influencing and negotiation skills and team building	1

3	Performance frameworks for an accountable organisation	1
4	Building a culture of continuous improvement	1
5	Strategy deployment and implementation	1

Indicative costs for the above programme, based on costs agreed for the original programme, are circa £15,500 plus VAT. Given the current circumstances and prevailing social distancing guidance, it is likely that delivery of the programme will primarily be online-based, although it is hoped that it may be possible to achieve a blend of online and face-to-face sessions. The Interim Director of Corporate Affairs has arranged a MS Teams meeting with Mrs A Uttley, NHS Providers, to discuss approach and timescales for delivery of the programme which is scheduled to be held on 3 September 2020.

Board members are requested to consider the scope of the development programme set out above and endorse continued engagement with NHS Providers to effect delivery of the programme.

7. Progress / Outcomes from the Wirral System Improvement Board

The System Improvement Board meetings were suspended during Covid-19 and NHSE/I are still in the process of scheduling future dates. Wirral University Teaching Hospital is expecting this to be in September 2020 but no definitive dates have been released.

8. Recommendations

The Board of Directors is recommended to:

- Receive and note the content of the report.
- Endorse the approach for the Board Development programme set out at s6 of the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Safeguarding Annual Report 2019-2020

Board of Directors	
Agenda Item	20/21 121
Title of Report	2 September 2020
Date of Meeting	13th August 2020
Author	Associate Director of Nursing for Safeguarding
Accountable Executive	Hazel Richards – Chief Nurse, Executive Director for Midwifery and Allied Health Professionals and Director of Infection Prevention & Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1, 3, 5
Level of Assurance • **Positive** • **Gap(s)**	Positive: • Compliance of the completion of Best Interests (MCA 2005) significantly improved. (CQC action) • Design of Mandatory E-Learning package in line with Safeguarding strategy and intercollegiate documents of adults and children. • Training of staff with regards to Child Protection Information Sharing (CP-IS) processes within Adults & Children's Emergency Department. (CQC action) • Safeguarding initiative tool to capture the voice of the unborn (CQC action). • Positive assurances in relation learning disabilities for LeDeR, reasonable adjustment and patient flagging systems. Gaps: • Protecting Vulnerable People (PVP) Mandatory training under 90% compliance. • Compliance of statutory Initial Health Assessments remain under 100%. • NHSI benchmarking exercise identification of requirement for environmental changes such as changing places. Space request form submitted to the environmental group.

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

Contents

Foreword.

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is committed to ensuring that the safeguarding of our patients, their families, our staff and our communities is at the foundation of our 'Together we will' Trust values.

We strive to improve and build upon the safeguarding practices we offer by promoting the trust ethos that safeguarding is everyone's business in the drive to continuously make improvements to the service we provide.

Effective safeguarding of adults, young people and children is heavily reliant on the development of robust professional relationships and multi-agency working arrangements. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to safeguarding and patient safety. There is a culture of 'Think Family' that is embedded throughout the Trust as it is recognised that children, young people and adults do not exist or operate in isolation of one another.

Glossary.

ADNS	Associate Director of Nursing for Safeguarding
BI	Best Interests
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panels
CLA	Children Looked After
CP-IS	Child Protection information sharing
CQC	Care Quality Commission
DNA	Did Not Attend
DoLs	Deprivation of Liberty Safeguards
ED	Emergency Department
FGM	Female Genital Mutilation
IFD	Integrated front door
IHA	Initial Health Assessments
IDVA	Independent Domestic Violence Advisor
HV	Health visitors
KPI	Key performance indicators
LA	Local Authority
LPS	Liberty Protection Safeguards
MAR	Multi Agency Referral
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MSAB	Merseyside Safeguarding Adult's Board
MSP	Making Safeguarding Personal
NOK	Next of Kin
NRLS	National Reporting and Learning System
OPD	Out Patients Department
PBL	Pre-Birth Liaison
PiPoT	People in Positions of Trust
PVP	Protecting Vulnerable People Training

PSQB	Patient Safety Quality Board
RRM	Rapid Response Meeting
SAG	Safeguarding Assurance Group
SARs	Serious Case Reviews
SIRG	Serious Incident Review Group
SJR	Structured Judgement Review
SOP	standard operating procedure
SUDIC	Sudden Unexpected Deaths of Child
WHCC	Wirral Health and Care Commissioning
WISE	Wirral Individual Safe Care Every Time Accreditation Programme
WLSSG	Wirral Local Safeguarding Strategy Group
WRAP	Workshops to Raise Awareness of Prevent
WSCP	The Wirral Safeguarding Children Partnership

Introduction.

The Chief Nurse, Trust Executive Lead for Safeguarding and the Associate Director of Nursing for Safeguarding are pleased to introduce the Wirral University Teaching Hospital Safeguarding Annual Report for the period of 2019-2020.The purpose of the report is to provide a declaration of assurance that the trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services.

The term "safeguarding" covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect and which enables them to retain independence, wellbeing, dignity and choice. Safeguarding also encompasses prevention of harm, exploitation and abuse through provision of high quality care, effective responses to allegations of harm and abuse, responses that are in line with multi-agency procedures and lastly, using learning to improve services to our patients.

The Trust Safeguarding Team continues to provide a range of activities to support key areas of safeguarding work, embrace change and respond to emerging themes both local and nationally and strive to ensure all safeguarding processes are robust and effective.

Due to the nature of safeguarding we work collaboratively in partnership with a number of external agencies. The report reflects the high level of activity across all work streams in order to improve processes and build on existing systems and procedures. We continue to strive to further improve and achieve good compliance against all our safeguarding standards internally and externally in order to safeguard the most vulnerable in our society. Safeguarding is everyone's business, but this cannot be achieved without the dedication and professionalism of all staff and partners.

The 2019-20 Annual Report provides the Board of Directors with;

- An overview of the national and local context of safeguarding and current Trust position.
- Assurance that that the Trust is meeting its statutory obligations and national safeguarding standards.
- Analysis of the annual safeguarding activity including progress made against the objectives set out in the Safeguarding Annual Report 2019-20.
- An overview of the Trust safeguarding priorities and challenges it may face as it moves forward in 2020/21.

Definitions.

***Safeguarding*:** The Care Quality Commission (CQC) states; 'Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care' (CQC, 2016).

***Safeguarding Children*:** A child is defined within the Children Act 1989 as "an individual who has not reached their 18th birthday", the fact that a child may;

- Live independently
- Is a parent themselves
- Is in custody
- Is a member of the armed forces

does not change their entitlement to protection under The Children Act (1989). This is important because young people aged 16 and 17 years with safeguarding needs access, 'adult' services in the

Trust and are seen and treated by adult trained and registered staff who may not acknowledge this entitlement.

Safeguarding Adults: An adult is an individual aged 18 years or over.

The Care Act (2014) defines an 'adult at risk' as:

- An adult who has care and support needs (whether the needs are being met or not).
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All Wirral University Teaching Hospital NHS Foundation Trust (WUTH) all staff have a statutory responsibility to safeguard and protect those who access their care regardless of their position in the organisation. However, some defined named safeguarding roles exist, they include;

Named Professionals.

Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

All NHS providers must identify a Named Doctor a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife, (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

From April 2019 - March 2020 the WUTH named professionals were;

- Named Doctor for Children and Young People – Dr Elizabeth Thompson
- Named Doctor for Children Looked After – Dr Vidya Raghavan
- Named Nurse for Children and Young People – Jillian Murray
- Named Professional (Nurse) for Adults – Karolyn Shaw
- Named Midwife – Michelle Beales-Shaw

The Chief Nurse, Ms Hazel Richards is the Trust Executive Lead for Safeguarding as of January 2020. Prior to this period the Chief Nurse was Ms Gaynor Westray until her retirement in July 2019 when this position was then undertaken by Acting Chief Nurse Mr Paul Moore.

To support the Named Professionals the safeguarding structure can be located in appendix 1.

1 Statutory Framework and National Policy Drivers.

There are significant differences in the laws and policies that shape how we safeguard children and adults. The legal framework to protect children is contained in Working Together to Safeguard Children (2018) and for adults, the Care Act (2014).

However, the overarching objective for both is to enable children and adults to live a life free from harm, abuse or neglect. This report provides a summary of how WUTH discharges its statutory duties in relation to:

- Children Act (1984, 2004).
- Children and Social Work Act (2017).
- Working Together to Safeguard Children (2018).

- Safeguarding Adults at risk in line with the Care Act (2014).
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- The Counter-Terrorism and Security Act (2015).
- CQC registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13.
- CQC National Standards of Quality & Safety -Outcomes 7-11: Essential Standards of Quality and Safety.

1.1 Working Together to Safeguard Children (2018).

The Children Act (1989) and Section 11 of the Children Act (2004) placed a statutory duty on all NHS Trusts to make arrangements to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions.

On 1 September 2019 in line with 'The Children and Social Work Act (2017)' the new multi-agency safeguarding arrangements – 'The Wirral Safeguarding Children Partnership (WSCP)', went live and replaced the previous safeguarding board (WSCB) arrangements. Structure can be found in appendix 1.

The new arrangements are led by three statutory partners the Local Authority, Police and Wirral Health and Care Commissioning previously known as Clinical Commissioning Group (CCG). The changes as a result of the new multi-agency safeguarding arrangements that affect WUTH are;

- There is a new WSCB multi-agency thresholds document (2019) still containing the 4 levels, however the document was updated to now include examples of lived experiences of the child to support staff in the completion of the appropriate level of support and help.
- A new multi-agency Neglect Strategy updated to include the WSCBs commitment to using the Graded Care Profile 2.
- 'Serious Case Reviews'; are now referred to as 'Child Safeguarding Practice Reviews'. Child Safeguarding Practice Review Panels will be responsible for deciding how the system learns lessons on a national level, while local responsibility will remain with the LSCP's.
- The responsibility for 'Child Death Overview Panels (CDOP)' was transferred from the Department for Education to the Department of Health's new 'Child Death Review Partners' and includes reviewing the deaths of all children who are normally resident in the local area, and if appropriate, for non-resident children who die in the local area.
- A new section included in 'Working Together', (2018) placing emphasis on organisational responsibility towards people who work in positions of trust. The guidance states, "Organisations and agencies working with children and families should have clear policies for dealing with allegations against people who work with children."

The Wirral Safeguarding Children's Partnership (WSCP) uses a variety of ways to test the strength of safeguarding arrangements across agencies in Wirral but one of the key ways is by the use of an annual safeguarding audit called the 'Section 11 Audit' for organisations such as the National Health Service and a Section 175 Audit for schools and colleges.

Wirral Pre-Birth Liaison (PBL) monthly meetings have continued throughout the year supporting families and the unborn by providing early help access. This year an independent chair was appointed in order to ensure robust assurance and accountability processes were in place in accordance with the WSCP Framework.

Trust Position.

- All Trust safeguarding policies, procedures and training were recently reviewed and updated to take account of the new WSCP definitions and arrangements.

- WUTH is represented at the Wirral WSCP by the Associate Director of Nursing for Safeguarding.
- The Trust has a standard operating procedure (SOP) and policy in place 'People in Positions of Trust (PiPoT)' to manage and respond to all allegations against members of staff regarding both adults and children. (Appendix 3)
- The Named Nurse for Safeguarding Children completed the multi-agency training package to become a licensed trainer for the Graded Care Profile 2 and facilitated 4 external multi-agency sessions. Staff requiring this training are midwives, continuing care and specialist nurses within paediatrics. The delivery of the programme continues into 2020/21.
- During 2019-20 the Trust has recorded 15 child deaths for Wirral. Out of the 15 deaths, 6 cases were recorded as Sudden Unexpected Deaths of Child (SUDIC) and 9 deaths were expected. Notifications of all deaths have been documented as Part A of the Child Death Overview Panel (CDOP) paperwork and have been shared with appropriate partners as per CDOP processes.
- The trust participates in Wirral Safeguarding Children's Partnership (WSCP) Section 11 audits, any gaps in assurance are addressed by the development of action plans and monitored via the trusts internal Safeguarding Assurance Group (SAG). Any areas of concern are escalated to, The Patient Safety Quality Board (PSQB).
- During 2019-20, there have been 3 child safeguarding practice reviews which required Trust involvement.
- Development of a thresholds guide to support staff when making referrals into children's social care to ensure the correct level of service is requested and avoid/reduce any inappropriate referrals.
- Child exploitation screening tool embedded within Cerner Millennium directly linked to children's social care via the, Integrated Front Door (IFD). This was recognised as an outstanding example of excellent multi-agency working.
- Training of staff with regards to Child Protection Information Sharing (CP-IS) processes within Adults & Children's Emergency Department, children's ward and moving forward into 2020-2021 progressing into the Neonatal Unit.
- A multi-agency audit has been completed evidencing better recognition and escalation of safeguarding concerns by midwives with the appropriate request of support at booking appointments.
- Collaborative working and development of process between health visitors (HV) and midwives to ensure better opportunity for multi-agency safeguarding joint working. HV are now informed at the booking appointment if a referral into Pre-Birth Liaison (PBL) has been made (CQC action).
- Inclusion of safeguarding training during preceptorship to support newly qualified midwives (CQC action).
- Priority given to capturing 'voice of the child/unborn' and evidencing 'professional curiosity' through training and auditing.
- Inclusion of PBL minutes within individual mother's electronic records to ensure safeguarding plans can be accessed by Trust staff.
- Creation of 'Always and Forever', memory boxes to recognise the importance of providing support to parents of children with care orders, or those that are being removed. This initiative provides evidence to support ongoing developments of the voice of the unborn/child processes.

1.2 Children Looked After (CLA) and Initial Health Assessments (IHA).

Children coming into care should have a high quality initial health assessment (IHA) within 21 days of becoming a Child Looked After (CLA). The Trust has a statutory and contractual responsibility to provide this service. Assurance of compliance is monitored via the quarterly Safeguarding

Accountability and Assurance Framework (2019) (SAAF) data submissions against a set of key performance indicators (KPIs). (SAAF can be located in appendix 4 of this annual report).

In Q1 it was identified that Initial Health Assessment requirements were under trajectory against the statutory compliance target of 100%. To improve compliance rates the Associate Director of Nursing for Safeguarding (ADNS) created a task and finish group to review systems and processes and also attends the external Health Outcomes multi-agency meeting. The following issues were identified as a contributing factors;

I. Clinic capacity and number of sessions being provided.
II. Did Not Attend (DNA) also known as 'was not brought' rates and late referrals/notifications from the local authority (LA) outside of the agreed 48 hours.

Significant improvements were achieved in Q2 following close monitoring through the provision of a monthly Safeguarding Assurance and Accountability Framework (SAAF) report. This was shared with the Designated Nurse for CLA and ensured that actions were taken in a timely manner.

Clinic capacity was reviewed and additional sessions provided to address waiting times.

A deep dive was undertaken in Q3 as a decrease in compliance had been noted for the percentage of IHAs completed and returned the local authority within the statutory 28 days of coming into care. This identified that notifications/referrals continued to remain and issue but also that WUTHs internal processes following receipt of notification/referrals from the LA were not robust. Amendments were made to the CLA database to further track identified gaps in WUTH processes was commenced during quarter four to monitor closely. A further audit is due at the end of Q1.

Trust Position.

- Delays when receiving notifications of CLA status from the LA continue however the trust is still managing to offer appointments within the 20 days. Delays are escalated by WUTH to the Local Authority and Designated Nurse for children/Looked After Children in Wirral Health and Care Commissioning.
- DNA rates have significantly reduced.
- Design of a database to provide live SAAF reports and to monitor CLA processes is planned to be available in June 2020.
- Q4 was unfortunately impacted further by the effects of the COVID restrictions which resulted in the closure of out-patients in line with national guidance and oversight by the designated doctor and nurse for CLA. WUTH made the decision to offer virtual and telephone consultation assessments and recognise that statutory timeframes cannot always be adhered too during this particular period of time. Any child deemed to be at high risk will be offered a face-to-face consultation. Recovery plans will be identified by the Named Doctor for CLA ready for when face to face appointments can begin to recommence moving forwards into 2020-2021.

1.3 The Care Act (2014).

The Care Act (2014) states that adult safeguarding is established as a core function of every local authority's care and support system. The Care Act sets out the statutory framework for safeguarding adults which replaced the, No secrets guidance (2000).

The Care Act (2014) requires each local authority to have a Safeguarding Adults Board (SAB) with core membership from the local authority, the police and the NHS. One of SAB's key functions is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

Wirral is part of the Merseyside Safeguarding Adult's Board (MSAB) which has statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively to safeguard and promote the welfare of adults who lives in Knowsley, Liverpool, Sefton and Wirral. (The MSAB structure can be located in appendix 5). Wirral Health and Care Commissioning (WHCC) Director of Quality and Safety is a member of the board and attends on behalf of the Wirral health economy. Communication from the board is cascaded to the WHCC Safeguarding Lead (Principle Social Worker /Designated professional) which is shared amongst NHS providers.

The Adults at Risk' Chapter 14 Audit was reopened by the MSAB in January 2019. All heath contributions are updated by Wirral Health and Care Commissioning throughout the year which is drawn from the Safeguarding Assurance and Accountability Framework (SAAF) (2019) which is provided by the Trust on a quarterly basis (SAAF is found in appendix 4). The Chapter 14 Audit remains open throughout the year to allow for ongoing updates, only closing for a period of time to allow for completion of the annual report by MSAB.

During 2018/19 there have been no legislative changes in policy or guidance in respect of safeguarding adults.

The Trust continues to support the work of the MSAB and principles of the Care Act (2014) and making Safeguarding Personal (MSP) to ensure the voice of the adult is captured at the earliest opportunity.

Trust Position.

- Trust safeguarding policies, procedures and training are in alignment with the North West multi-agency adult safeguarding policy and guidance.
- The safeguarding compliance dashboard is presented monthly at the Safeguarding Assurance Group.
- Representation at sub-groups of the MSAB.
- Attendance by the Associate Director of Nursing for Safeguarding (ADNS) at the Wirral Local Safeguarding Strategy Group (WLSSG).
- The MSAB commissioned a wide-ranging external peer review of its work which took place over a three day period in January 2020, The Trust was one of the partners invited to participate in the review feedback.
- Two cases have been referred for consideration at the Safeguarding Adult Review Sub Group which had Trust involvement. Recommendations were made for Serious Case Reviews (SARs) on both cases, which await allocation of independent authors. Any learning identified and subsequent action plans will be developed and monitored externally by the MSAB, Safeguarding Assurance Group and the Patient Safety Quality Board.
- There have been no Domestic Homicide Reviews completed during 2019-20 which required input from the Trust.
- Data collection of themes and trends within WUTH for 2019-2020 to supporting the work of MSAB.
- Development of the electronic adult Multi Agency Referral Form (MAR) to capture the voice of the adult in regard to their wishes.
- The Safeguarding Adult's Team have worked alongside the Informatics Team and Emergency Department Manager to develop the safeguarding section of the new launch point electronic patient record. The focus has been given to encourage and promote professional curiosity.
- Development of an adult safeguarding threshold guidance flowchart to support staff when making appropriate referrals. This is due to be launched 2020-2021. This will streamline and reduce the amount of inappropriate referrals into the safeguarding team and adult social care.

1.4 The Mental Capacity Act (2005).

The Mental capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care and treatment to people aged 16 and over who live in England and Wales.

The five principles of the Mental Capacity Act are:

1. Assume a person has the capacity to make a decision themselves, unless it's proved otherwise.
2. Wherever possible, help people to make their own decisions.
3. Don't treat a person as lacking the capacity to make a decision just because they make an unwise decision.
4. If you make a decision for someone who doesn't have capacity, it must be in their best interests.
5. Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future. Any individual is deemed to lack capacity to make a decision if they are unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh up that information as part of the process of making the decision

The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if restraint and restrictions are used to deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (2009) is due to be replaced by Liberty Protection Safeguards (LPS) with a planned implementation date of 1st October 2020.

Trust Position.

- Urgent and standard DoLS applications are made by front line staff via the Ulysses System Safeguarding Incident Form. For the period of 2019/20 a total 1721 referrals were processed as DoLS an increase of 279 or 20% from 2018/19. A slight reduction noted within Q4 was evident due to COVID-19 pandemic which saw a decrease of patients admitted into the hospital.
- All DoLS referrals are quality assured by the DoLS gatekeeper who reviews all MCAs and Best Interests (BI) which allows for further support and training for staff and in identified areas.
- Best interest (BI) documentation compliance was highlighted as an area requiring improvement in the 2018 CQC inspection, monitoring of compliance has continued highlighting improvements from last year. Despite improvements made full compliance if yet to be achieved as current compliance is 62% for 2019-2020. Graph located in appendix 6 of this report highlights quarterly improvements in BI completion compared to last year's annual report.
- The use of the Wirral Individual Safe Care Every Time Accreditation Programme (WISE) and perfect ward safeguarding inspections continues to monitor staff knowledge. Audits identify that staff do have good knowledge of MCA and BI.
- In order to make the MCA completion easier for staff minor changes made to the electronic MCA tool to include drop down options for different decisions.

- The MCA/DoLS section of the live safeguarding MPage was implemented at the beginning of the year to support front line staff in the completion of MCA/DoLS. Further amendments have been identified with IT and are still awaited to ensure full functionality is delivered.
- MCA and DoLS is a mandatory section within Protecting Vulnerable People training at all levels.
- The ADN for safeguarding is working in collaboration with the Local Authority and partner agencies to support one another with the implementation of LPS and its transition. Directive from Kenny Gibson National Head of Safeguarding for the NHS has advised against making local commissioning arrangements until the national guidance is available.
- A briefing paper for LPS has been written by the ADN for Safeguarding.

1.5 The Counter-Terrorism and Security Act (2015).

The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components:

- Pursue - to disrupt terrorist activity and stop attacks.
- Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities.
- Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack.
- Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack.

The NHS and its partners have a role in the 'PREVENT' section of this strategy.
Whilst the Trust continues to be a non-priority site, the reporting mechanism is required via NHS Digital and also via the Safeguarding Assurance Framework to Wirral Health and Care Commissioning.

The Counter-Terrorism and Security Act 2015, places a specific duty on statutory bodies including the police, local authorities and health organisations to have 'due regard' to help prevent people being drawn into terrorism. It also makes the channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) a legal requirement for public bodies across the country.

Trust position.

- Prevent awareness and training is included within all levels of the Protecting Vulnerable People Training (PVP) and also the Trusts safeguarding induction session. PVP training is recorded and included within the Trusts compliance reporting specific to role required skills and knowledge.
- Workshops to Raise Awareness of Prevent (WRAP) are the mandated requirement for prevent and delivered within PVP level 3. The Trust was compliant with PREVENT level 3 WRAP training requirements over the expected 85% compliance target for quarters 1, 2 and 3 however missed the agreed compliance for Q4 at 79.94%. It is felt that this was a result if the COVID 19 pandemic and subsequent cancelation of PVP training in March 2020.
- Due to COVID 19 pandemic and the cancelation of PVP training the Trust was not in a positon to provide a full quarter of data for the final quarter of the year. It was recognised by the national Safeguarding team who accepted figures will be affected in Q4 and then Q1 due to the lack of mandatory training taking place and agreed that no action would be taken with

those Trusts where figures were low. WUTH however did provide a submission for Q4 months of January and February to NHS Digital and Wirral Health and Care Commissioning.

- The Safeguarding team provide advice and support for staff reporting cases and liaise with the Counter Terrorist Regional Police to share information for Channel and in high risk cases. No referrals or concerns have been received within 2019-20.
- The Trusts Prevent lead is the Named Nurse for Safeguarding Adults and ensures that staff are provided with the appropriate training in line with the contest framework.

1.6 Inspections/Reviews.

Care Quality Commission (CQC) of Health Services for Children Looked After (CLA) and Safeguarding across Wirral – May 2019.

In May the Care Quality Commission (CQC) undertook a themed inspection/review of the safeguarding processes for Children/Child to be and Children Looked After health services across Wirral. As part of this inspection, the journey of the child to be was reviewed through the use of three tracked cases and also random dip sampling during the two days of inspection at WUTH within the Emergency department, Children's Ward and Maternity Services.

The report highlighted that there was identified evidence of good escalation of safeguarding concerns, multi-agency partnership working, staff knowledge on safeguarding processes and safeguarding supervision at WUTH. Areas identified for further development focused around staff and professionals' curiosity, voice of the child/unborn and Children Looked After and the timely completion of Initial Health Assessments. An action plan began immediately and the 1st action plan with WUTHs contributions was submitted as part of a multi-agency response in December 2019.

Trust position.

- Regular multi-agency CQC update meetings have continued throughout the year monitoring progress against agreed actions and timeframes chaired by the Designated Nurse for Children and Children Looked After and plan to continue into 2020-2021.

Trust CQC inspection October 2019.

The Trust underwent a further CQC Inspection in October 2019 and the findings of the inspection were published in March 2020. Findings highlighted some areas for improvement and specifically from a safeguarding service perspective three areas of improvement were identified:

- The Trust did not comply with the child protection information sharing (CP-IS) standard designed to safeguard children who were looked after or in protection.
- There was not a robust system for tracking and monitoring deprivation of liberty safeguards (DoLS) applications and when they expired.
- Compliance with the statutory requirements for the completion of Initial Health Assessments (IHA) for Children Looked After (CLA) undertaken within the required timeframes.

However positive practice and processes identified were:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients that lacked capacity to make their own decisions or were experiencing mental ill health.

- Safeguarding processes had improved since last inspection and there was an effective system in place for the application of deprivation of liberty safeguards.
- Staff had training in key skills, understood how to protect patients form abuse and managed safety well.

Trust position.

- An action plan has begun to be developed following the CQC inspection and changes required have begun to take place and updates will be presented through trust governance structure and quarterly reports.

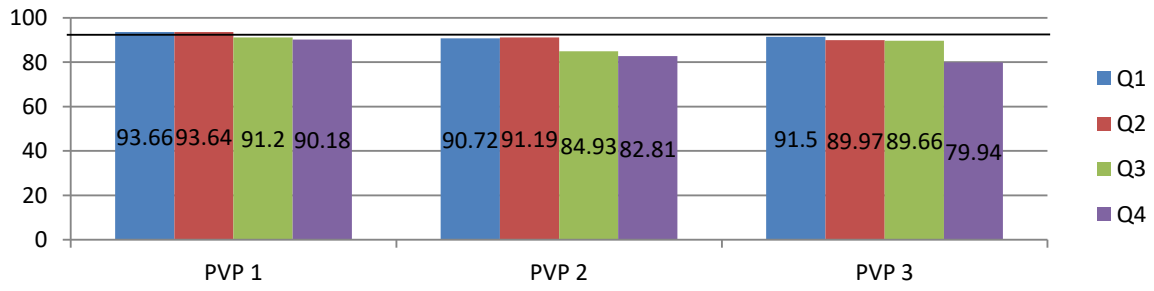
2 Protecting Vulnerable People Mandatory Training (PVP).

In April 2019 the new Protecting Vulnerable People Training Strategy 2019-2021 was produced detailing the planned content and implementation of the safeguarding education and training programme. The strategy outlines the pathway for staff to access appropriate safeguarding education relevant to their role and competencies required written within the legislative framework and which reflects the findings and recommendations from the Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document (2014) and the Safeguarding Adults: roles and competencies for health care staff Intercollegiate Document (2018).

Required roles and competencies changes will see approximately 1200 staff requiring PVP level three training that were only previously required to complete level two PVP. The proposed changes from level two to level three is an additional half a day plus an E-Learning package for those identified staff requiring additional hours such as midwives and urgent care staff. A bespoke ELearning package has been designed and is due to go live April 2020. The new programme and levels of PVP training will allow for collection of compliance of those staff requiring additional hours which has not been collected previously, providing further assurance to our commissioners and external regulators. It is important to recognise that these changes will reflect within the compliance levels once the transition takes place and trajectory's will be provided to ensure there is enough capacity for the safeguarding team to deliver the face to face aspects of level 3.

Trust position.

- Unfortunately the Trust did not reach its mandatory training compliance target of 90% for PVP by the end of the year for levels two and three, however successfully achieved compliance across all quarters for level one PVP. Without the support, commitment and dedication from all of the divisions then this would not have been achieved. The graph below highlights the training compliance across the four quarters. Q4 compliance was impacted by the COVID-19 pandemic when all mandatory training was cancelled temporally. Appendix 8 highlights PVP training compliance by month and levels.



- The Safeguarding Ambassadors programme was identified as a key objective for 2017-18; its aim was to offer further support, advice, training and education to a cohort of staff who would then be well equipped to spread their skills and knowledge to their colleagues in their own teams, wards and departments supplementing the safeguarding team.
  Safeguarding Ambassadors are expected to complete a course, based on both adults and children's intercollegiate documents and other relevant national standards including learning disabilities over a twelve month period, during which the candidates are expected to achieve a pass rate of 90%. The 1st cohort of Safeguarding Ambassadors was launched in May 2019.
- Safeguarding clinics at Clatterbridge site were formalised to provide staff with the opportunity to discuss any non-urgent issues with a member of the safeguarding team during the visibility walkabouts and remain on site. The clinics were also used to provide bespoke training and the completion of perfect ward audits. This has been well received by staff on the Clatterbridge site and will recommence once COVID 19 pandemic restrictions are lifted.
- Throughout the year increased visibility and bespoke training continues on the WUTH main site to multiple departments and wards, including ED breakfast clubs covering all aspects of the safeguarding service. Bespoke sessions are implemented for various reasons such as any identified learning from incidents, lessons learnt following multi agency reviews, following perfect ward or any requests made from staff or ward managers.

3 Governance Arrangements for Safeguarding.

3.1 Safeguarding Assurance Group (SAG) and Patient Safety and Quality Board (PSQB).

The Safeguarding Assurance Group (SAG) provides opportunity for challenge and assurance with regard to the safeguarding arrangements within WUTH, monitor compliance and benchmarking with external standards, clinical effectiveness indicators including Care Quality Commission (CQC) outcomes and addresses any gaps in service.

The SAG meets quarterly which allows for a defined and joint approach to safeguarding across all divisions within the Trust. The group has divisional representation alongside the named/lead professionals and is attended externally by the designated professionals for Adults, Children and Child Looked After from the Clinical Commissioning Group to allow scrutiny and oversight.

SAG membership includes the compliance with safeguarding standards, including the safeguarding assurance framework and mandatory safeguarding training compliance.

The Associate Director of Nursing for Safeguarding provides a quarterly report into the Patient Safety Quality Board (PSQB) and yearly annual report, areas identified as high priority/concern may be required to provide monthly reporting until further assurance has been received.

Governance structure arrangements can be located in appendix 9.

3.2 Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults.

The purpose of the Safeguarding Accountability and Assurance Framework (SAAF) is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Wirral health and Care Commissioning. (SAAF is located in appendix 4).

3.3 Risk Register.

Closed risks.

- **Risk 2928 - The Trust is illegally depriving patients of their liberty – Closed**
  7 day Urgent Deprivation of Liberty Safeguards (DoLS) application now be issued by frontline staff from the moment that it is deemed the patient lacks capacity to consent to care and treatment via the Safeguard/Ulysses system (safeguarding incident form). This ensures that patients are lawfully deprived of their liberty as soon as restrictions are put in place.

- **Risk 3094 - Delays in Mental Capacity Assessment completion – Closed**
  The Trust may be unlawfully detaining patients due to MCA and best interest (BI) assessments not being completed in a timely fashion; therefore applications for DoLS cannot be progressed by the Safeguarding Team. There has been a significant increase in compliance of MCA/BI/DoLS being completed in a timely fashion. Safeguarding team continue to audit compliance via Wirral Individual Safe Care Every Time Accreditation Programme (WISE) and perfect ward safeguarding inspections. Decision to close risk to the risk register made at the Safeguarding Assurance Group February 2020 with assurances to continue to monitor compliance.

Open risks.

- **Risk 0220 - Domestic Abuse Safety Triggers – open October 2018.**
  Patients not provided opportunity to disclose domestic abuse as a result of locally agreed safety trigger questions. Trigger questions went live in March 2019 in all areas of WUTH expect the Emergency Department (ED) and Out Patients Department (OPD). Delays due to new build of IT system for ED, trigger question will be part of new IT build. OPD awaiting date to be transitioned onto Cerner Millennium and trigger questions will form part of new build.

- **Risk 0221 - Female Genital Mutilation (FGM) screening Cerner – open April 2018.**
  FGM routine enquiry is currently only asked in Maternity services. Routine enquiry question is required to be added to Gynaecology Assessment Unit and Urodynamics. Delays are due to the OPD IT build as above in risk 0220.

- **Risk 86 - Children Looked After (CLA) completion of timely Initial Health Assessments (IHA) – open December 2019.**
  IHA requirements remained under the statutory compliance of 100% due to identified gaps externally of late referrals and notifications and internally in relation processes. Escalation reporting to the local authority in place and SOP developed with auditable timeframes.

- **Risk 347 - Process for recording NOK on Cerner – open October 2019.**
  This risk is not specific to safeguarding however was discovered through a safeguarding case where by NOK details were changed for a child taken into care. Due to the related records functionality in Cerner NOK changes also replaced the records of identified NOK to the updated NOK. Informatics team have been liaising with Cerner Millennium regarding IT set of rules to stop the reported risk for occurring. To be tested in the non-live system and if successful will be transferred onto the live system. Informatics plan to revisit in April 2020 due to prioritisation of the capacity manager project.

3.4 Safeguarding Incident Reporting.

Safeguarding incident notifications are integrated into the Trusts Safeguard database to record all safeguarding incidents both internally and externally. Following receipt of the incident documentation received by the safeguarding team, it is recorded in the Cerner Millennium System to ensure all staff

has access to all safeguarding information. The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS). Any alerts required are escalated to Wirral Health and care Commissioning and the CQC as required. The Associate Director Nursing for Safeguarding or a deputy attends the weekly trusts Serious Incident Review Group (SIRG) to provide safeguarding expertise and advice.

3.5 Safeguarding Supervision and Support.

Safeguarding supervision is provided to all health practitioners who case hold safeguarding cases.

Following recommendations from The Care Act (2014), the policy has been amended to include practitioners who support adults. Work is underway to ensure that emergency department staff are included within this.

The Named Nurse, Named Midwife, Named Nurse for Adults at Risk, and Named Doctors all access safeguarding supervision from Designated Nurses and Doctor and are 100% compliant with the agreed key performance indicator, assurance is provided via the SAAF on a quarterly basis to the Wirral Health and Care Commissioning.

4 Further safeguarding activity.

There has been an increase in complex and challenging cases being identified by staff. This year saw an increase of 753 referrals into the team compared to 2018-2019. The upward trend has been noted year on year in terms of activity with the inclusion of learning disabilities data for the first time. In addition to areas already identified within this annual report work within the safeguarding team also includes the areas below:

4.1 Harmful Practices and Female Genital Mutilation (FGM).

There have been three referrals received raising concerns of known or suspected FGM and three cases referred regarding honour based abuse within the last 12 months.

All cases pertain to both adult and children safeguarding concerns. The honour based abuse cases were referred into a closed Multi Agency Risk Assessment Conference (MARAC) for robust safety planning and support. The FGM cases followed appropriate safeguarding processes and as all were pregnant were referred into PBL.

No cases of forced marriage have been reported during 2019-2020.

4.2 Domestic Abuse.

The domestic abuse agenda continues to be a significant priority area within the Trust. The last twelve months has seen some key developments such as the appointment into the vacancy for the Hospital Independent Domestic Violence Advisor (IDVA) providing increased visibility within ED and bespoke training to all areas. The IDVA also supports the Named Midwife/Lead for Domestic abuse and Harmful practices.

Work has taken place to ensure that Trust staff, who may be experiencing domestic abuse, are supported not only by the safeguarding team but line managers. Bespoke training has been provided to managers by the IDVA in order to support their own staff should they choose not to receive support from the safeguarding team. Covert cards so not to raise awareness with potential perpetrators have also been designed as a method of sharing contact numbers for specialists within

the safeguarding team to be given to staff. There has been a noted increase in staff accessing support/disclosing domestic abuse from various avenues.

Referrals are also received from Merseyside Police to notify us of any domestic abuse incidents for pregnant women or babies less than four weeks of age. This is completed as an information sharing process and to request additional support from the midwifery service.

The release of the Domestic Abuse Bill is awaited from parliament and will be reflected within polices and training once available.

4.3 Learning Disabilities.

The Trust has integrated three of the National Learning Disability Improvement Standards (2018) into the delivery of care for people with learning disability when accessing services, they are;

- Respecting and Protecting Rights
- Inclusion and Engagement
- Workforce

The application of electronic flags are in line with the NHS Long Term Plan (2019) which identify the requirement of digital flagging in patient records to a indicate learning disability by 2023 -2024. This has allowed patients attending the Trust to be supported earlier through the use of reasonable adjustments and the support of our learning disability practitioner. Electronic flags have also allowed for analysis of data through collaboration with partner organisations that can now identify that during 2019-2020 approximately 15.5% of Wirral's population with a known learning disability had an admission into the Trust. A referral pathway was established for internal and external referrals into the learning disability service which now allows robust collection of data for the first time.

The Trust is committed to providing equal access to health care through the application of reasonable adjustments and to comply with the legal requirement of The Equality Act (2010).
Electronic reasonable adjustment risk assessments and care plan were embedded within Wirral Millennium in 2019/20. The overarching aim of the assessment is to identify patients support needs and through providing the required RA to be implemented thus promoting improved outcomes during the hospital admission. Compliance is monitored via audit and is presented via the monthly safeguarding dashboard and at the SAG.

Wirral Mencap Treat Me Well Group continues to be a valued service within the hospital setting. The group promotes inclusion and engagement from people across Wirral with a learning disability and or autism, their families and carers. Members identified that they would like hospital staff to undertake training to enhance their understanding of the needs of people with learning disabilities, as well as the opportunity to provide feedback of their hospital experience. A public and staff webpage has also been designed which is dedicated to learning disabilities to support those who access our services.

Family and friends test easy read material has been produced to assist individuals with learning disabilities and or autism sharing their feedback and experience in hospital. In line with the governments guidance and pending learning disability mandatory training requirements a learning disability training package has been developed as part of mandatory PVP training.

As the National Learning Disability Mortality Review (LeDer) advances the Trust has remained fully informed of the progress nationally and regionally. The learning disability nurse represents the Trust at local LeDer steering groups and as a trained LeDer reviewer supports the trust mortality lead to ensure reviews are conducted for deaths of people with learning disabilities and is reflected within the learning from deaths policy. The Trust has made commitment for all patients with a learning disability that deaths will be reviewed by the learning disability nurse and a medical professional using a tool

called a structured judgement review also known as SJR. Plans for the development of a learning from deaths group is planned for early 2020-2021.

5 Looking Forwards into 2020-2021.

Safeguarding remains a priority area of work for the Trust and this section defines the strategic priorities and work plan within safeguarding as we move forward into 2020-2021.

The strategic safeguarding aims related to the Trusts workforce are;

- To recover the mandatory 90% compliance in all levels of safeguarding training across the organisation post COVID 19 pandemic by quarter three 2020.
- Delivery of the new PVP strategy mandatory training package.
- To audit effectiveness of training through Perfect Ward and policy key performance indicators to learn and continuously improve safeguarding practices.
- Domestic abuse will continue to have a high priority within the work of the team key priorities will be to embed and audit routine enquiry within the emergency department and out patients departments.
- Ensure the voice and views of all vulnerable individuals and those who support them is heard and applied to ensure good personal outcomes and improve the outcomes for individuals.
- The Trust will continue to work closely with and support the work of WSCP and MSAB for Children and Adults, and all of their respective partnership organisations at both strategic and operational levels.
- Work alongside informatics to further streamline safeguarding functions within Wirral Millennium.
- Monitor progression of LPS and the Domestic Abuse Bill to ensure the Trust is ready to meet statutory requirements.
- To complete, embed and monitor effectiveness of all identified actions following CQC inspections.
- Continue to audit and improve the statutory compliance of timely IHA completion both internally and externally.
- Further development of the learning disability agenda throughout the organisation through training and partnership working and development of a Learning Disability and Autism Strategy.
- Support the lead for mortality in the development of a ‘Learning from Deaths Group’ to review deaths and share learning across the organisation.

6 Conclusion and Recommendations.

There have been a number of challenges during 2019-2020 for the safeguarding service but overall the Trust is in a strong position moving forward into the coming year. The Trust understands the areas which require focus and are fully sighted on these. There have been many positive aspects to comment on during the past year, in particular the stabilisation of the safeguarding team through the appointment of the substantive Associate Director of Nursing.

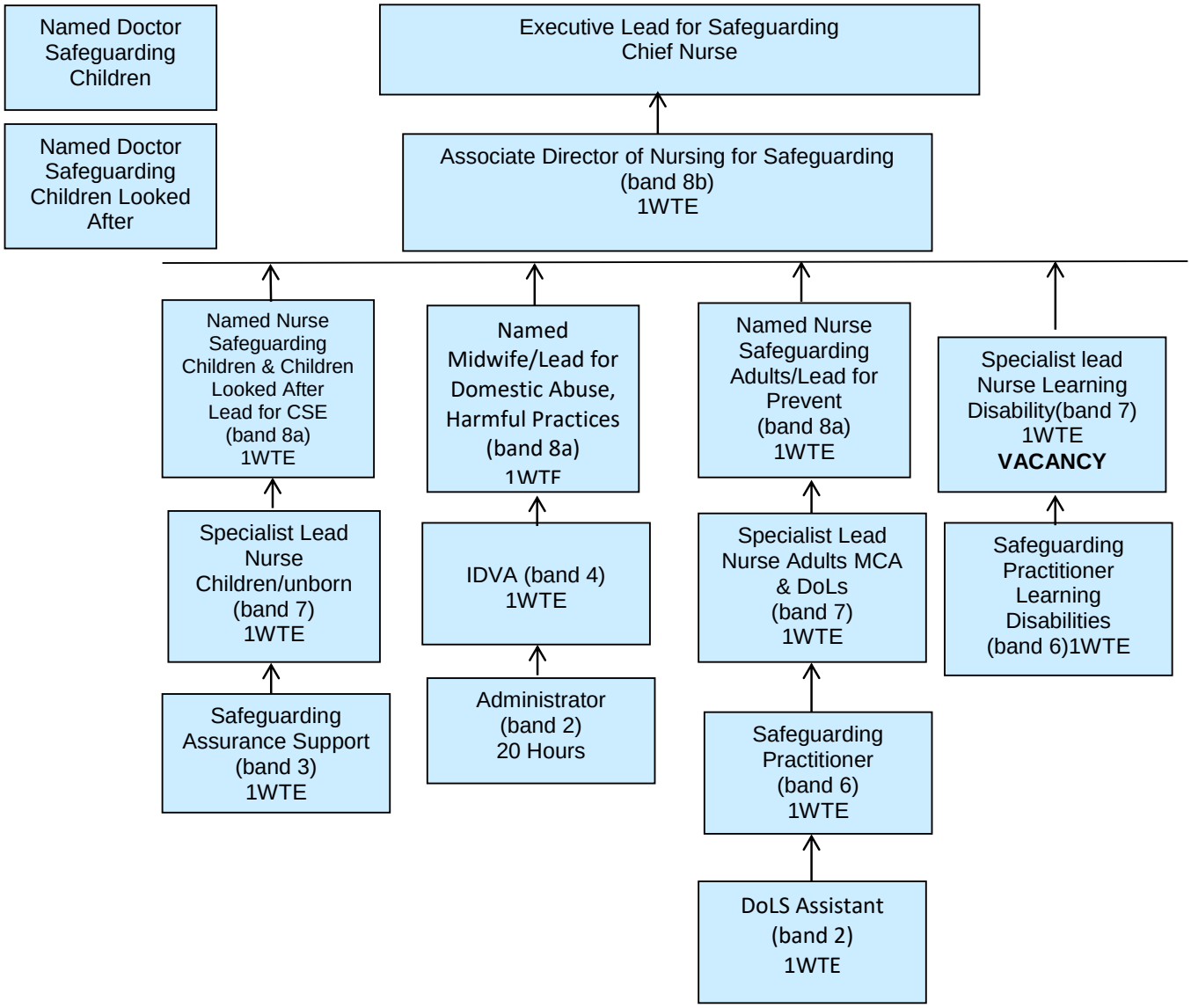
The safeguarding team has an understanding of purpose, roles and responsibilities not only to each other but to how this fits into the wider organisation and most importantly our patients who access services at our Trust. As the Associate Director of Nursing for Safeguarding I look forwards to the coming year in leading and supporting the service to further strengthen the arrangements in place to support the safeguarding agenda and the Trust on its journey to become ‘Outstanding’ as rated by the Care Quality Commission.

The Annual Report demonstrates how the Trust continues to adapt to changing priorities and has achieved its statutory duties in order to effectively safeguard patients and staff who use our services.

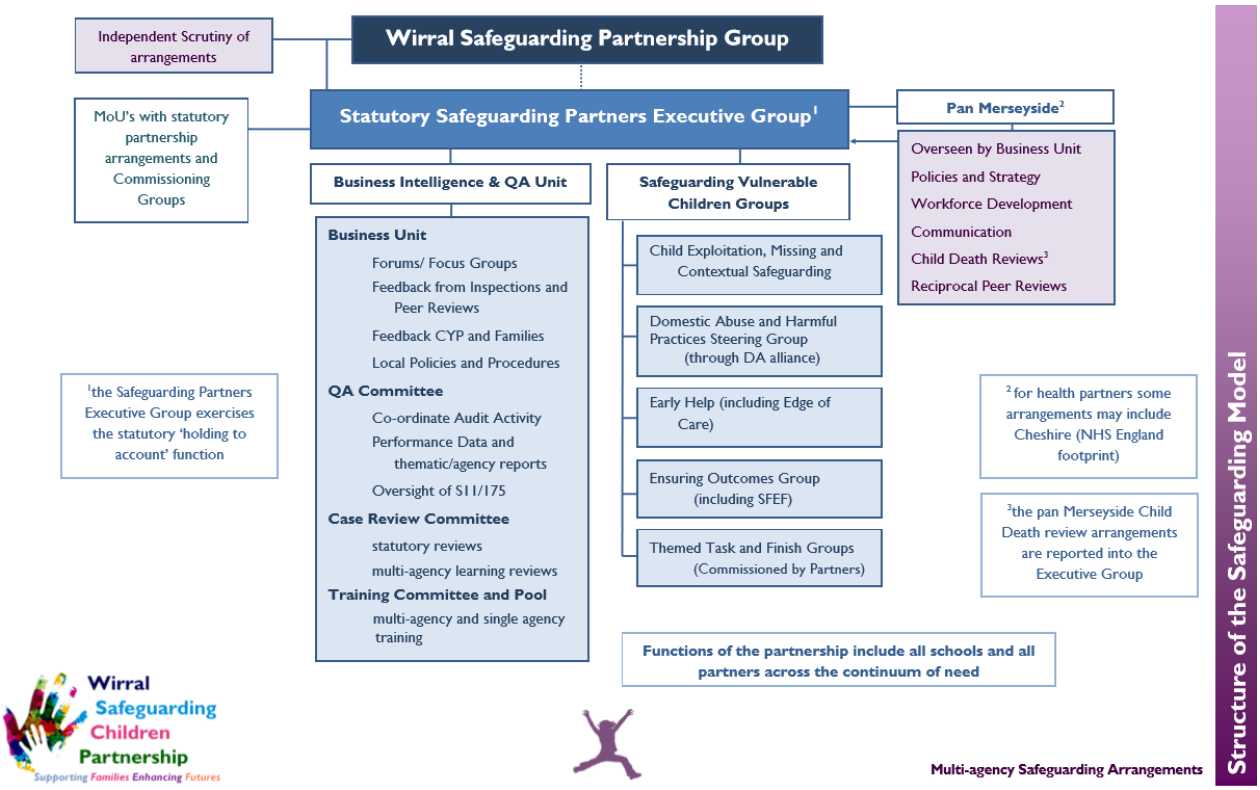
It is requested that the Patient Safety & Quality Board receive the content of the Safeguarding Annual Report and note the improvements made over the past year. This would not have been possible without the hard work and commitment of the Safeguarding Team and all Trust staff who work tirelessly in ensuring, *'Safeguarding is Everyone's Business'*.

7 Appendices.

7.1 Appendix 1 – Safeguarding Team Structure



7.2 Appendix 2 – Wirral Safeguarding Children's Partnership (WSCP) governance structure



7.3 Appendix 3 - People in Positions of Trust (PiPOT – Allegations against staff)

All organisations that provide services to children, young people and adults at risk must ensure those who work with them are competent and safe to do so. Similarly, everyone who comes into contact with them in their work have a duty to safeguard and promote their welfare. Under Local and National procedures each Local Authority is obligated to appoint a Named Officer, whose duty is to be involved in the management and oversight of cases when an allegation has been made against a professional. This individual for children and young people is identified as the Local Authority Designated Officer or LADO. In the case for an allegation against an adult the requirement for local authorities to monitor adult allegations made against 'Persons in a Position of Trust' (PiPoT) under the care act 2014.

The purpose of this guidance is to provide a framework for managing cases where allegations have been made against a person in a position of trust (PIPOT) and is focussed on the management of risk based on an assessment of abuse or harm against an adult with care and support needs. It ensures appropriate actions are taken to manage allegations, regardless of whether they are made in connection with the PIPOT's employment, in their private life, or any other capacity. Each agency as part of the safeguarding board arrangements is required to provide assurance that arrangements are in place to deal with arrangements under the PiPOT. The Trust sets out in its PiPOT policy a process for management of such allegations known as a 'Rapid Response Meeting' (RRM). The policy clearly sets out the processes following an allegation against a member of staff and the requirements to be discussed and actioned at the RRM within 24hrs.

In comparison from last year to this year 52 cases have be discussed and managed through the RRM pathway throughout 2019-20 compared to 66 cases last year. Of those 52 cases 5 were in relation to children and 47 Adults.

It is important to highlight that the majority of cases were managed via the divisions, Human Resources or complaints however a very small amount did require investigation by partner agencies such as the Local Authority and the Police under safeguarding statutory processes.

Challenges / Priorities

- Policy not yet been reviewed as it was published in September 2018 and is due in August 2021 which will also include audit of process and effectiveness. This will featured within the Safeguarding Cycle of business for 2020-21
- Ensure that Prevent WRAP training continues to achieve the identified national 80% and above compliance. Currently delivered as part of PVP level 3 mandatory training

7.4 Appendix 4 - Safeguarding Assurance and accountability Framework (SAAF).

Adults

INDICATOR	Reporting Frequenc	Threshold	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4
STAFF TRAINING						
Percentage of staff who have had MCA/DoLS Level 2 training	Quarterly	>90%				
Percentage of staff who have had MCA/DoLS Level 3 training	Quarterly	>90%				
Percentage of eligible staff who have had prevent training	Quarterly	>90%				
Level 1 Training for all staff (Inc MCA/DoLS/Prevent)						
Percentage of Staff who have had training within the past 3 years	Quarterly	>90%	93.66	93.64	91.2	92.29
Level 2 Training for all relevant staff (Inc MCA/DoLS/Prevent)						
Percentage of Staff requiring training who have completed the training within the past 3 years	Quarterly	>90%	90.72	91.19	84.93	85.01
Level 3 Training for all relevant staff (Inc MCA/DoLS/Prevent)						
Percentage of Staff requiring training who have completed the training within the past 3 years	Quarterly	>90%	91.5	89.97	89.66	86.67
STAFF SUPERVISION						
Specialist Safeguarding Professionals/Safeguarding Supervisors						
Number of Staff requiring supervision	Quarterly		3	3	1	1
Percentage of staff who have had supervision within the quarter	Quarterly	100%	100	100	100	100
Lead/Named Nurse Safeguarding Adults						
Number of Staff requiring supervision	Quarterly		1	1	2	2
Percentage of staff who have had supervision	Quarterly	100%	100	100	100	100
ADULT SAFEGUARDING INTERNAL MONITORING						
Number of Deprivation of Liberty Authorisation requests (DoL)	Quarterly		421	484	400	363
Number of Independent Mental Capacity Advocate (IMCA) requests	Quarterly		2	3	7	18
Numbers of Adult Safeguarding referrals to Local Authority	Quarterly		103	116	100	99
Numbers of Adult Safeguarding referrals to Local Authority resulting in DASS assessment & review	Quarterly		54	59	37	49
ADULT SAFEGUARDING PROTECTION FROM AVOIDABLE HARM						
Governance arrangements and shared learning from incidents and Serious Incidents (SI)						
Numbers of Adult Safeguarding Serious internal incidents reported	Quarterly		0	0	0	0
Internal safeguarding incidents investigated and appropriate action taken by the organisation	Quarterly		15	23	24	19
High Risk Cases						
Number of MARAC cases where children are involved (where information sharing is required)	Quarterly		226	31	12	6
Number of MACSE cases (where information sharing is required)	Quarterly		29	62	94	84
Number of cases of FGM identified	Quarterly		0	2	0	0
Number of cases referred to Channel Panel	Quarterly		0	0	0	0

Children

INDICATOR	Reporting Frequency	Threshold	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4
STAFF TRAINING						
Level 1 Training for all staff						
Percentage of Staff who have had training within the past 3 years	Quarterly	>90%	93.66	93.64	91.2	92.29
Level 2 Training for all relevant staff						
Percentage of Staff requiring training who have completed the training within the past 3 years	Quarterly	>90%	90.72	91.19	84.93	85.01
Level 3 Core Training for all relevant staff						
Percentage of Staff requiring training who have completed the training within the past 3 years	Quarterly	>90%	91.5	89.97	89.66	86.67
STAFF SUPERVISION						
Formal safeguarding children clinical supervision for staff carrying Safeguarding cases						
Number of Staff requiring supervision	Quarterly		16	16	40	51
Percentage of Staff who have had supervision within the Quarter	Quarterly	90%	100%	100%	91%	80.4
Specialist Safeguarding Professionals						
Number of Staff requiring supervision	Quarterly		3	3	4	4
Percentage of staff who have had supervision within the quarter	Quarterly	100%	100	100	75	75
Lead/Named Nurse/Midwife Safeguarding Professionals						
Number of Staff requiring supervision	Quarterly		3	3	3	3
Percentage of staff who have had supervision	Quarterly	100%	100	100	100	100
Safeguarding supervision sessions provided by the Designated Doctor						
Number of Named Doctors requiring supervision	Quarterly		1	1	1	1
Percentage of safeguarding supervision sessions held with Named Doctor	Quarterly	100%	100	100	100	100
Percentage of paediatricians requiring SG peer review sessions who have attended	Quarterly	90%	91	96	83	86

SAFEGUARDING CHILDREN PERFORMANCE MEASURES						
Early Help						
Number of TAFs initiated by a health professional	Quarterly		0	0	1	0
Number of TAFs led by a health professional	Quarterly		1	0	0	0
Number of TAFs in which a health professional is involved	Quarterly		8	7	4	1
Referrals to Children's Social Care						
Total Number of known contacts initiated by health practitioners to Children's Social Care CADT	Quarterly		170	176	148	130
Total Number of known contacts initiated by health practitioners to Children's Social Care CADT progressing to referrals	Quarterly		45	54	66	47
33 Progressed to Level 3 and 4						
Total Number of Child Protection Medicals undertaken by Paediatricians	Quarterly		35	34	21	34
Percentage of total number of Child Protection Medical reports returned to Children's Social Care within 5 working days.	Quarterly	80%	69%	91.17	90.5	91.17

Initial Case Conferences						
Total number of Initial Case Conferences invited to	Quarterly		15	23	18	3
Total Number of Initial Case Conferences attended	Quarterly		15	23	18	3
Total Number of Initial Case Conferences reports provided	Quarterly		15	19	18	3
High Risk Cases						
Number of MARAC cases where children are involved (where information sharing is required)	Quarterly		226	31	12	6
Number of MACSE cases (where information sharing is required)	Quarterly		29	62	94	84
Number of cases of FGM (or risk of) identified in under 18yrs	Quarterly		0	0	0	0
Number of cases referred to Channel Panel	Quarterly		0	0	0	0
Planning/Discharge Meetings						
Number of Antenatal Planning Meetings	Quarterly		99	3	45	51
Number of Postnatal Planning Meetings	Quarterly		3	26	5	1
Number of Discharge Planning Meetings	Quarterly		3	3	5	1
CHILDREN ATTENDING A&E						
Number of children who attended A&E who were known to be subject to a child protection plan in Wirral	Quarterly		74	47	67	48
Number of attendances for under 18yr olds where accidental injury is the primary or secondary diagnosis	Quarterly		5	9	13	27
Number of attendances for under 18yr olds where non-accidental injury is the primary or secondary diagnosis	Quarterly		4	4	9	1
Number of attendances at A&E for under 18 year olds where self-harm related issues/overdoes and poison is the primary or seconadary diagnosis	Quarterly		55	52	104	97
Number of attendances for under 18 year olds where a alcohol related issue is the primary or secondary diagnosis	Quarterly		27	19	19	13

Children Looked After

INDICATOR	Reporting Frequency	Threshold	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4
Health Assessments						
Initial Health assessments (IHA)						
Number of IHAs requested by Wirral children's social care	Quarterly		47	49	38	42
Number of IHAs completed	Quarterly		36	63	36	37
Number of IHAs requested within 48 hours of children coming into care	Quarterly		12	5	17	16
Percentage of IHAs requested within 48 hours, undertaken by paediatricians within 20 working days of coming into care	Quarterly	100%	0	60%	82	37.5
Percentage of IHAs completed and returned the the local authority within 28 days of coming into care	Quarterly	100%	3	58.5%	11.70%	19
Number of IHAs outstanding - Complete embedded detail sheet	Quarterly		23	11	0	1
Percentage of IHAs undertaken which have been quality assured	Quarterly	100%	61	93.7%	95.60%	100
Number of IHAs failed to meet quality standards - Complete embedded detail sheet	Quarterly		0	22	22	26
IHAs undertaken for Wirral Children placed out of borough						
Number of IHAs requested for Wirral children placed out of borough	Quarterly		5	13	5	5
Number of IHAs completed for Wirral children placed out of borough	Quarterly		2	3	0	0
IHAs undertaken for out of borough children placed in Wirral						
Number of IHAs requested for out of area children placed in Wirral	Quarterly		2	6	3	6
Number of IHAs completed for out of area children placed in Wirral	Quarterly		1	4	1	4
Number of IHAs returned to WUTH by Out of Area CCG due to quality issues - please comment	Quarterly		0	0	0	0
Number of IHAs undertaken by paediatricians for out of area children within 20 days of coming into care	Quarterly		1	0	0	1
Adoption						
Pre-Adoption Medical Reports (PMR)						
Number of PMRs requested by Wirral Children's Social Care	Quarterley		16	15	6	11
Number of PMRs completed by Paediatricians	Quarterley		5	4	6	9
Number of PMRs outstanding - please insert comments	Quarterley		10	11	0	2

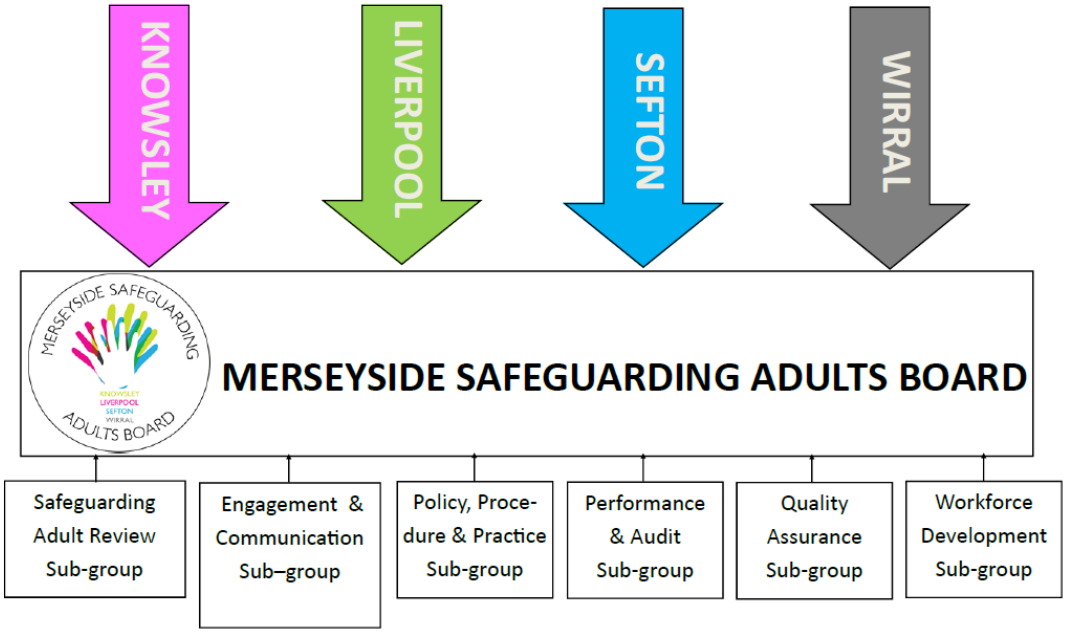
STAFF TRAINING/DEVELOPMENT						
All Paediatricians undertaking initial health assessments should undertake level 3/4Level			Children Looked After Training (Intercollegiate		Role Framewo	
Percentage of Paediatricians who have completed specific IHA training within 3 years	Quarterly	100%	100	100	100	100

7.5 Appendix 5 – Merseyside Safeguarding Adults Board (MSAB) governance structure.

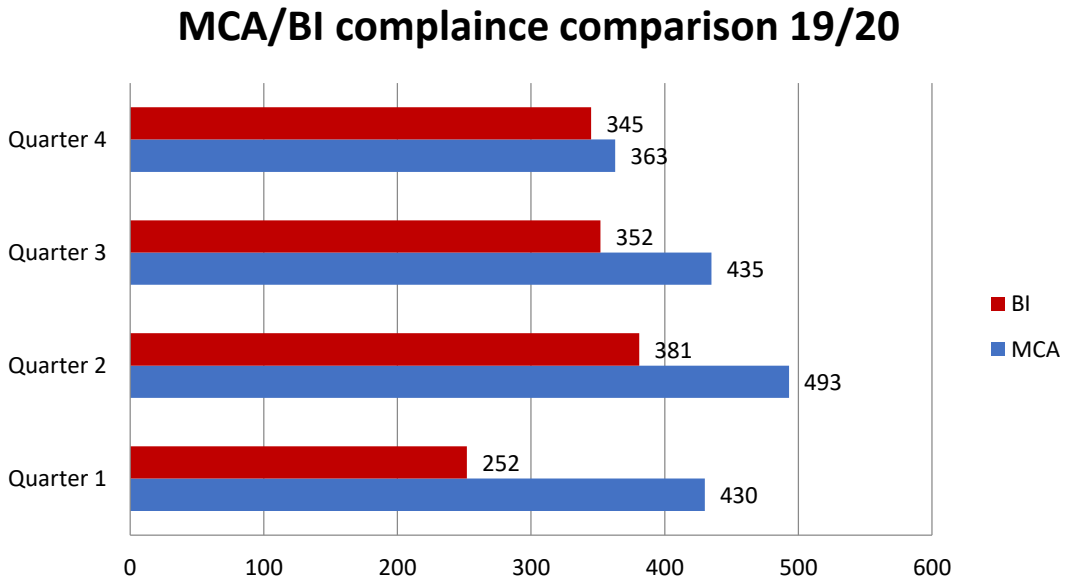
The Board has agreed a number of sub groups to take forward various work streams

The subgroups of the MSAB are as follows:

1. **Safeguarding Adults Review Sub Group**
2. **Engagement and Communication Sub Group**
3. **Policy, Procedure and Practice Sub Group**
4. **Performance and Audit Sub Group**
5. **Quality Assurance Sub Group**
6. **Work Force Development Sub Group**

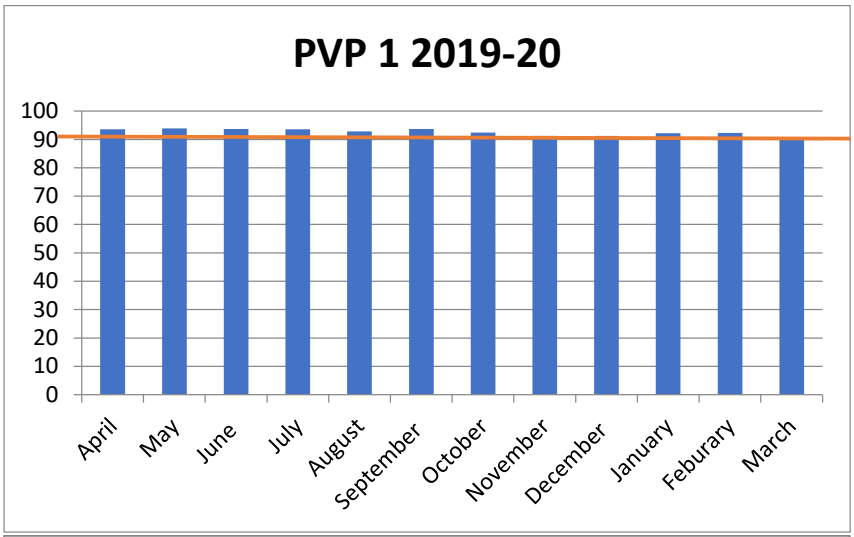


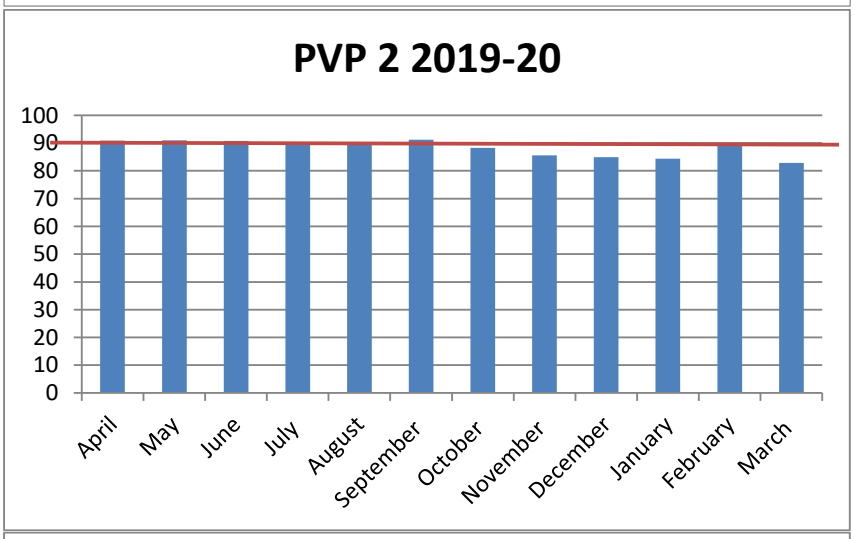
7.6 Appendix - 6 Best Interests

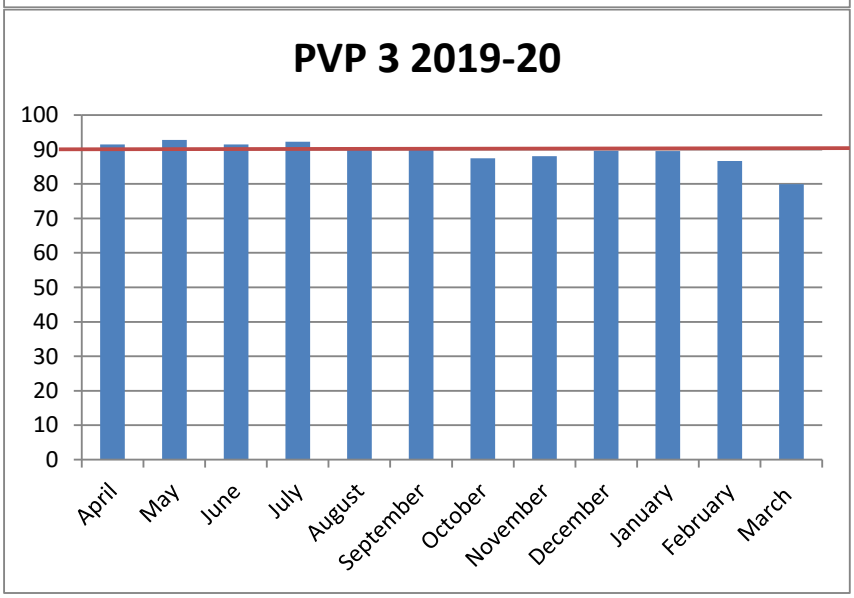


Q1 – 58.60% increase in compliance of best Interests.
Q2 – 77.28% increase in compliance of best Interests.
Q3 – 80.92% increase in compliance of best Interests.
Q4 – 95.04% increase in compliance of best interests.

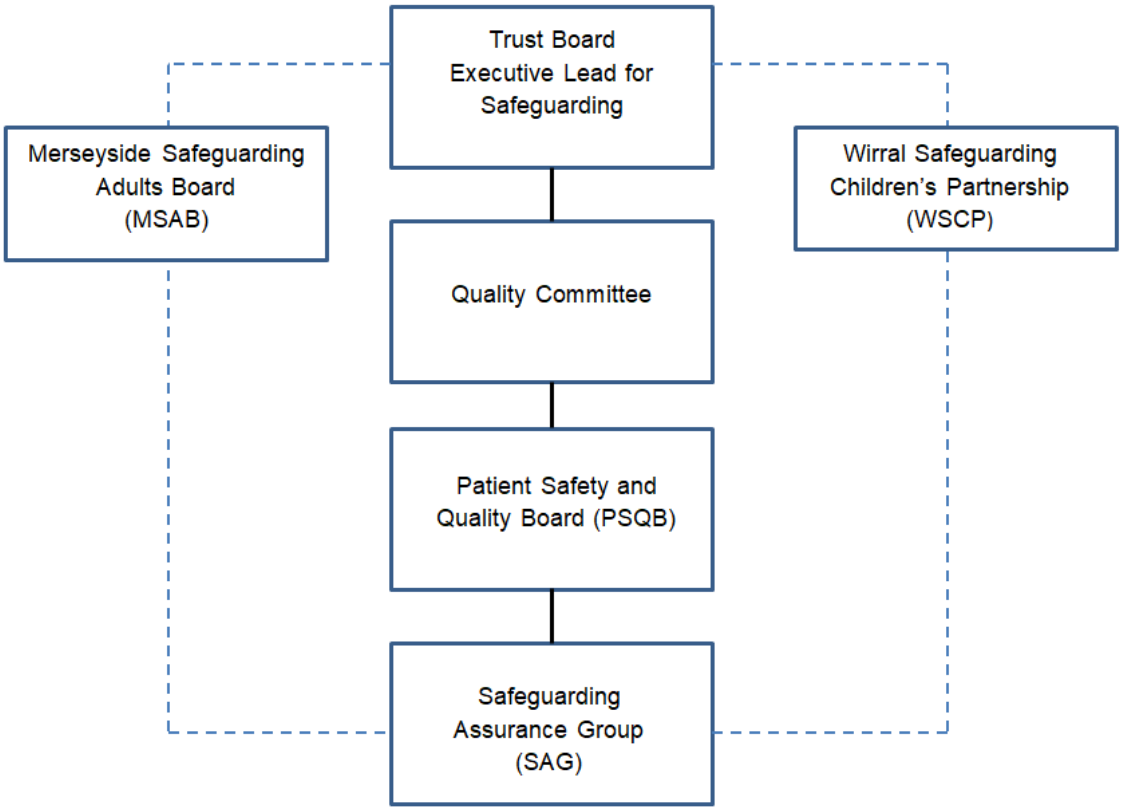
7.7 Appendix 7 Protecting Vulnerable People Training compliance







7.8 Appendix 8 - Governance Structure arrangements



Board of Directors	
Agenda Item	20/21 122
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	2 September 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 19th August 2020 the members received a presentation on the 'Development of structures for Service Improvement, Quality Improvement and Productivity and Efficiency Teams'. Members also received full update presentations on the priority programmes of Outpatients, Flow and Theatres together with an update on the Patient Portal initiative. 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)** includes a new item under the 'Workforce Planning' pillar of 'CIP Projects' (yet to be defined).

PROGRAMME STATUS

In terms of the overall ratings assessments **(see slides 3 and 4)**, there has been improvement, compared to July, in the governance evidence relating to the portfolio and further progress is required. The delivery ratings have seen a modest improvement with one project moving from a red to amber rating.

1.1. Governance Ratings

Eight of the eleven 'live' programmes are green rated for governance, with one attracting an amber rating, and two 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 again six programmes green rated for delivery while four are amber rated and one is 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.

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 **slides 6-10**.
2.2 Flow. The metrics for the Flow project are shown at **slides 11 and 12**.
2.3 Perioperative. The metrics for the Perioperative project are shown at **slides 13 and 14**.

At the Programme Board of 19th August 2020, it was agreed that, in future, programme teams should provide a brief text to give context and commentary on these metrics for the priority programmes.

3. Service Improvement Team

The new operating model for the Service Improvement Team was received by the Programme Board at its meeting of 19th August 2020, entitled 'Development of structures for Service Improvement, Quality Improvement and Productivity and Efficiency Teams'. The Programme Board approved the paper and proposals.

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 19th August 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 16 and 17**) 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
August 2020

wuth.nhs.uk

V2.7_11 Aug 20_JG

P Priority Project

Digital Enabling Project

WUTH Trust Board of Directors

NHS Wirral University Teaching Hospital NHS Foundation Trust

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**
- CIP Projects — **Lead: TBD**

Linked to programmes governed by

Healthy Wirral

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

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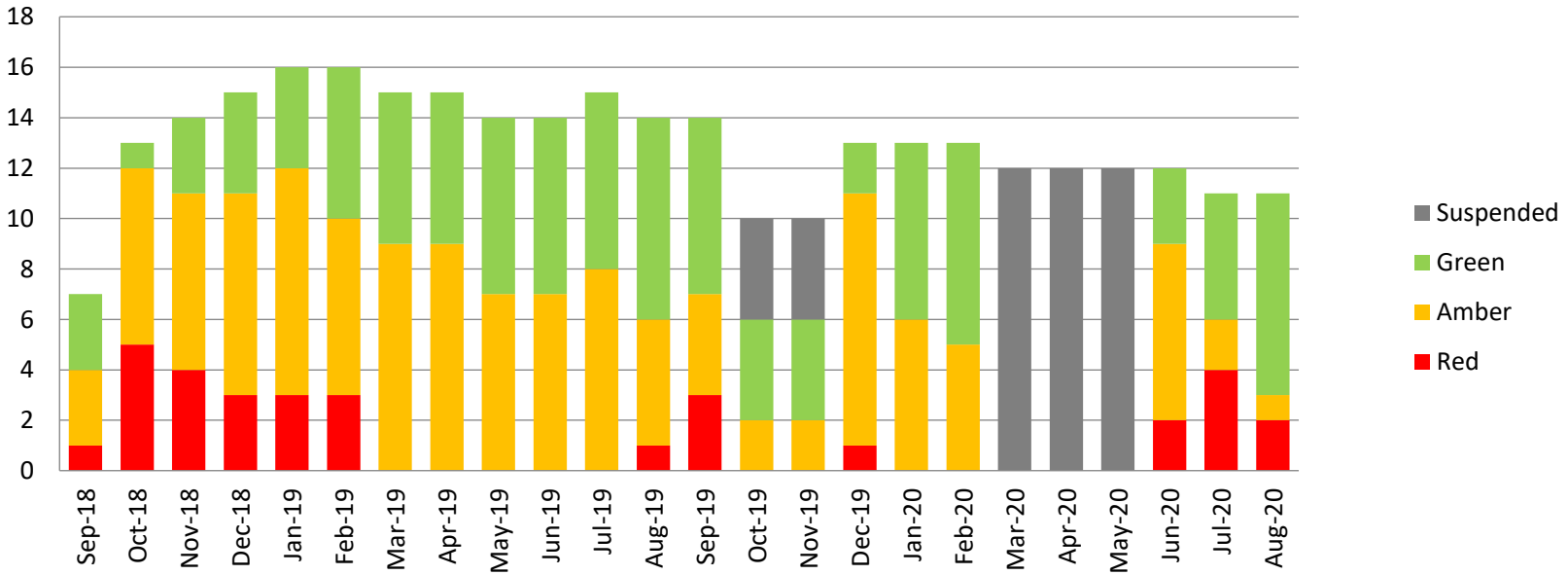
Assurance - Governance ratings

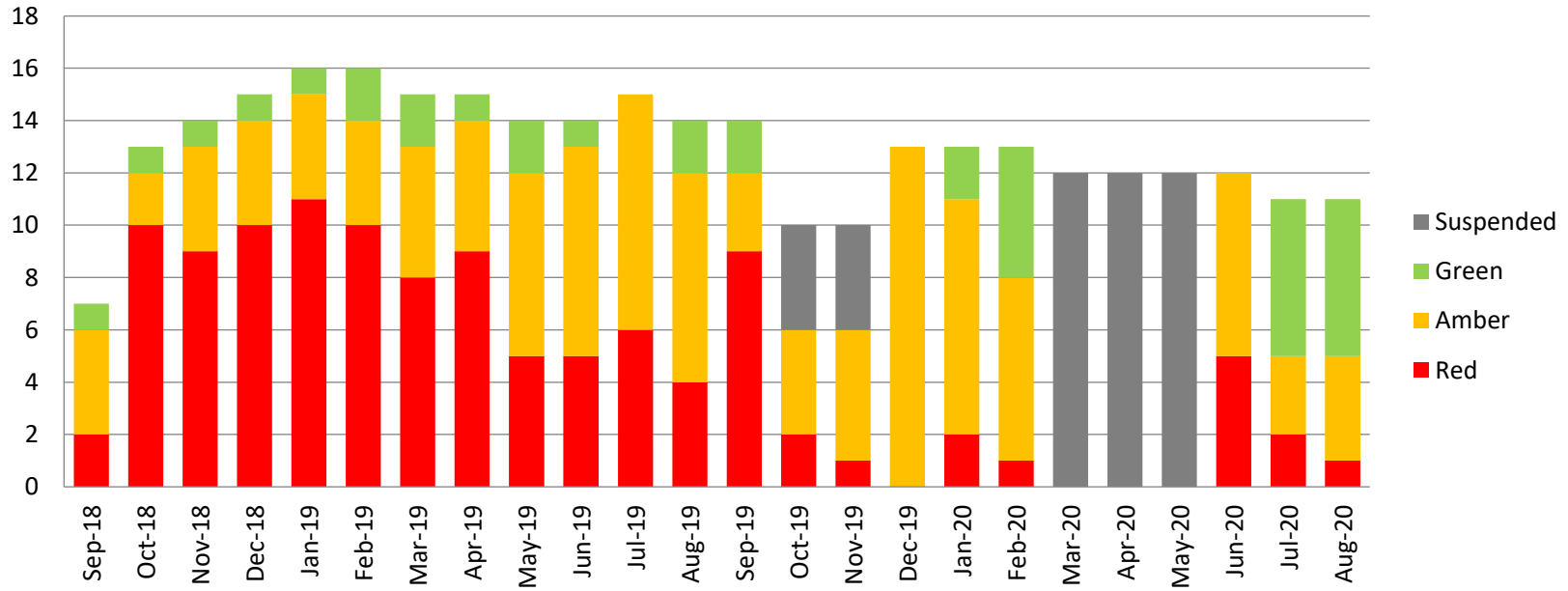


Change Programme Assurance Report - Trust Board Report - August 2020

J Gibson – External Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Assurance - Delivery ratings



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Wirral University Teaching Hospital
NHS Foundation Trust

Priority Projects Metrics

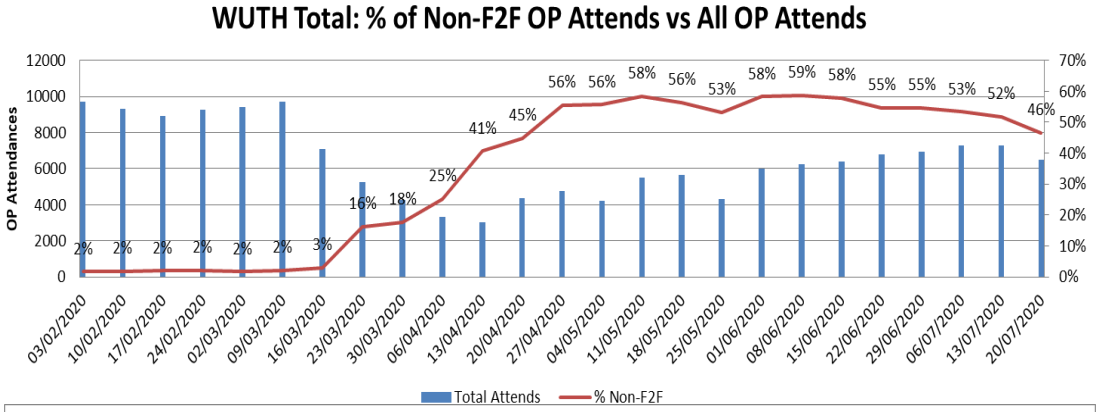
Programme Board 19 Aug 20

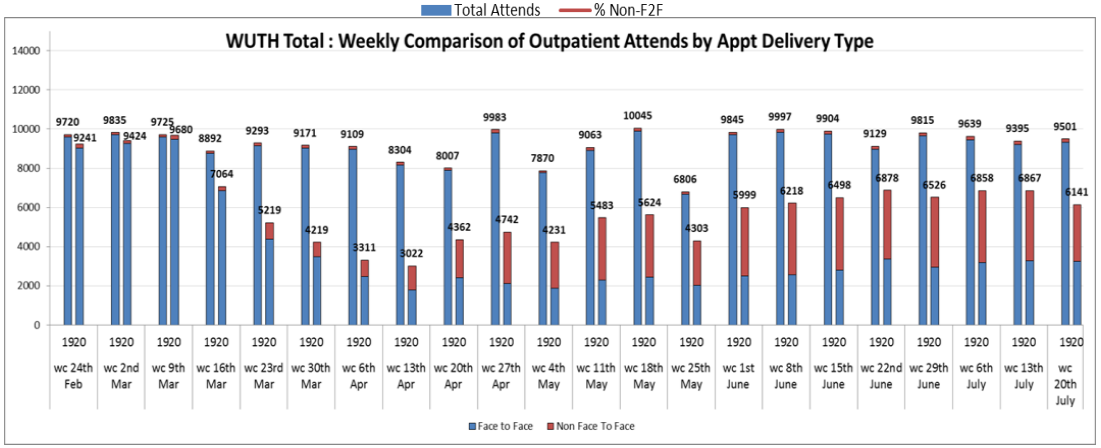
Senior Responsible Owners

wuth.nhs.uk

Outpatient Consultations at WUTH Metrics Programme Board 19 Aug 20

Wirral University Teaching Hospital NHS Foundation Trust





Simon Stevens - 3rd Phase of NHS response to Covid letter 31/07/20

- Defines:
  New appts 25% Non-F2F, FU appts 60% Non-F2F

Based on divisional submission by specialty, of intended % Non-F2F – Trust aggregated value

- New appts **37%** Non-F2F
- FU appts **45%** Non-F2F
- Further validation to be undertaken with Divisions

Trust Level Narrative:

- Overall % Non-F2F has reduced in July, as overall activity has increased.
- Increases in F2F activity are accounted for by large increases in Obstetrics, Physio, Ophthalmology and Orthopaedics.

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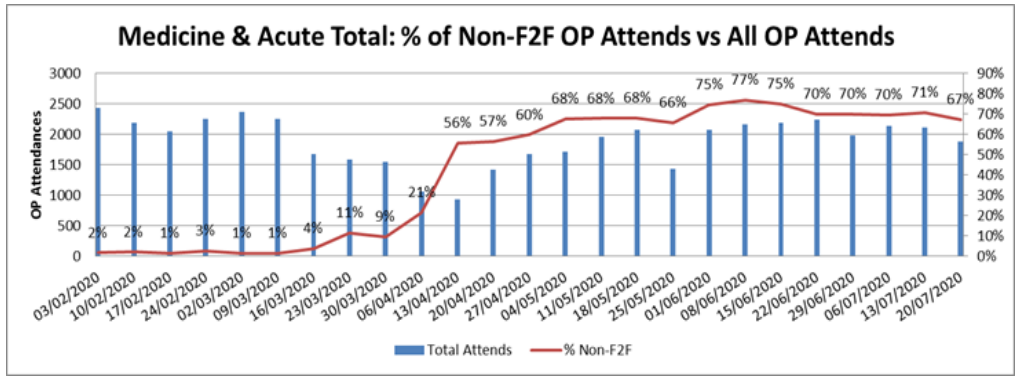
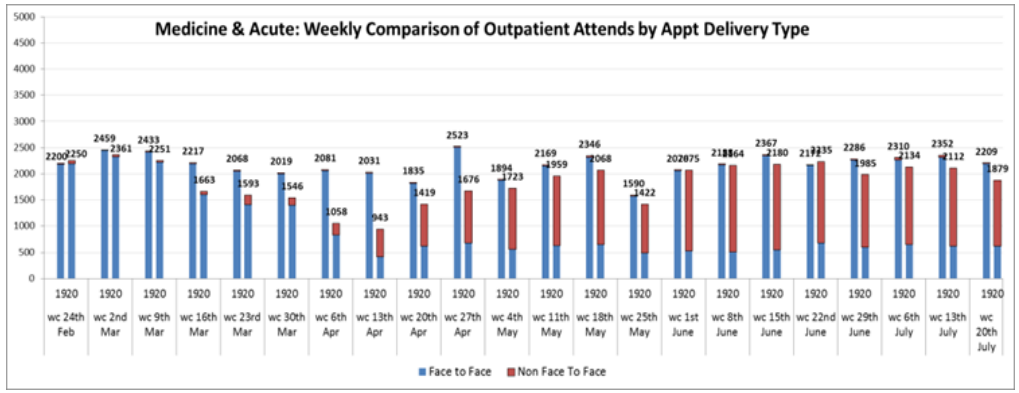
Outpatient Consultations at WUTH

Medicine & Acute

Wirral University Teaching Hospital NHS Foundation Trust





Based on divisional submission by specialty, of intended % Non-F2F

- New appts **66%** Non-F2F
- FU appts **79%** Non-F2F

Divisional Narrative:

verbal update

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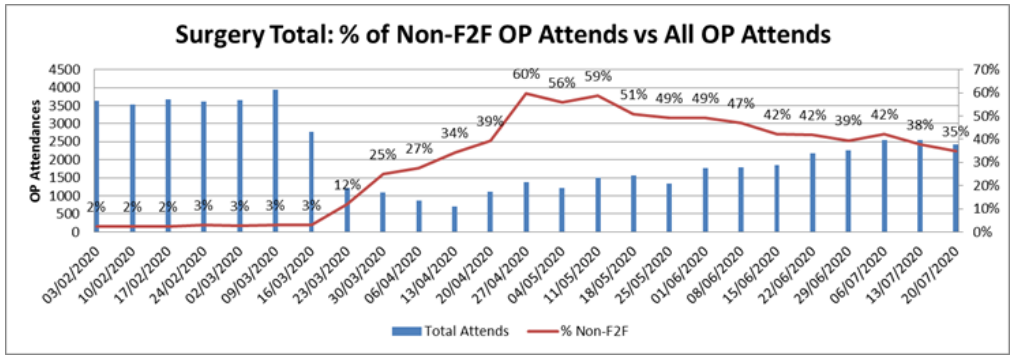
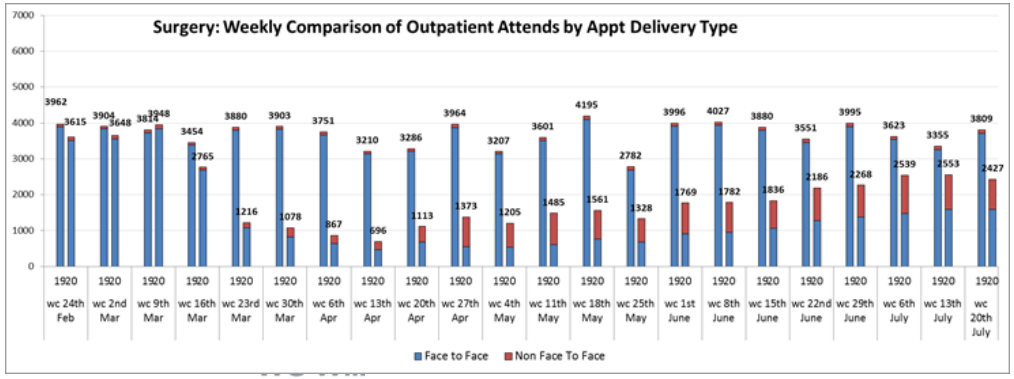
Outpatient Consultations at WUTH

Surgery

Wirral University Teaching Hospital NHS Foundation Trust





Based on divisional submission by specialty, of intended % Non-F2F

- New appts **29%** Non-F2F
- FU appts **42%** Non-F2F

Divisional Narrative:

verbal update

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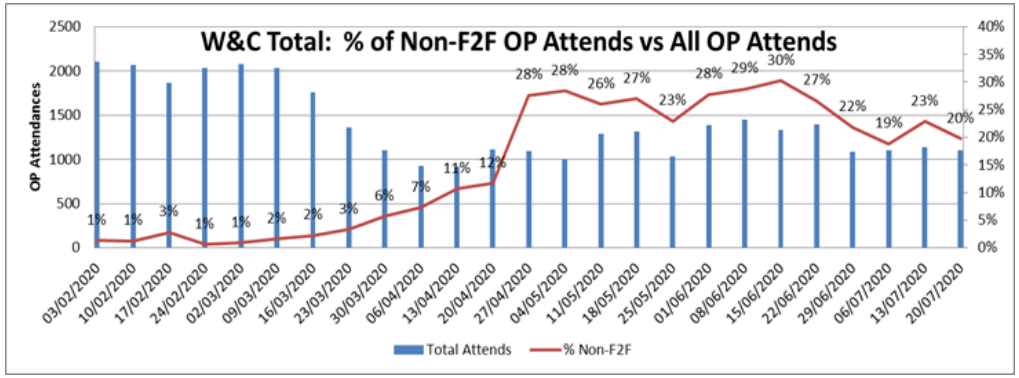
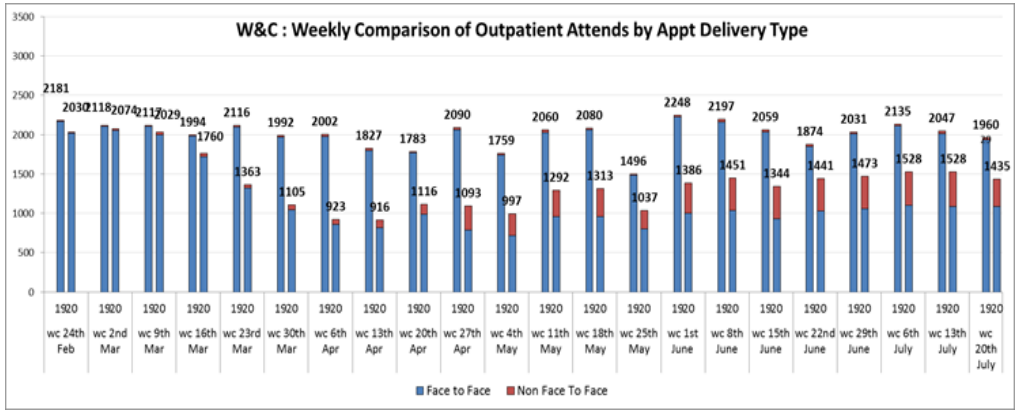
Outpatient Consultations at WUTH

Women and Children's

Wirral University Teaching Hospital
NHS Foundation Trust





Based on divisional submission by specialty, of intended % Non-F2F

- New appts **37%** Non-F2F
- FU appts **28%** Non-F2F

Divisional Narrative:

verbal update

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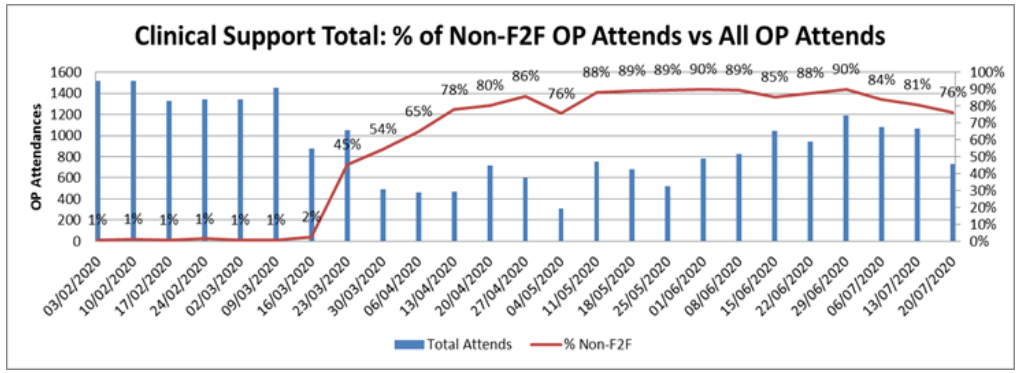
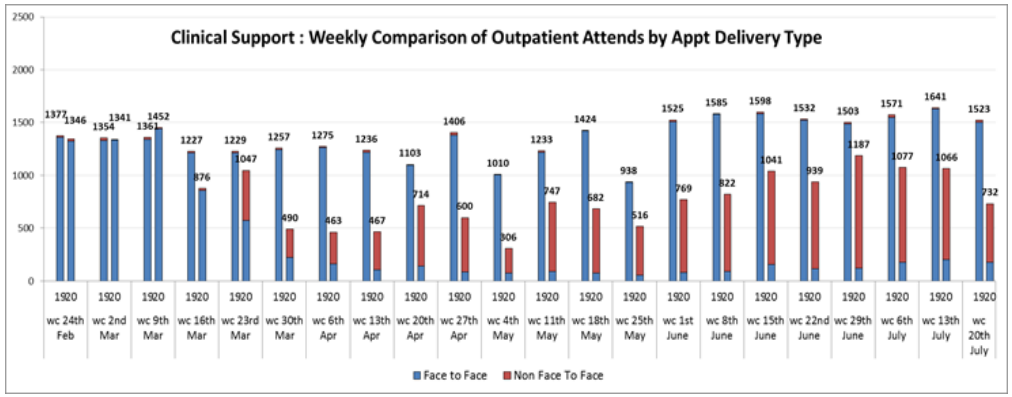
20-21 122 Change Programme Summary, Delivery & Assurance

Outpatient Consultations at WUTH

Clinical Support

Wirral University Teaching Hospital
NHS Foundation Trust





Based on divisional submission by specialty, of intended % Non-F2F

- New appts **20%** Non-F2F
- FU appts **20%** Non-F2F

Divisional Narrative:

verbal update

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20-21 122 Change Programme Summary, Delivery & Assurance

Flow Metrics – Steering Group 10 Aug 20

Wirral University Teaching Hospital NHS Foundation Trust

Patient Flow Improvement Group Reporting Meeting - August 2020									
ID	Description	Reporting Period	Period Target	Jul-20	Jun-20	May-20	YTD Target	YTD Performance	YTD Variance
Patient Flow									
1	Bed Occupancy	Jul-20	93%	83.6%	82.8%	78.8%	93%	78.3%	-14.7%
2	Time spent in A&E (Minutes)	Jul-20	240	172	167	153	240	163	-77
3	Average current in-patient LOS (Closed Spells)	Jul-20	TBC	4.13	4.69	4.69	TBC	4.95	
		Week Commencing	Target	28/07/20	21/07/20	14/07/20	07/07/20	30/06/20	23/06/20
4	Total Number of Long Stay Patients - >=21 days	28/07/2020	52	54	52	48	43	48	55

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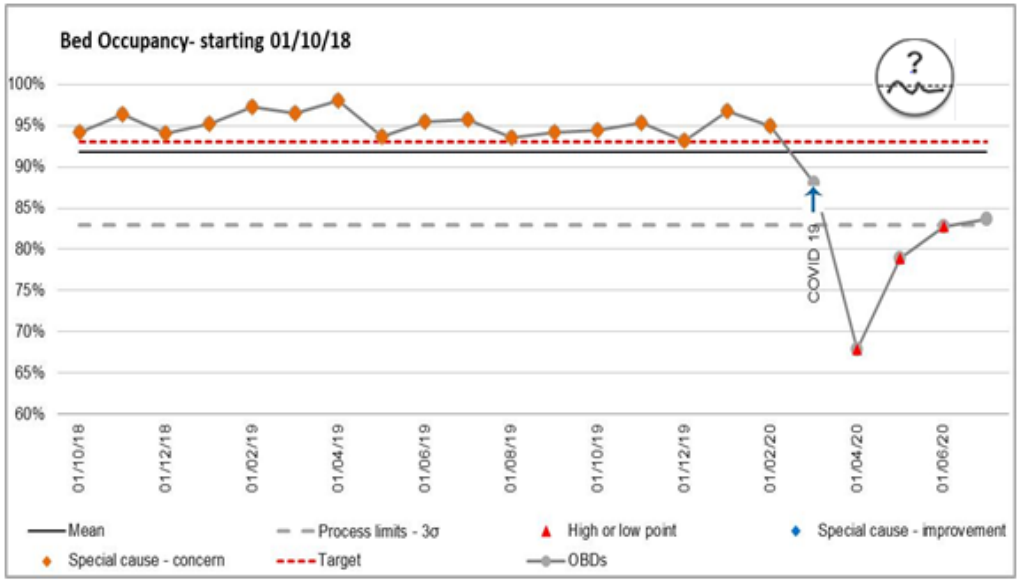
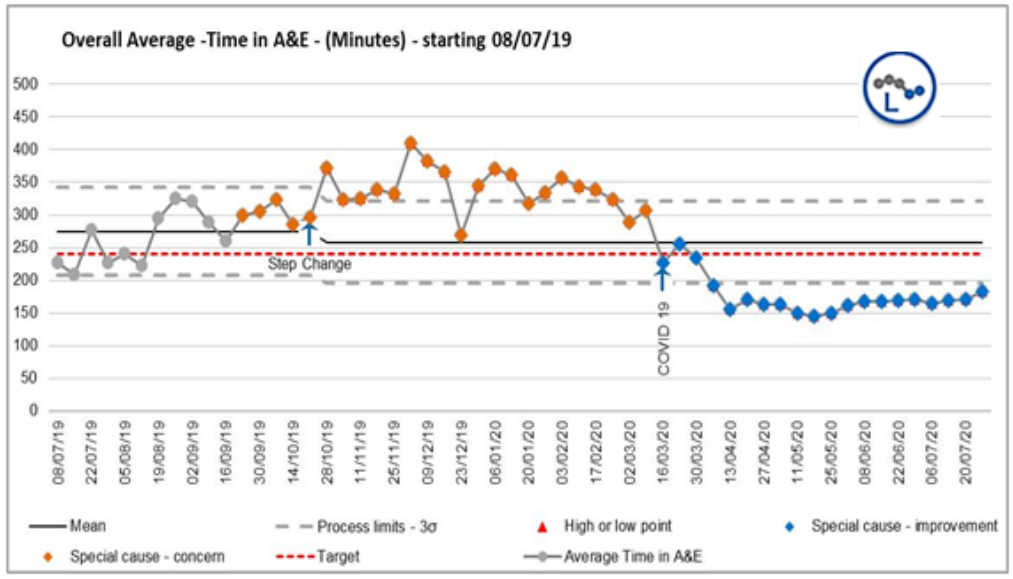
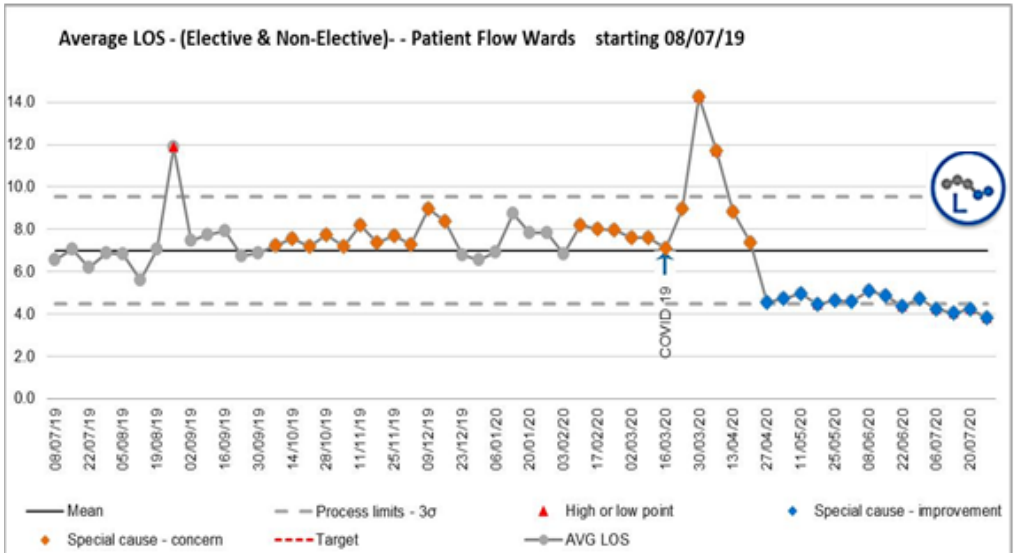
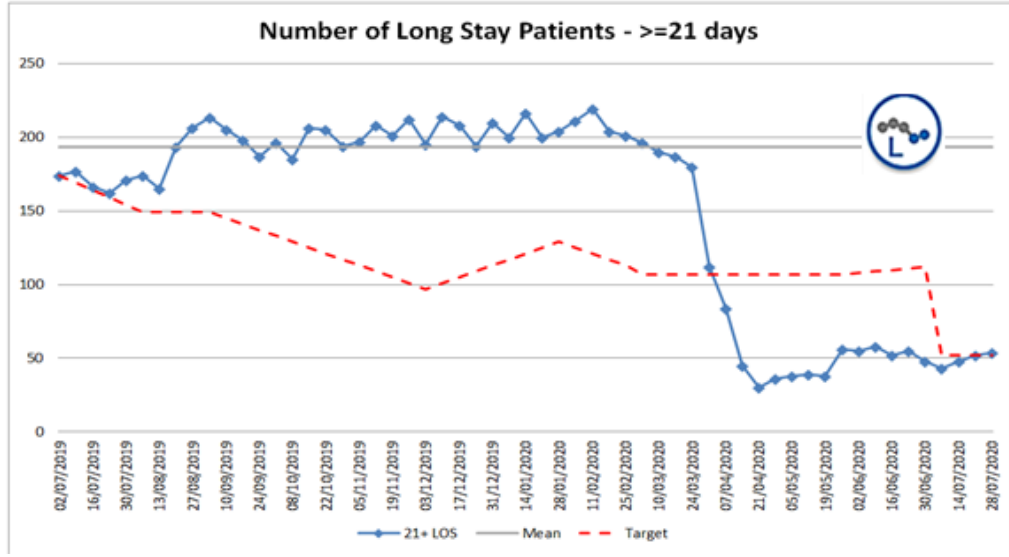

Bed Occupancy- starting 01/10/18
100%
95%
90%
85%
80%
75%
70%
65%
60%
01/10/18
01/12/18
01/02/19
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
COVID 19
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
OBDs

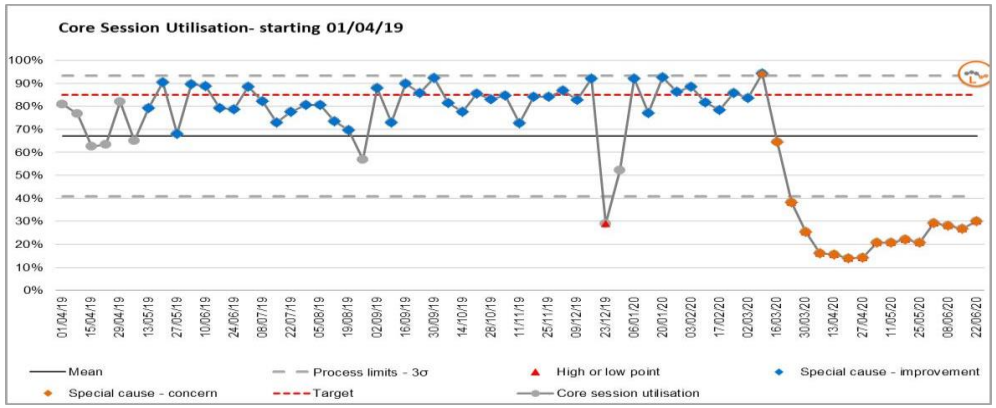

Overall Average -Time in A&E - (Minutes) - starting 08/07/19
500
450
400
350
300
250
200
150
100
50
0
Step Change
COVID 19
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Average Time in A&E

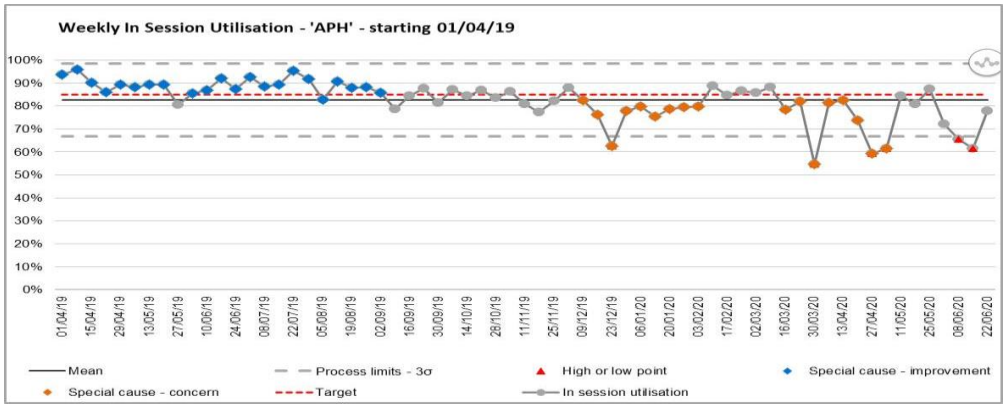

Average LOS - (Elective & Non-Elective)- - Patient Flow Wards starting 08/07/19
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
COVID 19
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
AVG LOS

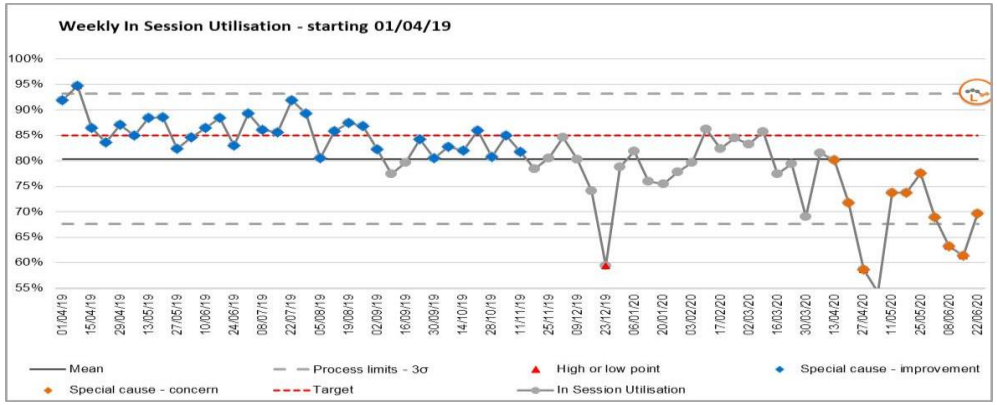

Number of Long Stay Patients - >=21 days
250
200
150
100
50
0
21+ LOS
Mean
Target

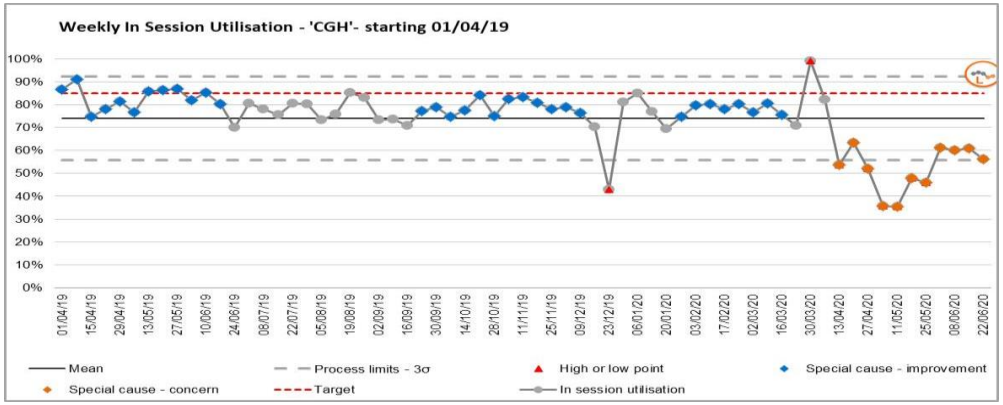
Perioperative KPIs - Programme Board 19 Aug 20

Wirral University Teaching Hospital NHS Foundation Trust



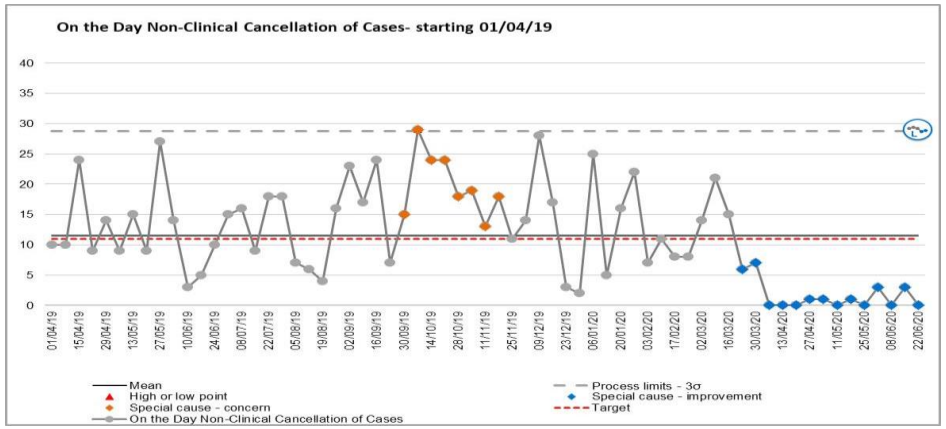


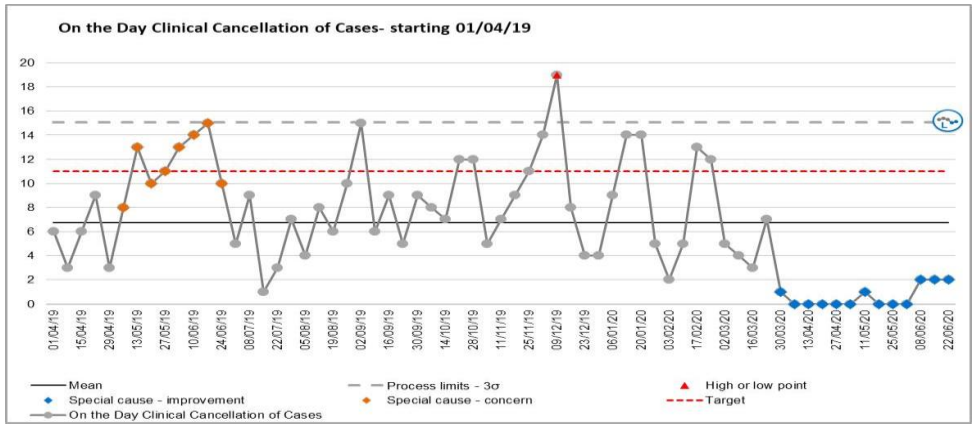


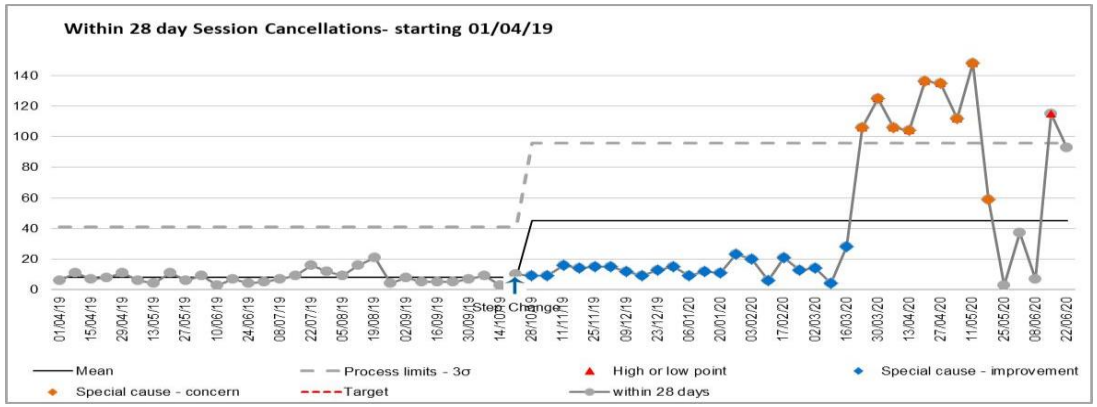


Perioperative KPIs - Programme Board 19 Aug 20

Wirral University Teaching Hospital
NHS Foundation Trust







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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Programme Assurance Ratings

Joe Gibson
20 August 2020

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Green	Delivery	Amber

- The data for the key '21day + LoS' metric for the Flow Programme is last reported at 28 Jul 20 as 54 Long Stay Patients compared to the revised period target of 52; the target line on the graph has been moved to reflect the new threshold.
- The 'Front Door Project Post-COVID Re-Start' (PowerPoint), 6 Jun 20, states benefits have been agreed; however, latest workbook (SharePoint 18 Aug 20) shows a total of 59 metrics (albeit many repeated across several assessment units) with 33 target outcomes and 33 baselines (on different lines) yet to be defined.
- **The 'Capacity Management' system, launched 9 March 2020, is now reported as delivering a 95% accurate picture of the Trust position; the system needs to be 100% accurate. The review of the bed bureau working model will report to the Programme Board in October. Continuing accuracy checks should be monitored until a stable (3-6 month) 100% reliability is established.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Amber

- The revised PID v0.5 dated 4 Mar 20, including an extensive schedule of benefits and measures, remains extant. As well as the Steering Group there is evidence of a 'Patient Safety and Experience Project Group' and an 'Operational Excellence Project Group'.
- The Benefits Tracking Tool shows 9 metrics on track while 11 metrics require further work to be defined; of the 7 benefits presented to the Steering Group (10 Aug 20) 5 had improvement targets 'TBC'.
- **The project needs to clarify and complete its benefits realisation plan in order to assure delivery.**

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Green	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 had stabilised in a range of 52-59% over the 12 weeks 27 Apr - 13 Jul; the most recent data point for 20 Jul shows a reduction to an overall 46% against an activity level of 65% compared to the same week in 2019.

- **Compliance and Exceptions:** The programme team continues to work with the 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 had identified 'clinical exceptions where face-to-face (is) necessary have been quantified and signed off by (the) Division'; at that time, for 8 specialties, this identification and Divisional sign off remained a work in progress. A detailed report on the completion of this work should be presented to a future Programme Board.

- **One Patient Record:** The programme aims to implement 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 were stated as being rated as 100% (green) with 'no case notes required'; the remaining 20 specialties were in a range between 20-90% rated. A detailed report on the completion of this work should be presented to a future Programme Board.

- **Target: The programme target for overall delivery by remote means (cited in PID 2 Jul 20, as 50% Non face-to-face) is being refined using a comprehensive bottom-up approach of analysis and validation of exceptions with Divisions. This work will mediate the two reference sources:**

    - **The Simon Stevens - 3rd Phase of NHS response to Covid letter, 31 Jul 20 defines: New appts 25% Non-F2F, FU appts 60% Non-F2F.**
    - **Divisional submission by specialty, intended % Non-F2F - Trust aggregated value: New appts 37% Non-F2F, FU appts 45% Non-F2F**

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Workforce Planning - Programme Assurance Update – 11 August 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 - Jul 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 – 11 August 2020

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

Independent Assurance Statement

1. Scope defined in PID v10 dated 3 Mar 20 (benefits to be completed by 30 Apr 20). The 'Front Door Project Post-COVID Re-Start' (PP), 6 Jun 20, states benefits have been agreed; however, the PID shows all 39 target improvement dates yet to be agreed and many baselines to be established. **2. & 3.** There is a ToR, Issue v3.0 dated 7 Jan 20 and evidence of team meetings up to 31 Jul 20; incl. meeting packs, actions logs and attendance records. **4.** There is a list of stakeholders and a 'Front Door Stakeholder Engagement Log', with activities to end Jun 20. There is 'as is' process mapping. A Comms Plan/evidence of comms would give further assurance. **5.** A EA/QIA v1 has been drafted for the Front Door AU and awaits sign-off once there is clarity on the future design. **6.** The project plan, workbook v12 dated 11 Aug 20, is updated to w/c 10 Aug 20. There are a number of delayed actions and the plan extends to early Oct 20 albeit many benefits are planned for delivery in Jan 21. **7.** The 'Benefits Tracking Tool' shows the ED Improvement Plan rated green. Other benefits are re-scheduled, per exception report to Prog. Board, to be delivered by 1 Jan 21 but around 50% lack baseline data and/or target outcome. **8. & 9.** There are 5 risks on the register; most with Jul 20 review dates (1 dates back to Dec 19); 9 additional (potential) risks raised on 30 Jul 20 are undergoing risk assessment. There are 8 live issues logged. **Most recent assurance evidence submitted 11 Aug 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 – 11 August 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, v0.11 dated 13 Feb 20, remains extant on SharePoint. A new draft 'Sustain and Review' phase document v0.7 dated 10 Aug 20 has an expanded table of metrics (from 4 to 7); all baselines are now established and of the 9 associated targets, just 1 remains 'tbc'. **A** 'Patient Flow Vision' (on a page) was uploaded on 6 Aug 20. **2 & 3.** Evidence of CapMan project meetings is uploaded in an 'Action Log' to 6 Aug 20. The 'Divisional Sign Off' process, including commitments, was completed prior to implementation on 9 Mar 20. **4.** There is now a revised Comms Plan for Phase 2, uploaded on 11 Aug 20; 4 actions are rated by the project as green and 5 are rated amber. **5.** EA has been drafted and QIA signed-off. **6.** The Capacity Management Project Plan in the workbook dated 10 Aug 20 shows actions updated to w/c 27 Jul 20 with several actions behind schedule. The Plan itself only extends to end Sep 20. **7.** As described above, metrics for the 7 benefits are now largely developed and with target implementation dates of Dec 20. **8 & 9.** There is a risk register as part of the workbook, it states that the one remaining risk was transferred to the issue log on 22 Jun 20. There is now a total of 5 recorded issues with owners and status. **Most recent assurance evidence submitted 11 Aug 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 – 11 August 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 6 Aug 20. **4.** There is evidence of stakeholder engagement and guidance, including a 'Flagship Ward' plan extending to the end of September 2020. The Comms Plan for the project shows actions RAG rated and is updated to 31 Jul 20. **5.** There are 'post-COVID' EA/QIA drafted awaiting sign-off. **6.** The project plan - in the workbook dated 7 Aug 20 - shows actions broadly on track with all actions complete by 28 Sep 10; however, original PID benefits schedule extends to 31 Mar 21. **7.** There is a 'Benefits Tracking Tool' within the workbook, giving 5 key metrics: 33% of patients discharged before midday; and 4 related to LoS of patients with LoS at - 7 day+, 10 day+, 14 day+ and 21 day+. 'Home before midday' needs a target date as do 2 of the LoS metrics (the other 2 are on 'maintain'). The key 21day LoS (Long Stay Patients) target has been achieved as a result of health economy COVID measures (trending at 53 against <52 target at 7 Aug 20). **8. & 9.** There is a risk register with 3 open risks last reviewed on 6 Aug 20. There are no recorded issues. **Most recent assurance evidence submitted 7 Aug 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 – 11 August 2020

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

Independent Assurance Statement

1. The PID v0.7 dated 24 Jul 20 has been uploaded, the changes include: a full review of the PID, milestones added and benefits updated. There are now 7 benefit types described with associated metrics, including baselines, targets and achievement dates. The milestone dates have been re-scheduled (post-COVID) and show the 'Sustain & Review' phase completing in April 2021. **2.** The Project Lead and Programme Manager now meet weekly for 30mins but there is no evidence of any 'project team' (6 roles are cited in the PID) meetings since May 20; so clinical leadership and engagement at the project team level are absent. There is an action log for meetings with actions arising in July and also an attendance record. **6.** The project plan is updated to w/c 27 Jul 20 and reflects the updated milestones in the revised PID and is broadly on track; however, there is a 5 month delay to the 'Trauma Documentation' build, an exception report has been drafted and needs sign-off. **8 & 9.** There is a populated risk register, with five risks, and the 'date of last review' is 24 Jul 20. There are six open issues, including non-attendance at project meetings, and these were last reviewed on 29 Jul 20. **Most recent assurance evidence submitted 6 Aug 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 – 11 August 2020

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

Independent Assurance Statement

1. The revised PID v0.5 dated 4 Mar 20, incl. 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 Prog. Board in June 2020. **2.** As well as the Steering Group 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 28 Jul 20. **4.** There is a Comms Plan, 19 Feb 20, which covers stakeholder engagement both with the programme an individual work streams through 2020. The plan is now supplemented by a Comms tracker updated to Aug 20; evidence of Comms deliverables has also been uploaded as supporting evidence. **5.** The QIA was revalidated in Oct 19. **6.** The detailed project plan is on track, 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 shows 9 metrics on track while 11 metrics require further work to be defined; of the 7 benefits presented to the Steering Group (10 Aug 20) 5 had improvement targets 'TBC'. **8 & 9.** Risks ands issues are now logged in the workbook and are updated to 21 and 28 Jul 20 respectively. **Most recent assurance evidence submitted 10 Aug 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 – 11 August 2020

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

Independent Assurance Statement

1. The Theatre Scheduling PID v1.0 Final (v3 dated 27 Feb 20) approved by the Perioperative Steering Group on 28 Jul 20. **2.** There is evidence of a 'Theatre Scheduling System' Action Log with entries up to 24 Jun 20 and a record of meetings (with minutes) to 25 Jun 20. **6.** There is a Theatre Scheduling workbook v1.3 uploaded on 28 Jul 20; the project plan is largely on track and shows post-implementation activities will complete in Nov 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 31 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 – 11 August 2020

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

Independent Assurance Statement

1. The DRAFT PID v3.0 revised 2 Jul 20 (labelled 30 Jul 20) has been agreed by the Outpatients (3 Aug 20) and Programme Steering Groups (10 Aug 20) will need to be endorsed by the Programme Board. The benefits, post COVID-19 changes, are defined in the PID. **2.&3.** An Outpatients Transformation Project Team ToR is in place at v2.0, authorised 10 Jun 20, with evidence of meetings to 3 Aug 20 together with an Action Log. **4.** The 'Outpatients Comms Plan', last updated 10 Jun 20, describes the comms approach but needs to be tracked (RAG rated for progress); there is also evidence of 'Clinical Feedback' and 'Patient Feedback' exercises. **5.** The revised QIA/EA, raised after the rapid (COVID-19 driven) changes, is prepared and awaits sign-off. **6.** The project workbook, dated 6 Aug 20, shows the project plan broadly on track to w/c 3 Aug 20 - a new baseline was established by exception report to June 20 Prog. Board, with project completion in Mar 21. **7.** The Benefit Tracking Tool describes two benefits (ratified in new PID) with benefit tracking in a separate folder. The WUTH Total of NonF2F Attends (target 50%) has been trending down from a high of 59% on 8 Jun to 46% on 20 Jul. **8 and 9.** There is a populated risk register, with 11 live risks, last updated to 5 Aug 20. There are 3 closed issues and 2 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 – 11 August 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 9 Jul 20 and also the agenda of a project meting on 23 Jul 20. An 'Action Log' tracks task completion, with 2 actions currently open (due by 20 Aug 20) and the remainder shown as complete. **6.** The workbook 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 8 live risks reviewed to 7 Aug 20 (and 1 to 1 Jul 20). One project issue has been closed and one remains live, raised on 1 Jul 20. **Most recent assurance evidence submitted 7 Aug 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 – 11 August 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 was approved at Programme Board, May 20. A proposed change to scope, 'Patient Portal Mass Registration Proposal' dated 24 July 20, was presented to the Programme Steering Group on 10 Aug 20 but was not agreed. The project will be subject to consideration at the Programme Board on 19 Aug 20. **2.** There is an Action Log and evidence of meetings to 5 Aug 20. **3.** The ToRs for the Working Group are in evidence with authorisation and review dates. **4.** The Comms and Engagement plan has been produced and has been updated to end July 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, updated to 5 Aug 20, which shows that the activities and tasks are largely on track. **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 22 Jul 20 and there are also 7 issues logged in the workbook. **Most recent assurance evidence submitted 5 Aug 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 – 11 August 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 to DPSOC dated 5 Aug 20 summarising the current status of the project. **2.** There is evidence of project meetings and discussions to 10 Aug 20 and a ToR for the project group. **6.** There is a Digital Dictation workbook uploaded to SharePoint on 11 Aug 20 and the project plan has been updated to w/c 3 Aug 20 and is largely on track. **8 & 9.** The risk register for the project shows the date of last review for the four open risks raised as 10 Aug 20. There is one open issues recorded. **Most recent assurance evidence submitted 11 Aug 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	20/21 123
Title of Report	Report of the Safety Management Assurance Committee held 3.8.20
Date of Meeting	2 September 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 3 August 2020.

1. Chair of Health and Safety Committee Report

There was good attendance at the meeting with representatives from all of the Divisions apart from Women & Children's. Key issues considered during the meeting were as follows:

The Committee reviewed current Health & Safety-related risks, of which there were 22, with the highest scoring risk relating to medical records and the storage of paper records.

The top six clinical incidents were noted as follows:

- Violence and Aggression (90)
- Sharps (25)
- Unsafe Environment (22)
- Slips, Trips & Falls (22)
- Collision with an Object (20)
- Manual Handling (12)

Since 1 April 2020, there have been a total of 14 RIDDOR reportable incidents, 2 of which resulted in over 7 day absences from work. As a result of the recent changes to report certain COVID events, there will be a substantial increase in the overall number of RIDDOR reportable events within the financial year. This however will be similar across all NHS organisations.

Two Duty of Care notices have been issued which relate to the improper disposal of sharps or clinical waste.

The Committee noted that meetings of the NITS Group and Violence & Aggression Group, which had been suspended due to the Covid-19 pandemic, were scheduled to resume in July 2020. The Committee was also updated on an incident relating to a high legionella count identified on Ward 20. The incident was subject to investigation and a number of recommendations were made as a result of the investigation. A Water Safety report will be considered at the Health & Safety Committee meeting in August 2020.

The Committee noted that actions identified in the CQC inspection report were being progressed to ensure that the Trust is able to evidence improvement in relevant health and safety requirements. Progress had been made against the actions and will continue to be monitored by the Committee until completion.

2. Divisional Exception Reports and Dashboards

Exception Reports and Dashboards for the following Divisions were reviewed and discussed in detail by the Committee:

- Estates and Facilities
- Medicine and Acute
- Diagnostics and Clinical Support

3. Legionella Investigation Report 48894

The Committee was advised that concerns regarding the risk of legionella on Ward 20 were first highlighted to the Quality & Safety Assurance Committee in March 2018. The report presented to that meeting identified the requirement for further investigation on the pipework and required remedial works. Remedial work was undertaken on 10 outlets, including work comprising a full audit in order to identify routes of pipework and potential 'dead legs' to enable the creation of more water pressure to balance the system enabling water to flow out of the circuit and return at above the required levels.

New monitoring systems were also installed to monitor temperatures on a daily basis. Filters were installed in showers and at clinical wash hand basins. The ward remained open for the duration of the work which limited remedial work undertaken in the ceiling space. Point of Use (PoU) bacterial filters were fitted to all clinical wash hand basins. However, these are generally a temporary solution until a more permanent solution can be implemented. These filters have remained in place since 2018.

Although flushing compliance had been achieved, the Water Safety Group escalated on 28 May 2020 that both Bronze Command and the Chief Nurse were to be informed of the requirement to

close Ward 20 to undertake more extensive action and to ensure patient and staff safety. The Chief Nurse then initiated a Local Review in order to ensure the following:

- That appropriate actions had been taken in response to the incident to safeguard the safety of patients and staff
- To gain an understanding of the Trust's escalation processes and confirm that they were effectively applied and appropriate to the level of risk
- Assess lessons learned from the incident.

The Committee was advised that actions had been taken which had resolved long-standing issues and that water samples were indicating 100% compliance. This subject is recorded on the Risk Register but the risks associated with ward closures and financial implications will delay full resolution. However, remedial works have been included in the 2020/21 capital programme. The Committee was content to take some reassurance from this and recommended that the subject be reported to the Board.

4. Legal Services Annual Report

The Committee was advised that this report had also been presented to the Patient Safety Quality Board and the Quality Assurance Committee. The Committee noted that 31 non-clinical claims had been settled at a cost to the NHS of £974,693 with 75% of this sum relating to settlement of 2 high value claims. Both of these claims concerned work-related stress. If excluded from the total, the average cost incurred in settling a non-clinical claim in 2019/20 was circa £8,300.

The Committee noted that 20 non-clinical claims had been successfully defended and closed with no payment being made to the claimant. A number of our claims are being settled without payment which indicates that our process is improving and generating more robust evidence to allow us to defend claims successfully.

5. Cycle of Business

The Committee considered and agreed the Cycle of Business in the context of work to be undertaken going forward. The Committee also considered whether the frequency of meetings should be adjusted so that the Committee would meet on a bi-monthly cycle in common with other Board Committees. Frequency of future meetings will be confirmed following further discussion.

Steve Igoe
Chair, Safety Management Assurance Committee

BOARD OF DIRECTORS	
Agenda Item	20/21 123
Title of Report	Report of the Safety Management Assurance Committee held 26.8.2020.
Date of Meeting	2 September 2020
Author	John Sullivan, 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 26 August 2020. Unfortunately due to annual holidays and urgent restart pressures the meeting was not quorate.

The decision to move the meeting's frequency to 2 monthly from monthly is still to be made.
The committee received the following reports:

- Assessment of the H&S Management Committee performance and governance
- Divisional H&S Exception reports and dashboards for Women & Children and Surgery Divisions
- Water Safety Group -- Chair's report
- Safety Management Assurance Committee Cycle of Business

Key points taken from the meeting:

- Contractor work control in clinical areas was discussed following a reported incident in Surgery. The committee was assured that lessons had been learned and improved processes for work control implemented across the Trust.
- Congratulations were passed onto the H&S Team for facilitating the achievement of a ROSPA Gold Award 2020. H&S engagement has improved markedly and the culture is moving in the right direction. The committee noted that culture change is the way to embed the improvements.
- There are many H&S related audits happening in the Trust but not being captured centrally. Therefore not providing assurance. This will be an area of focus in the 2020/21 H&S Work plan.
- The committee supported the work to provide more H&S Advisor resource in Estates and Facilities Division.
- Number one of the top six non clinical incidents was physical assaults at 532 incidents in 2019/20.The committee supported the work to set up a multidisciplinary expert group to critically examine violence and aggression assaults and seek appropriate preventative actions.
- The committee were pleased to hear that the Water Safety Group now meets monthly rather than quarterly providing improved assurance following recent Legionella issues.

The next meeting is planned for 29th September 2020 unless the change to 2 monthly frequency is approved.

John Sullivan
Non-Executive Director

Board of Directors	
Agenda Item	20/21 124
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	2 September 2020
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Charitable Funds Committee 7 August 2020

This report provides a summary of the progress of the Charitable Funds Committee which met on 7 August 2020.

1. Head of Fundraising Report

The Committee received a report on the recent activities of the Charity team. This included the fundraising activities since the last meeting and also the coordination and support provided in relation to public donations over the COVID-19 period.

It was noted that the last five months have been unprecedented as the Trust and wider community have responded to the COVID-19 pandemic. Inevitably, this has meant postponement of a number of fundraising activities which had been planned over the period, however, the team have quickly adapted and have provided a wide range of alternative support to the Trust and its staff.

Key activities are as follows:

- The Charity Team have led the co-ordination of significant levels of donations of goods for staff
- "Salute the NHS" to provide meals to frontline staff during the COVID-19 pandemic was launched.
- 6 year old Will Ritchie who has complex health needs has walked each day totalling a marathon in a month and raised over £14,000 for the hospital
- Scottish Power Energy Networks and partners David T Hughes Contractors Ltd undertook a week long project resulting in approximately 100 volunteers landscaping areas, remarking visitors car park and painting thank you messages.
- A COVID-19 support fund was launched in April 2020 to provide support to staff, volunteers and our hospital. £50,000 raised in the first 6 weeks and has been supported by the Wirral Globe
- The Trust has received £273,500 funds from the national NHS Charities Together appeal. The Head of Fundraising and the Director of Communications and Engagement have met with the Chief Executive to discuss plans to spend the funds including staff suggestions from the ideas board.
- Plans to launch the 'Rainbow Flower' appeal where donors can purchase a flower to display in their garden to show support to the charity.

The Tiny Stars Neonatal Appeal activity has been paused due to COVID-19. The Committee supported a relaunch of the appeal in Spring 2021 and extend for the whole of 2022 / 2023 financial year

For regular updates please visit wuthcharity.org or via social media - @wuthcharity. To lend your support to the Tiny Stars campaign please 'like' and 'share' the planned events as much as possible.

2. Finance Report

The committee reviewed the month 4 financial report and noted that the necessary pausing of traditional fundraising activities has had an impact on income. Total income recognised to date is £211,000. Donations received total £121,000, of which, £112,000 was received into the newly established COVID-19 fund. However, the donations received from both national and local COVID-19 appeals, would enable the Trust to make some significant investments which will benefits staff and patients and this will be discussed further at the next meeting.

It was also noted that 2 Static Echo machines had been purchased from the Heart fund costing £195k.

3. Staff Recharges

The charity team quickly responded to the needs of the Trust during the initial phase of the pandemic. This included:

- the creation and management of a volunteer database,
- coordination and distribution of donations in kind to staff throughout the hospital

- led the establishment and ongoing distribution of thousands of donated meals per day to staff working on the front line

In light of this, the committee agreed that it would be inappropriate to continue to charge the costs of the team to the charity for the period 1 April 2020 to 31 July 2020 and instead these costs would be met by the Trust.

4. APH League of Friends (LoF)

The Head of Fundraising updated that the League of Friends have advised of their intention to continue management of the League of Friends shop in the interim. The League of Friends has recruited a number of new Trustees and a new Treasurer has also been appointed.

5. Recommendations to the Board of Directors

The Committee asks the Board to note the following items:

- The Committee supported a relaunch of the Tiny Stars appeal in Spring 2021 and extend for the whole of 2022 / 2023 financial year.
- That charity team costs for the period 1 April 2020 to 31st July 2020 will be funded by the Trust given that the team were supporting Trust COVID-19 activities during this period.

Board of Directors	
Agenda Item	20/21/ 126
Title of Report	Communications and Engagement Monthly Report
Date of Meeting	2 September 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 Director of Communications and Engagement is reviewing suitable metrics such as media monitoring to support Board assurance.

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 acute Trusts.

Charitable fundraising is measured by the funds raised, but is also a significant factor in staff engagement. As the COVID-19 funds are collated, the Trust charity will be making recommendations for spend on significant staff and patient wellbeing projects.

There is separate assurance of charity activities provided through the Board committee for charitable funds and the committee Chair's Report will be tabled for the September Board meeting.

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

Our Infection Prevention and Control (IPC) Team have launched an awareness campaign, aimed at keeping things 'SIMPLE'.

It's a clear – and simple – way to remember the aspects of IPC. Over the next six weeks, our Trust will be running a campaign on six key themes:

- **S**urveillance.
- **I**nvasive devices.
- **M**ulti-disciplinary groups.
- **P**ersonal protective equipment.
- **L**essons learnt.
- **E**nvironmental cleanliness.

The campaign started with an overview of the organisms associated with infection prevention and control. This included a helpful guide to the reportable organisms and the best way to guard against them. The campaign also serves as a reminder of the other important aspects of IPC, alongside COVID-19 measures. Read the first newsletter **here.**

Keep it SIMPLE.

- The team supported campaigns such as The World Health Organisation's World Breastfeeding Week and the Drymester campaign Went in bulletin and social media

- We are also preparing for the launch of 'NHS 111 First'- a new service, which aims to reduce overcrowding and risk of transmitting COVID-19 in hospital emergency departments, which will be rolled out across the North West in time for winter. The enhanced NHS 111 First service will offer a booked time slot in emergency departments to patients with an urgent – but not serious or life-threatening illness or injury.

2. Media

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

A six-year-old boy Will Ritchie, 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. Will has also been selected as one of the NHS Coronavirus heroes to be featured in the Blackpool Illuminations

The Wirral Globe featured an article on the new uniforms launched for staff at WUTH. A social media campaign and extensive internal communications have promoted the smart new look for WUTH staff.

A feature appeared in The Globe about a group of Chinese doctors who had spent time at Arrowe Park Hospital last year to learn about best practice and this year they donated funds to the WUTH Charity COVID-19 appeal. Link to Chinese doctors article.

- The award of capital funding of £1.5m for immediate investments in ED and social distancing measures for clinics was also featured in local, regional and national media as part of a £300m packages from the Government.

- The Wirral Globe featured coverage of patients waiting more than 18 weeks for routine treatment being at a record high due to COVID-19. We continue to communicate the fact that we're open and running all services in order to encourage patients to attend where they need to or are planned for an appointment (Link to article on waiting times)

Internal Communications and staff engagement

- We resumed a normal cycle of 2 'In Touch' staff Bulletins a week with important information on PPE, clinical guidance, staff wellbeing and support; Trust-wide initiatives, NHS information, learning and development; and charity/community updates. The closing issue of the COVID-19 Bulletin featured a thank you video to staff from CEO, Janelle Holmes on behalf of the Executive Team.

- We are resuming the Trust magazine, with a September issue in production.

- We produced our 'From the Board' summary with a communication to staff covering the Board's August 2020 meeting.

- We are preparing for the 2020 staff survey, which will run in September 2020. We have reappointed Quality Health as our contractor for the survey.

- We are taking part in a pilot for the NHS People Pulse, which is a 'temperature check' employee sentiment product that NHS People has created for trusts to share in free of charge until January 2021. We have received our first report, which will be shared at the next Workforce Advisory Committee.

- Communications on the 'lockdown' of Arrowe Park Hospital continue on the reduced entrances and exits for staff and patients and enhanced IPC measures. The next phase of ID badge renewal, to then enable door access control, was communicated to staff. The door lockdown will commence the second week in September.

Charity

- We have exceeded £116,000 in donations via The Wirral Globe Appeal for local COVID-19 support. These monies will be added to the received £80,000 and £50,000 allocations from The NHS Charities Together fundraising – an additional £143,000 is expected to be confirmed in September 2020. Proposals are being developed to invest in staff wellbeing and welfare at both hospital sites.

- As reported in the media section, our top fundraiser, 6 year old Will Ritchie, and #willsmarathonmonth has been successfully nominated by our head of fundraising, Victoria Burrows to feature in a special NHS heroes' tribute installation at Blackpool Illuminations. Switch on via a virtual event and concert is at 9.30pm September 4th.

- Fundraising activity by the Charity team has resumed. We have launched our Challenge 100 individual medal challenge and our Wirral Rainbow Flower project is in planning and will be launched early September.

- An adapted fundraising calendar and strategy are currently being developed for agreement by the Charity Committee.

- The Charity Committee met last month and the Chair's Report will be presented at the Board meeting.

Stakeholders

- We continue to highlight the Keep Wirral Well partnership campaign to the public in relation to COVID-19 and other general health promotions - Keep Wirral Well.

- We met with CCG communications colleagues to progress joint priorities on winter planning, flu, NHS 111 First, the Healthy Wirral Partnership and Keep Wirral Well.

- The CCG contacted Primary Care colleagues and GPs on our behalf directly with a communication from Medical Director Nikki Stephenson to help GPs reassure patients about the IPC and environmental safety measures in place at all our hospitals. This is part of reset and recovery communications to encourage patients to attend appointments or ED where necessary.

- We took part in a stakeholder discussion to help shape the next phase of the Healthy Wirral strategic narrative and pilot project in Medicines Optimisation.

- 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, led by the Council CEO.

- We have nominated colleagues who have provided exceptional public and NHS service for the national COVID-19 honours and for the NHS Parliamentary Awards, nominated by local MPs for NHS organisations in their constituency.

Sally Sykes
Director of Communications and Engagement
24th August 2020

Board of Directors	
Agenda Item	20/21 127
Title of Report	The NHS People Plan 2020/2021
Date of Meeting	2 September 2020
Author	Cathy McKeown/ Jacqui Grice
Accountable Executive	Jacqui Grice Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive- Many aspects of the People Plan feature in our workforce offering. Gaps- additional requirements are being identified as per the brief
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

Board of Directors Brief regarding NHS People Plan 2020/21 - Action for us all

1. Background

The work to develop ***We are the NHS: People Plan 2020/21 – action for us all***, has been led by NHS England and NHS Improvement and Health Education England, with significant collaboration and contributions from people working across the NHS and the wider health and social care sectors.

Our NHS is made up of 1.3 million people who care for the public with great skill, compassion and dedication. Wirral University Teaching Hospital NHS Foundation Trust contributes to life in the Wirral region, not only being one of the largest employers but by supporting the health and wellbeing of the community and playing a leading role in research, education and innovation. The trust has circa 6000 staff to support.

Prior to Covid-19 the Trust had already responded to the interim People Plan, published in June 2019, and had developed a workforce strategy that set out to support its people. Then we endured the pandemic, with an earlier start than other Trusts in the UK due to housing guests from Wuhan. Many actions contained in the interim People Plan were implemented at pace as staff all over the country from every profession and staff group worked as teams to care for the public.

The People Plan 2020/2021 captures the response to Covid-19 and sets out the needs of our people to allow us to continue providing and developing services.

2. Introduction

The NHS People Plan 2020/21, along with "Our People Promise" was published on 6th August 2020. The Plan sets out what our NHS people can expect from their leaders and from each other. It builds on the creativity and drive shown by our NHS people in their response, to date, to the COVID-19 pandemic and the Interim People Plan. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people and work together differently to deliver patient care.

This plan sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take, over the remainder of 2020/21. It includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

The arrival of COVID-19 acted as a springboard, bringing about an incredible scale and pace of transformation, and highlighting the enormous contribution of all our NHS people. The NHS must build on this momentum and continue to transform – keeping people at the heart of all we do.

Our NHS People Promise is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace. For many, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must all pledge to work together to make these ambitions a reality for all of us, within the next four years. The People Promise is central to the People Plan and has been developed to help embed a consistent and enduring offer to all NHS staff. From 2021, the NHS Staff Survey will be redesigned to align with the People Promise.

3. Call to Action

Each local system is asked to develop a local People Plan in response to the national plan to be reviewed by regional and system level people boards. Whilst the Trust developed a local People Strategy in 2019 in response to the Interim People Plan, employers are encouraged to develop their own local People Plan. National metrics will be developed by September 2020 to track progress using the NHS Oversight Framework. The Plan makes clear the intention to see an increased role for systems to work with its constituent parts.

NHS Employers have set out actions for employers, systems and national bodies to enable the delivery of the plan. These are based on the following themes:

- Health and Wellbeing
- Flexible working
- Equality and Diversity
- Culture and Leadership
- New ways of delivering care
- Growing the workforce
- Recruitment
- Retaining Staff
- Recruitment and deployment across systems

4. Gap Analysis

At Trust level, the HROD Senior team are undertaking a gap analysis against the NHS People Plan to map our current provision and identify focus areas for 2020/21 as a priority. Our local People Plan will be developed based on this. The initial review will be undertaken by 26 August 2020. To date, initial gaps identified include a comprehensive approach in these areas:

Health and Wellbeing – Finalise and roll out of new IPC training plan, safe support for staff working from home, appointment of wellbeing guardian, continue free car parking at work (at least during the pandemic) safe rest spaces for staff, offer physical activity for staff during the day, every member of staff to have health and wellbeing conversations and new starters to have health and wellbeing induction, wellbeing / wobble rooms.

Flexible working – Roll out of new Working Carers Passport to support people with caring responsibilities, review of current flexible working arrangements and move towards an agile workforce, able to carry out a wide variety of roles from home as well as healthcare premises.

Equality and Diversity – Review recruitment and promotion practices to ensure staffing and those in leadership roles (including Non-Executive representation) reflects the diversity of the community and regional and national labour markets, include equality, diversity and inclusion in staff health and wellbeing conversations, ensure workforce leadership is representative of the overall BAME workforce, ensure elimination of ethnicity gap when entering into formal disciplinary processes.

Culture and Leadership – Review governance arrangements to ensure that staff networks are able to contribute to and inform decision making processes. Most actions are being led by NHSe/I and should be supported. These include competency frameworks for leaders, embedding a just and learning culture, talent management, free on line training, resources and tools to support leaders, joint training programme for FTSU Guardians and WRES experts, response to KARK review, leadership observatory to share best practice and commissioning research to support leaders.

New ways of delivering care – Structured approach to ongoing workforce transformation, expanding capabilities for flexible workforce, use of HEE's new on line learning hub, readiness for generalist training, transformation tools and Quality Improvement.

Growing the workforce – Support for the HEE goals around clinical workforce training places and placement capacity implications, protected time for training, support the delivery of pre-registration blended models and technology enhanced learning, research capability, national learning hub for volunteers.

Recruitment - .Apprenticeship pathways, extending work with schools, Growing NHS ambassadors to talk in schools about NHS work and careers. International recruitment, return to practice as part of recruitment drives. Build on volunteering success, Capitalise on the goodwill of NHS returners.

Retaining Staff – Designing roles to fit with each person's needs, preferences, skills and experiences. Career conversations mid-career workforce planning capability and systematic approach. Consistent approach to retention schemes, people pulse.

Recruitment and deployment across systems - Emphasis on system working and local partnerships, work with schools as above.

5. Next Steps

Cheshire & Merseyside HRD network will discuss an initial system response (gap analysis and issues) on 2 September 2020.

Executive Directors to have the opportunity to discuss the Trust gap analysis and input into the development of a Trust People Plan response from 8 September 2020, both at their regular weekly meeting and a workshop towards the end of September to discuss planning in greater detail.

The draft Trust level People Plan to be brought to Board of Directors for discussion and further input on 4 November 2020.

6. Conclusions

We are the NHS: People Plan 2020/21 – action for us all*,* sets out an ambitious vision for us to creative a workplace that values our people and will enable us to nurture existing staff and recruit new people who will be attracted to a caring, supportive employer who can articulate how they will develop career pathways in the 21st century. If we are to develop the Trust as an employer of choice and work on a system wide basis to improve the health and well-being of our population, we must embrace its approach.

7. Recomendations

The Board is asked to note the contents of the presentation and briefing paper and support the work being carried out to develop a local and system wide response.