Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

7 October 2020

Meeting of the Board of Directors
12.30pm - Wednesday 7th October 2020
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21 130	Apologies for Absence	Chair	Verbal	N/A
20/21 131	Declaration of Interests	Chair	Verbal	N/A
20/21 132	Chair's Business	Chair	Verbal	N/A
20/21 133	Key Strategic Issues	Chair	Verbal	N/A
20/21 134	Minutes of Previous Meeting – 2 September 2020	Board Secretary	Paper	4
20/21 135	Board Action Log	Board Secretary	Paper	15
20/21 136	Patient Story	Chief Nurse	Video	N/A
20/21 137	Chief Executive's Report	Chief Executive	Paper	16
Performance & Improvement				
20/21 138	Quality and Performance Dashboard and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	20
20/21 139	Month 5 Finance Report 2020/21	Chief Finance Officer	Paper	44
20/21 140	Use of Independent Sector	Chief Operating Officer	Paper	66
Governance				
20/21 141	Financial Envelope for Months 7-12 2020/21	Chief Finance Officer	Presentation	N/A
20/21 142	Monthly Safe Staffing Report	Chief Nurse	Paper	70
20/21 143	Workforce Disability and Inclusion (WDES) and Workforce Race Equality Standards (WRES) Report	Director of Workforce and OD	Paper	82
20/21 144	Legal Services Annual Report	Chief Nurse	Paper	120
20/21 145	Health & Safety Annual Report 2019 - 20	Chief Nurse	Paper	145
20/21 146	Change Programme Summary, Delivery & Assurance	External Programme Assurance	Paper	165

20/21 147	Capital Committee – Terms of Reference	Director of Strategy and Partnerships	Paper	204
20/21 148	Report of Finance Business Performance and Assurance Committee	Chair of Finance Business Performance and Assurance Committee	Paper	210
20/21 149	Report of Audit Committee	Chair of Audit Committee	Paper	213
20/21 150	Report of Quality Committee	Chair of Quality Committee	Paper	216
20/21 151	Report of Workforce Assurance Committee	Chair of Workforce Assurance Committee	Paper	218
20/21 152	Report of Trust Management Board	Chief Finance Officer	Paper	221
20/21 153	Communications and Engagement Monthly Report	Director of Communications & Engagement	Paper	224
20/21 154	Shadow Board Feedback	John Sullivan, Non-Executive Director	Verbal	N/A
Standing Items				
20/21 155	Any Other Business	Chair	Verbal	N/A
20/21 156	Date of Next Meeting – 4 November 2020	Chair	Verbal	N/A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

2 SEPTEMBER 2020

VIRTUAL MEETING VIA MICROSOFT TEAMS

Present

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

In attendance

Jacqui Grice	Interim Director of Workforce
Paul Buckingham	Interim Director of Corporate Affairs
Jill Hall	Interim Director of Corporate Affairs (Desig)
Sally Sykes	Director of Communications & Engagement
Mr Jonathan Lund	Associate Medical Director, Women & Childrens
Paul McNulty	Divisional Director, Surgery*
Lee Bennett	Clinical Theatre Manager*
Joe Gibson	External Programme Assurance*
Angela Tindall	Public Governor
Ann Taylor	Staff Governor

Apologies

Mrs Jayne Coulson	Non-Executive Director
Mrs Sue Lorimer	Non-Executive Director

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 20-21/107	**Apologies for Absence** Noted as above.	
BM 20-21/108	**Declarations of Interest** There were no Declarations of Interests.	
BM 20-21/109	**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 CIP Projects, which had yet to be defined and initiated, had been incorporated in the programme scope detailed on page 221 of the meeting pack. He then noted the Governance and Delivery ratings, on page 222 and page 223 respectively, and advised that there was a positive trend for each rating. Mr J Gibson then provided an overview of performance against metrics for the priority projects and concluded his report by noting that	

Reference	Minute	Action
	divisional narrative would be included for each project from October 2020. In response to a question from Mr J Sullivan, regarding red ratings for Workforce Planning, the Interim Director of Workforce provided an overview of actions to address the absence of a dedicated Workforce Planner and noted work with clinicians to fully understand and identify priority areas. She advised that workforce-related CIP projects were unlikely to be defined before December 2020. In response to a follow-up question from the Chairman, the Chief Executive noted the impact of the Covid-19 pandemic on progress and advised that workforce programmes would need to be informed by the service strategies which were currently being prepared. She noted the introduction of a Capacity Manager role as a positive development and advised that she expected that lost ground would be regained through the alignment of work programmes with ongoing rest and recovery work and winter planning. <u>Theatre Scheduler System</u> Mr P McNulty introduced a presentation on a new Theatre Scheduling System and noted that work on the system had been progressed throughout the Covid-19 pandemic. Mr L Bennett then delivered the presentation which covered the following subject areas: • Starting Point • Our Process • Where We Are Now • Future Developments Mr P McNulty advised that the system was now fully operational and, in response to a question from the Chairman, advised that he was working with the Chief Information Officer to determine the status of intellectual property rights in the context of potential commercial opportunities. Mr P McNulty then provided an overview of how the system would support delivery of key performance indicators with far greater visibility and oversight. He advised that there was positive Consultant support for the attainment of what were challenging targets. In response to a question from Mr J Sullivan, Mr P McNulty advised that there was not a direct correlation between improvement in theatre utilisation and performance against the RTT standard as the patient volumes would differ. The Chief Operating Officer endorsed this response but noted that increased theatre throughput would benefit RTT performance. The Chief Executive advised that implementation of the system had enabled the Trust to book out theatres six weeks in advance for the first time. The Chairman thanked Mr P McNulty and Mr L Bennett for the informative presentation on what was a positive service development. He asked them to pass on the thanks of the Board to all of those involved in delivery of this project. ***The Board of Directors:*** • ***Received and noted the Change Programme – Summary, Delivery & Assurance report.*** • ***Received and noted the Theatre Scheduler System presentation.***	

Reference	Minute	Action
	Mr J Gibson, Mr P McNulty and Mr L Bennett left the meeting.	
BM 20-21/110	**Chair's Business** The Chairman welcomed Ms J Hall, Interim Director of Corporate Affairs (Designate), to the meeting and thanked Mr P Buckingham for his work in undertaking this role for the previous three months. The Chairman then briefed the Board on continued progress on integrated working with partners in the local health economy through productive meetings involving the Chairs and Chief Executives of partner organisations. He emphasised the importance of this collaborative approach continuing post-Covid-19. The Chairman concluded his briefing by noting that a recruitment process would be undertaken to identify a replacement Non-Executive Director for the position currently held by Dr J Coakley. ***The Board of Directors:*** • ***Received and noted the verbal briefing.***	
BM 20-21/111	**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 20-21/112	**Minutes of Previous Meeting** The Minutes of the meeting held on 5 August 2020 were agreed as a true and accurate record.	
BM 20-21/113	**Action Log** The Board reviewed the Action Log. The Interim Director of Corporate Affairs advised that the action relating to proposals for planned capital projects and project support had been deferred due to cancellation of the Finance, Performance & Business Assurance Committee meeting on 20 August 2020.	
BM 20-21/114	**Chief Executive's Report** The Chief Executive presented a report which included the following subject areas: • 2021-2026 Our Strategy • Clinical Service Strategies • Safe Staffing Update • Serious Incidents • RIDDOR Update She briefed the Board on the content of the report and noted that amendments to the 2021-2026 Our Strategy document, discussed at the	

Reference	Minute	Action
	previous Board meeting on 5 August 2020, had been jointly agreed by the Chief Executive and Chairman. She then provided the Board with an overview of progress with the development of the supporting clinical service strategies. ***The Board of Directors:*** • ***Received and noted the Chief Executive's Report.***	
BM 20-21/115	**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 work to address issues associated with Emergency Department delays which were resulting in breaches of the 4-hour standard. He then briefed the Board on performance against RTT and Cancer standards and noted work with the Cheshire & Merseyside Cancer Alliance in relation to performance trajectories for the Cancer standards. In response to a question from the Chairman, the Chief Operating Officer advised that increased activity levels were resulting in increased long length of stay and noted mitigating actions included in both the patient flow programme and CQC action plan. The Medical Director advised that increased Consultant cover was serving to reduce instances of long length of stay but acknowledged that there was a financial implication associated with this additional cover. In response to a question from Dr J Coakley, the Chief Operating Officer confirmed that there remained a national expectation that 33% of daily discharges would be achieved by noon each day. He advised that the Trust's performance in this respect had improved with the 33% mark currently being achieved at 2.00pm rather than 4,00pm. The Chief Nurse briefed the Board on performance against quality metrics and noted a change in the reporting of Gram-Negative bacteraemia. She advised the Board of one incidence of MRSA infection in July 2020 and provided an overview of the circumstances of the case which had provided a number of learning opportunities. She concluded her briefing by noting a steady improvement in the levels of Safeguarding training being undertaken. The Medical Director provided the Board with an overview of Covid-19 related research activity and advised that non-Covid-19 related studies were now being resumed and noted that additional nurse research support had been secured to support the increased research activity. The Interim Director of Workforce then briefed the Board on performance against workforce metrics and advised that a data issue which had affected sickness absence reporting had now been resolved. She advised the Board of actions relating to absence management, with an initial focus on addressing long-term absences, and noted that, while the Trust's absence rate (5.8% on 16 August 2020) was higher than many, the Trust was not an outlier nationally with regard to levels of sickness absence. In response to a question from Mr J Sullivan, the Interim Director of Workforce advised that the Staff Attendance graph on page 34 of the meeting pack would be re-aligned for the next Board report in October 2020. The Interim Director of Workforce concluded her briefing by providing an	

Reference	Minute	Action
	overview of performance against the Appraisal metric and, in response to a question from the Chairman, the Medical Director confirmed that medical appraisals had restarted and advised that a Medical Revalidation report would be presented to the Board of Directors in November 2020. ***The Board of Directors:*** • ***Received and noted the Quality & Performance Dashboard, together with associated Exception Reports, for the period to 31 July 2020.***	
BM 20-21/116	**Month 4 Finance Report** The Chief Finance Officer presented a report which detailed the Trust's financial position as at 31 July 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 4 position as follows: • Income guarantee support of £8.3m in July 2020 to offset reductions in activity. • Revenue costs of circa £1.6m incurred in responding to the Covid-19 pandemic. • Additional top-up finding of £121k to support the break-even position. The Chief Finance Officer the briefed the Board on guidance on the national funding regime for the period August 2020 to March 2021 which was published on 31 July 2020. She noted that current arrangements would continue in August and September 2020 with revised arrangements, which are intended to support system partnership working and the restoration of elective services, being implemented from 1 October 2020. She advised that, while the framework was known, there was currently little detail available on practical application. The Chief Finance Officer then referred the Board to s7 of the report and provided an overview of progress against the Capital programme. She noted that the overall value of the programme now totalled circa £15m following additional capital allocations and advised of the increased risk to delivery associated with a larger programme than originally planned. She noted work to secure additional project management and support capacity and advised that a comprehensive assessment of what was realistically achievable over the remainder of 2020/21 would be undertaken. In response to a question from the Chairman, the Chief Finance Officer advised that the assessment would be completed in the next three weeks. The Chairman noted his discomfort with the current position against the programme, The Chief Executive acknowledged this comment but noted the recent engagement of two very experienced individuals which would enable work to be progressed at pace. The Chief Finance Officer noted the adoption of different working patterns to enhance progress, e.g. weekend working to progress the theatre lighting project, and the 'packaging' of a number of smaller schemes to form a discrete set of larger projects. ***The Board of Directors:*** • ***Received and noted the Month 4 Finance Report.***	

Reference	Minute	Action
BM 20-21/117	**Operational Delivery – Phase 3 Planning Submission** The Chief Finance Officer and Chief Operating Officer jointly delivered a presentation on the Phase 3 Planning Submission which covered the following subject areas: • Phase 3 Recovery Planning Process • Assumptions Underpinning Activity Submissions • Draft Activity Submission – 24 August 2020 • Use of Independent Sector • Financial Forecast • Capacity Planning • Next Steps In response to questions, the Chief Operating Officer noted constraints to the Trust's use of the independent sector and advised of a reliance on Trust staff to support activity for a range of procedures. He noted that fortnightly meetings were being held with Spire Murrayfield representatives to maximise throughput. In response to comments from the Chairman, who queried whether local independent sector providers were out of step with other providers in the region, the Chief Operating Officer again noted the heavy reliance on Trust staff to support activity and noted work to triangulate declared capacity with what was actually being offered. The Medical Director commented on potential impact on staff welfare and the Director of Strategy & Partnerships advised that the types of surgery offered locally were fairly basic in comparison to the range of procedures available other Spire facilities. In response to a question from Dr J Coakley, regarding alternative approaches in the context of limited independent sector availability, the Chief Operating Officer noted initiatives to maximise available Trust capacity, such as weekend working, and noted 7-day robot use as an example. The Chairman commented on the need to be able to clearly articulate why only limited use could be made of the independent sector locally and requested that a report on this subject be prepared for consideration at the next Board meeting on 7 October 2020. The Chief Finance Officer noted that work on the Financial Forecast had been undertaken in advance of information on the detailed funding envelope being available and advised that the work had been a local, rather than a national, requirement, She advised the Board that work was now being undertaken to respond to a national submission by 7 September 2020. In response to a question from Mr J Sullivan, who expressed surprise that the assumptions did not include the potential for a second Covid-19 spike, the Chief Finance Officer advised that the approach was consistent with guidance to assume that the 'R rate' remains at 1 or below. ***The Board of Directors:*** • ***Received and noted the Phase 3 Planning Submission presentation.***	**AM**
BM 20-21/118	**Urgent and Emergency Care Upgrade Programme** The Director of Strategy & Partnerships presented a report which detailed	

Reference	Minute	Action
	progress with the Urgent and Emergency Care Upgrade Programme. He briefed the Board on the content of the report and noted the use of weekly highlight reports to track progress. He then provided an overview of the status for each of the six elements of the programme as follows: • Strategic Case - Status Green-rated • Economic Case - Status Green-rated • Financial Case - Status Amber-rated • Commercial Case - Status Amber-rated • Management Case - Status Green-rated • Clinical Case - Status Green-rated The Director of Strategy & Partnerships noted the intention for team members to visit hospital sites in Wythenshawe and Tameside where similar projects had previously been undertaken. He then provided an overview of the Governance structure for the programme. The Chairman noted the Governance structure and commented on the need for effective Board oversight of the programme. He proposed that an additional Board Committee be established to provide this oversight and suggested that membership could comprise the Chairs of current Board Committees. Mr S Igoe endorsed the need for effective oversight and suggested that arrangements should ensure that the programme was able to draw on the professional skills and experience of those involved. In response to a question from Mr J Lund, regarding involvement of Women's and Children physicians, the Director of Strategy & Partnerships advised that he would ensure that appropriate individuals were included in the project working group. In response to a question from Mr J Sullivan, regarding assurance that new ways of working would be considered, the Director of Strategy & Partnerships confirmed that changes to ways of working would be explored through effective staff engagement and consideration of best practice approaches. ***The Board of Directors:*** • ***Received and noted the Urgent and Emergency Care Upgrade Programme report.***	
BM 20-21/119	**CQC Compliance & Action Plan - Progress Report** The Chief Nurse presented a report which detailed progress against actions arising from the CQC Inspection Report which was published on 31 March 2020. She briefed the Board on the content of the report and noted the status of both 'Must Do' and 'Should Do' actions as at July 2020 with good progress made against each set of actions. The Chief Nurse then noted a limited number of overdue and 'at risk' actions where progress had been impaired as a result of the Covid-19 pandemic. The Chief Operating Officer advised that he expected progress to be made against patient flow-related actions as part of the reset and recovery programme. The Chief Nurse concluded her report by assuring the Board that regular engagement was being maintained with CQC representatives to ensure that they were fully informed on progress. She noted that an invitation to attend an Executive Team meeting had been extended to CQC representatives as	

Reference	Minute	Action
	part of this engagement. ***The Board of Directors:*** • ***Received the report and noted the assurance provided on progress with the action plan.***	
BM 20-21/120	**Maternity & Neonatal Services Report** The Chief Nurse presented a report which provided a comprehensive overview of Neonatal and Maternity services at the Trust. She briefed the Board on the content of the report and noted the information provided on Neonatal services included at s6 of the report. She advised that discussions were ongoing with colleagues from Liverpool Women's Hospital and Alder Children's Hospital regarding the establishment of a Cheshire & Merseyside Neonatal Partnership and noted the benefits for patient care which would accrue from such arrangements. The Chief Nurse then referred the Board to s5 of the report and noted the Trust's position in the context of regional performance. Mr J Lund briefed the Board on the stillbirth data included in s5 of the report and noted the difference in cases which were fully managed by the Trust. In response to a question from the Chairman, regarding the transfer rate referenced on page 7 of the report, Mr J Lund advised that he would check whether it was possible to adjust the data to provide a more accurate reflection of the circumstances for such transfers. The Chief Nurse concluded her report by noting the Thematic Review of Serious Incidents included at Appendix 1 of the report and advised that no theme had been identified in relation to CTG interpretation. She noted that outcomes from the Thematic Review would be shared with Wirral CCG following the Board meeting. ***The Board of Directors:*** • ***Received and noted the Maternity and Neonatal Services report.***	
BM 20-21/121	**Progress against Enforcement Undertakings** The Interim Director of Corporate Affairs presented a report which detailed progress against the revised enforcement undertakings issued by NHS Improvement on 24 July 2020. He briefed the Board on the content of the report and noted in particular the proposed approach for a Board Development programme which was detailed at s6 of the report. He advised that a meeting with NHS Providers to progress this approach was scheduled to be held on 3 September 2020. The Board endorsed the approach to the Development programme and there followed a discussion on means of delivering the programme in the context of current social distancing guidelines. The Board noted the benefits of face to face engagement and agreed that this approach should be adopted if feasible and practicable to do so. The Medical Director commented on the need to ensure that content of the programme would be complementary to the development programme currently being undertaken by the Executive	

Reference	Minute	Action
	Team. ***The Board of Directors:*** • ***Received and noted the content of the report.*** • ***Endorsed the approach for the Board Development programme set out at s6 of the report.***	
BM 20-21/122	**Safeguarding Annual Report 2019/20** The Chief Nurse presented the Safeguarding Annual Report 2019/20. She briefed the Board on the content of the report which provided a comprehensive account of progress made during the year across each of the separate Safeguarding elements. She noted in particular the priority given to capturing the 'voice of the child' and evidencing professional curiosity through training and auditing. The Chairman thanked the Chief Nurse for what was an informative and helpful report. ***The Board of Directors:*** • ***Received the report and noted the Safeguarding Annual Report 2019/20.***	
BM 20-21/123	**Report of Safety Management Assurance Committee** The Board considered reports which detailed business conducted during meetings of the Safety Management Assurance Committee held on 3 August and 26 August 2020. Mr S Igoe noted that a verbal briefing on the matters considered during the meeting held on 3 August 2020 had been provided at the Board of Directors meeting on 5 August 2020. Mr J Sullivan then briefed the Board on the content of the report for the meeting held on 26 August 2020 and noted that the frequency of future meetings had yet to be determined. Mr S Igoe iterated his support for a two-monthly meeting cycle, which was consistent with arrangements for other Committees, and advised that he would liaise with the Chief Nurse to progress this matter. ***The Board of Directors:*** • ***Received and noted the reports of the Safety Management Assurance Committee.***	
BM 20-21/124	**Report of Charitable Funds Committee** The Chief Finance Officer presented a report which detailed business conducted during a meeting of the Charitable Funds Committee held on 7 August 2020. She briefed the Board on the content of the report which covered the following subject areas: • Head of Fundraising Report • Finance Report	

Reference	Minute	Action
	• Staff Recharges • Arrowe Park Hospital - League of Friends She noted in particular the Committee's support for re-launch of the 'Tiny Stars' Neonatal Appeal in Spring 2021 and advised that the appeal had been temporarily suspended as a result of the Covid-19 pandemic. The Chief Finance Officer also advised that the charity team costs for the period 1 April - 31 July 2020 would be funded by the Trust as the team was proactively support Trust Covid-19-related activities throughout this period. ***The Board of Directors:*** • ***Received and noted the report of the Charitable Funds Committee***	
BM 20-21/125	**Report of Trust Management Board** The Chief Executive briefed the Board on key issues considered during a Trust Management Board (TMB) meeting held on 27 August 2020 and noted in particular consideration of Phase 3 recovery plans and development of both the Trust and Wirral System winter plans. She advised that the TMB had also approved a pilot approach for international nurse recruitment. ***The Board of Directors:*** • ***Received and noted the verbal briefing.***	
BM 20-21/126	**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 the support being provided for an infection prevention and control awareness campaign, 'SIMPLE', based on the following six key themes: • **S**urveillance • **I**nvasive Devices • **M**ulti-disciplinary Groups • **P**ersonal Protective Equipment • **L**essons Learnt • **E**nvironmental Cleanliness The Director of Communications & Engagement noted discussions earlier in the meeting relating to the Hospital Upgrade Programme and advised that this subject would feature in the next Leaders in Touch session on 7 September 2020. She also noted that the Communications Team was actively supporting the Director of Strategy & Partnerships with work relating to the new Trust Strategy. ***The Board of Directors:*** • ***Received and noted the Communications & Engagement monthly report.***	

Reference	Minute	Action
BM 20-21/127	**NHS People Plan** The Interim Director of Workforce presented a report which provided a briefing on the recently published NHS People Plan 2020/21. She briefed the Board on the content of the report and noted that the NHS People Plan was not quite what had been expected and, partly as a result of the Covid-19 pandemic, was primarily focused on the next 12 months as opposed to providing a longer term plan. The Interim Director of Workforce then provided an overview of the accompanying briefing document which covered the following subject areas: • Introduction • Background • Commitments • Our People Promise • Asks to Local Employers and Systems • System Working • What Next The Interim Director of Workforce noted the commitment relating to 'Looking after our People' and advised that the Trust was exploring opportunities for use of charitable funds to provide staff facilities for exercise and rest areas. She also noted the 'Growing for the Future' commitment and commented on both a greater focus on the use of apprenticeships and the need the develop diversity across the workforce, including Board and senior manager levels. The Interim Director of Workforce concluded her report by a noting a requirement to appoint a Wellbeing Guardian by November 2020. She advised that any of the Non-Executive Directors who may be interested in undertaking this role should contact her directly for further information. ***The Board of Directors:*** • ***Received and noted the NHS People Plan 2020/21 report.***	
BM 20-21/128	**Any Other Business** There were no matters raised as Any Other Business.	
BM 20-21/129	**Date of next Meeting** The next Board of Directors meeting would be held on Wednesday, 7 October 2020, commencing at 12.30pm.	

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Chair

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Date

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

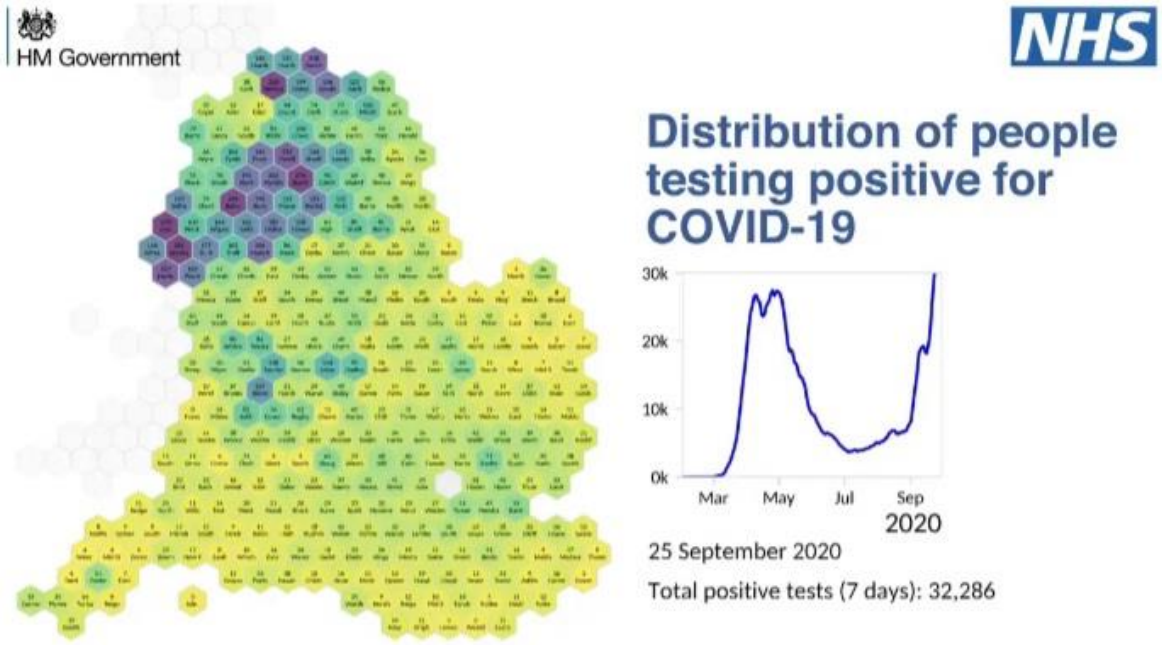
No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 02.09.20						
1	BM20-21/117	Report to be submitted to the Board outlining why only limited use could be made of the independent sector	**AM**	On Agenda	October 2020	
Date of Meeting 05.08.20						
1	BM 20-21/091	**Month 3 Finance 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	Deferred due to the Finance, Performance & Business Assurance Committee not taking place
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	Not due
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	20/21 137
Title of Report	Chief Executive's Report
Date of Meeting	7 October 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 September 2020.

1. Covid-19 Update

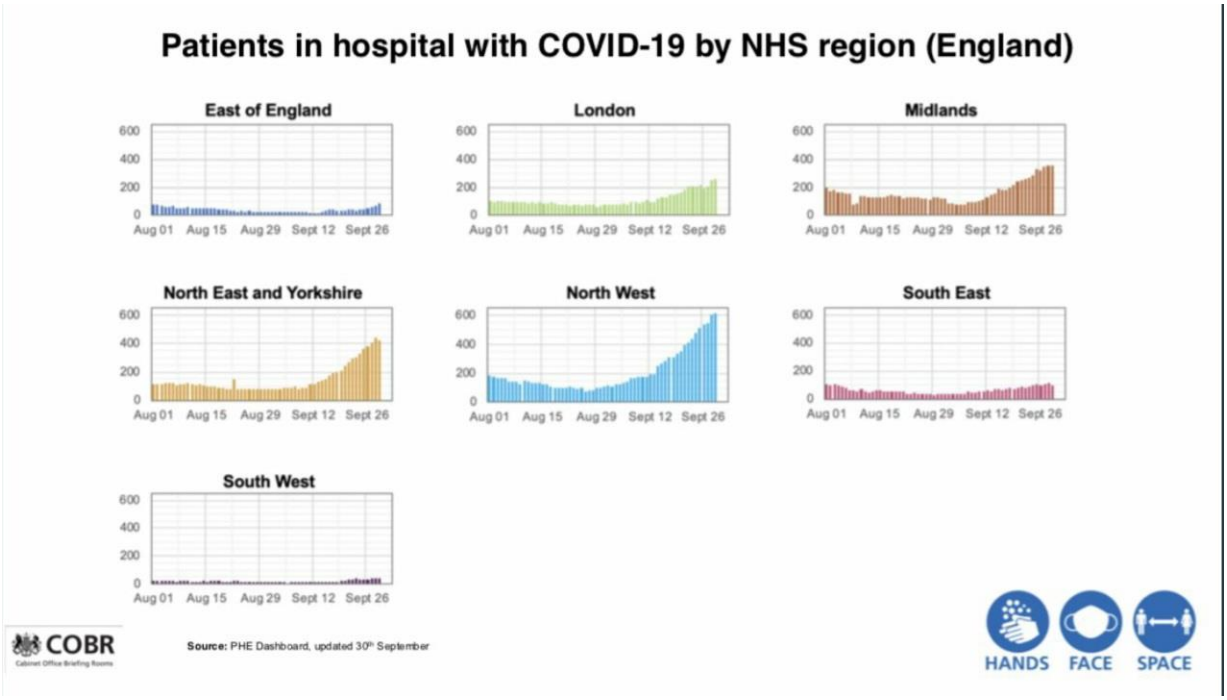
The incidence of Covid-19 has increased especially in the North West, and this includes Wirral. This has been reflected in the national media and has resulted in local lockdown arrangements on Wirral.



The 14 day infection rates in Wirral for this period were 300.3 per 100 000. By comparison, the 14 day infection rates for England were 95.1 per 100 000.

The percentage positivity rate is increasing, especially in working age adults. In the week ending 25th September the % of positive tests was 7.2%. In the summer, this rate was less than 1%.

Unsurprisingly this has resulted in an increase in hospital admissions.



The Trust is continuing to deliver elective care in line with the Reset and Recovery plan but delivering this along with urgent and Covid care is a challenge. This is compounded by high staff absence which has been affected by the need to isolate following Test and Trace advice, especially since the re-opening of schools.

The Trust is monitoring activity and outcomes through its Command and Control meetings, whose frequency has been increased, along with usual governance assurance processes.

2. Reset and Recovery update

The COVID phase 3 reset and recovery plans requested that Trust's submitted details of the level of activity that was able to be restarted in comparison with the same period in 2019/20.

Activity	Sep Plan	Sept Actual	Oct	Nov	Dec	Jan	Feb
Outpatients	81%	93%	87%	88%	90%	91%	90%
Day case	75%	73%	85%	86%	85%	86%	87%
Inpatients	80%	88%	87%	86%	85%	86%	85%

The submission was made against the background of the regional planning assumption of a stable COVID position from August and throughout winter.

3. Workforce

The HRD's of 4 Cheshire and Merseyside Trusts (WUTH, LUFT, Merseycare and NWAS) have been invited to work collaboratively and bid for monies from Region to access additional resources that would positively impact sickness absence figures.

Similarly, WUTH has been invited by the Cheshire International Recruitment Collaborative to participate in a joint bid to secure funding in order to launch an International Recruitment campaign for nurses to join Cheshire Trusts. This will be in addition to any efforts taken locally at Trust level.

4. Health and Wellbeing

Since the start of the pandemic, the Trust has ensured staff have been supported, via a diverse and varied number of schemes, from a personal Health and Wellbeing perspective.

Working with our Charity, we are now also providing additional rest areas for staff, as well a considering a range of further services to support the Workforce.

5. Flu Vaccination Programme

To support the Government's expectation, that all NHS front-line health workers will receive the vaccine, the Trust has launched its 2020 campaign.

6. 2021-2026 Our Strategy

Our Strategy is currently going through the final revision of the design stage; ready to be launched in October 2020.

Clinical Service Strategies

We have undertaken sixteen clinical service strategy workshops since July and a further eight are scheduled for October. In total 32 workshops will be undertaken; once completed an overall clinical service strategy will be produced.

Enabling Strategies

The Trust's 5-year strategy will be delivered through seven enabling strategies: Clinical Service Strategy; Workforce and Education; Patient Experience, Quality and Safety Strategy; Estates Strategy; Digital Strategy; Research and Innovation Strategy; and Financial Strategy.

By May 2021 each of the enabling strategies will have been defined and approved by the Trust Board. Following completion of the Clinical Service Strategy we will start the Patient Experience, Quality and Safety Strategy, and the Estates Strategy.

7. Serious Incidents

In August 2020 three serious incidents were declared. One related to a pressure ulcer, one following a patient fall and the third related to a change within the Trust's internal Millennium System. A full detailed investigation has been initiated to ensure learning is identified and appropriate actions implemented.

8. RIDDOR Update

There were no RIDDOR reports submitted in August.

Board of Directors	
Agenda Item	20/21 138
Title of Report	Quality Performance Dashboard and Exception Reports
Date of Meeting	7 October 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 August 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 47 indicators that are reported for August (excluding Use of Resources):

- 19 are currently off-target or failing to meet performance thresholds
- 22 of the indicators are on-target
- 6 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 August 2020.

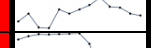
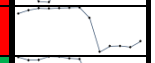
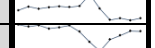
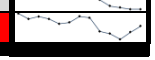
Quality Performance Dashboard

September 2020
Upated 01-10-20

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-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	0.09	0.13	0.13	0.13	0.32	0.31	0.17	0.21	0.21	0.20	0.12	0.18	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	94.6%	96.1%	94.9%	94.1%	97.5%	98.7%	98.0%	97.7%	97.7%	97.5%	97.4%	97.2%	97.2%	97.4%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.6%	97.6%	97.1%	97.8%	97.3%	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.1%	96.7%	97.4%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	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	National reporting ceased		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	1	0	5	4	5	5	4	4	3	4	1	4	4	16	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	0	0	0	0	2	0	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, with a varying trajectory of a max 6 to 8 cases per month	SOF	6	7	8	6	7	4	4	3	6	5	5	1	4	21	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 77 for financial year 2020-21, with a varying trajectory of a max 6 or 7 cases per month	WUTH	7	2	5	6	6	8	9	1	7	4	6	8	5	30	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	1	0	0	0	0	1	0	1	0	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	100%	99%	100%	100%	99%	100%	100%	100%	100%	99%	99%	100%	99%	99.3%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	0	1	0	1	0	0	2	0	2	0	2	6	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	98%	99%	99%	99%	96%	96%	96%	96%	91%	95%	95%	98%	95%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	92.9%	93.6%	92.4%	91.2%	91.2%	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	75.9%	81.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	90.3%	91.2%	88.3%	85.5%	84.9%	84.4%	85.0%	82.8%	80.6%	71.4%	71.8%	73.5%	72.1%	73.9%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	90.3%	90.0%	87.5%	88.1%	89.7%	89.5%	86.7%	79.9%	51.5%	19.7%	19.0%	42.0%	48.3%	48.3%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.40%	94.38%	94.33%	94.14%	94.10%	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.41%	94.41%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	93.96%	94.25%	93.99%	93.82%	93.87%	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.63%	94.88%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	2.03%	1.21%	0.86%	0.77%	0.86%	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	1.79%	1.00%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	10.6%	10.9%	11.0%	11.3%	11.3%	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.1%	11.1%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	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	9.9	9.9	

Quality Performance Dashboard

September 2020
Upated 01-10-20

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	92.0%	96.0%	97.8%	97.2%	97.5%	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	99.0%	96.9%	
	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%	98%	96.8%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	17.9%	18.8%	17.2%	17.1%	19.3%	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	18.6%	19.4%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	410	431	443	441	444	446	448	383	174	209	210	202	239	239	
	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	205	193	194	208	207	200	198	108	35	54	48	53	59	59	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	3.5	3.5	4.0	3.6	4.6	3.4	3.6	3.9	3.5	3.4	3.5	2.8	2.9	3.2	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	4.6	5.1	4.8	5.0	5.2	5.1	5.2	6.7	4.8	3.4	3.6	3.3	3.6	3.7	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	1130	1092	1118	1057	1080	1115	1006	827	667	870	941	1016	1012	901	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	9	15	10	13	11	16	16	23	6	2	1	0	National reporting suspended	2	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	85.3%	81.0%	82.9%	81.0%	77.3%	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	75.5%	70.6%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	24	23	17	26	10	10	14	4	2	0	2	3	5	12	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	92%	88%	87%	84%	87%	85%	80%	National reporting suspended	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%	11%	11%	10%	11%	10%	11%	National reporting suspended	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	97%	96%	97%	96%	97%	97%	97%	National reporting suspended	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	34%	30%	33%	29%	27%	27%	27%	National reporting suspended	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	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	National reporting suspended		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	92%	92%	91%	94.8%	99%	97%	98%	National reporting suspended	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	24%	23%	22%	22%	33%	22%	20%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		

Quality Performance Dashboard

September 2020
Upated 01-10-20

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-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	79.9%	75.6%	72.7%	70.8%	72.1%	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	85.0%	85.0%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	1	0	1	33	95	40	24	21	0	0	0	0	0	0	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	108	210	170	366	431	198	76	80	148	84	82	78	92	97	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	79.89%	79.59%	79.03%	78.09%	78.10%	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	51.30%	51.30%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	24,846	24,721	24,368	23,597	23,233	22,988	23,207	22,350	21,284	21,288	21,383	23,034	24,486	24,486	
	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	15	56	200	413	616	733	733	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	98.3%	99.1%	99.5%	99.2%	99.1%	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	83.5%	65.8%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	93.3%	94.3%	95.0%	93.7%	94.4%	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	89.3%	90.2%	
	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	97.3%	96.5%	96.7%	97.0%	97.1%	97.2%	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	93.3%	95.9%	
	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	89.9%	87.8%	85.0%	87.5%	85.9%	85.9%	85.9%	86.0%	87.4%	86.2%	82.1%	80.7%	75.3%	82.3%	
	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	184	166	193	195	148	186	160	125	74	99	119	143	124	112	
	Patient Experience: Number of complaints received in month - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	TBC	WUTH	22	15	31	13	10	8	16	14	7	8	15	11	18	12	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	100%	100%	100%	86%	88%	100%	100%	100%	94.8%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	2	2	4	3	0	3	0	1	0	1	5	1	0	1	

Quality Performance Dashboard

September 2020
Upated 01-10-20

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-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	37	50	56	48	41	55	49	117	326	181	151	87	30	775	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	83.4%	82.7%	83.8%	81.4%	80.9%	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	81.3%	84.3%	84.3%	

	Indicator	Objective	Director	Threshold	Set by	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-1.498	1.468	0.088	-0.488	-9.543	-0.668	-2.929	2.377	0.00	0.00	0.00	0.00	0.00	0.000	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-1.106	1.972	-1.507	-1.638	-8.755	-1.818	-2.445	-0.589	0.00	0.00	0.00	0.00	0.00	0.000	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	3	3	3	3	3	4	4	4	2	2	2	2	2	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	-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%	0.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	-8.2%	-24.3%	-24.7%	1.8%	-8.4%	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	34.5%	24.4%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-17.4	-15.0	-14.6	-10.9	-14.1	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-97.9	-97.9	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	19.8%	64.2%	61.7%	57.2%	54.4%	53.8%	50.7%	74.8%	101.0%	100.4%	61.1%	53.0%	44.6%	44.6%	

(*) 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 September 2020

Safe Domain

Pressure Ulcers – hospital acquired category 3 and above

Executive Lead: Chief Nurse

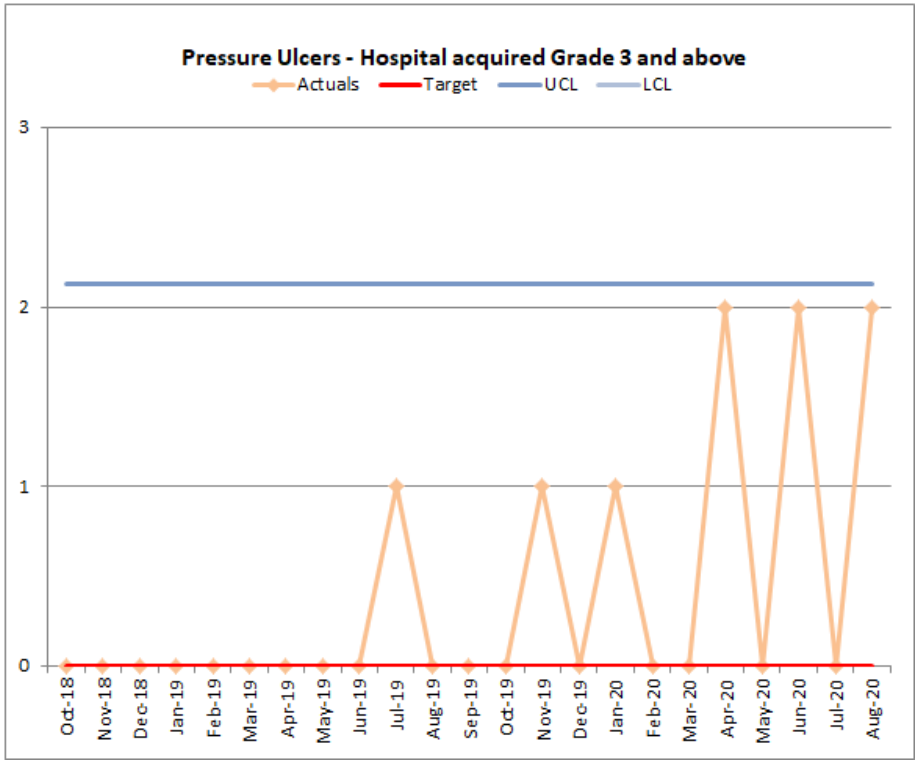
Performance Issue:
WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above. There were two cases in August 2020.

Action:
Two category 3 pressure ulcers were recorded in August 2020. Following a full review of both incidents one was deemed unavoidable identifying no lapses in care due to the clinical presentation of the patient. The other Root Cause Analysis identified documentation gaps and inconsistent repositioning of the patient, these issues have been addressed locally and also form part of the SSKIN training package for roll out across the Trust from October 2020. New products are also being procured (30 degree tilting wedges) that will assist staff to reposition patients comfortably to assist with relieving pressure on patients skin.

The Trust has a comprehensive Tissue Viability Improvement Action Plan that is monitored via the Pressure Ulcer Steering Group reporting to Patient Safety Quality Board. The last meeting held September 2020 noted all actions within the action plan were progressing well and remained on target. The group has six task and finish groups led by the Lead AHP and Senior Nurses to ensure actions are progressed timely.

Expected Impact:

The Trust will see a reduction in hospital acquired pressure ulcers.



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse

Performance Issue:

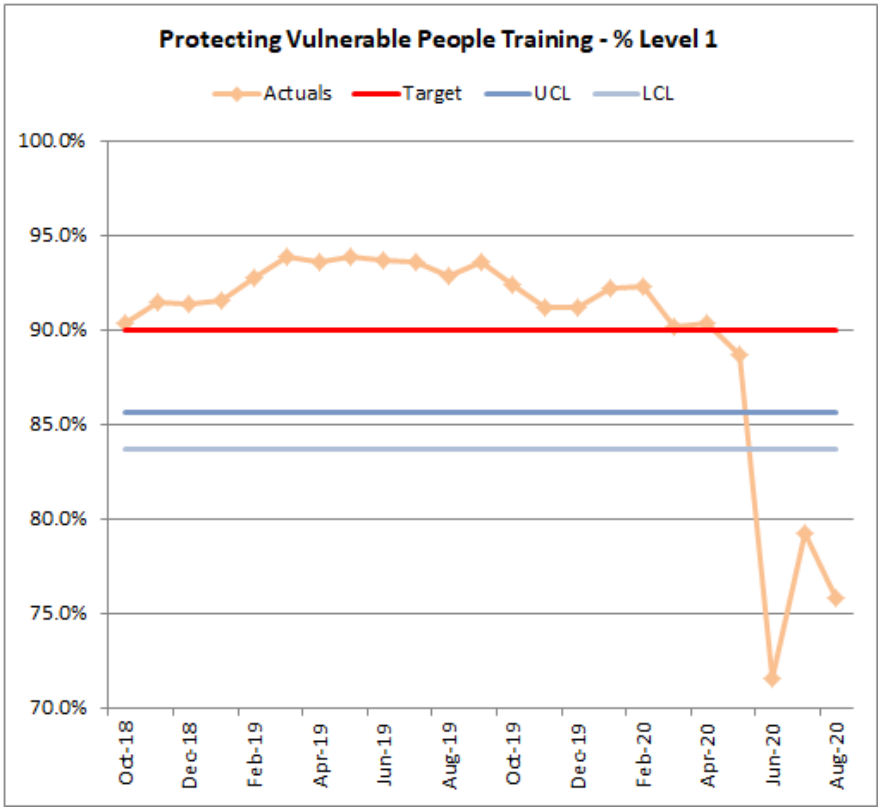
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Although regularly achieved, performance against this standard has been deteriorating and is at 75.9% for August 2020.

Action:
Compliance and trajectories continued to be monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance is also reported in the quarterly Safeguarding Performance Report to Patient Safety Quality Board.

Due the COVID 19 pandemic all mandatory training was suspended temporarily from March to July 2020 which has had a detrimental impact on compliance levels. The Trust saw a slight drop in August that was anticipated due to the number of staff starting at the Trust who will be accessing training PVP training in September 2020. PVP level 1 is completed on Induction and via the intranet and can be accessed by staff at any time.

Expected Impact:

PVP level 1 training compliance will increase 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:

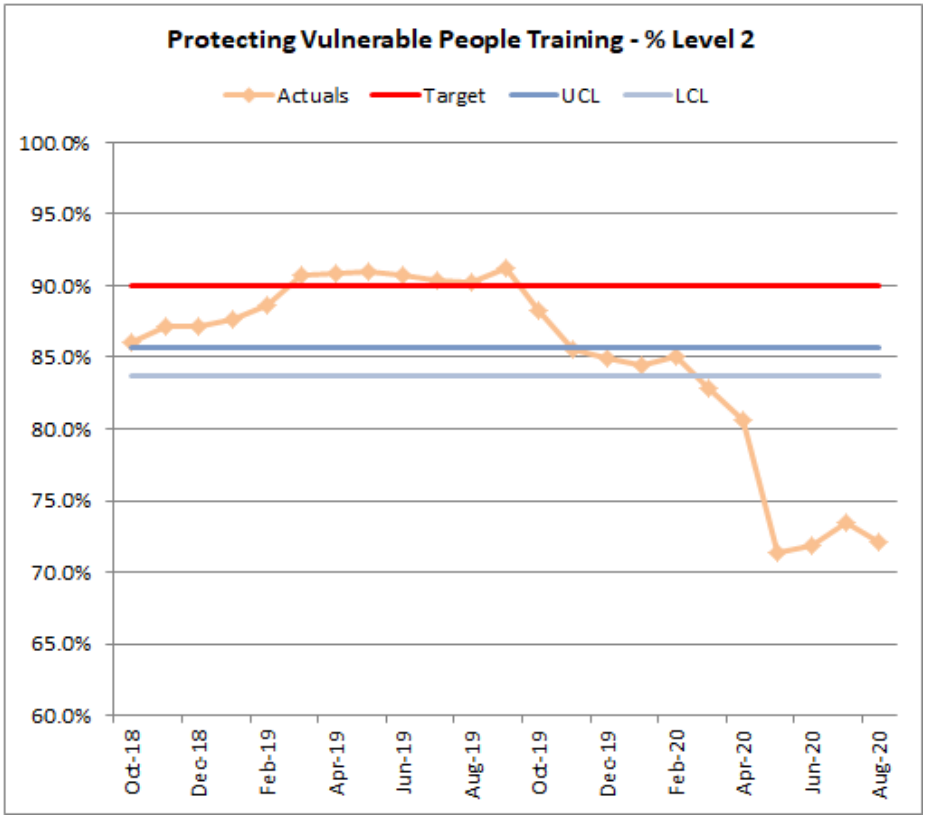
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been deteriorating and not achieved since September 2019, with August slightly decreased to 72.1%.

Action:
Compliance is monitored via the Safeguarding Assurance Group and at Divisional Performance Reviews (DPRs). PVP training compliance is also reported in the quarterly Safeguarding Performance Report to Patient Quality Safety Board.

In March 2020 all mandatory training was suspended until July 2020 due to the COVID 19 pandemic which has had a detrimental impact on the compliance levels.

The Trust saw a slight decrease in compliance in August that was anticipated due to the number of staff starting at the Trust who will be accessing training PVP training in September 2020. PVP level 2 is completed via the intranet and can be accessed by staff at any time. Increased scrutiny is being provided on areas with low compliance.

Expected Impact:
PVP level 2 training compliance will increase expecting to achieve the Trust target by the end of quarter 2.



Protecting Vulnerable People Training - % Compliant Level 3

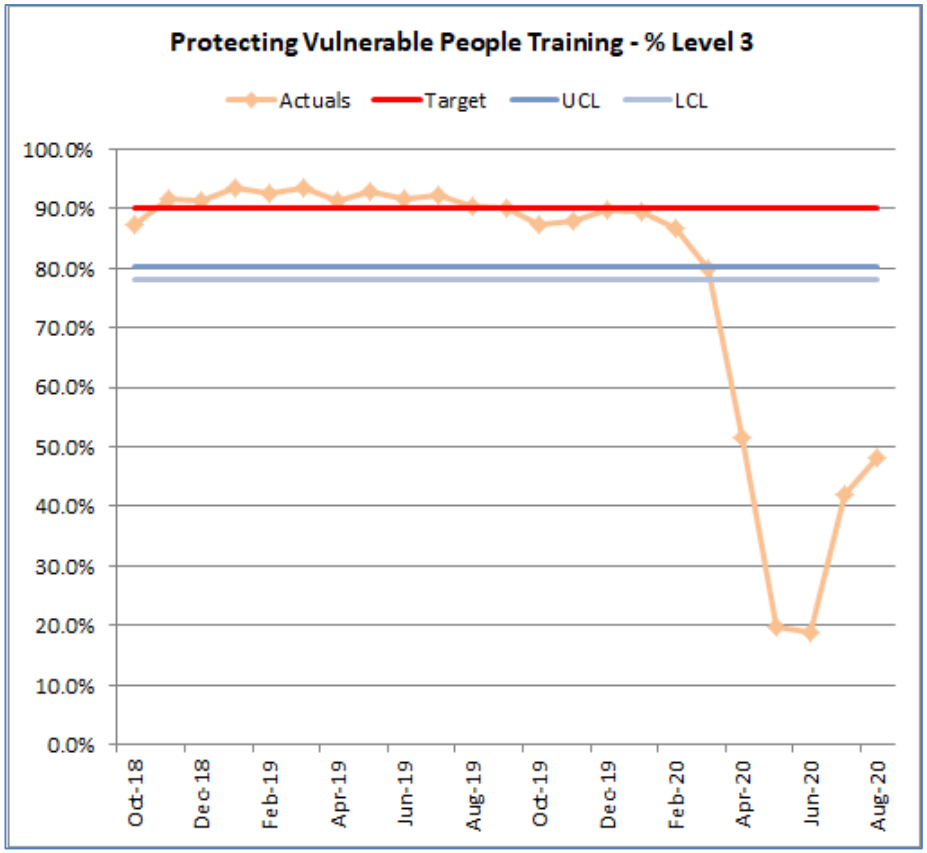
Executive Lead:
Chief Nurse

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, though August continued the improvement up to 48.3%.

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 positive increase in compliance during the month of August 2020.

Divisional compliance and trajectories continue to be monitored via the Safeguarding Assurance Group and at Divisional Performance reviews (DPRs). PVP training compliance is also reported in the Quarterly Safeguarding Performance Report to Patient safety Quality Board. A review of PVP level 3 compliance undertaken mid-September 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)

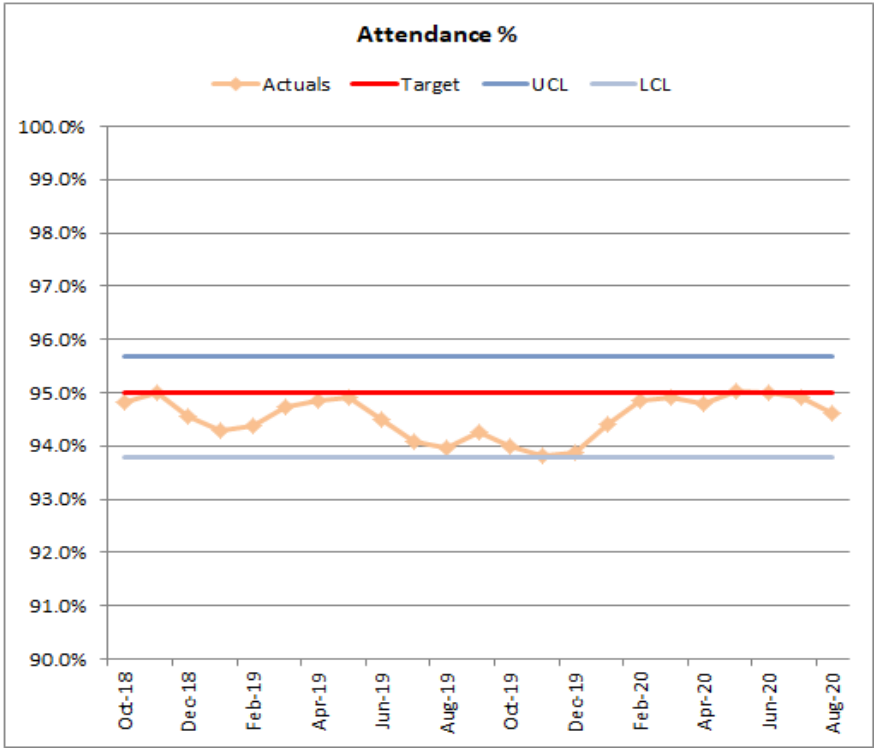
Executive Lead: Director of HR / OD

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 August continued below the standard at 94.63%. The rolling 12-month performance was 94.41%.

Action:
The Directorate working with operational business partners is in the process of implementing a number of actions to address sickness (deep dive).

These include:

- Development of sickness absence reduction plans with each Division's management triumvirate which are reviewed via twice monthly meetings
- All long-term sickness cases of 4 months + are being individually reviewed with support from senior HR staff with the aim of returning staff returning to work on a planned basis, or terminating employment (in line with Trust policy) where there is no likely return to work in the near future. Several contracts have been terminated this month in line with Trust processes.
- Focused actions to address individual sickness at Band 2 level across the organization. These include listening events planned in Oct - Nov for staff and managers to understand issues and identify solutions to endemic absence issues.
- Cheshire and Merseyside HRDs including WUTH have met to make a bid regionally for national funding which is available for national areas of high sickness rates – the Northwest has been singled out as having significant sickness rates and up to £2M is



available for the system to bid against. All organisations have common themes – Long COVID, MSK and staff with mental health issues struggling to access services for the levels of psychological support required. Despite the restrictions in place following the earlier national Social Partnership Forum agreement there has been progress made with staff side agreement on managing staff sickness and a further number of terminations are expected next month.
Expected Impact: Subject to Covid-19 outbreaks skewing the figures, reduction in long term sickness rate over the next 2 months following a period of intense proactive sickness management of individual cases by operational and corporate staff.

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. In August there was an increase to a rate of 1.79%, with the rolling 12-month rate at 11.14%.

Action:

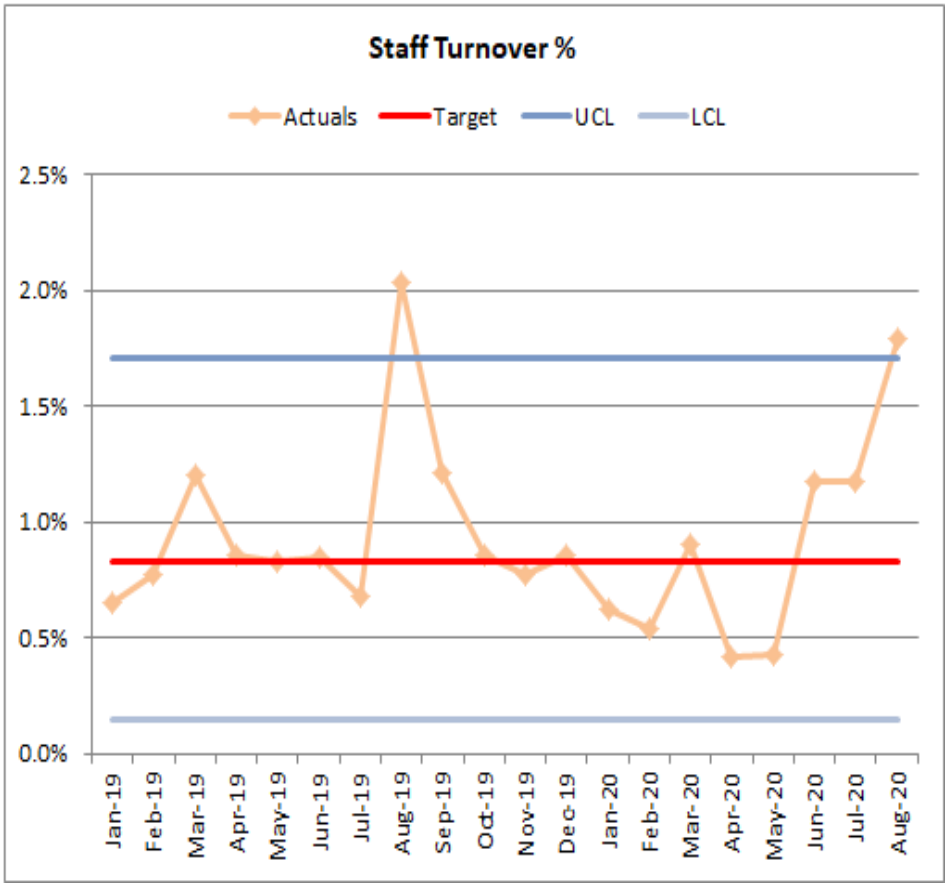
Following a period where turnover from March 20 was depressed due to the cessation during COVID of staff who had secured alternate employment outside of the Trust moving into these roles; these subsequent moves have taken place over the summer.

The upturn in turnover in July and August also reflects the impact of Yr3 student nurses (53) seconded to the Trust during COVID. If the student nurse cohort is excluded from the turnover calculation the monthly rate for August would reduce to 0.85% and the rolling 12-month rate reduces to 10.19%.

As reset and recovery continues more focus will be given to improving retention as was the case prior to the COVID outbreak.

Expected Impact:

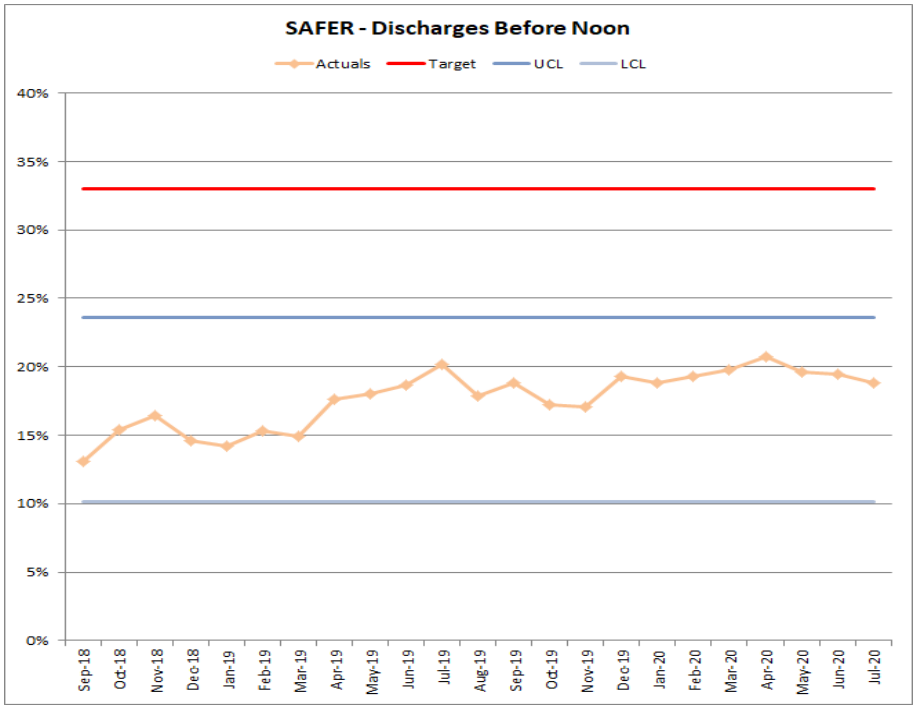
With the caveat around any future COVID impact this peak should now start to fall down to Board target levels.



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. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%
Action: Within the patient flow improvement program there is a key workstream around ward processing and initial rollout on 2 medical wards is showing promising results, with wider roll out in September to 2 surgical wards.
Expected Impact: During August the precise time that 33% of discharges was delivered was 1.59pm The precise time of attainment will continue to be detailed to the Board, with the expected impact that the time will continually be brought forward to earlier in the afternoon.



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 was an upward trend in August to 59.

Action:

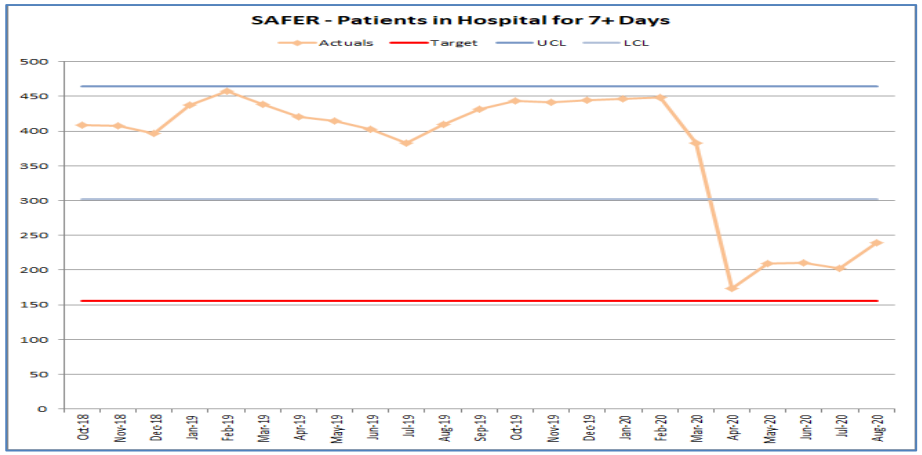
The Wirral system has daily discharge cell meetings as part of the COVID response to expedite all ready to be discharged patients from the acute sector, and there are 3 times weekly hospital and social care cells with executive oversight.

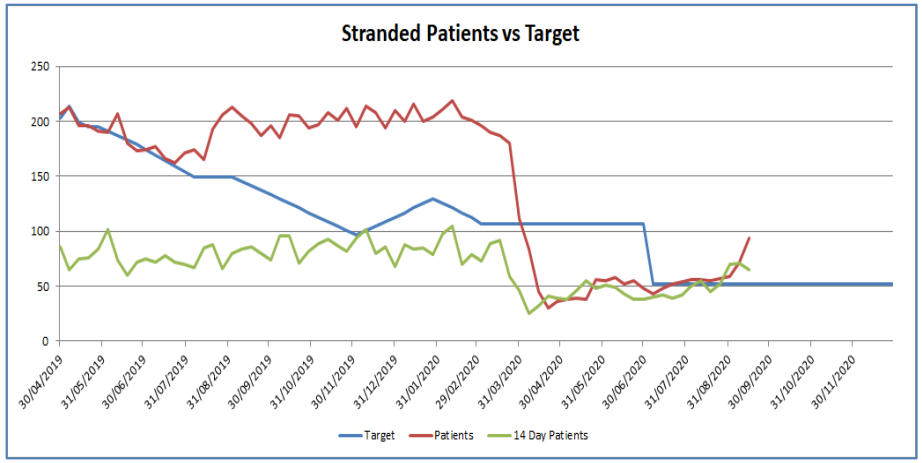
The priority actions agreed during September are:-

1. Plans to address the deterioration in the number of ready for discharge patients across all pathways – which should involve more agile use of the emergency commissioned beds
2. System approach to the closure and reopening of care sector homes for IPC reasons.
3. A robust solution for positive COVID patients able to be cared for outside of the acute hospitals.

Expected Impact:

The Wirral winter system plan has been set around a planning assumption of 60 LLOS patients, with triggers and governance for the system to respond should this be passed.





Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

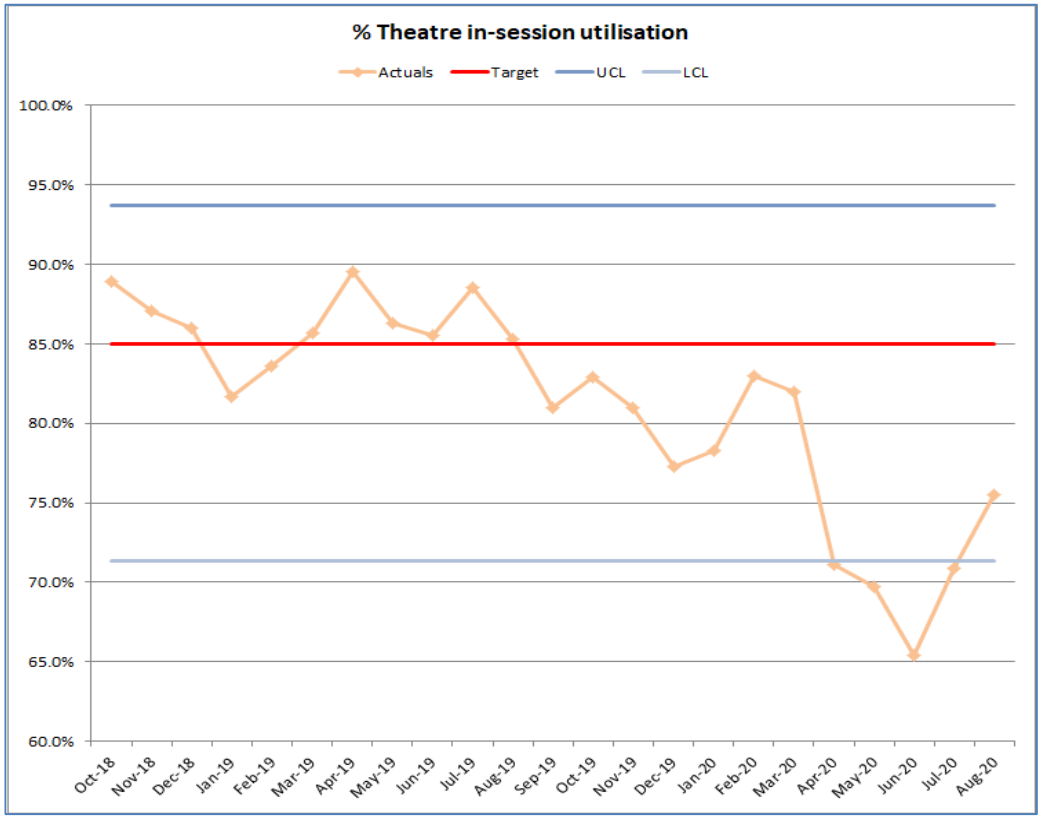
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. With the support of the theatre transformation programme this was regularly achieved from March 2019. However from August 2019 performance deteriorated, largely due to the cancellation of elective activity 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 August was an improved 75.5%.

Action:

Theatres are now increasing activities and booking ahead for up to 6 weeks as the elective restart program commences. Utilisation is expected to increase steadily from August and will continue to do so in line with recovery and restart trajectories.

Expected Impact:

It is expected that previous levels of core utilisation will be attained except where theatre sessions require the higher level of PPE and cleaning associated with patient and procedures as a result of safe COVID management.

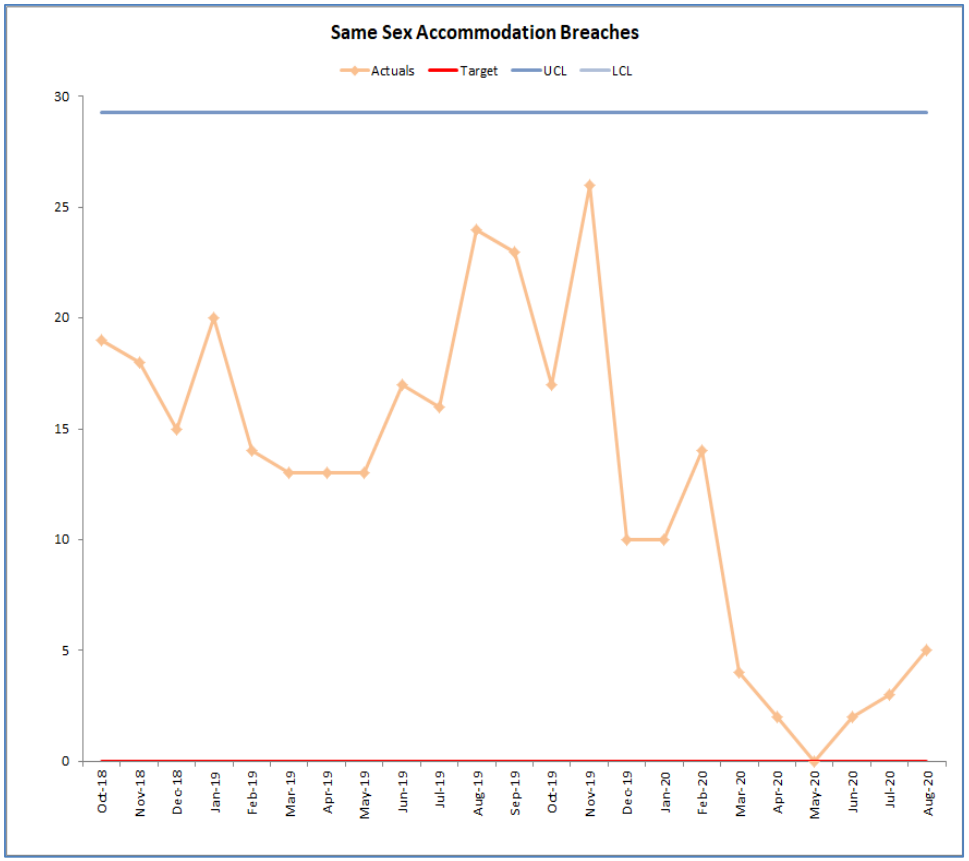


Caring Domain

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 5 such breaches in August.



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 5 breaches in August 2020 due to bed occupancy being above 80 % creating pressure (due to the reduced bed base) this pressure was also compounded by the limited availability of side rooms across the Trust and increases in COVID positive patients.
A standard operating procedure (SOP) has been produced with discussions with all Divisional leads and bed management, to give an escalation ladder for critical care discharges from categories 1 to 4.
For example:
Category 1 (Routine): Critical Care has at least one available bed.
• Patients will be expected to be discharged within **four hours** of decision to discharge. This should not exceed 24 hours which signifies a critical incident.
• ***Escalation*:** Nurse in charge of the unit escalates to bed bureau/hospital

coordinator teams. This SOP has been discussed with Critical care and bed management teams and there will be a zero tolerance of critical care breaches in October and then this will be extended. This standard will ensure flow is maintained throughout critical care and all patients will have prompt transfer into/out of the unit.
Expected Impact: There will be a reduction in same sex accommodation breaches. This will ensure the patient goes to the correct specialty bed to continue their follow up and treatment within 24 hours of deemed fit for discharge.

Responsive Domain

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

Executive Lead: Chief Operating Officer

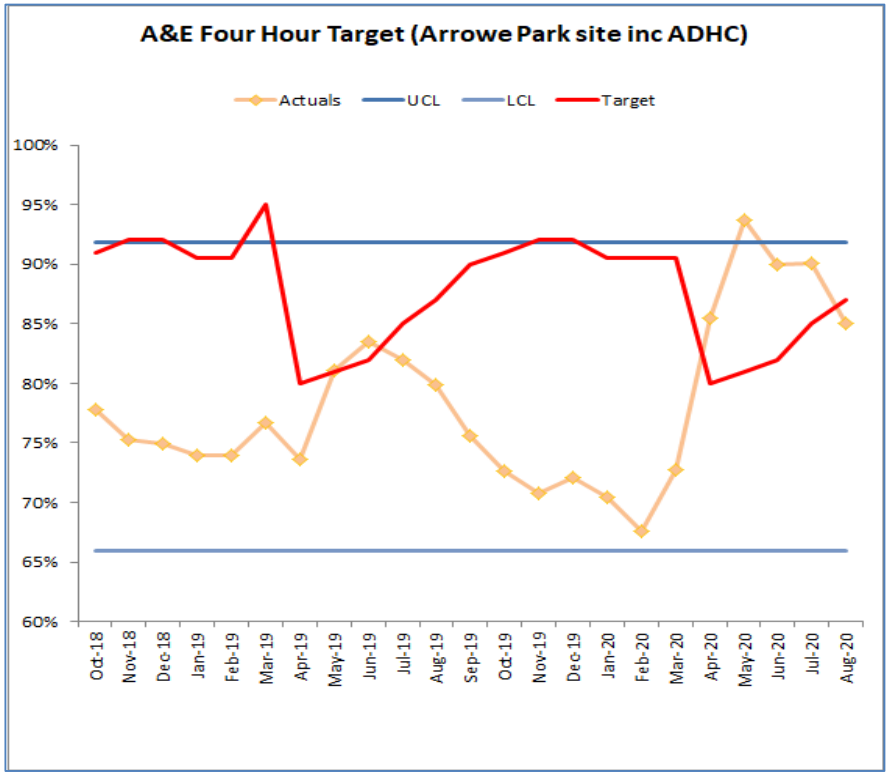
Performance Issue:

Performance from February has increased significantly and above the previous year's position. However this is clearly linked to reduced demand and COVID interventions to elective programmes which has resulted in much lower levels of bed occupancy.
Since August demand for A&E services has returned to that of previous years, and the restarting of elective services has commenced.
Performance in August has dropped by 5% but remains above that of the previous year. Of significance the main cause of breaches is due to delays within the department rather than beds.
There were no patients in August that waited longer than 12 hours in ED from decision to admit to actual admission ('12 hour trolley wait').

Action:
The workforce is challenged and the footprint of the A&E department is much redesigned to manage both COVID and non COVID patients safely. The nursing team has amended their working patterns to match the demand and the medical workforce has been bolstered.

Expected Impact:

Delays attributed to ED delays are expected to reduce from September.



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.

Since the directive to cease all non-urgent elective activities as part of the COVID response this metric has sharply declined.

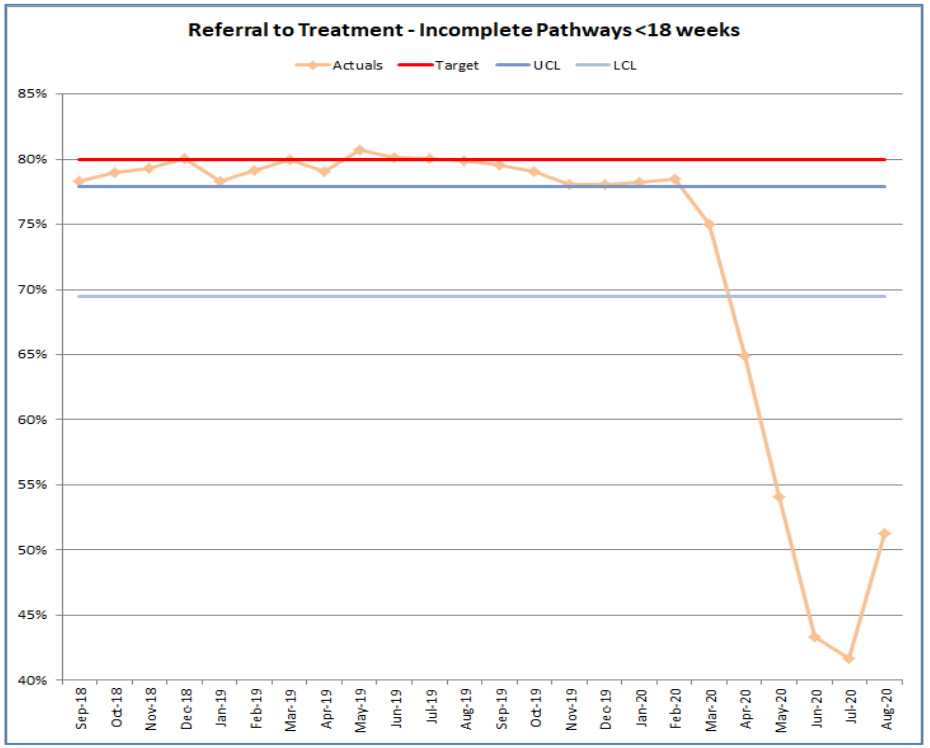
Action:

The Trust has commenced its restart of non covid activities and is currently achieving the submitted trajectories to NHSE/I.

The performance upturn in August is partly commensurate with that restart but also the effect of less patients moving across the 18 week threshold due to lower levels of referrals since March 2020. Referrals are now increasing month on month overall and in key specialties is already back to pre-covid levels which will abate the improvement seen in August.

Expected Impact:

It is expected that the performance will improve by circa 1% per month after September, subject to any change in COVID demands over the winter months.



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 August 2020 was 83.5%, continuing the sustained improvement across recent months.

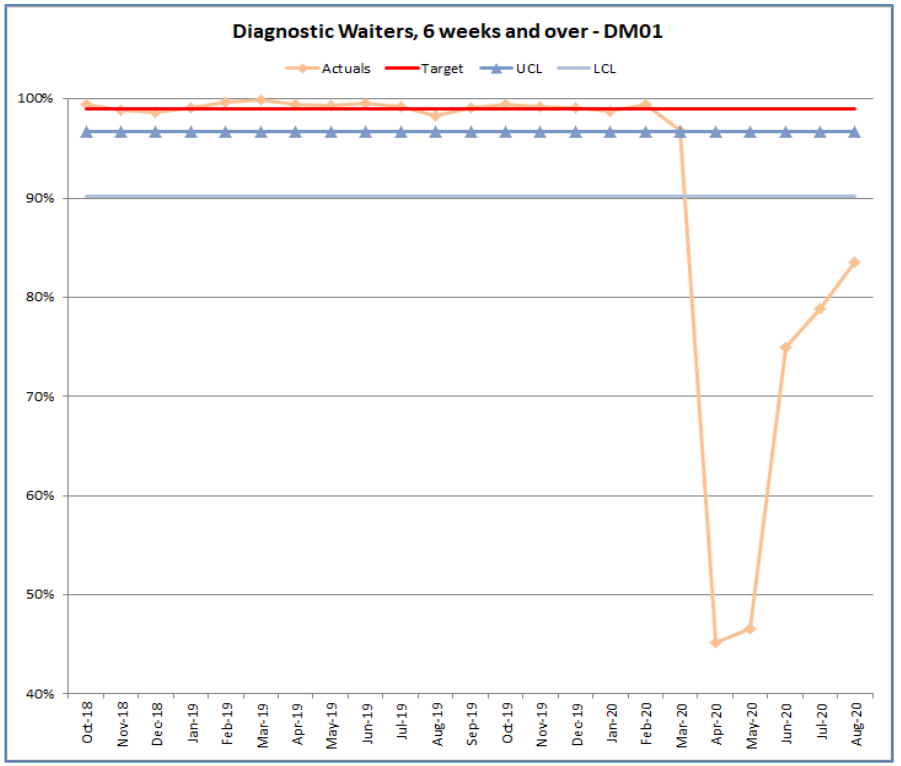
Action:

The recovery in diagnostic waits continues, and measures have put in place to safely manage the procedures, clinical environment and patient waiting rooms.

Scheduling systems have been implemented as opposed to open access and non-urgent backlogs are being addressed.

Expected Impact:

It is expected that diagnostic capacity will be at 100% by October and a return to delivery of this standard is expected during November.



Well-led Domain

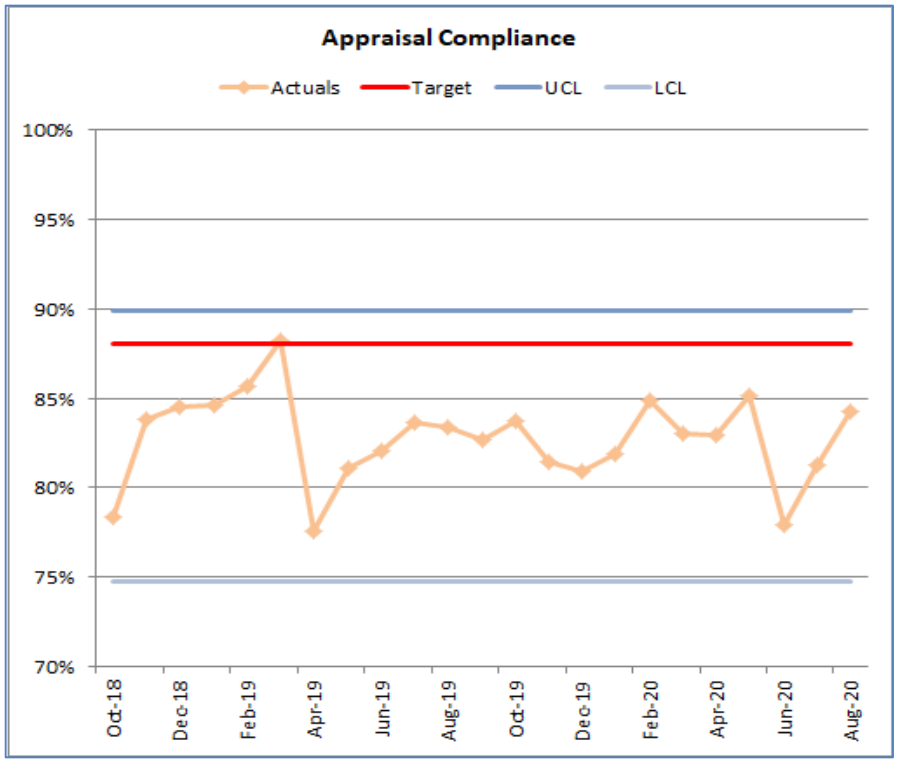
Appraisal compliance %

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, a significant dip was seen in June but there has been a 3% increase since last month with overall compliance at 84.3%. The Medical & Acute and Surgical Divisions are achieving compliance and Corporate Services remain the lowest performing Division at 68.8%, although improved by 4.9% since last month. Finance and Procurement and Informatics have the highest level of non-compliance but this is reflective of the significant impact on workload during the COVID peak they were subject to. These areas now have a schedule of appraisals booked over the next 6 months despite continued pressure and workload due to continuing COVID pressures and the recovery and reset programme. It should be noted that Estates and Facilities are now above the compliance target achieving a 12% increase since July. Appraisal data is now available which identifies staff that has been non complaint for more than 12 months and these staff will be targeted Divisions and departments.

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. Guidance has been provided on undertaking appraisal via Microsoft Teams where appropriate. Capacity to undertake appraisals during the pandemic has been restricted. 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 with some caution around a 2nd wave of the pandemic. 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	20/21 139
Title of Report	Month 5 Finance Report 2020/21
Date of Meeting	7.10.2020
Authors	Julie Clarke John McManus
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 5 Finance Report 2020/21

Contents

- The overall Mth 5 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 August of £6.1m.
  - Revenue costs incurred in responding to Covid locally of (c£0.6m).
  - "additional top-up" funding of c£0.4m

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

- The Trust has seen a ***net*** increase in the operating position of £0.4m and has therefore assumed additional "top up" income to offset this. This ***net*** position is driven by the costs of managing the COVID-19 activity which has significantly reduced this month offset by underspends relating to the continued reduced bed occupancy and associated activity levels. A lower other income position also impacts the top up required to break-even.

- 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 increases.

- The Covid spend in M5 has significantly reduced to c£0.6m in August which compares to a run rate of £1.5m Apr-Jul. This spend reflects the reduction in Covid activity in the hospital and increased governance on covid cost recording.

- Cash balances at the end of August 2020 were £39.9m; reflecting the accelerated cash payments made to providers to support their liquidity position. NHSI have committed to payment of block income in advance for the remainder of the financial year.

- 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. It will im be important to develop the 2021/22 CIP programme over the next 6 months so that savings can be reolised from 1 April 2021.

- 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.
  - Additional national allocations for Critical Infrastructure (£1.4m), A&E (£1.4m), and Restoration of Cancer Services (£0.8m).

- Capital requirements to support the local response to Covid 19.
- Capital expenditure is detailed in section 6.

- 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.

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

- The financial regime from M7-M12 with regards sytem based financial envelopes is detailed later in the report (Section 4.5) and also subject to a separate item on the agenda.

- All organisations are expected to demonstrate that clear financial 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.

3. Dashboard, overview and Risks

3.1 Mth 5 Performance Dashboard

		Current Period			Year to date		
		Budget	Actual	Variance	Budget	Actual	Variance
I&E Performance (£'000)	On Plan	0	0	0	0	0	0
NHSI UoR rating	On Plan		2	2		2	2
NHSI Agency Performance (£'000)	NHSI cap	656	431	226	3,277	2,477	800
Capital spend (£'000)	On Plan	1,391	209	(1,182)	6,263	2,793	(3,470)

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, and initial guidance for Mth 7 onwards has confirmed advance payment of block income will continue. 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 recently been allocated additional funding for A&E, critical infrastructure repair, and restoration of cancer services. This will be a challange to deliver over the winter period if COVID activity continues to grow. However, schemes have been identified, and the teams are focussed on these as key priorities.
- 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.
- Additional project resource has been mobilised in order to accelerate delivery of the estates elements of the programme, however, longer term, the capacity of the Capital team needs to be reviewed in the light of the significant increase in the size and complexity of the capital programme

4.1 Income and expenditure

For the period April to August 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 August (month 5) the Trust has delivered a "break-even" position overall as expected by NHSI, further "additional" top up funding has been required of c£0.4m.

Costs incurred in managing Covid have significantly decreased from the previous month £0.6m in August which reflects the reduction of Covid activity in the Trust. Total Covid spend ytd is c£6.6m for the Trust.

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 recovers to the required trajectories.

An analysis of the M5 finnacial position is provided in Table 1 below.

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

Month 5 Financial Position	Budget (Mth 5)	Actual (Mth 5)	Variance	Year To Date Budget	Year To Date Actual	Variance
NHS income from patient care activity	27,598	21,406	(6,191)	137,996	91,087	(46,909)
Income Guarantee	0	6,084	6,084	0	46,492	46,492
National Top-up	2,562	2,562	(0)	12,810	12,810	(0)
Additional top up		432	432		1,061	1,061
Non NHS income from patient care	457	326	(131)	2,286	1,678	(608)
Other income	2,527	1,820	(707)	12,675	10,581	(2,094)
Total Income	**33,144**	**32,630**	**(514)**	**165,768**	**163,710**	**(2,058)**
Employee expenses	(22,365)	(22,042)	323	(111,859)	(109,172)	2,687
Operating expenses	(10,353)	(9,711)	642	(51,778)	(46,328)	5,451
Covid 19 costs	0	(555)	(555)	0	(6,585)	(6,585)
Total expenditure	**(32,718)**	**(32,308)**	**410**	**(163,638)**	**(162,085)**	**1,553**
Non Operating Expenses	(426)	(345)	81	(2,130)	(1,642)	488
Actual Surplus / (deficit)	**0**	**(22)**	**(22)**	**0**	**(17)**	**(17)**
Reverse capital donations / grants I&E impact	0	22	22	0	17	17
Surplus/(deficit) - Control Total	**0**	**(0)**	**(0)**	**0**	**0**	**0**

The Mth 5 income position includes:

- **Income guarantee** – the impact of the block agreement of £6.1m 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 5 of (c£0.4m) ensuring a "break-even" position was delivered.

It should be noted that divisional budgets are set in line with the Trusts funding arrangements and therefore at levels consistet with the run rate from 2019/20. Any under/over spend against this plan is therefore a reflection on how costs are behaving against last year.

Pay costs (£0.3m below plan): Pay costs in Mth 5 are still under plan but has stepped up as activity increases particular non-elective. The underspend continues to reflect the reduced need of non-core staff in clinical areas which are driving lower bank, agency and WLI payments although these are all increasing as activity increases.

Actual agency staff costs in August were (c£0.4m) which continues to be under the NHSI ceiling.

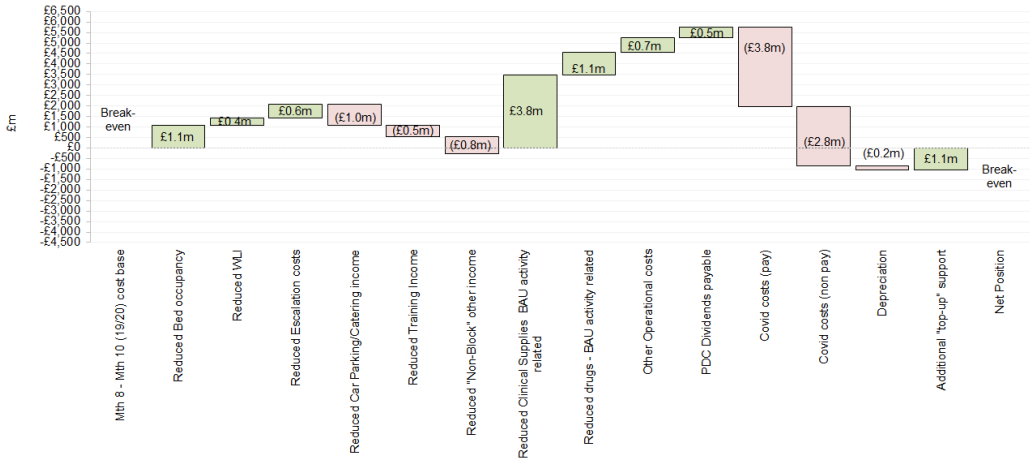
Non pay costs (£0.6m underspend): Non-pay associated with clinical supplies and drugs increased in August 2020 compared to July, reflecting the increase in activity

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.

Other Income : Lower other income (Private patients, ICR, Research and other income generation) is recovered through the top up payment as per guidance. M5 reflects an adjustment for the CCC SLAs as they ceased a level of services with their move to the Liverpool Royal.

COVID-19 costs: In total, c£0.6m 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 5 position including the impact of covid costs.



4.2 Income

At the end of August 2020, the Trust overall income position is below plan by (c£2.1m).

The clinical income position is supported by the "block" agreement the under recovery pre-dominately 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 August 2020

	Current month			Year to date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Elective & Daycase	4,281	2,388	(1,893)	21,403	6,609	(14,794)
Elective excess bed days	83	24	(59)	417	116	(301)
Non-elective	8,487	7,102	(1,385)	42,433	31,052	(11,381)
Non-elective Non Emergency	986	1,091	105	4,929	4,938	9
Non-elective excess bed days	357	152	(205)	1,784	559	(1,225)
A&E	1,286	1,267	(19)	6,430	5,211	(1,219)
Outpatients	3,056	1,820	(1,236)	15,280	7,765	(7,515)
Diagnostic imaging	189	136	(53)	946	487	(459)
Maternity	483	419	(65)	2,417	2,241	(176)
Non PbR	7,185	5,826	(1,359)	35,926	26,129	(9,797)
HCD	1,299	1,195	(104)	6,495	6,086	(409)
CQUINs	190	190	0	950	950	(0)
National Top up	2,562	2,562	0	12,810	13,841	1,031
Income Guarantee	0	6,085	6,085	0	46,493	46,493
Total income from patient care (SLAM)	30,444	30,257	(187)	152,219	152,477	258
Other patient care income	87	511	424	443	441	(3)
Non-NHS: private patients & overseas	13	0	(13)	67	3	(65)
Injury cost recovery scheme	72	42	(31)	362	208	(154)
Total income from patient care activities	30,617	30,810	193	153,092	153,128	36
Other operating income	2,527	1,820	(707)	12,675	10,582	(2,093)
Total income	33,144	32,630	(514)	165,768	163,711	(2,057)

Key points are as follows:

In Mth 5 the Trust position is supported by the "block" arrangement by a further c£6.1m, increasing the year to date support received to £46.5m.

Operationally activity performance was as follows:-

- A&E activity is at 101% of the previous run rate (average attendances in August were 248 per day, the pre – COVID-19 expected number was 245 per day). This represents an increase of 7% (16 attendances per day) from July.
- NEL activity is at 98% of expected levels, this is an improvement of 6% from the July position.
- EL/DC activity has improved by 3% from July. It continues at c46% below 19/20 levels.
- Births were slightly above plan.
- Direct Access Radiology/Pathology have increased slightly from the July 2020 position
- Rehab. bed days have increased in August however it remains below the previous run rate.
- Private patient activity, and ICR activity as well as other income (research, education and SLA/ income generation schemes) are all below budget but recovered by the top up payment.

4.3 Expenditure

4.3.1 Overall pay expenditure (including covid) for the period ending 31st August 2020

Overall pay costs were below by c£0.1m in August and by (£1.1m) YTD.

The table below details pay costs by staff group.

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

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
Consultants	(43,615)	(3,569)	(3,450)	119	(17,846)	(17,826)	20
Other medical	(30,803)	(2,561)	(2,610)	(49)	(12,800)	(12,926)	(126)
Nursing and midwifery	(75,979)	(6,127)	(6,028)	99	(30,658)	(30,576)	82
Allied heath professionals	(15,195)	(1,250)	(1,259)	(9)	(6,249)	(6,462)	(213)
Other scientific, therapeutic and technical	(6,031)	(486)	(499)	(13)	(2,412)	(2,496)	(84)
Health care scientists	(12,533)	(1,016)	(1,006)	10	(5,081)	(5,164)	(83)
Support to clinical staff	(50,805)	(4,230)	(4,324)	(94)	(21,149)	(21,797)	(649)
Non medical, non clinical staff	(30,910)	(3,036)	(2,998)	38	(15,215)	(15,286)	(70)
Apprenticeship Levy	(1,039)	(90)	(68)	22	(449)	(403)	46
Total	(266,910)	(22,365)	(22,242)	123	(111,859)	(112,936)	(1,077)

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 Covid pay spend is c£3.7m YTD. Hence the underlying pay underspend is c£2.6m underspent.

For M5 there is an underspend of £0.1m which includes £0.2m for Covid costs hence the underlying pay position is £0.3m underspent.

Table 5 below details pay costs by core/non-core category for August (incl. covid costs).

Table 5: Pay analysis by type including Covid costs

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	(247,825)	(19,934)	(20,315)	(381)	(99,697)	(103,134)	(3,436)
Bank	(6,743)	(1,061)	(938)	123	(5,310)	(4,437)	873
Medical bank	(5,695)	(625)	(492)	134	(3,127)	(2,487)	640
Agency	(5,608)	(655)	(430)	226	(3,276)	(2,476)	800
Apprenticeship Levy	(1,039)	(90)	(68)	22	(449)	(403)	46
Total	(266,910)	(22,365)	(22,242)	123	(111,859)	(112,936)	(1,077)

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

Table 6 – Operational pay costs (excluding Covid)

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
Consultants	(43,615)	(3,569)	(3,384)	185	(17,846)	(17,277)	569
Other medical	(30,803)	(2,561)	(2,638)	(78)	(12,800)	(12,387)	413
Nursing and midwifery	(75,979)	(6,127)	(5,983)	144	(30,658)	(29,898)	760
Allied heath professionals	(15,195)	(1,250)	(1,244)	5	(6,249)	(6,190)	60
Other scientific, therapeutic and technical	(6,031)	(486)	(498)	(12)	(2,412)	(2,466)	(54)
Health care scientists	(12,533)	(1,016)	(994)	22	(5,081)	(5,078)	4
Support to clinical staff	(50,805)	(4,230)	(4,270)	(40)	(21,149)	(20,611)	538
Non medical, non clinical staff	(30,910)	(3,036)	(2,962)	74	(15,215)	(14,863)	352
Apprenticeship Levy	(1,039)	(90)	(68)	22	(449)	(403)	46
Total	(266,910)	(22,365)	(22,042)	323	(111,859)	(109,172)	2,687

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. M5 has seen some WLIs undertaken in other specialties
- The reduction in the attendances in A&E & non-elective patients eliminated the need for any escalation areas to be open in August; this is reflected in the above position.

Non pay

Non pay expenditure, excluding depreciation, is below plan by c£0.6m in August, and £5.4m YTD.

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

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	(35,160)	(2,983)	(2,737)	246	(14,917)	(11,694)	3,223
Supplies and services - general	(5,200)	(444)	(338)	106	(2,223)	(1,683)	540
Drugs	(24,369)	(1,951)	(1,740)	211	(9,753)	(8,670)	1,083
Purchase of HealthCare - Non NHS Bodies	(8,116)	(646)	(445)	201	(3,213)	(2,405)	808
CNST	(13,136)	(1,070)	(1,079)	(9)	(5,350)	(5,395)	(44)
Consultancy	(562)	(69)	0	69	(343)	0	343
Other	(26,419)	(2,358)	(2,476)	(119)	(11,815)	(12,091)	(277)
Total	(112,963)	(9,520)	(8,815)	705	(47,613)	(41,938)	5,676
Depreciation	(11,256)	(833)	(896)	(63)	(4,165)	(4,390)	(225)
Total	(124,219)	(10,353)	(9,711)	642	(51,778)	(46,328)	5,451

Key points are as follows:

- The main driver of the underspend is reduced clinical and general supplies costs of c£0.4m in mth and c£3.8m YTD, a direct correlation to the reduced/paused elective programme.
- Drug costs continue to underspend in August reflecting the reduced activity levels.
- The "Other" category above incorporates a number of areas, including IT (Cerner) costs where there are increased contractual spend compared to last year.

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 August 2020, an additional £0.6m costs for both pay and non-pay have been incurred. The YTD spend is £6.5m. The revenue cost impact of COVID-19 is collected and submitted to NHSI as part of routine monthly reporting to allow national cost tracking.

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

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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: YTD Covid revenue costs

Month 5 Covid Position (£k)	Apr (M1)	May (M2)	Jun (M3)	Jul (M4)	Aug (M5)	Year to Date
Total income	**0**	**0**	**0**	**0**	**0**	**0**
Medical Staff	(339)	(376)	(204)	(198)	(38)	(1,156)
Nursing Staff	(245)	(482)	(313)	(446)	(64)	(1,549)
Other Staff	(238)	(208)	(279)	(221)	(96)	(946)
Total Pay	**(823)**	**(1,066)**	**(796)**	**(864)**	**(198)**	**(3,651)**
Medical Equipment & PPE	(492)	(527)	(192)	(452)	(181)	(1,845)
Other	(243)	(204)	(100)	(274)	(174)	(994)
Total Non-Pay	**(735)**	**(731)**	**(292)**	**(726)**	**(355)**	**(2,839)**
Total Covid Expenditure	**(1,558)**	**(1,797)**	**(1,088)**	**(1,591)**	**(553)**	**(6,586)**

During August a further c£0.2m was spent on pay costs, directly associated with COVID-19. This was a significant reduction compared to previous months.

Non pay costs associated with COVID-19 were c£0.4m in August again a significant reduction compared to July.

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

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), £1.4m for Critical Infrastructure Risk Repairs (CIR), and £0.8m for Restoration of Cancer Services.

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

4.5 Funding regime.

There are two finance funding regimes:

- 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:

- 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.

This is subject to a more detaiuled presentation on the agenda at which point more will be known about how some of the system level funding steams will be allocated.

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 August 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 £1.1m has been spent against funding bids submitted of £0.9m, with the Trust approving £0.2m 'at risk' against further funding awards.

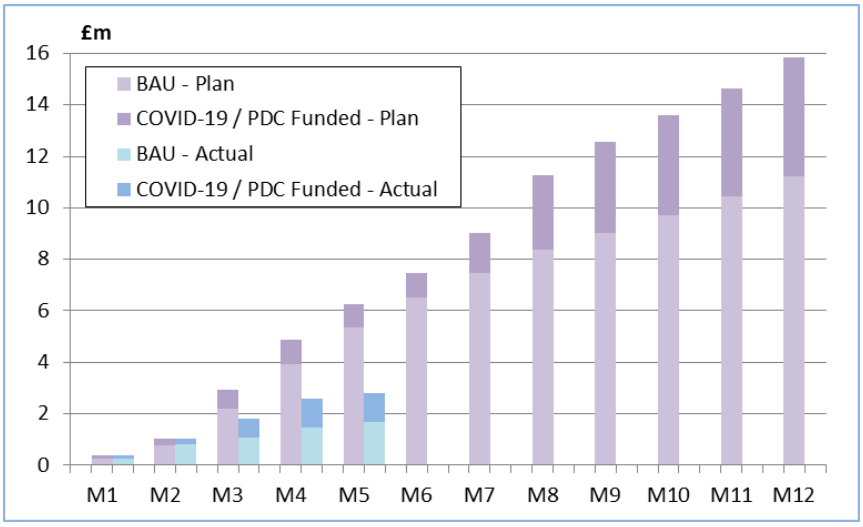
In recent months the Trust has been awarded further capital funding comprising: £1.4m to support Urgent & Emergency Care (UEC) facilities in preparation for winter pressures, £1.4m for Critical Infrastructure Repairs (CIR) of which £0.7m will be spent within HDU/ITU and £0.7m at Clatterbridge, and most recently £0.8m to support the Restoration of Cancer Services which will be spent upgrading and extending Endoscopy capacity. Total capital plans now stand at £15.8m.

A detailed analysis of the capital programme to month 5 is set out in Appendix3. Actual YTD capital spend total is £2.8m which largely comprises COVID-19 capital requirements (£1.0m) and schemes brought forward from 2019/20 (£1.4m). A further £3.6m of capital orders have been placed to date and £2.2m of Estates projects are currently in their design phase.

Project management support has been engaged to ensure the delivery of the £1.4m UEC programme before Christmas and to maximise the delivery of other building works, particularly where the need to increase operational capacity conflicts with the need to close ward space for refurbishment works.

An assessment of delivery capacity is being undertaken with a view to identifying unavoidable slippage by the end of month 6 to allow alternative programmes to be considered and/or a reduction in the overall WUTH programme to be declared.

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 on 23rd 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 5 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%	-97.9	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%	-25.0%	1
	Overall NHSI UoR rating				**2**

6. Conclusion & Recommendations

At the end of August 2020 (Mth 5), the Trust is reporting a "break-even" position.

This position includes "*additional"* top up support of c£0.4m for August (c£1.1m 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 August 2020, a further £0.6m was spent in managing the pandemic response, increasing the year to date costs to c£6.6m. 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.

From 1st October 2020 (Month 7) to 31st March 2020 (Month 12), the funding regime will change. Systems have been 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. Work is ongoing across the wider Cheshire & Merseyside partnership to determine how best to distribute the system level funding streams. Futher updates will be provided to the Board of Directors under a separate agenda item as more information is available.

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.

Recommendations

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

Claire Wilson
Chief Finance Officer
October 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 5 Budget Reconciliation	**Breakdown by Budget Type**		
	Income £'000	**Expenditure £'000**	**Deficit £'000**
Base Budget 20/21	165,732	(165,732)	0
Pharmacy PCN Scheme / GPCP Scheme	0	0	0
Pharmacy HEE training budget allocation	0	0	0
Other minor budget changes	36	(36)	0
M5 Closing Budget	165,768	(165,768)	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 31.07.20 £'000	Actual as at 31.08.20 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	160,999	160,417	(582)	↓
14,029	Intangibles	13,612	13,508	(104)	↓
723	Trade and other non-current receivables	669	645	(24)	↓
176,244		**175,280**	**174,570**	**(710)**	↓
	Current assets				
3,991	Inventories	3,849	3,896	47	↑
24,375	Trade and other receivables	15,216	15,736	520	↑
0	Assets held for sale	0	0	0	→
5,931	Cash and cash equivalents	39,969	39,818	(151)	↓
34,297		**59,034**	**59,450**	**416**	↑
210,541	**Total assets**	**234,314**	**234,020**	**(294)**	↓
	Current liabilities				
(41,874)	Trade and other payables	(36,615)	(36,280)	335	↑
(3,000)	Other liabilities	(32,253)	(32,637)	(384)	↓
(85,234)	Borrowings	(85,292)	(85,070)	222	↑
(2,926)	Provisions	(2,491)	(2,421)	70	↑
(133,034)		**(156,651)**	**(156,408)**	**243**	↑
(98,737)	**Net current assets/(liabilities)**	**(97,617)**	**(96,958)**	**659**	↑
77,507	**Total assets less current liabilities**	**77,663**	**77,612**	**(51)**	↓
	Non-current liabilities				
(2,588)	Other liabilities	(2,552)	(2,543)	9	↑
(6,274)	Borrowings	(6,252)	(6,246)	6	↑
(7,304)	Provisions	(7,234)	(7,220)	14	↑
(16,166)		**(16,038)**	**(16,009)**	**29**	↑
61,341	**Total assets employed**	**61,625**	**61,603**	**(22)**	↓
	Financed by Taxpayers' equity				
80,106	Public dividend capital	80,384	80,384	0	→
(65,492)	Income and expenditure reserve	(65,486)	(65,508)	(22)	↓
46,727	Revaluation reserve	46,727	46,727	0	→
61,341	**Total taxpayers' equity**	**61,625**	**61,603**	**(22)**	↓

- Year to date capital additions total £2.8m with the majority of spend relating to Covid-19 response and schemes carried forward from 2019/20.
- Cash and Other current liabilities (deferred income) have increased significantly due to the early receipt of NHS Block income under the amended NHSI financial regime. This advanced payment will continue through the financial year under initial guidance issued re contracting arrangements post September 2020.
- Current borrowings include £83.9m of DHSC loan which has been repaid on the 23rd September 2020, funded by receipt of Public Dividend Capital (PDC).

7. Appendices

Statement of Cash Flows

	Month Actual £'000	Year to date Actual £'000
Opening cash	**39,969**	**5,931**
Operating activities		
Surplus / (deficit)	(22)	(16)
Net interest accrued	36	102
PDC dividend expense	310	1,546
Unwinding of discount	(1)	(6)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	323	1,626
Depreciation and amortisation	896	4,390
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	0	(96)
Changes in working capital	(627)	32,260
Investing activities		
Interest received	4	8
Purchase of non-current (capital) assets [1]	(478)	(4,385)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	0	96
Financing activities		
Public dividend capital received	0	279
Net loan funding	0	0
Interest paid	(262)	(261)
PDC dividend paid	0	0
Finance lease rental payments	(6)	(30)
Total net cash inflow / (outflow)	**(151)**	**33,887**
Closing cash	**39,818**	**39,818**

[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	Distance to Go
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Total Internally Generated Funding	10,740		10,740	10,740	0	5,684	
PDC (Public Dividend Capital) - UTC	500	0	500	420	80	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	
PDC - Restoration of Cancer Services	0	792	792	792	0	0	
External Funding - donations/grants	0	96	96	96	0	0	
Total funding	**11,240**	**4,688**	**15,928**	**15,848**	**80**	**5,963**	
Expenditure							
Prior year(s) capital commitments	3,526	(321)	3,205	3,285	(80)	1,417	1,868
Estates	4,383	(361)	4,022	4,022	0	13	4,009
Informatics	575	(4)	571	571	0	42	529
Medicine and Acute	300	116	416	416	0	0	416
Clinical Support and Diagnostics	369	77	446	441	5	23	418
Surgery	1,363	64	1,427	1,427	0	135	1,292
Women and Children's	0	23	23	23	0	0	23
Other	0		0	0	0	0	0
Contingency[2]	224	406	630	0	630	0	0
UTC / Hospital upgrade programme	500	0	500	420	80	52	368
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
Restoration of Cancer Services	0	792	792	792	0	0	792
Donated assets	0	96	96	96	0	96	0
Total expenditure (accruals basis)	**11,240**	**4,688**	**15,928**	**15,447**	**481**	**2,793**	**12,654**
Capital programme funding less expenditure	**0**	**0**	**0**	**401**	**(401)**	**3,170**	
Capital expenditure	11,240	4,688	15,928	15,447		2,793	
NBV asset disposals	0	0	0	0		0	
Donated assets	0	(96)	(96)	(96)		(96)	
CDEL impact	**11,240**	**4,592**	**15,832**	**15,351**		**2,697**	

[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.

- A BAU capital plan of £11.24m (within the C& M capital envelope) has been increased by:
  - submitted bids for £0.9m re COVID-19 phase 1 response
  - £1.4m PDC support awarded for Critical Infrastructure Repairs
  - £1.4m PDC support awarded for Urgent & Emergency Care capital works to improve patient flow through A&E in support of winter pressures. This must be spent in 2020.
  - £0.8m PDC support awarded for Restoration of Cancer Services
- Actual YTD capital spend totals £2.8m, largely due to Covid-19 response (£1.0m) and schemes brought forward from 2019/20 (£1.4m). Orders are with suppliers for a further £3.6m, the most significant individual schemes being Cath Lab Refurb £0.9m, community radiology equipment £0.4m and monitoring equipment £0.6m. Design works have been commissioned on a further £2.2m of Estates projects.
- Project management support has been engaged to support the delivery of the £1.4m Urgent & Emergency Care project pre Christmas and to help maximise capital project delivery, particularly where the need to increase operational capacity restricts the ability to close ward space for refurbishment.
- A review of the capital programme is being undertaken to identify potential slippage by the end of M6 to allow alternative programmes to be considered and/or a reduction in the WUTH programme to be declared.

Board of Directors	
Agenda Item	20/21 140
Title of Report	Use of the Independent Sector
Date of Meeting	7 October 2020
Author	Nic Cundle-Carr – Head of Business Improvement
Accountable Executive	Anthony Middleton, Chief Operating Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The purpose of this paper is to inform the board of the issues related to the use of the nationally commissioned independent sector capacity and specifically to Wirral University Teaching Hospital and Spire Murrayfield.

2. Background

As part of the national response to the COVID pandemic an instruction was given to all providers of independent sector hospitals that their facilities and staff were to be prioritised for collaborative use with the NHS and that any planned activities should be suspended. Payment for such provision was agreed at national level.

Accordingly Spire Murrayfield (SM) and the Trust were engaged in reviewing a number of options available at the start of commencement, with SM expressing a desire to be the COVID isolation unit. It was clear from the discussions that whilst SM has physical capacity and a well laid out design their staffing model was such that only surgical nursing provision could be provided and therefore this was not an appropriate clinical model

Like other IS units it was determined that SM would be best used to provide outpatient and elective services, both during the first wave when all non-urgent activities were cancelled and more latterly as part of the recovery and reset of services.

3. Operational Usage

The utilisation of the IS capacity has proved challenging both for the Trust and SM due to different approaches to the 2 sectors management of COVID and the availability of clinical resources.

Listed below is a summary of the operational challenges:

- Due to only nursing provision available at the IS, the Trust was required to provide anaesthetists, surgeons and surgical assistants whom are already employed by the Trust to work across both NHS sites
- No overnight stays could be accommodated due to limited on call arrangements.
- SM could not provide pre-operative swabbing.
- SM Covid measures in the theatre environment were different to NHS national guidance or limited by resource and therefore throughput was much reduced.
- The Spire group require swabbing of doctors every 10 days which clashed with existing commitments of NHS doctors, or hampered one off use.
- Operating lists were cancelled due to nurse staffing shortages and could not be rearranged within 3 weeks.
- Outpatient room availability confirmed on ad-hoc basis proved challenging to give patients reasonable notice.
- Last minute patient cancellations were unable to be rebooked due to IT systems and differing protocols.
- Inconsistent operational liaison.

4. Performance Monitoring

From early summer NHSE/I have been producing weekly tracking of IS utilisation. This has not been made available to Trusts until very recently and has been generated at a national level using a portal arrangement which has been populated by the independent sectors head office.

The report does not detail the split of usage by NHS provider, rather the IS site in total, and has routinely showed the usage of SM to be one of the lowest across Cheshire & Merseyside and this has understandably been the subject of weekly discussion between regulators and the Trust, and indeed regulators and SM.

5. Reporting Change

As part of those discussions and the recent recommissioning of IS capacity it has been recognised that the Spire Group has been presenting its capacity availability based on the physical construct i.e. the number of theatres and clinics available for use, but not the capacity able to be staffed by the IS. This difference was significant, for instance theatre capacity was being published at 135 hours per week whereas in reality only 44 hours were able to be utilised.

NHSE/ I have clarified that the representation of capacity through the national reporting was not consistent and distorted earlier utilisation reporting, but it is now believed to be consistent and there is trust is the comparable positions.

6. Oversight

Both organisations have moved to nominate a single point of operational contact and this has streamlined and improved communication meaning there is a clearer plan of activities for services such as Endoscopy, CT and Oral Surgery rather than ad hoc arrangements.

Similarly the COO of the Trust now meets on a fortnightly basis with the general manager of SM and has been used to amend working practices on a local level, such as the standing requirement to lockdown outpatient clinics at 3 weeks to 7 working days which is allowing greater flexibility in booking urgent patient appointments.

There is recognition that national IS guidance differs from NHS practice, for example staff swabbing and those issues have been escalated through the regional systems for discussion at national level, although there is no indication that any alignment is forthcoming.

The Trust now has weekly visibility of the IS utilisation report being generated nationally, and tracks our own uptake through the weekly operational delivery model framework, where the ability to staff this capacity is balanced with the ability to restart services on the APH and CGH sites.

7. Current Usage

The Trust is now using the following capacity per week at SM:

- Day case / Endoscopy – 50%
- Outpatients – 16%
- Diagnostics – 90%

Whilst the above figures appear very low it should be noted that the use of the elective and diagnostic capacity puts the Trust in the top quarter of Trusts across Cheshire & Merseyside, which demonstrates the challenges being faced by all.

The outpatients figure remains low and indeed is in the bottom quarter by comparison but with the change in booking processes the expectation is that 30% can be achieved during October.

8. Recommendations

The board is asked to recognise the operational challenges in utilising the IS capacity and the steps both providers have taken to improve utilisation.

Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital

Monthly Board of Directors Safe Staffing Report

Board of Directors	
Agenda Item	20/21 142
Title of Report	Monthly Board of Directors Safe Staffing Report
Date of Meeting	7 October 2020
Author	Tracy Fennell - Deputy Chief Nurse. Johanna Ashworth-Jones- Senior Analyst, Corporate Nursing Team.
Accountable Executive	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC).
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6
Level of Assurance • **Positive** • **Gap(s)**	Positives • The Trust has robust systems and processes in place to monitor and flex staffing to meet the changing demands of the organisation and patient requirements. • MIAA reported the Trust as having substantial assurance for safe staffing processes in 2019. • The Trust has a number of processes that review and record patient quality indicators, incidents and patient experience metrics against staffing data to identify emerging risks. • The Trust continually fulfils its duty to undertake 6 monthly establishment reviews in line with National Quality Board / NHSI guidance using recognised acuity and dependency tools. Gaps • The Trust currently has a 16% band 5 registered nurse vacancy rate.
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	Choose an item.

1. Executive Summary

The purpose of this paper is to provide the Board of Directors with a review of nurse staffing during August 2020. As the Trust has seen a static vacancy rate of 16-17% (Band 5 registered nurses (RN)) for a number of years the Chief Nurse recommended a monthly staffing report should be presented to the Board of Directors to increase the visibility of safe staffing assurances and risks. This was a recommendation from the Francis Report in 2013. It was recommended this report should escalate monthly any known consequence on patient care, safety or experience. This recommendation was approved at the Workforce Assurance Committee in July 2020.

This report identifies a number of actions being taken to reduce and mitigate the risk of lower than planned nurse staffing numbers. Wards working on minimum staffing levels are noted to have seen an impact on the quality of care provided to patients.

The report also outlines actions that are being taken where possible to prevent staff moves. Regrettably it is acknowledged some staff moves will always be inevitable for some short notice changes to rotas to ensure the safety of wards. These staff moves are recognised to be having a detrimental impact on the satisfaction of staff.

The report informs the Board of Directors the steps the Trust is taking to reduce the vacancy rate, by reviewing the Retention and Recruitment Strategy, the introduction of the Wirral Nurse Programme, commitment to the International Nurse Recruitment Programme and development of a People Plan. It is noted the impact of the above will not been seen immediately, thereby creating increasing challenges for the Trust throughout winter which potentially will continue to impact on the quality of care provided to patients.

2. Background

An overview of assurance mechanisms was presented to the Workforce Assurance Committee (WAC) in July 2020. WAC noted that an external review of safe staffing assurances was undertaken by Mersey Internal Audit Agency (MIAA) in 2019 which reported the Trust as having substantive assurance around staffing processes, with a good system of internal control being applied consistently. WAC agreed that the strong levels of assurance could be enhanced further by ensuring the Board of Directors has oversight of staffing data monthly from October 2020.

As the Trust has seen a static vacancy rate of around 16-17% for a number of years, WAC remained keen to ensure the Board of Directors has oversight of the impact this presents 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 the monthly safe staffing report, the availability of a number of metrics and intelligence reports is required to ensure a comprehensive analysis is undertaken. In the current cycle of business, finalisation and validation of data is undertaken for the previous month during the first week of each calendar month. To ensure it is able to review a full month's appraisal of staffing, it was agreed the Board of Directors will receive the first report featuring the August 2020 staffing position at the 7 October 2020 Board of Directors meeting and monthly thereafter.

3. Current Position

3.1 Vacancies / Pipeline / Attrition Rates / Sickness

The Trust's overall band 5 vacancy rate for August 2020 was 18.05% (across all band 5 positions in the Trust (158 WTE)). When reviewing high demand areas such as inpatient base wards and theatres, this figure was noted to be higher, at 20.15%. This is a slight increase on previous months.

The highest directorate vacancy rate continues to be in the Medicine & Acute Division with a vacancy rate of 23% (102.6 WTE), with Perioperative Medicine at 18% (26.4 WTE - see Appendix 1), although Critical Care is also noted to have an 18% vacancy rate (12 WTE) this is seen as a lower risk due to planned

recruitment events and the historic ability to successfully recruit to this area. Although the Trust has 84 band 5 nurses planned to commence with the Trust, only 36 WTE are expected to commence in September 2020. The remaining nurses due to join the organisation have commencement dates up to September 2021.

On average the rolling 12 months turnover rate for all nursing posts is 11.05% (168 WTE). The Trust's stability index for all nursing and midwifery posts is 90.13%; for band 5s, however, it is currently 85.98%, which is slightly lower than our peers in Cheshire and Merseyside (NHS Improvement Model Hospital).

A rising monthly nursing and midwifery sickness figure of 6% in August 2020 has further compounded the existing pressure on vacancies (Appendix 2).

3.2 Hospital Position at Month 5 (August 2020).

The Trust has seen a significant change in service provision and patient activity as well as a reduction in bed numbers to enable social distancing. In addition, in August 2020 lower occupancy rates at 66.9% (average midnight bed occupancy, Appendix 3) were noted as a result of the COVID-19 pandemic. Furthermore, a number of wards / areas have been reduced / remodeled or closed to allow the Trust to respond to the changing patient need as a result of COVID-19 pandemic. Other wards have also remained temporarily closed to enable completion of estates maintenance work required to ensure any pseudomonas risks are addressed in a timely manner.

3.3 Reporting requirements for nurse fill rates / Care Hours per Patient Day (CHPPD).

Following the outcome of the Francis Report into Mid Staffordshire (Francis 2013) and the Keogh review into the quality of care and treatment provided in 14 hospitals Trusts in England (Keogh 2013), Trusts were asked to report nurse staffing fill rates to NHS England via UNIFY (fill rate is calculated by dividing the total number of actual hours worked by the total number of planned funded establishment hours).

Due to the factors identified in section 3.2, staffing levels were readjusted to provide lower nursing fill rates in August 2020 in many areas. This was possible due to the reduced number of patients that were inpatients in base wards during August 2020. As a result lower day fill rates are recorded at 79% and night fill rates at 94% (registered nursing staff, Appendix 4).

Since 2016 Trusts must also comply with National Quality Board (NQB 2016) guidance and the recommendations set out in the Developing Workforce Safeguards document (NHSI, 2018). The document states that CHPPD should be visible within staffing reports to provide a consistent measure for monitoring and benchmarking. The monthly NHS England UNIFY submission now provides oversight of both nurse fill rates and CHPPD for external reporting purposes.

The Trust has consistently maintained a range of 7.2 to 7.7 CHPPD for the previous 12 months; however the impact of reducing beds / lower occupancy and ward closures has seen this figure significantly increase to 9.9 CHPPD in August 2020 (including Allied Health Professionals). The latest national benchmark figures from the NHSI Model Hospital recorded February 2020 are noted in Appendix 5C noting a Trust figure of 7.5 slightly lower than the national median of 8.0 CHPPD.

4. Safe Staffing Oversight Tracker Review

The Trust has developed the Safe Staffing Oversight Tracker (SSOT) to ensure the Trust is able to track and monitor any emerging risks on a daily basis and actions made to mitigate risks. It is anticipated the SSOT will be discontinued following successful implementation of the SafeCare E-Roster module that will enable a real time review of staffing requirements based on patient need.

In the absence of SafeCare, as a temporary solution SSOT has the benefit of providing a visual heat map of staffing across the Trust taking into account the professional judgement assessment undertaken on each shift by the Matron or Associate Director of Nursing and a record of any quality impacts on care, safety and patient experience. Compliance with use of the SSOT is monitored and overseen by the Divisional Nurse Directors (DNDs) and the Deputy Chief Nurse (DCN).

During August 2020 the SSOT recorded 359 shifts that were considered to fall below minimum safe staffing levels. Of these, 132 shifts were late shifts and 148 night shifts (Appendix 6). Senior Nurses are required to make a professional judgement on whether wards are safely staffed if minimum staffing levels fall below the expected range. Of the 359 shifts identified as a concern, only one was declared as red (high risk) and this was a late shift on ward 18 due to extreme unforeseen acuity of patients. There were 29 which were considered as amber (medium). 100% of shifts where staffing was deemed to below suitable levels had a mitigation plan and additional support identified for the area, although this was not always to the desired skill mix or grade.

Appendix 7 identifies the wards that had high numbers of shifts that were below minimum staffing levels repeatedly throughout August 2020. A detailed review has identified that these wards were safe and expected to have lower staffing levels due to a change of function, amalgamation with another ward or change of patient mix in all areas. The only exception was Ward 10 where sickness was recorded as an additional pressure. Mitigating actions were enacted for Ward 10 in line with the Trust's Safe Staffing Escalation Policy when staffing fell below expected levels.

To support short notice gaps in rotas, 232 staff moves were recorded in the SSOT, of which 78 were noted to be on a late shift and 90 staff moves reported on night shifts (Appendix 8). The negative impact of staff moves on staff wellbeing and retention is widely recognised in nursing literature and feedback from staff. To avoid these staff moves actions are being taken to ensure nights and weekends are covered first. Wards are working against a number of ERostering KPIs to ensure rotas are efficiently managed in line with the Trust ERostering Policy, nights and weekend cover is one of the agreed KPIs routinely monitored. KPIs are monitored monthly by the Divisional Nurse Directors overseen by the Deputy Chief Nurse reporting to Workforce Steering Group.

5. NHSP / Agency Use

The Trust has continued to request NHSP where necessary to fill nursing gaps, with 1,577 registered nurse shifts requested in August 2020 (fill rate 69%) compared with a pre-COVID-19 request rate of 3,333 registered nurse shifts per month and a fill rate of 67.6% (January 2020). The Trust continues to use low numbers of agency shifts; 36 registered nurse shifts were requested in August 2020 (fill rate 88%) compared with a pre-COVID-19 request rate of 37 requests in January 2020 (68% fill rate - Appendix 8).

The majority of staff registered with NHSP are also contracted as WUTH substantive employees who undertake additional duties through NHSP. Although the Trust have reduced number of shifts requested from NHSP this has not translated in improved fill rates due to the known fatigue and emotional strain experienced by frontline WUTH clinicians during the COVID-19 pandemic. Since the COVID-19 pandemic many staff have been less inclined to take on additional shifts to ensure their own health and wellbeing is maintained.

6. Quality Impact Analysis of Vacancy Factor in Month 5 (August 2020).

During August 2020, 68 episodes were recorded within the SSOT where the quality of care provided was below the expected standard and staffing levels were also deemed to be below the agreed minimum staffing levels. The highest reported area related to delayed or missed observations (30 episodes) and delayed response to NMEWs (10 episodes). None of the 68 episodes resulted in moderate or severe harm. An overview can be seen in Appendix 10.

Seven non-harm falls were also noted to have occurred on shifts with less than minimum safe staffing levels; however a Root Cause Analysis undertaken following the falls has provided assurance staffing was not an influencing factor for these patients.

In August the Trust declared three serious incidents and a further 21 rapid reviews were undertaken in line with the Incident Report Policy. Two falls incidents (one SI and one rapid review) identified that staffing may have been a contributory factor. Although staffing levels were noted as planned, an unexpected increase in patient acuity potentially compromised the care provided at that time.

In August 2020, 21 formal complaints were reported and 136 informal concerns to the Patient Experience Team. Low staffing did not feature as a factor or theme in any of the feedback received from patients or families during this period.

7. Safe Staffing Incidents

In August 2020 64 incidents were reported for safe staffing, with all recorded as low or no harm.

The areas with the highest frequency of staffing incidents reported are as follows: Emergency Department, Colorectal Unit, Ward 17 / SEU.

The Emergency Department had nine incidents reported relating to staff moves and low staff numbers. These incidents detail inability to offer comfort checks and drinks timely as well as delays in medications due to high acuity.

The other two highest reporting areas were Ward 17 and the Colorectal unit who also recorded delays in care, missed breaks, staff moves and increased acuity of patients that wasn't anticipated. No incidents were recorded as moderate or severe harm

Two incidents indicated that all staffing grades were lower than required, however it was noted that the Matron provided clinical cover working on the ward.

8. Actions Taken to Improve Staffing

To ensure wards are suitably staffed, normal controls remain in place to ensure mitigations are deployed in line with the Safe Staffing Escalation Policy. Additional measures have been taken during the COVID-19 pandemic to upskill and enhance the competencies of nursing staff to enable them to work safely in other areas. This increased training has also enabled the Trust to benefit from the use of student nurses to supplement the workforce and utilisation of non-ward-based nurses to return to ward-based nursing.

Recruitment campaigns continue both corporately and divisionally to maintain the regular intake of around 160 nurses per annum. In addition the Trust has just committed to recruit 22 international nurses as a proof of concept; these nurses are expected to arrive in the Trust in January 2021.

The Trust is seeking to improve retention of staff, including junior nurses with a review of the preceptorship programme and development of the Wirral Nurse Programme also planned for launch in Spring 2020.

The Trust has also committed to undertake work as part of the response to the National People Plan to support the workforce in 2020/2021. The draft Trust level People Plan is to be brought to Board of Directors for review on 4 November 2020.

9. Conclusion

The Trust continues to see high numbers of band 5 nursing vacancies across the Trust and higher levels in base wards and theatres. Despite actions being taken to reduce the risk of low staffing numbers, wards working on minimum staffing levels are noted to report the impact this has on the quality of care provided to patients. The Trust currently has a number of measures to supplement the workforce through the use of temporary staffing and non-ward based staff who are returning to practice on wards as a result of the COVID pandemic. Despite this, high numbers of unexpected staff moves are still required to cover short term sickness to ensure the safety of wards which is having a negative impact of the wellbeing of staff. Regardless of all actions being taken to avoid staff moves (as highlighted in section 8), moves to cover late notice gaps in rotas remain inevitable whist the vacancy rates remain high. The Trust is taking steps to reduce the vacancy rate, and reduce sickness rates however the result will not been seen in the short term, creating increasing challenges for the Trust throughout winter potentially impacting on the quality of care provided to patients.

Daily staffing monitoring processes continue, with a good system of internal control being applied constantly to ensure gaps are filled and manged effectively in line with the Safe Staffing Escalation Policy. Quality indicators are also monitored through use of Business Intelligence monitoring systems, Perfect

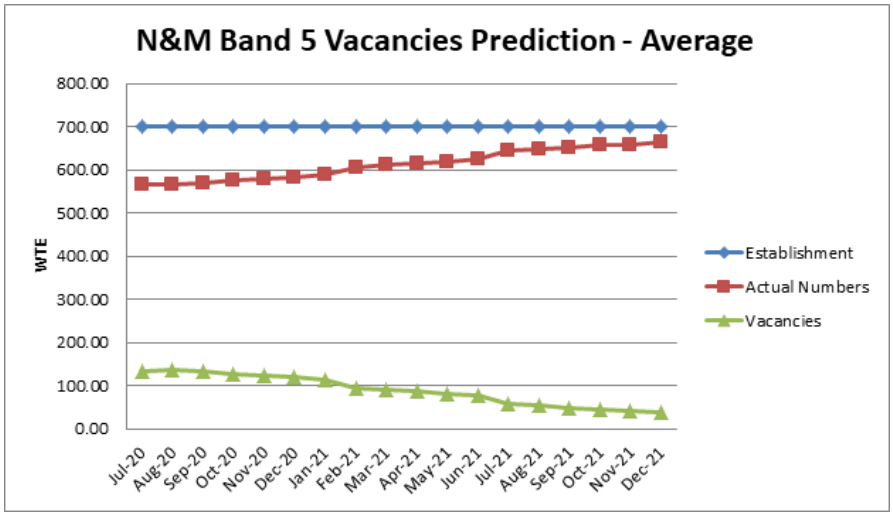
Ward applications, patient feedback and Ward Accreditation, with any areas of concern escalated to enhanced monitoring and scrutiny by the Deputy Chief Nurse in scheduled Corporate Reviews until sustainable improvement is evident.

10. Recommendations

The Board of Directors is requested to note the report and advise of any changes required to the structure of the report.

Appendix 1

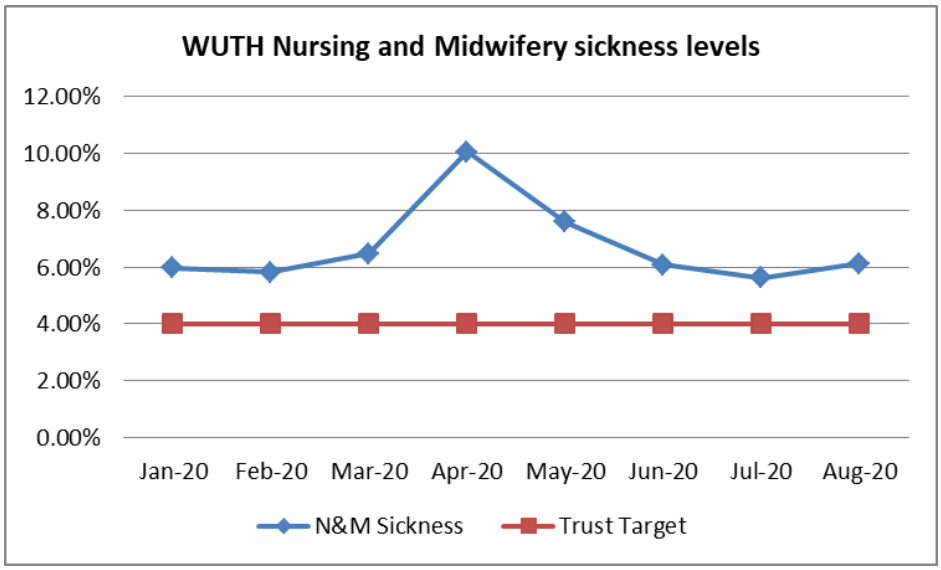
1A Predicted vacancies rate January 2020 - December 2021



1B Trust vacancy by division and expected pipeline August 2020 (end column RAG rating of vacancy factor)

Division	Vacancy	Vacancy %	FTE Budgeted	FTE Actual	Pipeline	Variance between RN Vacancy and RN Pipeline recruitment	Band 4's	Pharmacy	Discharge Trackers	Variance between RN Vacancy and total of Mitigation and Pipeline	DND Vacancy Judgement RAG
Medical	102.6235	23.13%	443.69	341.0665	62.52	40.1	7	1	0	21.83	Red
Surgical	16.38	11.57%	141.62	125.24	9	7.85	0	0	0	7.34	Green
Perioperative	26.49	18.09%	146.38	119.89	1	25.48664	0	0	0	9.89	Amber
Critical Care	12.86	23.96%	53.67	40.81	2	10.85668	0	0	0	11.08	Amber
Trust Totals	158.3468	20.16%	785.36	627.0132	74.05	84.29336	7	1	0	50.14	Red

Appendix 2
Nursing and midwifery sickness January 2020 – August 2020



Appendix 3
Average occupancy rate % at midnight August 2020 (including Clatterbridge)

Month	% Occupancy
Apr-19	46.5%
May-19	54.0%
Jun-19	55.2%
Jul-19	57.2%
Aug-19	66.9%
Sep-19	0.0%
Oct-19	0.0%
Nov-19	0.0%
Dec-19	0.0%
Jan-20	0.0%
Feb-20	0.0%
Mar-20	0.0%
YTD	

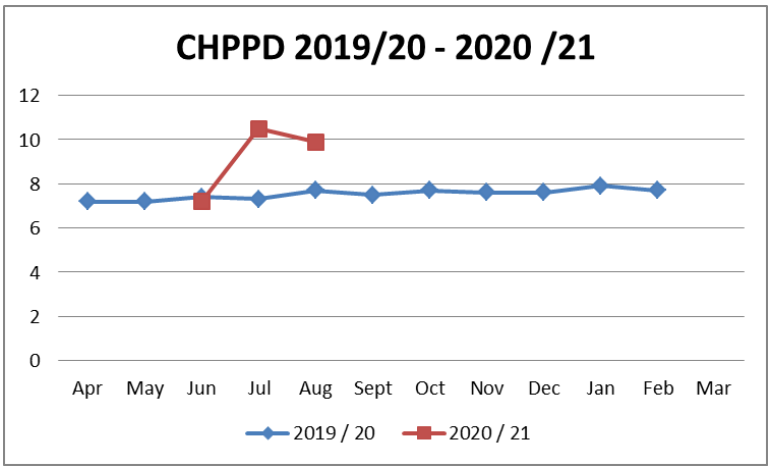
Appendix 4
August 2020 registered and unregistered nurse fill rates.

August Fill rates					
Registered Nurses		**Non Registered Nurses**		**Registered Allied Health Professionals**	**Non Registered Allied Health professionals**
Day	Night	Day	Night	Day	Day
79%	**94%**	**76%**	**97%**	**85%**	**65%**

Appendix 5
5A August 2020 - Care Hours Per Patient Day

August 2020 CHPPD				
Total	**Registered Nurses**	**Non Registered Nurses**	**Registered Allied health Professionals**	**Non registered Allied Health Professionals**
9.9	**4.8**	**4.2**	**0.7**	**0.1**

5B Trend of CHPPD April 2020 - March 2020



5C Screen shot form NHSI model hospital portal demonstrating WUTH CHPPD benchmarked against peers February 2020

CHPPD	Data period	Trust value	Peer median	National median	Chart
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Feb 2020	7.5	8.1	8.0	
Care Hours per Patient Day - Total Nursing and Midwifery staff	Feb 2020	6.9	8.1	8.0	
Care Hours per Patient Day - Total AHPs staff	Feb 2020	0.5	0.0	0.0	

Appendix 6
6 A Numbers of red Shifts (below minimum staffing levels) as reported on Safe Staffing Oversight Tracker.

Total Number of RN Red Shifts during August			**359**
Early	**Late**	**Night**	**Twi**
72	**132**	**148**	**7**

RAG rating for Staffing levels on SSOT
RED- Below minimum staffing levels
AMBER – Below established staffing levels but not lower than minimum staffing levels
GREEN – Staffing levels at agreed establishment

6 B Professional judgement ratings regarding safety of ward where shifts are recorded as **"**red shifts" (below minimum staffing levels) on Safe Staffing Oversight Tracker

Professional Judgement rating for the 359 RN red shifts during August			
Red	**Amber**	**Green**	**Blank**
1	**29**	**320**	**9**

RAG rating for professional judgement
RED- High risk of care being compromised
AMBER – Medium risk of care being compromised
GREEN – Low risk of care being compromised
BLANK- professional judgement not recorded

Appendix 7
Wards with highest numbers of "red shifts" (below minimum staffing levels) as reported on Safe Staffing Oversight Tracker.

Ward	Number of Red RN Shifts	Professional judgement		
		Red	Amber	Green
38	75	0	2	71
UMAC	41	0	3	38
33	30	0	2	28
ED	25	0	4	21
30	25	0	0	25
10	16	0	1	15
26	15	0	1	14

(RAG rating noted in Appendix 6)

Appendix 8
Staff Moves reported in August 2020

Total number of staff moves 232	
Registered Nurses	CSW
101	131

Appendix 9
Temporary staffing requests and associated fill rates August 2020

Temporary staffing source	Total number of shifts	Registered- staff	Non Registered – staff
Bank Filled	**3904**	**1577**	**2327**
Bank Unfilled	**1731**	**1056**	**675**
Percentage of Bank Filled	**69%**	**60%**	**78%**
Agency Filled	**36**	**36**	**0**
Agency Unfilled	**5**	**5**	**0**
Percentage of Agency Filled	**88%**	**88%**	**NA**

Appendix 10
Reports of gaps in care on shifts with staffing lower than minimum agreed staffing levels

Date	Ward	Shift	Fall	Meds Error	Complaints	Staffing incidents	Special 1:1	Missed Breaks	Delayed / Missed Obs	Delayed / Missed m NEWS	Delayed / missed pressure care	Delayed Meds
07/08/2020	10	Late	Yes	No	No	No	No	No	No	No	No	No
16/08/2020	10	Early	No	No	No	No	No	Yes	No	No	No	No
19/08/2020	12	Night	No	No	No	No	No	Yes	No	No	No	No
15/08/2020	26	Late	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes
18/08/2020	26	Late	Yes	No	No	No	No	No	No	Yes	No	No
26/08/2020	26	Late	No	No	No	No	No	Yes	Yes	Yes	Yes	Blank
19/08/2020	26	Late	No	No	No	No	No	No	No	Yes	No	Blank
28/08/2020	26	Late	No	No	No	No	No	No	No	Yes	No	No
31/08/2020	26	Late	No	No	No	No	No	No	No	Yes	No	No
12/08/2020	27	Early	Blank	Blank	Blank	Blank	Blank	Yes	Blank	Blank	Blank	Blank
06/08/2020	30	Night	Yes	No	No	No	No	No	No	No	No	No
18/08/2020	30	Late	Blank	Blank	Blank	Blank	Blank	Yes	Yes	Yes	Blank	Blank
17/08/2020	32	Late	Blank	Yes	Yes	Yes	Blank	Yes	Yes	Yes	Blank	Yes
20/08/2020	33	Late	Yes	No	No	Yes	No	No	Yes	Yes	No	Blank
25/08/2020	33	Late	No	No	Yes	No	No	Yes	Yes	Yes	No	Yes
18/08/2020	33	Late	No	No	No	Yes	No	No	No	No	No	No
19/08/2020	33	Late	No	No	No	Yes	Yes	Yes	No	No	No	Blank
20/08/2020	33	Early	No	No	No	Yes	No	Yes	No	No	No	Yes
28/08/2020	33	33	No	No	No	No	Yes	No	No	No	No	No
03/08/2020	33	Night	Blank	Blank	Blank	Blank	Blank	Yes	Blank	Blank	Blank	Blank
18/08/2020	33	Night	No	No	No	No	No	No	No	No	No	Yes
15/08/2020	38	Late	Yes	Blank	Blank	Blank	Blank	Blank	Blank	Blank	Blank	Blank
05/08/2020	24 IPC	Late	Blank	Blank	Blank	Blank	Blank	Blank	Yes	Yes	Blank	Blank
05/08/2020	AMU	Night	Yes	No	No	No	No	No	No	No	No	Blank
25/08/2020	AMU	Night	Blank	Yes	Blank	Blank	Yes	Blank	Blank	Blank	Blank	Yes
24/08/2020	AMU	Night	Blank	Blank	Blank	Blank	Blank	Yes	Yes	Yes	Blank	Yes
03/08/2020	AMU	Night	No	No	No	No	No	No	No	No	Yes	No
03/08/2020	CRC	Night	No	No	No	No	No	No	Yes	No	No	No
20/08/2020	ED	Late	Blank	Yes	Blank	Blank	Blank	Blank	Blank	Blank	Blank	Blank
13/08/2020	ED	Late	Blank	Blank	Blank	Blank	Blank	Yes	Yes	Blank	Blank	Yes
30/08/2020	M2 Ortho	Night	No	No	No	No	No	Yes	No	No	No	No
Total			**7**	**3**	**2**	**6**	**3**	**14**	**10**	**12**	**3**	**8**

Board of Directors	
Agenda Item	20/21 143
Title of Report	Workforce Disabilities Equalities Standard Report (WDES) for 2019/20
Date of Meeting	7 October 2020
Author	Sharon Landrum, Diversity and Inclusion Lead
Accountable Executive	Jacqui Grice, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1A, 1B, 4A, 7D
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting and approval
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	Yes – as part of a wider diversity and inclusion analysis so available on request.

1. Executive Summary

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. The WDES is mandated by the NHS contract and will apply to all NHS Trusts and Foundation Trusts from 1 April 2019.

This information will then be used by the relevant organisations to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

The group is asked to approve the report and the associated action plan so that the documents can be published via our internal and external websites and shared with our commissioning colleagues and NHS England.

Key Findings identify that**:**

1.1 Overall, the experiences of our disabled staff are less positive than compared to non-disabled colleagues. There are however, a number of positive improvements this year particularly with regards

to staff survey feedback, however work must continue in order to ensure progress continues and key areas of concern are addressed.

1.2 Significant improvement can be seen in the number of staff who felt that adequate adjustments have been put in place to support them within the workplace. This is extremely pleasing to see, as it was highlighted as an area of concern within last year's report. Further work continues to support staff who require reasonable adjustments, and their managers, and so it is hoped that progress in this area will continue.

Whilst a number of positives can also be seen from the report, two key areas of concern are however apparent this year:

1) There has been a significant reduction in the number of disabled staff who reported the last time they experienced harassment, bullying or abuse at work.
2) Trust Board representation is identified as non-diverse

A number of steps have been taken to ensure disabled staff have a voice and are involved in improvements moving forwards. It is hoped that the findings of this report will create an enhanced focus on monitoring and ensuring improvements are made to support our disabled staff

2. Background

Ten metrics have been developed to capture information relating to the experience of disabled staff in the NHS. Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The ten Metrics have been informed by research by Middlesex and Bedford Universities, conducted on behalf of NHS England, and by Disability Rights UK on behalf of NHS Employers and are now mandated within the NHS Standard Contract.

Each Trust is required to prepare and submit an annual report containing data relating to disabled staff in the workforce and progress towards improvement. The report should be shared with coordinating commissioners and published.

The full report is attached with details for each metric required, along with annual comparative data. An update on last year's action plan is also included along with key actions identified to move forwards.

Data for the required metrics has been uploaded to the appropriate reporting portal and once approved; the attached report will then be made accessible via our public website to fulfil NHS England reporting requirements. This must be completed by 31 October 2020.

3. Key Issues/Gaps in Assurance

Whilst a number of positives can be seen from the WDES report attached, key issues identified are:

3.1 Experiences for disabled staff are still lower than non-disabled colleagues
3.2 A reduction in the number of disabled staff reporting bullying, harassment and abuse
3.3 Incomplete data regarding the recruitment process, with particular reference to those who have been appointed. A backlog exists within the recruitment team therefore numbers are not fully accurate with regards to the number and percentage of staff appointed. Trac was also introduced part way through 2018 therefore data is also not directly comparable
3.4 Continued low self-reporting rates within ESR. Only 1.9% of staff have identified within ESR that they have a disability which impacts on the credibility of the data and ultimately, the identification of key areas of concern.
3.5 Non-diverse board representation, although the recent appointment of the Workforce director means we have 1 Executive who identifies with a disability.

4. Work undertaken to support our staff with disabilities and long-term health conditions

WUTH Sunflowers, the Trust's staff network for those with disabilities and long-term health conditions, continues to meet regularly. In conjunction with network members the following has been developed / delivered:

4.1 New Disability and Long-term health condition policy
4.2 New reasonable adjustment planning documentation
4.3 New support leaflet
4.4 Disability self-reporting questionnaire developed.
4.5 Dedicated health and wellbeing event planned however postponed due to COVID-19. To be rescheduled for 2021.
4.6 Continued sign-up to the Government's Disability Confident Scheme
4.7 New read and write software purchased to support greater accessibility across all Trust computers.
4.8 Increased numbers of new disabled parking spaces made available in new parking plans.
4.9 Disability mentors in place
4.10 Reverse mentoring programme piloted and to be further rolled out.
4.11 The Trust signed up to and preparing to launch the Hidden Disabilities Sunflower Lanyard Initiative
4.12 The Trust signed up to the TUC Dying to work campaign, which seeks to recognise terminal illness as a protected characteristic under the Equalities Act (2010)
4.13 A variety of engagement opportunities held with staff

5. Next Steps

Once approved, the report will be uploaded to the Trust's public facing website pages by 31 October 20 and will complete the reporting requirements for 2019/20.

Work will then continue in conjunction with staff network members, to progress actions agreed.

6. Conclusion

The Trust has been working hard to advance the diversity and inclusion agenda by working proactively to foster good relations and advance opportunities for all, with a specific focus on those who share a protected characteristic, which includes our staff with disabilities and long-term health conditions.

This report provides an overview on the variety of work undertaken within 2019/2020 to work towards improvements in these areas, with a number of improvements showing in the attached WDES report.

Whilst a number of improvements can be seen, experiences of disabled staff are still unfortunately lower than that of non-disabled colleagues. Therefore, concentrated efforts must continue in order to continue improvements made so far.

7. Recommendations

1) Members to note and approve the WDES report and associated action plan

Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Disability Equality Standards (WDES) Report

September 2020

Sharon Landrum, Diversity and Inclusion Lead

together we will

wuth.nhs.uk

Contents

Background

Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff.

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff.

WDES comprises of ten metrics that have been developed based on research by Middlesex and Bedford Universities, conducted on behalf of NHS England, and by Disability Rights UK on behalf of NHS Employers. The metrics have been reviewed as part of a consultation process with NHS staff across the country. The WDES has now been mandated in the NHS contract and became effective for all NHS Trusts and Foundation Trusts from 1 April 2019.

Trusts are therefore required to ensure data for all ten metrics is uploaded to a government portal by no later than 31 August 2020 and a detailed report, including an action plan to address any differences is made public by no later than 31 October 2020.

The WDES has been mandated by the NHS Standard Contract and all NHS Trusts and Foundation Trusts will be required to publish their results and develop action plans to address the differences highlighted by the Metrics with the aim of improving workforce disability equality.

Full details of the metrics are attached at Appendix A.

Executive Summary

This is the second report on the Trust's performance against new metrics that have been discussed and reviewed nationally and implemented as part of the standard contract for NHS Trusts.

The report allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.

Overall, the experiences of our disabled staff are less positive than compared to non-disabled colleagues. There are however, a number of positive improvements this year particularly with regards to staff survey feedback, however work must continue in order to ensure progress continues and key areas of concern are addressed.

Significant improvement can be seen in the number of staff who felt that adequate adjustments have been put in place to support them within the workplace. This is extremely pleasing to see, as it was highlighted as an area of concern within last year's report. Further work continues to support staff who require reasonable adjustments, and their managers, and so it is hoped that progress in this area will continue.

Two key areas of concern are however apparent this year:

i) There has been a significant reduction in the number of disabled staff who reported the last time they experienced harassment, bullying or abuse at work.
ii) Trust Board representation

Work will now take place to ensure actions are taken forward in these areas and are included within the action plan at appendix A.

Recruitment reporting data is not directly comparable this year due to reporting issues:

i) TRAC was only introduced part way through 2019, therefore this years' data cannot directly compare to a full year for 2018/19
ii) Backlogs exist in completing the process on TRAC for those who have been appointed, and therefore numbers of those appointed and their demographics are not fully up to date. A plan is in place within the recruitment team in order to address this and therefore data will be reviewed as soon as practicable.

A number of steps have been taken to ensure disabled staff have a voice and are involved in improvements moving forwards.

The Trust launched a staff network for those with disabilities and long-term health conditions, now named WUTH Sunflowers. The group have met regularly since they established in 2018 and members are involved in reviewing the WDES data and actions required in order to make improvements. Regular feedback is provided to the Diversity and Inclusion Steering Group and via the workforce governance structure.

It is hoped that the findings of this report will create an enhanced focus on monitoring and ensuring improvements are made to support our disabled staff.

Metric 1

Staff breakdown for 2019/20 (all staff)

As at the 31st March 2020, the self-reporting rate for those staff with a disability within WUTH is 1.9%.

A total of 116 staff have identified they have a disability, with 77 staff in a clinical role and 39 staff in a non-clinical role.

Breakdown of disability declaration categories by clinical and non-clinical

	Total Clinical Staff	% of Clinical	Total Non-Clinical Staff	% of non-clinical	Combined	% overall
Disabled	77	1.8	39	1.9	116	1.9
Non-disabled	2543	60.5	996	48.4	3539	56.6
Not declared	172	4.1	109	5.3	281	4.5
Prefer not to answer	1	0.0	0	0.0	1	0.0
Unspecified	1409	33.5	912	44.4	2321	37.1
TOTAL	4202	100.0	2056	100.0	6258	100.0

A full breakdown of staff per cluster (as per the WDES metric) is to follow on the next page.

Percentage of staff in A4C paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

		Clinical				Non-Clinical				Total Headcount	Total WTE	Total % of Row	Total % of Column
WDES Cluster	Employee Disability Description	Headcount	WTE	% of Row	% of Column	Headcount	WTE	% of Row	% of Column				
Cluster 1 Bands 1-4	No	795	674.81	54.03%	18.61%	800	574.26	45.97%	36.24%	1595	1249.07	100.00%	23.97%
	Not Declared	58	45.54	41.70%	1.26%	97	63.66	58.30%	4.02%	155	109.20	100.00%	2.10%
	Unspecified	399	331.62	35.58%	9.14%	792	600.34	64.42%	37.89%	1191	931.96	100.00%	17.88%
	Yes	29	24.45	55.28%	0.67%	26	19.78	44.72%	1.25%	55	44.23	100.00%	0.85%
Cluster 2 Bands 5-7	No	1296	1131.08	89.95%	31.19%	131	126.33	10.05%	7.97%	1427	1257.42	100.00%	24.13%
	Not Declared	79	59.02	87.28%	1.63%	9	8.60	12.72%	0.54%	88	67.62	100.00%	1.30%
	Unspecified	846	713.25	89.30%	19.67%	92	85.43	10.70%	5.39%	938	798.67	100.00%	15.33%
	Yes	40	34.07	79.55%	0.94%	9	8.76	20.45%	0.55%	49	42.83	100.00%	0.82%
Cluster 3 Bands 8a & 8b	No	98	91.15	71.50%	2.51%	37	36.33	28.50%	2.29%	135	127.48	100.00%	2.45%
	Not Declared	10	8.65	81.22%	0.24%	2	2.00	18.78%	0.13%	12	10.65	100.00%	0.20%
	Unspecified	65	59.44	72.36%	1.64%	23	22.71	27.64%	1.43%	88	82.15	100.00%	1.58%
	Yes	3	3.00	42.86%	0.08%	4	4.00	57.14%	0.25%	7	7.00	100.00%	0.13%
Cluster 4 8c - 9 & inc VSM	No	13	11.85	36.97%	0.33%	21	20.21	63.03%	1.28%	34	32.06	100.00%	0.62%
	Not Declared	3	3.00	75.00%	0.08%	1	1.00	25.00%	0.06%	4	4.00	100.00%	0.08%
	Unspecified	3	3.00	42.86%	0.08%	5	4.00	57.14%	0.25%	8	7.00	100.00%	0.13%
Cluster 5 Consultants	No	173	164.40	100.00%	4.53%			0.00%	0.00%	173	164.40	100.00%	3.15%
	Not Declared	15	14.50	100.00%	0.40%			0.00%	0.00%	15	14.50	100.00%	0.28%
	Unspecified	78	74.98	100.00%	2.07%			0.00%	0.00%	78	74.98	100.00%	1.44%
	Yes	2	2.00	100.00%	0.06%			0.00%	0.00%	2	2.00	100.00%	0.04%
Cluster 6 Career Grades	No	73	59.91	100.00%	1.65%			0.00%	0.00%	73	59.91	100.00%	1.15%
	Not Declared	3	2.11	100.00%	0.06%			0.00%	0.00%	3	2.11	100.00%	0.04%
	Unspecified	18	13.20	100.00%	0.36%			0.00%	0.00%	18	13.20	100.00%	0.25%
Cluster 7 Trainee Grades	No	95	94.25	100.00%	2.60%			0.00%	0.00%	95	94.25	100.00%	1.81%
	Not Declared	4	4.00	100.00%	0.11%			0.00%	0.00%	4	4.00	100.00%	0.08%
	Prefer Not To Answer	1	1.00	100.00%	0.03%			0.00%	0.00%	1	1.00	100.00%	0.02%
	Yes	3	2.60	100.00%	0.07%			0.00%	0.00%	3	2.60	100.00%	0.05%
Other	No			0.00%	0.00%	7	7.00	100.00%	0.44%	7	7.00	100.00%	0.13%
Grand Total		4202	3626.88	69.60%	100.00%	2056	1584.41	30.40%	100.00%	6258	5211.29	100.00%	100.00%

Key Findings:-

The number of staff identified as disabled are significantly low at WUTH and fall below the national average of 3%. Declaration rates within the staff survey are 19.6%. Self-declaration rates are still low, with 37.1% of staff still unspecified and therefore work is needed to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

Levels of disabled staff are equal amongst clinical and non-clinical staff; however there are higher levels of non-disabled staff within clinical areas and higher levels of unspecified within non-clinical areas.

Metric 2

This refers to the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

A new TRAC Recruitment system was introduced for use with all posts with effect from 1 September 2018. Data collected and contained within this report can only therefore be compared to 2018/19 information collated from 1 September 2018 until 31 March 2019.

The following chart provides the data for each of the recruitment phases, broken down by disabled and non-disabled applicants.

	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Outcome: Recruited	Outcome: Recruited (%)
None Disabled	18,005	93.9	10,818	94.1	387	87
Disabled	778	4.1	538	4.7	9	2
Do not wish to disclose / unstated	386	2	141	1.2	49	11
Total	**19,169**	**100**	**11,497**	**100**	**445**	**100**

Annual Comparison

	% applied		% shortlisted		% appointed	
	2019	**2020**	**2019**	**2020**	**2019**	**2020**
None disabled	94.8	93.9	95.3	94.1	91.9	87
Disabled	3.1	4.1	3	4.7	1.4	2
Do not wish to disclose / unstated	2.1	2	1.7	1.2	6.7	11

Guaranteed Interview Scheme

The Trust operates a guaranteed interview scheme as part of its commitment to disabled people, whereby if applicants meet the essential criteria, they are guaranteed an interview. The table below highlights the numbers affected at each stage of the recruitment process.

Guaranteed Interview Scheme data

	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Outcome: Recruited	Outcome: Recruited (%)
None disabled	4,458	23.3	2,461	21.4	118	26.5
Disabled	567	3	402	3.5	6	1.3
Not stated	14,144	73.8	8,634	75.1	321	72.1
Total	**19,169**	**100**	**11,497**	**100**	**445**	**100**

Annual Comparison

	% applied		% shortlisted		% appointed	
	2019	**2020**	**2019**	**2020**	**2019**	**2020**
No	13.2	23.3	11	21.4	22.3	26.5
Yes	1.9	3	2	3.5	0.5	1.3
Not Stated	84.9	73.8	87	75.1	77.2	72.1

Key Findings

Of the 19,169 total applications received via TRAC, 778 applications (4.1%) were from disabled applicants, 18,005 applications (93.9%) from non-disabled applicants and 386 (2%) did not wish to disclose or were unstated as to whether they had a disability or not.

11,497 (60%) applications were shortlisted and of those, 538 were disabled (4.7%), 69.2% of the disabled applicants who applied (62.2% in 2018/19). 10,818 shortlisted applications were from non-disabled applicants (60.1% of those that applied) and 141 applications did not wish to disclose this information or were unstated (36.5% of those who applied).

445 (2.3%) were appointed, 9 applicants (2%) were disabled, 387 applicants (87%) were non-disabled and 49 applicants (11%) did not wish to disclose or were unstated.

The data highlights significant increases in the number of applications and shortlisted applicants, however this is not directly comparable to 2019 as TRAC was introduced part way through 2019 (September 2019). In addition, the data highlights a lower level of increase in the number of staff appointed. The recruitment process was part of a shared service, however as of 01/04/20 this service was brought back in-house and as a result, a backlog currently exists with processing completed applications via TRAC and therefore data for this element is not up to date. This has been escalated within the Trust and a plan is in place to address. Data for this metric cannot therefore be fully comparative at present. Data will be reviewed as soon as practicable and any additional findings will be included within the 2020/21 report.

Metric 3

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year.

For the 2 year rolling period ending 31 March 2020, only 1 person entered the formal capability process, and they were non-disabled.

National NHS Staff Survey Findings

The next 4 indicators are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

Metric 4

Results of this metric are based on Q13 of the National Staff survey.

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months
   ii) Managers
   iii) Other colleagues

Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months		2018	2019	National Average 2019
	Disabled staff	34.4%	31.9%	33.9%
	Non-disabled staff	23.9%	24.0%	27.3%

Percentage of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months		2018	2019	National Average 2019
	Disabled staff	26.3%	23.7%	19.7%
	Non-disabled staff	15.5%	14.6%	11.0%

Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months		2018	2019	National Average 2019
	Disabled staff	34.9%	28.7%	28.1%
	Non-disabled staff	19.5%	19.4%	18.4%

Part b) - looks at the percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work they or a colleague reported it (Q13d).

46.3% of disabled staff (205 people), reported that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it as opposed to only 45.1%, 574 non-disabled staff. Whilst reporting levels are higher than for non-disabled staff, there has been a significant reduction in the number of disabled staff feeling able to report this year (55.5% in 2017/18) and now falls just below the national average of 46.7%.

Key findings

It appears from the data that whilst the number of staff who have experienced harassment, bullying and abuse from others still remains higher for disabled staff, the experiences have improved in the last year, significantly so in some areas. That said, there has been a significant reduction in the number of disabled staff reporting.

Metric 5

This metric is also taken from the national staff survey results and is the percentage of staff believing that trust provides equal opportunities for career progression or promotion (Q14).

Fewer disabled staff than non-disabled staff believe the Trust offers equal opportunities for career progression or promotion and the results for disabled staff falls below the national average.

	2018	2019	National Average 2019
Disabled staff	75.9%	76.0%	79.1%
Non-disabled staff	85.4%	86.5%	85.6%

Metric 6

This metric is again taken from the national staff survey results (Q11e) and looks at the percentage of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties.

Whilst it continues to appear from the results that more disabled staff than non-disabled staff feel pressure to come to work, despite not feeling well enough to perform their duties, improvements can however be seen in the results this year.

Metric 7

This metric looks at the percentage of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Improvements can be seen this year with all staff feeling more valued than last year. That said, the results still show that disabled staff feel less valued than non-disabled colleagues and results fall below the national average.

	2018	2019	National Average 2019
Disabled staff	29.1%	32.5%	37.4%
Non-disabled staff	40.8%	44.1%	49.5%

Metric 8

This metric is also taken from the national staff survey results and seeks to identify the number of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b)

266, 72.9% of staff feel that the Trust has made adequate adjustment(s) to enable them to carry out their work. Whilst still falling below the national average of 73.3%, this is a significant improvement from last year (66.5%).

Metric 9

This metric is also taken from the national staff survey results and comprises of two elements:

a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall staff engagement score for the organisation

b) Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?

Staff Engagement Scores

In terms of part a) Disabled staff have a lower staff engagement score than that of non-disabled colleagues and both are below the national average, however both have increased by 0.1 this year.

	2018	2019	National Average 2019
Disabled staff	6.3	6.4	6.6
Non-disabled staff	6.8	6.9	7.1
WUTH	6.7	6.8	

Part b and key findings overall

All staff engagement scores fall below the national average, with the staff engagement score for disabled staff being lower than that of non-disabled colleagues (6.4% for disabled staff and 6.9% for non-disabled staff).

The Trust recognised that further work needed to take place in supporting its disabled staff and therefore additional roles and responsibilities were identified by way of a new Diversity and Inclusion Adviser, new Learning Disability Link Nurse and also a new Health and Wellbeing Manager.

	2018	2019	National Average 2019
Disabled staff	39.9%	35.1%	32.7%
Non-disabled staff	26.8%	23.4%	22.4%

Steps have been taken to ensure the voices of staff with disabilities are heard, by way of a disability and long-term health condition staff network that was established in 2018 and continues to meet monthly. Regular Trust-wide communications take place to promote the staff

network and to encourage staff to come forward and share thoughts and ideas and staff stories are shared with senior workforce committees so as to ensure lessons are learned and positive steps forward are taken.

A MacMillan cancer support forum was established and merged with the disability staff network offering staff the opportunity to contribute to improvements and to allow their voices to be heard.

A series of work streams were progressed including the development of a new disability policy and reasonable adjustment support documentation, new leaflets, sign up to assistive software to support staff and the purchase of sunflower lanyard initiative promotional materials.

The staff network was pivotal in the identification and development of these and had planned a wellbeing event on 17th March 2020 to launch new support, share stories and capture further ideas and suggestions. Due to COVID-19, unfortunately the event was cancelled and progress halted. 2020/21 will therefore see the launch and development of the work undertaken.

Metric 10

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

Key Finding:

As at 31 March 2020, the Trust had 14 voting members of the board, none of whom were BAME.

There are no BAME executive members of the Board identified as having a disability.

Conclusion

A number of improvements can be seen in the data; however that said, experiences are still lower than those of non-disabled colleagues and therefore work must continue in order to ensure improvements continue.

There are some additional factors regarding data, that impact on the Trusts ability to fully realise the true situation regarding disabled staff, with low self-reporting rates and delays in data entry for recruitment, concentrated efforts must take place to ensure improvements in these areas and ongoing monitoring must continue.

That said, continued efforts are in place to ensure that the voices of staff with disabilities or long-term health conditions can be heard and staff encouraged to be involved in identifying and driving forward improvements across the Trust.

A number of actions have been progressed within 2019/2020; however implementation was unfortunately stalled due to COVID-19. That said however, it is hoped that these will be launched soon and will result in improvements in staff experiences.

WDES Metrics

Workforce Metrics For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	**Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.** Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric is voluntary in year one.
National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13	a) **Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) **Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

WDES Metrics

Metric 5 Staff Survey Q14	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
Metric 6 Staff Survey Q11	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 Staff Survey Q5	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
The following NHS Staff Survey Metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q28b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
NHS Staff Survey and the engagement of Disabled staff For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score For part b) add evidence to the Trust's WDES Annual Report	
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.
Board representation Metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

WDES Action Plan Update – September 2020

No.	Objective	Actions	Lead	By	Progress	Comments
1	Increase disability self-reporting rates on ESR	• Continuation of additional drop in sessions to support staff access to ESR • Further Trustwide communications campaign to promote importance of self-reporting • Trustwide communications campaign • Sharing of staff stories and importance of self-reporting • Guidance documents on how to self-report your disability status • Targeted focus on key areas	ESR Team/ D&I Lead	Mar 20	Amber	Additional ESR drop in sessions held. Trust wide comms produced although no specific campaign launched. Questionnaire developed for use at wellbeing event to request central update of ESR information – event delayed.
2	Improve % of staff who feel the employer has made reasonable adjustments	• Survey of staff to uncover key priorities in improving awareness of reasonable adjustments and potential gaps or barriers • Support for managers in understanding their responsibilities to provide reasonable adjustments and what support is available • Sharing of staff stories who have received reasonable adjustments • Trustwide communications to promote support available	D&I Lead / HWB Lead	Mar 20	Green	Improvement achieved in last staff survey however a number of actions still to complete. New disability policy developed with new reasonable adjustment documentation and monitoring process ready for launch and awaiting final ratification.
3	Increase the staff engagement of disabled staff	• Further promotion of the disability and long-term health condition staff network and support mechanisms available for staff • Drop in opportunities for staff to access additional advice and support • Consider potential development opportunities aimed at disabled staff • Continue to promote new Trust values and behaviours and ensure all staff are monitored against the standards required • Trustwide communications to promote key areas.	D&I Lead / HWB Lead	Mar 20	Green	Staff engagement score improved. Staff network continues to be promoted with promotion via a variety of methods. Wellbeing event scheduled for March with community organisations, however cancelled due to COVID-19.
Additional Actions Required for 2020/21						
1	Ensure improvements are sustained	• Continue with actions identified above	D&I Lead	Mar 21		
2	Improve diversity representation at senior management levels	• Review Board level recruitment processes • Consider positive action required including links with community organisations to promote the Trust and opportunities	D&I Lead / Director of Workforce	Mar 21		

Board of Directors	
Agenda Item	20/21 143
Title of Report	Workforce Race Equalities Standard Report (WRES) for 2019/20
Date of Meeting	7 October 2020
Author	Sharon Landrum, Diversity and Inclusion Lead
Accountable Executive	Jacqui Grice, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1A, 1B, 4A, 7D
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting and approval
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	Yes – as part of a wider diversity and inclusion analysis so available on request.

1. Executive Summary

This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

The aim of the WRES is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

The group is asked to approve the report and the associated action plan so that the documents can be published via our internal and external websites and shared with our commissioning colleagues and NHS England.

Key findings identify that:

1.1 The percentage of BAME staff employed at WUTH has shown an increase this year from 6.9% in 2018/19 to 7.2% as at 31 March 2020.

1.2 The percentage of BAME staff employed at WUTH also continues to remain greater than the population of Wirral as a whole (5.5%, *2011 Census*).

1.3 Whilst overall levels of BAME staff have increased this year, levels are not consistent across the Trust, with significantly higher levels of BAME medical and dental staff. There is also a significant difference in the levels of BAME clinical and non-clinical staff, with 10.1% of clinical staff identifying as BAME as opposed to only 1.3% non-clinical staff.

1.4 There are no voting BAME Board members.

1.5 Statistics this year continue to show that BAME staff are less likely to be disciplined than non-BAME staff.

1.6 Recruitment data identifies positive increases across all areas of the process, with significant increases in applications from, and shortlisting of BAME people particularly. Data however is currently not directly comparable as 2019 data is based on a part year, as Trac was introduced in September 2019. Appointment data is also not accurate as current backlogs in processing completed applications. Therefore, whilst data appears positive, full comparisons are not available for this metric however will be reviewed as soon as practicable.

1.7 Four of the WRES indicators are based on the last staff survey. All of the indicators show positive improvements in results this year, 1 with a significant improvement. 3 of the 4 indicators also now fall below the national average with one only 0.2% above.

1.8 Whilst data has improved in all areas, results for BAME staff are still lower than that of non BAME colleagues in 3 of the 4 indicators and therefore work must continue in order to continue with improvements made.

2. Background

In 2014, the NHS Equality & Diversity Council reached a decision to implement a workforce race equality standard within the NHS 2015/2016 contract. The standard requires NHS organisations to demonstrate progress against a number of indicators of workforce equality including a specific indicator to address the low levels of black, Asian and ethnic minority board representation.

Results aim to foster an environment in the Trust whereby all staff feel engaged, valued and supported which, in turn, will contribute towards high quality patient care and improved health outcomes.

Each Trust is required to prepare and submit an annual report containing data relating to BAME staff in the workforce and progress towards improvement. The report should be shared with coordinating commissioners and published.

The full report is attached with details for each metric required, along with annual comparative data. An update on last year's action plan is also included along with key actions identified to move forwards.

Data for the required metrics has been uploaded to the appropriate reporting portal and once approved; the attached report will then be made accessible via our public website to fulfil NHS England reporting requirements. This must be completed by 31 October 2020.

3. Key Issues/Gaps in Assurance

Whilst a number of positives can also be seen from the recent WRES report, key issues identified are:

3.1 Experiences for BAME staff are still lower than non-BAME colleagues

3.2 BAME representation significantly higher within clinical staff than non-clinical and significantly higher within certain staff groups e.g. medical and dental staff

3.3 Incomplete data regarding the recruitment process, with particular reference to those who have been appointed. A backlog exists within the recruitment team therefore numbers are not fully accurate with regards to the number and percentage of staff appointed

3.4 Non-diverse board representation

4. Work undertaken to support our BAME staff

4.1 The Staff network was re-established in June 2020 and monthly meetings scheduled. Membership is growing steadily and an email distribution list developed, with Terms of Reference under discussion. Network members are getting to know each other and key local and national items are raised for review and discussion, although the network is still in its infancy.

4.2 The Trust was one of the first to include BAME colleagues within the health risk assessments and a proactive approach was developed to encourage and support BAME staff in completing them.

4.3 Innovative support developed to offer all BAME staff free one months' supply of Vitamin D, with a referral process for blood test, Occupational Health and GP support was built-in. Additional bone-screening testing was included for research opportunities. Recognised as excellent practice nationally.

4.4 Staff encouraged to share experiences and link in with national events e.g. National Inclusion Week and Black History month.

4.5 BAME Freedom to Speak Up (FTSU) Guardian appointed and FTSU Champions promoted as additional support and contact points

4.6 BAME specific development opportunities promoted

5. Next Steps

Once approved, the report will be uploaded to the Trust's public facing website pages by 31 October 20 and will complete the reporting requirements for 2019/20.

Work will then continue in conjunction with staff network members, to progress actions agreed.

6. Conclusion

The Trust has been working hard to advance the diversity and inclusion agenda by working proactively to foster good relations and advance opportunities for all, with a specific focus on those who share a protected characteristic, which includes our staff who identify as BAME.

This report provides an overview on the variety of work undertaken within 2019/2020 to work towards improvements in these areas, with a number of improvements showing in the attached WRES report.

Whilst a number of improvements can be seen, experiences of BAME staff are still unfortunately lower than that of non-BAME colleagues, therefore concentrated efforts must continue in order to continue improvements made so far.

7. Recommendations

1) Board members to note and approve the WRES report and associated action plan

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Race Equality Standards (WRES)

Report and Action Plan

September 2020

Sharon Landrum, Diversity and Inclusion Lead

together we will

wuth.nhs.uk

Contents

Background

All the available evidence shows that Black, Asian and Minority Ethnic (BAME) staff have a significantly inferior experience of the NHS as employees when compared to white staff. This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

The aim of the WRES is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

In the context of the WRES, white staff comprise of white British, white Irish and white other, whereas BAME staff comprise all other categories with the exception of "not stated".

The report shows annual comparisons to assess whether any improvements have been achieved.

Executive Summary

The key findings from our WRES analysis for 2019/20 are as follows:-

The percentage of BAME staff employed at WUTH has shown an increase this year from 6.9% in 2018/19 to 7.2% as at 31 March 2020.

The percentage of BAME staff employed at WUTH also continues to remain greater than the population of Wirral as a whole (5.5%, *2011 Census*).

Whilst overall levels of BAME staff have increased this year, levels are not consistent across the Trust, with significantly higher levels of BAME medical and dental staff. There is also a significant difference in the levels of BAME clinical and non-clinical staff, with 10.1% of clinical staff identifying as BAME as opposed to only 1.3% non-clinical staff.

There are no voting BAME Board members.

Statistics this year continue to show that BAME staff are less likely to be disciplined than non-BAME staff.

Recruitment data identifies positive increases across all areas of the process, with significant increases from in applications from and shortlisting of BAME people particularly. Data however is currently not directly comparable as 2019 data is based on a part year, as Trac was introduced in September 2019. Appointment data is also not accurate due to current backlogs in processing completed applications (Covid related). Therefore, whilst data appears positive, full comparisons are not available for this metric however will be reviewed as soon as practicable.

4 of the WRES indicators are based on the last staff survey. All of the indicators show positive improvements in results this year, 1 with a significant improvement. 3 of the 4 indicators also now fall below the national average with one only 0.2% above.

Whilst data has improved in all areas, results for BAME staff are still lower than that of non BAME colleagues in 3 of the 4 indicators and therefore work must continue in order to continue with improvements made.

Total Staff by Ethnicity 31 March 2020

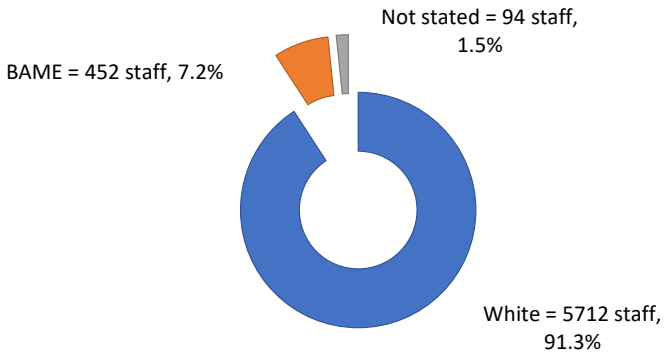
At 31 March 2020, a total of 6258 staff were employed by WUTH. Of these, 452 (7.2%) were BAME and 5712 (91.3%) were white. 94 staff however, (1.5%) were unstated for their ethnicity.

The results highlight therefore that there has been a significant increase in the number of BAME staff within the Trust, numbers still remain higher than that within the local population *(2011 census),* although as further data indicates this may be restricted to certain roles / levels.

% Employed by Ethnicity

Ethnic Group	2020	2019	2018	2017
White	91.3%	91.5%	91.7%	96.8%
BAME	7.2%	6.9%	6.8%	6.7%
Unknown	1.5%	1.6%	1.5%	1.7%

Staff Employed as at 31 March 20 by Ethnic Group



The definitions of “Black, Asian and Minority Ethnic” and “White” used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. “White” staff includes White British, Irish and Any Other White. The “Black, Asian and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated.”

The WRES Standard Indicators

Table 1. The Workforce Race Equality Standard Indicators	
Workforce Indicators For each of these four workforce indicators, compare the data for White and BAME staff.	

1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (*including Executive Board members*) compared with the percentage of staff in the overall workforce disaggregated by:
	• Non-clinical staff
	• Clinical staff – of which
	  • Non-medical staff
	  • Medical and Dental staff

2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* **Note:** *this indicator will be based on data from a two year rolling average of the current year and the previous year.*
4	Relative likelihood of BAME staff accessing non-mandatory training and CPD.
National NHS Staff Survey findings (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff.	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	Percentage believing that trust provides equal opportunities for career progression or promotion.
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) manager/team leader or other colleagues
Boards representation indicator For this indicator, compare the difference for White and BAME staff	
9	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WUTH as a whole workforce for 2019/20.

Key Findings:-

- The percentage of BAME staff employed at WUTH has increased from 6.9% last year to 7.2% this year.
- The percentage of BAME staff employed at WUTH (7.2%) is greater than the population of Wirral as a whole (5.5%, *2011 Census*), although the percentage is significantly higher in some areas e.g medical and dental staff, bands 5 and 8d
- The number of BAME clinical staff is significantly higher than non-clinical BAME staff with 10.1% of BAME staff being clinical and only 1.3% non-clinical.

Staff breakdown for 2019/20 (clinical and non-clinical combined)

Banding	White	BAME	Not Stated	Grand Total	% in Band 2020	% in band 2019	% in band 2018
Band 1	238	2	5	245	**0.8%**	1.3%	1.3%
Band 2	1590	63	17	1670	**3.8%**	4.0%	3.8%
Band 3	640	18	3	661	**2.7%**	2.8%	2.9%
Band 4	399	9	10	418	**2.2%**	1.5%	0.8%
Band 5	1053	119	13	1185	**10.0%**	9.3%	9.8%
Band 6	757	55	14	826	**6.7%**	6.2%	5.7%
Band 7	470	12	9	491	**2.4%**	3.3%	2.2%
Band 8A	158	12	5	175	**6.9%**	5.0%	6.4%
Band 8B	64	1	1	66	**1.5%**	3.2%	4.2%
Band 8C	21	0	1	22	**0.0%**	0.0%	4.0%
Band 8D	5	2	0	7	**28.6%**	12.5%	0.0%
Band 9	2	0	0	2	**0.0%**	0.0%	0.0%
M&D - Consultant	173	89	6	268	**33.2%**	33.2%	34.3%
M&D - Career Grade	47	43	4	94	**45.7%**	46.0%	54.6%
M&D – Trainee	71	27	5	103	**26.2%**	34.1%	27.4%
Other Incl VSM	24	0	1	25	**0.0%**	0.0%	0.0%
Grand Total	**5712**	**452**	**94**	**6258**	**7.2%**	**6.9%**	**6.8%**

Staff breakdown for 2019/20 (by Clinical and non-Clinical staff group)

Clinical/Non Clinical	Staff Group	White	BAME	Not Stated	% BAME in group	Grand Total
Clinical	Add Prof Scientific & Technic	239	11	2	4.4%	252
	Additional Clinical Services	1196	76	14	6%	1286
	Allied Health Professionals	344	18	9	4.9%	371
	Healthcare Scientists	123	11	2	8.1%	136
	Medical & Dental	291	159	15	34.2%	465
	N&M Registered	1521	150	21	8.9%	1692
Non-Clinical	A&C	1100	19	18	1.7%	1137
	Estates & Ancillary	898	8	13	0.9%	919
Grand Total		5712	452	94	7.2%	6258

Clinical staff breakdown for 2019/20 (by pay band)

Banding	White	BAME	Not Stated	Grand Total
Band 2	774	52	10	836
Band 3	295	14	1	310
Band 4	125	7	3	135
Band 5	944	116	12	1072
Band 6	695	52	8	755
Band 7	414	12	8	434
Band 8A	120	11	5	136
Band 8B	38	1		39
Band 8C	13			13
Band 8D	3	1		4
Band 9	1			1
M&D - Consultant	173	89	6	268
M&D - Career Grade	47	43	4	94
M&D - Trainee	71	27	5	103
Other Incl VSM	1		1	2
Grand Total	3714	425	63	4202

Non-clinical staff breakdown for 2019/20 (by pay band)

Banding	White	BAME	Not Stated	Grand Total
Band 1	238	2	5	245
Band 2	816	11	7	834
Band 3	345	4	2	351
Band 4	274	2	7	283
Band 5	109	3	1	113
Band 6	62	3	6	71
Band 7	56		1	57
Band 8A	38	1		39
Band 8B	26		1	27
Band 8C	8		1	9
Band 8D	2	1		3
Band 9	1			1
Other Incl VSM	23			23
Grand Total	**1998**	**27**	**31**	**2056**

Indicator 2

This indicator relates to the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

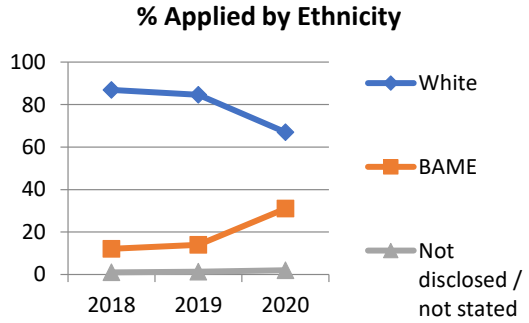
A new TRAC Recruitment system was introduced for use with all posts with effect from 1 September 2018. Data collected and contained within this report can only therefore be compared to 2019 data from 1 September 2018 until 31 March 2019. The following chart provides the data for each of the recruitment phases, broken down into ethnicity.

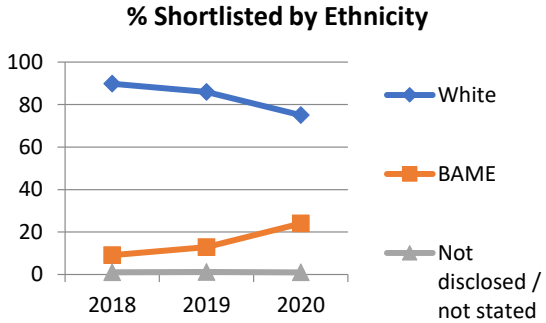
Summary of Data at Various Recruitment Stages

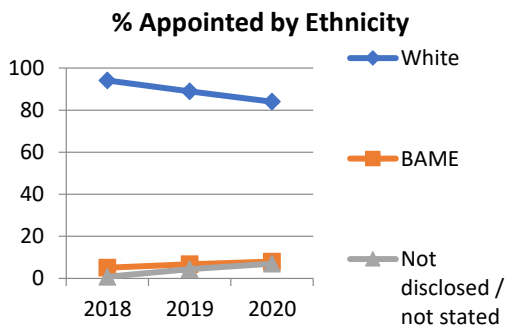
	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Outcome: Recruited	Outcome: Recruited (%)	Outcome: All	Outcome: All (%)
White	12,815	67	8,563	75	374	84	374	84
BAME	5,955	31	2,772	24	38	8	38	8
Not disclosed / Not Stated	399	2	162	1	33	7	33	7
Total	19,169	100	11,497	100	445	100	445	100

2018 to 2020 Data comparisons

	% applied			% shortlisted			% appointed		
	2018	**2019**	**2020**	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
White	86.9	84.6	67	89.8	85.9	75	94.1	88.9	84
BAME	12.1	14	31	9.1	12.9	24	5.1	6.7	8
Not disclosed / not stated	1	1.3	2	1.1	1.2	1	0.8	4.4	7







Key Findings

The data identifies a number of factors:

1) There has been a significant increase in the number of BAME applicants this year from 14% in 2018/19 to 31% in 2019/20.
2) There has been a significant increase in the number of shortlisted BAME applicants from 12.9% in 2018/19 to 24% in 2019/20
3) There has been an increase in the number of BAME applicants who were appointed from 6.7% in 2018/19 to 8% in 2019/20

Whilst there appears to be an increase in the percentage of BAME staff appointed, numbers appointed are low and the percentage increase is lower than that of the other stages. That said, the Trust previous had a shared recruitment service, which terminated on 31 March 20 and as a result a backlog currently exists whereby applications have not been fully completed on Trac. This has been escalated within the Trust and an action plan in place, however full data and analysis cannot be fully completed on this indicator until the backlog has been addressed.

There are however a number of positive steps forward with the recruitment data this year.

Personal development programmes have also been offered, specifically for our BAME staff to support their leadership development skills. This, along with generic leadership development programmes and integrated promotion of diversity within WUTH, has hopefully supported some of the achievements seen in this area. Further programmes and work will continue to take place to support and encourage confidence building and assertiveness within the interview and selection process for existing staff and relevant support should also be explored within local community groups.

Recruitment and selection masterclasses were held which contained a diversity and inclusion session and is now integrated within a new effective managers programme too. This seeks to highlight the importance of diversity at all stages of the recruitment process and aims to reduce any conscious or unconscious bias.

Consultants have also completed an unconscious bias development session.

Indicator 3

Key Finding: BAME staff are less likely to be disciplined than non-BAME staff.

This indicator relates to the relative likelihood of BAME staff entering the formal disciplinary process, compared with that of non-BAME staff.

For the 2 year rolling period ending 31 March 2020, 131 people entered the disciplinary process. 3 staff were BAME (0.6% of workforce numbers), 124 were white (2.1% of overall non-BAME workforce numbers) and 4 individuals have not disclosed their ethnicity (3.8% of not disclosed workforce numbers).

Indicator 4

Key Finding:-

Relative likelihood of BAME staff accessing non-mandatory training and CPD.

Data for this indicator has been extracted from ESR and excludes mandatory and role-specific training.

WRES Category	Headcount	Enrolment Headcount	Ratio
BME	454	425	0.94
White	5729	4805	0.84
Z NULL	113	9	0.08
Z Not Stated/Not Given	90	75	0.83

Key Findings

Data provided is based on ESR information and highlights that BAME colleagues are more likely than non-BAME colleagues to access non-mandatory training.

Data shows a significant increase this year and therefore whilst the data has been reviewed, further investigation is required in order to ensure accuracy and transparency of data.

National NHS Staff Survey Findings

The next 4 indicators are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

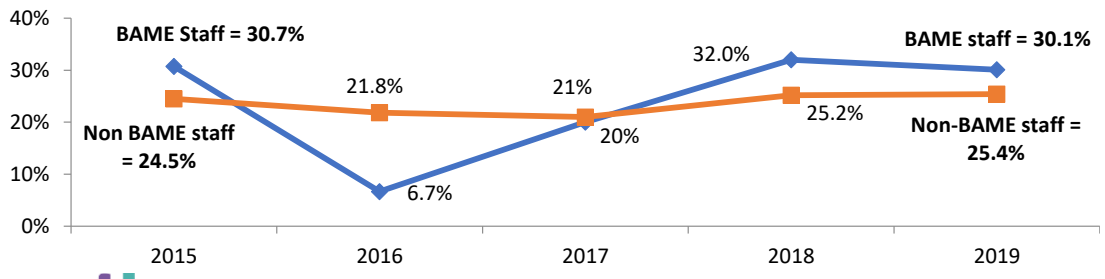
Staff Survey data changed in 2018 and moved away from the reporting of “key findings” to “themes” and therefore whilst question statements can be similarly compared, results are not directly comparable.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (Q13a).

	2015	2016	2017	2018	2019	National Average 2019
BAME Staff	30.7%	6.7%	20.0%	32.0%	30.1%	29.9%
Non BAME colleagues	24.5%	21.8%	21.0%	25.2%	25.4%	28.2%

Annual Data Comparison



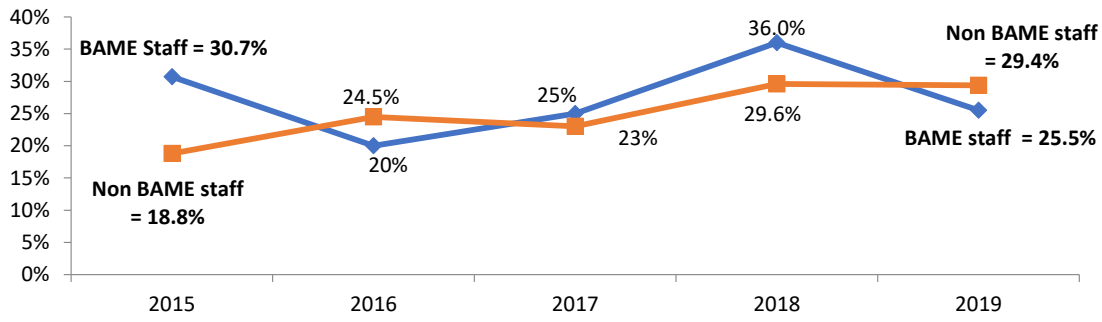
Key Finding:
The Trust's score for this question has improved this year from 32% to 30.1% and whilst still above the national average (29.9%) is now only a marginal difference. The ratio is however still higher than that of non-BAME colleagues (25.4%) and therefore needs to ensure that improvements comtinue.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (Q13c).

	2015	2016	2017	2018	2019	National Average 2019
BAME Staff	30.7%	20.0%	25.0%	36.0%	25.5%	28.8%
Non BAME colleagues	18.8%	24.5%	23.0%	29.6%	29.4%	25.8%

Annual Data Comparison



Key Findings:

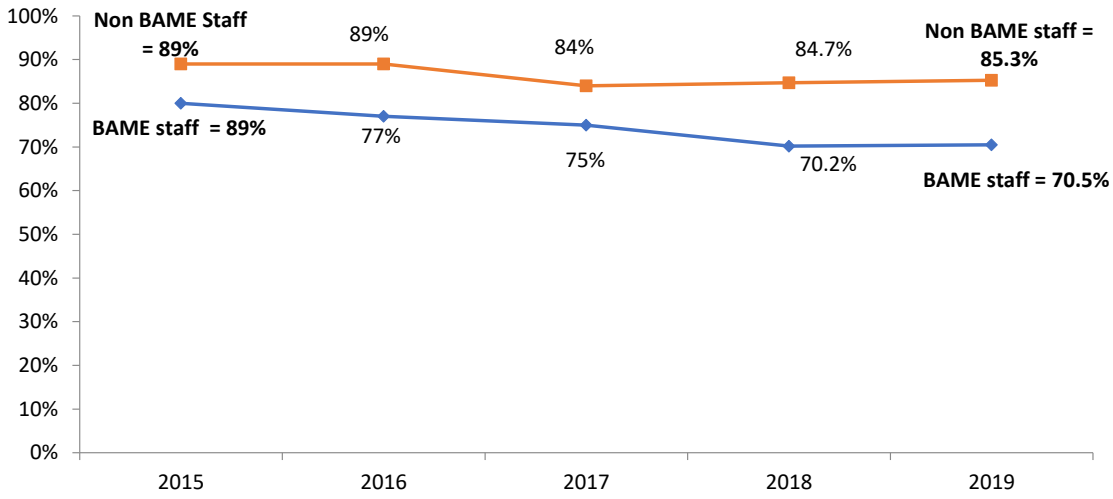
The Trust has significantly improved this year for this question from 36% to 25.5% of staff reporting that they have experienced harassment, bullying or abuse from colleagues in the last 12 months. This now falls below the comparison of non BAME colleagues and below the National Average.

Indicator 7

Percentage believing that trust provides equal opportunities for career progression or promotion.

	2015	2016	2017	2018	2019	National Average 2019
BAME Staff	80%	77%	75%	70.2%	70.5%	74.4%
Non BAME colleagues	89%	89%	84%	84.7%	85.3%	86.7%

Annual Data Comparison



Key Finding:

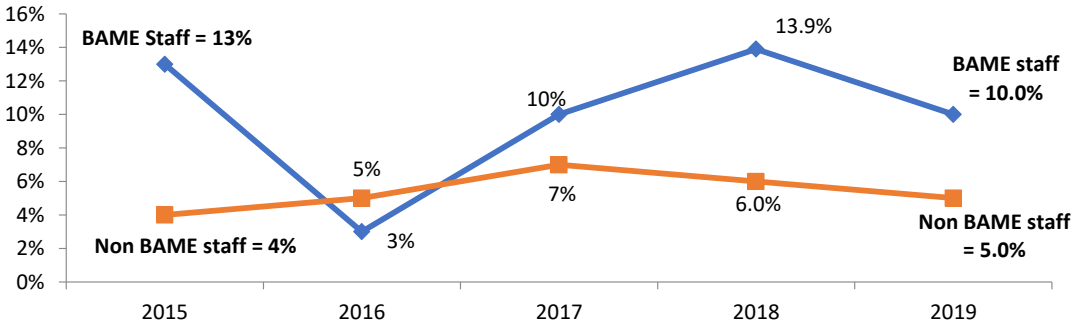
There has been a slight increase in BAME staff believing that the Trust offers equal opportunities for career progression or promotion (70.2% to 70.5% this year). However, the results are still significantly lower than that of non BAME colleagues. Both still remain below the national average.

Indicator 8

In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

	2015	2016	2017	2018	2019	National Average 2019
BAME Staff	13%	3%	10%	13.9%	10.0%	13.8%
Non BAME colleagues	4%	5%	7%	6.0%	5.0%	6.0%

Annual Data Comparison



Key Finding:

Results for all staff highlight an improvement this year with 10% of BAME staff feeling they have personally experienced discrimination at work from manager/ team leader or other colleagues as opposed to 13.9% last year. Non BAME staff has also reduced from 6% to 5% this year and both fall below the national averages.

Indicator 9

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

This indicator has changed slightly from last year as results are now required to be disaggregated into 2 categories as detailed above.

Key Finding:

As at 31 March 2020, the Trust had 14 voting members of the board, none of whom were BAME.

There are no BAME executive members of the Board.

This gives a percentage difference for both the Trust boards voting and executive membership and its overall workforce of - 7.2% (for 2018/19 it was - 6.9%).

Conclusion

A number of positive steps forward can be sign in the data this year, particularly with regards to the increase in the overall BAME staffing levels across the Trust and staff survey results.

Whilst the experiences of our BAME staff are still below those of non-BAME colleagues, a number of improvements can be seen and therefore work must continue in order to ensure improvements are sustained and areas of concern are addressed.

The Trust has also re-established it's BAME staff network and therefore experiences of Trust staff can be captured and ideas explored for further improvement.

WRES 2019/20 Action Plan Update – September 2020

Links	Lead	Actions	By	RAG	Comments
metrics 1, 2, 4, 7 and 8	D&I Lead	• Continue to explore ways of supporting BAME colleagues through network groups • Encourage staff to validate their own data via ESR self-service • Consider support programmes including RCN Cultural Ambassadors programme to offer specific expert support with a target of five cultural ambassadors to be identified locally.	Mar 20	Green	LIA engagement event held followed by an NHS Wirral BAME focus group held on 5 July 2018. A new NHS Wirral BAME staff network group established Dec 18 and monthly meetings held however stalled since March 19 due to potential rotation across Wirral. WUTH launched its own network however more concentrated efforts required to sustain. Further work undertaken and new network re-established June 20. Cultural Ambassador programme considered however delayed by RCN. Discussions underway for commencement early 2021.
metrics 2, 7 and 9	Head of Recruitment	• Encourage the recruitment conversion and progression rates of BAME staff; specifically:- • Continue to exercise robust recruitment and selection processes • All jobs to be recruited via new TRAC system so as to ensure robust recruitment data to be made available	Dec 18	Green	R&S monitoring data obtained for first time in 2018 so baseline data could be established. New TRAC system introduced from 1 Sep 19 and WRES report to contain new data which will support enhanced monitoring moving forwards. New Recruitment and selection masterclass session launched with D&I slot included. Significant improvements seen in number of BAME staff applying and being shortlisted and improvements seen in numbers being appointed although this could be improved further.
metric 3	L&D Manager / Deputy Director of Workforce	• Ensure that managers' training in disciplinary, capability and absence training to include aspects relating to Diversity, Inclusion and Human Rights (DIHR) • HR Managers will ensure that cases will only be progressed the rough formal disciplinary processes unless it is appropriate that they should do so.	Dec 18	Green	HR processes now have monitoring process in place to more robustly monitor cases by ethnicity. Reliant however on accuracy of ESR data D&I included on new effective manager development programme
metric 4	L&D Manager	• Continue to take steps to ensure our staff appraisal rates meet our 88% target	Mar 20	Amber	Steps taken to try and achieve compliance with 83.58% compliance rate as at 31 July 2019. Appraisal process reviewed with links to new Trust values and behaviours and training sessions under review so as to ensure meaningful appraisals take place. Documentation reviewed in line with new values and behaviours however trust couldn't achieve compliance target
metric 5	Head of Patient Experience	• Raise awareness of zero tolerance of harassment, bullying or abuse of BAME staff by patients, relatives or the public. • Provide guidelines to ward staff as to how to deal with patients who refuse to be assisted by staff (including BAME staff) or who are in other ways abusive	Dec 19	Amber	Trustwide campaign launched to promote awareness of B&H and includes examples relating to BAME staff. Zero tolerance in place across the Trust however no specific guidelines issued. B&H comms and education and training campaign commenced with various methods used to highlight B&H and how to report and deal with it. Speak up training also essential for all staff, with a higher level for managers.
metric 4, 6 and 8	Learning and Development Manager	• Continue to offer training and coaching to managers to enable them to better equip them to deal with performance, behaviour and attendance issues in a positive and supportive way. • Consider leaflets and posters raising awareness of DIHR and bullying and harassment • Increase the use of the e-learning programme to improve data	Nov 18	Green	As with metric 5. WUTH Leadership development framework and WUTH course directory updated and circulated to all areas to highlight suite of options available to all staff. Senior leadership development programmes in place along with monthly leadership masterclasses. E-learning programmes promoted more widely and one to one support sessions offered for staff to ensure sign up.

		captures			D&I session included on new effective managers programme. Reverse mentoring proposal agreed and will include BAME staff moving forwards.
Metric 1 and 7	D&I Lead	• Continue to include elements relating to DIHR and, specifically, conscious and unconscious bias in recruitment training	Aug 19	Green	Included on induction programme and e-learning for all staff. New recruitment masterclasses available with a DIHR slot. Face to face sessions offered to hard to reach areas e.g. hotel services. Unconscious bias training session planned for Consultants Nov 2019. D&I session included on new effective managers programme.
Metric 1 and 2	D&I Lead	• Establish links with local community groups supporting BAME communities • Identify pro-active ways to support staff and potential new recruits	Aug 20	Amber	D&I Adviser signed up to the Red Heart Campaign with Wirral Change. Linked with Wirral Community Advisory Group to create greater links and offer opportunities to work with external organisations and quarterly meetings held in a variety of locations e.g. Multicultural Centre and Wirral Deen Centre. Greater depth now required.
Additional Actions Identified for 2020/21					
Metric 9	D&I Lead / Director of Workforce	• Review senior management recruitment processes • Link with community organisations to promote senior opportunities • Consider additional developmental opportunities for senior BAME colleagues • Consider recommendations from NHSE/I Model Employer guide to increasing black and minority ethnic representation at senior levels across the NHS	Mar 21		
Metric 1	D&I Lead / Head of Recruitment	• Review recruitment and selection data to identify any areas of concern • Audit recruitment processes to identify any areas of potential bias • Consider positive action initiatives with community organisations involved where possible • Cultural Ambassador roles to be considered for recruitment as well as disciplinary processes • Review data available to highlight demographics of staff progression • Review retention rates for BAME staff			

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors

Legal Services Annual Report 2019-2020

Board of Directors	
Agenda Item	20/21 144
Title of Report	Legal Services Annual Report 2019-2020
Date of Meeting	7 October 2020
Author	Cathy McClarnon, Legal Services Manager
Accountable Executive	Hazel Richards, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR 3: Failure to achieve and/or maintain financial sustainability PR4 Catastrophic failure in standards of safety and care
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

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1 Executive Summary

Clinical claims

The Trust opened **54** new clinical claim files during 2019/20. This is 16% fewer when compared with the previous year and around 35% fewer than other, similar type, Trusts. The number of new clinical claims received has now fallen for 3 years in a row.

10 cases were also reported to NHS resolution under the Early Notification Scheme in respect of babies who had undergone head cooling, although no claims have been made in respect of any of these births.

78 clinical claims were settled during the year, at a total cost to the NHS of £22,283,024. 4 claims that each cost over £1 million were recorded as concluded during the year and a further 18 claims were settled with payments exceeding £100,000.

All clinical claims are handled in conjunction with NHS Resolution's Clinical Negligence Scheme for Trusts (CNST). The premium for membership of this scheme was a little over £1,375,000 less than the previous year.

21 clinical claims were successfully defended and closed with no payment having been made to the claimant.

Non-Clinical claims

The Trust opened **38** new non-clinical claim files during 2019/20. This is also 16% fewer than the previous year.

31 non-clinical claims were settled at a total cost to the NHS of £974,693 with 75% of this sum relating to the settlement of 2 high value claims which both related to work-related stress. Taking out the 2 high value cases, the average cost incurred in settling a non-clinical claim this year was around £8,300.

The majority of non-clinical claims are handled in conjunction with NHS Resolution's Liabilities to Third Parties Scheme for trusts (LTPS). The premium for membership of this scheme was a little over £15,000 more than the previous year.

20 non-clinical claims were successfully defended and closed with no payment being made to the claimant.

Inquests

4 Inquests were concluded during the year which required attendance at the Coroner's Court by Trust staff. No Regulation 28 (Prevention of Future Deaths) reports were issued to the Trust.

Corporate Services

The Corporate Services Division saw a 12% decrease in the number of new claims made related to their areas (down from 24 to 21). 12 claims related to slips/trips/falls

with lack of inspection and proactive maintenance of defective surfaces, predominantly inside the hospital, being a significant factor. 9 of the new claims appear to be defensible. 10 claims were closed with no payment being made to the claimant and 11 claims (with incident dates occurring between 2015-2019) were settled at a total cost of just over £114,000.

Clinical Support

The Division of Clinical Support received 5 new claims this year, all clinical, which is 2 more than last year. 2 of the new claims will be settled with the remaining still under investigation. 3 clinical claims were closed in year with no payment being made to the claimant. 4 claims were settled during the year. The amount incurred in settling claims for Clinical Support was a little over £482,000 with 80% of this figure relating to one claim dating back to 2012.

Medicine & Acute Specialties Division

The Division of Medicine and Acute Specialties received 31 new claims this year, an overall decrease of 14% when compared with last year. These are broken down into 17 clinical and 14 non-clinical claims. All new clinical claims have been categorised as green and around half of these appear defensible. The number of new staff claims has increased with injuries sustained in 3 incidents resulting in significant sickness absence. 14 claims were closed with no payment being made to the claimant. £2,105,518 was incurred in settling 40 claims.

Surgical Division

The Surgical Division received 18 new claims this year, 11 fewer than the previous year, an overall decrease of 38%. These were broken down into 16 new clinical and 2 new non-clinical claims. 10 claims were closed without payment to the claimant. 30 clinical claims were settled at an overall cost of around £3,750,000. 5 non-clinical claims were settled at a total cost of just over £30,000.

Women's & Children's Division

Women's & Children's Services received the same number of new claims this year as they did last year (17). 16 claims were related to clinical care and 1 was a staff claim. 2 new claims potentially have a high value if successful although the events in question happened in 2004 and 2008 and do not therefore reflect recent care. 4 claims for this Division were closed without payment this year. 16 clinical claims were settled during the year including 3 high value cases (arising from incidents occurring more than 10 years ago). The total amount incurred in settling the clinical claims for this Division was almost £16 million, due in the most part to the 3 high value claims.

2 Introduction

The purpose of this document is to provide an overview of claims for compensation made against the Trust for the period 1st April 2019 – 31st March 2020. It follows on from the previous year's Annual Legal Services Report.

The report contains information relating to claims made against the Trust in connection with both patient safety (clinical) and non-clinical incidents.

The report also contains information regarding Coroner's Inquests which have occurred during the year into the deaths of patients whilst in hosipital or with recent hospital care and at which Trust staff were requested to give evidence.

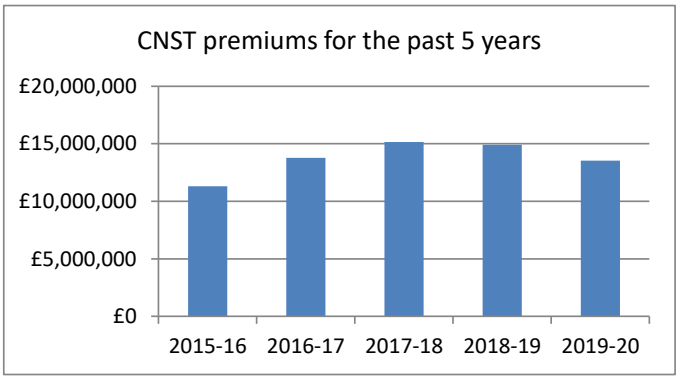
3 NHS Resolution Schemes

Claims for compensation made against the Trust are handled in-house by the Legal Services Team in conjunction with NHS Resolution (NHSR) and the Trust's panel solicitors; Hill Dickinson for clinical claims and Weightmans for non-clinical claims.

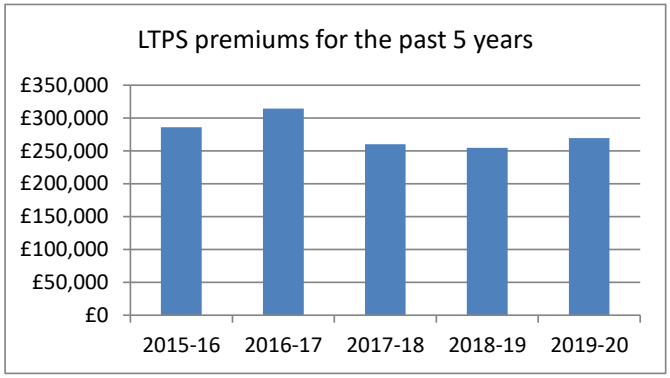
NHS Resolution Scheme membership premiums are calculated by taking into account a number of factors, such as Trust type, services provided, numbers of whole time equivalent staff and claims history.

The annual contribution for 2019/2020 paid by the Trust for membership of the Clinical Negligence Scheme for Trusts **(CNST)** with respect to clinical claims brought against the Trust was **£13,538,090.**

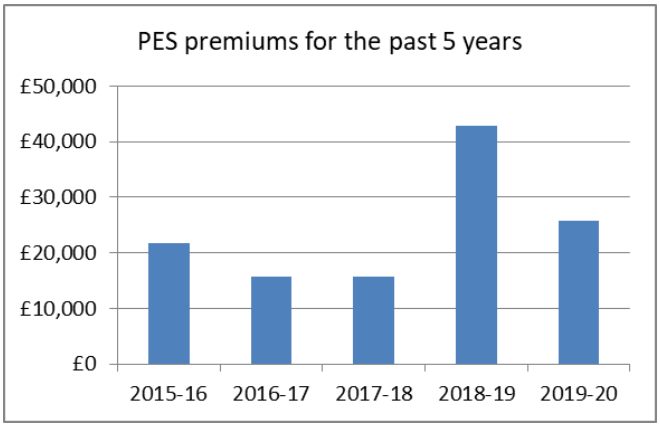
This amount is £1,375,442 less than the previous year's premium.



The annual contribution for 2019/2020 paid by the Trust for membership of the Liabilities to Third Parties Scheme **(LTPS)** with respect to non-clinical claims brought against the Trust was **£269,399.** This amount is a little over £15,000 more than the previous year's premium.



The annual contribution for 2019/2020 paid by the Trust for membership of the Property Expenses Scheme **(PES)** with respect to claims made by the Trust for loss of, or damage to, our property was **£25,726.** This sum is a little over £17,000 less than the previous year's premium.



4 Clinical Claims

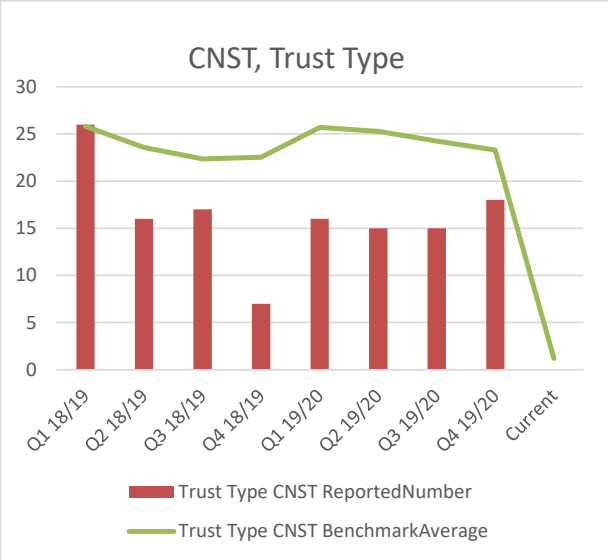
Clinical claims are demands for compensation made by or on behalf of patients who are dissatisfied with their clinical care. To succeed with their claim they will have to establish that the care that they received fell below a recognised and reasonable standard and that this failure in care caused otherwise avoidable harm.

During the financial year 2019/20, the Trust opened **54** new clinical claim files. This compares with 64 new clinical claims being opened last year and is therefore a decrease of 10 cases (or 16%) when compared with the previous year.

All new clinical claims are reported to NHS Resolution and handled in conjunction with NHSR through the Clinical Negligence Scheme for Trusts (CNST).

The following graph was produced by NHS Resolution and shows the number of new clincial claims reported by this Trust for the past 2 years (shown in the red columns) compared with the numbers reported by similar Trusts (shown by the green line).

Graph 1 – Number of new clinical claims received by WUTH when compared with similar type Trusts nationally.



The information supplied by NHSR includes Early Notification Baby (ENB) cases which are reported by the Trust to NHSR but are not necessarily the subject of an on-going claim against the Trust.

This graph shows that, even accounting for 10 ENB cases reported during the year, we have opened around 35% fewer new clinical cases in the past year when compared with our same member type.

The number of new clinical claims received by the Trust has fallen year on year for the past 3 years and, along with fewer high value claims being brought, explains why the Trust's CNST contribution is going down, even if the number and cost of settled claims has risen.

It also should be stressed that the numbers of new claims received remains relatively low when considering the numbers of patients treated at the Trust. Claims are made by approximately 0.01% of patients treated at the Trust in year, when considering the number of in-patient (106,121), out-patient (398,019) and A&E attendances (88,331).

99 clinical claim files were resolved throughout the year with **78** of these receiving settlement and **21** closing without any payment of damages being made to the claimant.

The total number of clinical claims currently on-going at the end of the year was **182.**

4.1 Number of New Clinical Claims Per Year (and current status at 1st April 2020)

The following graph shows the number of new clinical claims received per year for the past 10 years and whether or not the claim has been or will be settled.

It can be seen that the total number of new clinical claims received has been falling for the past 3 years after a period of 4 years between 2013-2017 when the Trust was consistently opening between 80-90 new clinical claims per year.

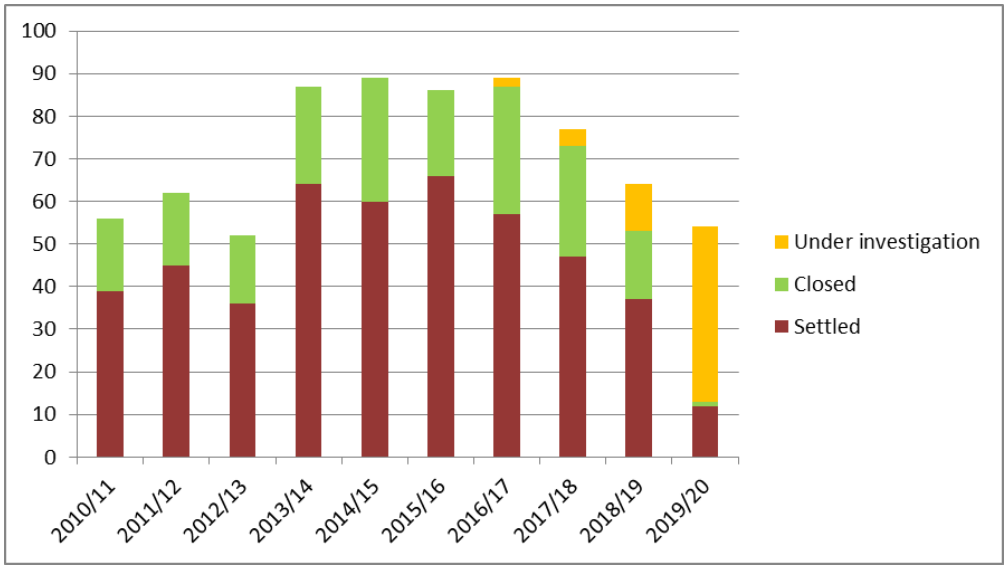
During the past 10 years the Trust has received 716 clinical claims.

463 claims have been settled, or a decision has been made that they will be settled, with a payment being made to the claimant (65%).

195 claims have been closed with no payment made to the claimant or are currently being defended (27%).

In 58 (or 8%) of cases the matter is still under investigation with no clear decision having been reached as yet regarding settling or defending the claim.

Graph 2 – Outcome of Clinical Claims received since 01.04.2010



The average number of new clinical claims received per year for the past 10 years is 72 and therefore last year's new claims (at 54) was 18 below the 10 year average.

4.2 Risk Scoring of new clinical claims

During the financial year 2019-20 all new and settled clinical claims have been scored against the Trust's risk scoring matrix. This allows the organisation to easily note which claims relate to the highest level of harm and/or have the highest cost implication for the Trust.

Claims with a total value of less than £100,000 and/or minor harm which is resolved within one month are scored green.

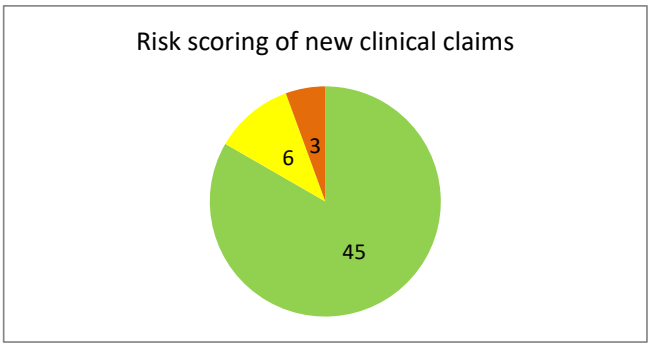
Claims with a total value of £100,000 - £1,000,000 and/or moderate harm which is resolved within one year are scored yellow.

Claims with a total value in excess of £1,000,000 and/or severe, permanent harm or death are scored orange.

45 of the 54 new clinical claims received this year (83%) have been scored green, anticipating that either the claim will be defended, or settled at an estimated total cost of less than £100,000. Patients will not have suffered avoidable harm that lasted beyond one month.

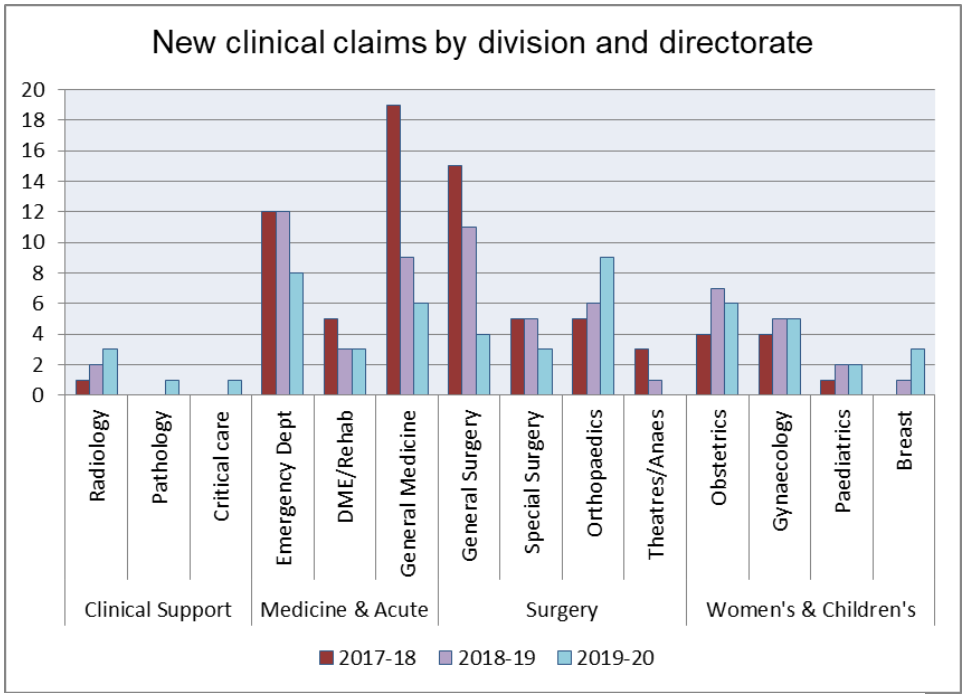
6 of the 54 new clinical claims received this year (11%) have been scored yellow. It is anticipated that these claims will not be defended and each has an estimated value in the region of £100,000 - £1 million, representing a moderate level of avoidable harm lasting up to one year.

3 of the 54 new claims received this year (6%) have been scored orange. These cases relate to severe, permanent harm or death which should have been avoided and/or claims valued at above £1 million.



4.3 Breakdown of New Clinical Claims Across Directorates & Divisions

Graph 3 – Breakdown of New Clinical Claims per Division for 2019/20 Financial Year (and compared with the 2 previous years).



Clinical Support received 5 new clinical claims this year, 2 more than last year.

Medical & Acute Specialties received 17 new clinical claims, (29% less than last year). At least 9 of these are likely to be settled although none appear to be of potentially very high value as all new claims were categorised green.

Surgery received 16 new clinical claims (30% less than last year). 3 of the new claims were categorised as yellow claims, and 1 was categorised orange.

Women's & Children's Division received 16 new clinical claims, an increase of 1 when compared with the previous year and including 2 orange and 2 yellow claims

4.3 Time Between Event and Notification of a Clinical Claim

Although claims should be made within 3 years of the event occurring (or 3 years of the date of knowledge of the event) the time between an event occurring and a claim being made can lead to difficulties in investigating events due to staff moving on or changes that have been made to practice in the intervening period.

For this reason it is vital that untoward clinical events are noted, reported and investigated when they occur.

(Claims relating to children, or patients who lack capacity to act for themselves are not subject to the same time constraints and may not be brought for many years).

The average time between the events giving rise to a claim and notification of the claim itself for the 54 new clinical claims opened this year was **28** months.

7 cases were excluded from this calculation as they related to events that occurred more than 5 and up to 15 years ago.

21 cases related to events that had happened more than 3 years earlier (39%).

Only 14 cases related to events that had happened within the previous 12 months (30%).

4.4 Previous Knowledge of Events now raised in new clinical claims

It is helpful for the Trust to have considered any adverse events at the time that they occur as clearly identification of a problem at the earliest opportunity can lead to immediate action and thus improve patient safety. It can also be very difficult to carry out an effective investigation after a lengthy time period which is emphasised by the timelag between an event occurring and a claim being made.

Whilst it is recognised that an incident form will not always have been completed, for example when it is alleged that there has been a failure to make a correct diagnosis, staff should be encouraged to report instances when earlier failures in care are spotted at a later date.

Early identification and consideration of an adverse event will:

- Provide timely assurance that the Trust is aware of current untoward events.
- Enable a prompt investigation whilst memories are fresh. This is particularly helpful where members of staff later move on and are not easy to contact.
- Lead to swift improvements in systems and processes.
- Provide an opportunity to capture information which may not be available at a later date, and which may assist if a claim is subsequently made. For example it will be eaiser to identify the policies in place at a particular time, or the correct version of a patient information leaflet.
- Enable the Trust to reach a swift decision about the defensibility of a claim, if one is made, which can reduce legal costs.

In 29 of the 54 new cases (54%) the Trust was already aware of the circumstances of the claim due to either the internal incident reporting process or because the claimant had previously raised their concerns via the NHS Complaints Procedure.

- 18 of the 54 new clinical claims opened this year had already been investigated through the complaints process (33%).

- 19 of the 54 new clinical claims opened this year had already been reported via the incident reporting system (35%).

- 11 of the 54 cases had undergone RCA/Serious Incident or local review/72 Hour investigation prior to receipt of the claim (20%).

In 8 cases there had been both an incident form and a complaint.

A certain proportion of new claims will be successfully defended, with no negligence found. In such cases one would not expect there to have been an incident form or internal investigation and so it will never be the case that we will have prior knowledge in the majority of new claims. It is therefore probably more useful to consider the issue of prior knowledge in cases that are settled as this should provide an indicator of how well the Trust has identified adverse events that have led to avoidable harm and a consequent claim for compensation.

This point is revisited below at 4.7 when the claims settled this year have been reviewed to consider whether or not an incident form had been completed prior to receipt of a claim.

4.5 Clinical Claims Closed Without Payment

21 clinical claim files were closed this year with no payments having been made to the claimant with respect to their allegations.

Cases that are closed without payment have been successfully defended with the Trust's care considered to have been of a reasonable standard. Approximately 25% of all clincial claims made against the Trust are closed in this way. It is important that the Trust defends allegations that cannot be sustained in order to protect the Trust's reputation and financial position.

In 18 of the 21 cases although no payment has been made to the claimant, and the Trust has not made any contribution to the claimant's legal costs, there were financial costs incurred for the NHS in investigating and defending the case. There can therefore be quite a substantial financial cost to successfully defending a claim.

A total of **£45,465** was incurred in defending these claims. In the remaining 3 cases no defence costs were incurred as NHS Resolution and Trust were able to handle the claim internally with no requirement for costs associated with obtaining external legal or medical input.

There is no excess applied to the handling of clinical claims by NHS Resolution (unlike non-clinical claims) and therefore NHSR meets all these payments on our behalf.

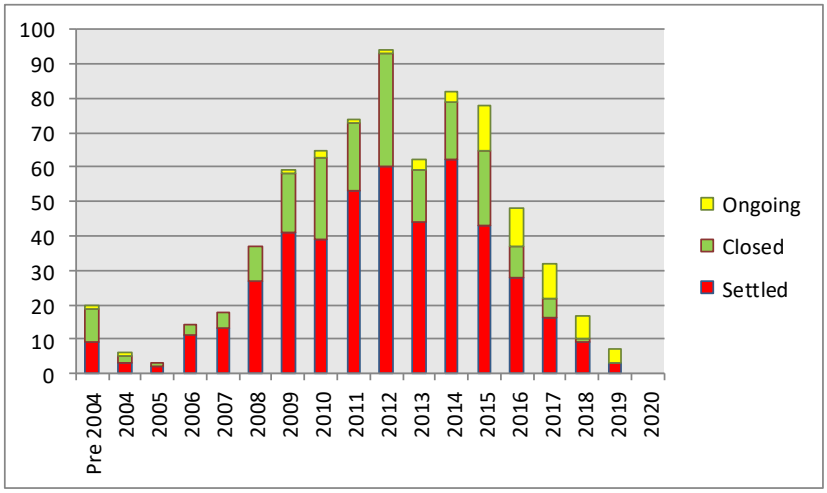
4.6 Settled Clinical Claims

78 clinical claim files were concluded during this financial year in which payments of damages had been made to the claimant (i.e. settled claims). All payments, which totalled **£22,283,024** were made by NHSR through NHS indemnity.

The sum reflects the total amounts paid on cases that the Trust has recorded as concluded in year. It is important to note that not all payments on these cases might have been made during this financial year as, for example, claimant's legal costs might have been agreed and paid many months after the claimant has received their compensation payment. Similarly, some payments may also have been made during this year on cases that have not yet been completely finished.

It takes on average around 4½ years from an event occurring to the conclusion of a claim. It is therefore apparent that sums paid out this year are not a reflection on how the Trust is currently operating, but represent payment for events that could well have occurred several years earlier. This is due to the time taken between the event occurring and the claim being made, the time taken to investigate and respond to the claim and the time taken to value the avoidable harm and agree a settlement figure.

This can be seen in the following graph which shows the last 10 years worth of new clinical claims received (2010/11 to date) plotted against the year in which the relevant care occurred. Very few claims relating to care during the past couple of years have been made yet although this is likely to be due to the lag between an event occurring and a claim being made.



We can expect to see some more claims made in the future which relate to events that occurred 2017-2020 and also a smaller number of claims that date back further, but overall it would appear from this information that the more recent care is leading to fewer clinical claims.

NHS Resolution will also be meeting the on-going costs associated with claims that have periodic payments. (Annual payments which are made each year in high value cases which have been agreed in previous years but which will continue for the life of the patient).

As stated earlier in the report, the premium paid this year for membership of CNST was **£13,538,090.**

Settled clinical claims figures by Division

Division	Damages	Claimant's Costs	Defence Costs	Total
Corporate Services (0 cases)	0	0	0	0
Clinical Support (3 cases)	£28,029	£53,227	£11,384	£92,640

Medicine & Acute	(29 cases)	£836,231	£660,553	£188,756	£1,685,540
Surgery	(30 cases)	£1,830,999	£1,490,443	£424,856	£3,746,298
Women & Children	(16 cases)	£14,108,263	£2,145,405	£504,878	£16,758,546
	78	*£16,803,522*	*£4,349,628*	*£1,129,874*	**£22,283,024**

Although the amount incurred in settling clinical claims this year appears extremely high when compared with other years, the following points should be kept in mind:

The final figure includes 4 claims that cost in excess of £1 million and a further 18 cases that cost between £100,000 - £1 million. It is rare for so many high value claims to conclude in one year and this is unlikely to be a repeating theme.

The events in question are also noted to be historic with none of the events relating to these high value cases having occurred in the past 5 years.

£ Million +	2000	2009
	1	3

£100K+	2005	2006	2009	2010	2011	2012	2013	2014
	1	1	2	2	2	4	3	5

Given the passage of time between a claim being made and being settled it is inevitable that the claims that were made during the 2013-17 period when the Trust received the highest number of new cases and which related to care that happened 2-3 years earlier, will be coming to resolution around now.

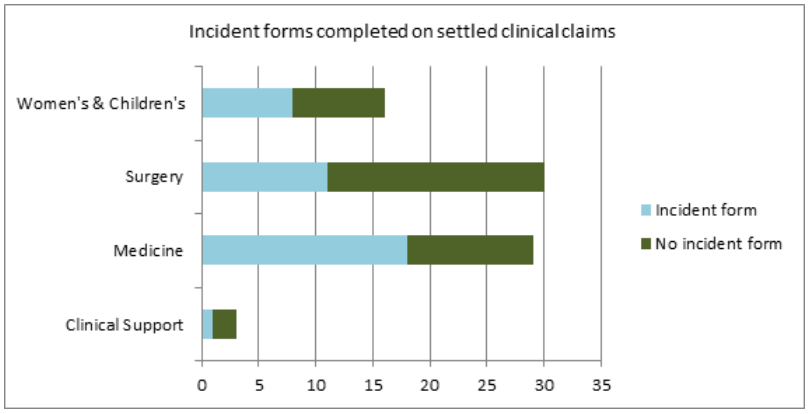
4.7 Previous Knowledge of Events – settled clinical claims

For a number of years we have counted how many of the new claims received during the year were already known to us via the incident reporting system. In last year's Annual Report we considered that it would be helpful to calculate which of the settled claims had previously been identified via an incident form.

Not all new claims will conclude with a settlement being made to the claimant and it would be informative to have a view in the Trust as to whether or not an event that results in a successful claim for compensation was recognised and reported at the time that it occurred.

In 39 of the 78 clinical claims settled last year the Trust was already aware of the events through the incident reporting system (50%).

The following graph breaks this down by Division.



Clinical Support
1 out of 3 (33%) claims settled this year had previously been reported.

Medicine
18 out of 29 (62%) claims settled this year had previously been reported.

Surgery
11 out of 30 (37%) claims settled this year had previously been reported.

Women's & Children's
8 out of 16 (50%) claims settled this year had previously been reported.

Details of all settled claims, including whether or not an incident form had been completed at the time of the relevant care, are shared with the Divisions each month. The Divisions should give consideration as to whether or not they are identifying adverse incidents at the time that they occur, rather than when a claim is subsequently made by or on behalf of the patient.

5 Non-Clinical Claims

Non-clinical claims are those brought against the Trust by either employees (EL claims) or members of the public (PL claims) who are seeking compensation with respect to injury sustained in the course of their employment or when visiting the site. Together these are referred to as LTPS claims and are managed under NHS Resolution's Liabilities to Third Parties Scheme.

During 2019/20 the Trust opened **38** new non-clinical claim files, a decrease of 7 cases or 16% when compared with 45 last year.

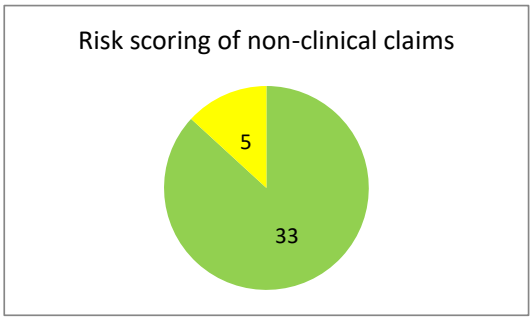
The number of new non-clinical claims made per year had fallen for 4 of the past 5 years prior to last year's increase and therefore this year's total is in keeping with the overall recent trajectory. It is also 7 below the 10 year average.

27 of the cases were brought by staff (71%) and **11** by members of the public (29%).

Non-clinical claims were scored against the Trust's Risk Scoring Matrix as follows:

33 claims were graded green (87%). (Minor harm which will resolve within a month).

5 claims were graded yellow (13%). (Moderate harm lasting 1 month – 1 year).



The claims graded yellow represent the more serious non-clinical cases.

A total of **51** non-clinical cases were resolved in the year with **31** non-clinical claims being settled and **20** non-clinical claim files being closed with no payments made to the claimant.

The total number of non-clinical claims open and on-going at the end of the year was **94.**

5.1 Number of New Non-Clinical claims received per year (and current status at 1st April 2020).

38 new non-clinical claims were recived during the financial year.

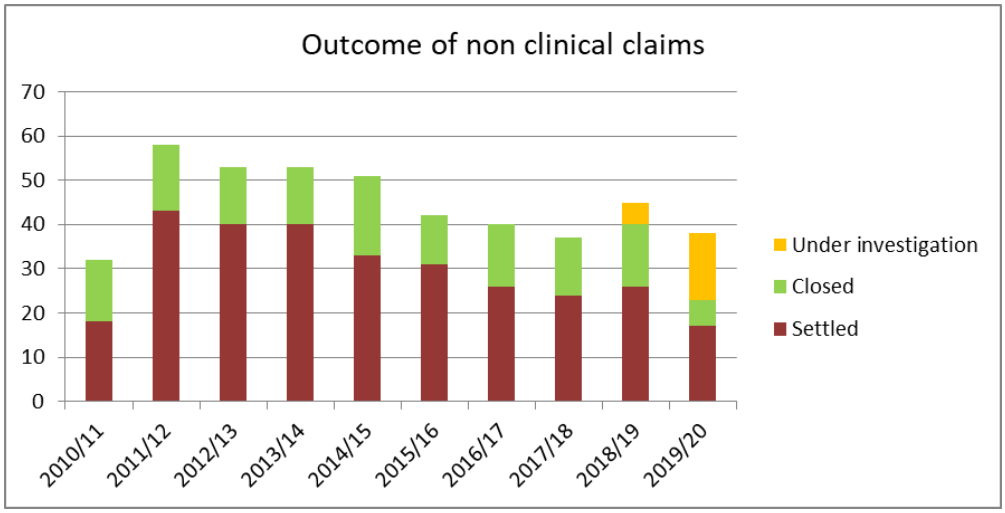
During the past 10 years the Trust has received 449 non-clinical claims.

298 claims have been settled, or a decision has been made that they will be settled, with a payment being made to the claimant (66%).

131 claims have been closed with no payment made to the claimant or are currently being defended (30%).

In 20 (or 4%) of cases the matter is still under investigation with no clear decision having been reached as yet.

Graph 5 – Outcome of Non Clinical Claims received since 01.04.2010

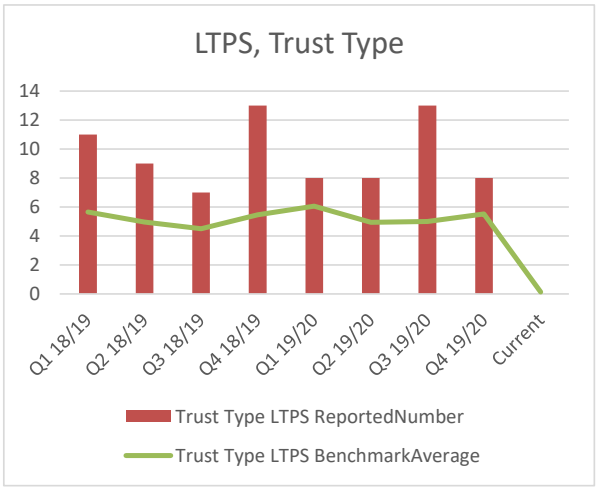


The average number of new clinical claims received per year for the past 10 years is 45 and therefore last year's new claims (at 38) was 7 below the 10 year average.

Whilst it remains to be seen what the final outcome of claims made during the past 12 months will be, it can be seen that the general trajectory for 6 of the past 8 years has been a decrease in the number of new non-clinical claims received and a decrease in the number of non-clinical claims that are settled.

The following graph was produced by NHS Resolution and shows the number of new non-clincial claims reported by this Trust during the past 2 years (shown in the red columns) compared with the numbers reported by similar Trusts (shown by the green line). Not all claims are reported as some low value claims, eg such as those relating to damage to vehicle paint work, are dealt with in-house.

Graph 6 – Number of new non-clinical claims received compared with similar type Trusts

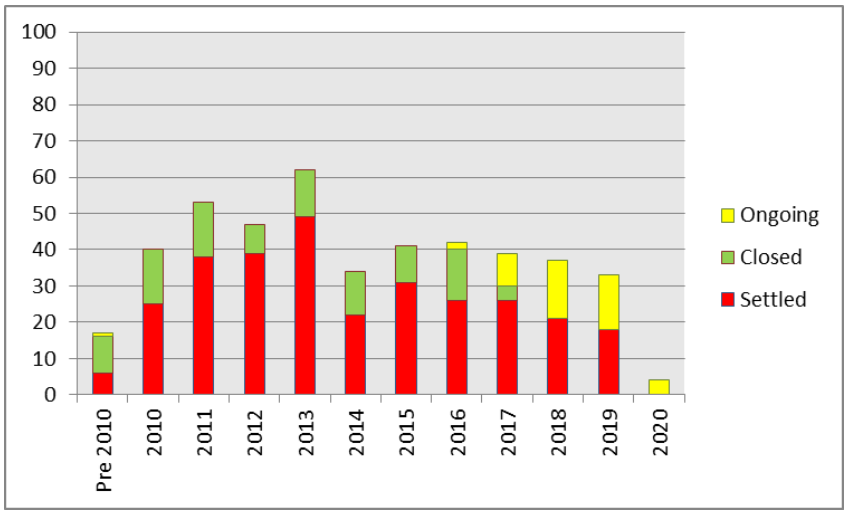


Reviewing this graph it appears that the average number of new non-clinical claims received last year for our type of Trust was 22 and therefore we have received a significantly higher proportion of new non-clinical claims when compared with our peers.

The previous 5 years' claims history for the Trust is considered by NHSR, along with the organisation's total income, number of average whole time equivalent staff and total pay cost when calculating the Trust's LTPS premium.

Divisions are asked at the Health & Safety Committee to look at the areas that are resulting in settled claims and consider what steps can be taken to improve safety.

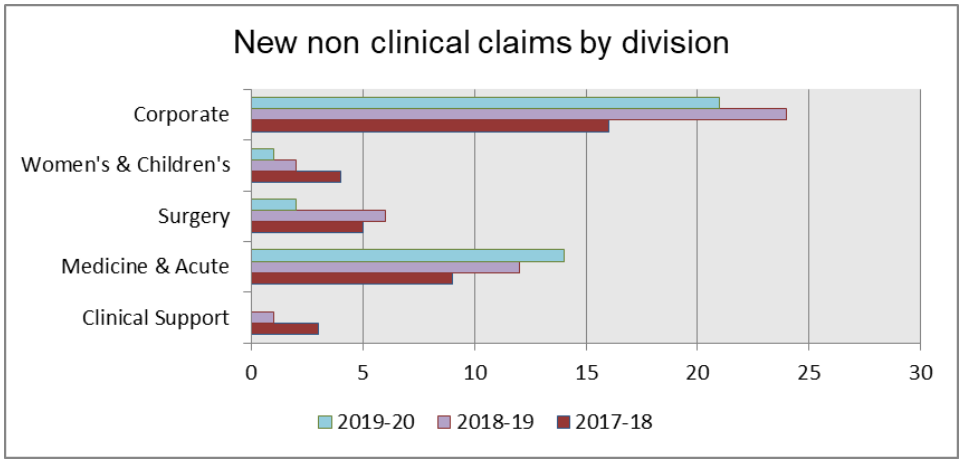
In contrast to claims made about clinical care, non-clinical claims are usually brought much sooner. The graph below shows the number of new non-clinical claims received during the past 10 years plotted against the year in which the injury occurred. It can be seen that there are far more claims relating to the more recent past than is seen with new clinical claims.



As the majority of new non-clinical claims relate to events that have occurred within the previous 4 months we hope that the gradual reduction that can be seen in events during the past 5 years resulting in claims will continue.

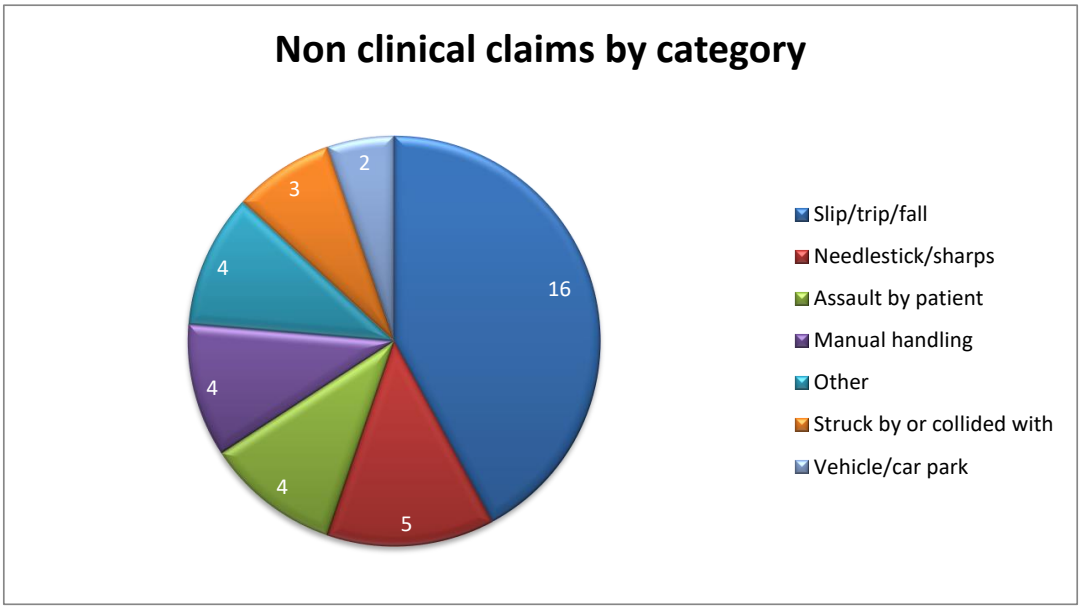
5.2 Breakdown of New Non-Clinical Claims Across Divisions

Graph 7 – Non-Clinical Claims per Division for 2019/20 Financial Year (and for the preceding 2 years)



5.3 Non-Clinical Claim Categories

Graph 8 – New Non-Clinical Claims by Category



Each new non-clinical claim is categorised with themes and trends far more readily apparent than is evident with clinical claims. The top 4 new non-clinical claim categories received this year were:

Slips /trips /falls

16 of the 38 new non-clinical claims (42%) related to slips/trips or falls. This is further broken down into 13 events that happened inside the hospital buildings and 3 events that happened in the grounds (roadway / car park / pavement).

Whilst slips/trips/falls is the most commonly occurring cause for a claim, and claims relating to this category have increased from the 12 received last year, a number of these cases are currently being defended. Pro-active inspection and maintenance records are invaluable in being able to demonstrate a sensible process for minimising risk of accidents. Prompt reporting and investigation of incidents also allows for capture of relevant information.

Needlestick / sharps injuries

5 of the 38 new non-clinical claims (13%) related to needlestick injuries.

Safe disposal of needles and sharps remains a common cause for a claim being pursued. Divisions should reinforce the message amongst staff using sharps.

Assault

4 of the 38 new claims (11%) related in one way or another to allegations of assault by a patient on a member of staff.

A Violence and Aggression multi disciplinary working group has been established this year to look at the types of incidents that might result in a claim being brought against the Trust in connection with assault. The group reports to the Health & Safety Committee.

Manual handling

4 of the 38 new claims (11%) related in one way or another to manual handling.

76% of the new non-clinical claims related to these 4 categories.

5.4 Time Between Event and Notification of a Non-Clinical Claim

The average time between an event occurring and the initial notification that a subsequent non-clinical claim was being made was **4 months.** (1 case was excluded as this related to events that occurred up to 40 years ago during the claimant's entire working career).

Only 2 of the 38 new cases related to events which had occurred more than 12 months before the claim was made (5%).

24 of the 38 cases related to events which had occurred within the previous 3 months (63%).

The comparatively short time in which non-clinical claims are made after the event itself occurred allows the Trust to gain a better perspective of the current safety status in the organisation than with clinical claims; many of which are only raised after some years have passed.

5.5 Previous Knowledge of Events – new claims

In 34 of the 38 new cases the Trust had already been notified of the events through the incident reporting system (89%).

- In 26 of the 27 the claims made by members of staff there was an incident form already completed prior to the claim being made. (96%).
- In 8 of the 11 the claims made by members of the public there was an incident form already completed prior to the claim being made. (73%)
- 15 of the 38 new claims had been investigated via Local or 72 Hour Review after the incident had been reported. (39%).
- 12 of the 27 new staff claims were reported to the Health & Safety Executive under RIDDOR regulations.
- 11 of the 12 new staff claims reported to the HSE had undergone Local or 72 Hour Review. It was felt that no further information could have been gained had a Local Review been carried out in the one case that was not investigated further following consideration at the Serious Incident Review Group (SIRG).
- In 3 staff cases a review was carried out despite the incident not meeting the criteria for reporting under RIDDOR.

This shows a relatively high level of reporting by staff when they themselves have suffered an accident or incident at work. Such prompt reporting allows the events to be investigated whilst the detail is still fresh in staff's minds and on occasions contemporaneous photographic evidence or cctv footage is obtained which can assist in the decision making process if a claim is made.

The only staff claim received during the year did not have an associated incident form. This claim relates to a historical period of employment (1970 -2000).

The level of reporting of incidents that happened to members of the public is slightly lower but may well represent a failure by these people to bring the matter to the attention of staff at the time.

Should any member of staff become aware that a patient or visitor to the Trust states that they have suffered an accident whilst on our premises then they should complete and submit an incident form in the usual way.

5.6 Non-Clinical Claims Closed Without Payment

20 non-clinical claim files were closed this year with no payments having been made to the claimant or in respect of claimant's legal costs.

16 of these claims were brought by members of staff and 4 were public liability claims.

£6,927 was incurred by the Trust in defending these claims.

Claims that are recorded as being closed without payment are considered to have been successfully defended. In practice this will be when liability for an injury has not been admitted as the Trust can demonstrate that it has taken all reasonable care to prevent the event occurring.

5.7 Settled Non-Clinical Claims

31 non-clinical claims were settled during the financial year with payments being made to the claimant under the LTPS. **27** settled cases were brought by employees (EL claims) with **4** public liability (PL) cases being settled in year.

In cases of claims being made by employees the Trust pays an excess of up to £10,000 in each claim, with an excess of £3,000 for each PL case. NHS Resolution meets any other amounts once the excess has been reached.

2 high value cases were concluded during the year, with each claim costing a total exceeding £300,000. Over 75% of the total amount incurred in settling 31 non-clinical claims this year related to the settling of these 2 cases.

The average cost of settling the other 29 claims was a little over £8,300.

The total amount paid out in cases settled during this year was: **£974,693.**

This is broken down into:

£179,800	paid by the Trust up to the excess
£794,893	paid by NHSR above the Trust excess

Division		Damages	Claimant's Costs	Defence Costs	Total
Corporate Services	(11 cases)	£75,064	£37,736	£1,283	£114,083
Clinical Support	(1 case)	£325,000	£49,000	£15,518	£389,518
Medicine & Acute	(11 cases)	£326,791	£69,466	£23,721	£419,978
Surgery	(5 cases)	£12,852	£16,975	£1,863	£31,690
Women & Children	(3 cases)	£10,698	£8,226	£500	£19,424
	31	*£750,405*	*£181,403*	*£42,885*	**£974,693**

As stated earlier in the report the premium paid this year for membership of LTPS was **£269,399.**

The cost to the Trust for dealing with non-clinical claims this year is therefore:

- LTPS membership premium £269,399
- Beneath excess payments on settled claims £179,800
- Beneath excess payments on closed claims £6,927

£456,126

5.8 Previous Knowledge of Events – settled non-clinical claims

In 87% of non-clinical claims that settled this year, the Trust was already aware of the circumstances prior to the claim being received. This is broken down into 100% of employer's liability claims and 0% of public liability claims.

In 26 of the 27 settled EL cases the Trust was already aware of the events through the incident reporting system and in the remaining 1 case the Trust there had been an internal investigation by the Human Resources Department.

The circumstances of the other 4 settled cases all related to claims brought by members of the public. 3 related to damage to vehicles and 1 related to a visitor tripping on a pothole and in none of these cases had the incident been reported.

This would suggest that the Trust is very well informed about incidents that have affected members of staff which become the subject of a claim, but less so about harm or damage experienced by members of the public.

6 Property Expenses Scheme

The Trust is a member of the Property Expenses Scheme (PES) which allows the Trust to claim against NHSR for losses or damage that we have suffered to our property. There is a £20,000 excess on this policy and therefore the Trust only makes claims against this scheme where loss or damage has occurred which has a value in excess of this amount.

The Trust paid a premium of **£25,726** for membership of this scheme for this year.

The Trust has not reported any property related claims to NHSR under the PES this year. However, staff are reminded to consider the £20,000 excess figure when considering events such as theft of property, damage to equipment etc and if the cost of the loss or damage is thought to be approaching or exceeding the excess then please notify the Legal Services Team who can explore whether or not a claim can be made against this scheme.

7 Inquests

21 Inquests were concluded this year.

12 cases were discontinued following receipt of a natural cause of death.
5 cases were heard at Inquest by the Coroner but no Trust staff were asked to attend to give evidence.

8.1 Regulation 28 Reports

The Coroner's rules mandate that Coroners must issue a Regulation 28 report (or Prevention of Future Death report / PFD) in circumstances where the Coroner has reason to believe that action can be taken which could reduce the risk of death to persons in the future.

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

9 Ad hoc legal queries

The Legal Services Team is happy to be contacted for advice on a wide range of issues which may have legal implications.

If you have a query which you think that the Legal Services Team might be able to help with, do not hesitate to contact the team on ext 2611. Out of Hours legal advice on matters which cannot wait can be obtained from the Trust's solicitor, Hill Dickinson, via the switchboard.

10 Staff Support

Staff whose acts or omissions are the subject of a claim, whether clinical or non-clinical, can understandably feel distressed or anxious about the events. A variety of means of providing support to these individuals is available and includes guidance on providing statements, ensuring that they are kept informed about what is required of them and what is happening with the claim and being given an opportunity to talk about the matter at any point. Specific professional guidance can be sought, depending on the nature of the concern, including access to legal representation, support from professional organisations and trade unions, and access to counselling services via the Occupational Health department.

11 Learning from Experience

It is critical that the Trust learns from incidents, complaints and claims in order to improve the service that we supply and reduce the likelihood of adverse situations recurring.

- All new clinical claims received into the Trust are investigated and, where possible, an internal view on liability sought. In the majority of clinical cases an external, independent opinion is also obtained. The situation may already have been explored either via the internal incident reporting process or via a formal complaint and any learning may have already been adopted.
- If a claim is considered to be defensible and a denial of liability is issued then it will be accepted that it is not necessary to consider any potential for learning.
- If a claim is to be settled, and the issue of learning has not previously been considered, then this will be highlighted to the Division. If there is no response then the issue will be raised via the monthly report to the relevant Divisional Management Team.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors

Annual Health and Safety Performance Report

Board of Directors	
Agenda Item	20./21 145
Title of Report	Health and Safety Management Annual Report
Date of Meeting	7 October 2020
Author(s)	Jacqueline Robinson, Associate Director of Governance Andre Haynes , Health & Safety Manager
Accountable Executive	Hazel Richards Chief Nurse , Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Safety
Level of Assurance • **Positive** • **Gap(s)**	Positive with some Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This report provides the Board of Directors with an overview of Health and Safety performance and assurance activities undertaken for the year 2019/20, together with an update on progress against the Health and Safety Action plan developed utilising recommendations from the independent Health and Safety Audit and other sources of intelligence.

Progress is continuing steadily in building the Health and safety management framework in accordance with ISO45001 following the assessment by Arcadis of the WUTH against this criteria. Progress also continues with the actions identified following the Arcadis Inspections and each division has a comprehensive action plan to address the recommendations made. The implementation of new processes and progress against the Arcadis Inspection improvement plan has slowed in the last month of quarter 4 2019/20 as a result of the Covid 19 global pandemic which has resulted in high levels of operational pressures and a requirement to focus on the challenges the pandemic poses to activity within the WUTH.

Improvements continue to be seen with regard to reduced EL/PL and there were 7 fewer claims in 2019/20 compared to the previous year. There was also a reduction in the number of RIDDOR reportable incidents with a reduction of 10 in 2019/20, this is encouraging given the overall increase in the number of incidents reported.

The H&S performance dashboard is now utilised at each H&S management Committee and Safety Management Assurance Committee, and each Division has been encouraged to ensure competent and authoritative representative from each of the divisions are available to present their Divisions data.

The ROSPA application submitted in January 2020 has been accessed by the ROSPA panel and the Trust was awarded ROSPA gold accreditation. The achievement of ROSPA Gold award is outstanding and reflects the progress and improvements made in Health & Safety management over the last year and the commitment and engagement to drive improvements forward. There still however remains significant work to be undertaken in order to have a fully compliant H&S management system and continued engagement will be required from Trust and Divisional leadership and the wider workforce.

The Health and Safety Improvement plan for 2020/21 includes gaps identified following the Arcadis Audit and gaps identified during the ROSPA evidence gathering. A Health & Safety Recovery Plan has been developed to ensure important work streams continue once the COVID-19 pandemic concludes.

2. Introduction

Following receipt of the audit report from Arcadis (external independent consultant) in August 2019 significant progress has been made to aligning the Trusts Occupational Health and Safety Framework to ISO45001.

Diagram 1: 7 Seven core elements of ISO45001

2.1 Summary of Key H&S improvement work undertaken in 2019/20

- Appointment of an independent External Auditor to audit and inspect the H&S Management arrangements of the Trust and full audit and a range of inspections undertaken
- H&S Improvement plans developed for all divisions following external inspections
- Re-establishing the Health and Safety Management Committee and ensuring consistent high attendance from members and invited representatives
- Developed a H&SMC cycle of business , H&S topic for each month and divisional H&S reports and exception reports developed and communicated to appropriate forums through the H&S Governance structure
- Establishing the Safety Management Assurance Committee which is led by the non executives to monitor Health & Safety performance for assurance
- Implementing a process for Urgent Action and Prohibition Notices, Letters of Recommendations and revising the existing process for issuing Duty of Care Notices
- Work to understand the organisations context in relation to Occupational and Health and Safety was undertaken and documented within the Health and Strategy
- A three year Safety Strategy with key objectives , targets and performance indicators was developed and approved
- The Health and Safety Responsibilities matrix was developed and approved;
- Consideration of H&S performance indicators was undertaken to ensure a balance between leading and lagging indicators and Trust wide and Divisional Specific Dashboard developed and implemented
- Utilisation of Perfect Ward to ensure monitoring relevant to H&S that was already being undertaken was pulled out into a Health and Safety dashboard – thus releasing capacity in clinical areas (as the separate paper based H&S inspection tools were no longer required) but also increasing awareness and engagement across the Trust.
- A COSHH audit was undertaken and issues regarding the deterioration of sump trays were addressed with the replacement of all trays previously purchased
- The process for safe use of Chlor Clean was reviewed with the involvement of key stakeholders and a wall mounted poster was developed and is now located in the sluices of all clinical departments
- A Manual Handling Improvement plan was developed and entered on to the Risk Register
- The ROSPA application was completed and a range of evidence collated to support the application
- Violence and Aggression working group established with key stakeholders including community psychiatric liaison
- NITS group re-established to monitor sharps safety management arrangements and compliance
- Health & Safety Annual Work developed for 20/21 and Health & Safety Recovery plan developed to ensure work steams continue once the COVID-19 pandemic concludes
- Developing a range of H&S processes to support the organization during the COVID-19 pandemic

2.2 Progress against Arcadis Audit Action Plan in 2019/20

The audit undertaken by Arcadis was received in August 2019 and provided the Trust with a baseline as to its current position against the international ISO 45001 standards. Progress against these standards are reflected in the below table under the key elements of the standards.

Table 1: Summary of audit actions completed or in progress :-

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

	Context	Leader & Worker Participation	Planning	Support	Operation	Improvement	Performance & Evaluation
		H&SMC meeting monthly & well attended – membership includes managers; staff; union reps	Risk registers reviewed to identify H&S risks that impact on organisational objectives – incl. as standing agenda item on H&SMC	H&S supporting document to sit alongside the ELearning presentation developed	Cycle of Business ensures risk, improvement plans & assurance communicated through H&S Committee.	Lessons from claims investigations built into OH&S communication	Divisional H&S dashboard developed and in use
		V&A multi-disciplinary working group established	The process for the issuing of duty of care notices has been reviewed		Actions tracked through robust Governance Arrangements.	Cleanse of incident reporting system to provide more accurate reporting	Divisional exception plan and tracker implemented
		Communication loop – established and effective reporting mechanisms incl. creation of Division H&S report				An improvement plan to address MSD's has been developed	ROSPA submission developed
In progress	Legal register in development	H&S policies currently being reviewed					

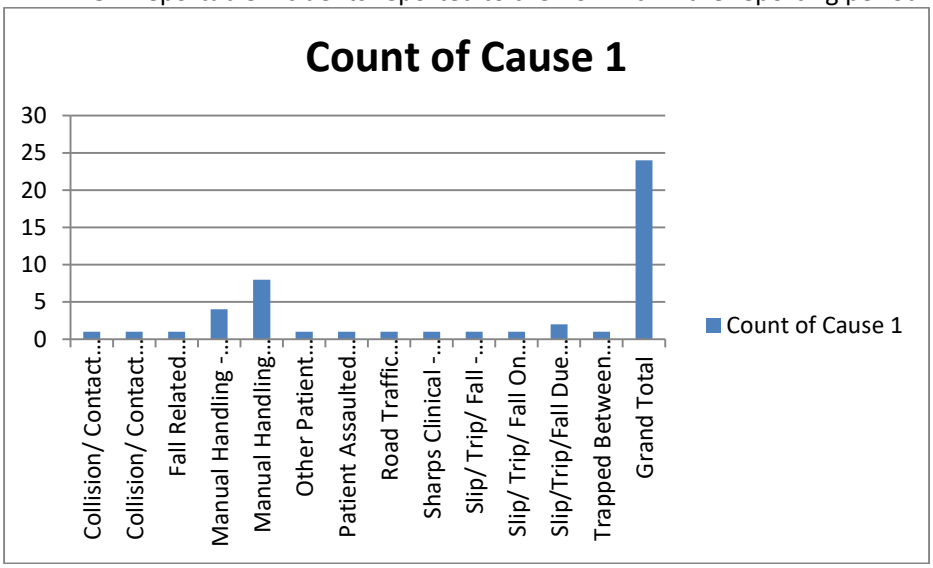
A Health & Safety recovery plan has been developed to ensure key work streams continue to progress once the covid 19 pandemic concludes and normal activity is able to resume . A Health & Safety Work plan for 20/21 has also been developed which includes a focus on revising Health and Safety policies; developing Divisional specific responsibility matrixes underneath the current senior leadership matrix already developed; reviewing and revising risk assessment processes; engaging managers and staff across Divisions to understand their services context; developing a Health and Safety audit plan and engaging senior leadership support in improving awareness and culture. **Please see Appendix 1 for further information**.

3. Performance and progress against identified priorities

The Trust dashboard for Health and Safety performance measurement is now embedded and forms part of the monthly H&SMC report. Each Division now has a Divisional specific dashboard which they are using to communicate H&S performance through their Divisional governance arrangements. They also present their performance at each H&S management Committee and Safety Management Assurance Committee – **See Appendix 2 for further information.**

4.1Trust Wide Performance dashboard highlights:-

- ***RIDDOR***:
  - 24 RIDDOR Reportable incidents reported to the HSE within the reporting period



  - There were 10 fewer riddor reportable events compared with the previous year which is encouraging given the overall increase in the number of incidents reported
  - Manual Handling was the highest incident type reported with a total of 12 and accounting for 50% of all riddor reportable events
  - There has been an increase in RIDDOR reportable incidents being reported within the statutory timescale although further work is still needed in order to achieve the required 100%
  - It is likely that the riddor reportable events will increase significantly as a result of recent changes to the reporting criteria for covid 19 dangerous occurrences, diseases and deaths

- ***H&S Incident reported in 2019/20:***
  - The number of H&S incidents/ near misses through Ulysses Safeguard increased from 1580 reported in 2018/19 to 1987 reported in 19/20. It is worth noting that 1242 of the total reported in 2019/20 were recoded as near misses. It is likely the increase in reported incidents can be attributed to increased awareness.

    **nb comparison with earlier reporting is not possible due to changes within the Ulysses system and the inclusion of non-incident data previously included*

  - Top 6 highest non-clinical incidents:-

- Physical Assaults (532)
- Unsafe Environment (214)
- Manual Handling (196)
- Sharps (134)
- Slips Trips Falls (119)
- Collision or Contact with Object (115)

Lessons learnt are shared with Divisions through Health and Safety Management Committee. Specific actions requested are detailed within Divisional H&S reports and sent to all Divisions.
The timely management of incidents reported and managed within the Ulysses system in 2019/20 stands at 51% and is only slightly higher than the 49% achieved in 2018/19.
The timely reporting and managing of H&S incidents is important as it allows for better investigation and retention of any evidence required to assess the risk and/ or respond to claims.

- ***Claims***
  - There has been a reduction in the average number of new EL/PL claims received in 2019/20 with a total of 38 , compared with the total of 45 received in 2018/19.

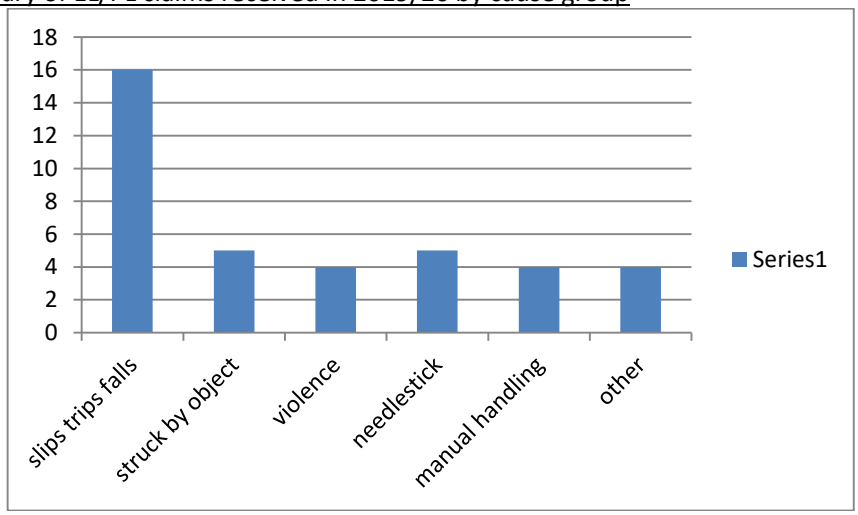
Table 2: Summary of actual EL/PL claims received in 2019/20 compared with previous year

60							
55	**53**						
50		**51**					
45			**42**			**45**	
40				40	**37**		38
35							
30							
25							
20							
15							
10							
5							
	13/14	14/15	15/16	16/17	17/18	18/19	19/20

Employer liability / Public liability claims – Cause groups

- 27 Employers liability claims
- 11 Public liability claims

Table 3: Summary of EL/PL claims received in 2019/20 by cause group



Themes identified from incidents resulting in a claim are detailed below:-

- **16 Slips, Trips and falls** – a number relate to incidents where water has been leaking from equipment or spillages; others are related to damaged or uneven flooring
- **5 Needle-stick injury** related to the following;-
    - 3 were domestics handling waste bags – all within Medicine but different wards (Ward 23, Ward 27 and ED)
    - 1 was a CSW picking up a patient's tray on Ward 26. Insulin needle from a self-injecting patient.
    - 1 was a nurse assisting with CPR. Needle was in patient's chest cavity where she was doing chest compressions (ED)
- **4 Violence and aggression** – relate to incidents where patients have been aggressive due to clinical condition with all 4 claims relating to AMU / MSSW
- **5 Struck by object** related to the following **:**
    - 1 was a visitor struck by a descending car park barrier
    - 1 was theatre staff struck by scissors on a retracting elastic
    - 1 was a domestic struck by a falling handrail in a bathroom on Ward 14
    - The other 2 were cars that were scratched on the post near the ticket machine
- **4 Manual Handling** – none related to patient handling activities.
    - 1 was catering staff moving a tray trolley on the ward which she claimed would not move easily.
    - 1 was a medical records porter moving boxes of casenotes.
    - 1 was HSSU staff putting cages of equipment into the washer.
    - 1 was physio assistant moving chairs to set up the gym for a pulmonary rehab class.

- **Mandatory H&S Training compliance**
    - Overall compliance with Health and Safety training and MH theory are both just below the target of 95% and whilst Moving & Handling people is below 90% there has seen a significant improvement in the last two quarters for this element of training.
    - Health & Safety - Level 1 – 91.76%
    - Moving & Handling - Inanimate Loads - 91.95%
    - Moving & Handling - People Handling – 85.28%

- **Attendance at H&S meetings**
    - There have been a total of 7 H&SMC meetings during the reporting period with good attendance and engagement with approximately 20 people attending each meeting.

4.2 ROSPA preparation and draft submission:-

- The Quality Strategy set an objective for 2019/20 of achieving at least Bronze level ROSPA award.
    - The ROSPA application submitted in January 2020 has been accessed by the ROSPA panel and the Trust was awarded ROSPA gold accreditation. The ROSPA Gold award is an outstanding achievement and reflects the progress and improvements made in Health & Safety management over the last year within the Trust and the commitment and engagement to drive forward these improvements. There still however remains significant work to be undertaken in order to have a fully compliant H&S management system and continued engagement will be required from Trust and Divisional leadership and the wider workforce.
    - Although significant progress has been made the gaps identified following the ROSPA application, and areas requiring further strengthening will help to inform the organizational action plan for 20/21

4.3 Regulator notifications/ activity

The Department of Transport carried out an inspection at Chester & Wirral NHS Microbiology Services in September. A letter was subsequently received identifying areas of non-compliance with the Carriage of Dangerous Goods Act. This was in reference to transport of infectious substances between sites and to Public Health Laboratories. An action plan has been developed and submitted. Actions included:-

- Establishing access to a Dangerous Good Safety Advisor
- Developing a Safety Plan and risk assessment
- Strengthening security training arrangements

The Division of Diagnostic and Clinical Support have now commissioned the services of a DGSA, who is currently reviewing the security plan and risk assessments developed by the Trust. He will attend the lab to undertake an audit, which will inform an annual report.
The DfT inspector is satisfied with the Trusts progress and will receive the above documents in February, he advises that he will then subsequently arrange a site visit to undertake a further inspection in the near future.

5 Further Improvements in work streams

Analysis and cross-referencing of various leading and lagging indicators has identified a number of priority work streams, in addition to the work being undertaken to develop and embed the Health and Safety framework across the Trust.

- Violence and aggression
  A working group for managing violence and aggression has been established in order to further improve existing control measures, reduce assaults and improve safety. The group is established with Clinical staff from the Trust; supported by Health and Safety; Patient Safety and Risk Manager; Security manager and CWP.

- Manual Handling
  Analysis of data has been undertaken and an improvement plan developed which includes communication and awareness raising activities. This has been added as a risk on the risk register and the actions are being monitored through Health and Safety Management Committee and the Safety Management Assurance Committee.

- Needle-stick injuries
  A needle-stick injuries and trends of sharps (NITS) group is in place to consider reduction plans. The duty of care notice processes has been strengthened to ensure that all Divisional managers are aware as to when a duty of care notice is issued at service/ ward level. The Health and Safety team have developed and introduced a 'Duty of Care log' which forms part of each Divisional H&S Report and will highlight any areas where non- compliance is repeated.

6 H&S Audit activity

There is a significant amount of audit and inspection activity undertaken across the organisation, however there still remain challenges in obtaining organizational oversight. A summary of known activity is:-

- All areas are required to complete quarterly Health and Safety inspections. These are undertaken and managed locally.
- The Perfect ward was utilized to integrate 17 key questions into audits already being conducted, one of the questions specifically asks for confirmation that the quarterly inspection has been completed. There is also assurance in other areas that are accredited such as labs who must show completion of inspections as part of their accreditation.
- In addition there were a further 4 audits relevant to Health and safety identified throughout the year these were:-
  - Arcadis Health and Safety Audits (ISO45001) – May 2019
  - IR(ME)R audit and CQC re-inspection (Nov 2019) – resulted in Radiology being rated as good
  - Inoculations and Exposure to Bodily Fluids-Auditing the Role of the Occupational health Department within the Policy – October 2019
  - COSHH cabinet audit – May 2019
- The CQC inspection that took place across the Trust October to November 2019 also included Health and Safety. There were no Trustwide actions identified, however the CQC identified the following in specific areas:
  <u>'Must Do' actions</u>
  - The service must ensure all premises and equipment are suitable for purpose and properly maintained. (Regulation 15)
  - The service must ensure oxygen is stored in line with health and safety best practice guidance (Regulation 15)

- The service must ensure all portable equipment is tested regularly. (Regulation 15)
- The diagnostic imaging service must ensure the risk to patients of MRI induced burns is mitigated by the development and implementation of a policy or standard operating procedure for staff to follow in the event of such an incident. (Regulation 17)

'Should do' actions

- The service should ensure that routine equipment checks are undertaken consistently
- The service should follow standard operating procedures when using cleaning products
- The service should follow trust process for maintaining equipment in ophthalmology
- The diagnostic imaging service should ensure that standard MRI safety labels are used on equipment within the MRI unit to identify equipment that is MRI Safe or MRI Not Safe
- The diagnostic imaging service should ensure that appropriate changing facilities are in place so that patients are not left alone in controlled areas when not undergoing a scan

The Health and Safety team have taken the opportunity to review these actions and where appropriate strengthen controls for the whole Trust.

7 Next Steps

Significant work has been undertaken to establish a framework by which Health and Safety can be effectively managed. Progress continues to be made on implementing the recommendations provided by the Arcadis External Audit; embedding new processes across the Trust; and introducing improvement mechanisms on a priority and risk based basis which is informed by the H&S performance indicators.

Consideration of how to reduce the risks of slips, trips and falls will be undertaken and actions identified will be incorporated into the over-arching improvement plan.

The H&S improvement plan will be updated and presented for approval and assurance through the Trusts governance arrangements to support the continued effort throughout 20/21.

7 Recommendations

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

Appendix 1 Health & Safety Work plan 20/21

No	Theme	Action Required	Progress	Lead	Due date	RAG
1.	**Legal Register**	Develop a legal register which is regularly reviewed and maintained	Work has already commenced in developing draft legal register	H&S Manager	Sept 2020	
2.	**H&S Covid 19 Recovery Plan**	Implement actions contained within the covid 19 H&S recovery plan	A Health & Safety recovery plan has been developed and will be implemented once covid 19 pandemic is over	H&S Manager	June 2020	
3.	**ROSPA**	Collate appropriate evidence and prepare a response for ROSPA award for 20/21 application submission		H&S Manager	Nov 2020	
4.	**Policy Development**	Review the Health & Safety Policy to simplify and develop management guides		H&S Manager	Sept 2020	
5.		Review the Manual Handling Policy to simplify and develop management guides		Manual Handling Specialist / H&S Advisor	Oct 2020	
6.		Review the Lifting Operations and Lifting Equipment (LOLER) Regulations Policy to simplify and develop management guides		Manual Handling Specialist / H&S Advisor	Sept 2020	
7.		Review the Provision and Use of Work Equipment (PUWER) Regulations Policy to simplify and develop management guides		Manual Handling Specialist / H&S Advisor	Oct 2020	
8.		Review the Display Screen Equipment Policy to simplify and develop management guides		Manual Handling Specialist / H&S Advisor	Nov 2020	
9.		Review the Inoculations and Exposure To Bodily Fluids Policy to simplify and develop management guides		H&S Manager	Sept 2020	

10.		Review the Prevention of Slips Trips and Falls to simplify and develop management guides		H&S Manager	Oct 2020	
11.		Review the Control of Substances Hazardous to Health (COSHH) Policy to simplify and develop management guides		H&S Manager	Nov 2020	
12.		Review the Management of Violence and Aggression Management Policy to simplify and develop management guides Separate current policy into 4 separate policies		H&S Manager	Nov 2020	
13.		Support Estates with the review of the Policy on contractor management (CDM) arrangements and ensure all requirements are implemented and monitored		H&S Manager	Dec 2020	
14.		Support Estates with the development of an asbestos management plan		H&S Manager	Oct 2020	
15.		Develop and implement a rolling programme of ongoing review of Safe Working Procedures and Guidance Notes to ensure current legislation is reflected		H&S Manager	Jan 2021	
16.	**Safety Manual**	Develop a H&S Manual to describe the interactions of the elements within the wider health and safety system		H&S Manager	Feb 2021	
17.		Identify and agree to work with one of the Divisions to identify the context of their services to aid with the development of a Divisional Specific safety Manual		H&S Manager	March 2021	
18.	**H&S Divisional Matrix**	Divisional specific H&S Responsibilities Matrix to be developed for Estates and Facilities , Diagnostics and Clinical Support and Woman's and Children's to support overarching responsibilities matrix		H&S Manager	March 2021	
19.		Divisional specific H&S Responsibilities Matrix to be developed for Medicine and Acute and Surgery to support overarching responsibilities matrix		Manual Handling Specialist / H&S Advisor	March 2021	

20.	**Risk Assessment Processes**	Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for **Display Screen Equipment (DSE)**		Manual Handling Specialist / H&S Advisor	April 2021	
21.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for **Manual Handling inanimate Loads (MHL)**		Manual Handling Specialist / H&S Advisor	April 2021	
22.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for **Manual Handling Patients (MHP)**		Manual Handling Specialist / H&S Advisor	April 2021	
23.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for **Job Activities**		H&S Manager	April 2021	
24.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for the prevention of **Slips Trips and Falls**		H&S Manager	April 2021	
25.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for **Control of Substances Hazardous to Health (COSHH)**		H&S Manager	April 2021	
26.		Develop a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for the **Management of Stress**		H&S Manager	April 2021	
27.		Assist the Accredited Security Management Specialist (ASMS) with the development of a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for the **Lone Working**		H&S Manager	May 2021	
28.		Assist the Accredited Security Management Specialist (ASMS) with the development of a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for the Management of **Violence and Aggression**		H&S Manager	May 2021	

29.		Assist the Accredited Security Management Specialist (ASMS) with the development of a unified approach across all departments, for risk assessment which includes reference to the hierarchy of controls for the Management of **Security and Premises**		H&S Manager	May 2021	
30.	**Risk Register**	A V&A improvement plan will be developed and agreed at the Violence and aggression work group and will be entered onto the risk register	A draft risk register entry will be developed which will be shared with the V&AWG group and entered onto the risk register once agreed	H&S Manager	Sep 2020	
31.		A MSD improvement plan has been developed and agreed at the H&SMC and has been entered onto the risk register	Completed	Manual Handling Specialist / H&S Advisor		**B**
32.		A Sharps safety improvement plan will be developed by the NITS group and entered onto the risk register	A draft risk register entry has been developed which will be shared with the NITS group and entered onto the risk register once agreed	H&S Manager	Sep 2020	
33.		A non clinical Slips Trips and Falls improvement plan will be developed and agreed at the H&SMC and entered onto the risk register	A draft risk register entry will be developed which will be shared at the H&SMC and entered onto the risk register once agreed	H&S Manager	Oct 2020	
34.		Assist the falls HARMS group with the development of a falls prevention improvement plan for the prevention of clinical falls	A draft risk register entry will be developed with input from the HARMS group and entered onto the risk register once agreed	Manual Handling Specialist / H&S Advisor	Sep 2020	
35.		Any new risks identified by incidents , claims or other sources will be entered onto the risk register and monitored in accordance with agreed process for risks	Existing risk register entries are monitored at RMC and H&SMC	H&S Manager	Ongoing	B
36.	**Document Control**	Establish document control system and a search friendly, document naming convention for health and safety documents on the intranet		Manual Handling Specialist / H&S Advisor	Nov 2020	
37.	**Communication of H&S information**	Develop a live and integrated safety intranet page to provide real-time performance information, guidance for colleagues, access to resources, and a forum to facilitate organisational learning and feedback		Manual Handling Specialist / H&S Advisor	Dec 2020	

38.		Quarterly H&S management bulletins of key topical issues and risks will be developed and communicated throughout the Trust using existing governance structure and communications forums	Topic of the month and risks are included within monthly , quarterly and annual H&SMC reports	H&S Manager	June 2020	**B**
39.	**H&S Improvement Plan following Arcadis Inspections**	Monitor the completion of Divisional Specific improvement plans at the H&SMC until all actions identified following the inspections are completed	A Trust wide draft dashboard has been developed which will be monitored at H&SMC until all actions are completed	H&S Manager	Dec 2020	
40.	**Audits and Inspections**	Establish an internal annual audit programme to be carried out by the H&S team to determine compliance against ISO 4500 and all H&S policies by end of Q4 2020/21	A draft audit schedule has been developed	H&S Manager	March 2021	
41.		Develop and agree a process for inspection of non-clinical areas and how this will be monitored for assurance		H&S Manager	August 2020	
42.		Establish viability of using Perfect Ward to enhance monitoring within Estates and Hotel Services.		Manual Handling Specialist / H&S Advisor	Nov 2020	
43.		Establish mechanism whereby senior managers undertake process reviews and communicate findings		H&S Manager	Nov 2020	
44.	**Establishing of Working Groups for Key Risks**	A violence and aggression working group has been established with involvement of key stakeholders including CWP and staff side union representative	Complete	H&S Manager		**B**
45.		A MSD working group will be established with key stakeholders to further develop and improve on existing arrangements aimed at reducing MSD associated risks		Manual Handling Specialist / H&S Advisor	Sept 2020	
46.		The WUTH has an established Needle stick Investigation and Trends of Sharps (NITS) Group to monitor sharps safety and further improve policies and processes covering sharps safety	Complete	H&S Manager		**B**
47.	**H&S Strategy / KPI;s**	Launch WUTH's safety culture assessment tool and achieve 25% colleague completion of the safety climate questionnaire - by Q4 2020/21		H&S Manager	March 2021	

48.		Monitor KPI's set within the three year safety strategy in order to achieve a 30% (10% each year) reduction of those incidents resulting in harm and lost time against 2018/19 baseline incident data for Cause Groups: - Needle-stick/sharps - Violence & Aggression (Physical Assaults) - Slips/trips/falls - Moving & Handling	KPIS set within the three year safety strategy will be measured and reported on at the H&SMC and SMAC	H&S Manager	March 2021	
49.		Identify other assurance activities being undertaken and build into the Cycle of business for the H&S Management Committee to ensure visibility	Water Safety and IRR is now included within the H&SMC agenda , further assurance activities to be identified	H&S Manager	Dec 2020	
50.	**Urgent Care notices and Duty of Care Notices**	Develop and agree a process so these two processes link in together where departments that repeat offenders receiving duty of Care notices are issued an Urgent Action notice		H&S Manager	Dec 2020	
51.	**Causes Groups on Ulysses**	Review all cause codes within Ulysses to ensure the system allows for easier analysis and identification of trends	Work on updating the Cause groups has already commenced however further work is required	H&S Manager	Nov 2020	
52.	**Investigation Prompts on Ulysses**	Investigation pro-forma's / questionnaires to be developed and linked to safeguard for improvement of the data for analysis of incident causes to better inform risk awareness and preventative measures	The system has been updated and includes sharps safety questionnaire further work is required for Manual Handling STF's, incidents involving work equipment and violence and aggression	H&S Manager	Sep 2020	
53.	**Training**	Develop incident investigation course within existing eLearning suite to aid content of investigations and improve knowledge.		H&S Manager	March 2021	
54.		Develop Job Activity, COSHH, Stress risk assessment courses within existing eLearning suite to aid with the completion of risk assessment process and improve knowledge.		H&S Manager	March 2021	
55.		Develop DSE, MH, and Safe Use of Work equipment risk assessment courses within existing eLearning suite to aid with the completion of risk assessment process and improve knowledge.		Manual Handling Specialist / H&S Advisor	March 2021	
56.		Identification of Key trainers for use within the Trust		Manual Handling Specialist / H&S Advisor	March 2021	

57.		Development of a Manual Handling Practical Seminar for Key Train the trainers		Manual Handling Specialist / H&S Advisor	Feb 2021	
58.		Development and implement a schedule for the training of identified Key trainers		Manual Handling Specialist / H&S Advisor	March 2021	
59.		Develop and implement a process for assessing competency of key MHP trainers		Manual Handling Specialist / H&S Advisor	March 2021	

Appendix 2 Trustwide H&S Performance dashboard (accurate as of 31/03/2020)

Total no. non-clinical safety incidents			
	2018/19 (monthly Av.)	2019/20 (monthly Av.)	Increase/ Decrease
No reported (monthly average)	1580 (131.66)	1987 (165.58)	↑
% incidents managed in Ulysses within Trust Timescale	49%	51%	↑
RIDDOR incident			
	2018/19 (monthly Av.)	2019/20 (monthly Av.)	Increase/ Decrease
No reported 2018/19	34 (2.83)	24 (2)	↓
% reported within timescale	61%	71%	↑

EL & PL Claims			
	2018/19(monthly Av.)	2019/20 (monthly Av.)	Increase/ Decrease
No. new claims received	45 (3.75)	38 (3.16)	↓

Riddor Injury Type	
Death	0
Specified injury	3
Over 7 day absence	20
No injury(DOcc)	1

Near Miss/ Non-compliance	
No. of near miss incidents reported	1242
No. of near miss incidents investigated	0
No. of non-compliances investigated	0

H&S Interventions

No. of informal advice	6
No.of letters of recognition	2
No. notice of urgent action	2
No. of suspension notices	0
No. of duty of care notices	17

H&S Assurance activity

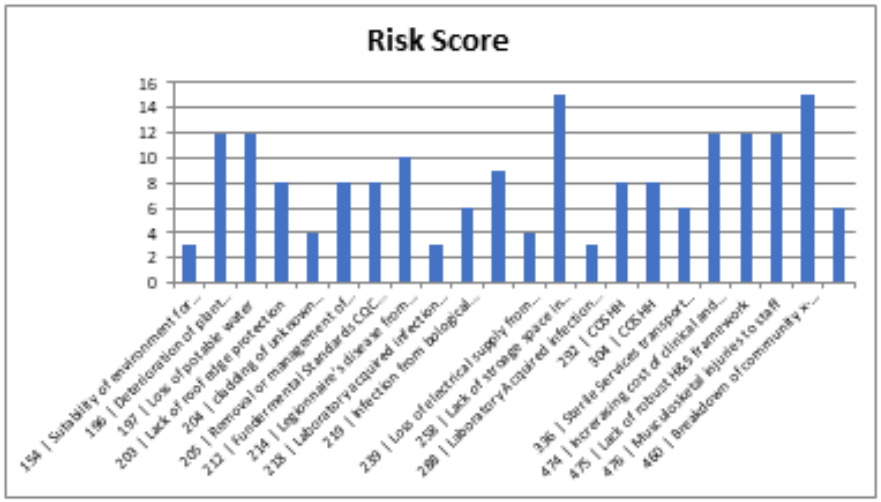
No. of inspections	2
No.of audits (excl. Perfect ward & C4C)	5
No. of investigations	22
No. of process reviews	0
No. of Senior team H&S tours	10

H&S Communication & Consultation

No. of HSM Committees	7	% attendance	87%
No.of SMA Committees	7	% attendance	88%
No. of Formal training sessions delivered	148	% Compliance Mandatory Training	
No. of H&S Comms	4	• H&S Level 1	91.76%
No. of Policies reviewed	3	• Moving & Handling	91.95%
		• M&H Practical	85.28%

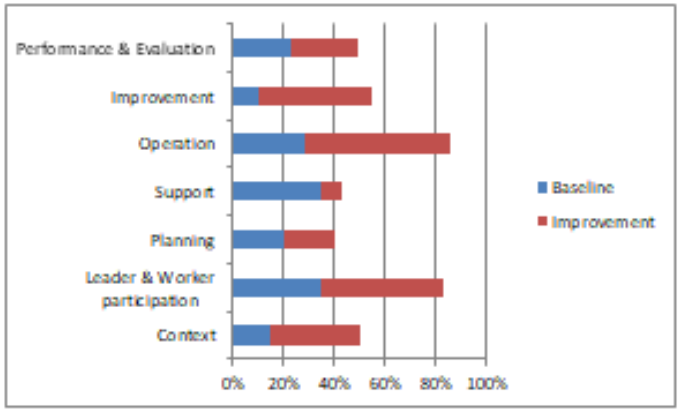
H&S Regulator

No. of informal advice	1
No. of enforcement letters	0
No. notices served	0
No. of formal cautions	0
No. of prosecutions	0



Perfect ward – Example

GAP Analysis Status March 2020



Board of Directors	
Agenda Item	20/21 146
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	7 October 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 16th September 2020 the members received a presentation on the procurement and deployment of the 'PM3' portfolio management tool as well as a further update on the evolution of the Service Improvement Team. Members again 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 of this assurance report to the Board of Directors. The scope of the programme **(slide 2)** was unchanged in September; however, the Programme Board has decided to broaden the scope to include 'Productivity & Efficiency' (CIP) and 'Quality Improvement' initiatives and these will appear in the next update.

PROGRAMME STATUS

In terms of the overall ratings assessments **(see slides 3 and 4)**, there has been slight deterioration, compared to August, in the governance evidence relating to the portfolio and further progress is required. The delivery ratings have seen a more significant deterioration, with 2 programmes moving into the red and 2 downgraded to amber; concerted action should now be applied to address the underlying issues.

1.1. Governance Ratings

Seven of the eleven 'live' programmes are green rated for governance, with two 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 currently just two programmes green rated for delivery while six are now amber rated and three are red rated. For the sake of clarity, amber ratings remain indicative of substantive issues albeit considered within the competency of the programme/project team to resolve. The areas for attention are, in particular, the definition and realisation of benefits and robust planning.

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 to 12**.
2.2 Flow. The metrics for the Flow project are shown at **slides 13 to 16**.
2.3 Perioperative. The metrics for the Perioperative project are shown at **slides 17 to 22.**

At the Programme Board of 16th September 2020, it was agreed that programme teams would continue to provide a brief statement (on the slides) to give context and commentary on these metrics for the priority programmes.

3. Service Improvement Team

An update on the new operating model for the Service Improvement Team was received by the Programme Board at its meeting of 16th September August 2020. This shows the timeline for the completion of the new operating model as the end of December 2020.

ASSURANCE

4. Programme Assurance - Ratings

The attached assurance report has been undertaken by External Programme Assurance and provides a detailed oversight of assurance ratings per programme / 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 16th September 2020.

5. Assurance Focus

In aggregate, the assurance ratings for the top three priority programmes - namely Flow, Perioperative Care and Outpatients - carry much greater weight than the other eight programmes and 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 24 and 25) 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.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

External Programme Assurance
September 2020

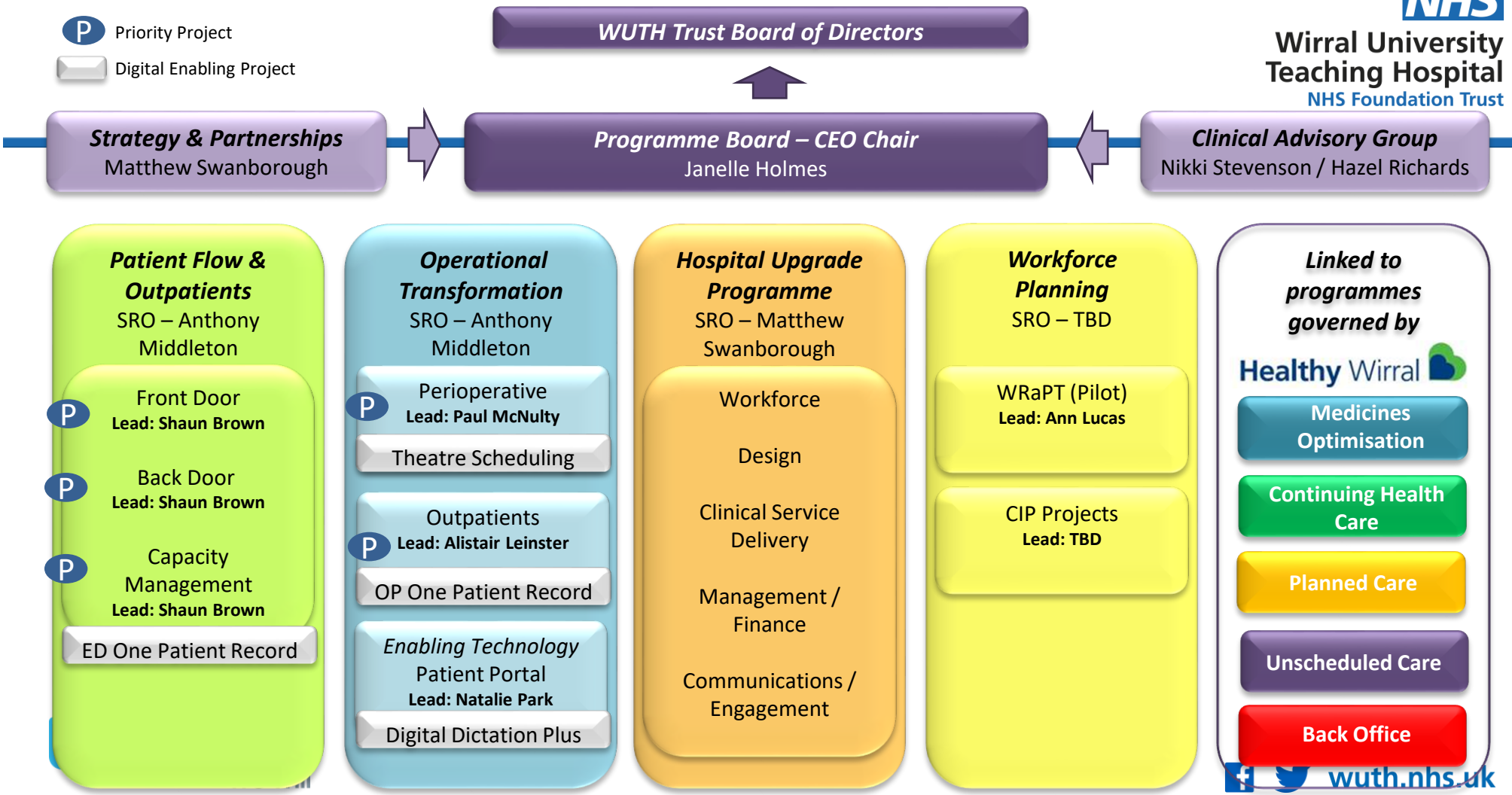
together we will

wuth.nhs.uk

V2.7_11 Aug 20_JG

P Priority Project

Digital Enabling Project

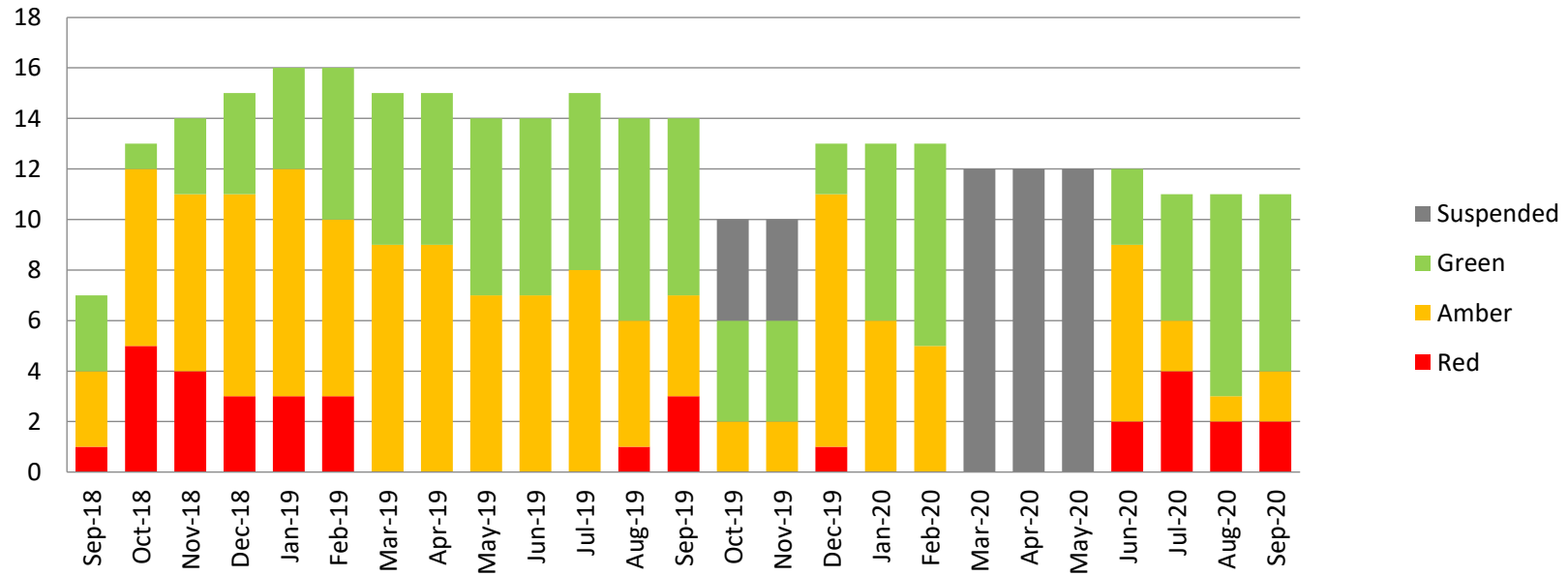


Change Programme Assurance Report - Trust Board Report - August 2020

J Gibson – External Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Assurance - Governance ratings



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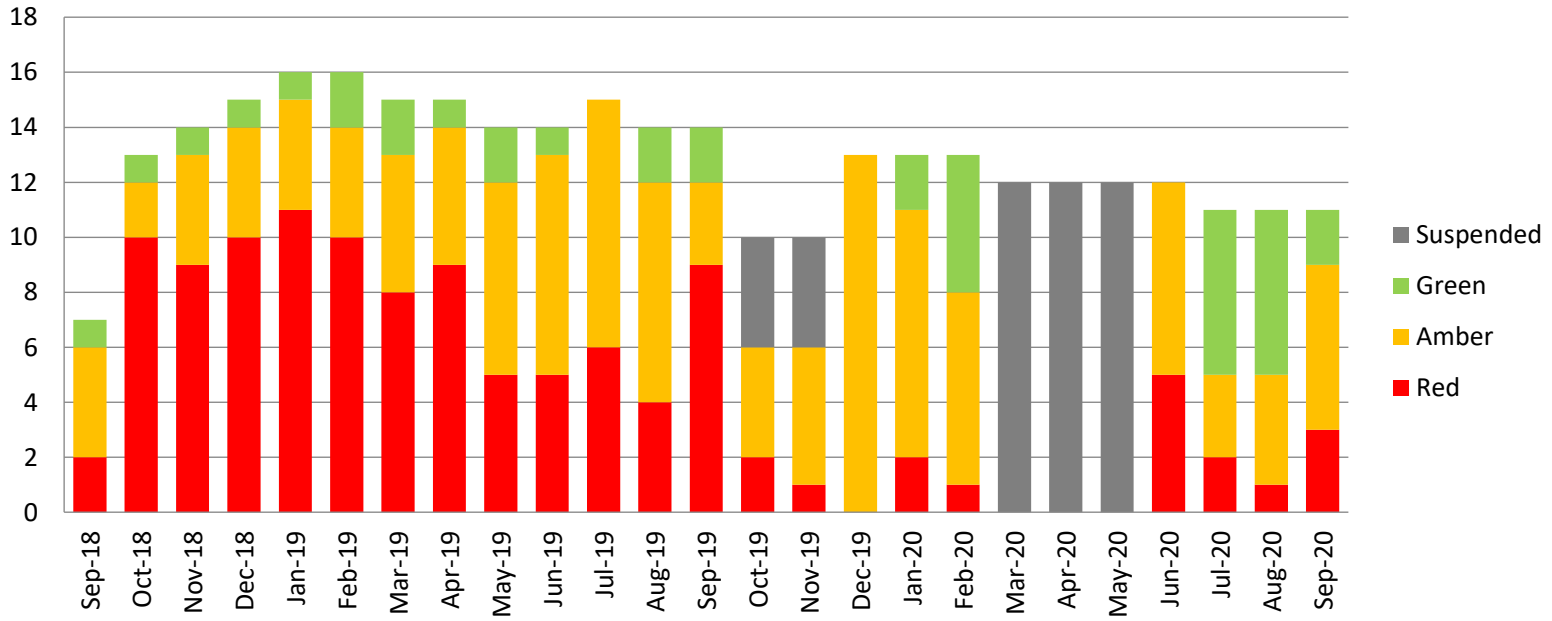
Change Programme Assurance Report - Trust Board Report - August 2020

J Gibson – External Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Assurance - Delivery ratings



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Priority Projects Metrics

Programme Board 16 Sep 20

Senior Responsible Owners

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Outpatient Consultations at WUTH

Trust-wide Non-F2F OP Attends

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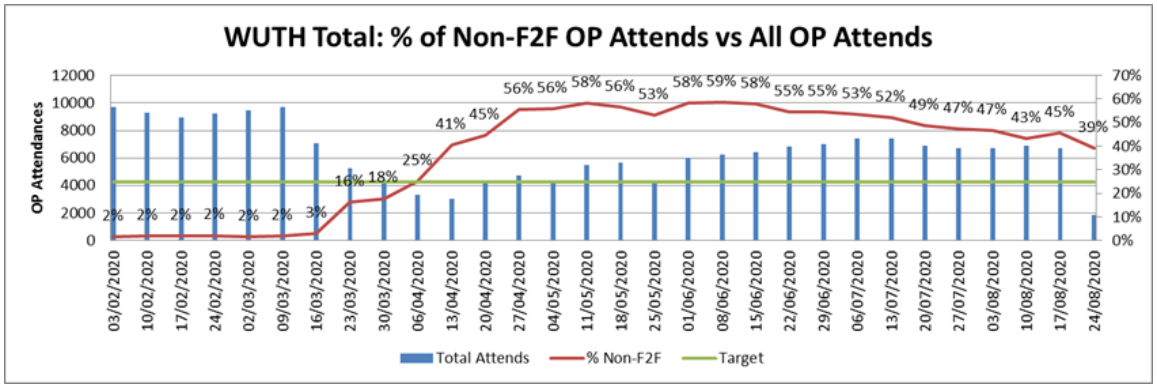

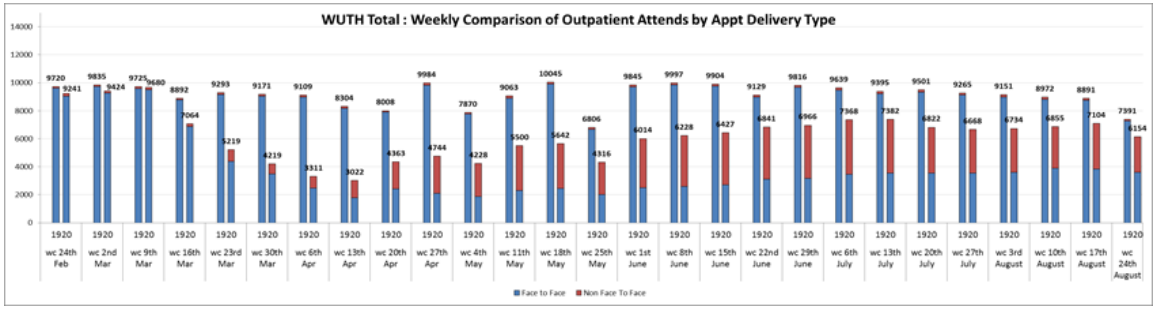

Simon Stevens - 3rd Phase of NHS response to Covid letter 31/07/20

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

Trust Level Narrative:

- Whilst the Trust has attained the national 25% Non-F2F target in August **(39%)** the 60% non-F2F target was not achieved **(40%).** 53% of new appointments were delivered non-F2F

- Following Programme Steering Group, the Outpatients Programme Team will bring a proposal **to October Programme Steering Group** to review the original target of 50% Non-F2F against the new NHSE defined targets of 25% total, 60% follow-up

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Outpatient Consultations at WUTH

Medicine & Acute 1/2

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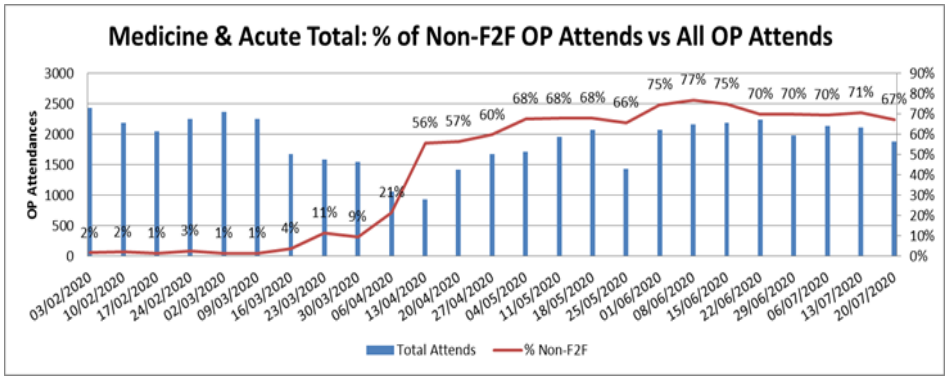

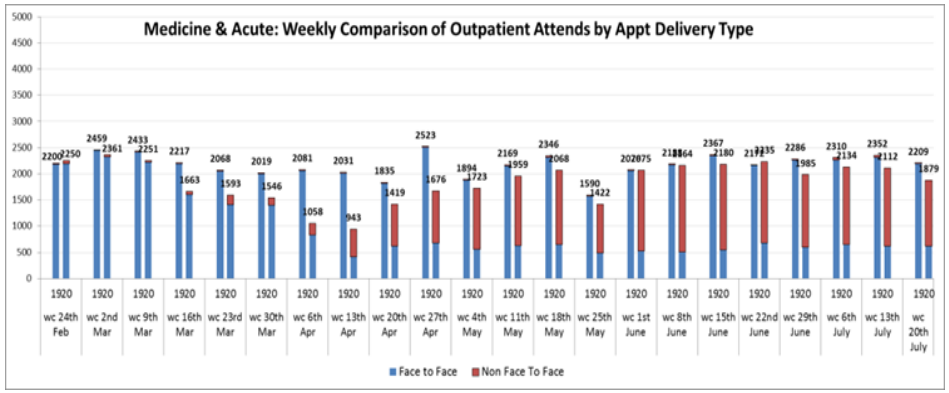

	Non-F2F			
Specialty	New %	F/Up %	Overall %	Commentary
Cardiology	92%	33%	50%	New:All consultant clinics are currently non-F2F. Proposal to be taken to CAG to increase number of F2F new appointments due to concerns over junior doctor ability to assess remotely. FU: Activity is being distorted by pacemaker clinic. Pacemaker clinic is F2F in order for device to be interogated. Could potentially move to remote working for this clinic but would require additional investment.
Clinical Haematology	96%	88%	89%	All clinics non-F2F with patients seen F2F based on clinic need.
Dermatology	28%	32%	31%	New: Currently only new 2WW referrals routinely seen as F2F (as agreed by CAG), however, this is high volume of consultant workload. Clinical triage of all referrals and any identified as needing F2F also being brought in. FU: Consultant clinic FU activity is non-F2F except where consultant identifies clinical need for F2F. FU activity is distorted by the various treatments that are performed on the Dermatology Ward, all of which are coded as outpatient FU.
Diabetic Medicine	36%	62%	60%	Diabetic foot service is F2F due to clinical need as agreed with CAG - unable to see / treat remotely. All other exceptions are according to clinical need as identified by treating consultant and as approved by CAG.
Diagnostic Imaging	n/a	0%	0%	N/a
Endocrinology	86%	98%	96%	All clinics non-F2F with patients seen F2F based on clinic need.
Gastroenterology	89%	49%	56%	New: All clinics non-F2F with patients seen F2F based on clinic need. Clinical team have highlighted issues with ability for junior doctors to undertake non F2F clinics and also increased need for new patients to be seen F2F - further proposal to be taken to CAG. FU: Consultant activity is non F2F, Division to review other activity being coded against outpatient line to further assess ability to increase non F2F.

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Outpatient Consultations at WUTH

Medicine & Acute 2/2

Wirral University Teaching Hospital NHS Foundation Trust

General Medicine	0%	14%	13%	No specific General Medicine specialty. Patients seen under this category will be a mixture of other specialties within this document.
Geriatric Medicine	77%	94%	86%	Patients being brought in for F2F by clinical need only following consultant assessment. Majority of clinics being run by telephone / Attend Anywhere.
Nephrology	52%	96%	89%	Higher proportion of new referrals seen F2F as unstable. Need F2F assessment to assess level of risk and agree treatment plan. Once stabilised, able to follow up as non-F2F.
Paediatric Dermatology	0%	78%	51%	As per Dermatology.
Rehabilitation Service	0%	0%	0%	N/a
Respiratory Medicine	78%	72%	73%	New: Further supported needed for sleep pathway to move virtual. Consultants currently undertaking 'virtual' review following completion of diagnostics, however, booking office have not recorded this activity on Cerner. FU: F2F activity is by clinical exception as determined by the relevant consultant.
Rheumatology	9%	91%	86%	Pathway agreed by CAG - clinical need to see new appointments as F2F due to need to undertake physical examination (inflamatory joint issues).
Stroke Medicine	100%	0%	100%	N/a

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Outpatient Consultations at WUTH

Surgery

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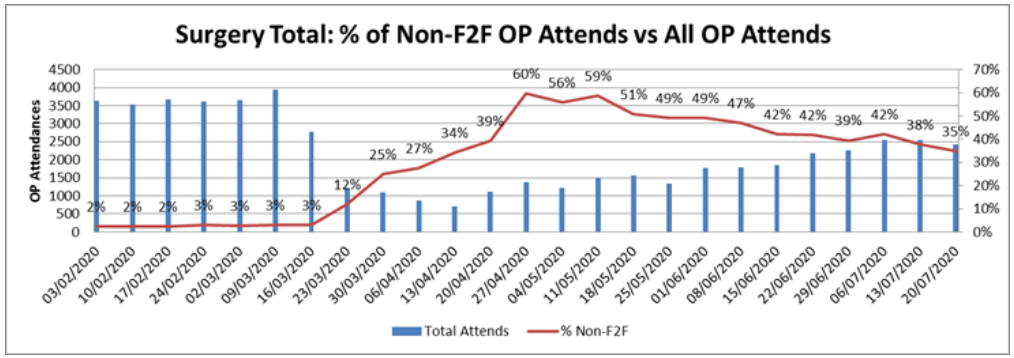
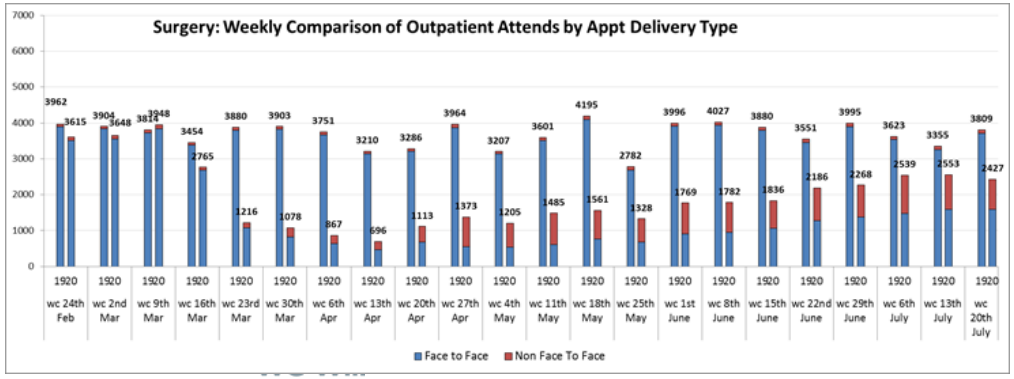
NHS Foundation Trust



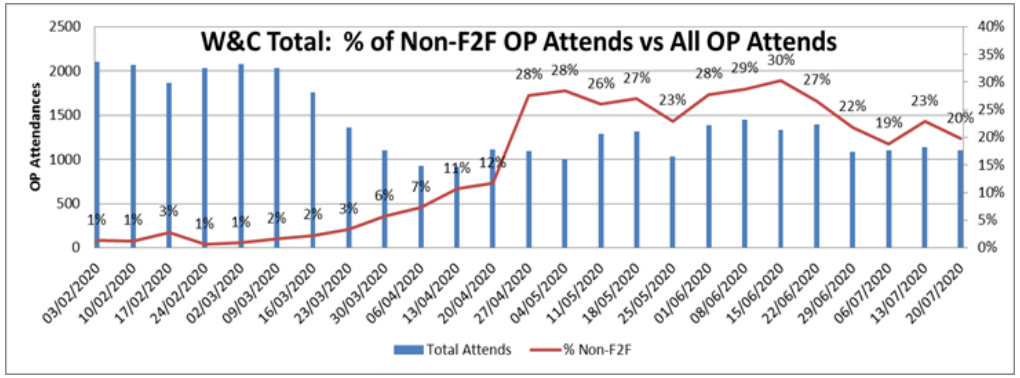


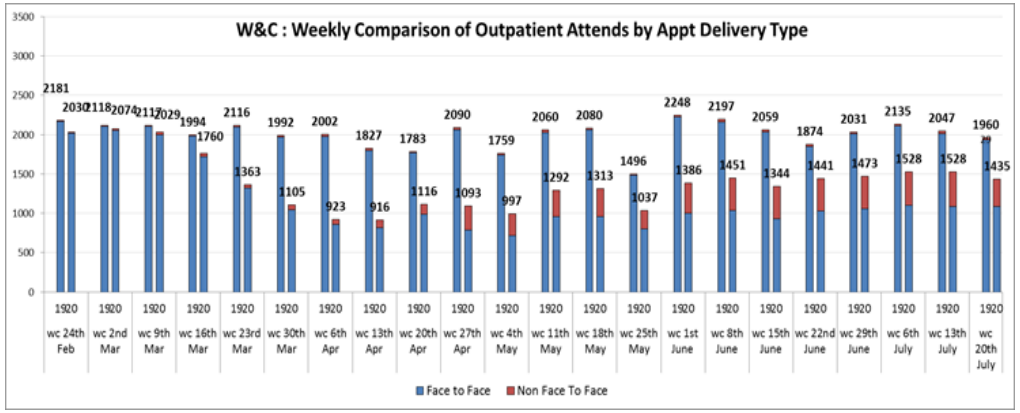
Specialty	Non-F2F New %	Non-F2F F/Up %	Commentry
Chronic Pain	10	10	Difficult patient cohort who need physical and psychological assessment. Potential to increase F/Ups via non F2F with new pathway, but maybe better to discharge to GP
Urology	70	40	Follow up aim is 60% - difficult to achieve in Urology due to clinical need to assess patients in person – 50% is achievable and clinically appropriate. Video based consultations not widely appropriate but exploring currently for joint cancer clinics
ENT	85	50	Follow up aim is 60% - difficult to achieve in ENT due to clinical need to assess patients in person – 50% is achievable and clinically appropriate
Ophthalmology	5	5	New clinics require examination of the eye and tests such as visual field screener, OCT, laser, injections, and use of slit lamp therefore unlikely to change. F/Up also unlikey to change as post-op cataract patients (high volume) in particular are being seen in the community
Orthopaedics	30	30	Patient examination, diagnostics and treatment. Non F2F New led to increased F2F follow ups
Colorectal	35	25	High demend for new virtual triage on 2WW pathway. Likely to increase to 40% additional 2WW clinic and IDA clinic built. F/Up F2F is high due to FIT, physcial examination, sensitive discussions and detailed diagnostics options discussions
UGI	40	30	New Clinics are be amended to be 1:1 ratio. F/up clinics require F2F post diagnostics, consent for surgery and post op follow up examination. Small number of long waiters being examined pre TCI
Vascular	0	65	New requires discussion as mist will attend one stop shop, but <10% could be virtual
OMFS	5	15	New patients require F2F for intra-oral examination, diagnostics e.g Nasoendoscopy. Non-F2F didn't progress patients on their pathways, F/Up as F2F as many need further examination and MOS
Orthodontics	0	15	New to move to video consultation once created. F/Up as F2F as many need further examination and treatment e.g. braces

Outpatient Consultations at WUTH

Women and Children's

Wirral University Teaching Hospital NHS Foundation Trust





	Non-F2F		
Specialty	New %	F/Up %	Commentary
Community Paediatrics	80%	55%	Exceeding numbers predicted as currently not able to do face to face school diagnostics this will fall back to 50%
Acute Paediatrics & Neonates	5%	37%	Exceeding Numbers predicted
Paediatric Audiology	0%	100%	At present all new patients are requiring diagnostic testing this is expected to fluctuate month on month, as a diagnostic
Gynaecology	57%	29%	Until a triaging process has been agreed all new patients are booked into a telephone new appointment resulting in a lot of the follow ups needing face to face due to diagnostics etc. Triaging / one stop clinic new appointments should improve the follow up telephone ratio
Breast	7%	37%	Results follow ups are still continuing as face to face, roll out of the video consultations could improve this ratio
HIV	0%	65%	
Obstetrics			

Outpatient Consultations at WUTH

Clinical Support

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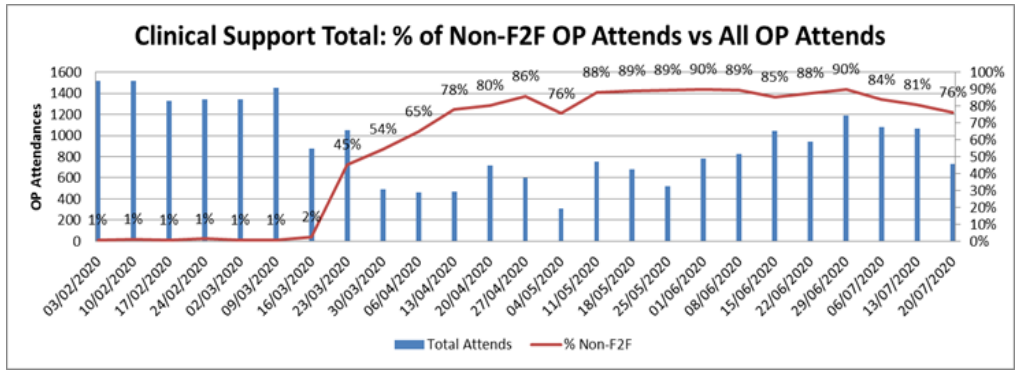

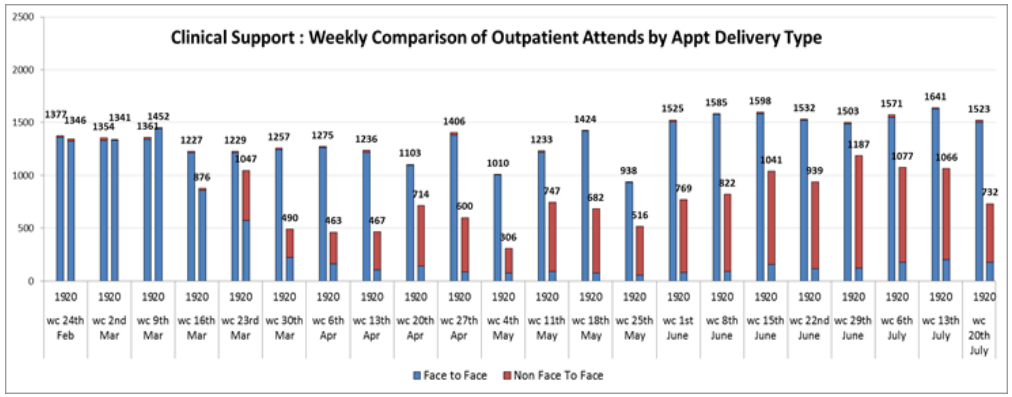

	Non-F2F			
Specialty	**New %**	**F/Up %**	**Overall %**	**Commentary**
Dietetics	83%	82%	84%	100% non face to face since lockdown. Data issues to be reviewed
Occupational Therapy	40%	57%	56%	Increase in F2F from 8/9/20 as APH outpatients re-opened. Some patients require F2F to assess/ fit splint
Physiotherapy	78%	68%	71%	20% of patients expected NF2F as full assessment required and therapy often manual. Triage results suggesting NF2F can increase to 40%. Increase in F2F from 8/9/20 as APH outpatients re-opened.
Speech And Language Therapy	74%	95%	88%	Incorrectly shown as 0%. Activity corrected for W16-present. Therapist requires sight of throat for swallow assessments.

Outpatient One Patient Record

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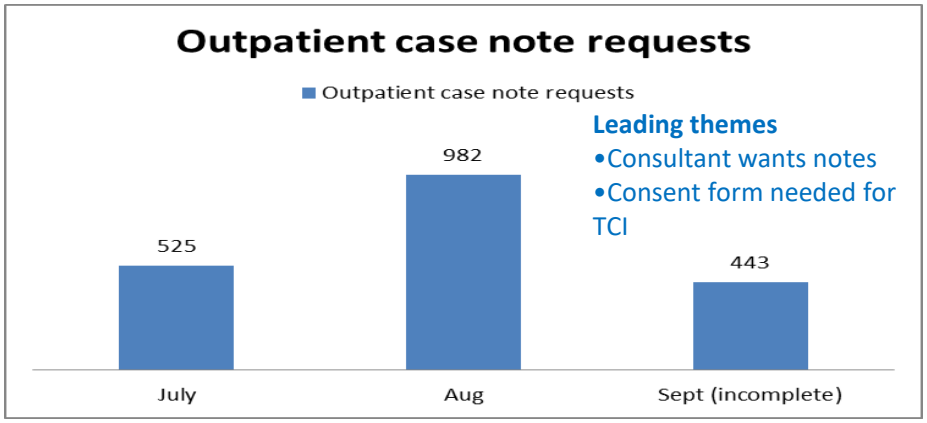

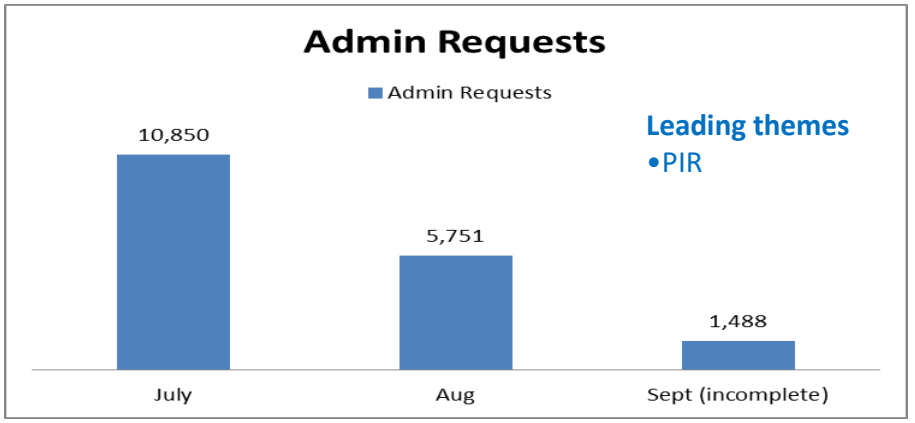

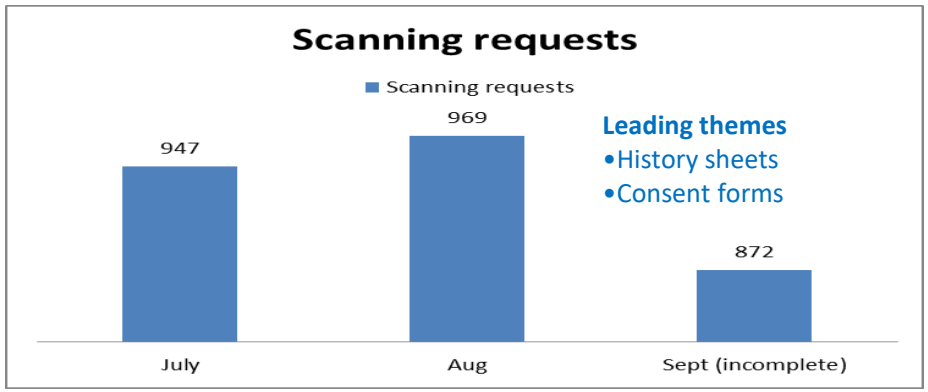

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Flow KPI's

Wirral University Teaching Hospital
NHS Foundation Trust

Patient Flow Improvement Group Reporting Meeting - September 2020									
ID	Description	Reporting Period	Period Target	Aug-20	Jul-20	Jun-20	YTD Target	YTD Performance	YTD Variance
Patient Flow									
1	Bed Occupancy	Aug-20	93%	85.3%	83.6%	82.8%	93%	80.0%	-13.0%
2	Time spent in A&E (Minutes)	Aug-20	240	189	172	167	240	173	-67
3	Average current in-patient LOS (Closed Spells)	Aug-20	TBC	4.48	4.13	4.69	TBC	4.84	
		Week Commencing	Target	01/09/20	25/08/20	18/08/20	11/08/20	04/08/20	28/07/20
4	Total Number of Long Stay Patients - >=21 days	01/09/2020	52	59	57	55	56	56	54

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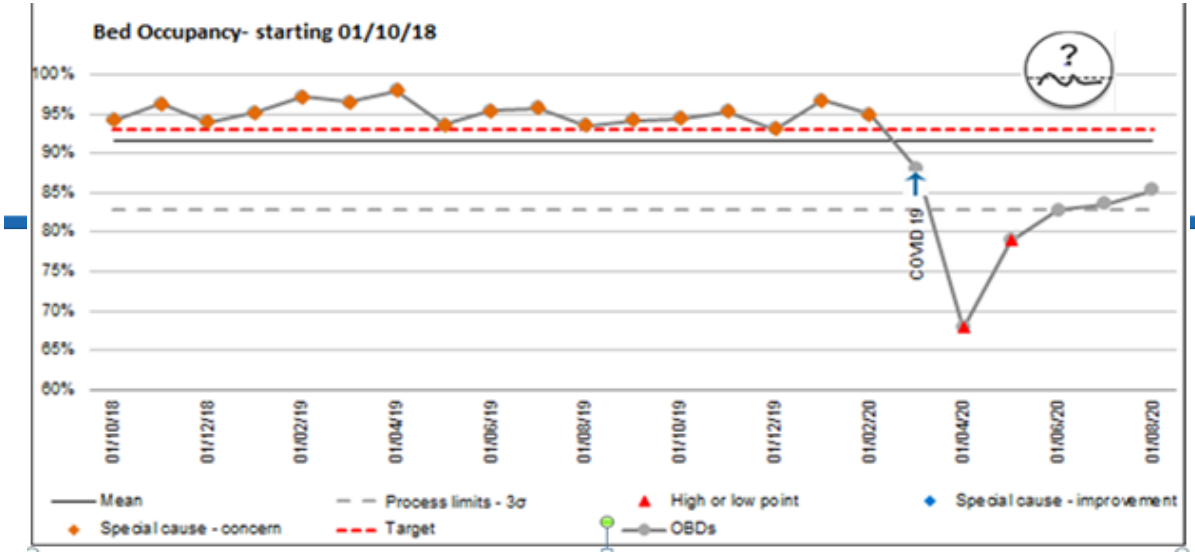

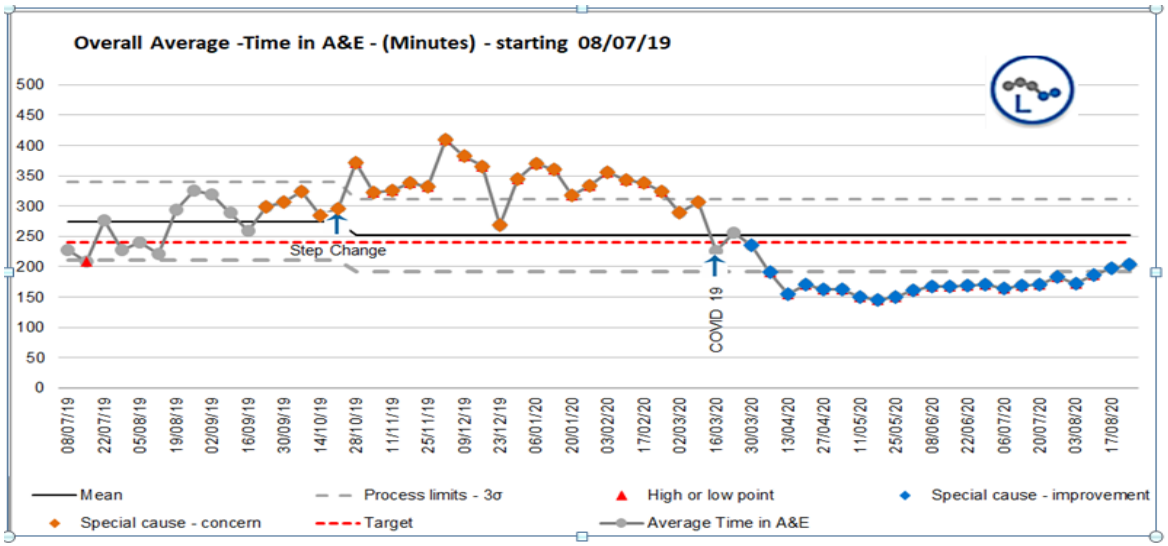

NHS
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- Bed occupancy dropped to a low of 67% in Apr ‘20 & has gradually risen to 85.3% in Aug ’20 against a target of 93%. It remains significantly below pre Covid occupancy

- Average time spent in A&E remains below the 4 hour target at 189 minutes in Aug ‘20

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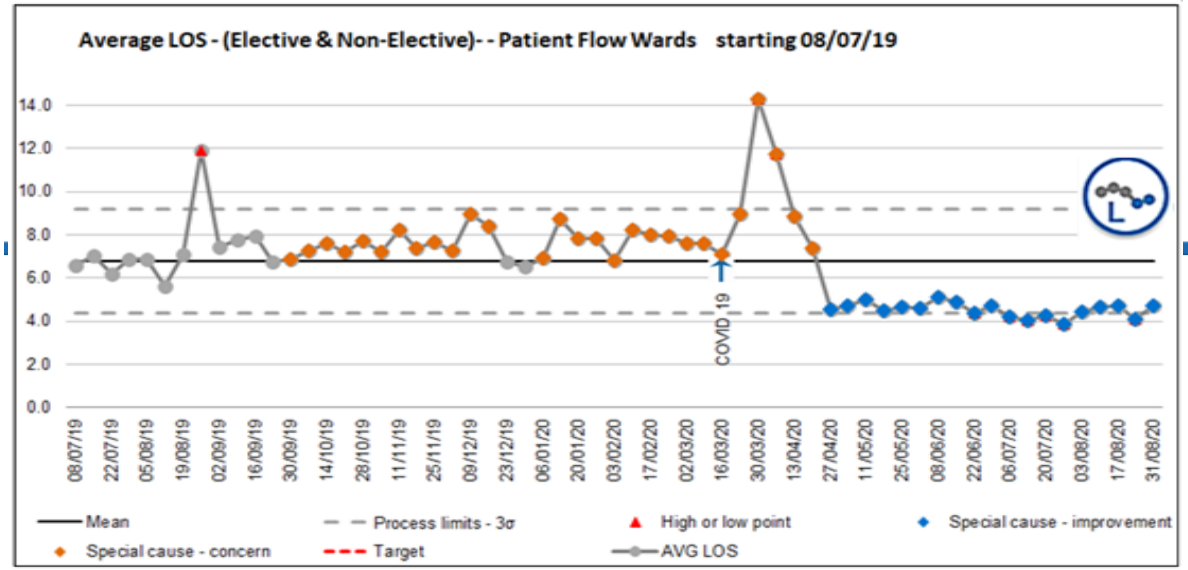

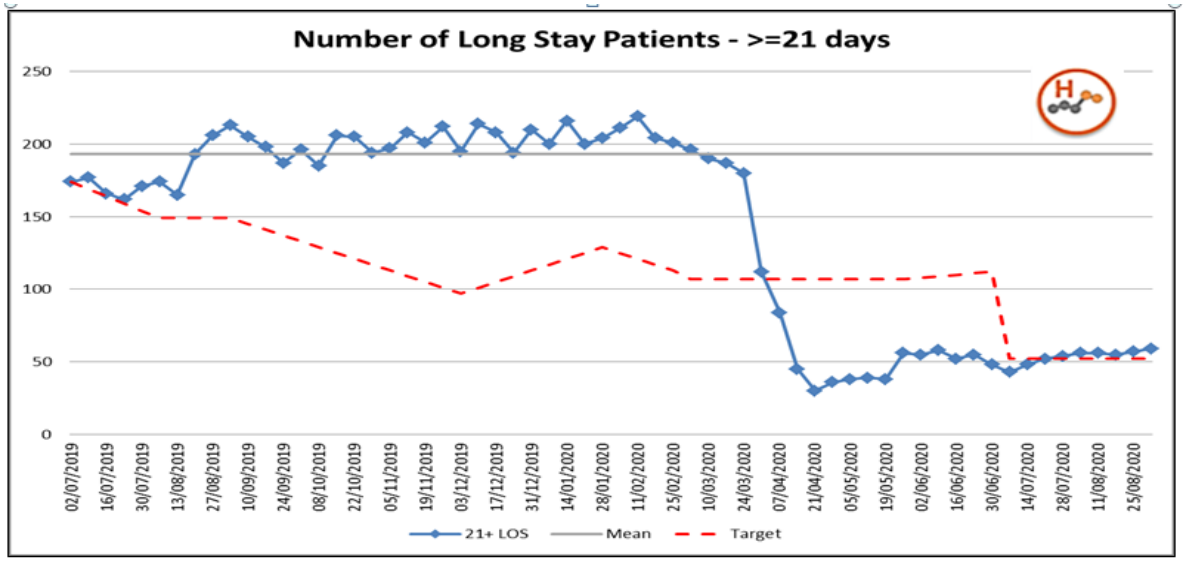

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- Average LOS dropped significantly in Apr ‘20 to below 5 days. This has been maintained with an average LOS of 4.48 days in Aug’20

- The number of patients with a LOS of 21 days or over remains significantly below pre covid levels with 59 patients in Aug ’20. NB: data for first week of Sept (not shown on graph) shows breach of target with 72 long stay patients

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Capacity Management KPI's

Wirral University Teaching Hospital NHS Foundation Trust

KPI	Baseline (March 9th - June 31st)	Target	July		August		Calc Notes
			avg	(n)	avg	(n)	
1. Reduction in waiting time: bed request to time leaving ED (median mins)	52	30 mins	38	1095 / 2453	49	1195 / 2613	View
2. Reduction in waiting time: transfer from Assessment Unit to Base Ward (median mins)	281.5	60 mins	350	65 / 1164	426	72 / 1265	View
3. Reduction in number of calls about beds between BB & Wards	239 over 24 hours	60 calls		128		Not recorded	
4a. Improvement in porter response times: job requested to job start - ED (median mins)	10	5 mins	11	797 / 3587	10	951 / 3816	View
4b. Improvement in porter response times: job requested to job start - Assessment Wards (median mins)	15	10 mins	17	177 / 2247	16	209 / 2314	View
5. Improvement in bed turnaround times - Dirty to Clean (median mins)	43	30 mins	24	6160 / 11476	23	6141 / 11318	View
6. Improvement in time (mins) from bed available & reserved to bed occupied- Assessment wards only (Base wards do not always have patients to fill empty beds)	25	25	29		32		View
7. Reduction in number of base to base ward moves after 8pm (one patient may have multiple moves)	186	0 moves		48		47	View
8. Information shown on Cap Man accurately reflects actual position	78%	100% accuracy		93%		94%	

Perioperative KPIs - Background

Wirral University Teaching Hospital
NHS Foundation Trust

- The scope of the Perioperative Improvement Programme was approved by Programme Board on 3rd March 2020
- That scope included a detailed benefits plan, linking each improvement project to a series of measurable objectives
- A revised benefits plan was approved in June 2020, having been adjusted to account for delays caused by COVID
- The purpose of this report is to demonstrate how the granular benefits detailed in the plan relate to the headline KPIs for the theatres service: i.e. how will the improvement projects lead to improved utilisation and cancellation rates

Perioperative Improvement Programme Benefits Plan

Perioperative Improvement Programme Benefits Plan as at June 2020

Ref	Benefits	Benefit Description	Target Outcome	Baseline	Benefit Status (RAG)
1	Programme Refresh				
1.1	The entire theatres service will be engaged in delivering transformational change	Increased engagement	Achieve a 80% average attendance rate across all working groups	48%	Revised target On Track
2	Pre-op triage service				
2.1	Patients will only have appropriate pre-operative assessments (e.g. if they are fit and well or if their surgery is unlikely to happen any time soon)	Reduce the total number of face to face pre-operative assessments. Overall capacity will be maintained as the remaining assessments will be completed via a pre-op triage questionnaire.	Number of pre-op assessments completed by form only	0 assessments completed by form only out of an average of 690 per month	Revised target On Track
2.2		Reduce the number of patients having at least one repeat pre-operative assessment for the same specialty within any six month period	The average number of patients per month having multiple pre-op assessments will reduce from 9.6% to 2% by April 2021	Average of 68 patients per month	Revised target On Track
3	Three phase recovery				
3.1	Patients' experience of post-operative recovery will be enhanced	APH day-case patients will report high levels of satisfaction with their care	100% FFT compliance	0 (proxy)	Revised target On Track
3.2			90% FFT positive rating	0 (proxy)	Revised target On Track
3.3		Patients will not wait as long between pre-op and surgery	TBC (target to be set in PPSE meeting on 10/03/2020)	30 days (proxy)?	Revised target On Track
3.4		Reduction in the failed day-case rate for non-clinical reasons	The number of elective admissions with an intended management of day case who stayed overnight will reduce from 8% of day-case patients per month to 2% of day-case patients per month	Average of 98 per month	Revised target On Track
3.5		Reduction in the average number of on day cancellations	The average number of on the day cancellations per month will reduce from 100 per month to 35 per month	Average of 100 per month	Revised target On Track

Improvement Trajectory

Ref		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
1.1				80%	80%	80%	80%	80%	80%	80%
1.1				80%	80%					
2.1	Revised target									
2.1	Actual									
2.2	Revised target									
2.2	Actual									
3.1	Revised target									652
3.1	Actual									
3.2	Revised target									978
3.2	Actual									
3.3	Revised target									
3.3	Actual									
3.4	Revised target									22
3.4	Actual									
3.5	Revised target									35
3.5	Actual									

Ref		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
1.1		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
1.1													
2.1	Revised target		67	113	148	189	214	278	318	318	318	319	319
2.1	Actual												
2.2	Revised target		47	44	37	30	21	16	13	14	15	13	11
2.2	Actual												
3.1	Revised target	987	964	1192	1258	1542	1457	1597	1369	1508	1558	1322	1087
3.1	Actual												
3.2	Revised target	1269	1085	1192	1192	1388	1311	1437	1232	1357	1402	1190	978
3.2	Actual												
3.3	Revised target												
3.3	Actual												
3.4	Revised target	28	24	26	26	31	29	32	27	30	31	26	22
3.4	Actual												
3.5	Revised target	35	35	35	35	35	35	35	35	35	35	35	35
3.5	Actual												

Ref		Jan-22	Feb-22	Mar-22	Apr-22	Financial Impact	Quality Impact
1.1		80%	80%	80%	80%		
1.1							
2.1	Revised target	320	320	320	320	Equivalent to £14,493	The pre-op service will
2.1	Actual						
2.2	Revised target	14	13	15	15	Equivalent to £6,677	The pre-op service will be
2.2	Actual						
3.1	Revised target	1410	1205	1324	1324	None	The theatres service will be actively seeking feedback from their
3.1	Actual						
3.2	Revised target	1269	1085	1192	1192	None	The theatres service will
3.2	Actual						
3.3	Revised target					? Will there be a	Patients won't wait as
3.3	Actual						
3.4	Revised target	28	24	26	26	? Equivalent reduction in bed days?	? Balancing measure: ensure no increase in readmissions?
3.4	Actual						
3.5	Revised target	35	35	35	35	None	Staff will spend less time discussing and recording cancellations
3.5	Actual						

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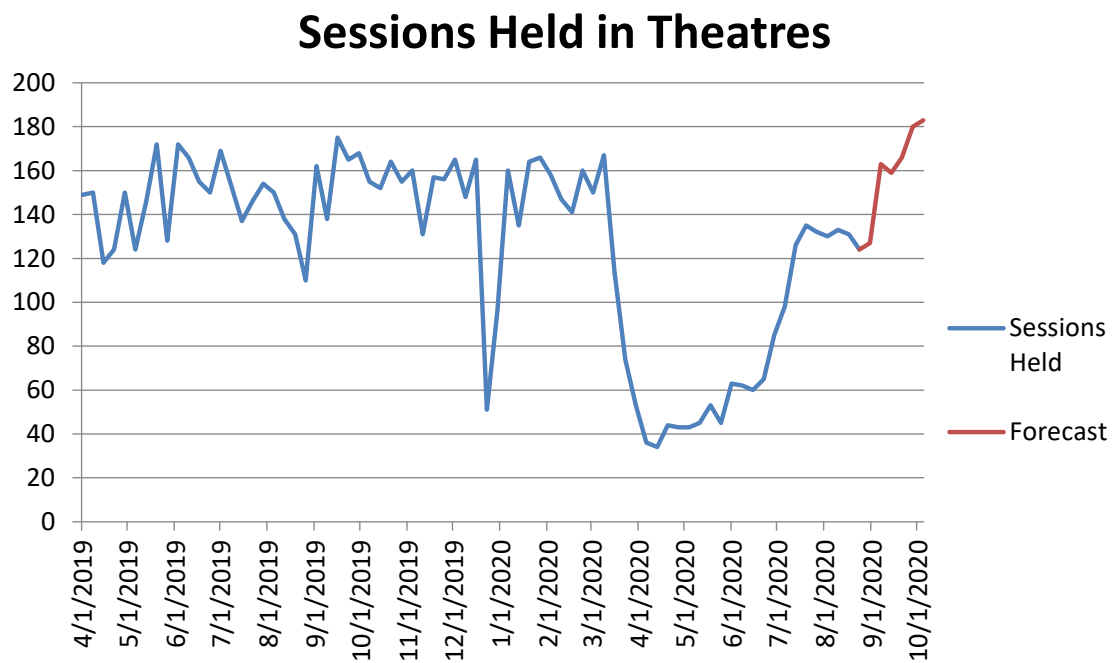
Perioperative KPIs - Context: activity

Wirral University Teaching Hospital NHS Foundation Trust

- Activity levels significantly decreased during the COVID-19 pandemic
- This chart shows the progress to date with resuming normal activity levels, together with a forecast to October 2020
- The forecast is based on the current 6 weeks lock down for scheduled sessions, which the department have been able to deliver through the introduction of new processes and procedures, supported by the implementation of the new scheduling system.
- This demonstrates a forecast above pre-COVID sessions



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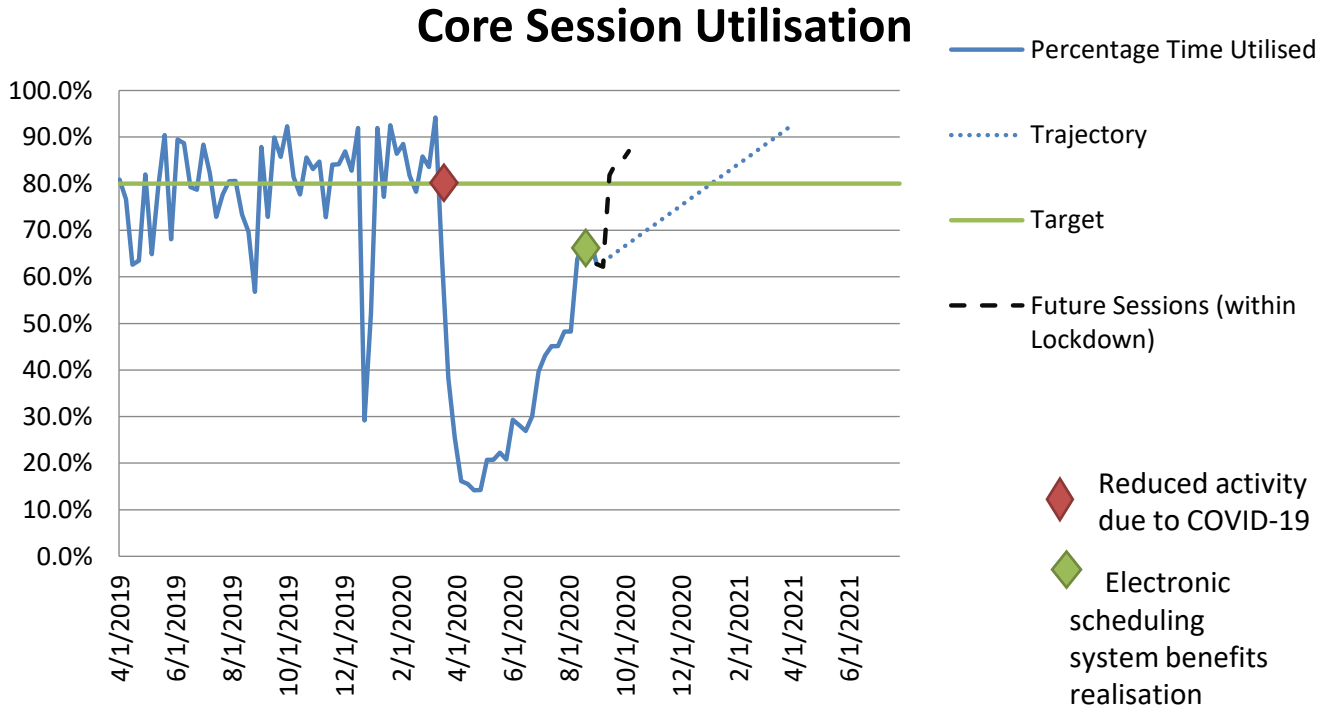
Core session utilisation

Wirral University Teaching Hospital NHS Foundation Trust

- The service aims to run a minimum of 80% of all available scheduled theatre sessions
- This chart shows the negative impact of COVID on core session utilisation and the positive improvements with recovery and restart to date
- Without any intervention, recovery to normal core session utilisation rates would have tracked on the dotted blue line, a slower recovery period
- With the intervention of locking down sessions at 6 weeks (supported by the electronic scheduling system), the service can offer a quicker recovery (dotted black line) and this is the current forecast as per 6 week lockdown.



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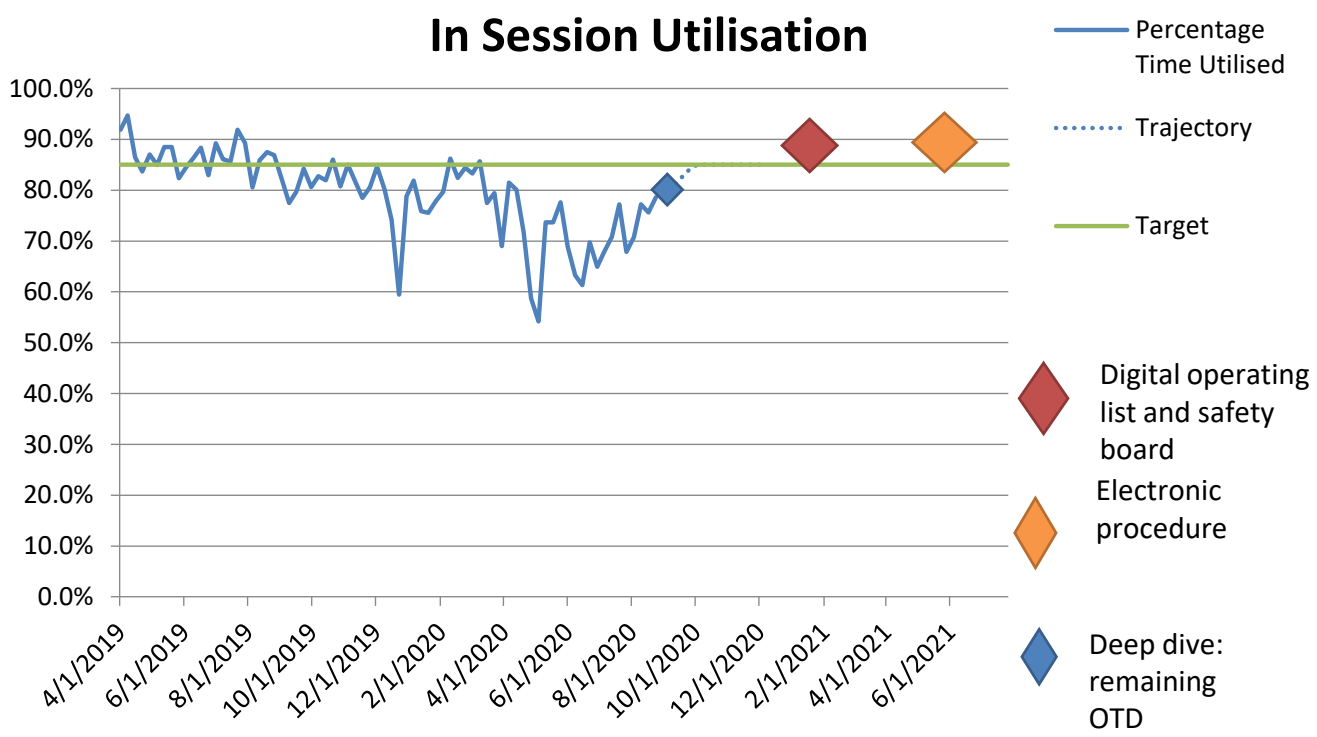
In-session utilisation

Wirral University Teaching Hospital NHS Foundation Trust

- The service aims to use a minimum of 85% of available time within all sessions
- Attainment of this measure was sporadic pre-COVID and then suffered a further downturn as a result of the pandemic
- This chart shows the impact of the restart and recovery work to date in bringing levels back and then which of the improvement projects will improve and sustain utilisation levels over the coming year.
- These projects are on track against the milestones



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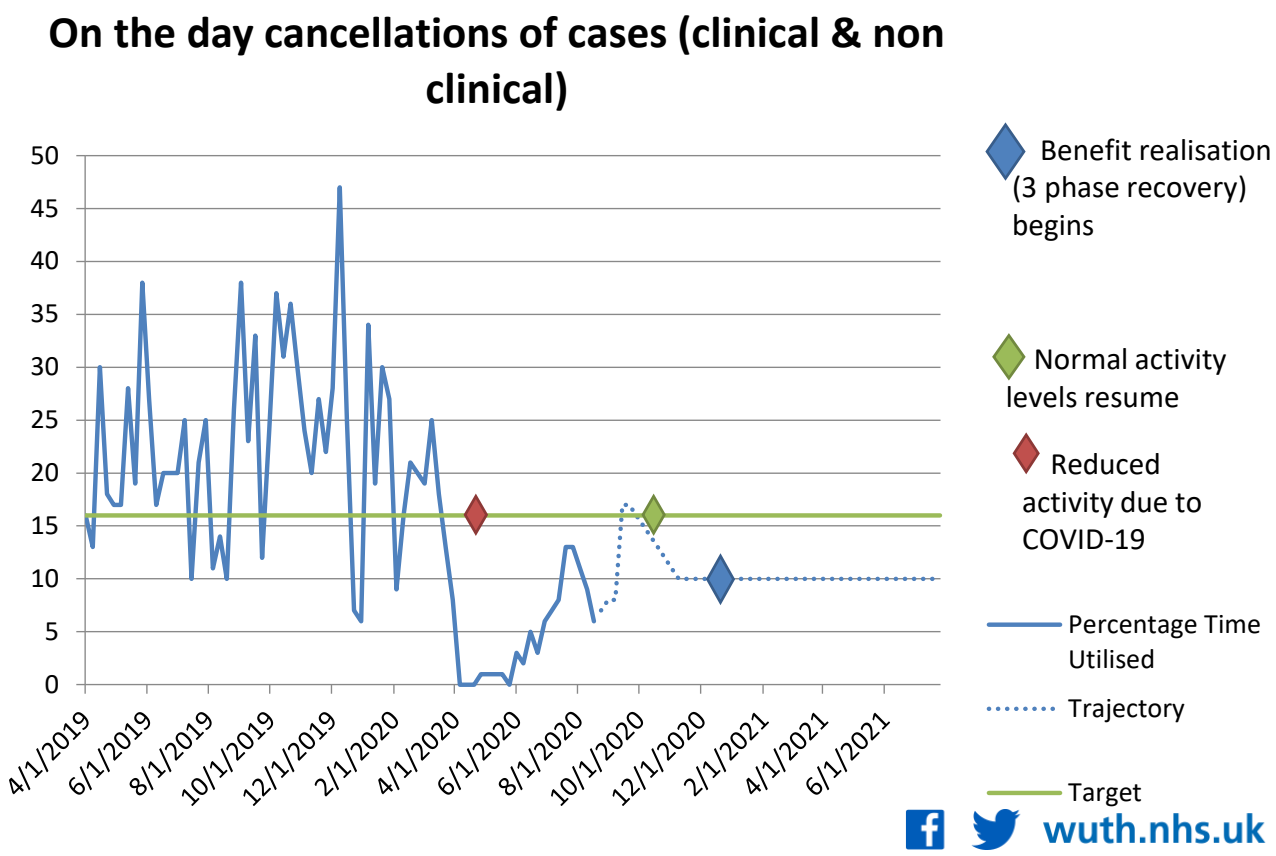
On the day cancellations: clinical and non-clinical

Wirral University Teaching Hospital NHS Foundation Trust

- The reduction in planned activity due to COVID has brought cancellations down but, as activity levels increase, we are seeing a corresponding or proportionate increase in cancellations
- This chart shows that there has been a small reduction in recent weeks, however this is suspected to be due to a delay in data entry in Cerner. One of the projects is specifically to address this issue with an aim for real-time reporting.
- The more sustainable impact on cancellations will come from the three phase recovery unit being fully operational, in December 2020



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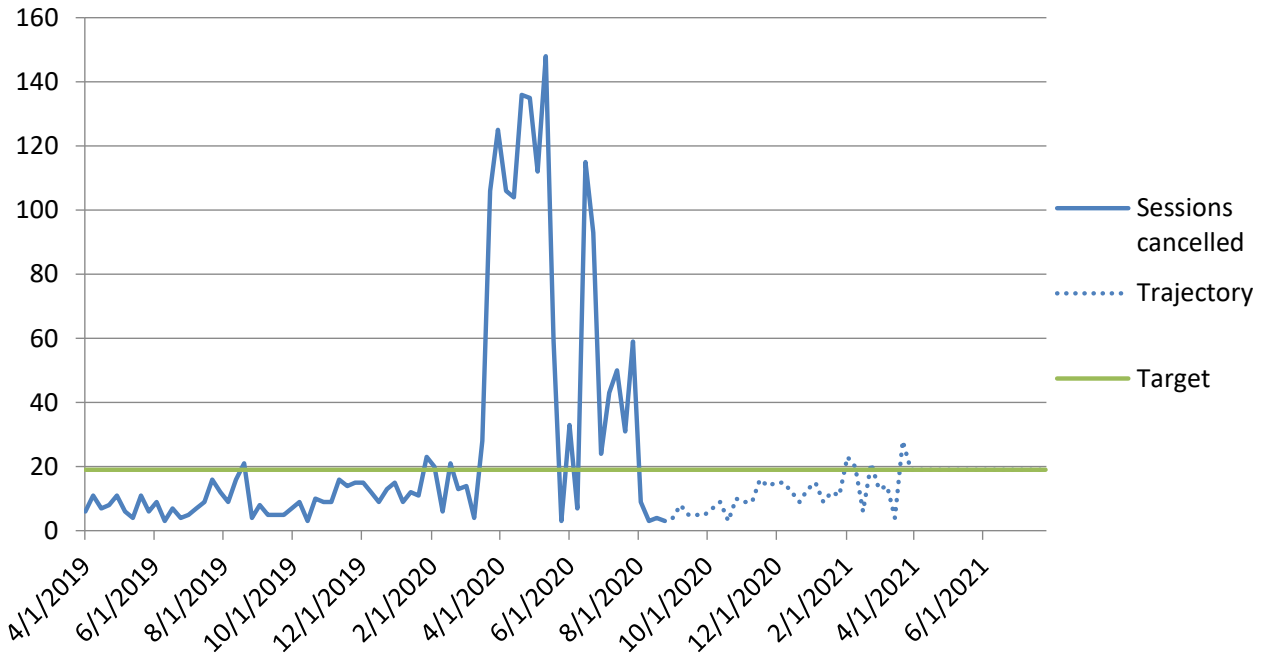
Late Notice Cancellations: within 28 days

Wirral University Teaching Hospital NHS Foundation Trust

- The reduction in planned activity due to COVID has increased cancellations but, as activity levels increase, we are seeing a corresponding or proportionate increase of late cancellations, which will be levelled off as improvements are introduced.
- As the theatre sessions are confirmed at a six week lock down (greater than 28 days), this is driving down the number of cancelations within 28 days.

Late Cancellations of Sessions (within 28 days)



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Wirral University Teaching Hospital
NHS Foundation Trust

Programme Assurance Ratings

Joe Gibson
16 September 2020

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

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Green	Delivery	Red

- The key '21day + LoS' metric for the Flow Programme is reported at the end of August as 59 Long Stay Patients against the target of 52; at the 'Back Door' project meeting on 3 September the number was reported as having risen to 74. Moreover, the 'Capacity Management KPIs' give cause for concern.
- The 'Front Door Project Post-COVID Re-Start' (PowerPoint), 6 Jun 20, states benefits have been agreed; The 'Benefits Tracking Tool' shows the ED Improvement Plan rated green. The 16 other (assessment unit) benefits are re-scheduled, per exception report to Prog. Board, to be delivered by 1 Jan 21, of these: 16 have no date of baseline; 8 have no baseline; 8 have no data entries; and 2 have no target.
- **The 'Capacity Management' system, launched 9 March 2020, is delivering a 93%/94% accurate accurate picture of the Trust position in July/August respectively; the system needs to be highly reliable (the Programme Board and Steering Group have called for 100%) because even at 95% one data point in 20 will be in error and the system unreliable. A plan needs to be devised to address the issue and accuracy checks continued until stable (3-6 month) 100% reliability is established.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Amber

- The revised PID v0.5 dated 4 Mar 20, as approved by the Programme Board - including an extensive schedule of benefits and measures - remains extant. The programme has devised revised trajectories, post the first phase of COVID-19, and these will now be monitored for evidence of the planned improvements.
- The 'Benefits Tracking Tool' shows 9 metrics on track (albeit 'actual' data entry starts in Dec 20 for most of these) while 11 metrics await 'further definition'; of these 11, 2 have benefit start dates of Dec 20 and 3 in Mar 21.
- **As stated in the previous report, 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 - September 2020 - Top 3 Priority Projects - Summary

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Amber	Delivery	Amber

- **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; this was to be achieved by providing outpatients services by remote (non-Face-to-Face) means. The % use of non-F2F options had stabilised in a range of 52-59% over the 12 weeks 27 Apr - 13 Jul; from 20 Jul to 24 Aug the range has moved down to 49-39% in a descending pattern. Setting this in context, as the programme reports: whilst the Trust has attained the national 25% Non-F2F target in August **(39%)** the 60% non-F2F target was not achieved **(40%);** 53% of new appointments were delivered non-F2F. **A QIA/EA should be completed and signed off, 6 months into the new way of working, to underpin quality assurance.**

- **Compliance and Exceptions:** As can be seen from the RAG-rated divisional reporting, the programme team continues to work with 36 specialties, across 4 divisions, to identify clinical exceptions that would admit a face-to-face consultation to occur. Detailed reports on the completion of this work should continue to be presented to future Programme Boards until such time as the position is stable and in line with Trust expectations.

- **One Patient Record:** The programme continues to implement a single patient record which will replace paper case notes in Outpatients. The programme is tracking the numbers of requests for notes and those numbers are still material. A detailed report on the solutions should be presented to a future Programme Board.

- **Targets to be resolved: As stated previously, 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 need to mediate the two reference sources:**

    - **The programme cites Simon Stevens - 3rd Phase of NHS response to Covid letter, dated 31 Jul 20: Overall 25% Non-F2F, FU appts 60% Non-F2F.**
    - **Divisional submissions by specialty - Programme Board 19 Aug 20 - gives % Non-F2F Trust-wide: New appts 37% Non-F2F, FU appts 45% Non-F2F**

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Workforce Planning - Programme Assurance Update – 7 September 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 – 7 September 2020

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

Independent Assurance Statement

1. Scope defined in PID v10 dated 3 Mar 20 (benefits to be completed by 30 Apr 20). There is a proposal, 'Front Door Project Case for Change', to be considered by the 'Programme Steering Group' on 9 Sep 20. **2. & 3.** ToR, v3.0 dated 7 Jan 20 and evidence of team meetings up to 31 Jul 20 but nothing more recent. **4.** There is a list of stakeholders and a 'Front Door Stakeholder Engagement Log', with a list of meetings to mid-Aug 20. 'As is' mapping has been conducted. A Comms Plan/evidence of comms would give further assurance. **5.** A EA/QIA v1 has been drafted, 3 Feb 20, for the Front Door AU and awaits sign-off once there is clarity on the future design. **6.** The project plan, workbook dated 2 Sep 20, is updated to w/c 30 Aug 20. There are a number of delayed actions and several revised milestones (RM) yet to be completed. The plan only extends to w/c 12 Oct 20, 6 weeks hence, while many benefits show delivery in Jan 21. **7.** The 'Benefits Tracking Tool' shows the ED Improvement Plan rated green. The 16 other (assessment unit) benefits are re-scheduled, per exception report to Prog. Board, to be delivered by 1 Jan 21, of these: 16 have no date of baseline; 8 have no baseline; 8 have no data entries; and 2 have no target. **8. & 9.** There are 10 risks on the register; most with Jul/Aug 20 review dates; however, the clinical engagement risk was last reviewed 12 Dec 19. There are 14 live issues logged. **Most recent assurance evidence submitted 4 Sep 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 – 7 September 2020

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

Independent Assurance Statement

1. The PID, 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'. **2 & 3.** Some evidence of CapMan project meetings is uploaded in an 'Action Log' to 13 Aug 20 as well as a 'Cap Man Triumvirate' Meeting of 3 Sep 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, updated 9 Aug 20; 6 actions are rated by the project as green and 3 are rated amber (the latter are without delivery dates). **5.** EA has been drafted and QIA signed-off. **6.** The CapMan Project Plan, workbook dated 4 Sep 20, indicates actions updated to w/c 7 Sep 20; however, several actions are behind schedule and some actions dating back to w/c 10 Aug have not been given a status or revised date. The Plan shows closure in Dec 20 with no further actions after w/c 28 Sep 20 (template is also missing October 2020). **7.** Metrics for the 9 benefits being reported to the Programme Steering Group on 11 Sep show 5 substantially off-track and only one hitting the target. **8 & 9.** The risk register shows 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 4 Sep 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 – 7 September 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. 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' dated 8 Jun 20. Guidance on the implementation of the (Gov't) 'Discharge to Assess' model was approved by the CAG at the beginning of Sep 20. **2. & 3.** The ToR for the Project Team is version 1.0 dated 27 Nov 19. There is evidence of project team meetings, with Action Log, to 6 Aug 20 but nothing more recent. **4.** There is evidence of stakeholder engagement and guidance: 'Flagship Ward', 'Ward Improvement Pack', 'Board Round Script'. The Comms Plan for the project shows 3 actions RAG rated but 7 actions due in August are unrated. **5.** There are 'post-COVID' EA/QIA drafted awaiting sign-off. **6.** The project plan was last updated w/c 27 Jul shows all actions will complete by 28 Sep 10; however, original PID benefits schedule extends to 31 Mar 21. Project meeting of 3 Sep 20 agreed the Ward Improvement Plan (runs to Dec 20) will be paused to allow communication of the 'Discharge to Assess' model. **7.** The workbook 'Benefits Tracking Tool' has 5 key metrics: 33% of patients discharged before midday (at 14% in July); and 4 related to LoS of patients. The project meeting of 3 Sep stated that the key 21-day LoS (Long Stay Patients) target of 52 has been breached and was standing at 74 (data awaited on SharePoint). **8. & 9.** The risk register has 3 open risks last reviewed on 6 Aug 20. No issues recorded. **Most recent assurance evidence submitted 4 Sep 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 – 7 September 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 and also an attendance record. **6.** The project plan is updated to w/c 30 Aug 20 and reflects the updated milestones in the revised PID and is broadly on track - the 5 month delay to the 'Trauma Documentation' build was covered by an exception report - albeit there is now a 2 week delay due to lack of 'IT resourcing issues'. **8 & 9.** There is a populated risk register, with five risks, and the 'date of last review' is 2 Sep 20. There are six open issues, including non-attendance at project meetings, and these were last reviewed on 2 Sep 20. **Most recent assurance evidence submitted 4 Sep 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 – 7 September 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 was 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 also a 'Patient Safety and Experience Project Group' (to 1 Sep) and an 'Operational Excellence Project Group' (to 4 Sep). **3.** The Perioperative Steering Group has ToRs revised in Jan 20 and evidence of meetings up to 25 Aug 20. **4.** There is a Comms Plan, 19 Feb 20, supplemented by a Comms tracker updated to 19 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 broadly on track, the exception report having been endorsed by Programme Board in June 2020 (establishing a new baseline), but with a number of delays emerging in WorkStream 8, Electronic Booking Form . **7.** The 'Benefits Tracking Tool' shows 9 metrics on track (albeit 'actual' data entry starts in Dec 20 for most of these) while 11 metrics await 'further definition'; of these 11, 2 have benefit start dates of Dec 20 and 3 in Mar 21. Revised KPI trajectories are being presented to the Steering Group on 9 Sep 20. **8 & 9.** There are 4 open risks (1 red rated last reviewed in Jun 20) and 3 issues logged in the workbook. **Most recent assurance evidence submitted 3 Sep 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 – 7 September 2020

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

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 (which shows 4 tasks overdue that were planned to complete in Jul 20) last uploaded 3 Aug 20 and a record of meetings (with notes) to 11 Aug 20. **6.** There is a Theatre Scheduling workbook v1.3 uploaded on 28 Jul 20; it is updated to w/c 6 Jul 20 but has not been updated since; it 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 1 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 – 7 September 2020

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

Independent Assurance Statement

1. The DRAFT PID v3.0 agreed by Outpatients (3 Aug 20) and Programme Steering Groups (10 Aug 20). The key benefit, defined therein as '50% of Outpatient Consultations to be converted to Non-face to face (Telephone or Video)', needs re-visiting. **2.&3.** Project Team ToR v2.0, authorised 10 Jun 20, with evidence of meetings to 2 Sep 20 and an Action Log (6 overdue actions from late Aug/early Sep). **4.** The 'Outpatients Comms Plan', last updated 10 Jun 20, is being replaced by each work-stream/rapid improvement project delivering a comms plan. One Comms Plan is in evidence for 'Video Consultations' and needs tracking (RAG rating). **5.** The revised Draft QIA/EA, raised after the rapid (COVID-19 driven), is prepared but still awaits sign-off. **6.** The project workbook, dated 1 Sep 20, shows the project plan broadly on track to w/c 30 Aug 20, a new baseline was established by exception report to June 20 Prog. Board, with programme completion in Mar 21. **7.** The KPI data at 24 Aug 20 shows the Trust exceeding, at 53%, the national 25% Non-F2F target for New appts but not achieving, at 40%, the national 60% Non-F2F target for Follow-Up appts. Both KPI results have been trending lower from mid-June 2020. **8 and 9.** There are 11 live risks, most updated to 2 Sep 20 (1 updated to 5 Aug 20). There are 7 closed issues and 4 open. **Most recent assurance evidence submitted 4 Sep 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 – 7 September 2020

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

Independent Assurance Statement

1. A PID v2.0 dated 3 Jul 20 is in evidence for 'Outpatient One Patient Record' and is reported as signed off by the Project Lead; 'high level benefits' are identified in the PID. There is also a 'Decisions and Actions' presentation dated 3 Jan 20. **2.** There is a project team ToR as approved on 31 Jan 20. There is a 'Meeting Log' on SharePoint which has evidence of meetings to 3 Sep 20 and also the agenda of the project meting on 3 Sep 20; the last 3 meetings have only had 2 participants (the PID defines a team of 6), wider attendance should be sought. An 'Action Log' tracks task completion, uploaded on 3 Sep 20, with 1 action overdue. **6.** The workbook is updated to w/c 7 Sep 20; it shows the plan largely on track with a final closure date of Apr 21. The Milestone Plan has been annotated to show 'Milestone revised due to review of Clinical Note Structure', the project plan also need to be amended to reflect this change. **8&9.** The workbook has a risk register, with 8 live risks reviewed to 3 Sep 20 (and 1 to 28 Aug 20). Two project issues are both now closed. **Most recent assurance evidence submitted 3 Sep 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 – 7 September 2020

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

Independent Assurance Statement

1. PID v1.0 dated 28 May 20 approved at Programme Board, May 20. The 'Patient Portal Mass Registration Proposal' dated 24 July 20, was presented to the Programme Steering Group on 10 Aug 20 but not agreed. At the Programme Board on 19 Aug 20 it was agreed that the project didn't require SIT resource but that it should not be transferred to DPSOC; a clear 'Step Back Plan' will be considered at Sep 20 Prog. Board. **2.** There is an Action Log and evidence of meetings to 19 Aug 20. **3.** 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 await sign-off. **6.** There is a comprehensive project plan, updated to 5 Aug 20, although this is largely in abeyance pending a decision on 'Scope' (see 1. above). **7.** The Benefits Tracking Tool now details benefits across 10 categories under 3 domains; all targets are currently given an amber 'draft' status by the project. The Portal Audit Data, to 29 Jun 20, shows some progress but well below the target set. **8 & 9.** Nine open **r**isks have been updated to Jun/Jul 20 and there are 2 open issues in the workbook. **Most recent assurance evidence submitted 26 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 – 7 September 2020

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

Independent Assurance Statement

1. The project is defined by: Digital Dictation Business Case v0.3, is labelled as 'approved by TMB on 22 Jun 20'; a draft PID, v0.1 dated 22 Jun 20; a position statement to DPSOC dated 5 Aug 20; and a 'Service Specification and System Requirements' v0.6. **2.** There is evidence in the Action Tracker of project meetings and discussions to 24 Aug 20 and a ToR for the project group. **6.** There is a Digital Dictation workbook uploaded to SharePoint on 2 Sep 20 and the project plan has been updated to w/c 24 Aug 20 and is largely on track. **8 & 9.** The risk register for the project shows 4 open risks raised with 3 last reviewed on 1 Sep and the remaining 1 reviewed on 17 Aug 20. There are 2 open issues recorded. **Most recent assurance evidence submitted 2 Sep 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	20/21 147
Title of Report	Capital Committee – Terms of Reference
Date of Meeting	7 October 2020
Author	M Swanborough, Director of Strategy
Accountable Executive	COO, CFO, DoS
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	Approval required
Data Quality Rating	Bronze – qualitative data
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

The attached report provides detail on the Terms of Reference for the Capital Committee. The Committee is established as an Assurance Committee of the Board of Directors to seek assurance on behalf of the Board of Directors with regards to the design, development and delivery of the Trust's capital programmes.

The Board of Directors is asked to approve the Capital Committee Terms of Reference.

2. Background

To provide assurance on the design, development and delivery of the Trust's capital programmes, including financial, operational delivery and future capital and estates plans a Capital Committee is sort. This Committee will be authorised by the Board of Directors to investigate any activity within its terms of reference. The Terms of Reference outlined in this report provides the requisite necessary to assure the Board of Directors of the Trust's capital programmes.

3. Next Steps

Following approval by the Board of Directors the Capital Committee will be established.

4. Recommendation

The Board of Directors is recommended to:

- Approve the Capital Committee Terms of Reference

Wirral University Teaching Hospital
NHS Foundation Trust

Capital Committee

Terms of Reference

Authors Name & Title: M Swanborough, Director of Strategy	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: Nil	
To be read in conjunction with the following documents: **Corporate Governance Manual (including Scheme of Reservation and Delegation and Standing Financial Instructions)**	
Document for public display? Yes	

Unique Identifier:	**Commencement Date: October 2020**	
Issue Status: DRAFT	**Issue No: 0.1**	**Review Date: Annual from commencement**
Authorised by: Board of Directors	**Authorisation Date: October 2020**	
After this document is withdrawn from use it must be kept in an archive for 10 years		
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Officer responsible for archive: Author		

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance on behalf of the Board of Directors with regards to the design, development and delivery of the Trust's capital programmes. This includes the financial and operational delivery of capital programmes and development of future capital and estates plans, within the context of the requisite licence regulatory requirements and statutory obligations. This is a Non-Executive chaired committee.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any reasonable request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources within the delegated limits of the Committees members.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.

The Committee has authority delegated by the Board of Directors to:

2.1 Receive assurance on all aspects of the delivery of capital programme and significant variances to planned levels of achievement.

2.2 Ratify and review policies and procedures required for effective management of capital programme and estates function across the Trust as defined by the Committees work plan, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups

2.3 Review proposed new developments and investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.

2.4 Review capital investments in line with the Board approved Treasury Management Policy.

2.5 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meeting.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To receive, monitor and seek assurance on risks relating to capital and estates, referred in accordance with the Risk Management Strategy

3.1.2 Approval of the Campus Master Plans and strategies for capital and estates that support the delivery of the Trust's Strategy and clinical service strategies

3.1.3 To monitor the implementation of the capital strategy, annual capital plan and estates delivery, directing action and support, where appropriate

3.1.4 To keep under review the land holdings of the Trust, advise the Board on acquisitions and disposals and monitor progress against schemes

3.1.5 To monitor and review business cases associated with major and minor capital developments

3.1.6 To receive audit reports and action plans, agree solutions and monitor progress

3.1.7 To monitor the development of capital commercial opportunities across the Trust

3.1.8 To agree a set of key performance indicators for the assessment of capital programmes and estates delivery

4. Equality and Diversity

The Committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

- Nominated Non-Executive Director (Chair)
- Chair
- Non-Executive Director – Steve Igoe
- Non-Executive Director – Sue Lorimer
- Non-Executive Director – Chris Clarkson
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy

6. Attendance

The following officers may attend the Committee:

- Director of Capital Planning
- Director of Estates
- Director of Corporate Affairs

Other officers of the Trust will be invited to attend as requested by the Committee.

All members are expected to attend all meetings with attendance being reviewed annually; attendance below 80% will be discussed with the Committee Chairman at the earliest opportunity.

7. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors

The Committee shall meet at least 4 times a year, in accordance with a planned business cycle that is agreed at the start of each year (April).

8. Reporting

The Committee will report to the Board following each meeting via a Chair's report.

Unapproved minutes will be circulated to committee member by email as soon as is practicable following the meeting.

9. Conduct of Committee Meetings

The Executive Director Lead, in liaison with the Chair of the Committee will ensure that the appropriate processes are followed:

- An annual capital plan reflecting the Committee's business cycle will be prepared by the end of March each year for the forthcoming year.
- Minutes and action log will be kept by the Committee Secretary on behalf of the Chair
- The agenda will include the following standing items:
    - Minutes of last meeting
    - Action Log
    - Risk
    - Financial Management and Assurance
    - Regulation
    - Performance and improvement
    - Group Reporting
    - Recommendations to the Board
    - Evaluation of Meeting and Papers
    - Date of next meeting

- The agenda and supporting papers will be sent out 3 working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.
- Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.
- Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.
- Distribution of minutes and archiving of documentation will be managed by the Committee Secretary in accordance with standard procedures.

BOARD OF DIRECTORS	
Agenda Item	20/21 148
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	7 October 2020
Author	Sue Lorimer, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1 PR3 PR5
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee

This report provides a summary of the work of the FBPAC which met on the 29th September 2020. Key focus areas are those which address the gaps in assurance in the Board Assurance Framework and areas of development work to bring to the attention of the Board of Directors.

1. Matters arising

The Committee noted the approval of the following business cases which had taken place outside the meeting:

- Community X-Ray Rooms (£359k) - this project is funded from the 2020/21 capital programme approved by the Board of Directors.

- Patient monitoring in surgery (£487k) - this project is funded from the 2020/21 capital programme approved by the Board of Directors.

- Microsoft N365 – to be implemented when current licences agreements expire.

2. Finance Report for the period ending 31st August 2020

The Committee received the month 5 finance report and noted the continued break even position supported in August by a £432k retrospective top up payment to cover the net costs of COVID-19.

Delivery of the capital programme in 2020/21 remains a key risk which was picked in in detail elsewhere on the agenda.

The committee discussed the need for continued focus on financial discipline and a robust understanding of the underlying run rate as we enter 2021/22. The need to keep a keen focus on system sustainability and strong messages about the underlying deficit will need to be managed given the temporary break-even positon we continue to report this year.

3. Finance regime for the period 1 October 2020 to 31st March 2021

The Chief Finance Officer shared a series of slides which updated the Committee on the recently released guidance on the finance regime which will be implemented from 1 October 2020.

The retrospective top up system will cease on 30th September 2020 and will be replaced by a fixed funded envelope allocated to each system. A number of funding streams have been allocated at Cheshire and Merseyside Health and Social Care Partnership (C&M HSCP) level and work is ongoing to determine how best to distribute these funds to individual organisations.

The Committee reviewed a summary of a draft plan submitted to C&M HSCP and further iterations are expected until the end of October 2020, including more detail on the funding streams allocated at C&M HSCP level.

It was noted that the CFO will provide a further update on this to the Board of Directors in its meeting on 7th October 2020.

4. Management of the Capital Programme in 2020/21

The committee received a presentation from the Chief Finance Officer and Chief Operating Officer setting out the risks, management and governance arrangements associated with delivering the significant capital programme in 2020/21. A number of actions have been taken to support and accelerate progress and to ensure that all projects are delivered safely. Two additional programme managers have been commissioned to support the in-house team.

The operational challenges of delivering a £16m capital programme over winter and during a pandemic are a key focus of the team developing the plans. Approximately £5m of this relates to additional allocations which have been notified to the Trust in the last 6 – 8 weeks.

Slippage on some of the significant ward refurbishments and other associated work is now inevitable and the forecast will be revised for month 6 following a detailed review by the Capital team.

The chair of the committee received confirmation that a capital governance assurance group was being established and that the Terms of Reference would be shared at the next board meeting.

5. Urgent Care Centre

The committee received a presentation form the consultants supporting the development of the Urgent Care Center Business Case which remains on target for completion at the end of October

2020. It was noted that this would be subject to review and approval at the newly established Capital assurance group.

6. Quality Performance Dashboard report

The Quality Performance Dashboard report was reviewed. Key risks on cancer, 52 week waits and RTT were discussed together with the performance against recovery phase 3 targets, which will be incorporated into future reports.

7. Renewal of Trust Insurance 2020/21

The Interim Head of Governance presented a proposal to renew the Trusts insurance which was due to expire on 29th September 2020. The committee challenged the requirement for private top-up insurance and asked that further work was done to understand the Trusts legal requirements for this.

Further checks were to be undertaken by Executives to clarify the conditions of Trust license, its legal position and also to understand what cover arrangements other Trusts have. A decision to extend for a limited period of 1 year would then be confirmed subject to the outcome of the clarifications points requested.

8. Recommendations to the Board

The Committee recommends that Board of Directors note the contents of this report.

BOARD OF DIRECTORS	
Agenda Item	20/21 149
Title of Report	Report of the Audit Committee
Date of Meeting	7 October 2020
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
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 Audit Committee

This report provides a summary of business conducted during a meeting of the Audit Committee held on 22 September 2020.

1.Internal Audit

a) **Progress report**- A detailed progress report from MIAA was received. Key messages for the Committee included:
   a. Confirmation of a review of the Trust's internal audit risk assessment and plan in the light of COVID-19.
   b. Confirmation of delivery and work being undertaken in relation to the 2020/21 plan.
   c. Follow up of previous actions raised.

d. Confirmation of continued support to the Trust within the workforce intelligence team and Organisational Development team.
e. A detailed Audit report was received in relation to Medicines Management which confirmed “moderate Assurance”.
f. A detailed Audit report was received in relation to Governance and Divisional Performance Review which confirmed “Substantial Assurance”.
g. A review was undertaken to assess the approach the Trust takes to maintaining and using the Assurance framework to support the overall assessment of governance, risk management and internal control. The review is being undertaken in three parts. In terms of the initial piece of work MIAA confirmed that processes in place to update the Assurance Framework are robust. The framework was visibly reviewed by the Organisation and clearly reflected the impact of COVID-19.

b) **Revised Internal Audit Plan** – This had been discussed with members of the Audit Committee out with of the meeting and agreed. The meeting formally ratified the updated and Revised plan for 2020/21.
c) **COVID-19 Financial Governance review**- As a response to the challenges presented in relation to financial Governance by COVID, a review was commissioned to look at the Trust’s responses to the issue. The assessment confirmed that the Trust had considered many of the Financial Governance risks arising from the COVID pandemic and a particular focus had been given to approval processes for revenue and capital expenditure. Some gaps had been identified and to the extent that they required resolution Management confirmed that they were being appropriately resolved.
d) **Internal Audit follow up** – MIAA confirmed positive action in following up and resolving issues raised in previous reports. The Committee noted the challenging longer timescales in relation to the IPC report (April 2021) and asked for an interim report in January to confirm progress was being made in resolving the issue thereby ensuring that the April dates identified were met.
e) **Anti-Fraud Progress report** – The regular Audit Committee report in relation to this issue was received from MIAA. Substantial activity had been undertaken in relation to: Strategic Governance; Inform and Involve; Prevent and Deter and Hold to Account. The plan delivery dashboard confirmed each indicator as green other than Inform and Involve which is Amber reflecting delays as a result of the impact of COVID-19.the trust is rated green on all NHSCFA Counter Fraud standards.

2.Governance and Other Assurances

a) **Financial Assurance Report** – The Committee reviewed the regular financial assurance report including summaries of losses special payments, debtors and impairments. It noted the continuing losses in relation to pharmacy from temperature issues and queried if this was a result of failing equipment. It was agreed that this would be reviewed by management. The Administration of one to one was discussed and a request made to consider the history of this supplier relationship and whether there were any lessons that could be learned.
b) **Single Tender Waivers** – the list was reviewed and whilst it was noted that the amount year on year had reduced the sums were still significant. The particular challenges of the capital programme going forward were noted. Management confirmed that the use of frameworks and specialist consultants would assist with the management of these issues.
c) **Tracking Audit Actions** – Positive progress continues in resolving issues raised as independently verified in the earlier update from MIAA.
d) **Compliance with Licence** – A detailed review of the NHS Foundation Trust Code of Governance was presented. This will be a regular item for Audit Committee scrutiny in the future. Many of the actions identified relate to the Governors and this and a detailed action plan will be discussed at the next Governor meeting.
e) **External Audit Tender** – The Committee were updated on the process for the required tendering process for External Audit for the year 2020/21 and beyond. This will also be raised and discussed at the next Governors meeting as the appointment of the External Audit provider is a matter for the Council of Governors.

f) **Risk Management committee report** – A detailed report was received on the current risk issues being considered by the Risk Management Committee. The report contained information in relation to: Areas being considered by the risk management committee (RMC); Issues that the RMC wished to bring to the attention of the Audit Committee; Assurances being gained in relation to those risks. RMC confirmed that it did not identify any risks for escalation. The Committee noted the report.

g) **Items for the Risk Register** – No specific issues were identified for escalation

Steve Igoe
Chair - Audit Committee
24th September 2020

Board of Directors	
Agenda Item	20/21 150
Title of Report	Report of the Quality Assurance Committee
Date of Meeting	7 October 2020
Author	Dr J Coakley, Non-Executive Director
Accountable Executive	Hazel Richards, Chief Nurse & Director of Infection Prevention & Control Dr Nikki Stevenson, Deputy CEO and Executive Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	BAF Update Approved Potential risk to quality or safety of care: • Serious incident report • CQC National Patient Survey • Draft Quality Account approval IPC Board Assurance Framework
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Choose an item
FOI status	Choose an item
Equality Analysis completed Yes/No **If yes, please attach completed form.**	Choose an item.

1. Executive Summary

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

2. **Serious Incidents & Duty of Candour**

A summary of recent SIs and completed investigations was received and noted. SIs remain stable at about four per month over the last twelve months. Brief summaries of the seven Sis in July and August, and assurance about the discharge of the Duty of Candour was given. Four recently completed SI investigations were reviewed and approved.

Fifteen new claims have been received and were noted by the committee.

An investigation into a serious incident from June 2020 (fractured neck of femur in an inpatient) was reviewed and approved.

3. **National Patient Survey**

This showed improvement against previous reports. Across twelve domains, performance was improved in seven (for example privacy in ED, cleanliness of wards, waiting lists), the same in two and worse in one (waiting to get a bed on a ward). Two domains were not comparable to previous years because the questions were different. Overall WUTH's performance was broadly in line with other local trusts, but scored better on providing help with meals. No indicator for WUTH was banded 'worse' than local trusts, the first time in three years that this has happened.

4. **Draft Quality Account approved**

Quality Accounts are required annually but the requirements have been significantly altered this year. In particular a Quality Report is not required and the deadline is not fixed, although a 'suggestion' of mid-December has been offered.

The priorities for last year were:

- Improve patient flow - some improvements but not consistently maintained
- Improve nutrition and hydration - significant improvement
- Reduce pressure ulcers - changes in methodology mean result not comparable to previous years

The suggested priorities for this year include

- Improved inpatient and outpatient patient experience judged by FFT
- Reduction in falls
- Reduction in healthcare associated infections
- Zero tolerance for hospital acquired category 3 pressure ulcers
- Nutrition and hydration MUST scoring 95% or greater
- Mortality reviews showing less than 2% avoidable factors

The draft Quality Account was approved by the Committee.

5. **Covid 19: IPC BAF**

Version 1.2 of the IPC BAF was published by NHSE/I in June 2020 and updated in the light of Covid 19. There are ten criteria in the IPC Code of Practice, and the trust added an additional criterion on leadership. A self-assessment exercise was carried out by representatives from across the divisions, corporate teams and the IPC team. Significant assurance was found for seven standards and limited assurance for four. Work will continue to test this again over the coming months.

6. **Review of BAF**

The committee approved the revised BAF for items relating to Quality Committee.

BOARD OF DIRECTORS	
Agenda Item	20/21 151
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	7 October 2020
Author	John Sullivan, Non-Executive Director
Accountable Executive Director	Jacqui Grice, Interim Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR2
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Chair's business

The meeting took place on Tuesday 22 September 2020 via Microsoft Teams. The normal agenda was resumed. Presenters of papers were requested to concentrate on 3 or 4 key points from their paper and thereby leave adequate time for Committee scrutiny. The Committee welcomed Jill Hall, who replaces Paul Buckingham on the committee, and Gary Sweeney the new interim Head of HR.

2. Workforce Dashboard.

The Committee welcomed the planned further analysis of Band 2 absence across the trust. The outlier absence levels will be investigated and root causes established to define corrective and preventative actions.

The emerging absence 'hot spot' in Women & Children Division was also noted.

3. Health & Well Being

With the greater emphasis from the Covid pandemic and focus from the NHS People Plan, a Non Executive Lead is recommended for the Trust's Health & Well Being agenda going forward.

Swabbing capacity is currently overloaded and demand is at much higher rates than previously.

The committee welcomed the organisational review of Occupational Health and Health & Well Being provisions at WUTH.

The committee reiterated the need for a Health and Well Being strategy aligned with the NHS People Plan and the WUTH Strategy.

4. NHS People Plan 2020/21 -- gap analysis

KPIs are expected for the elements of the plan and the Executive are to prioritise the Trust's response to the gap analysis. There is a sense of urgency given the 1 year duration of the plan.

It was noted that Trust Board action is required on future diversity and inclusion improvements within the Board and the Council of Governors. In addition the Trust Board will be required to form a position on greater use of flexible working and what that means in an acute hospital environment.

5. Flu Plan 2020/21

The plan was reviewed. Vaccination clinics have started. Staff vaccinations will be prioritised based on clinical risk.

6. Diversity & Inclusion Annual Report including Workforce Disability Equality Standards and Workforce Race Equality Standards.

The reports were received and approved. The Committee recorded their thanks to Sharon Landrum for the progress made to date with the D&I agenda.

7. Communications and Engagement Update

Current communications focus is on Covid pandemic developments and the launch of the Trust's new strategy. The committee noted the improvements in communications to staff since January 2020.

8. Workforce Steering Group report.

The committee welcomed the reinstatement of this meeting and the review of its terms of reference. The Group provides important assurance to the Workforce Assurance Committee.

9. Responsible Officer Advisory Group (ROAG)

Dr Nikki Stevenson updated the committee on the formation and responsibilities of the ROAG. A ROAG summary report will be provided to future Workforce Assurance Committee meetings.

10. Staff Story

It was agreed that a staff story would be reinstated on the agenda of this committee. A Ward 25 manager will be invited to the next committee meeting.

Date and time of next meeting

Tuesday 24 November 2020 1.00 -3.00 pm via Microsoft Teams.

BOARD OF DIRECTORS	
Agenda Item	20/21 152
Title of Report	Report of the Trust Management Board [TMB]
Date of Meeting	7 October 2020
Author	Claire, Wilson, Chief Finance Officer
Accountable Executive Director	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	
Data Quality Rating	
FOI status	Chairs report may be disclosed in full
Equality Impact Assessment Undertaken	

The Committee met on 24th September 2020 via Microsoft Teams. A summary of the topics covered is provided below:

1. **Divisional Updates**

The Trust Management Board received updates from each Division with the key points being as follows:

Surgery

- Division heavily focussed on elective programme recovery and utilisation of Independent Sector capacity to support this.
- Discussion took place on the issues being experienced with Spire Murrayfield and the ongoing work to manage this. Patient isolation period prior to admission is a particular issue currently as protocol at Spire is significantly longer than we have at WUFT.

- Colorectal 2 week cancer performance is a key area of focus.

Medicine

- Expected to meet recovery trajectories in September. Endoscopy is key area of focus.
- Winter planning been high on the agenda for the division with a number of schemes being launched in October to support flow.
- Currently recruiting to respiratory and ED clinical lead roles.

Women's and Children's

- Division back up to pre-COVID1-19 levels for 99% of specialities.
- Update provided on system wide Neonatal work.
- Notification received from CQC of SEND review, working with system partners on this.

Diagnostics and Clinical Support

- Microbiology service moving to 24/7 working from October 2020 as part of COVID-19 response. Positive development for patients and turnaround times.
- Update provided on Pathology collaboration with Chester. Aiming for Business Case to be developed by January 2020.
- Capital funding received for Critical care developments. Operational challenges of delivering this in the timeframe and decant options being considered.

Estates and Facilities

- Very large capital programme is key priority for division. Biggest schemes are ED and ICU which are complex and require significant stakeholder engagement. Additional resource has been brought in to support.
- Request for TMB members to support the working groups and understand operational elements of delivery.
- Long term sickness in hotel services is key focus area with some good progress in month.
- Positive outcome of environmental audit of catering services with both sites receiving 5 star ratings.

2. Quality and Performance Dashboard

The Quality Performance Dashboard was circulated to members highlighting key risks on cancer, 52 week waits and RTT. Key issues were being picked up in Divisional Performance meetings over next 2 weeks.

3. Finance Update

The Committee received the month 5 finance report and noted the continued break even position supported in August by a £432k retrospective top up payment to cover the net costs of COVID-19.

Delivery of the capital programme in 2020/21 remains a key risk given the operational complexity of the work over winter whilst we continue to manage high levels of COVID-19. Divisional teams were reminded that strong oversight and engagement in the development of schemes is a priority to ensure that projects are delivered safely and operational risks managed appropriately.

The CFO described the new finance regime coming into effect on 1 October 2020 and highlighted the early planning work which would be needed for next year's CIP programme noting that the biggest financial risk to the organisation would be failing to adequately address the underlying run rate deficit as we move into next year.

4. Winter plan 2020/21

TMB received an verbal update on Winter Planning & Capacity from the Interim Deputy Chief Operating Officer.

Plans to transfer elective activity to Clatterbridge site are being reviewed in light of challenges being experienced relating to Theatre Capacity. Further work is needed to plan for red/amber bed escalation in light if the growing levels of COVID-19 activity in the Trust.
All divisions have complied a winter plan which set out schemes to support patient flow and discharge over winter. The plans have been costed and will be considered by the Executive Team for approval. Full paper will be presented to next TMB meeting.

5. Digital Dictation Business Case

TMB considered the Outline Business Case (OBC) for digital dictation. The case was approved to move to the next phase of its development and a Full Business Case (FBC) would be brought to a future meeting. It was recognised that the payback period outlined in the OBC was not sufficient and that a more comprehensive benefit realisation plan would need to be developed as part of the FBC. It was noted that this work would be more easily progressed with clinical teams once the chosen software was identified as functionality could then be properly understood and implementation plans agreed. Final investment would be made once FBC is complete in line with Trust SFIs.

Claire Wilson
CFO
October 2020

Board of Directors	
Agenda Item	20/21 153
Title of Report	Communications and Engagement Monthly Report
Date of Meeting	7 October 2020
Author	Sally Sykes, Director of Communications and Engagement
Accountable Executive	Jacqui Grice, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Staff Survey assurance Reputation and stakeholder risks
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 and communications, 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 like social media stats are verifiable, the Trust currently does not have a media evaluation agreement in place. This is being addressed.

Staff engagement is measured in the annual NHS Staff Survey and does provide a robust benchmark for both year on year changes and comparisons with other Trusts. The pilot People Pulse survey is also giving some more 'temperature check' immediate feedback and we have done one cycle of this survey, with a second just launched for staff to take part.

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

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

4. Conclusion

There has been a significant amount of activity in support of the Trust's objectives and the Committee 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

- We continue to highlight the Keep Wirral Well partnership campaign to the public in relation to COVID-19 and have scheduled social media posts. The Keep Wirral Well campaign is also part of the local authority and their Public Health Director's response to containing or preventing local outbreaks Keep Wirral Well. The recent local lockdown measures have also been highlighted to staff along with 'Test and Trace' developments

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

- Our seasonal flu campaign is well underway with vaccination clinics ongoing and messages being shared with staff.

- We have begun communicating the new NHS 111 service for accident and emergencies. WUTH is in the phase 3 implementation roll out and set to introduce the service in November 2020

Media

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

- We publicised the roll out of new staff uniforms and this was covered positively. It's also the lead story in our relaunched September issue of the staff magazine 'In Touch'.
- Our top fundraiser 6 year-old Will Ritchie was successfully nominated by WUTH Charity to be featured in the Blackpool Illuminations - Coronavirus heroes - Blackpool illuminations
- In other positive move we saw the near final total of the Wirral Globe appeal raise £166,000 – and be their front page story.
- Charity stories abound this month with the launch of our Rainbow flower initiative as the next key fundraiser.
- In social media we continued to support campaigns such as the IPC campaign to 'Keep it SIMPLE' and CapMan the capacity management system, which garnered 500 and 1500 engagements respectively.
- We continued to amplify the local authority and NHSE/I messaging on 'Keep Wirral Well' and other national campaigns around Organ Donation Week and the 999 Emergency Services Day.
- There was coverage of increased waiting times and also reference to our capital investment secured for immediate improvements to the Emergency Department.
- We supported the World Health Organisation's global patient safety day with a media release featuring a quote from Chief Nurse Hazel Richards on how this year's theme of supporting staff wellbeing to enhance patient safety was very appropriate to the pandemic we face. We used World Patient Safety Day to launch our new internal Safety Bulletin - WHO patient Safety Day 17th September.

Media Statements

- We provided a statement to The Liverpool Echo in response to an enquiry generated from our Board papers about the measures to improve controls in respect of findings of Legionella in water supplies to 2 wards, which were closed for remedial action. There was no harm to staff or patients.

Internal Communications and staff engagement

- We reverted to a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, clinical guidance, staff wellbeing and support; and charity updates. We remain ready to step up frequency as the challenges increase around winter pressures and admissions of further cases of COVID-19.

- We are taking part in a pilot for the NHS People Pulse, which is a 'temperature check' product that NHS People has created and for trusts to share in free of charge until January 2021. We are into our second cycle now, which should derive comparative data to share shortly.

- We built on our new ways of working to communicate with Leaders and enhance executive visibility (a CQC action plan item) via MS Teams and relayed a session in the lecture theatre with Nikki Stevenson and the Exec team to 70 leaders and managers on September 8th, with a summary and video playback sent afterwards to 500 senior leaders.

  Nikki Stevenson, Claire Wilson, Matthew Swanborough and external speaker Chris Robson from consultants Akeso, who are working with us on the business case for the hospital upgrade programme, led the sessions focusing on the plans for a new Urgent and Emergency Care front door and ED configuration for Arrowe Park Hospital, plus an update on our broader capital plans.

- We re-introduced 'Messages from the Board' following the July, August and September meetings.

- We publicised a series of COVID-19 debriefing sessions for staff to share their experiences and lessons learned, which are giving valuable insights to prepare for the challenging winter ahead.

- We are preparing for the 2020 staff survey and we have reappointed Quality Health as our approved contractors. The survey paper copies have been delivered on-site and the email to all staff on email will commence 2 October.

- We have produced a 'You said: we did' booklet outlining the actions taken by Divisions in response to feedback in the last Staff Survey and with a joint foreword from Director of Workforce, Jacqui Grice and the Staffside Trades Union Chair Norman Robinson.

Charity

- The Challenge 100 individual medal challenge has had 15 pages set up with a total of £2,500 towards the £10,000 target received so far. All funds raised will go towards the Patient Wish fund.

- For the 40th Virgin London Marathon, 10 runners including Trust staff, volunteers and corporate supporters will be completing the virtual event on the 4th October. All funds raised will go towards the Patient Wish fund.

- As mentioned in the media section, the Wirral Rainbow Flower project was launched on Monday 21st September. A small display can be seen in the main entrance at Arrowe Park Hospital with further displays to be created at Clatterbridge Hospital and in community settings. Flowers are available for £25 via wuth.charity@nhs.net

- Charity social media performance for last month is, as follows:

  Facebook - total page likes 1368 (up 50 this month), 440 page views, post reach 15,321 and post engagements 3369
  Twitter – Followers 668, 21,600 impressions
  Just Giving performance – The COVID-19 appeal has received 1000 direct donations and is in the top 1% of performing pages currently on Just Giving

- Next event, to be announced in September, will be a Virtual Halloween Balloon race.

One Big Thank You on BBC One's 'The One Show'

- The WUTH Charity Critical Care fund and the Critical Care team received a boost recently thanks to the amazing efforts of fundraiser Danny De Brabander and his charity #TeamDDB.

- The Critical Care Team took part in a special One Big Thank You message to Danny on BBC1's The One Show last week to show their appreciation for all his efforts. You can see the thank you message at 13 minutes 50 seconds into the show by clicking **here** or on the image.

Stakeholders

- We continue to work with our system partners in Wirral and our CEO takes part in a regular update for local MPs with Wirral MBC. With local COVID-19 outbreaks increasing and tighter lockdown measures coming in on 22 September, we are active participants in the Wirral Council Outbreak Management Board with local elected councillors and council officials, pus other health system partners making decisions community-wide.

- We nominated staff for the national COVID-19 Honours and for the NHS Parliamentary awards, of which 3 were selected by our local MP to go forward to the regional finals. We submitted a team entry to the Parliamentary awards for the large number of colleagues who worked on the repatriation of guests from Wuhan and the Diamond Princess Cruise Liner.

Sally Sykes
Director of Communications and Engagement