Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

03 March 2021

together we will

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
12.30pm - Wednesday 3 March 2021
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21-237	**Apologies for Absence**	Chair	Verbal	N/A
20/21-238	**Declaration of Interests**	Chair	Verbal	N/A
20/21-239	**Patient Story**	Chief Nurse	Video	N/A
20/21-240	**Minutes of Previous Meeting – 27 January 2021**	Chair	Paper	1
20/21-241	**Board Action Log**	Chair	Paper	9
20/21-242	**Chair's Business**	Chair	Verbal	N/A
20/21-243	**Key Strategic Issues**	Chair	Verbal	N/A
20/21-244	**Chief Executive's Report**	Chief Executive	Paper	10
Performance & Improvement				
20/21-245	**Quality and Performance Dashboards**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	16
20/21-246	**Financial Report**	Chief Finance Officer	Paper	25
Strategy and Development				
20/21-247	**Strategic Planning Update**	Director of Strategy and Partnership	Paper	42
20/21-248	**Initial Capital Programme 2021/22**	Director of Strategy and Partnership	Paper	51
Governance				
20/21-249	**Monthly Safe Staffing Report**	Chief Nurse	Paper	59
20/21-250	**Guardian of Safe Working Q3 Report** (Helen Kerss to attend)	Medical Director	Paper	66
20/21-251	**Ockenden Review and Assurance of Maternity Services**	Chief Nurse	Paper	71
20/21-252	**Change Programme Summary, Delivery & Assurance**	Director of Strategy and Partnerships	Paper	112
20/21-253	**Board Assurance Framework**	Deputy Board Secretary	Paper	133

20/21-254	**Chair's Report – Quality Committee**	Committee Chair	Paper	155
20/21-255	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	159
20/21-256	**Any Other Business**	Chair	Verbal	N/A
20/21-257	**Date of Next Meeting –7 April 2021, 12.30 via MS Teams**	Chair	Verbal	N/A
20/21-258	**Exclusion of the Press and Public** To resolve that under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.			

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

27 JANUARY 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 12.30 and Concluding at 14.45

Present

Sir David Henshaw	Chair
Chris Clarkson	Non-Executive Director
Mrs Jayne Coulson	Non-Executive Director
Steve Igoe	Non-Executive Director
Mrs Sue Lorimer	Non-Executive Director
Steve Ryan	Non-Executive Director
John Sullivan	Non-Executive Director
Janelle Holmes	Chief Executive
Nicola Stevenson	Medical Director / Deputy CEO
Claire Wilson	Chief Finance Officer
Hazel Richards	Chief Nurse / DIPC
Anthony Middleton	Chief Operating Officer
Matthew Swanborough	Director of Strategy and Partnerships
Jacqui Grice	Director of Workforce

In attendance

Mike Ellard	Deputy Medical Director
Jill Hall	Interim Director of Corporate Affairs
Jonathan Lund	Associate Medical Director
Chris Mason	Chief Information Officer
Oyetona Raheem	Interim Deputy Trust Secretary (Minutes)
Sally Sykes	Director of Communications & Engagement
Philippa Boston	Staff Governor
Alison Owens	Public Governor
Robert Thompson	Public Governor
Angela Tindall	Public Governor

Apologies
None

*Denotes attendance for part of the meeting

Reference	Minute	Action
20/21 214	**Apologies for Absence**	
	Apologies were noted as reported above. The Chair formally welcomed Steve Ryan to his first Trust Board and recognised the presence of the four governors that attended.	
20/21 215	**Declarations of Interest**	
	There were no Declarations of Interests.	
20/21 216	**Patient Story**	
	The Board viewed a video of a patient who had been treated at WUTH for COVID-19 complications. The patient described the treatment received as excellent and expressed appreciation to the staff members for their empathy and kindness throughout his stay. The Chair conveyed appreciation of the Board to the patient for the positive comments.	

Reference	Minute	Action
20/21 217	**Minutes**	
	The minutes of the meeting held on 2 December 2020 were approved as an accurate record.	
20/21 218	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
20/21 219	**Chair's Business**	
	The Chair had participated in the Regional Chairs briefing at which there had been a discussion on clearing the 52-week wait backlog as part of the recovery and reset. He requested a recovery plan to come to the next meeting. The Chair also reported that work with the Wirral economy had continued to progress. There had been a minor concern with the Urgent Treatment Centre (UTC) Outline Business Case (OBC) raised by the CCG but that had now been resolved. The Chair requested comments on the Trust's position on dealing with the COVID-19 cases plateauing. The Medical Director advised that regionally, it was the beginning of the plateauing which was likely to be for an elongated period. **RESOLVED:** **To NOTE the Chair's Business**	AM
20-21 220	**Key Strategic Issues**	
	There were no additional strategic issues to report.	
20/21 221	**Chief Executive's Report**	
	The Chief Executive highlighted the steps that had been taken to deal effectively with the surge in COVID-19. Surge and business continuity plans had been invoked and there had been release of capacity from non-urgent cases to support critical care. The Chief Executive advised that a report would be coming to the next Board on how the COVID-19 recovery would be managed and the Trust's position within the Cheshire & Mersey region. Other issues highlighted by the Chief Executive included the employee COVID-19 asymptomatic self-testing which was due to change from Lateral Flow Device (LFD) tests to LAMP from March, 2021; commencement of the 'reset and recovery' programme and the anticipated outcome; the COVID-19 vaccination programme which had got off to a strong start nationally; and the Clatterbridge master planning which was progressing well. Two serious incidents had been reported in November both of which were being investigated under the Serious Incident Framework. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	**JH**
20/21 222	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard for their respective areas.	

Reference	Minute	Action
	The Chief Operating Officer (COO) gave explanations on the negative impact of COVID-19 demands on the 4-hour A&E targets. The 71% achieved had been similar to the previous year but there had been no 12-hour breaches since April 2020. There had been some challenges with ambulance delays in December and additional capacity had been introduced which had led to noticeable improvements. On the elective side from September to December 2020, the 'reset and recovery' had been achieved despite the COVID-19 impact. The COO added that the P1 and P2 categories of patients (those requiring immediate treatment or treatment within 4 weeks) had been kept going whilst those in the P3 and P4 categories (treatment could wait for 3 months or more) had been taken down. This had been done on the basis that the staff members providing the services were able to redeploy to other critical areas. The COO highlighted details of anticipated reduction in outpatient, inpatients and day cases as a result of the internal redeployments as well as how the independent sector had been engaged to reduce the backlog. The Chair requested clarification on where the Trust was on the outstanding elective cases of about 1000 patients. The COO acknowledged that there were about 1000 patients on the 52-week waiting list. He explained that a small amount of the P3 patients were being treated at Clatterbridge by staff members that could not be redeployed due to risk assessments. Some of the P3 surgeries were being outsourced to the independent sector. The Chair sought further clarification on the recovery plan for the outstanding elective cases. The CEO advised that she currently chaired the Cheshire and Mersey recovery cell and that the Trust was not out of line with other Trusts in the region. She anticipated that concerted efforts would be made in the next 3-4 weeks by all players in the region to turn the situation around. Steve Ryan wanted to know if patients and their primary care teams were regularly communicated with on available support for their health conditions. The COO advised that the vast majority of outpatient services were being maintained and gave explanations on regular communication through the Primary Care, CCG and GP surgeries in that regard. Director of Communications advised that there had been a campaign with partners including signposting alternatives to the public around 'choosing' well in winter for pharmacies and GP surgeries and that specific updates on the elective programme and prioritisation had been sent by the Chair of the CCG. Jonathan Lund added that all the patients on the waiting list had been written to and provided with their prioritised codes. Patients had been given the opportunity to challenge the prioritisation decision if they felt they had been assessed incorrectly. The Chief Nurse commented on the three mixed sex breaches in December and advised that the breaches might go up slightly in the January data. It had been agreed at Gold Command that due to risk of COVID-19 transmission at times of full capacity in ED, a risk assessment could be undertaken and sexes mixed for a maximum of 24 hours. The Director of Workforce gave updates on the sickness level which currently stood at 6.8%. The Trust had been running at 50:50 in terms of sickness relating to COVID-19 whilst 57 members of staff that were clinically extremely vulnerable had been shielding at home. The Trust was now in a position to	

Reference	Minute	Action
	launch the new sickness management strategy. It was recognised that many staff members had been under immense pressure due to the volume of work. She highlighted some policy changes and staff support mechanisms that have been introduced. Christopher Clarkson asked if there had been increase in stress related absence and how that was being managed. The Director of Workforce advised that the figures were about the same but there was anecdotal evidence that more staff members had been accessing the psychological support service provided. Webinars had been held around how to recognise signs of PTSD for instance and how to seek support. Christopher Clarkson commented on the need to conduct training for managers to recognise the signs of when staff members might need a break and support. John Sullivan sought clarification on risk assessments being completed by staff members, which currently stood at about 90%. JG advised that the percentage was about 90% and that it was an ongoing policy that every new staff member completes the risk assessment forms. If there was a change in people's health condition, they would be asked to complete a new risk assessment. The Chief Nurse advised that risk assessments had been used and operationalised effectively. It had been useful in determining staff members that could not work on certain wards. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard for the period to 30 December 2020.**	
20/21 223	**Month 9 Finance Report 2020/21**	
	The Chief Finance Officer (CFO) presented the month 9 financial report and highlighted the year to date surplus of £2m and a forecast surplus of £550k by the end of the financial year. Detailed explanations were given on additional funding received and anticipated expenditure which had been taken into consideration before arriving at the year-end projections. The CFO advised that there had been a capital spends of £8.4m against a year to date budget of £12.7m. The full year capital forecast was currently £13.1m. Notification of funding for two capital programmes had recently been received. The first was £700K from a bid for Urgent Care and the second one was in respect of a bid of £860k for procurement of mammography equipment. The CFO requested approval to raise the order for the mammography equipment that needed to be procured before the end of March. There was no objection to the request. Steve Igoe pointed out that the projected surplus was on the basis of COVID-19 funding and wanted to know if the COVID-19 funding represented a structured deficit built into the operations of the Trust. He also requested to know what had been done differently from the previous year to achieve a surplus. The CFO gave details of additional funding that had been received as temporary income guarantee to fund a temporary situation. The new financial regime was unlikely to include such income guarantee going forward. The Chairman commented on the need to be able demonstrate the efficiency of spending on individual programmes for which additional funding had been received.	

Reference	Minute	Action
	RESOLVED: **That the Board NOTED the report.** **That the Board APPROVED the request for purchase of mammography equipment in line with the Trust's procurement procedure.**	
20/21 224	**Infection Prevention Update and Assurance, including IPC BAF**	
	The Chief Nurse presented the IPC report and highlighted the updated version of IPC BAF which had been included. She advised that owing to certain meetings being paused during the current COVID-19 surge, the report had not been taken through the governance process as was usually the case. Notice of CQC focused inspection of infection control in January had been received, but this was later postponed. The report detailed the significant progress made against the majority of mandatory surveillance infections and the detail of recent COVID-19 outbreaks. The Medical Director advised that the COVID-19 infection rate was being closely monitored and that there had been a constant review of the mitigating actions. She added that the increased rate was a combination of community prevalence and the new variant of COVID-19. PHE guidance was being followed and there was regular audit to make sure that staff members were compliant with the guidelines. Weekly report was being received to ensure adherence to the basic protective measures including hand hygiene and use of face masks. The matter had been added to operational risks register. Opening of doors had been re-introduced where infection was not present, as well as testing of new patients to establish their COVID-19 status before being admitted to the wards. **RESOLVED:** **That the Board NOTED the report.**	
20/21 225	**Mortality Report**	
	Mike Ellard made a presentation to the Board on standardised hospital mortality, during which data and graphs were used to highlight the key issues including. • Crude mortality rate had been higher than regional average • No systemic issues had been identified with patient care from Medical Examiner or mortality review group. • Issues had been identified with documentation, coding (categorisation of income vs. mortality vs comorbidity) and length of stay (LoS). • Specialty respiratory and stroke national audits had shown mortality rates to be within / lower end of range • Getting it Right First Time (GIRFT) reports had highlighted coding issues with stroke and respiratory reports • Sepsis cases had been lower than expected • Urinary Tract Infection review had shown that 9 had sepsis on admission • Charlson comorbidity scores had been under reported Some of the planned actions were highlighted including review of coding practices and an education package for clinical staff. John Sullivan queried if there had been changes to coding practices prior to the rising cases on the SHMI. Mike Ellard gave explanations on internal investigations that had indicated that there were issues with the coding	

Reference	Minute	Action
	system. He added that length of stay was another factor that had been identified as having a big impact on the increased SHMI. Steve Ryan (new Chair of Quality Assurance Committee) was requested to liaise with the Medical Director and Deputy Medical Director to share ideas. **RESOLVED:** **That the Board NOTED the report.**	
20/21 226	**Monthly Safe Staffing Report**	
	The Chief Nurse presented the safe staffing report and highlighted that staffing level had dropped to below the minimum level due to vacancies, sickness and self-isolation. A winter allocation of about £700k from the region was expected to fund 100 more international RN recruits. The recruitment process was under way and it was anticipated that there would be another 100registered nurses in the Trust by the end of April 2021. That would significantly reduce the 26% vacancy rate in band 5 RNs. The Chief Nurse added that the winter nurse staffing escalation plan and had been implemented with twice daily staffing meetings and reviewing of the 7-day staffing plan ahead of time. The staffing incentive scheme had been further reviewed and there appeared to be a better uptake. There had been an 'impact on care' review during Month 9 particularly around late medication and delayed observation reporting. There had also been a review of all processes and systems aimed at releasing time to care. A list of ideas on how to ease the burden of nursing staff had been drawn up following meetings with ward managers and these were being implemented. The Chair commented on the fundamental shortage of nurses in the market place and expressed the need for a clear Board strategy for dealing with the issue. The Board was advised that a recruitment and retention strategy had been developed by the Workforce Department to address the matter. John Sullivan asked for an idea of how long it might take the international nurses being recruited to fully integrate into the service. The Chief Nurse advised that it would take between 10 and 12 weeks for the nurses to become fully independent. Steve Igoe suggested consideration to be given to Lifelong Learning Partnerships by working with further education colleges for training and progression to degree level outcomes and with the local Trusts for placement opportunities and work experience for trainee nurses. He also commented on the current proposal by the government to move back to a commissioned contract arrangement with universities for the supply of nurses and allied health professionals. This regime which had existed in the past had proved problematic in dealing with supply and demand requirements for trained and qualified health professionals. The Director of Workforce advised that 19 student nurses had started their induction that week with a further 12 expected. She added that conversation had begun with the Wirral Metropolitan College around Lifelong Learning Pathways. Further discussions took place on the wider ranging cross sector approach to recruitment. The Director of Finance advised that funding had been received for the international nurse recruitment exercise and that executive actions might be required to release funding for the process at short notice.	

Reference	Minute	Action
	RESOLVED: **That the Board NOTED the report.**	
20/21-227	**Change Programme Summary, Delivery & Assurance**	
	Director of Strategy used the previously circulated presentation slides to highlight the progress on the Change Programme and the current areas of focus. Governance ratings for January had seen some improvements with six of the seven 'live' programmes green rated. Delivery ratings for January had seen five programmes green rated, whilst two had been amber rated, noting that amber ratings remained an indication of substantive issues. **RESOLVED:** **That the Board NOTED the report.**	
20/21-228	**EU Exit Transition Period**	
	The COO talked the Board through the report and highlighted some of the steps that had been taken to comply with NHS directive on EU Exit plan and to mitigate possible impact on business as usual. **RESOLVED:** **That the Board NOTED the report.**	
20/21-229	**Progress Against Enforcement Undertakings**	
	The Chief Executive highlighted the key issues in the report including the progress on actions that needed to be completed before being released from the undertakings. **RESOLVED:** **That the Board NOTED the report.**	
20/21-230	**Charitable Funds Annual Report and Accounts / Receipt of Audit Opinion**	
	The CFO presented the report and accounts which had been reviewed by the Charitable Funds Committee and recommended to the Board for approval. It was noted that the Auditors report had been included in the pack. The Chair expressed appreciation to all those that had been instrumental to the development of the charity. **RESOLVED:** **That the Board APPROVED the Report and Accounts as recommended.**	
20/21-231	**Chair's Report – Audit Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held on 15 January 2021 including the WHO's Safer Surgery checklist that had not been completed consistently. Attention of the relevant officers had been drawn to the matter. Extraordinary meetings had been taking place as part of the Committee's oversight of identified HR issues.	

Reference	Minute	Action
	RESOLVED: **That the Board NOTED the report.**	
20-21 232	**Communications and Engagement Monthly Report**	
	The Board received the report of activity in the areas of staff engagement and communications, media and social media, charitable fundraising and stakeholder relations. The Director of Communications and Engagement gave explanations on the campaign around signposting healthcare options for local residents, how staff members' well-being was being supported and the redesign of the wellbeing sections of the website to make it easier to navigate. She added that the Medical Director had done a number of radio and TV interviews on COVID-19 related issues. **RESOLVED:** **That the Board NOTED the report.**	
20/21 233	**Introduction of new NED / Appointment to Board Committees**	
	The Board received the information about new appointment and schedule of Committee appointments for Non-Executive Directors. **RESOLVED** **That the Board APPROVED the Committee appointments schedule.**	
20/21 234	**Any other business**	
	None.	
20/21 235	**Date of Next Meeting** Wednesday 3 March 2021, via MS Teams	
20/21 236	**Exclusion of the Press and Public**	
	RESOLVED: That under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.	

……..……

Chair

……..

Date

Board of Directors Action Log
Updated – 27 January 2021
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.01.21						
1.	BM20-21/219	Prepare a recovery plan for clearing the 52-week wait backlog for the next meeting	**AM**	This item will be covered in the Reset and Recovery item which is on the agenda for the March Board.	3 March 2021	
2.	BM20-21/221	The Chief Executive advised that a report would be coming to the next Board on how the COVID-19 recovery would be managed and the Trust's position within the Cheshire & Mersey region	**JH**	This item will be covered in the Reset and Recovery item which is on the agenda for the March Board.	3 March 2021	
Date of Meeting 02.12.20						
1	BM20-21/191	Clinical and operational teams to present their plans to the Board in the new year	**MS**		April 2021	
3	BM20-21/199	Presentation to the Board on progress with the Planned Care Control Centre	**NCC**		April 2021	
Date of Meeting 04.11.20						
3	BM20-21/174	Update the Board on progress regarding work on the new strategy on Culture and Leadership	**JG/MS**		April 2021	Not Due
4	BM20-21/175	Seek clarification on the status of the additional license condition that was imposed by NHSI in 2018.	**JH**	Trust/the system to provide narrative and evidence against four areas identified to demonstrate progress and sustainability – information then considered by the Regional Management Team, CQC to decide the need for the System Improvement Board	April 2021	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.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20-21/244

BOARD OF DIRECTORS
3 March 2021

Title:	Chief Executive's Report
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
This is an overview of work undertaken and important announcements for the month of February 2021

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	No
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	No
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
N/A
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A

Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
N/A	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	Trust Board
Background papers / supporting information	N/A

BOARD OF DIRECTORS MEETING IN PUBLIC
3 March 2021

Chief Executive's Report

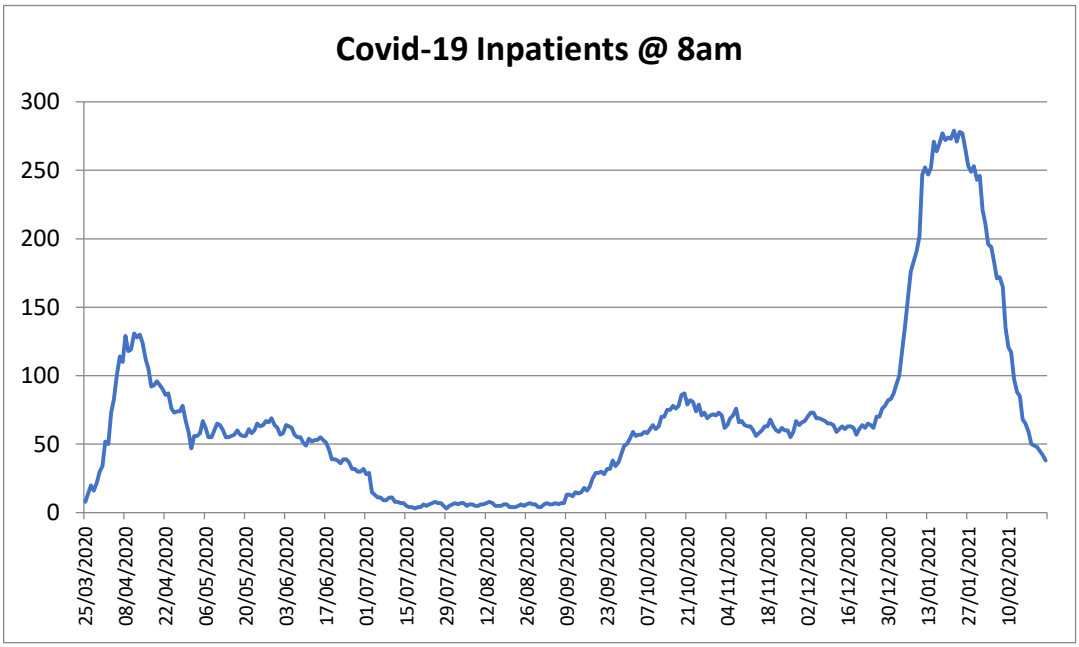
Purpose

This report provides an overview of work undertaken and any important announcements in February 2021.

Introduction / Background

1. COVID-19 Update

The number of inpatients with COVID-19 peaked mid-late January, significantly exceeding the numbers in the first surge. In the last few weeks, there has been a significant decline in the number of patients being treated for COVID-19 (see graph below). This is due to a variety of factors including reducing community incidence, the effect of lockdown, and the successful Wirral vaccination programme which began in December. As a consequence, the Trust has reduced the number of red wards (two wards from 10 at the time of writing) and created more capacity for patients with non-COVID-19 related conditions. Critical care occupancy and patient acuity continues to be challenging.



2. Reset and Recovery

Planned care activities have been restarted in line with phase 3 national plans, and are being delivered with the optimum focus of COVID-19 safety measures.

The Phase 3 national expectation was that plans should deliver the following %'s of activity in comparison with the same period last year:

Outpatient Activity – 100% from September
Daycase Activity – 80% in September, 90% from October to February
Elective Activity – 80% in September, 90% from October to February

Activity - January	Trajectory	Actual	Variance
Outpatients	100%	80%	-20%
Daycase	90%	61%	-29%
Inpatients	90%	45%	-45%

It should be noted that during January and February non urgent routine planned care activities have been stepped down to release staffing to sure up essential services during the latest wave of COVID-19 pressures. The Trust has set out its approach to a restart from March in a later paper to the Board of Directors.

3. Vaccination Programme

The Clatterbridge Vaccination Centre opened on the 8th December 2020 and is working closely with GPs within the local Primary Care Networks and other secondary and tertiary care organisations across the system to ensure that our local population is vaccinated at the earliest opportunity. This programme of work is being coordinated by Wirral Health and Social Care Commissioning Group (WHCCG) and has been managed in line with national Joint Committee for Vaccination & Immunisation (JCVI) guidance.

The first vaccine made available to the Trust was the Pfizer BioNTech preparation which has the well publicised, ultra-low temperature (ULT), cold chain and movement restrictions. During the first week in February 2021 the Trust also received the Oxford Astra Zeneca (AZ) vaccine which has cold chain restrictions only.

In addition to the staff vaccination programme, the Pharmacy team have been coordinating the vaccination of hospital inpatients with the AZ vaccine and accelerated courses of vaccination required for patients who are immunocompromised or commencing immunosuppressive treatments. Specialist allergy sessions have been facilitated by the team with on hand anaesthetic support for patients who have suffered an allergic response to their first dose of the COVID-19 vaccine or have experienced other vaccine allergies.

The ambition from the Secretary of State for Health to offer all over 16s a vaccination by July 2021 followed by the need for second doses and possible future boosters means that it is likely that the vaccination centre will continue to operate for the next 6-9 months. To support this, more sustainable management arrangements are being made for the next phase of our work. The longer term future of the venue and responsibility for its operation is subject to a system wide discussion.

4. Serious Incidents

In December 2020, four serious incidents were declared; one relating to a delay to outpatient follow up, the second was a hospital acquired pressure ulcer, the third related to delayed treatment and the fourth was related to the management of a deteriorating patient.

In January 2021, four serious incidents were declared; one relating to a delay to outpatient follow up, the second a missed diagnosis, the third a fall during admission and the fourth complications during a home birth.

All incidents are being investigated under the Serious Incident Framework to identify opportunities for learning and actions to drive improvement and reduce future risk.

5. RIDDOR Update

There were 2 RIDDOR reports to the HSE in December 2020 and none in January 2021; of the two reported one related to the potential exposure to COVID-19 and the other related to an assault of a member of staff by a patient.

6. Research Contribution to Major Study

WUTH are part of the national COVID-19 RECOVERY trial and have recruited 400 patients to date.

The RECOVERY trial is the largest COVID-19 drug trial in the world (circa 30 000 patients have entered) and has provided vital evidence about the effectiveness of drugs, enabling rapid transition into clinical practice.

It was the RECOVERY trial that identified the benefit of dexamethasone that is now used worldwide as a result.

According to the latest data from National Institute for Healthcare Research (NIHR) WUTH is the second highest performing Trust in the country in terms of percentage of COVID-19 admissions recruited to the trial.

This is thanks to the hard work and efforts of the team including Principal Investigator Dr Andrew Wight; Senior Research Nurse Liz Bailey; Paula Brassey, Research Manager; all the respiratory consultants; the junior doctors; ANPs; the Research Department; the Pharmacy Department and the Transfusion Team.

7. New Service - The Cheshire and Merseyside Adult Gender Identity Collaborative (CMAGIC)

The Cheshire and Merseyside Adult Gender Identity Collaborative (CMAGIC) has been launched. This is a partnership of clinicians, commissioners, providers and service users involved in the support and care of transgender and non-binary individuals within Cheshire and Merseyside.

WUTH colleagues have played a big part in helping to set up this collaborative, especially Dr King Sun Leong, Associate Medical Director for Medicine and Acute Division, who the Trust's Diversity and Inclusion Lead Sharon Landrum described as 'absolutely pivotal' to the set-up of the new service.

CMAGIC is one of three gender dysphoria services newly located within primary care and sexual health. The service is commissioned by NHS England, with other networked pilot provision being in Greater Manchester and London.

CMAGIC is supporting the delivery of a new specialist gender identity clinic available to individuals living in Wirral, Liverpool, South Sefton, Halton, Knowsley, Southport and Formby, St Helens, Cheshire, Vale Royal and Warrington.

8. Capital Programme Delivery

New Cardiac Cather Lab
The new, state of the art Cardiac Catheter Lab is now open, following a £1.2 million refurbishment.

The Lab team at Arrowe Park Hospital carries out between 900 and 1000 procedures each year. These include Diagnostic Coronary Angiography, to support diagnosis of structural or circulatory heart disease and permanent pacemaker implantation, which has taken place at the Arrowe Park site since 1994.

Currently the team provides ongoing care for around 2,500 Wirral residents, who have been fitted with pacemakers and cardiac devices. The teams also insert and monitor implantable loop recorder devices that can help to identify the causes of fainting. The Lab here at WUTH has close links to Liverpool Heart and Chest Hospital, which ensures that patients needing complex devices, imaging and percutaneous cardiac intervention (PCI) are referred promptly.

Upgrade of Emergency Department (ED) Majors Area
A £1 million upgrade has now been completed in the Emergency Department at Arrowe Park with the aim of improving emergency care for patients. The upgrade has provided eight side rooms, to allow for enhanced infection control measures.

The Trust was awarded Government funding for this scheme in August last year. The project has been completed in just 12 weeks and is part of the Trust's strategy to keep patients safe during the busy winter period, while still responding to the ongoing COVID-19 pandemic.

The department upgrade has given the ED team a real boost in morale. They've been facing some major challenges over the last year and the new state of the art facilities mean they are able provide the highest quality of care to our patients who are unwell with COVID-19, in a spacious, clean, safe environment.

9. Interim Governance Arrangements

In November 2020, the Board of Directors extended the interim meeting arrangements until end of March 2021, in line with NHS England / Improvement directive, to free-up capacity and resources during the COVID-19 pandemic. The Executive Team has reviewed the interim arrangements and due to the reduction in the number of COVID-19 cases, it is proposed to revert back to the business as usual meeting schedule with effect from 1st April 2021, albeit meetings continuing to be held via MS Teams until national guidance changes.

Conclusions

N/A

Recommendations to the Board

The Board is requested to note the Chief Executive's report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21-245

BOARD OF DIRECTORS
03 March 2021

Title:	Quality Performance Dashboard
Responsible Director:	Executive Directors
Presented by:	Executive Directors

Executive Summary
This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of January 2021.

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
All strategic priorities identified in the BAF
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)

N/A	
Previous considerations by the Board / Board sub-committees	N/A
Background papers / supporting information	N/A

BOARD OF DIRECTORS MEETING IN PUBLIC
03 March 2021

Quality Performance Dashboard

Purpose

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of January 2021.

Introduction / 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 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.

Key Issues

Of the 49 indicators that are reported for January (excluding Use of Resources):

- 27 are currently off-target or failing to meet performance thresholds
- 22 of the indicators are on-target

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.

An additional dashboard on workforce metrics as regularly presented to the Workforce Assurance Committee is included for information.

Next Steps

WUTH remains committed to attaining standards through 2020-21.

Conclusions

Actions to improve are noted in the exception reports on the qualifying metrics to provide monitoring and assurance on progress *(exception reports have been suspended for the current phase of the Covid-19 pandemic)*.

Recommendations to the Board

The Board of Directors is asked to note the Trust's performance against the indicators to the end of January 2021.

Quality Performance Dashboard

January 2021
Upated 22-02-21

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	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	0.13	0.32	0.31	0.25	0.14	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.17	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.8%	96.2%	95.8%	96.2%	96.4%	95.8%	95.1%	95.3%	95.4%	95.1%	95.2%	94.7%	90.3%	94.95%	
	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	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	97.2%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	95.2%	97.0%	96.9%	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	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	5	4	4	3	4	1	4	4	2	3	2	4	4	31	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	2	0	0	0	0	0	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	4	4	3	6	5	5	1	4	1	5	10	8	4	49	
	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	8	9	1	7	4	6	8	5	3	7	3	1	3	47	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	1	0	1	0	0	0	0	0	0	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	100.0%	100.0%	100.0%	100.0%	99.1%	99.0%	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	99.6%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	1	0	0	2	0	2	0	4	0	0	1	0	1	10	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	96%	96%	91%	95%	95%	98%	96%	94%	91%	93%	Not Avail	94%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	78.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	84.4%	85.0%	82.8%	80.6%	71.4%	71.8%	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	76.0%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	89.5%	86.7%	79.9%	51.5%	19.7%	19.0%	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	79.0%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.48%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	94.31%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.94%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.7%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	7.9	7.7	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	9.9	8.0	8.5	10.1	9.5	8.1	8.1	

Quality Performance Dashboard

January 2021
Upated 22-02-21

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	96.7%	
	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%	96%	98%	97%	95%	96.6%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.7%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	446	448	383	174	209	210	202	239	309	305	279	319	371	371	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	200	198	108	35	54	48	53	59	92	95	86	112	98	98	
	Length of stay - elective (actual in month - Patient Flow wards only) **	Safe, high quality care	COO	≤5.3 days average	WUTH	4.5	5.9	4.9	6.8	5.5	6.2	3.6	3.8	4.8	3.9	4.1	3.4	2.8	4.5	
	Length of stay - non elective (actual in month - Patient Flow wards only) **	Safe, high quality care	COO	≤7.3 days average	WUTH	7.8	7.8	9.9	6.9	4.7	4.7	4.2	4.5	5.4	5.8	5.4	4.3	4.7	5.1	
	Emergency readmissions within 28 days **	Safe, high quality care	COO	≤1,110 per month	WUTH	1115	1006	827	667	870	941	1016	1012	1014	1007	992	1020	1027	957	
	Delayed Transfers of Care **	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	2.1%	2.1%	3.3%	2.3%	3.3%	2.3%	2.1%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	71.4%	76.2%	

Quality Performance Dashboard

January 2021
Upated 22-02-21

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020/21	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	10	14	4	2	0	2	3	5	1	0	0	3	2	18	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	n/a	n/a	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	87%	84%		
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	n/a	n/a	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	TBC	92%		
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	n/a	n/a	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	95%	94.0%		
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	n/a	n/a	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	80%	100%		

Quality Performance Dashboard

January 2021
Upated 22-02-21

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	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	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	64.6%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	40	24	21	0	0	0	0	0	0	0	0	0	0	0	
	Ambulance Handovers: > 30 minute delays **	Safe, high quality care	COO	<5%	WUTH				7.8%	3.8%	3.5%	3.2%	4.2%	8.3%	13.8%	9.2%	13.2%	18.0%	8.5%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	68.40%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	22,988	23,207	22,350	21,284	21,288	21,383	23,034	24,486	24,212	22,945	21,633	21,792	21,880	21,880	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	0	0	15	56	200	413	616	733	806	777	704	666	899	899	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	79.1%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	92.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	–	–	93.4%	–	–	90.2%	–	–	92.48	-	-	94.20			
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	97.2%	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	94.8%	92.1%	98.0%	97.4%	97.2%	97.9%	96.4%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	–	–	97.6%	–	–	98.6%	–	–	92.44	-	-	97.55			
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	85.9%	85.9%	86.0%	87.4%	86.2%	82.1%	80.7%	78.6%	82.6%	82.9%	85.3%	85.4%	81.7%	83.3%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	–	–	85.9%	–	–	85.3%	–	–	80.68	–	–	84.60			
	Patient Experience: Number of concerns received in month - Level 1 (informal) **	Outstanding Patient Experience	CN	≤173 per month	WUTH	186	160	125	74	99	119	143	124	183	178	161	150	196	143	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal) **	Outstanding Patient Experience	CN	≤3.1	WUTH	1.50	3.10	2.70	1.30	1.50	2.80	2.10	3.40	4.20	3.80	3.20	1.32	3.80	2.74	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	86%	88%	100%	100%	100%	100%	100%	94%	100%	97%	97%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	3	0	1	0	1	5	1	0	2	1	4	2	2	2	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

January 2021
Upated 22-02-21

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020/21	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review		
	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	55	49	117	329	181	152	86	31	126	328	215	163	595	2206	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	81.3%	84.3%	76.3%	73.0%	74.1%	76.2%	72.9%	72.9%	

	Indicator	Objective	Director	Threshold	Set by	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020/21	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-0.668	-2.929	2.377	0.00	0.00	0.00	0.00	0.00	0.00	0.78	0.74	0.51	-0.16	1.873	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-1.818	-2.445	-0.589	0.00	0.00	0.00	0.00	0.00	0.00	0.39	0.53	0.34	-0.14	1.118	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	4	4	4	2	2	2	2	2	2	2	2	2	2	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	-18.1%	-18.1%	-17.7%	0.0%	0.0%	0.0%	0.0%	0.0%	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	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	23.2%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-28.0	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	53.8%	50.7%	74.8%	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	67.5%	

(*) Updated Metrics

Caring - 'Friends & Family Test : overall experience

Caring - 'Friends & Family Test : overall response rates

Metric Change

The national patient experience metrics have been amended to reflect an overall experience of very good and good

Response rates have been removed as national metrics as no longer valid

(**) Updated Thresholds

Threshold Change

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 20-21/246

BOARD OF DIRECTORS

03 MARCH 2021

Title:	Month 10 Finance Report
Authors	Robbie Chapman, Julie Clarke, Jillian Burrows
Responsible Director:	Claire Wilson, Chief Finance Officer
Presented by:	Claire Wilson, Chief Finance Officer

Executive Summary

This paper reports the financial performance for the Trust for the period ending 30th January 2021 (Month 10).

The year to date (YTD) position is a surplus of of £1.871m with a £2.0m surplus forecast by the end of the financial year.

The M10 position is a deficit of £0.2m. This is a slight deterioration compared to the plan but in line with the revised forecast submitted to NHSI in November.

The £1.5m favourable movement in the forecast from the position previously reported to the Board is the result of £1.5m of Independent Sector costs which will now be funded as part of the national contract.

Delivery of the capital programme continues to progress well with current plans expected to deliver in line with the £13.2m previously reported. Efforts are being made to bring forward any additional essential equipment purchases to bring total spend as close to the original capital plan as possible.

Work is ongoing to assess the Trusts liability in relation to untaken annual leave by staff which has increased significantly over the third wave of the pandemic. The Chief Finance Officer will provide a verbal update in the meeting on the latest analysis.

The Board of Directors are asked to note the financial position of the Trust for the period ending 30th January 2021 and note the potential adverse impact on the Trust forecast of annual leave liabilities for our staff.

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
Regular monitoring and assurance of financial performance supports risks associated with financial sustainability.	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
Financial sustainability supports licence conditions	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
Reports financial performance against revenue and capital budgets.	
Specific communications and stakeholder /staff engagement implications	
N/A	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
N/A	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	Reviewed by Finance, Business Performance Assurance Committee on a bi-monthly basis.

Contents

1. Executive summary

2. Background

3. Dashboard and risk

4. Financial performance

   4.1. Income
   4.2. Expenditure: Pay
   4.3. Expenditure: Non-Pay
   4.4. Expenditure: COVID–19

5. Financial position

   5.1. Statement of Financial Position
   5.2. Capital expenditure
   5.3. Statement of Cash Flows
   5.4. Treasury
   5.5. Working capital
   5.6. Use of Resources

6. Appendices

1.1 Table 2: Financial position – M10

Month 10 Financial Position	Forecast (Mth 10) £'000	Actual (Mth 10) £'000	Variance £'000	Year To Date Actual £'000	Plan £'000	Year End Forecast £'000	Variance £'000
NHS income - patient care	27,373	20,618	(6,755)	186,935	330,279	227,710	(102,568)
Income Guarantee	0	6,748	6,748	69,490	0	83,388	83,388
National Top-up	3,213	3,207	(6)	28,196	34,647	34,610	(37)
Additional top up	0	0	0	2,846	0	2,930	2,930
Covid 19 income	2,108	2,307	199	8,409	11,451	12,616	1,165
Non NHS income - patient care	370	379	9	3,675	4,693	4,295	(398)
Other income	2,098	2,246	147	39,212	28,643	43,416	14,774
Total Income	**35,163**	**35,505**	**342**	**338,763**	**409,712**	**408,966**	**(747)**
Employee expenses	(22,848)	(22,944)	(96)	(223,552)	(272,732)	(270,488)	2,244
Operating expenses	(11,051)	(10,533)	519	(97,898)	(124,397)	(119,514)	4,883
Covid 19 costs	(1,121)	(2,117)	(996)	(12,268)	(7,889)	(12,812)	(4,923)
Total expenditure	**(35,021)**	**(35,594)**	**(573)**	**(333,718)**	**(405,018)**	**(402,814)**	**2,204**
Non Operating Expenses	(326)	(67)	259	(3,277)	(4,515)	(3,930)	585
Actual Surplus / (deficit)	**(184)**	**(155)**	**29**	**1,768**	**179**	**2,222**	**2,043**
Reverse capital donations / grants I&E impact	23	(7)	(30)	103	140	100	(40)
Surplus/(deficit) - Control Total	**(161)**	**(162)**	**(1)**	**1,871**	**319**	**2,322**	**2,003**

1.2 The year to date (YTD) position is a surplus of of £1.871m with a forecast of £2m surplus. This is an improvement compared to the plan submitted to the Board in October 2020 and broadly in line with the revised forecast submitted to NHSI in November 2020.

1.3 The M10 position is a deficit of £0.2m. This is a slight deterioration compared to the plan but in line with the revised forecast submitted to NHSI in November.

1.4 The £1.5m favourable movement in the forecast from the position previously reported to the Board is the result of £1.5m of Independent Sector costs which will now be funded as part of the national contract. However, it should be noted that the Trust is still in the process of calculating its liabilities in relation to annual leave not taken by staff and this is likely to have a significant deteriation on the forecast as the work on this progress.

1.5 Income reflects the reduced activity in respect of patient care offset by the income guarantee funding arrangement. We received £6.7m in respect of the income guarantee in month and have now received £69.5m YTD.

1.6 We no longer receive additional top up income but our COVID-19 activity is allocated on the basis of our expenditure in the first 3 months of the pandemic along with the reimbursement of direct costs.COVID-19 income was £2.3m in M10 of which £1.8m is the block funding, £0.3m of income for the testing programme and a further £0.2m for the vaccination programme. The vaccination testing income was not included in our forecast.

1.7 Expenditure reflects reduced activity in respect of elective activity offset by much higher COVID-19 costs. At £2.1m the expenditure on COVID-19 in M10 was our highest since the pandemic began. Further detail is discussed later in the report.

1.8 We currently forecast a year end surplus of £2.3m, an improvement of £2m against plan and an £1.5m forecast submitted to NHSI in November. This improvement is wholly attributable to changes in the way treatments by the independent sector are funded.

1.9 Cash balances at the end of M10 were £44.6m. The early payment of block income is forecast to end in February 2021 and as a result cash balances are expected to reduce significantly in March 2021.

1.10 The Trust has recorded capital spend of £8.9m against a year to date budget of £16.6m. The full year capital forecast is currently £13.1m.

2. Background

2.1 The funding regime is consistent with the prior period and will remain in place until the end of the financial year. Initial indications are that the current financial regime will remain in place until at least Q2 of 2021/22.

3. Dashboard and risks

3.1 Mth 10 Performance Dashboard

	Indicator	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	2020/21
Use of Resources	I&E Performance (monthly actual)	0.00	0.00	0.00	0.00	0.00	0.00	0.78	0.74	0.51	-0.16	1.873
	I&E Performance Variance (monthly variance)	0.00	0.00	0.00	0.00	0.00	0.00	0.39	0.53	0.34	-0.14	1.118
	NHSI Risk Rating	2	2	2	2	2	2	2	2	2	2	2
	CIP Performance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	NHSI Agency Performance (monthly % variance)	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	23.2%
	Cash - liquidity days	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-14.1	-28.0	-28.0
	Capital Programme (cumulative)	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	67.5%

3.2 Risk summary (as per risks identified in risk register)

3.2.1 Risk 1 – Failure to manage financial position

- The revised M7-M12 financial envelope is dependent on cost management alongside the delivery of activity trajectories; winter; the management of covid activity and the centrally funded vaccination and testing programmes. This report demonstrates that, as of M10, we are managing

3.2.2 Risk 2 – Failure to deliver CIP

- The M7-M12 CIP target was £0.5m. The Trust's cost improvement programme was put on hold after the onset of the 2nd wave of COVID-19 but is offset by non-recurrent reductions in expenditure. Planning has begun for a more challenging CIP target for 2021/22 but the programme is unlikely to commence until Q2.

3.2.3 Risk 3 – Failure to complete capital programme

- 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 in the final quarter of the financial year. Whilst significant progress has been made in M10 we are still behind the required trajectory. This situation is exascerbated by the 3rd wave of COVID-19.

4. Financial Performance

4.1 Income

4.1.1 The Trust has received £338.7m YTD, a reduction of £1m against plan but a £0.4m improvement against the forecast submitted to NHSI in November.

Table 3: Income analysis for M10.

	Forecast (Mth 10)	Actual (Mth 10)	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective & Daycase	4,240	1,733	(2,507)	22,093	50,743	30,526	(20,217)
Elective excess bed days	83	36	(47)	569	993	734	(259)
Non-elective	8,419	6,989	(1,431)	66,829	101,455	83,658	(17,798)
Non-elective Non Emergency	974	858	(116)	9,720	11,755	11,665	(90)
Non-elective excess bed days	355	89	(265)	1,166	4,270	1,875	(2,394)
A&E	1,273	1,072	(201)	10,801	15,354	13,347	(2,007)
Outpatients	3,022	2,313	(710)	20,221	36,419	26,256	(10,163)
Diagnostic imaging	187	183	(4)	1,405	2,257	1,779	(477)
Maternity	480	457	(23)	4,409	5,787	5,369	(419)
Non PbR	7,092	5,577	(1,515)	58,225	86,416	55,426	(30,990)
HCD	1,259	1,418	159	13,003	15,327	15,520	193
CQUINs	189	189	0	1,896	2,273	2,274	0
National Top up	3,213	3,207	(6)	28,112	34,647	37,577	2,930
Income Guarantee	0	6,748	6,748	69,490	0	83,388	83,388
Sub-Total Board Clinical Income	30,788	30,869	82	307,939	367,697	369,394	1,697
Other patient care income	114	20	(94)	758	1,113	987	(125)
COVID-19 Income	2,108	2,307	199	8,409	11,451	12,616	1,165
Non-NHS: private patient & overseas	12	(14)	(26)	38	125	62	(62)
Injury cost recovery scheme	42	77	35	625	684	708	24
Total Patient Care Income	33,064	33,260	195	317,769	381,069	383,768	2,698
Other operating income	2,098	2,246	147	20,990	28,643	25,193	(3,449)
Other non operating income		0	0	5		5	5
Total income	35,163	35,506	343	338,763	409,712	408,966	(746)

4.1.2 The under-performance in patient care activity income across elective, non-elective, outpatients and non-PbR is offset by the income guarantee as reflected in the table above. This reflects the lower non-COVID-19 activity in the hospital.

4.1.3 COVID-19 income in M10 of £2.3m reflects an additional £0.3m for the vaccination programme costs incurred in January and income of £0.1m to support lateral flow testing.

4.1.4 We currently forecast income of £408.6m, a reduction of of £1.1m against plan. However, with additional funding in respect of the vaccination programme this is expected to increase.

4. Financial Performance

4.2 Expenditure: Pay

4.2.1 The Trust has spent £223.6m on pay costs YTD, a reduction of £2.4m against plan but £0.1m higher than M10 forecast.

4.2.2 It should be noted that the Trust is still in the process of calculating its liabilities in relation to annual leave not taken by staff by the year end and this is likely to have a significant deteriation on the pay budgets as the work on this progresses.

4.2.3 Table 4 details pay costs by staff group and Table 5 details pay costs by pay category type.

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

Pay analysis (exc Covid)	Forecast (Mth 10) £'000	Actual (Mth 10) £'000	Variance £'000	Year To Date Actual £'000	Plan £'000	Year End Forecast £'000	Variance £'000
Consultants	(3,930)	(3,719)	211	(36,541)	(44,154)	(44,353)	(199)
Other medical	(2,408)	(2,299)	110	(25,007)	(31,676)	(30,020)	1,657
Nursing and midwifery	(6,185)	(6,204)	(19)	(60,424)	(73,933)	(72,748)	1,185
Allied health professionals	(1,298)	(1,350)	(52)	(12,792)	(15,473)	(15,388)	85
Other scientific, therapeutic and technical	(515)	(513)	2	(5,044)	(6,122)	(6,075)	47
Health care scientists	(1,040)	(1,042)	(1)	(10,276)	(12,381)	(12,356)	25
Support to clinical staff	(4,289)	(4,230)	59	(41,366)	(51,061)	(49,918)	1,143
Non medical, non clinical staff	(3,099)	(3,503)	(404)	(31,256)	(36,893)	(38,617)	(1,724)
Apprenticeship Levy	(83)	(84)	(1)	(846)	(1,039)	(1,013)	26
Total	(22,848)	(22,944)	(96)	(223,552)	(272,732)	(270,488)	2,244

Table 5: Pay analysis by pay type

Pay analysis (exc Covid)	Forecast (Mth 10) £'000	Actual (Mth 10) £'000	Variance £'000	Year To Date Actual £'000	Plan £'000	Year End Forecast £'000	Variance £'000
Substantive	(20,833)	(20,963)	(130)	(205,568)	(245,334)	(248,282)	(2,948)
Bank	(877)	(994)	(117)	(7,511)	(11,009)	(9,245)	1,764
Medical Bank	(350)	(330)	20	(4,582)	(7,294)	(5,481)	1,813
Agency	(705)	(573)	132	(5,045)	(8,057)	(6,468)	1,589
Apprenticeship Levy	(83)	(84)	(1)	(846)	(1,039)	(1,013)	26
Total	(22,848)	(22,944)	(96)	(223,552)	(272,732)	(270,488)	2,244

4.2.4 The Trust's YTD underspend on pay costs is wholly attributable to reduced spend on bank and agency compared to plan. This is offset by an increase in substantive pay.

4.2.5 In M10 we spent more on substantive staff costs due to additional use of overtime compared to forecast. The majority of this overtime was incurred at premium rate but there was an increase in plain rate overtime at B8 and above.

4.2.6 In M10 the higher bank costs were in Surgery and Radiology whilst lower agency spend related to Neonatal, Microbiology and the inability to fully appoint agency to support the winter plan in Medicine.

4.2.7 We currently forecast year end pay costs of £270.5m, a reduction of of £2.2m against plan.

4. Financial Performance

4.3 Expenditure: Non-Pay

4.3.1 Non-pay expenditure YTD is £97.9m, £5.8m lower than plan and £0.5m lower than M10 forecast figure.

Table 6: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Forecast (Mth 10)	Actual (Mth 10)	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Supplies and services - clinical	(2,922)	(2,579)	343	(25,267)	(34,910)	(30,917)	3,993
Supplies and services - general	(388)	(375)	13	(3,569)	(5,065)	(4,325)	740
Drugs	(1,930)	(2,045)	(115)	(18,913)	(23,508)	(22,773)	734
Purchase of HealthCare - Non NHS Bodies	(1,009)	(641)	368	(4,929)	(7,197)	(5,572)	1,625
CNST	(1,079)	(1,079)	0	(10,789)	(12,894)	(12,947)	(53)
Consultancy	0	(5)	(5)	(5)	(411)	(5)	406
Other	(2,814)	(3,037)	(223)	(25,643)	(29,982)	(30,872)	(890)
	(10,142)	(9,761)	381	(89,115)	(113,967)	(107,411)	6,555
Depreciation	(910)	(772)	138	(8,783)	(10,430)	(10,603)	(173)
	(11,051)	(10,533)	519	(97,898)	(124,397)	(118,014)	6,383

4.3.2 M10 saw a £0.3m reduction in clinical supplies across all divisions as a result of reduced elective activity. There was also a £0.4m reduction in spend with the independent sector in respect of patient choice. This was offset by further increased expenditure on Drugs due to greater use of high cost drugs in the two clinical divisions.

4.3.3 We currently forecast year end non-pay costs of £118m, a reduction of of £6.4m against plan. This is due to all outsourced activity through the independent centre being funded by NHSE.

4. Financial Performance

4.4 Expenditure: COVID–19

4.4.1 We incurred a further £2.1m of COVID-19 costs in M10, the largest in month spend since the start of the pandemic. The year to date spend is now £12.3m.

Table 9: YTD COVID-19 revenue costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Jan (M10) £'000	Year to Date £'000
Medical Staff	(263)	(386)	(204)	(199)	(37)	(165)	(84)	(52)	(64)	(103)	(1,556)
Other Clinical Staff	(367)	(626)	(574)	(560)	(126)	(293)	(272)	(470)	(373)	(912)	(4,572)
Non Clinical Staff	(182)	(52)	(47)	(105)	(37)	(58)	(32)	(44)	(132)	(190)	(879)
Total Pay	(812)	(1,065)	(824)	(863)	(200)	(516)	(388)	(566)	(568)	(1,205)	(7,008)
Clinical Supplies	(189)	(591)	70	(99)	(122)	(68)	(42)	(207)	(177)	(366)	(1,792)
Other Non-Pay	(556)	(140)	(333)	(627)	(233)	(273)	(395)	(153)	(211)	(545)	(3,467)
Total Non-Pay	(746)	(731)	(263)	(726)	(355)	(341)	(437)	(361)	(388)	(912)	(5,260)
Total Covid Expenditure	**(1,558)**	**(1,796)**	**(1,087)**	**(1,589)**	**(555)**	**(857)**	**(825)**	**(927)**	**(957)**	**(2,117)**	**(12,268)**

4.4.2 £1.2m of our COVID-19 costs in M10 related to pay with £0.9m on non pay. This split is consistent with the rest of the year.

4.4.3 The COVID-19 YTD position is £12.3m of which £0.5m is vaccination costs and £0.5m is testing costs. The latter costs are both funded centrally outside the Cheshire & Merseyside Healthcare Partnership envelope.

5.1 Statement of Financial Position (SOFP)

5.1.1 The movement in total assets employed at M10 is the movement in capital spend offset by the movements in trade receivables and payables.

Actual as at 31.03.20 £'000		Actual as at 31.12.20 £'000	Actual as at 31.01.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	162,692	162,536	(156)	↓
14,029	Intangibles	13,126	13,022	(104)	↓
723	Trade and other non-current receivables	611	598	(13)	↓
176,244		**176,429**	**176,156**	**(273)**	↓
	Current assets				
3,991	Inventories	4,262	4,100	(162)	↓
24,375	Trade and other receivables	14,858	16,110	1,252	↑
0	Assets held for sale	0	0	0	→
5,931	Cash and cash equivalents	44,721	45,550	829	↑
34,297		**63,841**	**65,760**	**1,919**	↑
210,541	**Total assets**	**240,270**	**241,916**	**1,646**	↑
	Current liabilities				
(41,874)	Trade and other payables	(38,706)	(39,442)	(736)	↑
(3,000)	Other liabilities	(34,861)	(35,094)	(233)	↑
(85,234)	Borrowings	(1,144)	(1,163)	(19)	↑
(2,926)	Provisions	(3,228)	(3,321)	(93)	↑
(133,034)		**(77,939)**	**(79,020)**	**(1,081)**	↑
(98,737)	**Net current assets/(liabilities)**	**(14,098)**	**(13,260)**	**838**	↓
77,507	**Total assets less current liabilities**	**162,331**	**162,896**	**565**	↑
	Non-current liabilities				
(2,588)	Other liabilities	(2,507)	(2,498)	9	↓
(6,274)	Borrowings	(5,717)	(5,711)	6	↓
(7,304)	Provisions	(6,649)	(6,764)	(115)	↑
(16,166)		**(14,873)**	**(14,973)**	**(100)**	↑
61,341	**Total assets employed**	**147,458**	**147,923**	**465**	↑
	Financed by				
	Taxpayers' equity				
80,106	Public dividend capital	164,268	164,888	620	↑
(65,492)	Income and expenditure reserve	(63,537)	(63,692)	(155)	↓
46,727	Revaluation reserve	46,727	46,727	0	→
61,341	**Total taxpayers' equity**	**147,458**	**147,923**	**465**	↑

5.1.2 Cash and current liabilities (deferred income) remain high in year due to the early receipt of NHS block income under the amended NHSI regime for 2020/21. Cash balances will reduce to normal levels in March 2021 and it is expected that funding flows with return to their usual timings in 2021/22.

5.2 Capital Expenditure – January 2021

	Full Year Budget			Full Year Forecast		YTD	
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual	Distance to Go
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Total Internally Generated Funding	10,740		10,740	10,740	0	9,510	
PDC (Public Dividend Capital) - UTC	500		500	300	200	0	
PDC - COVID-19	0	925	925	925	0	859	
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	
PDC - Critical Care	0	664	664	664	0	0	
PDC - Cyber Security	0	40	40	40	0	40	
External Funding - donations/grants	0	132	132	132	0	0	
Total funding	**11,240**	**5,428**	**16,668**	**16,468**	**200**	**10,409**	
Expenditure							
Prior year(s) capital commitments	3,526	(180)	3,346	3,261	85	2,304	957
Estates	4,383	(372)	4,011	(323)	4,334	160	(483)
Informatics	575	(93)	482	490	(8)	490	0
Medicine and Acute	300	186	486	537	(51)	105	432
Clinical Support and Diagnostics	369	306	675	706	(31)	610	96
Surgery	1,363	256	1,619	1,249	370	1,019	230
Women and Children's	0	67	67	67	0	47	20
Other	0		0	0	0	100	(100)
Contingency[2]	224	(228)	(4)	0	(4)	0	0
UTC / Hospital upgrade programme	500	(80)	420	319	101	301	18
COVID-19 response	0	925	925	986	(61)	982	4
Critical Infrastructure Repair	0	1,434	1,434	1,313	121	173	1,140
Urgent & Emergency Care	0	1,508	1,508	2,249	(741)	1,613	636
Restoration of Cancer Services	0	792	792	792	0	766	26
Critical Care	0	664	664	583	81	86	497
Cyber Security	0	40	40	55	(15)	55	0
Mammography Scanner	0		0	820	(820)	0	820
Donated assets	0	132	132	125	7	125	0
Total expenditure (accruals basis)	**11,240**	**5,357**	**16,597**	**13,229**	**3,368**	**8,935**	**4,294**
Capital programme funding less expenditure	**0**	**71**	**71**	**3,239**	**(3,168)**	**1,474**	
Capital expenditure	11,240	5,357	16,597	13,229		8,935	
NBV asset disposals	0	0	0	0		0	
Donated assets	0	(132)	(132)	(125)		(125)	
CDEL impact	**11,240**	**5,225**	**16,465**	**13,104**		**8,810**	

5.2.1 he BAU capital plan at M10 remains in line with M9 at £16.6m. Actual YTD spend totals £8.9m (£8.4m M9). Whilst expenditure has been relatively low in January, a number of schemes are at an advanced stage and will be completed over the next 6 weeks. We therefore remain on track. We received additional PDC in January of £1.5m; £0.8m for Mammography Scanners and an additional £700k for UEC. These schemes will complete in March 2021.

5.3 Statement of Cash Flows – January 2021

	Month Actual £'000	Year to date Actual £'000
Opening cash	**44,721**	**5,931**
Operating activities		
Surplus / (deficit)	(155)	1,767
Net interest accrued	19	192
PDC dividend expense	49	2,831
Unwinding of discount	(1)	(12)
(Gain) / loss on disposal	0	89
Operating surplus / (deficit)	(88)	4,869
Depreciation and amortisation	772	8,800
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(30)	(125)
Changes in working capital	1,879	37,577
Investing activities		
Interest received	0	12
Purchase of non-current (capital) assets [1]	(2,318)	(10,273)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	0	132
Financing activities		
Public dividend capital received	620	84,783
Net loan funding	0	(84,392)
Interest paid	0	(378)
PDC dividend paid	0	(1,330)
Finance lease rental payments	(5)	(56)
Total net cash inflow / (outflow)	**829**	**39,619**
Closing cash	**45,550**	**45,550**

5.3.1 We have received £620k of PDC in month relating to COVID capital spend.

5.3.2 Cash balances remain high due to early payment of block contract income. This continued arrangement, and the anticipated break-even position, will eliminate the need for in-year support in the form of additional Public Dividend Capital (PDC).

5.4 Treasury

Borrowings summary January 2021

	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 20	Loan Repayment Sept 20	Loan Balances Jan 21	Forecast Repayment 20/21	Forecast Closing Balances Mar21
	£'000	Years	%	£'000	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	(375)	3,000	(375)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	(133)	3,715	(133)	3,583
3. Interim revolving working capital support	23,289	5	3.50	23,289	(23,289)	0	0	0
4. Uncommitted interim revenue support	40,389	3	1.50	40,389	(40,389)	0	0	0
5. Uncommitted interim revenue support	20,206	3	3.50	20,206	(20,206)	0	0	0
	97,884			91,107	(84,392)	6,715	(508)	6,208

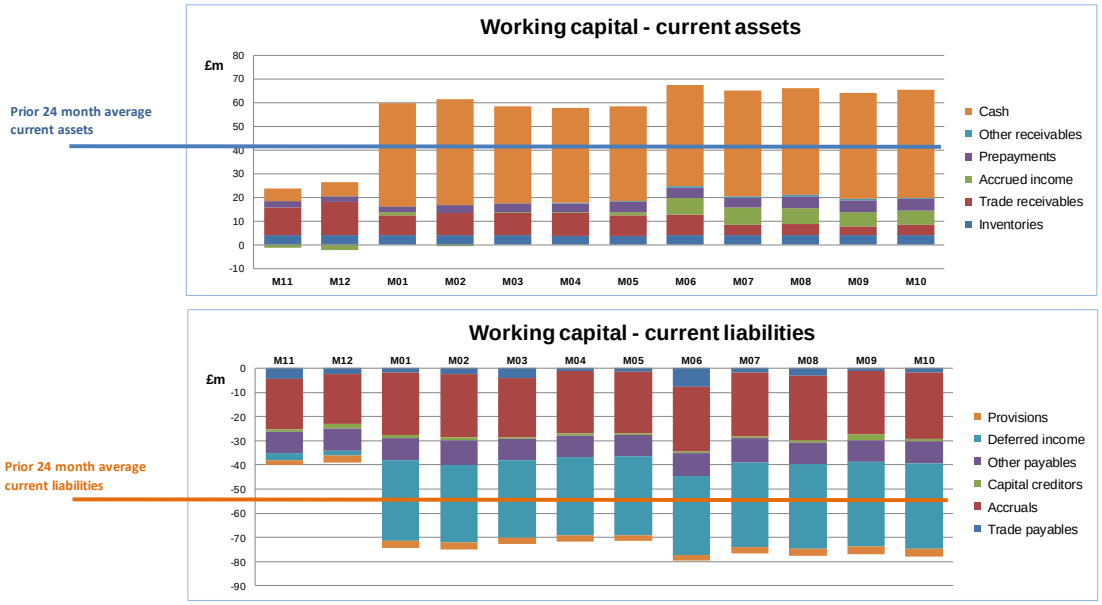
This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

5.4.1 As part of reforms to the NHS cash regime, £83.9m of interim revenue support and working capital loans were repaid in September by the issue of additional Public Dividend Capital. Interest charges on these loans prior to repayment have also been waived in year.

5.4.2 The Trust's remaining borrowings, comprising capital loans, will remain on existing terms and will be repaid at a level of £1m per year.

5.5 Working capital profiles by month

5.5.1 2020/21 working capital shows the impact of early NHS Block receipts. The profiles below show January 2021 (M10) working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.



5.6 Single oversight framework: Use of Resources (UoR) rating (financial) summary table

	Metric	Descriptor	Weight %	Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-16.3	4	-17.0	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.8	1	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.5%	2	0.9%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.2%	1	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-8.0%	1	0.0%	1
	Overall NHSI UoR rating				**2**		**2**

5.6.1 The liquidity rating of 4 remains unchanged from 2019/20. The capital service capacity metric remains at 1 and has been significantly improved from a 4 in 2019/20 as a result of the year to date surplus position and the cessation of interest charges on all but capital bor-rowings. The M10 UoR rating is 2 and this rating is expected to continue for the remainder of the year.

Conclusion and Recommendations

The year to date (YTD) position is a surplus of of £1.871m with a £2.0m surplus forecast by the end of the financial year.

The £1.5m favourable movement in the forecast from the position previously reported to the Board is the result of £1.5m of Independent Sector costs which will now be funded as part of the national contract.

Delivery of the capital programme continues to progress well with current plans expected to deliver in line with the £13.2m previously reported. Efforts are being made to bring forward any additional essential equipment purchases to bring total spend as close to the original capital plan as possible.

Work is ongoing to assess the Trusts liability in relation to untaken annual leave by staff which has increased significantly over the third wave of the pandemic. The Chief Finance Officer will provide a verbal update in the meeting on the latest analysis.

The Board of Directors are asked to note the financial position of the Trust for the period ending 30th January 2021 and note the potential adverse impact on the Trust forecast of annual leave liabilities for our staff.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 20/21-247

BOARD OF DIRECTORS
03 MARCH 2021

Title:	Strategic Planning Update
Responsible Director:	M Swanborough, Director of Strategy and Partnerships
Presented by:	M Swanborough, Director of Strategy and Partnerships

Executive Summary
This presentation provides an update on the development of the Trust's enabling strategies, which builds on the Trust's 21-26 Strategy.

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Risk related to the operational translation and delivery of the enabling strategies
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Nil
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Nil
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Nil
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)

Nil	
Previous considerations by the Board / Board sub-committees	N/A
Background papers / supporting information	N/A

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

2021-2026 Our Strategy:
Enabling Strategies Update

February 2021

together we will

Introduction and Background

Developing Our 2021-2026 Strategy

The journey to develop our new strategic direction began early 2020, through a robust process of research and engagement.

We reviewed national, regional and local context as well as carrying out strategy development workshops to engage with over 2500 staff, patients and visitors who told us what matters most to them.

The aim was to develop a clear and concise vision, values all are expected to uphold and specific strategic objectives which will guide the development of the detailed strategy.

Our 2021-2026 Strategy launched January 2021 and will be delivered through seven enabling strategies.

Our 2021-2026 Objectives and Priorities

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

- Our six strategic objectives and priorities demonstrate our intension to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system.

- We will be a Hospital Trust that patients, families and carers recommend and staff are proud to be part of.

together we will

Strategic Framework
Our Enabling Strategies

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. Clinical Service Strategy Engagement Workshops

- Engagement on the Clinical Service Strategy took place with 32 clinical service workshops having been undertaken over the past 8 months.
- During the workshops a SWOT analysis was completed by the specialty team to determine the current service position and identify areas for development or improvement.
- Detailed discussion led to the identification and formation of their clinical service priorities, aligned to our strategic objectives.
- Each specialty Clinical Service Strategy was shared with the wider stakeholder group before finalisation.
- Each Division have received their Clinical Service Strategies for review and sign off prior to final sign off by Trust Management Board and Trust Board.

b. Clinical Service Strategy

- Clear key themes arose from the 32 Clinical Service Strategies. These key themes form the overall Clinical Service Strategy which details our clinical service priorities for the next 5 years, aligned to our strategic objectives.
- Overarching Clinical Service Strategy has been drafted.
- The Clinical Service Strategy will act as a thread running through each of the remaining enabling strategies. This approach is designed to empower clinical teams to direct the future of their services and provide the best acute hospital services to the communities we serve.

c. Monitoring Progress

- The Divisions are currently translating their Clinical Service Strategies into their 2021/22 operational and strategic plans.
- The introduction of the accountability performance framework (APF) will monitor quarterly progress against trajectories.

together we will

Strategic Framework
Our Enabling Strategies

Wirral University Teaching Hospital NHS Foundation Trust

a. Digital Strategy
- Our Digital Strategy aims to deliver our strategic objectives by delivering digitally enabled best care for everyone.
- 4 digital domains aligned to our strategic objectives will form the overall Digital Strategy: digital foundations, digital innovation, digital education and digital intelligence.
- Digital Strategy completion May 2021.

b. Digital Foundations Engagement Workshop
- Digital foundations is made up of the following 5 key elements: end user computing, IT service continuity and recovery, networking and communications, security, governance & risk management.
- The digital foundations workshop took place 10th February 2021 during which a SWOT analysis was completed by the IT team to determine their current position and using our strategic foundation model basic, better and best, each of the 5 elements which make up digital foundations were discussed, to map out their priorities over the next 5 years.
- Workshop outputs have been shared with the wider team for sign off.

c. Digital Education
- Digital education is currently in development and from research undertaken to date, the key elements of focus will be digital staff and digital patients.
- This digital education domain will require wide range clinical engagement and therefore we are planning a workshop date which provides 6 weeks notice to promote a well represented session. In addition patient engagement will be required to establish digital education requirements to enable our patients to access digital health care services.

d. Next Steps
- Develop digital innovations and digital intelligence domains.

together we will

Next Steps
Our Enabling Strategies

Wirral University Teaching Hospital NHS Foundation Trust

a. Estates Master Plans

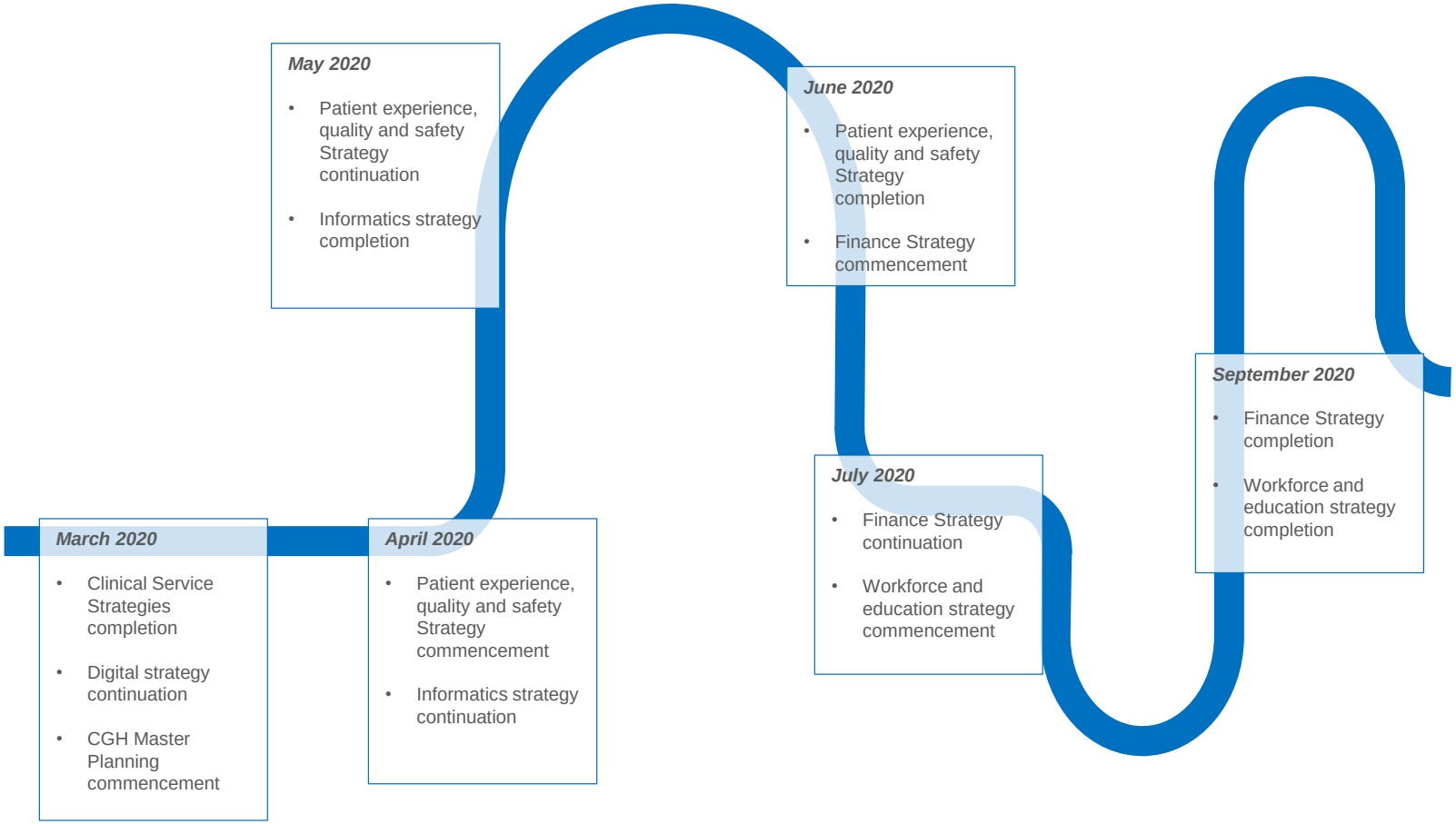
- Work in underway in developing our Estates Master Plans starting at CGH, working in conjunction with campus partners.
- Infrastructure priorities from each of the 32 Clinical Service Strategies have been grouped into key themes, including: outpatients, theatres, bed base, improving and maintaining facilities/environment and office space.
- Clinical services expressing priorities in relation to CGH have been mapped out, overlaying activity and co-dependencies.

b. Patient Experience, Quality and Safety Strategy

- Engagement with our new Head of Quality is planned for March 2021 with kick start and development from April 2021.

together we will

Enabling Strategies Roadmap – Q1 & 2 21/22



Agenda Item: 20-21/248

BOARD OF DIRECTORS
03 MARCH 2021

Title:	Initial Capital Programme 2021/22
Responsible Director:	M Swanborough, Director of Strategy and Partnerships
Presented by:	M Swanborough, Director of Strategy and Partnerships

Executive Summary
This document sets out the approach for the development, prioritisation and allocation of capital funding for the 21/22 financial year, along with the management and delivery of the capital programme across the financial year

Recommendation: (e.g. to note, approve, endorse)
To note

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Risk relating to backlog maintenance
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
NA
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Capital funding
Specific communications and stakeholder /staff engagement implications
Staff Engagement on capital project delivery through Leaders In Touch
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Improvements in patient and staff facilities

Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
Nil	
Previous considerations by the Board / Board sub-committees	Capital Sub-Committee
Background papers / supporting information	

Wirral University Teaching Hospital
NHS Foundation Trust

Approach to the 21/22 Capital Programme

February 2020

v5

1. Background and scope

a. Background

- Wirral University Teaching Hospital NHS Foundation Trust operates an annual capital programme across the organisation, with funding allocated each February and March and delivery tracked across the financial year.
- Over the past five years, the Trust has used a number of approaches to prioritise and allocate capital funding across the organisation. In more recent times, this has been a risk based approach, using the Trust risk system as a basis for the allocation of funding to capital projects.
- Over the past three financial years, the Trust has also seen slippage of capital programme delivery to budget, with underspends across individual projects as well as collective programmes, primarily across estates. This variance was most significant in 2019/20, with the Trust recording a capital underspend of 28% to budget.
- In 20/21, the Trust put in place a number of steps to improve delivery of the capital programme and reduce slippage, including the formation of the monthly Capital Management Group and weekly Capital Programme Review as well as the appointment of the Director of Capital Planning and Capital Planning Team.

b. Scope

- This document sets out the approach for the development, prioritisation and allocation of capital funding for the 21/22 financial year, along with the management and delivery of the capital programme across the financial year.

2. Historical Capital spend and trends

a. Overview of historical capital spend

- Across the current and past three financial years, the Trust has averaged a capital spend of approximately £11m, primarily funded through the Trust, with some additional NHS England and NHS Digital funding across this period for specific programmes, including the NHS Global Digital Exemplars, ICU upgrades and A&E refurbishments. In addition, the Trust received funding through direct donations and the Trust Charity.

b. Examination of historical capital spend

- As part of the development of the approach for the 21/22 Capital Programme, analysis was undertaken of capital spend over the past four years. This showed a changing picture in capital expenditure over this period, with 35% of capital expenditure on estates (primarily in 20/21), 37% on equipment and 28% on information technology.
- The diagrams, right, also highlight the low portion of expenditure on the hospital estate between 2017/18 and 2019/20.

Diagram: Capital spend percentage by type: 17/18 – 20/21

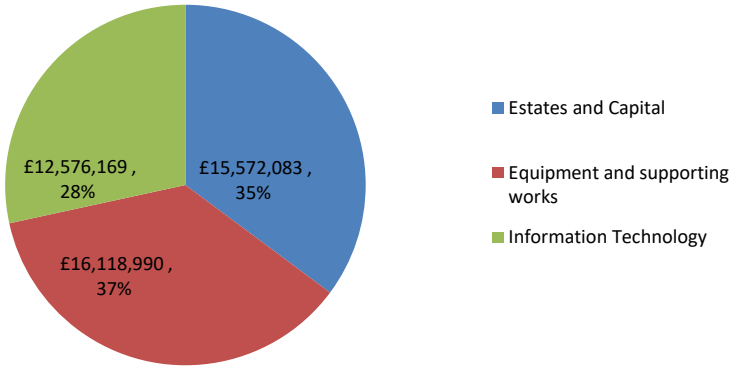
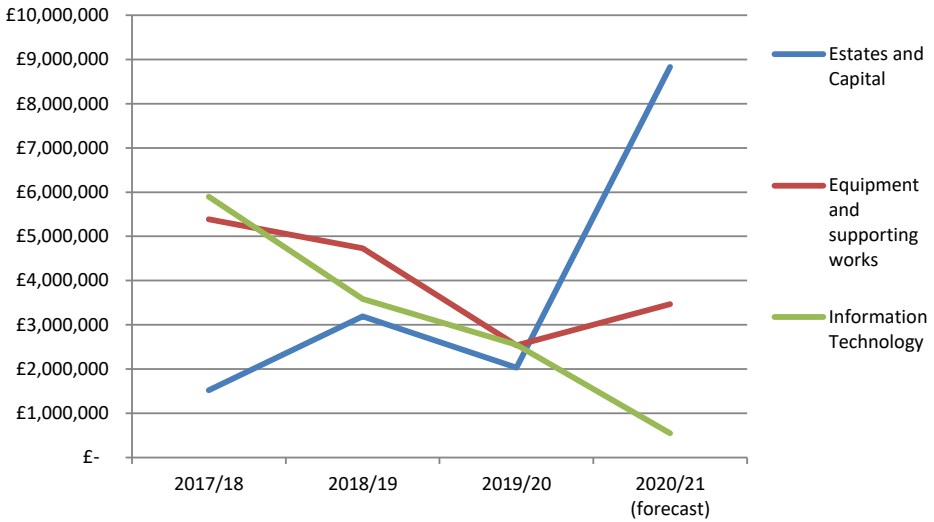


Table: Capital spend by service line : 17/18 – 20/21

Area	2017/18	2018/19	2019/20	2020/21 (forecast)
Estates and Capital	£1,522,144	£3,190,000	£1,340,000	£1,804,000
Information Technology	£2,188,530	£1,373,000	£2,135,000	£501,000
Information Technology (GDE)	£3,708,149	£2,647,000	£414,000	
Medicine and Acute	£908,187	£130,000	£280,000	£484,000
Surgery	£381,854	£556,000	£898,000	£1,318,000
Womens and Children	£154,214	£538,000	£61,000	£68,000
Diagnostics and Clinical Support	£2,194,343	£3,340,000	£789,000	£676,000
Trust wide & central schemes	£782,203	-£437,000	£296,000	£4,620,000
Donations and Charity	£965,022	£165,000	£194,000	£132,000
Prior Year Commitments		£0	£693,000	£3,242,000
Total	**£12,804,647**	**£11,502,000**	**£7,100,000**	**£12,845,000**

Diagram: Capital spend by type: 17/18 – 20/21



3. Current challenges

a. Current capital challenges

- There are a range of capital challenges for the Trust including estates backlog maintenance and renewal, equipment replacement and technology or statutory capital requirements.
- In addition, there is the challenge of delivery of the capital programme to budget, with the programme historically under delivering to budget.

b. Maintenance and replacement challenges

- The major challenge across the Trust estates is backlog maintenance and repairs. The Six Facet Survey completed by Nous Group in January 2019, highlighted a backlog maintenance risk of £31.7m, with £21m rated as high or significant risk to the organisation.
- As detailed in the table, right, the majority of this backlog maintenance risk is at the Arrowe Park Hospital site, potentially impacting on the delivery of clinical services. Current high risk areas include fire systems, electrical systems, mechanical systems, medical gases, heating, flooring and ventilation.
- There are similar challenges with medical equipment across the Trust, with some equipment in disrepair or being used past specified lifespan.

Table: Estates maintenance backlog by risk level

Hospital site	Backlog Costs (Incl. % Uplift)	Backlog Risk Totals (Incl. % Uplift)			
		Low	Moderate	Significant	High
Arrowe Park Hospital	£29,176,396	£6,498,934	£2,607,888	£12,989,946	£7,079,627
Clatterbridge General Hospital	£2,558,071	£1,245,913	£287,130	£950,613	£74,416
Total	**£31,734,467**	**£7,744,847**	**£2,895,018**	**£13,940,559**	**£7,154,043**

4. 21/22 Capital Programme budget and commitments

a. 21/22 Capital Programme budget and funding

- Based on recent analysis, it is estimated that the Trust will have a capital budget of £13m, based on depreciation estimates and capital underspends from 20/21. This excludes funding for the design and construction of the urgent and emergency care centre which will be funded and managed separately from the 21/22 capital programme.
- As part of the 21/22 capital programme, there are a funding number of commitments from the prior years, as detailed in the table, right, including GDE and estates schemes. This reduces the remaining 21/22 capital budget to £7.0m.

Table: Proposed Capital funding estimate: 21/22

2021/22 Capital Funding Estimate	Estimate Plan
	£
Internal Depreciation	10,900,000
less:	
Donated Asset Depreciation	(270,000)
Capital Loan repayment	(1,015,000)
Capital Element of Finance Leases	(65,000)
plus:	
Donated Asset Income	0
Cash Reserves b/fwd from previous years* (to be approved)	3,500,000
less:	
Funding not used - locally declared underspend	0
BAU Forecast	**13,050,000**

Table: Proposed Capital funding commitments : 21/22

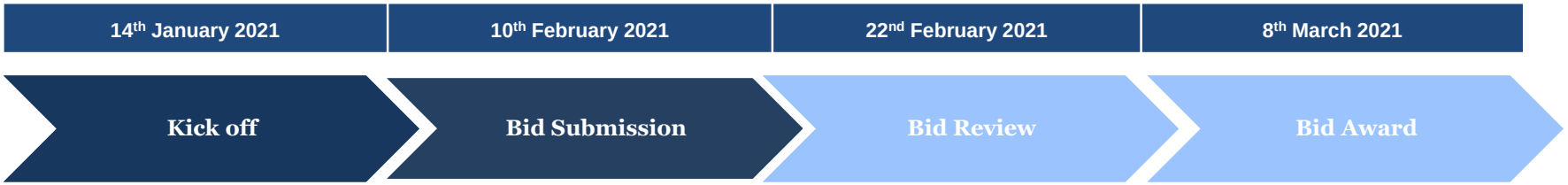
Area	Item	Estimated spend
Information Technology	IT - GDE	£304,000
Information Technology	IT - GDE - opthamology medisoft	£33,000
Information Technology	IT - Wireless Network Refresh	£80,000
Capital and Estates	Estates -Ward Refurbishment (2 wards)	£2,400,000
Capital and Estates	Estates - Hot/Cold Water Distribution	£346,000
Capital and Estates	Estates - Bleep system (ward 10)	£60,000
Capital and Estates	Estates - Carpark APH (preliminary works)	£400,000
Capital and Estates	Critical Care Upgrade (PDC)	£870,000
Capital and Estates	Capital Delivery Resource	£400,000
Capital and Estates	Soft FM Staff changing areas	£500,000
Capital and Estates	Contingency (5%) - equipment and estates	£652,500
Total		**£6,045,500**

5. Approach to 21/22 Capital Programme bids and requests

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital Programme bid approach and timeframes

- The diagram below details the timeframes for the submission of capital bids, review and award of bids and approval by Trust Board sub-committees. This includes the formation of a Capital Bid Panel to review and award bids.
- For the 21/22 Capital Programme bid process, the Trust will use the NHS Capital Physical Condition Ranking Protocol as a basis for identification, ranking and review of bids, as highlighted on the following page.



Kick off

- Approval of approach by Executive
- Divisions notified of capital bid approach and sent documentation and template
- Documents and templates sent to Divisional triumvirates, including supporting documentation

Bid Submission

- Divisions to submit bid submission forms and associated documentation (items over £75k) to Director of Strategy and Assistant Director of Finance
- Submissions collated and initial review undertaken

Bid Review

- Capital Bid Panel convened (CFO, COO, Director of Strategy, Head of Procurement)
- Bid Review meeting held
- Clarification sessions with Divisions held

Bid Award

- Successful bids notified
- Procurement routes agreed
- 21/22 Capital Programme to be approved by Capital Committee and FBPAC , then Board

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21-249

Board of Directors
3rd March 2021

Title:	Monthly Safe Nurse Staffing Report
Author :	Tracy Fennell - Deputy Chief Nurse Johanna Ashworth-Jones - Programme Developer, Corporate Nursing Team
Responsible Director:	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)
Presented by:	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)

Executive Summary

The safe nurse staffing dashboard provides an oversight of areas related to the provision of nurse staffing, both RN and CSW. Month 10 saw a significant increase in the number of RN and CSW shifts required to safely staff wards due to increasing acuity and dependency, coupled with the need to staff 11 red wards which brings an added work pressure because of the level of PPE required. Sickness was also the highest level since M4.

To maximize the fill rate the nurse incentive scheme was revised so staff could book a single shift at a time. This improved uptake and reduced unfilled shifts; the Trust has also block booked a number of agency RNs to support safe staffing levels in the Emergency Department , Critical Care , General Surgical and Elderly Medicine Wards.

The Trust has continued to use the Winter Staffing Escalation Plan to ensure deployment of senior nursing and non-ward based nursing staff to work clinically. The Trust also remains on track with the International Recruitment Programme to support the recruitment of up to 100 international nurses before end of April 2021. The first cohort of 14 nurses arrives from India on 24 February 2021, they are expected to be working on the wards as RNs in April 2021 following successful completion of the Objective Structured Clinical Examinations (OSCE).

Recommendation: (e.g. to note, approve, endorse)
To note

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes / No

Our partners: provide seamless care working with our partners	Yes / No
Digital future: be a digital pioneer and centre for excellence	Yes / No
Infrastructure: improve our infrastructure and how we use it.	Yes / No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
BAF references 1,2,4,6. Nurse Staffing is scored as 16 within Medicine and Acute Positives. • The Trust has robust systems and processes in place to flex and monitor nurse staffing to meet the demands of the organisation and patient requirements. • Despite the demand for registered nurse (RN) hours increasing from 28638 to 42759 hours per month the Trust has maintained NHSP fill rates at 57% through the use of the nurse incentive scheme. • 100 international nurses that are expected to arrive in the Trust before the end of April 2021 Gaps. • The Trust has seen an increase in the use of agency nurses utilised to fill RN staffing gaps to 2.30% • The Trust has seen an increase in RN sickness rates to above 9 % and CSW sickness to above 12 % (M10).	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
NHSI – developing Workforce Safeguards , CQC Essential Standards	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
Nursing expenditure	
Specific communications and stakeholder /staff engagement implications	
Stakeholder confidence	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
NMC Code , NHS Constitution, NHS People Plan	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
NA	
Previous considerations by the Board / Board sub-committees	Monthly safe nurse staffing report to Board since October 2020
Background papers / supporting information	NA

BOARD OF DIRECTORS MEETING IN PUBLIC
3rd March 2020

Monthly Safe Staffing Report

Purpose

This report provides the Board of Directors with information, assurances and risks associated with the safety of nurse staffing within the Trust.

1 Current position: areas to note

1.1 Vacancies

Due to a technical fault in ESR it transpired that data reported for M8 and M9 was incorrect. This has now been revised (noted blue on the dashboard Appendix 1). RN vacancies rates have steadily increased since M6 (16.9%) to M10 (19.42%).

1.2 Sickness

RN and CSW sickness are noted to be at the highest level seen since M4, reported at 9.17% RN and 12.34% CSW in M10.

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M10 the SSOT recorded 689 shifts that fell below minimum staffing levels for RNs; this is a significant increase from the 499 red shifts recorded in M9. There were no shifts in red when assessed using professional judgement, as appropriate controls or mitigations were put in place.

1.4 Impact on Care

A retrospective review is undertaken of all shifts that fall below minimum staffing levels to identify any potential or actual harms that may have occurred. These are be recorded on the SSOT and compared to Trust incident data.

Key areas to note for M10 are:

- Increased number of falls (26 compared to 19 in M9)
- Increase in the number of shifts where staff missed breaks (119 from 107 in M9)

- Reduction in reported medication errors (2 compared to 27 in M9)
- Reduction in number of times patients had delayed pressure area care (46 from 145 in M9)

Incident reports are being reviewed for triangulation to identify any potential harm as a result of reduced staffing levels.

1.5 Recorded incidents relating to safe staffing for nursing

There was an increase in reported incidents during M10 with a total of 102. These are currently under review to identify themes such as staff moves, missed breaks or lower staffing numbers.

2. Actions to mitigate risks

The Corporate Nursing Team continues to monitor standards of safety and quality using the mini WISE/ spot check programme. The outcomes of reviews will be reported to Patient Safety Quality Board in March 2021. This is in addition to the existing assurance mechanisms.

During Q3 the Trust purchased and implemented updated falls prevention technology; Rambleguard mats and electronic sensor devices for bathroom. Focused work has taken place in wards with higher numbers of falls. Reducing falls overall and those resulting in harm, will be a priority for the Quality Improvement team.

Nurse staffing meetings continue at a minimum of twice daily and a Matron is on a late duty every day to oversee safe staffing. Staffing concerns are reported in Bronze Command each day. The Trust has continued to use the Winter Staffing Escalation Plan to ensure deployment of senior nursing and non-ward based staff to work clinically.

The Trust remains on track with the International Recruitment Programme to support the recruitment of up to 100 international nurses before end of April 2021. The first cohort of 14 nurses arrives from India on 24 February 2021, they are expected to be working on the wards as RNs in April 2021 following successful completion of the Objective Structured Clinical Examinations (OSCE). Further cohorts are due to arrive in March, April and May.

Cohort	Arrival	OSCE date	Wards
1+2 (21 Nurses)	WC 22/ 28 Feb (TBC) and 8 March	13/14/28th April	End April / May
Cohort 3, 4 , 5 ,6 (total 87 nurses)	WC 18 March (cohorts 3 and 4) WC 20 April (cohorts 5 and 6)	14-18th June	End June
Strand B (28 nurses)	End May	July / August	July /August

The Trust is part of the national recruitment programme for CSWs. We are aiming to reduce vacancies to zero during Q1 2021/22.

3. Establishment reviews

The Trust is required to undertake a six monthly acuity and dependency study to support establishment reviews, as outlined in the NHS Improvement (NHSI) Developing Workforce Safeguards document (2018).

Due to the ongoing instability of wards and the imminent impact of the reset and recovery programme in Q1 it is recommended the Trust does not undertake the acuity and dependency study in March. The senior nurses will continue to use professional judgement to manage the fluctuating demands of staffing until the effects of the COVID-19 pandemic have reduced and the impact of the additional 100 international nurses can be seen. The previous study in Summer 2020 yielded unreliable data owing to the arrangements for managing the pandemic. It is likely that the next study will be undertaken during late Summer 2021.

4. Conclusions

M10 has been challenging for nurse staffing due to high sickness, vacancies and the implications of COVID-19 on clinical practice. The review of staffing incidents will reveal any additional impact to those already detailed within and will be reported next month. The flexibility introduced for the nurse incentive scheme has mitigated many risks by supporting better fill rates.

The high vacancy rate should reduce into the new financial year when the 100 plus international nurses and additional CSWs start in the Trust.

5. Recommendations to the Board

The Board of Directors are requested to note the contents of report and to support the decision to undertake one acuity and dependency study at the end of Q2 in anticipation of a full nurse staffing establishment review in early Q3 that will inform the Winter Nurse staffing plans for 2021/22.

Appendix 1
Safe Staffing Assurance Dashboard July to January 20/21

	Safe Staffing Board Assurance Dashboard 2020								
Data Source	Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total		9.6	8	8.5	10.1	9.5	8.1	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses		4.8	3.8	4.1	5.2	4.8	4	
Corporate Nursing	Care Hours Per Patient Day - CSW's		4.2	3.5	3.7	4.1	3.8	3.4	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	79%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	86%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	77%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	95%	
Corporate Nursing	Trust Occupancy Rate	57.20%	66.90%	79.50%	79.50%	76.10%	79.30%	83.50%	
Corporate Nursing	Occupancy Rate - APH	63.10%	72.10%	81.50%	79.10%	76.00%	80.30%	82.30%	
Corporate Nursing	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	50%	
Workforce	Vacancy Rate (Band 5 RN's)	18.46%	18.05%	16.94%	16.61%	17.66%	18.10%	19.42%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.57%	20.16%	18.73%	17.11%	17.72%	18.49%	19.89%	
Workforce	Vacancy Rate - All RN (All grades)	9.81%	9.90%	9.40%	8.67%	9.79%	9.57%	10.79%	
Workforce	Vacancy Rate (CSW's)	5.89%	5.86%	7.86%	7.77%	8.11%	6.28%	6.79%	
Workforce	Sickness Rate - RN	5.69%	6.12%	6.38%	6.80%	6.95%	6.49%	9.17%	
Workforce	Sickness Rate - CSW	10.46%	9.58%	10.09%	8.82%	7.59%	8.18%	12.34%	
Workforce	Absences Rate - RN	4.84%	2.36%	2.60%	1.55%	1.76%	1.50%	2.39%	
Workforce	Absences Rate- CSW	4.96%	3.33%	3.17%	1.55%	2.17%	1.56%	2.64%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	0	
Corporate Nursing	Number of RN Red Shifts		359	445	454	243	499	689	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	26	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	2	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	1	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	33	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	38	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	119	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	278	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	237	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	46	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	299	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	1	1	
Corporate Nursing	Total Number of staffing incidents	30	53	80	75	25	90	102	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	1	
Complaints team	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	
Corporate Nursing	Staff Moves		232	329	140	164	172	TBC	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	43952	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	42759	
NHS Professionals	% of requested filled RN's	67.80%	62.80%	61.70%	60.20%	72.70%	58.90%	57.50%	
NHS Professionals	% of requested CSW filled	86.30%	80.20%	76.50%	71.10%	85.30%	68.10%	62.80%	
NHS Professionals	% of Agency staff used RN	3%	3%	3%	2%	6%	1%	2.30%	
NHS Professionals	% of Agency staff used CSW	0	0	0	0	0%	0%	0%	

Agenda Item: 20/21-250

BOARD OF DIRECTORS
3 March 2021

Title:	Guardian of Safe Working Quarterly Report
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director and Deputy CEO
Presented by:	Dr Helen Kerss

Executive Summary

The Guardian of Safe Working is a senior person, independent of the management structure, within the organisation by whom the doctor in training is employed. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms & Conditions (TCs) for doctors and dentists in training.
This report provides:

- Details of the actual number of doctors in training.
- Details of the exception reports submitted for the reporting period by speciality and grade.
- Details of breaches of standards of safe working hours and fines incurred.
- Details of locum bookings

Recommendation:
(e.g. to note, approve, endorse)

- Board to note the Guardian of Safe Working report.
- Working hours continue to be monitored and rotas are being reviewed to ensure compliance.
- O&G junior doctor rota review by April 2021
- Clear work schedules need to be visible and issued in a timely manner
- A workforce review and strategy needs to be developed

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	No
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
N/A	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
CQC staffing	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
CIP in reducing locum spend	
Specific communications and stakeholder /staff engagement implications	
NA	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
NA	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
NA	
Previous considerations by the Board / Board sub-committees	Workforce Assurance Committee
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
3 March 2021

GUARDIAN OF SAFE WORKING REPORT

Purpose

To provide an update on compliance with the safe working directive as set out in the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

Introduction / Background

The number of gaps present in the trainee medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive, and to reduce overall locum and agency spend. There are currently a total of 346 (340.7 WTE) doctors/dentists in training in the Trust.

To monitor compliance with the working hours' directive, Doctors/Dentists in Training (DiT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. This report details a summary of vacancies, exception reports and locum bookings submitted for the Q3 2020 (August to October).

Vacancies

Table 1.1 below shows the number of vacancies per month

Table 1.1

Vacancies by month						
Division	Grade	August	September	October	Total gaps (average)	Number of shifts uncovered
Medical and Acute	F1	0	0	10	3.33	0*
Medical and Acute	ST1-2	6	6	4	5.33	0*
Surgery	ST1-2	0	2	2	1.33	0*
Surgery	ST3-5	2	0	0	0.66	0*
Total		8	8	16	10.66	

*vacancy shifts filled by agency/bank

Exception reports

The system of exception reporting ensures that departures from planned working hours, working pattern or access to planned training opportunities are recorded. DiTs report exceptions where day-to-day work varies from that in the agreed work schedule. Upon receipt of an exception report, a discussion takes place with the DiT and their educational supervisor to understand what action is necessary to address the exception, and to ensure that it remains an exception. If the additional work was a result of workplace requirements, payment or time owing in lieu is agreed as appropriate. The Guardian of Safe Working

assesses whether a fine is required.

Fines are levied when working hours breach one or more of the following provisions:
a) The 48 hour average weekly working limit
b) Contractual limit on maximum of 72 hours worked within any consecutive 7-day period
c) Minimum 11-hour rest has been reduced to less than 8 hours
d) Where meal breaks are missed on more than 25 per cent of occasions.

The tables below provide a summary of the exception reports submitted during the Q3 period.

Exception reports for this reporting period were submitted by all grades of DiTs.
During Q3, the main reasons for exception report submission were staffing levels, workload and the inability to finish shifts on time. It is noted that this period was during the Covid pandemic.

All exceptions approved for payment have been actioned.

Table 1.2. Exception reports by specialty

Exception reports by specialty				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	2	2	0
General Medicine	0	12	12	0
General Practice	0	12	12	0
General Surgery	0	13	13	0
Obs & Gynae	0	8	8	0
Traumatic and Orthopaedic Surgery	0	4	4	0
Total	0	51	51	0

Table 1.3. Exception reports by grade

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	16	16	0
F2	0	14	14	0
SHO	0	18	18	0
SPR	0	3	3	0
Total	0	51	51	0

Table 1.4. Response time for exception reports

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	6	7	3	0
F2	13	0	1	0
SHO	13	3	2	0
SPR	1	2	0	0
Total	33	12	6	0

In summary, 51 exception reports were submitted during this Q3 period. No fines have been issued.

Issues have been raised in regard to the rota within Obstetrics and Gynaecology in that the evening handover period was not included in the rota despite the DiTs being requested to attend. A rota review is being undertaken.

Locum and agency bookings

There continues to be a high requirement for locum bookings, particularly within ED and Medicine, in order to maintain agreed safe staffing levels, as shown in the tables below:

Table 2.1. Locum bookings by department

Locum bookings by department					
Department	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worke
Acute Medicine	26	26	0	226.33	226.33
Critical Care	1	1	0	12.5	12.5
ED	282	280	2	1616.03	1616.03
ENT	13	13	0	52	52
GP	1	1	0	8.75	8.75
Medicine	345	196	149	1601.75	1601.75
Neonates	20	20	0	222.5	222.5
Obs &Gynae	32	24	8	231	231
OMFS	14	14	0	67.25	67.25
Ophthalmology	13	13	0	200	200
Paeds	25	25	0	274.25	274.25
Surgery	76	34	42	335.33	335.33
Trauma and Orthopaedic	31	30	1	311.5	311.5
Urology	28	28	0	245	245
Total	907	705	202	5404.19	5404.19

Table 2.2. Locum bookings by grade

Locum bookings by grade					
Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
F1	63	63	0	413	413
F2	87	87	0	625.66	625.66
SHO	443	278	165	2018.28	2018.28
SPR	314	277	37	2347.25	2347.25
Total	907	705	202	5404.19	5404.19

Conclusions

Doctors and Dentists in training continue to submit exception reports as appropriate. Exception reports are dealt with in a timely manner. All those approved for payment have been processed.

There have been 51 exception reports during the Q3 period. No fines have been issued.

The Guardian of Safe Working supports the DiTs and is proactive in involving them in rota design. Clear work schedules need to be visible and issued in a timely manner

The Trust still has significant need for locum doctors, especially in ED and Medicine. This needs to be addressed through a comprehensive workforce review and strategy development.

Recommendations to the Board

It is recommended that the Board note the content of this report and support a comprehensive workforce review and strategy development in order to assist to mitigate risk, safeguard the safe working hours for doctors in training, ensure patient safety and deliver a sustainable medical workforce.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21 251

Board of Directors
3rd March 2021

Title:	Review of Ockenden Report and Assurance of Maternity Services
Author :	Debbie Edwards Director of Nursing & Midwifery, Women & Children's Division Anne Marie Lawrence, Interim Deputy Head of Midwifery/ Governance Lead, W&C Division
Responsible Director:	Hazel Richards, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC)
Presented by:	Hazel Richards, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC)

Executive Summary

In recent years there have been a number of reports identifying poor quality maternity care within Trusts which have included a failure to escalate appropriately, poor governance processes, a lack of incident reporting (including serious incidents) and ineffective leadership. These have been identified through complaints, CQC inspections, independent reviews and investigations. The Independent Review of Maternity Services at Shrewsbury and Telford by Donna Ockenden is the latest of such reports which can be found via the following link:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Part 1 of the review was published in December 2020 with Part 2 due to be published in the Winter of 2021. Other such reports that are due to be published include Cwm Taff and East Kent which are due in the Summer of 2021.

To provide assurance and oversight of safe and effective maternity care at WUTH the Women's & Children's (W&C) Divisional Triumvirate presented to Board of Directors in August and September 2020; and subsequently to the CCG. The reports were also shared with CQC.

This report details WUTH's compliance with the Ockenden Report "Immediate and Essential Actions" (IEA's); and provides reference to the Maternity Safety Actions (CNST-Maternity Incentive Scheme) and its link to 'Urgent Priorities' (Appendix 1). Further improvement work by NHSE/I and the Local Maternity System (LMS) includes the introduction of the Perinatal Quality Surveillance Model (PQSM) the aim of which is summarized within the report.

The latest outlier data report is included in Appendix 2. WUTH is identified and confirmed as not being an outlier with the exception of:

- Caesarean section rates where WUTH has an exceptionally low elective caesarean section rate compared to other providers and
- A higher than anticipated emergency rate. This is explained further in the report.

Recommendation: (e.g. to note, approve, endorse)
To note

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it	No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
BAF references 1, 2, 4 and 6 1. The Trust is compliant with the 7 IEAs from the Ockenden Report 2. From the Regional Dashboard WUTH is confirmed as not being an outlier with the exception of 2 areas – explored within the report.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

Previous considerations by the Board / Board sub-committees	Maternity Assurance reports in August and September 2020.
Background papers / supporting information	The Independent Review of Maternity Services at Shrewsbury and Telford by Donna Ockenden. December 2020.

BOARD OF DIRECTORS MEETING IN PUBLIC
3rd March 2021

Maternity Services update:

WUTH Compliance against the 7 Immediate and Essential Actions (IEA's) from the Ockenden Report – Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020)

Purpose

This report will detail the evidence and compliance against the Ockenden 7 IEAs. The data from the NW regional maternity dashboard will also provide information and assurance to the Board, on the safety of maternity services at the Trust.

Introduction / Background

The importance of Board level scrutiny of maternity services cannot be underestimated. This has been demonstrated many times through the lens of failing services and national enquiries; for example Cwm Taff; Shrewsbury and East Kent; and historically Morecambe Bay. Such outcomes have included preventable perinatal mortality, perinatal and maternal morbidity and maternal death.

An in-depth assurance report was presented to the Board of Directors in September 2020.

In 2015 following the publication of the Kirkup Report, the need for improvement in the delivery of maternity care was identified at the Trust. In the same year the CQC rated maternity services at the Trust as "Requires Improvement". At this time there were significant cultural issues and a lack of effective leadership within the maternity service. Significant action and transformation was undertaken. In 2018 the maternity service was rated as "Good" by CQC. There has been and continues to be considerable innovation and improvement work in line with the recommendations from the National Maternity Transformation Programme.

Following publication of the Ockenden Report in December 2020 Trusts were directed by NHSEI to undertake a gap analysis of the 7 "Immediate and Essential Actions" (IEA's) identified within the report. All compliance returns have been submitted to the Local Maternity System (LMS) and NHSE/I within timeframe.

Compliance with the Immediate and Essential Actions and Urgent Clinical Priorities

1. Assessment and Assurance Tool

The completed Assessment and Assurance tool (appendix 1) includes compliance status with the 7 IEA's, the Urgent Clinical Priorities and a cross reference to the 10 Maternity Safety Actions within CNST.
The following table outlines the summary evidence required to meet the 7 IEA's:

Immediate & Essential Action's (IEA's)	Minimum Evidence	Compliance	Comments
1: Enhanced Safety			
a) Perinatal Clinical Quality Surveillance Model	**A statement of commitment to follow the new regional process that will be implemented in January 2021.**	**Compliant**	The Trust is compliant from a provider perspective as statement of commitment provided to implement an Improvement plan once the Perinatal Clinical Quality Surveillance Model is published and introduced by both NHSEI and C&M LMS.
a) SI's shared with Boards/LMS/ HSIB	**SI's must be shared with Trust Boards and any sub boards or committees will not be accepted as compliant; examples of evidence may include Trust Board minutes as well LMS Board minutes and a monthly return of cases submitted to HSIB.**	**Compliant**	The Trust has submitted all 3 SI's for 2020 which has been acknowledged by the C&M LMS SRO. Trust have a process for submitting SI's to HSIB / Public Board however, the maternity SI's are to be submitted in full to Quality Committee. SI reports also submitted to Public Board on the 3rd March 2021.
2: Listening to Women and their Families			
a) Robust service	**Minutes of meetings**	**Compliant**	There is significant

feedback mechanisms	**where co-production has taken place with the outputs available i.e. service user information / involvement in guideline development etc.**		evidence (including an annual report, minutes of meetings) to support user involvement with the co-production of maternity services. The MVP Chair is also a safety champion and is involved in guideline/SOP development.
b) Exec/Non-Exec directors in place	**Name of the Executive Board Level Safety Champion and the Name of the Non-Exec Director Board Maternity Champion.**	**Compliant**	Hazel Richards – Chief Nurse is the Executive Board Level Safety Maternity Champion and Steve Ryan is the named Non – Executive Director Board maternity champion.
3: Staff training and working together			
a) Consultant led ward rounds twice daily	**Standard Operating Procedure for a minimum of twice daily consultant obstetrician ward rounds with supporting audit (spot check audit to be completed prior to 15th Jan submission if not already available as part of annual audit cycle).**	**Compliant**	WUTH is currently piloting a revised rota to meet the requirements of the twice daily ward rounds – both in the day and at night. This will be evaluated in March 2021 therefore compliance may be impacted at this time if the pilot rota not able to continue. Job plans and funding dependent.
b) MDT training scheduled	**Up to date Maternity Services Department Multi-Disciplinary Training Needs Analysis.**	**Compliant**	MDT TNA in place and is reviewed annually. The LMS are required to validate the training 3 times a year but there is currently no process in place- same awaited.
c) CNST funding	**A statement of**	**Compliant**	WUTH has to date

ring fenced for maternity	**commitment that year 3 (21/22) CNST incentive scheme refunds will be for use within maternity services.**		supported the CNST monies being ring fenced for maternity services. A statement of commitment from the Director of Finance further supports compliance.
4: Managing complex pregnancy			
a) Named consultant lead/audit	**Name of the Consultant Obstetric Lead with supporting audit from the previous 12-month annual audit cycle or spot check audit complete prior to submission on 15th Jan 2021.**	**Compliant**	There are named consultant leads for those women who experience a complex pregnancy. An audit has been undertaken and further ongoing audit is included in the Divisional forward annual audit plan (FAAP).
b) Development of Maternal Medicine Centre's	**Standard Operating Procedure and care pathway to which identifies how women are referred into a Regional Maternal Medicine Centre if the Trust does not have its own on site.**	**Compliant**	There are pathways/SOPs in place which identify those women needing referral to a Regional Maternal Medicine Centre. WUTH does have a named Maternal Medicine Consultant who further supports the management of women requiring specialist input in pregnancy. Further work is ongoing nationally reviewing current Maternal Medicine Centres.
5: Risk assessment throughout pregnancy			
a) Risk assessment recorded at every contact	**Spot check audit completed prior to the 15th Jan submission (if not already available as part of the annual audit cycle) plus a**	**Compliant**	The electronic record has a mandated field to ensure staff assess the woman's clinical risk at each visit. A spot check audit has been

	statement of commitment to sign up to the National Antenatal Risk Assessment process when available.		undertaken demonstrating compliance with continued audit planned on the Divisional FAAP. A commitment to sign up to the national antenatal risk assessment process (once published) further supports compliance with this IEA.
6: Monitoring Fetal Wellbeing			
a) Second lead identified	• **Midwife Lead for Fetal Monitoring and Well Being identified** • **Name of the Consultant Obstetrician Lead for Fetal Monitoring and Well Being identified**	**Compliant**	The Trust is fully compliant with Saving Babies Lives Bundle which incorporates the monitoring of fetal wellbeing. The Trust has a total of 3 Leads including a Midwifery and Obstetric Lead.
7: Informed Consent			
a) Pathways of care clearly described, on website	**A working link must be provided to access the website directly for review**	**Compliant**	The Trust website has a link to maternity services and information including pathways of care for women however it has been identified that the website needs further development and a T&F Group led by the Divisional Director has been set up to progress this work.

2. Perinatal Quality Surveillance Model (PQSM):

A national recommendation that was identified within the Ockenden report is the proposed introduction of a Perinatal Quality Surveillance Model (PQSM). Providers are awaiting its publication by NHSE/I which will further inform the LMS of its governance framework and reporting processes.

The purpose of the PQSM is to implement five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. The principles integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

The five principles in summary include:

Principle 1 – Strengthening trust-level oversight for quality through:
• Appointing a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
• The Trust Board undertaking a 3 monthly review of maternity and neonatal safety and quality.
• Ensuring that all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
• The use of a locally agreed dashboard.
Principle 2 – Strengthening LMS and ICS role in quality oversight:
NHS England and NHS Improvement are asking every system to be ready to operate as an ICS from April 2021, in line with the timetable set out in The NHS Long Term Plan. This will typically involve a single CCG aligned to each ICS and as CCGs merge and commissioning decisions become more streamlined across the ICS footprint, there will be the need for a managed transition for quality oversight. The ICS will have oversight of quality surveillance, planning and improvement, accountable to NHS England and NHS Improvement regional teams.
Local maternity systems were established to support the delivery of safer and more personalised maternity care and they bring together providers, commissioners, local authorities, service user voice representatives and other local partners to deliver a system plan. As ICS's evolve to become accountable for the quality and sustainability of services, the LMS should work with the ICS to take on a more formal role in perinatal clinical quality oversight alongside transformation and improvement activity.
Principle 3 – Regional oversight for perinatal clinical quality:
Each region has a quality committee or group which reports to the national Executive Quality Group. Each region also has a joint strategic oversight group (JSOG), which reports to the national JSOG however, these meetings are not maternity specific and are already in existence as part of standard quality oversight.
Principle 4 – National oversight for perinatal clinical quality:
The NHS England and NHS Improvement Executive Quality Group is the national governance group that oversees quality surveillance groups and receives escalations and reports.
A new Maternity Safety Surveillance and Concerns Group (MSSCG) was set up at national level in November 2020. It enables the timely identification and escalation of any trust-level concerns by national partners who have insight into maternity and neonatal services.
Principle 5: Identifying concerns, taking proportionate action and triggering

escalation:
Wherever possible, oversight, action and response should take place at provider level with the support of the safety champions and trust board, and other trusts in the LMS. A range of sources of intelligence should be drawn on to appraise the board that the quality of care is not deteriorating. Examples of such intelligence which should warrant further enquiry ahead of a decision to escalate include but are not limited to:
• Outlier status for perinatal and/or neonatal mortality
• Concerns identified through Trust Board, LMS or regional dashboard
• Thematic reviews identifying poor care as a contributory factor to outcomes
• Service user concerns, including themes from the CQC maternity survey
• Concerns raised by HSIB, NHS Resolution, through the Invited Review process, NMC, GMC and/or the Deanery (including any themes from trainee or staff surveys)
• Concerns raised by CQC
• Triangulated data which suggests a need for further enquiry.

3. Divisional Quality and Safety report

The Division currently produces a monthly Quality & Safety report that includes Divisional maternity and neonatal performance which is being reviewed in line with Principle 5, and will form a revised perinatal specific report.

4. Regional Dashboard / Outlier report

Monthly data is submitted to the regional North West Coast (NWC) Dashboard and this is plotted with other maternity providers to identify any areas of concern.

The latest outlier report is included in Appendix 2. WUTH is identified and confirmed as not being an outlier with the exception of:

- caesarean section rates where WUTH has an exceptionally low elective caesarean section rate compared to other providers and
- a higher than anticipated emergency rate.

Following a deep dive it was confirmed that a high proportion of emergency caesareans are in fact ‘semi elective’ and are cases that cannot be scheduled into planned available capacity. The need for an additional elective caesarean section list has been identified and this is currently being explored.

WUTH has one of the lowest rates of stillbirth within the region which correlates to the successful detection rates the Trust has regarding growth restriction in pregnancy. The Trust is in the Top 10 Trusts who successfully detect small for gestational age babies intervening before problems and complications develop. This is evident in the graph demonstrating babies born under the 3rd centile.

WUTH has a low ‘term’ admission rate which is due to the improvement with transitional care on the postnatal ward and the collaborative working between maternity and neonatal services.

5. Serious Incidents – 2020

Serious incidents (SI's) are reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria. In 2020 WUTH reported 3 SI's relating to maternity services however one of these was downgraded after its initial STEIS reporting.

Information included in the summary of SI's in 2020 has been redacted due to them being patient identifiable. SI reports will be presented at Quality Committee where the Board of Directors has oversight of the full report/s. All learning from SI's are tracked through an improvement plan which is monitored by the Divisional Governance Team, and also shared regionally with Safety Leads from other providers across Cheshire & Merseyside and Lancashire & South Cumbria.

Conclusions

The evidence included in the report supports compliance with all 7 IEA's, safety actions and urgent clinical priorities with a commitment to further improve once NHSEI have published further guidance on the Perinatal Quality Surveillance Model. Compliance with the process for the review of NICE Guidance, Midwifery workforce and the RCM Manifesto regarding strengthening midwifery leadership is met.

The outlier report further evidences Trust performance against clinical outcomes when compared to other providers across the North West Coast. WUTH is not an outlier and can demonstrate favorable outcomes with key clinical metrics.

Recommendations to the Board

The Board of Directors is asked to note:

- The declaration of compliance with all 7 IEA's including compliance with meeting the identified urgent clinical priorities.
- Compliance to the Safety Actions that link to the Maternity Incentive Scheme (CNST).

The updated and revised perinatal specific report will be included in the quarterly report to the Public Board of Directors in June; September and December 2021 providing appropriate update on Perinatal Safety within the W&C Division.

Appendix 1 :

Maternity services assessment and assurance tool

Wirral University Teaching Hospital NHS Foundation Trust

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance

that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
See narrative below	See narrative below	It is evident at WUTH that actions taken for delivering improvement are effective within its maternity service given the overall reduction in incidents resulting in moderate or severe harm. This evidence also includes a reduction in complaints, poor outcomes and overall satisfaction with the service. As a maternity provider within Cheshire & Merseyside WUTH is not identified as an outlier on the North West Coast Outlier Register with no recurrent themes identified when undertaking reviews.	Work proactively with the LMS in Cheshire & Merseyside to identify and support a process for monthly / quarterly reporting of SI's. To continue working with HSIB for timely investigations and outcomes to further support staff and service users.	The Director of Nursing & Midwifery has overall responsibility for ensuring the Trust works with the LMS for reporting of SI's and with HSIB. The timescale for the reporting of SI's to the LMS is dependent on the timeliness of agreement of process however all 2020 SI's have been reported to the LMS	Once published by NHSEI the LMS will provide and advise on its process for the reporting of SI's.	The Trust has robust processes in place for the reporting of SI's and is delivering on the linked maternity safety actions from CNST – Safety Action 1; 2 and 10. Refer to further narrative below regarding Trust Governance processes.

		WUTH is actively involved in the sharing of any learning identified following an SI as part of the Safety Special Interest Group (SIG). WUTH is also active in sharing other policies/SOPs and processes developed with other providers for shared learning/action.		week beginning 1st February 2021..		

Immediate and Essential Action 1: Enhanced Safety

The Maternity Service at WUTH has a local dashboard which is shared with Wirral Clinical Commissioning Group on a monthly basis through the contracts team. The dashboard is a standard agenda item on the Women's Clinical Governance meeting with exceptions also discussed at the Senior Midwife / Consultant meetings. The dashboard forms part of the Women & Children's Divisional quality assurance report which is presented to the Divisional Management Board (DMB) every month. WUTH also report direct into the North West Coast (NWC) regional dashboard on a monthly basis which is a more detailed dashboard consisting of a significant number of metrics. These are discussed at the Cheshire & Merseyside (C&M) Safety SIG meeting when a report of those organisations identified as outliers are discussed. These key metrics are also discussed at the C&M Stillbirth SIG and at the NWC Maternity Clinical Experts Group (CEG) as part of the outlier register which is coordinated and closely monitored by the Strategic Clinical Network (SCN).

WUTH will commit to support further discussion of the metrics within the dashboard at future LMS stakeholder meetings, when assurance will be provided to address any metrics/clinical outcomes identified as a concern. This discussion will also take place within the Divisional Clinical Governance meeting and DMB and escalated appropriately through Trust governance structures to Patient Safety Quality Board (PSQB) / Quality Committee The quarterly Maternity Services paper to Trust Board will also include reference to the dashboard with reporting by exception, including an outline of all appropriate action/s taken.

Every SI is reported on both the local and regional dashboard which provides an oversight of the total number of SI's within the region, Lessons learnt from both SI's , HSIB and from those cases meeting the criteria for review using the Perinatal Mortality Review Tool (PMRT) are shared at the Safety SIG, Stillbirth SIG and MAT CEG in addition to being shared within the Division. WUTH have senior staff representation at all of these meetings from either the Divisional Director of Nursing & Midwifery / Deputy, Consultant Obstetrician/s and Divisional Governance

representation. The Deputy HOM/Governance Lead and Fetal Medicine Consultant also chair the Stillbirth SIG regionally.

All cases of intrapartum stillbirth, maternal deaths, neonatal deaths and HIE are investigated and all have external representation from within the region as standard. Evidence from PMRT cases can be used to further support this as can the Board report. WUTH also supports the external review of cases within other Trusts and the SCN monitor such attendance.

From a Trust perspective there are robust processes in place within its Governance structure for the reporting of SI's and WUTH reports all SI's as per National policy. It has been agreed by the Executive Safety Champion that the detail of all maternity SI's will be presented at Quality Committee and the lessons learnt explained providing further assurance. The CEO reports every SI to Public Board on a monthly basis and this will be further enhanced for maternity SI's with a more detailed paper going to the Board of Directors meeting on a quarterly basis with redacted patient identifiable information. This process will further develop to mirror those arrangements agreed by the LMS for the reporting of all SI's across the region, including the triangulation of the ongoing assurance processes being introduced by NHSEI.

The Trust has achieved compliance of all 10 Safety Actions outlined in the CNST Maternity Incentive Scheme (MIS) in both Year 1 (2018) and in Year 2 (2019). The Trust is on target to be fully compliant in Year 3 (2020) of the MIS, however this has been difficult given the impact of the Covid Pandemic. An MIS action plan is in place and given the recent update on the timeframe, work continues to ensure the Trust meets all requirements of the MIS by July 2021 thereby delivering on the linked maternity safety actions

Link to Maternity Safety Actions

Action 1: All cases of intrapartum stillbirth, maternal deaths, neonatal deaths and HIE have external representation from within the region as standard – this can be evidenced from the quarterly board report which is pulled from PMRT. As a provider we are meeting all of the requirements of safety action 1 and will commit to continue working closely with the LMS to ensure they have oversight of all such cases.
Action 2: WUTH submit as per timetable to MSDS on all elements and have met all such requirements to date. The IT team have worked closely with the maternity team and in particular the IT midwife to further develop the electronic maternity system – Cerner Millenium to meet the increasing requirements of MSDS. A regular report in the form of a scorecard from NHSX confirms WUTH compliance in its reporting to MSDS. WUTH can also confirm its compliance with the MSDSv2 Information Standards Notice, DCB1513 and 10/2018.
Action 10: WUTH has reported 100% of qualifying cases for the year 2019/20 to NHS Resolution Early Notification scheme. All qualifying cases are reported to HSIB with the current timeframe of cases being 2020/21.

Link to urgent priorities:

A) For the reporting of all SI's across the region including triangulation with safety work/assurance processes undertaken by the LMS / NHSE/I.
a) A statement of commitment for WUTH to follow the new regional process that will be implemented in 2021 is agreed. A plan is being

developed with the region to implement the perinatal clinical quality surveillance model/tool. The Trust will further support the LMS in the implementation of the plan to ensure all aspects of the Perinatal Clinical Quality Surveillance Model are in place regionally. Compliance against this action will therefore be in line with LMS processes once assurance processes are in place from all providers.

From a Trust perspective there are robust processes in place within the Governance structure for the reporting of SI's and WUTH reports all SI's as per National policy. The Divisional have its own dedicated Governance team which further enhances effective working and close monitoring of processes. The CEO reports every SI to Public Board on a monthly basis and this will be further enhanced for maternity SI's with a more detailed paper going to Board of Directors on a quarterly basis with redacted patient identifiable information. WUTH also supports the narrative and learning from each SI Review being presented to Quality Committee to ensure the Board have further oversight of any themes and that there is evidence of learning which is invaluable within maternity services. This process will change further moving forward and will be in keeping and mirror those arrangements agreed by the LMS

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-

executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.						
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?** .	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
A Non Executive Director (NED) has been appointed – Mr Steven Ryan who will be providing oversight of WUTH maternity services to the Trust / Public Board. He works closely with the Trust Executive Safety Champion – the Chief Nurse (Hazel Richards) and the Chair of the MVP (Victoria Walsh) to provide independent oversight of the maternity service and will ensure that the service user voice is represented at Board level.	The minutes of the Board of Directors /Public Board meeting will evidence the quarterly Maternity Service update paper. This paper will also include the reporting requirements of the independent senior advocate once in post.	A report from the Safety Champions including the NED will be included in the quarterly Trust Board report. The independent senior advocate role is being developed by NHSE/I and once the JD/detail is in agreed and remuneration/detail re implementation from NHSE confirmed WUTH will support. Once in place, service users will evaluate the feedback from an advocacy perspective.	The Trust will support the independent senior advocate who will report into the Trust and LMS, once guidance from NHSE/I regarding the job description and remuneration is approved nationally.	NHSE/I are to lead on developing the role of the independent senior advocate. Anticipated timeframe is Spring 2021.	This is dependent on the requirements of the senior independent advocate role.	To continue with collaborative working / effective links with MVP and Safety Champions. To continue with the current process of debrief for parents and for staff following adverse events including the ongoing support by the PMA team.
Link to maternity safety actions						

Action 1: The quarterly Trust Board Mortality report includes any learning from maternal / perinatal cases and the Trust mortality paper is circulated for inclusion in CG meetings and DMB. The Trust has external representation at all of its PMRT meetings to evidence openness and transparency in the cases reviewed.
Action 7: Close partnership with MVP for co-production of services which can be evidenced through social media, production of a video, fortnightly joint on line open forum / listening events, annual MVP report and poster. The MVP chair has been present at interviews for senior leadership positions, has presented at staff meetings/online listening events and was involved in the recent IOL suite redesign. MVP are involved in the development of maternity services and are supporting with improved work with the BAME population on the Wirral identifying how specific needs can be met. The MVP Chair is involved and leads in the co-production of maternity services ensuring the engagement of service users from across the Wirral. The MVP Chair also works closely with the LMS providing feedback on work undertaken. This role will also extend into Neonatal services to further support Perinatal Safety. The MVP is also involved in the learning from concerns and has recently undertaken a 15 Steps review of maternity services with the maternity team. Involvement in the Facemums project has also provided opportunity to work with service users improving their maternity experience.
Action 9: The Trust has a full complement of safety champions who meet bimonthly undertaking walkabouts to clinical areas(although challenging of late) and there is also safety champion representation from both Wirral CCG and the chair of MVP. This increased safety champion representation will endeavour to include the independent senior advocate post holder moving forward to further support openness and transparency.
A named Non-exec director who will support the executive safety champion is in place and when the independent senior advocate is in post they will also support.

Link to urgent clinical priorities:
The Trust has a robust process in place for gathering service user feedback. The Trust has performed well with the Quality Health patient survey and was identified in the top 9 Trusts in England. There are processes in place for Friend and Family (FFT) feedback although during the pandemic reporting nationally has been on hold. Social media (coordinated by the MVP) and patient stories have featured heavily in providing service user feedback which has been particularly beneficial of late in ensuring we provide effective support to pregnant women and their families. Facebook live sessions are held fortnightly with the Consultant Midwife and MVP. Other Trust processes for obtaining service user feedback are varied include feedback via the Trust website; surveys; debriefing sessions; raising of concerns both informally and formally when improvements to services are introduced. The Induction of Labour suite was recently named by service users after a poll was undertaken by the MVP where over 100 service users identified a preference.
See above evidence to support IEA 2 – WUTH has a named NED to further support the Executive Safety Champion and MVP Chair.

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
WUTH will meet all of the requirements of IEA 3 once a mechanism is in place for external validation of training by the LMS 3 times a year. Training delivered currently at WUTH includes PROMPT which is recognised MDT Training and	Robust systems in place which will be able to feed into LMS once mechanism agreed	Robust reporting to Board in place. Once additional LMS process agreed this will be reported into. Any risks that pertain to non- compliance with the Assessment and Assurance log will be escalated via governance	Await LMS external validation process to be agreed regarding the validation of training. Await the outcome of the pilot and review the current work force plans of consultants to comply with ward	LMS to action the validation process. The Divisional Triumvirate to agree actions to support the compliance with the	None regarding validation of training – await update from LMS. Significant resource may be required once the outcome of the pilot is clear.	There is a robust system for reporting to Board and once the pilot is complete the Division will ensure all associated risks are included in the Divisional risk register.

accredited nationally therefore WUTH is compliant from a provider perspective. A pilot is currently ongoing to provide two ward rounds daily which include one in the day and one at night. This is to be reviewed at the end of March 2021. All monies allocated to training have been ring fenced to date in a separate budget line and used for its intended purpose – this will continue into 2021/22.	Process of audit to review the impact of the pilot and to look at the feasibility of changing job plans. Should this not be an option then the Trust will not be compliant without further resource and this will feature on the Divisional Risk Register.	processes and will also be included in the quarterly Board paper.	round requirements.	safety action to ensure twice daily ward rounds when a SOP will be developed outlining the process. Where not possible the Divisional Director of N&M will coordinate the addition to the risk register and escalated to Board.	This will be escalated appropriately and WUTH will ensure the LMS have clear oversight of any risk.	

Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

The LMS is not currently sighted on the compliance training reports and training content for organisations however this is discussed at Safety SIG and can feed into the LMS as standard, but a separate validation process is awaited. PROMPT training is currently delivered with annual planning of the Programme to ensure that it is fit for purpose. The Training Needs Analysis includes all staff who care for pregnant women including trained and untrained staff both in the Surgical and W&C Division

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

As noted above WUTH are currently piloting a new on-call system which has included changes to consultant PA's in order to achieve compliance – this will be reviewed after 9 weeks (early March) and has resulted in increased cost to the Division in the short term. A SOP will be developed at this time to support. Audit of the current arrangements confirms that the Trust is compliant with this action however we are mindful that this may change. Further audit of twice daily ward rounds is included in the Divisional forward annual audit plan (FAAP).

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.
WUTH can evidence that training monies have been utilised for this purpose historically and will still continue to be the case. Monies have also be utilised to further develop in-house training through a number of specialist midwives posts which further support the Trust to achieve safety in maternity services.
A statement of commitment from the Director of Finance further evidences a commitment that year 3 (2021/22) CNST Incentive Scheme refunds will be ring fenced for use for training / other safety related work within maternity services.
CNST refund for 2020 is supporting the business case for the installation of a central monitoring system and an analyst post which will support the data quality and cleansing that is required. Any additional monies that are secured are dedicated to upskilling and improving safety (eg support the Maternity/Neonatal programme) regional monies further support development of services eg WUTH is the host Trust for MSW development across Cheshire and Merseyside and are working closely with local education establishments to develop apprenticeships and provide relevant training to staff.

Link to Maternity Safety actions
Action 4: A review of BR+ took place in 2014 with a further partial review undertaken in 2017. A Birthrate+ review is currently being undertaken (between January – March 2021) and the Trust will implement any recommendations from the review once identified. However maternity workforce is included in the 6 monthly staffing paper that goes to Board and the Trust have recently supported the implementation of the Birthrate+ App which replaces the Acuity tool currently in use. This will support further improved speciality reporting to Board.

There is evidence to support the neonatal/obstetric workforce planning process which in place and is evidenced within the Trust. The Neonatal ODN also have over sight of safe staffing within neonatal services providing update as required and on request.
Action 8: The Trust has achieved compliance with this action in MIS Years 1 and 2 and can evidence compliance for Year 3 despite the significant impact of the Covid Pandemic. Processes are in place both in the Surgical and Women & Children's Division to support the release of staff to attend each year. The process for PROMPT is externally validated and mechanism in place for reviewing it. Midwifery staff also commit are supported to attend an additional training day that is midwifery specific. In addition all medical and midwifery staff are required to complete and pass the K2 CTG Training package.

Link to urgent clinical priorities:
a) Consultation with the Consultant team took place regarding amending job plans has taken place. It was agreed that a 9 week pilot be undertaken that involved changes to PA sessions (to accommodate covering the revised ward round requirements). A review of this pilot will take place in March 2021 however the changes have ensured compliance with two ward rounds daily..
b) There is an MDT training schedule in place which is reviewed annually however, the Trust await further guidance regarding the implementation of any validation process within the LMS.

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
WUTH have robust pathways for managing women with complex pregnancy conditions and all such women have a named consultant. Work is ongoing at present with Specialist	A supporting audit that reviews whether there is compliance with this standard is included in the FAAP and an initial snap shot audit undertaken indicated that there was significant compliance with high	All audits are presented within the W&C Division as they are included in the Divisional annual programme of audit. These are collated and are coordinated by the Division feeding into the Trust audit lead who	Review of audits for assurance as part of FAAP. Audit is undertaken in a timely manner and any actions are implemented to further improve compliance with this standard.	This is coordinated by the Trust audit lead and also monitored within the Division as part of FAAP schedule.	No additional resource as existing robust process are in place	Process is embedded which mitigates any risk.

Commissioning regarding the requirements of a Maternal Medicine centre but links are currently in place with Regional units that support collaborative working.	risk women having a named consultant. Further detailed audit awaited and is due to take place in March 2021. MDT process is in place within the maternity services where high risk women / complex pregnancies can be discussed which are embedded and working well. Agreed plans of care are kept in maternal (and neonatal if applicable) notes and review of the pregnancy outcome takes place.	also oversees any actions identified from the audit undertaken. These improvement plans are monitored centrally by the Trust audit lead.				

Women with complex pregnancies must have a named consultant lead
There is a process in place where those women who experience a complex pregnancy have a Named Consultant Lead. The Fetal/Maternal Medicine service employs two dedicated Fetal/maternal medicine Leads to further support process including the coordination of MDT working.

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
The MDT process is embedded within the service and a number of specialist midwives (from the High Risk Midwifery Team) support the MDT process and provide an identified link midwife to the woman during her care.
Although there are pathways in place for women with complex pregnancies for additional assurance the Trust will support the further work identified by the LMS in coordinating generic consistent clinical pathways across C&M – this is to be discussed and agreed at the next Maternity Clinical Experts Group meeting.

Link to maternity safety actions

Action 6: WUTH have been compliant in Year 1 and Year 2 of MIS with the implementation of Saving Babies Lives Bundle. Further improvement work has been undertaken in 2020 and the Trust has implemented all elements of SBL2 care bundle and can demonstrate compliance in Year 3 of the MIS..

Link to urgent clinical priorities

a) Process in place, audit added to the FAAP for assurance – please refer to above narrative.
b) There are pathways in place for referral to specialist centres - Liverpool (fetal), Manchester (cardiac) and Sheffield (accreta). See above narrative for further detail.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Cerner support the electronic maternity	Compliance with regards to identifying	Recorded on the FAAP. Reported	None, appropriate and effective	Divisional Audit &	None, robust processes in	Robust processes in

record and includes a mandatory field - risk assessment. This is embedded within the digital health record for all encounters and therefore can be audited for compliance. Compliance with MSDS requirements namely Safety Action 2: no 12 regarding compliance with personalised care plan field is met.	that risk assessment has been completed is through audit. This is included on the Divisional FAAP and will be audited March 2021. MSDS submission will provide compliance data - regarding completion of the personalised care plan.	through Divisional audit processes. Any improvement plan will be monitored through the Divisional governance team. MSDS submission / reports regarding personalised acre plans.	processes in place.	assurance lead as per FAAP schedule.	place.	place. Continued monitoring of compliance through audit process.

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.

Cerner has risk assessment field embedded within the digital health record for all encounters. Compliance with the completion of assessing the risk assessment of women at each visit is audited. This is currently recorded as an ongoing audit on the FAAP for assurance purposes.

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Risk assessment is undertaken at each visit and the option regarding place of birth discussed. There is a Birth options process in place and intended place of birth would be updated commensurate of the risk assessment. If a woman chooses an option that is not in keeping with policy / guidance then more detailed discussion takes place regarding risks and potential alternative options. The woman is given an appointment with the Consultant Midwife who coordinates and is present at the birth options clinic. If still choosing an option that isn't supported from a risk perspective then the woman sees the consultant and a detailed plan of care put in place. This is then shared with all stakeholders and updated accordingly. The woman is supported through the process of choosing the most appropriate place of birth whilst considering any related risk factors.

Link to maternity safety actions:

Action 6: The Divisional has had a separate action plan to meet compliance of implementing SBLv2. There is evidence that supports the compliance with this (see further detail above).

Link to urgent clinical priorities:
This can be obtained from the risk assessment information and evidenced on the mailer bot which will be added to the FAAP (PCP discussed). Home birth preparation/checklist is further evidence to support that discussion with the women and her partner takes place regarding place of birth.

Immediate and essential action 6: Monitoring Fetal Wellbeing
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
WUTH has two fetal monitoring lead midwives (Band 7 and AMP Band 8a)and a lead Consultant - we are sending a third senior midwife on the masterclass training course to support the fetal physiology teaching sessions to reduce the risk of single point of failure. Compliance with SBL2 provides evidence of compliance	Lead Obstetrician is also EBC lead and three other fetal monitoring leads support PROMPT and fetal physiology sessions in addition to undertaking care metrics audits which look at categorisation, prioritisation and escalation of CTG's. Compliance report of training is in place.	K2 training compliance rates have been increased to 90% - staff must get 90% to pass the module. Repeated failures are identified by the PDM midwife and escalated to fetal monitoring leads for proactive support for both midwifery and medical staff.	None, robust process in place.	Fetal monitoring leads as part of business as usual.	WUTH representation at all SIG's is essential and Lead Consultant is also seconded to EBC as the Local Development Lead for Each Baby Counts Learn and Support.	Care metrics audit in place to proactively review random selection of CTG's each month. All incidents requiring MDT review at CIF also have CTG review in addition to peer reviews on an hourly basis in clinical practice.

Link to Maternity Safety actions
Action 6: Separate action plan for SBL2 care bundle completed and sent to SCN – evidencing compliance with SBL2
Action 8: PROMPT training schedule in place - on track to achieve target of 90% by April 2021

Link to urgent clinical priorities:

a) WUTH has two fetal monitoring lead midwives and a lead Consultant - we are sending a third senior midwife on the masterclass training course to support the fetal physiology teaching sessions to reduce the risk of single point of failure**.**

b) SBL2 Leads have responsibility for overseeing practice and training. A further two leads have been identified to further support QI work. Safety SIG and Stillbirth SIG also provide an opportunity to share ideas, learning and processes.

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Updated guidance is available on the hospital website, parent craft classes and video tours are also available to access.	Fortnightly catch up sessions with MVP Chair, Fortnightly Facebook live listening event with Consultant midwife/MVP chair.	Via patient feedback in various forms such as FFT, MVP, pals data and complaints.	To ensure guidance is updated as and when evidence is available. To introduce Learning disability link midwife into enhanced care team.	Regular review of patient information by internet leads	Funding for further developing website.	Continue with current system which is working well until an updated website launched.

WUTH have a well-established Birth Options clinic run by a Consultant Midwife who supports women to make an informed choices including:

- WUTH is the only provider in Cheshire and Merseyside to offer all 4 place of birth options for women
- On target to achieve 51% of CoC by March 2021 which improves outcomes and patient experiences which is evidenced through audit.
- Bounty app used for up to date information/leaflets supporting informed choice.
- Personalised care plans for all women supported and compliance audited.
- Website development group set up to progress further website improvement with MVP / Service user input.

Link to Maternity Safety Actions:
Action 7: We have excellent links with Wirral MVP and work together on a number of QI's to evidence coproduction of maternity services. MVP is present on all senior leadership interviews and reviews all relevant policies/leaflets alongside service users.
The IOL suite was designed in conjunction with MVP and the name was picked following a poll by service users on MVP social media pages. The guidelines/leaflet that supports the processes within the suite was also coproduced.

Link to urgent clinical priorities
Recent review of process/es undertaken based on review of an example of Chelsea and Westminster Hospitals website – information currently available to service users. See narrative above regarding website development.

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Birthrate+ commenced in WUTH in January 2021 as part of a pre-planned workforce planning schedule.	We monitor our staffing as part of the local and regional dashboard and are within previous Birthrate+ timescales.	Maternity contribute to the Trusts 6 monthly staffing report which is presented at Trust Board. Further improved reporting to be introduced given introduction of Birthrate+ Tool / App.	None, actioned as part of CNST safety actions.	None, actioned as part of CNST safety actions	None, actioned as part of CNST safety actions and funded by WUTH.	Birthrate+ is commencing a 3 month prescheduled staffing review in January 2021.

Link to Maternity safety standards:
Action 4: CD/CSL for Obstetrics to provide as per CNST
Action 5: Birthrate+ commenced in WUTH in January 2021 as part of a pre-planned workforce planning schedule.

Before commencement of Birthrate+ in 2021, the midwife to birth ratio is within the recommended ratio evidencing commitment to the maternity workforce required standard (between 1:25-1:29) by the Director of Nursing & Midwifery.. There is also an embedded process of monthly reviewing staffing incidents, this takes place with senior staff oversight.

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

All guidance is reviewed on receipt into the Trust and a gap analysis undertaken to determine compliance. Any non/partial compliance is tracked monthly via clinical governance meetings.	Monthly at CG meetings and any non-compliance escalated and tracked via action plans.	All guidance is reviewed as part of a review programme and updated on a regular basis (1, 2 or 3 yearly). Guidance is updated by the author and sent out trust wide for comments for a 2 week consultation period before being presented at LWSG for approval and finally ratified at the women's CG meeting.	Robust processes in place. WUTH participate in regional special interest groups including MAT CEG and ensure regional guidance is followed where available	Robust process in place.	Continue to ensure representation at regional SIG's and adoption of regional guidance where available.	Robust process in place.

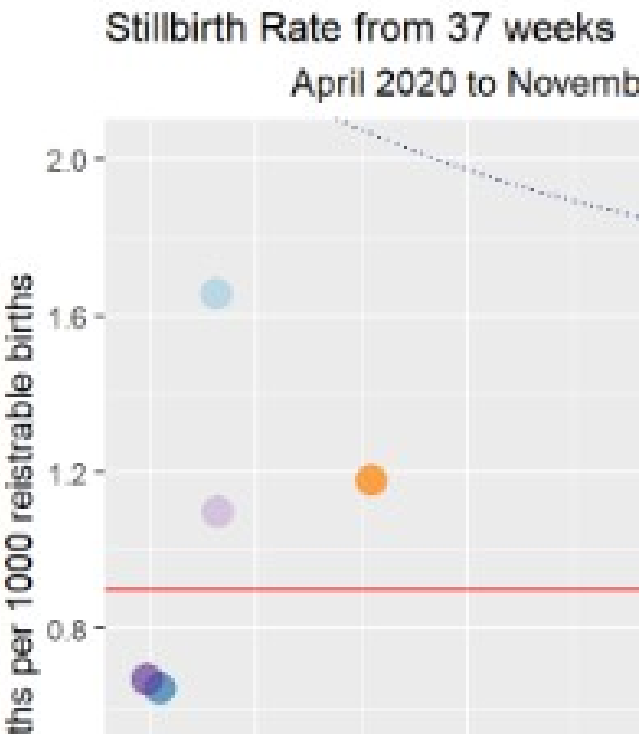
WUTH is committed to supporting leadership training and development future for midwifery and leadership development for DOM's and aspiring HOMS to be utilised (RCM).

WUTH meets all of the 7 Steps to strengthen midwifery leadership – a gap analysis of the RCM Manifesto was undertaken. Revision of the HOM and midwifery management structure has taken place. DOM – has direct access to Board with operational HOMS deputising..

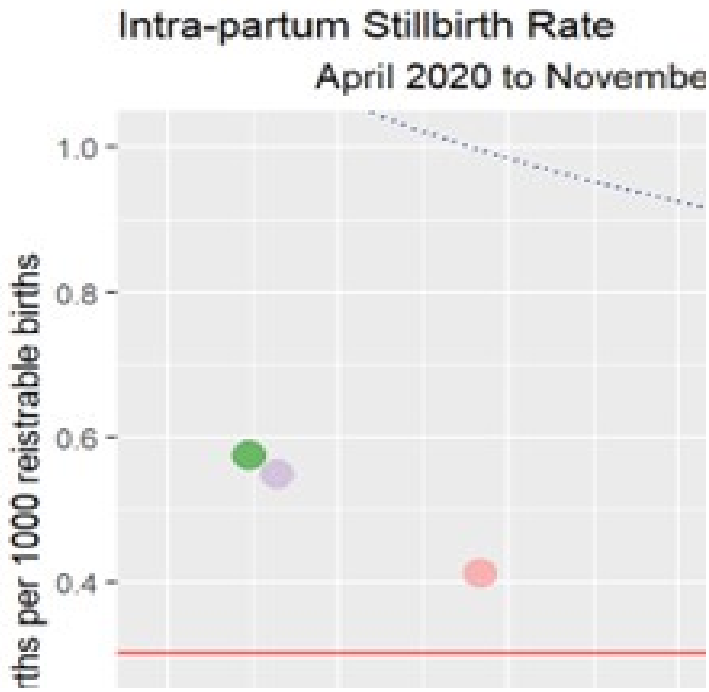
The Director of Midwifery provides strategic lead for Maternity Services of WUTH, representing WUTH regionally and nationally.

Finally, compliance with all 7 IEA's has been collated by the LMS with full compliance anticipated once the LMS/NHSE processes are introduced including the Perinatal Quality Surveillance Model.

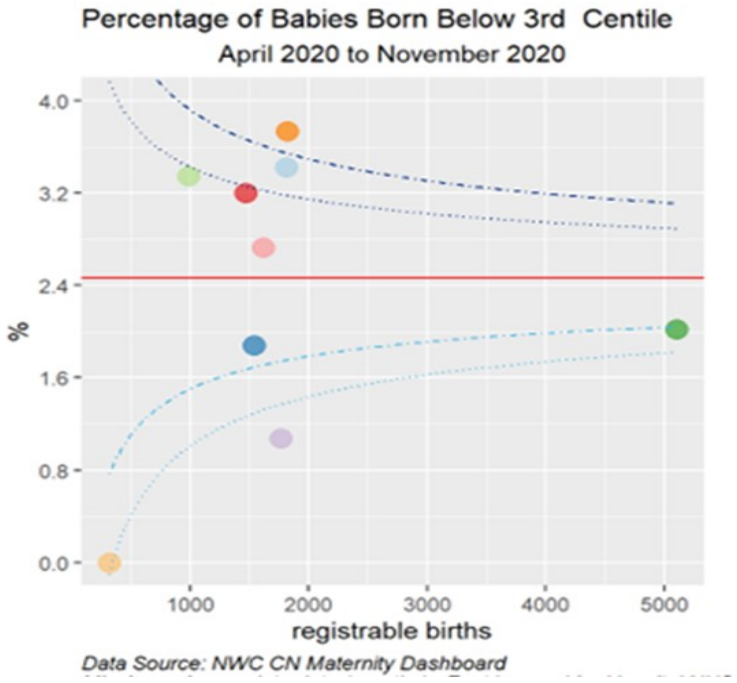
Appendix 2: Outlier Report



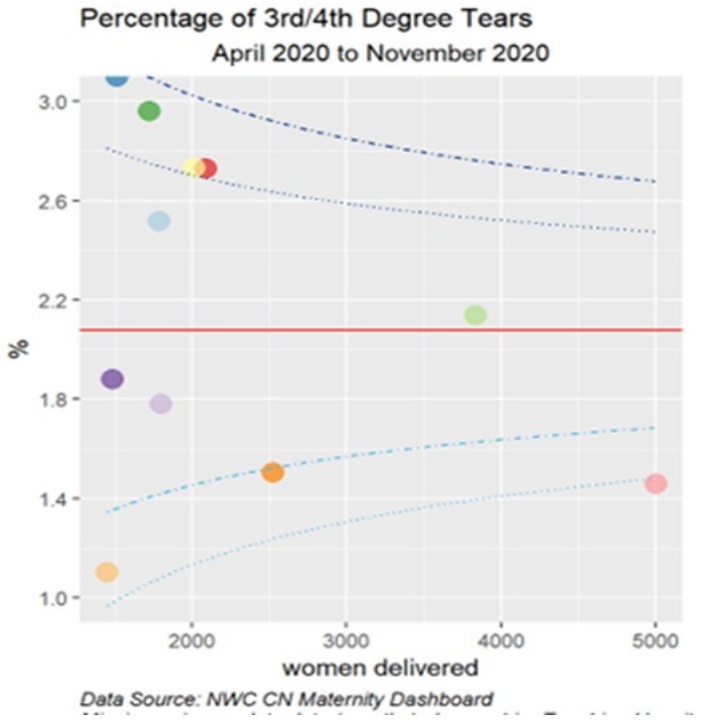
WUTH has a stillbirth rate of 0.0 from 37weeks. This links in with a positive rate of detecting small for gestational age babies.



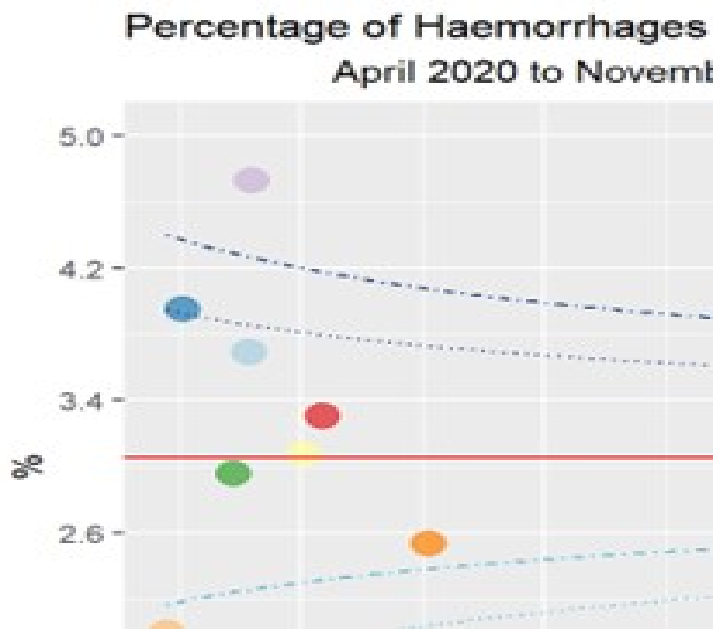
WUTH has an intrapartum stillbirth rate of 0.0 – an intrapartum stillbirth is a StEIS reportable incident.



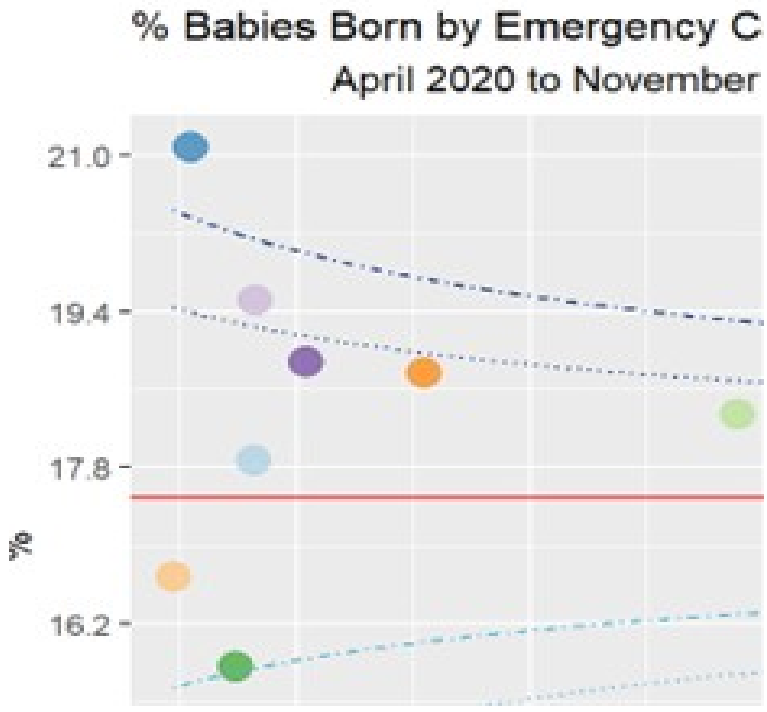
WUTH has a babies born below the 3rd centile rate of 1.1 – this outcome reflects the improvement work undertaken within SBL2 and links to the fact that WUTH is consistently within the Top 10 providers nationally for detecting small for gestational age (SGA) babies.

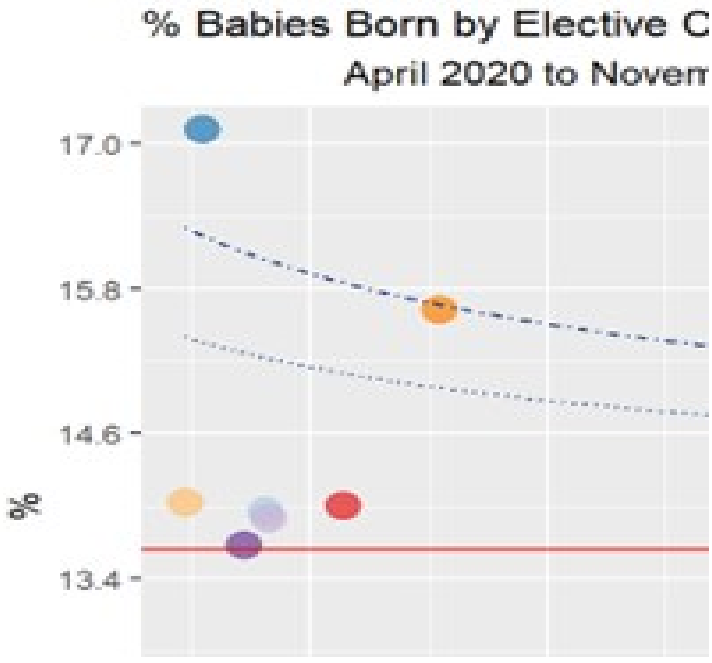


WUTH has a positive detection rate of 3rd and 4th degree tears – it is estimated that first times mums can have a rate of up to 6% and consequent pregnancies.

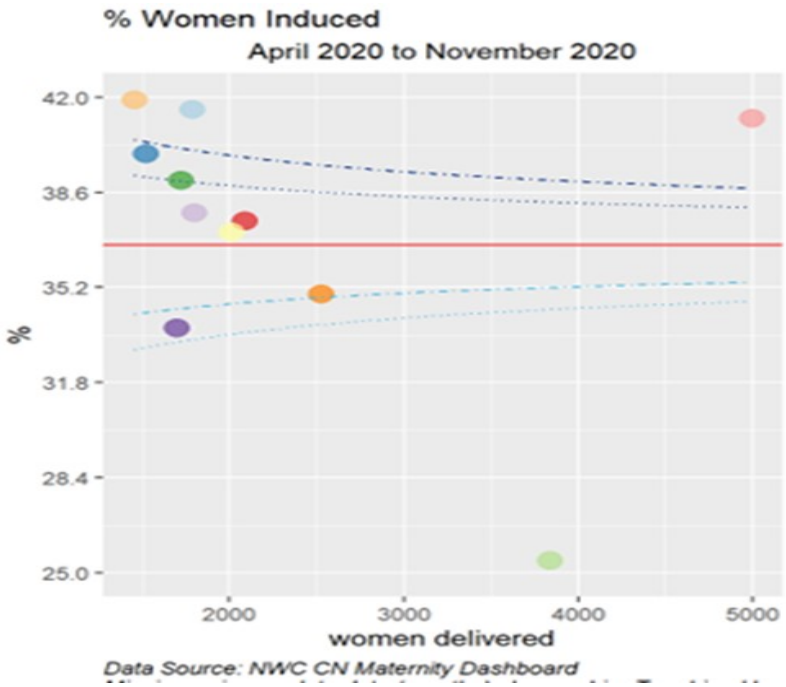


WUTH has a 3% PPH detection rate which average compared to other rates across the North West Coast (NWC) and is also in keeping with a national rate of PPH>1500ml of between 2.7% – 4.3%.

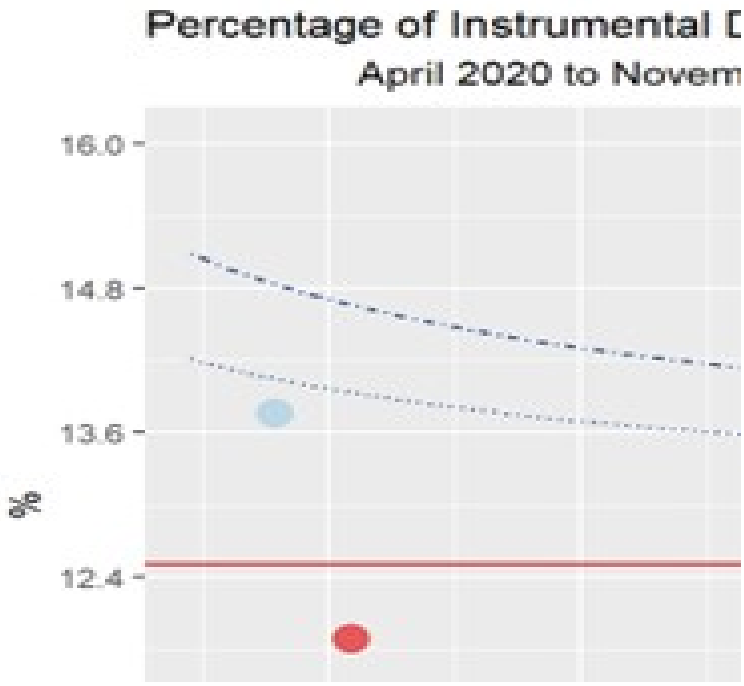




WUTH has a higher than average emergency caesarean section rates however the elective caesarean section rate is the lowest across the NWC. A deeper dive into these findings confirmed that the anomaly with the rates was due to insufficient capacity for elective surgery therefore surgery is done as "semi-elective" which contributes to an increase in emergency caesarean section rates. When the "semi elective" caesarean section cases were excluded from emergency figures WUTH was not an outlier with elective nor emergency caesarean section rate



The rate of induction of labour has increased significantly over recent years (average rate of 31.6% in 2017-18) however WUTH is not identified as an outlier across NWC.



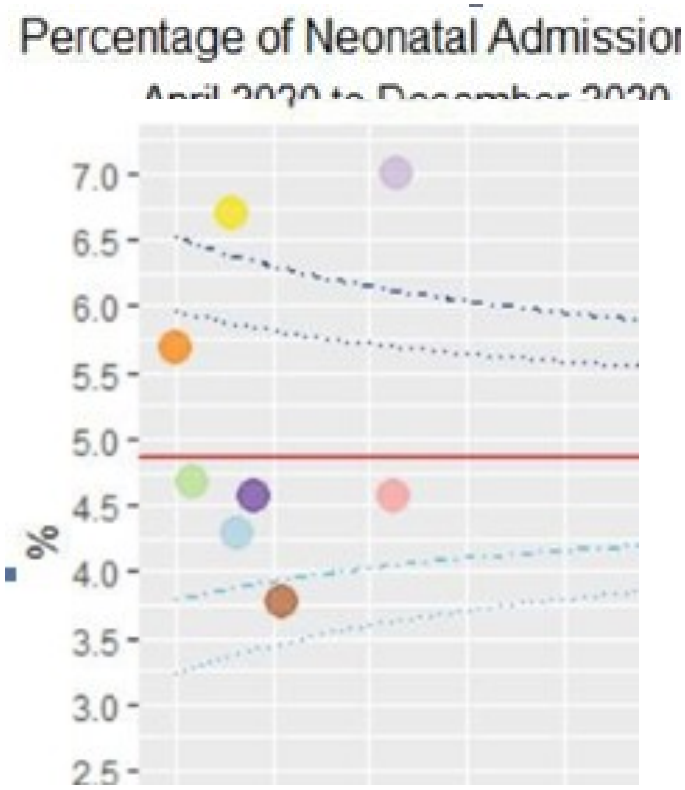
WUTH has an instrumental delivery rate of 10.9% which is in keeping with majority of other providers across the NWC. This compares favorably to a rate of 11% nationally in 2017.

WUTH has a % rate of term deliveries (above 37weeks) of less than 91% which is the lowest rate across the NWC. This rate when triangulation of other metrics is positive given WUTH has a high detection of SGA babies which are induced/ delivered early by caesarean section resulting in an overall reduction of stillbirth.

April 2020 to November 2020

Provider	Formal Complaints	Reportable STEIS Incidents	Reportable HSIB cases	PMRT Case Reviews
1	11	3	5	6
2	8	5	8	39
3	15	3	3	5
4	10	2	0	8
5	13	1	10	13
6	NA	NA	N/A	NA
Wirral University Teaching Hospital NHS FT	6	2	5	15

- ***WUTH has the lowest number of formal number of formal complaints across C&M.***
- ***In 2020 (From January – December) the overall number of StEIS reportable incidents was 2.***
- ***There were 5 cases that met the criteria for HSIB which has specific criteria for reporting.***
- ***There were a total of 15 Perinatal Mortality cases that were reviewed as per the national Perinatal Mortaility Review Tool (PMRT) with external representation.***



WUTH has a Term Admission rate of less than 4% which reflects the improvement work in improving transitional care facilities. Babies are therefore whenever possible kept with their mother on the postnatal ward in the Transitional care area, rather than being admitted to the Neonatal unit resulting in separation from the mother.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21-252

BOARD OF DIRECTORS
03 March 2021

Title:	**Change Programme Summary, Delivery & Assurance**
Responsible Director:	Matthew Swanborough, Director of Strategy and Partnerships
Presented by:	Matthew Swanborough, Director of Strategy and Partnerships

Executive Summary
The Programme Board planned for 17th February 2021, along with the Programme Steering Group meeting scheduled for 8th February 2021, were both cancelled by Gold Command due to operational pressures throughout the organisation as a result of the COVID-19 pandemic. In addition, two of the three Transformation Programme Steering Group meetings were cancelled, however the Perioperative Medicine Steering Group was held 2nd February 2021. The information presented at the meeting, coupled with the Programme and associated Project information held in PM3 system has informed the Assurance review presented.

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
NA
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

N/A	
Specific communications and stakeholder /staff engagement implications	
N/A	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
N/A	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	Monthly reports to the Board
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
3 MARCH 2021

Change Programme Summary, Delivery & Assurance

Purpose

To inform how the Transformation Programmes and the projects that support them are progressing and to indicate the confidence level for delivery.

Introduction / Background

PROGRAMME SUMMARY

1. Overview

The Programme Board planned for 17th February 2021, along with the Programme Steering Group meeting scheduled for 8th February 2021, were both cancelled by Gold Command due to operational pressures throughout the organisation as a result of the Covid Pandemic. In addition, two of the three Transformation Programme Steering Group meetings were cancelled, however the Perioperative Medicine Steering Group was held 2nd February 2021. The information presented at the meeting, coupled with the Programme and associated Project information held in PM3/ S:Drive PM3 folder has informed the Assurance review presented.

PROGRAMME STATUS

There have been three additions to the assurance schedule: two Service Improvement Rapid Improvement projects *(111 Frist Phase 2 and ERT Phase 2)* and one Digital Enabler *(Electronic Consent)* in February.

1.1. Governance Ratings

For February, two of the three programmes were green rated for Governance, with one attracting an amber rating (no change from the January ratings). For the Digital Enabler and Service Improvement projects, five were green rated with the remaining two amber, this is based upon the PM3/ S:Drive PM3 evidence.

1.2. Delivery Ratings

February saw one programme green rated for Delivery while the other two were amber rated (no change from the January ratings). For the Digital Enabler and Service Improvement projects, five were green rated, one amber and one red. 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.

ASSURANCE

2. Programme Assurance - Ratings

The attached assurance report has been undertaken by the Head of Service Improvement and provides a detailed oversight of assurance ratings per programme / project. The report provides a summary of the assurance as a gauge of the confidence in eventual delivery and the actions needed to improve those confidence levels are described in the assurance statements for each.

Conclusions

See above

Recommendations to the Board

The Board of Directors is asked to note the Trust's Change Programme Assurance Report and consider the following recommendation:

That the Board of Directors requests Senior Responsible Owners / Executive Sponsors to direct their projects to further improve confidence in delivery.

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NHS Foundation Trust

Change Programme Summary

Programme Assurance
February 2021

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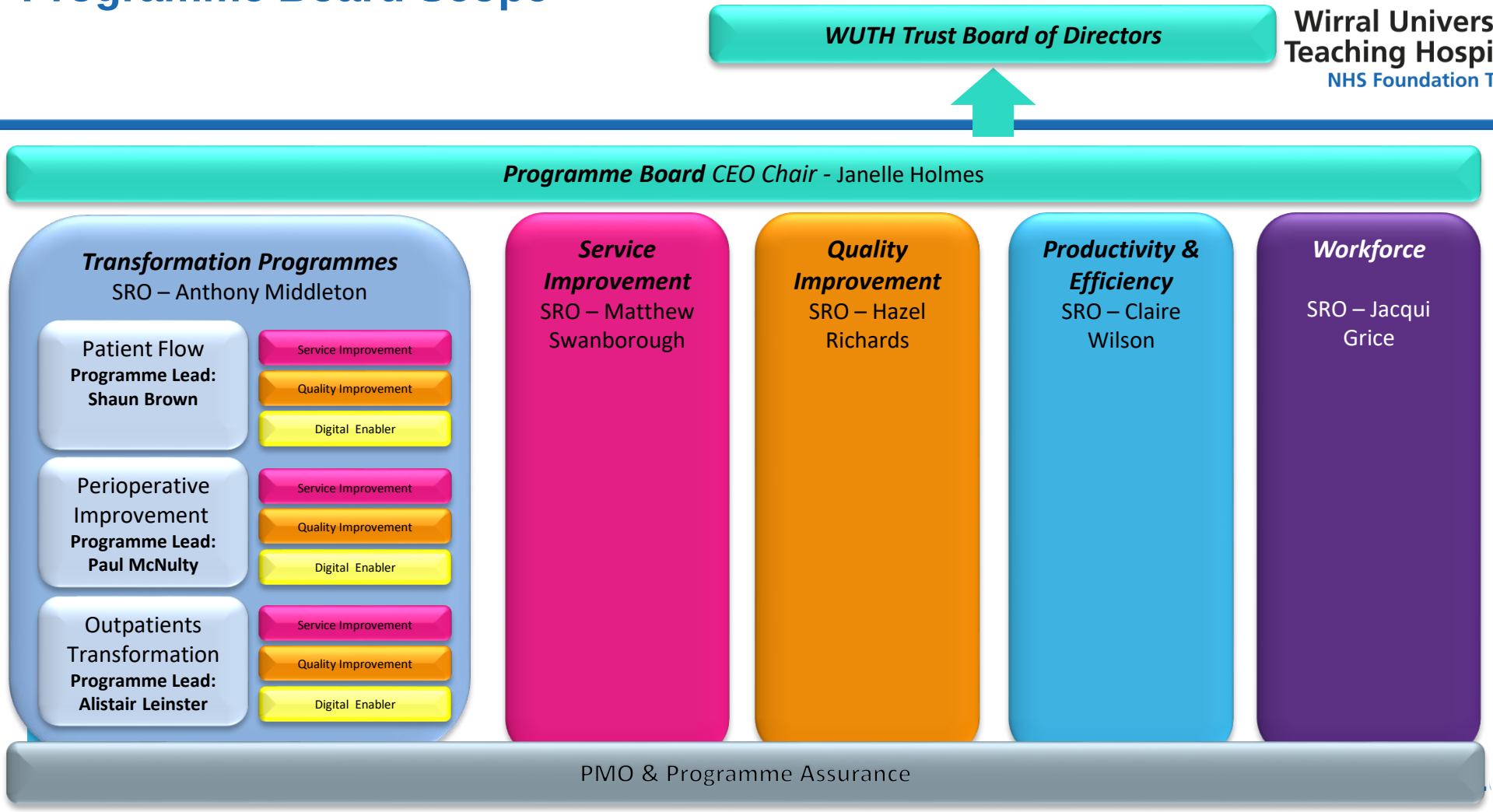
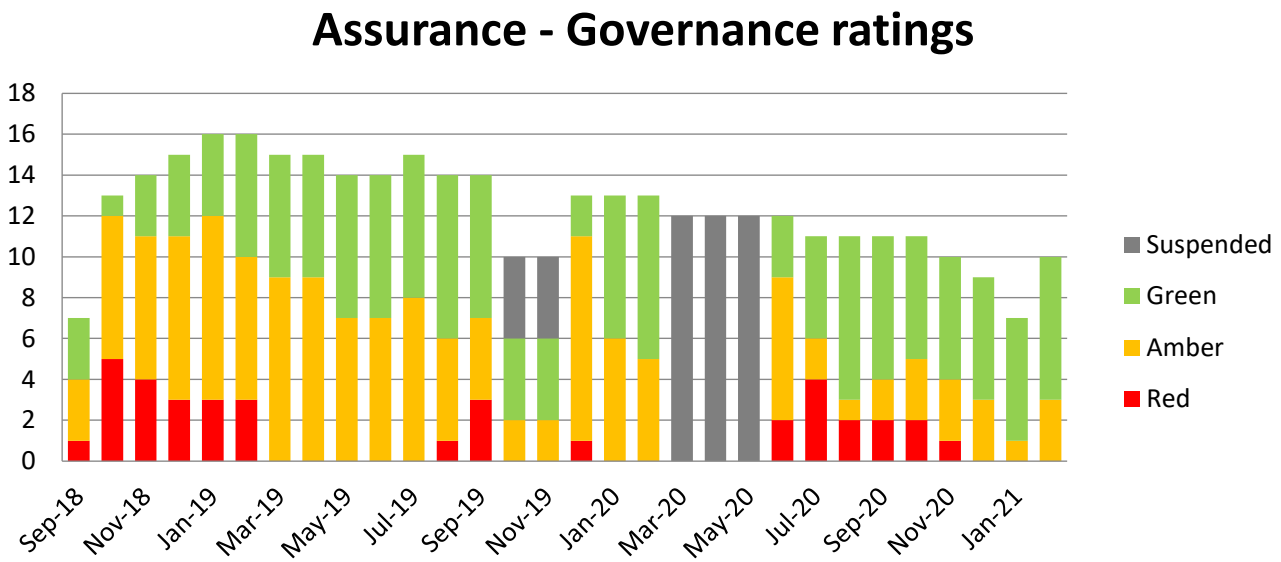
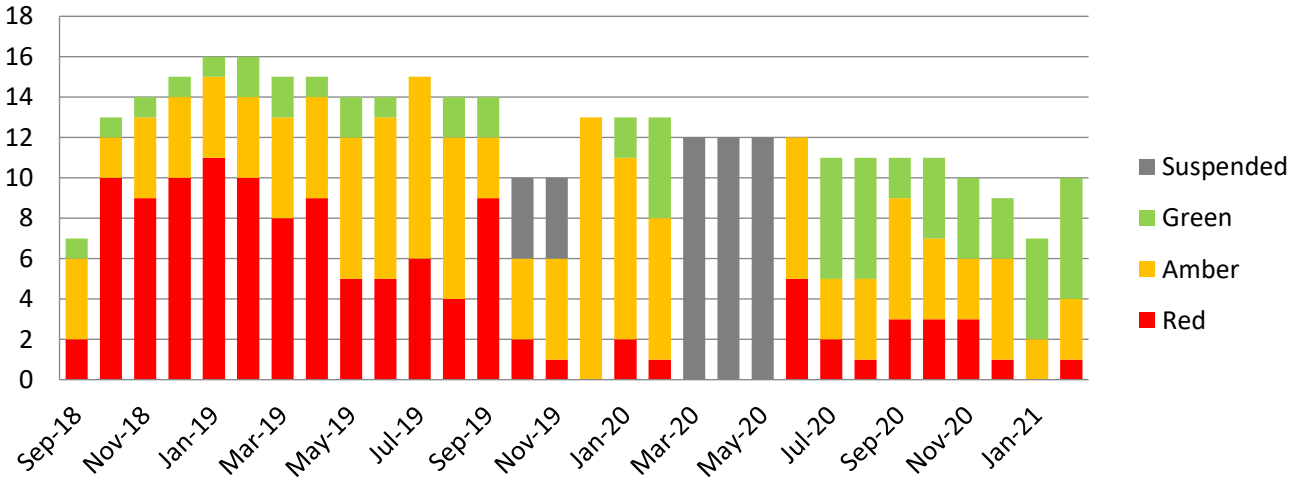
Programme Board Scope




Assurance - Governance ratings
18
16
14
12
10
8
6
4
2
0
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Suspended
Green
Amber
Red

Assurance - Delivery ratings



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Programme Assurance Ratings

17 February 2021

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Change Programme Assurance Report -
Trust Board Report - February 2021 - Top 3 Priority Projects - Summary

Programme Assurance

Wirral University Teaching Hospital
NHS Foundation Trust

Improving Patient Flow	Governance	Amber	Delivery	Amber

- Metrics for Bed Occupancy and Average Length of Stay are within Flow Programme targets at 89% and 6.3 days respectively. Metrics for 21 day+ LOS and time spent in ED exceed Programme targets with 114 LLOS patients and 287 minutes respectively. *The Programme has been impacted by a high level of demand for services due to Covid.*

- The programme is planning to focus, over the next 3 months, improvement work on a small number of key standards in the Flow Vision. Aims for measurable improvement within a specified period of time are being developed.

- **A plan is in development to identify improvements which will contribute to an increase in the number of Discharges before Midday, including the associated benefits to staff and patients; what will improve, by how much and by when. This will be tracked by those accountable for delivery and assurance.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Green

- The revised PID v1.0 dated 3 Mar 20, as approved by the Programme Board - including an extensive schedule of benefits and measures - remains extant. The programme has devised revised trajectories and these are now being monitored for evidence of the planned improvements.

- **The KPIs declared by the programme, as agreed by the Programme Board, continue to show the positive impact of the changes the programme is driving.**

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Change Programme Assurance Report -
Trust Board Report - February 2021 - Top 3 Priority Projects - Summary

Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Green	Delivery	Amber

- **Overall Aim:** 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.

- **Overall Progress: January's figures have continued to be adjusted (Swabbing pre-surgery / admission removed) to improve data quality. This has increased overall performance.** As the programme reports: the Trust has attained the national 'overall' **25%** Non-F2F target in December at **38%** (was 33% in December); the **60%** 'follow-up' non-F2F target was not achieved, reported at **39%** (was 33% in December). **The QIA/EA has been revised following feedback from Dr Nicola Stevenson and Hazel Richards and action taken as instructed; revised QIA has been resubmitted for Clinical Executive level Sign Off.**

- **Compliance and Exceptions:** The programme team continues to work with 37 specialties, across 4 divisions, to identify clinical exceptions that would permit a face-to-face consultation to occur.

- **Targets resolved: As agreed at the Programme Board, 18 November 2020, the programme targets for overall delivery by remote means have been confirmed using a comprehensive bottom-up approach of analysis and validation of exceptions with Divisions:**
  - For total appointments Non-F2F%, i.e. New + FU attendances, no intervention is needed and this figure will continue to be monitored for assurance.
  - For total Follow Up Appointments Non-F2F%, an action plan and trajectory have been developed to achieve: 45% by Mid-February 2021 (what the predicted level was based on Divisional Submissions June 2020) and 60% by end of May 2021 (NHSE target for follow up appointments Non F2F). February target has not been achieved despite improvements being made and will continue to be worked on at Programme level.

Note 1: 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.
Note 2: 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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Improving Patient Flow - Programme Assurance Update – 17 February 2021

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

Independent Assurance Statement

1. The 'Vision for Patient Flow' v2 is uploaded to PM3. 'Scope' is the 'PID for Patient Flow' presented at the Prog. Steering Group 9 Nov 20. The Programme team agreed at the Patient Flow Steering Group meeting 5 Jan 21 to concentrate resource on achieving an improvement in 'Discharge before Midday'. This has not progressed due to a pause in the programme. **2. & 3.** ToR updated Oct 20 is uploaded to PM3. Action Tracker available up to meeting of 5 Jan 21. **4.** There is a Comms Plan in PM3; milestones have been added to the Programme Project in PM3 to track delivery. **5.** QIA for the Programme was approved at the Patient Flow Steering Group meeting 5 Jan 21 and is awaiting Exec sign off. **6.** Programme and associated Projects are effectively managed in PM3. **7.** The Flow dashboard was reviewed at the Patient Flow Steering Group meeting 5 Jan 21 and 'Discharge by Midday' identified as the objective to focus on. A plan for 'how much, by when' is still to be developed due to project pause. **8. & 9.** Programme risks and issues are managed in PM3 (last updated 14 Jan 21). **Most recent assurance evidence submitted 05 Feb 21.**

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
2.1	**Patient Flow Programme**	The Flow programme will work to ensure that all patients receive care and treatment in accordance with the standards within the Trust Flow Vision V2.0 The Flow programme will implement and monitor projects to support the delivery of the flow standards in the Flow Vision	Anthony Middleton		○	●	●	●	○		○	○	○	○

SERVICE IMPROVEMENT: 111 First Phase 2 - Project Assurance Update – 17 February 2021

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

Independent Assurance Statement

1. The 111 First Phase 2 system-wide PID dated 8th Dec was been approved at the Patient Flow Steering Group. The 111 First project proposal has not been approved by the project team due to a project pause. **2.** The project team is defined and a meeting schedule is in place. The team has not met due to the project pause. **6.** The PM3 milestone tracker shows 5 milestones, 2 of which have revised dates due to the project pause. **7.** There are National '111 Sitrep' metrics and 'ED Sitrep' metrics. The '111 First Local Metrics' report and a Benefits & Controls report were uploaded on 8th Feb '21. **8&9.** There are no risks and issues identified for this project. The project team have not met due to the project pause. **Most recent assurance evidence submitted 08 Feb 21.**

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
2.1a	**111 First Phase 2** (Service Improvement Project)	Expand and refine the offer from Phase 1 of 111 First: Offer slots and set up direct booking into assessment units and specialty clinics by the 111 and the Wirral CAS service Review of "111 First" phase 1 using information from bespoke reports/ patient feedback	Anthony Middleton											

Perioperative Medicine Improvement – Programme Assurance Update – 17 February 2021

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

Independent Assurance Statement

1. The revised PID v1.0 dated 3 Mar 20 was signed-off by the Proj. Steering Group (and is updated by the Oct 20 'Scope' slide). The Exception Report and Re-start Plan (post-COVID Wave 1) was approved by the Prog. Board in June 2020. **2.** As well as the Steering Group, there was a 'Patient Safety and Experience Project Group' and an 'Operational Excellence Project Group. These meetings have now amalgamated due to the focus being Digital Enablers, this change started from 19/01/21. Evidence of meeting taking place 19/01/21 and next one scheduled for 23/02/21. **3.** The Perioperative Steering Group has ToRs revised in Jan 20 and there is evidence of meetings up to 5 Jan 21. **4.** There is a Comms Plan in place which is tracked. **5.** The renewed QIA signed off 4 Dec 20 is evidenced in PM3 **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the 'EBF' project are RAG rated separately for that project line). **7.** KPIs are defined and on track. 8 & 9.Programme risks and issues are managed in PM3 (all reviewed in February Steering Group). **Most recent assurance evidence submitted 05 Feb 21.**

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. EAQuality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is definedon track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3.1	**Perioperative Programme**	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		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Theatre Scheduling - Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Ged Hussey	Implementation	Green	Green

Independent Assurance Statement

1. The Theatre Scheduling PID v1.0 Final (v3 dated 27 Feb 20) approved by the Perioperative Steering Group on 28 Jul 20. **2**. The Perioperative Digital Enabler projects are discussed at the 'Operational Excellence Project Group' evidence of meeting 11 Dec 20. **6.** The Theatre Scheduling project plan in PM3 shows that 'post-implementation enhancements' have been completed. Closure report was signed off at the Perioperative Steering Group meeting Feb 21. **8. & 9.** Project risks and issues are managed in PM3 (all reviewed in Dec 20). **Most recent assurance evidence submitted 05 Feb 21.**

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
3.2a	**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		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Booking Form- Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Ged Hussey	Implementation	Green	Green

Independent Assurance Statement

1. The PID, CPO 1091, (undated but) uploaded 26 Nov 20, defines the project and was approved at the next Steering Group on 1 Dec 20. **2.** The Perioperative Digital Enabler projects are discussed at the Perioperative Digital Enablers Project Meeting, evidence of meetings on 19th January and next one scheduled for 23rd February. **6.** The milestone plan on PM3 has been updated to reflect agreed revised Milestones all of which are on track **8&9.** Project risks and issues are managed in PM3; 1 open risks recorded and promoted to Programme (last updated 02/02/21). 2 open issue last updated 02/02/21. **Most recent assurance evidence submitted 05 Feb 21.**

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
3.2b	**Electronic Booking Form** (Digital Enablement - Perioperative Care)	Project benefits as defined at the meeting of 17 Dec 19: Data quality for planned procedures would be improved as new booking forms have additional procedures and information resulting in better quality of patient information in the EPR. Review and re-build of the procedure catalogue will allow accurate information in the EPR (demonstrating the surgery teams are better able to schedule / manage their resources).	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Consent - Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Ged Hussey	Initiation	Amber	Amber

Independent Assurance Statement

1. The PID, CPO 1091, (undated but) uploaded 26 Nov 20, defines the project and was approved at the next Steering Group on 1 Dec 20. **2.** The Perioperative Digital Enabler projects are discussed at the Perioperative Digital Enablers Project Meeting, evidence of meetings on 19th January and next one scheduled for 23rd February. **6.** The milestone plan on PM3 has been updated to reflect agreed revised Milestones all of which are on track **8&9.** Project risks and issues are managed in PM3; 1 open risks recorded and promoted to Programme (last updated 02/02/21). 2 open issue last updated 02/02/21. **Most recent assurance evidence submitted 05 Feb 21.**

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
3.2c	**Electronic Consent** (Digital Enablement - Perioperative Care)	This project aims to deliver an electronic consent solutions within Wirral Hospital Trust. Currently consent process is to use paper and send this to be scanned into the patients electronic medical record, this is then viewed and verified electronically at the point of visit.Whilst the current process is fully mapped out it is not without risks, and has yet to have a SOP formally signed off by the Trust Consent Lead. This project is looking at confirming the formalising the current processes to reduce clinical risk, as well as reviewing the options of implementing electronic solutions..	Anthony Middleton											

Outpatients Improvement - Programme Assurance Update – 17 February 2021

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

Independent Assurance Statement

1. The PID v4.0 was agreed by Outpatients Transformation Steering Group (OTSG) on 30 Nov 20. The key benefits are defined therein. **2. & 3.** Project Team ToR has been updated (v3.0) awaiting sign off, and there is evidence of meetings up to 6 Jan 21. February meeting cancelled due to operational pressures; risks, issues and actions still reviewed by group outside of this. **4.** There is a tracked Comms Plan in place **5.** QIA/EA has been revised following feedback from Dr Nicola Stevenson and Hazel Richards and action taken as instructed; revised QIA awaits sign-off at clinical executive level. **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the 'OPR' and 'Attend Anywhere' projects are RAG rated separately for that project line). **7.** Non F2F trajectory is in place and being tracked the Programme has initiated a Vision and KPI RI project to identify additional KPIs to monitor as part of the programme**. 8. & 9.** Programme risks and issues are managed in PM3 (all reviewed in Feb 21)**.**
Most recent assurance evidence submitted 05 Feb 21.

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
4.1	Outpatients Programme	The primary focus of the programme is to ensure Value at Every Encounter. This is value to the patient, the Clinician(s) and the Trust. To the patient, the aim is to ensure that they are provided with the diagnosis, treatment, or information that they need. To the clinician, the aim is to ensure that every time they see a patient, they have the information and time they need to provide a quality clinical encounter. For the Trust, the aim is to ensure a high quality, clinical encounter, with no waste of resource and which results in positive patient experience/feedback.	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Outpatients One Patient Record - Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Nickee Smyth	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined in the PID v2.0 dated 3 Jul 20 which is uploaded to PM3. **2.** There is a project team ToRv2.0 as approved on 31 Jul 20. There is an Action Tracker and Attendance Log for project meetings up to 27 Jan 21. **6.** The PM3 milestone plan shows revised dates for 5 milestones, agreed by Programme team, all of which are now tracking green. **8&9.** Project risks and issues are managed in PM3 (all reviewed Feb 21). **Most recent assurance evidence submitted 05 Feb 21.**

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
4.2a	**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		●	●					●		●	●

DIGITAL ENABLEMENT: Attend Anywhere - Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Michelle Murray	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined in the PID v0.6 dated 8 Apr 20 which is uploaded to PM3. **2.** There is a Project Group Action Log and record of meetings up to 16 Dec 20 (January's meeting has been cancelled due to Operational pressures) **6.** PM3 shows the majority of key milestones were completed on time. Remaining milestones have revised dates for which they are now tracking green and a project closure date has been set for 19 Feb 21 **8. & 9.** Project risks and issues are managed in PM3 (Evidence of review in Dec 20/Jan 21). **Most recent assurance evidence submitted 05 Feb 21.**

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
4.2b	**Attend Anywhere** (Digital Enablement - Outpatients Improvement)	Attend Anywhere is a video consultation platform. It is a web based product which enables clinicians to conduct video consultations with outpatients. The objective is to make Attend Anywhere available as a third option for outpatient consultations, alongside telephone and face to face. It is envisaged that this platform would be used in both scheduled clinic settings and also in unscheduled settings such as 'Hospital at Home'.	Anthony Middleton		●	●					●		●	●

SERVICE IMPROVEMENT: Electronic Referral Triage Phase 2 - Project Assurance Update – 17 February 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Jordan Bailey	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined by the proposal, using a lean canvas, that has been uploaded to PM3. It was approved on 18 Dec 20 and states that: 'at the end of this Rapid Improvement Project the Trust will have implemented Electronic Referral Triage System across each of the Specialties'. **2.** A 'core team' is listed on PM3 and there is an Action Log and Attendance Tracker for project meetings to 05 Feb 21. **6.** The milestone plan is on track and currently tracking green. **7.** Project progress metrics have been uploaded which show good progress towards achieving the "picture" described in the Lean Canvas: 'at the end of this Rapid Improvement Project the Trust will have an implemented Electronic Referral Triage System across each of the specialties'. **8. & 9.** There are 2 open risks logged on PM3 and these were last reviewed on 28 Jan 21. No issues have been raised to date. **Most recent assurance evidence submitted 05 Feb 21.**

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
4.3	**Electronic Referral Triage - Phase 2** (Service Improvement Project)	Adoption of standardised Electronic Referral Triage system within the Trust. All referrals will be electronically triaged by Clinicians to maximise the benefit from the first consultation and direct patients accurately along the most appropriate Clinical Pathway. This will reduce unnecessary new and follow-up visits and thereby improve patient experience.	Anthony Middleton		●	●					●	●	●	●

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 20/21-253

Board of Directors
3rd March 2021

Title:	Board Assurance Framework
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Andrea Leather, Deputy Board Secretary

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate strategic risks and also enables the board to gain assurance about the effectiveness of these controls.

This report presents the Board with an overview of all the risks currently recorded on the BAF, and outlines movement of all risks recorded in line with Quarter 3 reporting period.

Updates since the last review by the Board on 4 November 2020 are highlighted in blue.

Recommendation:
(e.g. to note, approve, endorse)

To note the updates to the Board Assurance Framework 2020/21

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)

The BAF has identified a number of links to the significant risk register, as detailed in the report.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
As detailed in the report.
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
N/A

Previous considerations by the Board / Board sub-committees	The Board last reviewed the BAF 2020/21 in November 2020
Background papers / supporting information	N/A

Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
3rd March 2020

Board Assurance Framework 2020/21 Update

Purpose

This report provides the Board of Directors with an overview of all the risks currently recorded on the Board Assurance Framework (BAF), and outlines movement of all risks recorded in line with Quarter 3 reporting period.

Introduction / Background

Following the launch of Strategy 2021-26, the Board of Directors at its meeting in November 2020 agreed that the Board Assurance Framework should be revised and aligned to the six Strategic Objectives and Priorities identified, namely:

- Outstanding Care – provide the best care and support
- Compassionate workforce – be a great place to work
- Continuous Improvement - Maximise our potential to improve and deliver best value
- Our partners - Provide seamless care working with our partners
- Digital future - Be a digital pioneer and centre for excellence
- Infrastructure - Improve our infrastructure and how we use it.

The new BAF will be developed over the coming months, starting with a workshop facilitated by Mersey Internal Audit Agency (MIAA) on developing a BAF that meets best practice and is fit for purpose, agreeing principle risks, controls and assurances. In addition, the Board are to confirm a Risk Appetite based on the GGI Risk Appetite Matrix.

In preparation of the development of the new BAF 2021/22, the Executive Team has reviewed all outstanding risks as reported to the Board in November 2020 identifying those risks that can be transferred to the new BAF. Risks that were either considered complete or they are no longer applicable based on the new objectives/priorities have been closed.

Recommendations to the Board

The Board of Directors are requested to:

- note the updates to the Board Assurance Framework 2020/21.
- note the development of a new Board Assurance Framework aligned to the strategic objectives/priorities as outlined in the new Strategy 2021-26.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework – Quarter 3 2020/21

This quarter the BAF has undergone a thorough review with a number of changes made, including a slight change to the layout. The changes have been highlighted in blue. Due to pressures some of the changes have not been validated by the lead Executive.

The Executive Team are asked to:

1. Discuss the updates in the BAF
2. Review the risk scores and agree any changes.
3. Discuss the inclusion of a newly identified Threat in relation to the Estate

How to use the BAF

The key elements of the BAF to be considered are:

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

Key to lead committee assurance ratings:

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

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

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

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

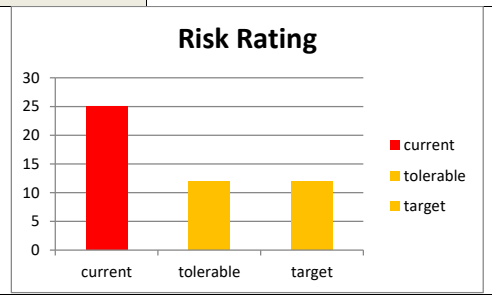
Board Assurance Framework (BAF): 2020/21

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

Link to SRR	Ref	Primary Risk Scenario's	Risk Score					Target Risk	Lead Assurance Committee	Page No.
			Apr	July	Oct	Jan	March			
	PR1	Demand that overwhelms capacity to deliver care effectively	C5xL5 =25 ⟺	C5xL5 =25 ⟺	C5xL5 =25 ⟺	C5xL5 =25 ⟺		**12 High**	FBPAC	3
397/398 DRR-0018	**PR2**	Critical shortage of workforce capacity & capability	C5xL4=20 ⟺	C5xL4=20 ⟺	C5xL4=20 ⟺	C4xL4=16 ↓		**12 High**	WAC	6
319/320	**PR3**	Failure to achieve and maintain financial sustainability	C5xL4=20 ⟺	C5xL4=20 ⟺	C5xL4=20 ⟺	C5xL4=20 ⟺		**8 Med**	FBPAC	10
214/627/796/ 536/767/735	**PR4**	Catastrophic failure in standards of safety and care	C5xL3=15 ↓	C5xL3=15 ⟺	C5xL3=15 ⟺	C5xL3=15 ⟺		**9 Med**	Quality	13
212/485/609/ 797/799	**PR5**	A major disruptive event leading to rapid operational instability	C5xL5=25 ↑	C5xL5=25 ⟺	C5xL5=25 ⟺	C5xL5=25 ⟺		**5 Med**	FBPAC	16
	PR6	Fundamental loss of stakeholder confidence	C5xL2= 10 ↓	C5xL2=10 ⟺	C5xL2=10 ⟺	C5xL2=10 ⟺		**5 Med**	Board	21

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 1: Demand that overwhelms capacity to deliver care effectively** A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards						**Strategic priority**	**Outstanding Care:** provide the best care and support
Lead Committee	Finance, Business & Performance Assurance Committee	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**		
Executive lead	Chief Operating Officer	**Consequence**	**5. Very high**	4. High	4. High	**Risk appetite**	Open	
Initial date of assessment	01.04.20	**Likelihood**	**5. Very high**	3. Possible	3. Possible	**Links to the significant risk register**		
Last reviewed	22.02.21	**Risk Rating**	**25. significant**	**12. High**	**12. High**			
Last changed	22.02.21							



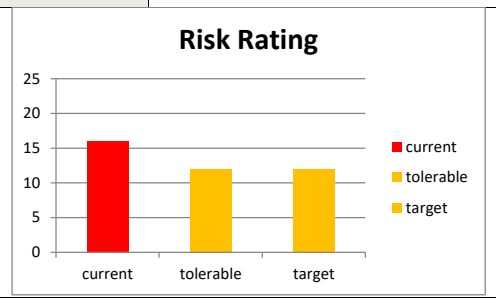
Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
1.1 Threat: Exponential **growth in demand for care** caused by an ageing population (forecast annual increase in emergency demand of 4-5% per annum); -2% reduced social care funding and increased acuity leading to more admissions & longer length of stay **NOTE: for COVID related matters see risk identified in PR5**	• Emergency demand & patient flow management arrangements • Winter capacity plan • Access Policy in place • Detailed operational plans agreed annually • Activity based contract and commissioners • Workforce model adjusted for planned activity • ED Streaming • Defined escalation areas (act as flood plain) during periods of exceptional pressure • Discharge procedures • Use of admission avoidance schemes • Use of SHOP model medical review • Ambulatory & Day case care **Contingency controls** • Emergency preparedness (Surge plan) • Expansion into corridor / designated escalation area • Reverse cohort area expansion within A&E footprint implemented • Quality matrons conduct patient safety checks for all patients in corridor/escalation area – reintroduce if required. • Staffing plan for escalation	• Higher than expected length of stay (LOS) • Normalised reliance upon escalation areas during pressure • Insufficient daily discharges to deliver net patient flow • Standards of care in corridors or escalation areas during periods of very high demand and very high bed occupancy • Reliability of SHOP implementation • Optimising patient care when prolonged stay in ED • Accessibility of intermediate care beds and domiciliary care providers • Potential surge of patients once COVID-19 restrictions are lifted	Patient flow transformation programme **SLT Lead:** COO **Timescales:** As per change programme **NOTE:** Superseded during COVID – overseen by Bronze/Silver Command Introduction of system wide Command Centre during periods of exceptional demand **SLT Lead:** COO **Timescales:** as required Review IDT senior leadership following whole system improvement focus during 3rd wave **SLT Lead:** COO **Timescales:** Q4 20/21 Daily system-wide discharge cell meeting **SLT Lead:** COO **Timescales:** Q4 20/21 Divisional plans for recovery to be developed **SLT Lead:** COO **Timescales:** **Q4 20/21**	Level 1 • Divisional performance reviews (monthly); • QA processes to ensure high quality, safe care in ED. Reported quarterly to PSQB • Live tracking of LoS via BI Portal • Daily monitoring of all patients with a LoS of 20+ days by Senior Divisional Triumvirate and System Lead for Discharge • Stranded patient reviews (2 per week) – focus on over 21 days • Overall bed occupancy rate (daily) • Ambulance Handover times (daily) – improved NW Ambulance performance • Command Centre meetings – 2 per day • System-wide dashboard of acute, intermediate and domiciliary care capacity and performance. Level 2 • Q&P Dashboard (monthly) • PFIG Report to Board (monthly); • Wirral A&E Delivery Board • Programme Board report to Board of Directors (monthly) • Responsive domain 'Deep Dive' – FBPAC (Nov '19) Level 3 • System Improvement Board • Limited scope external audit – Quality Account 2018/19 • CQC inspection report (March '20) • Contract meetings • MIAA Activity Data Capture – Limited Assurance (Sept '19) • Model hospital – data submissions to regulator (monthly / annually)	None identified	

Board Assurance Framework (BAF): 2020/21

Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
1.2 Threat & Opportunity: Operational f**ailure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	• Emergency preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL • Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse • Reliance on Walk-in-Centres / Urgent Care Centre • Urgent Care Board(UCOG & UCEXG) • System partners escalation process	Not within the Trusts sphere of control. In the event of GP practice collapse on Wirral there would likely be surges in demand for secondary care	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing	Level 2 • Reports to TMB • Hospital Upgrade Programme - Urgent Care (Board June '20) Level 3 • Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); • LHRP Assurance Process • Urgent Care Board (monthly)	Uncertainty re: fragility of general practice in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of General practice in Wirral	
1.3 Threat & Opportunity: Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH	• Preparedness contingency in the event of surge in activity –Trust mitigation action plan – OPEL; Escalation Action Plans - OPEL • Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse • Reliance on Walk-in-Centres / Urgent Care Centre • Urgent Care Board (UCOG & UCEXG) • System partners escalation process	Not within the Trusts sphere of control. In the event of collapse, emergency procedures will govern the response	Engage with Commissioners **SLT Lead:** COO **Timescales:** Ongoing Review Contingency plans **SLT Lead:** COO **Timescales:** Ongoing	Level 2 • Reports to TMB Level 3 • Confirm and Challenge by NHS England Regional team and CCGs (Ongoing); • LHRP Assurance Process • Urgent Care Board (monthly)	Uncertainty re: fragility of neighbouring providers in the Wirral **Action:** A request to be made to review CCG BAF to better understand fragility of neighbouring providers in the Wirral	

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 2: Critical shortage of workforce capacity & capability** A critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards						**Strategic priority**	**Compassionate workforce:** be a great place to work **Continuous Improvement:** Maximise our potential to improve and deliver best value
Lead Committee	Workforce Assurance Committee	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**		
Executive lead	Director of Workforce	**Consequence**	**4. high**	4. High	4. High	**Risk appetite**	Open	
Initial date of assessment	01.04.20	**Likelihood**	**4. High**	3. Possible	3. Possible	**Links to the significant risk register**	397, 398 DRR/0018	
Last reviewed	18.02.21	**Risk Rating**	**16. significant**	**12. High**	**12. High**			
Last changed	18.02.21	**Anticipated change**	Intensifying					



Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
2.1 Threat: There is a national shortage of registered nurses and in some specialities for other health care professionals including medical staffing. This is affected by the demographic factors, uncertain impact after Brexit and increased competition. The threat has been further exacerbated as a result of the current Covid-19 pandemic with increased demand on clinical care.	• Strategic approach to local, national, international Recruitment campaigns for key posts (Band 5 nursing staff; CSW, medical staffing specialties) • Corporate recruitment activity in place • E-rostering and job planning to support staff deployment • Defined safe medical & nurse staffing levels for all wards & departments/ Safe Staffing Standard Operating Procedure • Access to temporary staffing within defined authorisation levels • 'No deal' EU Exit Planning Team – including workforce planning – action cards/ global communications/ EU exit page on intranet (Now disbanded) • ~~Draft Nursing workforce strategy paper being developed by Corporate nursing to include international recruitment~~ • Additional resource in corporate nursing to lead on nursing workforce plan • Ward establishment reviews and flexible skill mix changes • New pension policy in place to enable consultants to continue to work in the Trust which will assist in improvement of consultant retention • Divisional partnership reviews inclusive of recruitment and retention issues • Progressing with Divisional Strategic and operational plans including workforce planning • Medical staffing review completed (audit undertaken by MIAA with recommendations) • Workforce Strategy and Implementation Plan • Vacancy rates for nursing posts monitored through workforce governance structure and Divisions • Zero hours - new contracts issued in line with guidance • Recruitment Team in house with effect from 1st April 2020 • ~~New fully established recruitment team~~ • No longer have doctors on zero hour contracts. However,	Vacancy rates / high locum use and hard to recruit medical posts Robust Workforce Planning including triangulation of integrated rostering data for all workforce groups Implementation of priorities from the medical staffing review – actions being progressed though Audit Committee Workforce strategy needs review in line with national People Strategy (Aug 2020) – gap analysis exercise undertaken and approved by Trust Board December 2020 Workforce information and business intelligence enabling visibility of key workforce data intelligence to aid planning of workforce deployment	Bed modelling, & specialty capacity/ demand review - workshop April '21. Divisions to identify opportunity for change – discussion at TMB June '21 **SLT Lead:** COO **Timescales:** Q2 21/22 • Strategic and innovative recruitment methods being progressed with future operating model of Recruitment function being progressed through Audit Committee • International recruitment underway for key posts with appointment of Recruitment Project Lead to focus on achieving International Recruitment targets by end Q4 20/21. • Agreed recycling policy with LNC in December 2019. Medical Director, Finance Director and Director of workforce working on process to receive applications from consultant medical staff to opt out of current pension arrangements.	**Level 1** • Divisional performance reviews – workforce metrics (monthly) • Workforce steering group – all KPI's (Bi Monthly) • Workforce Steering Group – Chair's report • Safe Staffing Report – recruitment (quarterly) • Finance & Workforce Scrutiny meeting (weekly) On hold during COVID • Exception reports (QPR) for Attendance, Appraisal and turnover • M&A Bed modelling update – TMB (June '20) **Level 2** • People Strategy & Plan – Updates provided to WAC • Quality and Performance dashboard- Workforce metrics (monthly); • Report of Workforce Assurance Committee to Board (Bi Monthly); • FBPAC reports (Monthly) **Level 3** • MIAA Safe Nurse Staffing (Substantial) • MIAA Recruitment Process Review (Substantial) • MIAA Consultant Job Planning (Limited)	Lack of assurance re: control of locum use. **Action:** Medical Staffing Action Plan, improvements in control report via WSG Change/Improvement programme progressed through Audit Committee 2/3/21	

Board Assurance Framework (BAF): 2020/21

Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
	potential for future claims • Strategic review of workforce directorate including full resource and system assessment to future proof service delivery • Introduction of 'return to practice' and 'Bringing Back Staff' programme to respond to additional resource requirements due to Covid pandemic • Cases settled and ET claims withdrawn regarding Zero hour contracts in relation to doctors		• Recruitment to medical staffing lead (secondment) complete and review of team resource underway to drive forward and ensure sustained service provision in place **SLT Lead:** Dir Workforce **Timescales:** Q4 20/21	• National Staff Survey and Staff Engagement Index		
		Lack of control re: recruitment including resources, knowledge, governance. Immediate risk ceased and actions/ mitigations being tracked via audit committee	• Recovery plan including training and upskilling of staff within the recruitment team to bring up-to-date with current systems and processes and to train new staff **SLT Lead:** Dir Workforce **Timescales:** Q1 21/22			
			BI and workforce data intelligence – senior role recruited to. Immediate risks relating to data managed. Further MIAA audits in progress and scheduled for 21/22 FY. Consultant in place to review service provision and resources/ team structure. Gaps in assurance, mitigations and actions being tracked via audit committee **SLT lead:** Dir Workforce **Timescales:** Q2 21/22 Consultant job planning policy review underway and actions from MIAA audit being progressed. **SLT lead:** Medical Dir & Dir Workforce • **Timescales** Q1 21/22			
2.2 Threat: Decrease in workforce productivity arising from reduced attendance and staff morale **NOTE: for COVID related matters see risk identified in PR5**	• Staff Communication bulletin; • Schwartz rounds (on hold during COVID) • Divisional action plans from staff survey • Policies (Inc. staff development; appraisal process; sickness policy) • Procurement of specialist support for PTSD via Red Poppy • Wellbeing resources available for staff including access to Psychological support via Trust intranet and hard copy booklets • Leadership and management development framework in place and range of educational opportunities	• Unsustainable levels of sickness absence • Gaps in assurance regarding attendance management data • Inefficient absence and HR case management systems	Establishment of attendance management team – impact review to be completed at end of 2020. **SLT Lead:** Dir Workforce **Timescales:** Q4 2020/21 Introduce changes for effective absence data collection and review impact following period of adoption **SLT Lead:** Dir Workforce **Timescales:** Q1 20/21	**Level 1** • Divisional performance reviews – workforce metrics (monthly) • Workforce Steering Group – all KPI's (monthly) • Adopted National People Pulse Pilot July 2020- Jan 2021. • Establishment of 'Respect' at Work Group (monthly) • Exception Report – Board of Directors (monthly)	Change/Improvement programme progressed through Audit Committee 2/3/21	

Board Assurance Framework (BAF): 2020/21

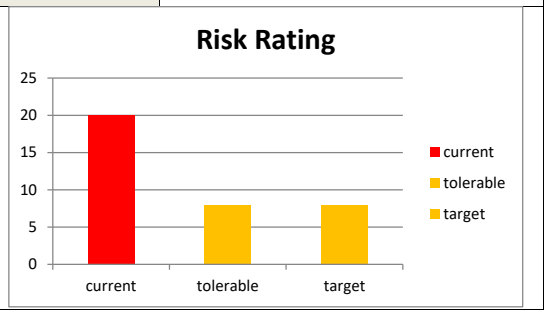
Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
	• Executive & SLT visibility; Ask the Senior Team and Leaders In Touch, Messages from the Board • Active D&I Staff support networks; • Freedom to Speak up Guardians • Guardian of Safe Working appointed for medical workforce • Review and relaunch of respect at work group • Occupational Health Support (as required) • Health & Wellbeing team in place, embedding of Health & Well-being Programme and Employee Assistance Programme • Rewards & recognition i.e. annual staff awards, Thank you cards • Review and relaunch of Attendance Management policy and supporting procedures • Oversight of People Plan via Workforce Assurance Committee • Assurance in place re robust workforce data to support timely and accurate management of attendance • Consistent approach to workforce risk assessments including template available on Trust intranet and via HR Business Partners or Occupational Health • Covid-19 debriefing sessions complete and actions being progressed. Full review of occupational health service provision including review of health and wellbeing plan underway. Includes review of resources, systems and processes to sustain provision for future. • New Attendance Management Policy introduced Q3 20/21	Longer term consequences post COVID eg: mental health, health and wellbeing, employment claims (re availability of equipment)	Business case for more interactive absence/HR case management system to future proof process and create more responsive data tracking **SLT Lead:** Dir Workforce **Timescales:** Q1 20/21 Health and wellbeing Plan reviewed in the light of COVID with short and medium term actions put in place. Longer term actions to support consequences now being developed and will be seen in updated Health and Wellbeing Plan with alignment with the People Plan. **SLT Lead**: Dir Workforce **Timescale**: Q4 20/21	• Leaders In-Touch Forum • Central Absence Line established for COVID special circumstances, now reverting to ESR arrangements • **Level 2** • People Strategy & Plan – Updates provided to WAC • Health and Wellbeing Plan to WAC • Health and Wellbeing Update reports to WSG • FTSU Reports to WAC • Quality and Performance dashboard- Workforce metrics (monthly); • Report of Workforce Assurance Committee to Board (Bi Monthly); • FBPAC reports (Bi-Monthly) • Weekly workforce dashboard to Executives • Monthly divisional dashboards including granular exception reports • Workforce Key Performance Indicators (KPI's) – WAC (bi-monthly) • Annual legal services report (As PR3) **Level 3** • National Staff Survey (Mar '20); • CQC Report (Mar '20); • Medical engagement survey (Nov '19) Next survey 2021 • Staff FFT (Q1,2,4) • Claims management MIAA assurance (As PR3) • People Pulse Pilot (July 2020 – Jan 2021) • MIAA Sickness and Absence Reporting review		
	• Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action & extreme weather event) • The LHRP co-ordinated response. • Annual Review of EPRR Assurance Statement of Compliance	Limits to the extent contingencies can provide the state required in emergency	Covid debrief to be undertaken to review arrangements for widespread disruption to availability of staff **SLT Lead:** COO **Timescales:** Next test by end Q1 21/22	**Level 2** • Resilience Assurance report to RMC (Mar; Sept) • EPRR Assurance Statement of Compliance **Level 3** • Confirm and Challenge by NHS England Regional team and CCGs; • LHRP Assurance Process	None identified	

Board Assurance Framework (BAF): 2020/21

Strategic threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (Evidence that the controls/ systems which we are placing reliance on are effective) Dcoumetn / process	**Gap in Assurance/ Action to address gap and issues related to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
2.3 Threat: Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training	• Induction; Mandatory & role specific training programmes available, Training postponement during Covid but now restarted. Virtual Induction introduced. • Corporate teams provide support and training as required, Exercises to test business continuity and incident management plans including loss of technology • ESR training record • Protected budgets for training & development • Practice educators • **Effectiveness of mandatory training knowledge acquisition in practice**: o 80% of the core 10 mandatory training subjects are available via e-learning. The remaining 20% (2) are practical sessions and therefore need to be face to face. o All Clinical skills programmes are based on national standards and competencies. o Education Review completed 2019 o Delivery of training reviewed due to social distance requirements, use of virtual learning	Due to the impact of COVID-19 the Induction programme and mandatory training was suspended. Induction was delivered virtually and Mandatory training restarted Learning & Development Agreement funding for Junior Doctors - impact due to Covid and reduction in training which forms Trust's commitment to support funding	Review virtual induction as part of post covid debriefs Head of OD liaising with HEE regarding impact of Covid on LDA	**Level 1** • Education Review – TMB (Oct '19) • Divisional Performance Reviews (3 monthly) • Quarterly Role Specific Training Reports • Education Governance Group (Bi-Monthly) monitor mandatory training and appraisal compliance • Workforce Assurance Committee (Bi-monthly) • Finance meetings to monitor spend **Level 2** • Q&P Dashboard- Mandatory training (monthly); • Report of Workforce Assurance Committee to Board (Bi-monthly) • Launch of Values & Behaviours • Workforce Key Performance Indicators (KPI's) (WAC, bi-monthly) • Health and Education England **Level 3** • Staff survey (2019 results = Mar '20) 2020 Opens September 2020 – Outcomes embargoed until end March '21)	None identified	

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 3: Failure to achieve and/or maintain financial sustainability** Inability to deliver the annual required financial plan trajectory resulting in a failure to achieve and maintain financial sustainability.						**Strategic priority**	**Continuous Improvement:** Maximise our potential to improve and deliver best value **Infrastructure:** improve our infrastructure and how we use it.
Lead Committee	Finance, Business & Performance Assurance Committee	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**		
Executive lead	Chief Finance Officer	**Consequence**	**5. Very high**	4. High	4. High	**Risk appetite**	Open	
Initial date of assessment	01.04.20	**Likelihood**	**4. high**	2. Likely	2. Likely	**Links to the significant risk register**	319, 320	
Last reviewed	05.02.21	**Risk Rating**	**20. significant**	**8. Medium**	**8. Medium**			
Last changed	05.02.21	**Anticipated Change**	Intensifying					

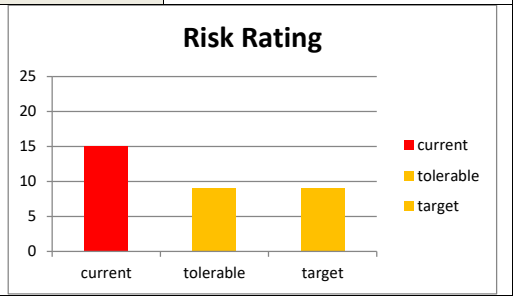


Risk course (what might cause this to happen)	**Controls** (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance rating**
3.1 Threat: Increased cost & income volatility as a result of tariff changes; deteriorating condition of clinical estate; dependency on temporary staffing; growth in competition from the private health sector; contract penalties/ fines leading to uneconomic services ****2020/21 temporary finance regime supports greater certainty of income position for 2020/21 but this regime will end on 31st March 2021.**	• Annual plan, including control total consideration; reduction of underlying financial deficit • Contract terms reduce risk of income volatility • SFI's authorisation limit (scheme of delegation) • Core financial control Policies / Procedures • Access to Working Capital support • Budgetary controls/Budget at Ward & Dept level • Training for budget holders • Procurement processes and Team • Risk based annual capital planning process • Embedded service line reporting • Courses throughout the year provided for Budget holders • Introduction of extra-ordinary controls: CEO/DoF led scrutiny panel (vacancies, CIP, non-core pay); Discretionary non-pay sign off escalation; Forecasting review based on issues and interventions • KPI meetings (all Divisions) to drive and improve standards of e-rostering • Development of Regulatory approved System Financial Recovery Plan (FRP)	• Not all budget holders have completed training • Compliance with escalation as per SFI • MTFM not yet agreed • Effectiveness of budget management @Divisional/ Corporate/ Ward/ Dept • Operational productivity impacting adversely on income and expenditure • Robust capacity plan which will need to incorporate the impact on productivity of Covid-19 measures. • Job planning and e-roster • Estates Strategy in development • Unbudgeted expenditure, including that related to meet regulatory requirements arising in year without mitigating savings • ~~Decommissioning of services provided to Clatterbridge Cancer Centre (CCC)~~	Develop & agree MTFM **SLT Lead:** CFO **Timescales:** End of Q1 2021/22 ~~Establishment of a Joint Working Group to oversee decommissioning of services provided to CCC~~ Build robust demand and capacity plan for 2021/22 to underpin financial plan **SLT Lead:** CFO/COO **Timescales:** Q1 2021/22 Development of a Financial Strategy & Recovery Plan with system partners **SLT Lead:** CFO **Timescales:** To be developed in line with national timetable Q1 2021/22	**Level 1** • Divisional risk reports to Risk Committee bi-annually; • E-roster data reviewed at Workforce Steering Group (quarterly) • Weekly COO/CFO/HRD led scrutiny panel (vacancies, CIP, non-core pay) • Temporary Financial Governance Arrangements for COVID (Board – April '20) **Level 2** • Finance report presented to Board (monthly) • Significant risk report to RMC (monthly); • Chairs report escalated to FBPAC & Board; • Q&P Dashboard (monthly) • Annual Report & Accounts **Level 3** • Internal audit • External audit • ~~Signed contract with WHCC/NHSE~~ • ~~System Finance Report to Board (monthly)~~ • ~~System Financial mitigation plan 2019/20 (submitted Dec '19)~~ • Procurement Processes (MIAA) – Moderate Assurance • Financial Systems Key controls and Financial Reporting (MIAA) – Substantial Assurance • Risk Management Process (MIAA) - Substantial Assurance • Head of Internal Audit Opinion (April '20) • External Audit Findings – Board (June '20)	No contracts in place for 2020/21. Contract process for 2020/21 suspended by NHSI to support COVID response. Financial plan developed to incorporate agreed funding streams ~~for M1 to M4 as~~ set nationally. ~~Income levels for M5 onwards have been estimated but no contract in place.~~ **Action:** To be kept under constant review in light of changing national COVID guidance. Robust demand and capacity planning to support ~~Phase 3~~ Covid-19 recovery and impact on recurrent productivity into 2021/22 **Action:** To be developed in line with national timetable (Q1 2021/22)	

3.2 Threat: Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues ****CIP planning suspended in 2021/22 to support COVID-19 response**	• CIP planning processes and coordination of delivery • Agreed CIP plans at Divisional and Dept level • Access to Working Capital support • Programme Board • SRO's identified for CIP programme • CIP planning; scoping; approval and initiation process in place with QIA and clinical sign-off • CIP delivery oversight meeting • Healthy Wirral System 5yr Recovery & Sustainability plan	• Planning halted as a result of Covid-19. Will need to be re-established for 2021/22 • Unidentified CIP in year • Slippage in agreed schemes • Effectiveness of oversight • CIP planning only relates to current financial year • Capacity and capability to drive significant efficiency schemes	• Introduction of CIP challenge and check process to monitor progress against target • Executive leads identified ~~for 2020/21.~~ • financial mitigations and PIDs developed. • PA Consulting commissioned to support development of 2020/21 CIP programme. Resources being identified to develop specific in-house financial turnaround capacity. Head of Capacity has been appointed **SLT Lead**: CFO **Timescales:** End of ~~Q4 2020/21~~ Q12021/22 Develop & agree Medium Term Finance Model (MTFM) - linked to other Trust Strategies and Healthy Wirral Plans **SLT Lead**: CFO **Timescales:** End of Q4 2020/21	**Level 1** ▪ Divisional reports to Programme Board ▪ CIP Scrutiny Panel (weekly) **Level 2** ▪ Finance report presented to Board (monthly) ▪ Chairs report escalated to FBPAC & Board; ▪ Q&P Dashboard (monthly) ▪ Annual report & Accounts **Level 3** ▪ Internal audit/ External audit;	Efficiency requirement for 2020/21~~ M1 to M4 has been~~ suspended by NHSI as a result of COVID. **Action:** To be kept under constant review in light of changing national COVID guidance.	
3.3 Threat: Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels	• Treasury loan process/NHSI Capital approval process. • Planned and preventative maintenance regime in place based on compliance • Reactive maintenance regime to repair immediate issues as they arise with dedicated Budget for Backlog maintenance ~~– circa £1.2 million~~ • Dedicated Capital Budget for improvement works on the Physical Environment.	• The condition of the current estate and ageing medical devices presents a significant maintenance and affordability burden in a restrained operations environment • Restrictions on availability of central capital funding • ~~Review and identify area of capital programme that does not impact backlog maintenance – relates to Car Park.~~ • Lack of equipment replacement programme to inform capital programme	Draft Estate Strategy to be developed informed by 6 facet survey **SLT Lead:** Director of Strategy **Timescales:** ~~Q3 20/21~~ Q4 2020/21– timeframe revised to align with development of Trust Strategy Medical Devices Procurement Group to review equipment replacement programme **SLT Lead:** Deputy MD **Timescales:** Q3 20/21	**Level 1** • Divisional risk reports to RMC (monthly) • Backlog report presented to RMC -March 19; • Compliance Audit undertaken (every 6mths) **Level 2** • Significant risk report to RMC (monthly) • IPC & Estates Capital Plan (Sept '19) **Level 3** • PLACE audits (annually) • 6 Facet survey – Board of Directors – Aug '19 • Environmental Health reports	NHS Premises Assurance Model Developed to identify areas of risk and reviewed annually.	
3.4 Threat: Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society	• Specialist H&S advisors & legal team employed • Membership of CNST scheme • H&S policies and procedures/ staff training • Investigation processes; action planning and sharing lessons learnt to reduce likelihood of recurrence • Clinical audit and effectiveness programme • Other insurance policies • Safety Management Strategy • Established Board-level Safety Management Assurance Committee. • H&S Performance & Assurance Dashboard • H&S elements included in Perfect Ward • H&S audit schedule developed	• Maturity of the safety management system is currently at 'emerging' level • Limited monitoring of compliance with H&S requirements • Restricted adaptive capacity • Restricted awareness of lessons learnt through clinical negligence claims and robust processes for implementation of actions to address issues identified • Uncertainty around legal risk following COVID pandemic	Develop a Trust-wide & Divisional specific H&S Manual to describe the interactions of the elements within the wider health and safety system **SLT Lead:** CN **Timescales:** ~~Q4 2020/21~~ Q2 2021/22	**Level 1** • Divisional H&S reports to SMAC (monthly) • H&S Committee report - SMAC (monthly) • Divisional monthly report of claims • **Level 2** • H&S report to RMC (6 monthly) • H&S Update and Dashboard (SMAC – monthly) • SI Panel • IR(ME)R Compliance Audit (SMAC Nov '19) • Legal Services Annual Report (Sep 20) **Level 3** • Authorised engineers reports; UKAS • NHSR claims profile; MHRA inspection reports; HSE inspection/ Environmental Health inspections; CQC inspection reports • Independent safety management audit (Arcadis) • Claims Management, MIAA – Substantial Assurance • RoSPA Gold Award achieved (Mar 20)	None identified	

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 4: Catastrophic failure in Standards of Care** A Catastrophic failure in standards of safety and quality of patient care across the Trust resulting in multiple incidents of severe, avoidable harm and poor clinical outcome						**Strategic priority**	**Outstanding Care:** provide the best care and support **Digital future:** be a digital pioneer and centre for excellence
Lead Committee	Quality	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**		
Executive lead	Medical Director/Chief Nurse	**Consequence**	**5. Very high**	3. Moderate	3. Moderate	**Risk appetite**	Open	
Initial date of assessment	01.04.20	**Likelihood**	**3. Possible**	3. Possible	3. Possible	**Links to the significant risk register**	214, 627, 796, 536, 767, 735	
Last reviewed	19.02.21	**Risk Rating**	**15. significant**	**9. Medium**	**9. Medium**			
Last changed	19.02.21	**Anticipated change**	Uncertain					



Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk rating RAG**
4.1 An outbreak of infectious disease (such as pandemic Covid-19, influenza; norovirus; infections resistant to antibiotics, high legionella counts) that forces closure to one or more areas of the hospital and/or causes avoidable serious harm or death to service users **NOTE: See also PR1** **NOTE: for COVID related matters see risk identified in PR5**	• DIPC is the Chief Nurse and is directly accountable to the CEO and Board of Directors • IPC service provided Trust wide by the IPC Team incl. seven day and out of hour's on-call service; IPC Programme of work • Infection Prevention & Control policies/ procedures • Staff training • IPC Environmental Safety Matron in post • Antibiotic stewardship • Environmental cleaning Procedures / Standards in all areas • Decontamination standards – CSSD; Flu vaccination prog • Strict adherence to single use items • Water flushing and testing regime with escalation process • Bed occupancy managed by leads that attempts to minimise risk of cross contamination • Mattress decontamination / disposal & replacement • Robust Infection Prevention Control plan in response to *Clostridium difficile* outbreak, seasonal infections such as flu / Noro Virus, Covid 19 • PPE • Ward Managers prioritising areas for maintenance works to inform overall Estates Strategy • **Command Structures eg Daily Bronze command, Clinical Advisory Group (the latter is chaired by the EMD) Outbreak meetings**	• A robust Wirral-wide plan for tackling Gram-Negative infections • Microbiology capacity for IPC • Short-term vacancies in IPC team • Inability to social distance in all wards will increase the risk of nosocomial transmission.	• Isolating or cohorting infectious patients • Enlisting public support to continue to restrict visiting in line with C&M pandemic guidance • Estate refurbishment plans as agreed by the Board of Directors • CDI action plan • Contingency plans for Influenza and winter viruses (tested in December '19) • Covid escalation plan	**Level 1** • Perfect ward/ ward accreditation audits; Divisional reports to IPCG • Weekly PPE and Environmental Group meetings **Level 2** • IPC- Improvement Plan – PSQB/Quality; Quality • CDI Action Plan (Quality) • Water Safety Group reporting to H&SC and SMAC (from August 2020) • Performance Dashboard; Weekly escalation report IPC specific; IPCG/ PSQB oversight • Annual Flu Plan – progress report to WAC (Sept – March metrics to be included in QPR) • Weekly DIPC review of HCAI including hospital onset COVID • IPC Board Assurance Framework (Board June '20 – also shared with CQC) updated August 2020 reported to Trust Board • **Level 3** • IPC Improvement plan; MIAA Internal audit reports; PHE reports • IPC Review MIAA – Limited Assurance (Actions now complete) • Report IPC data to CCG (CQPD)	None identified	

Board Assurance Framework (BAF): 2020/21

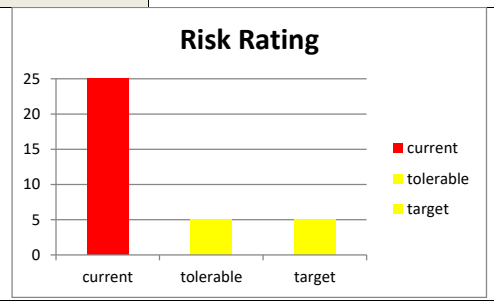
Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk rating RAG**
4.2 A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction **NOTE: for COVID related matters see risk identified in PR5**	• Monthly Patient Safety & Quality Board (PSQB) with work programme aligned to CQC registration regs • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems • Clinical audit programme & monitoring arrangements • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe medical & nurse staffing levels for all wards & departments • Ward assurance/ metrics & accreditation programme • CAS Implementation process • Mortality review policy & process • Real time review of incident reports and complaints handling • Consistently deliver at least 90% compliance with VTE assessment within 12 hours of admission • Safety bulletin monthly • Medicine alerts	• ~~Current levels of mortality review and structured jusgement review where these are indicated~~ • Exposure to serious incidents (above trajectory in 1 out of the last 3 months, as at Mar '20)	Appointment of Medical Examiners: **SLT Lead:** Deputy MD Actions to address serious incidents exposure are outlined on a case by case basis, and where appropriate are linked to the CDI action plan.	**Level 1** • Perfect ward/ ward accreditation audits (ongoing) • FTT and electronic patient/relative feedback kiosks *(nationally suspended April '20 onwards)* • Primary Mortality Reviews + structured judgement reviews. Quarterly/Annual Report to Board. • VTE Committee review with clinical lead • All Complaints – Executive sign off **Level 2** • Quality Performance Dashboard (monthly); • PSQB reports (monthly) • Quality Account (annual) – ***Note: deferred for 2019/20;*** • KLOE inspections local inspections; • Serious Incident Review Group (weekly) • Safety Summits (monthly) **Level 3** • CCG oversight of SI's (monthly) • CQC Insight tool(monthly); • Dr Foster updates; • MIAA SI- significant assurance • MIAA audit re safe staffing: Significant assurance • Patient/ Staff surveys • SHIMI / HSMR data • MIAA Management of Complaints - Moderate Assurance • Report IPC data to CCG (CQPD)	None identified	
4.3 Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine) **NOTE: See also PR1**	**Key Measures** - We have the ability to measure metrics shown in the rest of the BAF e.g. VTE and MUST **Training** – end users are not provided access unless they are trained. **Continuous improvement of the EPR** Governance structure and processes in place to prioritise areas of development and improvement based upon a rationale of risk mitigation and prospective benefits. Schedule of work for developments is set by the organisation based on the above criteria.	**Extended measures** Controls are sporadic and not part of an overall agreed compliance framework. **Training** – a lack of qualitative measures for compliance against a core set of competencies. No refresh training programme in place, hence no regular measure taken. **Innovation** – Governance is in place to prioritise innovation work. No consistent approach to providing effective communication or training material for new functionality and no measures to assess users for additional competencies.	**Digital Education Strategy** – As part of the IT Strategy a Digital education strategy is being formed which will look at a number of areas: **Core competency Framework:** The development of a matrix of core competencies for each job role to which staff can be measured against. **Skills assessment baseline:** to assess the digital maturity of users in the organisation and identify the gaps to be addressed. **Regular competency assessments:** against which staff can be measured, facilitated by an on-line catalogue of readily available training material with a modular approach allowing staff to access and complete at their own convenience.	**Level 1** • Training statistics – numbers of staff trained • Perfect Ward assessments of compliance • Limited report out at Digital Programme Oversight Committee (DPSOC) **Level 2** • Data Quality audits • MIAA Audits on use of the system and accuracy of data • "Lights on" data available to show operational efficiencies of current user base.	Currently no visibility of the levels of digital knowledge within the organisation **Action:** To provide meaningful evidence on a quarterly basis of compliance with competencies by division and identify gaps to be addressed. Divisional responsibility for ensuring all staff have been trained and are competent. To facilitate the above there is a need for financial investment of approximately £50k in a Learning Management System. Capital bid to be	

Board Assurance Framework (BAF): 2020/21

Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk rating RAG**
			Integration with performance framework: To establish system competencies as part of the overarching performance framework. To facilitate the above there is a need for financial investment of approximately £50k in a Learning Management System. Capital bid to be submitted Feb 2021. **SLT Lead:** Dir IT & Collaboration required with HR / Divisional Triumvirates. **Timescales:** Digital Education Strategy to be agreed by End March 2021. A delivery plan will then be written to inform specific timescales.		submitted Feb 2021. **Timescales:** Digital Education Strategy to be agreed by End March 2021 A delivery plan will then be written to inform specific timescales.	

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 5: Major disruptive incident (leading to rapid operational instability)** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						**Strategic priority** ALL STRATEGIC OBJECTIVES
Lead Committee	Finance, Business & Performance Assurance Committee	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	
Executive lead	Chief Operating Officer	**Consequence**	**5. Very high**	5. Very high	5. Very high	**Risk appetite**	Minimal
Initial date of assessment	01.04.20	**Likelihood**	**5. Very high**	1. Very unlikely	1. Very unlikely	**Links to the significant risk register**	212,485, 609, 797, 799
Last reviewed	22.02.21	**Risk Rating**	**25. significant**	**5. Medium**	**5. Medium**		
Last changed	22.02.21	**Anticipated change**	Intensifying				



Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance Rating**
5.1 Threat: A large-scale **cyber-attack** that shuts down the IT network and severely limits the availability of essential information for a prolonged period	• Data Security Assurance Framework (IGAF) • Fire wall controls • Access controls • VPN access • Anti-virus and updates • Mandatory Data Security Training • Business Continuity plans & BIA – Divisional & IT specific • Pilot site unified cyber risk framework • Cyber risks logged	Lack of co-ordination of incident response across region	Implement funded program to co-ordinate cyber security across the Mersey in liaison with NHS(E) Operational plans will address gaps, dependent on financial resources being available Development of a Regional response plan is in process. The plan will be tested using a desktop exercise mid 2021 with regional partners. Central funding has been used to implement improvements in Privileged Access controls, Antivirus, Training and monitoring platforms. **SLT Lead:** Dir IT & info **Timescales:** Plan by end of Q1 20/21, implementation by end of Q1 21/22.	**Level 1** • IG & Clinical Coding Group • Cyber Security Progress Report to FBPAC (Sept '19) • Report to Risk Management Committee (Quarterly) **Level 2** • Data Security and protection toolkit submission to Board and Board level training received. **Level 3** • Business Continuity Confirm and Challenge NHSE • LHRP Assurance Process • Cyber Essential Scheme Test Specification – Accreditation received (reassessment due March 2021) • National Cyber Essential Certification (Board of Directors – Sept '19) • MIAA Data Security & Protection Toolkit (Substantial) • MIAA audits on Cyber and Infrastructure undertaken • MIAA Cyber Security Organisational Controls (Moderate Assurance(January 2021) • MIAA IT Infrastructure (Limited Assurance)	None identified	

Board Assurance Framework (BAF): 2020/21

Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance Rating**
Threat: A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels • Operational strategies & plans for specific types of major incident (e.g. fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) • Strategic, Tactical, Operational command structure for major incidents • Business Continuity, Emergency Planning & security policies • Power failure action cards • Business Impact assessments • Major incident plan and action cards • ~~6 Facet survey commissioned. Interim report – August '19 Board.~~ • Emergency generators and second water supply	Deterioration of plant equipment & Fabric of building due to age of estate and availability of funding & extent of work required.	Development of Estates Strategy following receipt of 6 facet survey **SLT Lead:** ~~COO~~ CFO **Timescales:** Q2 21/22 – timeframe revised to align with development of Trust Strategy	**Level 1** • EPRR Twice yearly report to RMC **Level 2** • Monthly Significant Risk Report to Risk Committee • EPRR annual report (Sept) • Communication testing (every 6 months) **Level 3** • EPRR Core standards compliance rating (+ve); • Facet survey (May '19) • MIAA Internal audit report – Emergency planning (May 19) • April 2019 notification of NHSE review of EPRR core standards – Rating of "Substantial" assurance received for 2018/19	None identified	
Threat: A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period	• CAS alert system – Disruption in supply alerts • Procuring critical supplies through NHS SC –national distribution channels are prioritised during times of significant disruption or vulnerability. • Identified categories of goods/service susceptible to potential disruption (EU Exit)) • Management of key suppliers at National level (EU Exit) • Timely renewal of contracts- which reduces the Trusts exposure to risk • Due diligence of suppliers during the procurement process • BCP's for suppliers of critical goods and services • Contract Management • ~~MEDPRG~~ – Cinical Procurement Group (CGP)considers trials of new and alternative medical equipment, devices and products • Effective stock management system and processes • Timely payment of suppliers • Use of national datasets to identify (a) where WUTH is an outlier in terms of supply route (b) alternative sources /products. • Informal Mutual Aid arrangement with Cheshire Mersey Health Partnership (CMHP) EU Exit A comprehensive list of suppliers of critical goods and services was identified and the Trust collaborated with CMHP to issue an EU Exit questionnaire to those suppliers on behalf of the cohort. Supplier responses were RAG rated and plans put in place where any concerns were identified (very few).	Lack of comprehensive visibility of (a) critical supplies and services and (b) supply chain risks . Impacts on ability to plan effectively for supply chain disruption/failures.	Development of a comprehensive Critical Supplies Risk Register. Develop a Contingency plan for critical supplies which may include:- • Review of existing supply agreements • Dual sourcing where practicable and financially viable. • BCP's for All suppliers of essential/critical goods and services • Stock building of essential and critical supplies EU Exit The more formal Critical Supplies Risk Register will be developed during Q2 21/22 using the work done in preparation for the EU Exit as the basis for the register **SLT Lead:** Chief Finance Officer **Timescale:** Q2 21/22	**Level 1** • ~~Medical Equipment Devices and Product Review Group (MEDPRG)~~ **Clinical Procurement Group (CPG)** **Level 2** • EPRR Twice yearly report to RMC (Mar; Sept) • EPRR Annual Report (Sept '19) • EPRR Compliance Statement (Sept '19) **Level 3** • Letter of assurance, DoH	None identified	

Board Assurance Framework (BAF): 2020/21

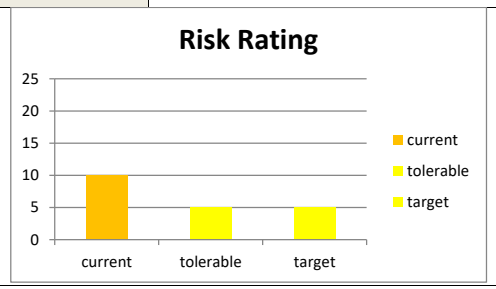
Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance Rating**
5.2 Threat: A pandemic disease outbreak that results in a temporary or prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community **NOTE: also see PR1, PR2 and PR4** Still the threat of another pandemic from another origin running alongside COVID Threat: Threat of concurrent pandemic or other major incident being during the current pandemic period we are in	• Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels (Mutual Aid) • Emergency demand & patient flow management arrangements • Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including pandemic) • Workforce, Clinical and Operational command structure for major incidents, with identified Executive Leads • Regional & National Communication & Guidance • Provision of supplies and procurement via national programme • National speciality guidelines • 3rd sector support i.e. private facilities • Visibility of sickness absence data to provide assurance on capacity for safe staffing • National command and control structures established across Cheshire and Merseyside • Introduction of revised Command structure • Daily workforce attendance reporting (Sitrep daily, report weekly) All visiting stopped except in exceptional circumstances. Family Support Team set up. • Fit testing programme. 40+ trainers and 4 machines. • Operational dashboard – reviewed daily (workforce supply, bed occupancy, supplies, mortuary and staff swabbing • Surgery restricted to urgent (inc cancer) and emergency cases only – under oversight of C&M Gold Command • All face to face out-patient clinics cancelled and where possible telephone/skype consultations • Utilisation of national supply chain and mutual aid programme; equipment monitoring and dashboard of equipment in stock/ utilised; implementation of appropriate alternatives for critical shortages as per national guidance • Development of Trust Recovery Plan • Introduction of new technologies to support virtual appointments and meetings • Twice daily report of all medically optimised patients within WUTH • 7/7 Twice daily Integrated Discharge team Command & Control meetings to discuss all medically optimised patients identified for discharge home with support or into Intermediate Care. • 7/7 Twice daily Integrated Discharge team Command & Control meetings to discuss all medically optimised patients identified for discharge home with support or into Intermediate Care. • Mandatory training paused to create capacity for Covid and upskilling which will impact on compliance rates	Critical supply chain ~~National command and control structures not fully established across Cheshire & Merseyside~~ Lack of capacity across a range of areas such as: beds, staffing, critical care equipment and personal protective equipment Staff readiness with transferrable skills – staff working in unfamiliar areas and appropriate training needs Identify staff training needs for redeployment –~~medicine into acute~~ ~~Increase in LoS for patients awaiting Covid swab results prior to discharge~~ Reveiwed 2 weekly Significant staff absence Insufficient access to rapid swabs Differing capability / capacity with partners to manage COVID Variable availability of specific types of FFPE masks Exponential increase in absence rates amongst Care Home and Domiciliary Care staff could significantly reduce Community Care capacity	• Pandemic Planning • Regular fit testing of staff when different FFP3 masks are available • Covid Vaccination Programme	**Level 1** • Command Structure – Bronze, Silver, Gold and Clinical Advisory Group • Temporary Financial Governance Arrangements for COVID (Board – April & July 2020) • COVID Workforce Risk Assessment & PPE (Board – June '20) • Addendum to SFI's/SO's (Board- April & July 2020) • COVID preparedness and updates (monthly) • COVID Training Task and Finish Group established March 2020 (now with Education Governance Group) • Upskilling Training completion reports available April 2020 • Education Governance Group (Bi Monthly) • COVID Recovery & Reset Plan (Board – June, July, August 2020) • Board Review of Interim Governance Arrangements – July 20 **Level 2** • WAC training reports • Workforce Steering Group – all KPI's (monthly) • Workforce Steering Group – Chair's report • People Strategy & Plan – Updates provided to WAC • FTSU Reports to WAC • Quality and Performance dashboard- Workforce metrics (monthly); • Report of Workforce Assurance Committee to Board (Bi Monthly); **Level 3** • National Staff Survey (Mar 2020); • Staff FFT (Q1,2,4) • Revised timeframe for year-end reporting (NHSE/I)	None identified	

Board Assurance Framework (BAF): 2020/21

Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Assurance Rating**
		Unknown how long disease will continue and therefore the prolonged impact of continuity of services (COVID/Non COVID) including Staff resilience and well being Unknown long term consequences of COVID-19	• Links to National, Regional and local updates – reviewed, escalated and circulated as appropriate • Command structures – National, Regional, Local and Trust • Working with system partners for the phased introduction of referrals into the Trust • Staff support including health and wellbeing, staff support team, Occupational Health		None identified	

Board Assurance Framework (BAF): 2020/21

Principal risk (what could prevent us achieving this strategic priority)	**PR 6: Fundamental loss of stakeholder confidence** Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public						**Strategic priority**	**Our partners:** provide seamless care working with our partners
Lead Committee	Board	**Risk Rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**		
Executive lead	CEO	**Consequence**	**5. Very high**	5. Very high	5. Very high	**Risk appetite**	Open	
Initial date of assessment	01.04.20	**Likelihood**	**2. Unlikely**	1. Very unlikely	1. Very unlikely	**Links to the significant risk register**		
Last reviewed	19.02.21	**Risk Rating**	**10. High**	**5. Medium**	**5. Medium**			
Last changed	19.02.21	**Anticipated change**	Uncertain					



Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Risk rating RAG**
6.1 Threat: Changing regulatory demands (including Covid-19) or reduced effectiveness of internal controls resulting in failure to make sufficient progress on agreed quality improvement actions; Or widespread instances of non-compliance with regulations and standards	• Quality & corporate governance & internal control arrangements • Conflicts of interest & whistleblowing management arrangements • Routine oversight of quality governance arrangements & maintenance of positive relationships with regulators • Formal notification process of significant changes (Relationship manager, CQC; Chief Inspector of Hospitals) • Internal KLOE inspections in clinical areas • Exec visibility & visits • Clinical & management audit • Policies and procedures • External oversight from regulators via System Improvement Board • Delivery of all elements of 2020 CQC inspection 'must do and should do's' • Governance & Assurance processes • FTSU Guardians • Bi-monthly assurance reporting to Board on progress against undertakings moved across from 'plans to improve control'	Compliance:- • Financial sustainability ***(refer to PR3 for action, control and assurances)*** • 2020 CQC rating of 'Requires Improvement' (inc Use of Resources) • Patient Flow Management ***(refer to PR1 for action, control and assurances)*** Revised Enforcement Undertakings issued by NHSI 24 July 2020		**Level 1** • Ward accreditation metrics • Managing Conflicts of Interest – New Policy • Freedom to Speak Up – WAC (bi-monthly) • Freedom to Speak UP – Board (bi-annually) **Level 2** • PSQB Report to Quality Committee • Quality Performance Dashboard • CQC Action Plan 2020 Approach (Board – June '20) **Level 3** • CQC Inspection report 2020 (inc use of Resources) – Requires Improvement • System Improvement Board (NHSI/E) – (bi-monthly)Monthly • System Finance Report to Board (monthly) • Board to Board – CCG (bi-annually) • Healthy Wirral Programme Board • Unplanned Care Board (monthly)	None identified	
6.2 Threat: Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust	• Communications department to handle media relations • Established relationships with regulators • Trust website & social media presence • Internal communications channels • Continued public & stakeholder engagement utilising a wide range of consultation & communication channels; • Communications & Engagement Strategy Trust Board • Surveys and Friends and Family Testing • Consultation on proposed strategy and service changes • Development and implementation of Patient Experience Strategy • Regular MP updates in conjunction with local authority • Stakeholder engagement via Healthy Wirral Partnership • Cheshire & Mersey Hospital Cell • Leaders Forum in place • Developing local partnerships with Healthwatch and Maternity Voices.	Established processes to improve engagement with stakeholders Changes to governance with emergence of Integrated Care policy	Comms / PR Strategy Implementation Plan **SLT Lead:** DoHR **Timescales:** Q3 2020 • Quarterly meeting with Wirral Globe • Introduction of 'Ask Janelle' column in the Wirral Globe – starting February 2020 – suspended due to Covid-19 • Revised Communications Strategy in development • Board briefing on ICP and ICS policy and direction of travel • Board Working Group to support development of ICP model for Wirral health system	**Level 1** • Media Analysis (WAC, bi-monthly) • Top Leaders Programme – Media Training • Patient Stories – Board (monthly) • Review of complaints – PSQB (monthly) • Messages from the Board – (monthly) • Patient Experience Implementation Plan – PFEG reporting to PSQB (monthly) • Staff stories – Workforce Assurance Committee (bi-monthly) and Board on a quarterly basis • National Medical Engagement Survey – Board 2021 • Regular meetings with staff side and trade unions • Communications & Engagement report – Board (monthly) • Improved relationship with Wirral Globe – successful fundraising appeal **Level 2** • Communication / Press statements	None identified	

Board Assurance Framework (BAF): 2020/21

Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Source of assurance (& date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gap in Assurance/ Action to address gap**	**Risk rating RAG**
			• Updates to Healthy Wirral Programme Board **SLT Lead: DoS&P** **Timescales:** April 2022	• Patient Experience Strategy (Oct '19) • Operational Plan (Annual) – submitted to regulators *(suspended 20/21)* **Level 3** • FFT recommendation ratings *(suspended April '20)* • NHS Choices ratings • National In-patient Survey – Board (Nov '19) • Healthy Wirral 5 year Strategy (Board Nov '19) • Cheshire & Merseyside 5 year Plan (Board Jan '20)		
		Conflicting priorities, financial pressures and/or ineffective governance resulting in a breakdown of relationships amongst STP partners and an inability to influence further integration of services across acute, primary & social care providers	• Representation on STP Committees • Leadership of STP Planned Delivery • Engagement with STP Partners and Commissioners **SLT Lead:** DoS&P **Timescales:** 2025			

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20-21/254

BOARD OF DIRECTORS
03 MARCH 2021

Title:	Report of the Quality Assurance Committee
Author:	Steve Ryan, Non-Executive Director
Responsible Director:	Dr. Nikki Stevenson, Executive Medical Director / Deputy CEO
Presented by:	Steve Ryan, Non-Executive Director

Executive Summary
This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 15th February 2021.

Recommendation: (e.g. to note, approve, endorse)
For noting

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
N/A
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors statutory role,

significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	Quality Assurance Committee
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
03 MARCH 2021

Report of the Quality Assurance Committee

Purpose

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 15th February 2021.

Introduction / Background

1. Nosocomial coronavirus infections in patients with hip fracture

The Committee noted a report examining issues and potential gaps in assurance on the controls for this care pathway. This was based on key-lines-of-enquiry outlined by NHS England for a survey across 23 North-west Trusts. Since 1st April 2020, 397 patients have been treated with a low mortality of 4% (below the pre-COVID-19 national average rate of 6.9%). The performance of the service is already known to be in the top 9 of the 174 providers in the 2019 National Hip Facture Database. The challenges and responses to identifying and isolating patients and supporting staff working in both trauma and elective care were discussed. The helpful progress in point of care testing and other faster diagnostic methodologies were noted.

2. Surgical site infection (SSI) surveillance programme

This programme has been re-launched following a strategic review and the appointment of an SSI nurse, together with the development of patient information materials. This follows a lack of submission by the Trust for 2019/2020. The programme will go beyond the minimum requirements of 1 surgical specialty for each quarter of the year. It will encompass general surgery, trauma and orthopaedics and maternity and gynaecology – all reporting each quarter. Surveillance information will be reviewed at Infection Prevention and Control Committee and Patient Safety and Quality Board (PQSB) prior to submission (currently to Public Health England).

3. Ophthalmology

The Committee noted that following concerns being raised about risks of visual loss in patients due to delays in care, executive oversight was now in place to support appropriate action. The Committee asked to receive a more detailed update at its next meeting.

4. World Health Organisation (WHO) surgical checklist

Following concerns having been raised and an audit conducted, and reported to PQSB in December 2020, a range of immediate actions were taken and communicated to theatre staff and arrangements made for on-going audit and

oversight. An important on-going action is the modification of the informatics platform (WM Cerner) to support staff in completing and overseeing the checklist. Updates will continue to be provided to the Committee through PQSB.

5. 4Ways radiology reporting quality assurance

4Ways are an independent provider commissioned by the Trust to undertake radiology reporting remotely. The work the Trust directs to 4Ways is risk assessed, so that more complex and more challenging reporting is maintained "in house". PQSB reported that 4Ways had demonstrated that they met standards of expected practice in discrepancy reporting and that their systems of oversight were judged to be proficient.

6. Complaints

It was noted in Quarter 3 that here had been a 23% reduction in both formal and informal complaints. Themes of complaints included those around communication with families, especially in light of current limitations on visitors. Our responses included managers and clinicians scheduling time to contact family members to update them where possible. Acknowledgment of complaints within 3 days above the benchmark of 90% was achieved throughout Quarter 3 and was 100% in December.

Conclusions

N/A

Recommendations to the Board

The Board is requested to note the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20-21/255

BOARD OF DIRECTORS
03 March 2021

Title:	Communications and Engagement Report
Responsible Director:	Jacqui Grice, Director of Workforce
Presented by:	Sally Sykes, Director of Communications and Engagement

Executive Summary
The report covers the Trust's communications and engagement activities since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement.

Recommendation: (e.g. to note, approve, endorse)
To note the progress in communications and engagement this month.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	No

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
NA
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Risk 133 – reputation and loss of stakeholder confidence
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
Fundamental purpose is to ensure positive relations are maintained
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Patient confidence and staff engagement are influenced by communications, media

relations, campaigns, issues management and positive engagement.	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
None	
Previous considerations by the Board / Board sub-committees	Monthly reports
Background papers / supporting information	Report attached with appropriate links embedded.

BOARD OF DIRECTORS MEETING IN PUBLIC
3 March 2021

Monthly Report of the Director of Communications and Engagement

Purpose

To advise the Board of significant progress in communications, marketing, media relations, employee communications, patient communications, awareness campaigns and stakeholder and staff engagement.

Introduction / 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.

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

Campaigns

- We continued to provide extensive support to the WUTH vaccination hubs and the national roll out with patient facing materials and advice, social media, broadcast media and staff communications. This has included communications to target BAME groups, pregnant women and to overcome vaccine hesitancy. We have also supported the roll out to new cohorts in the JCVI prioritised programme and further stakeholder communications to encourage eligible partner organisations' staff to book their vaccines.

- In addition to celebrating WUTH's performance as a major contributor of patients into the RECOVERY research clinical trial – where we have recruited over 400 patients, we also promoted the PRINCIPLE trial, which is a nationwide clinical study from the University of Oxford to find COVID-19 treatments for the over 50's that can be taken at home. PRINCIPLE is still open to those who have received a COVID-19 vaccination. (How to join the trial — PRINCIPLE Trial)

- We also supported the Wirral Partnership Trust's activities during Children's Mental Health Week, including the launch of a new text chat helpline for children and young people.

- We promoted World Cancer Day, which takes place on every 4th February is the global uniting initiative led by the Union for International Cancer Control (UICC). It aims to raise worldwide awareness and to

improve education to help prevent cancer deaths through access to life-saving cancer treatment and equal care for all.

Media

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

- We highlighted the £1m investment in our Emergency Department at Arrowe Park which was covered in The Liverpool Echo and The Wirral Globe. The developments were also highlighted to staff and it's a significant morale boost for colleagues to see new investment going into our hospitals and improving patient experience.
- There was also coverage of a new service in an unusual approach to personalised prosthetics now offered by the Wirral Limb Centre.
- The main focus of our media work since the Board last met was the national and regional coverage of our experiences one year on from the repatriation of guests from Wuhan and the Diamond Princess Cruise Liner to Arrowe Park Hospital. A selection of the coverage is outlined below and there was also a national piece on BBC Breakfast on the one year anniversary day itself, with an interview with Medical Director and Deputy CEO, Dr Nicola Stevenson. (Some clips have been edited for brevity and should not be reproduced without permission). The coverage coincided with one of the peak weekends in the surge in cases in our hospital and nationally.

  ITV Granada Reports
  BBC Radio Merseyside audio
  LBC News
  Liverpool Echo

- Dr Stevenson also took part in a podcast with the Innovation Agency and colleagues local GP Dr James Perry, WUTH's Head of Strategic Planning Mike Gibbs and Wendi Shepherd from Pubic Health England - you can listen to it by clicking here. The podcast is intended for healthcare professionals to learn from the challenges of establishing Britain's first mass quarantine site in 40 years.
- We communicated NHS CEO Sir Simon Stevens' national thanks to staff for the year's work on the pandemic and Sir Simon referenced, during the daily Downing Street Media briefing, the year that had elapsed since the quarantined guests arrived at Arrowe Park from Wuhan
- The Times Court Circular reported a telephone call from HRH,The Duke of Cambridge to WUTH CEO Janelle Holmes, in which the Duke thanked staff, on behalf of himself and the Duchess of Cambridge, for all their hard work during the pandemic

Media Statements

- We provided a response from Dr. Nicola Stevenson to an enquiry from The Liverpool Echo on nosocomial COVID-19 infections covered in the December report to the Board on Infection Prevention and Control.

Internal Communications and staff engagement

- We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, patient feedback and thanks, clinical guidance, staff wellbeing and support; and charity updates.
- All staff were invited weekly 'In Touch' online briefings, building on the positive feedback and engagement with over 240 staff who joined the first open session. The Executive Team gave situation updates about our hospitals – COVID-19, vaccination hubs, vaccination cohorts and ongoing winter pressures.
- We recognise the many challenges our staff are facing during the COVID-19 pandemic. We regularly promote the range of staff support available along with some national services on the health and wellbeing website pages. We produced a payslip leaflet, wellbeing posters and a wellbeing services directory folder for every ward and key departments in the hospitals.
- We have developed a distinctive identity for health and wellbeing communications for staff and are also now reorganising website content to follow the same categories of support and highlighting the many internal and external resources available.
- The first ever Race Equality Week in the UK took place between the 1st and 7th of February. Race Equality Week is a UK-wide initiative, uniting hundreds of organisations and individuals in activity to address the barriers facing race equality in the workplace. We promoted the initiative to staff and via our staff networks.
- We have received the national Staff Survey results, which are classed as National Statistics and embargoed for external publication until 11th March 2021. Communication of the results and action planning will follow the publication of the survey results.

WUTH Charity update

- On the COVID-19 support fund, the local appeal total is very close to reaching £150,000. This will be communicated to the Wirral Globe with a message of thanks for their support, which has been tremendous. Plans are being drawn up for a significant investment in staff wellbeing and rest facilities. The money from the appeal with The Globe and the share from Captain Sir Tom Moore's fundraising will enable us to create lasting and much needed staff rest and wellbeing spaces.
- We marked the sad news that Captain Sir Tom Moore had passed away and shared social media posts of staff at the Clatterbridge Vaccination Hub joining the national clapping tribute.
- The Charity team continued to support staff in January and February, arranging weekly drops of refreshments and 2 free breakfasts for all COVID-19 wards, ED and Critical Care. Further support has also been secured from Premier Foods, and local supermarkets.
- In developing corporate support, relationships with a number of companies are now being nurtured. These include Home Instead (home and social care provider), Royal Sun Alliance and Premier Foods. Vauxhall have donated laptops to the Charity to be used for community engagement, volunteer administration support etc. They have also offered two corporate volunteer days for their staff in April. The Head of Fundraising is working with Paul Mason, Director of Capital Planning & Portfolio Development to plan this in kind contribution from volunteers.

- A ‘Small change for Big change’ campaign will be launched this month. The Charity team will be distributing collection boxes for people to collect their loose change at home / non-public settings.
- After a successful first virtual event last year, Virgin Money London Marathon has announced the virtual event will return on October 3rd 2021. We have successfully secured 25 places for this event and will be opening our ballot for these places from next week.

Stakeholders

- We worked across the system to signpost the best healthcare options for Wirral residents this winter, including for the first time the use of the Council’s roadside matrix signs for brief and important messages to the public.
- We shared Healthwatch’s Bulletin with our staff and continue to work collaboratively with them.
- We also worked with Healthy Wirral on the key messages for Healthy Wirral in system working, which is likely to come to the fore with the Government’s proposals for greater place-based integrated care collaborations.

Conclusions:

As above

Recommendations to the Board

The Board are asked to note the report, and to note the very high level recognition and thanks from the Royal Family and the NHS, recognising the work of our staff.

The Board are asked to note the forthcoming Staff Survey results publications