NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

7 April 2021

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
12.30pm - Wednesday 7 April 2021
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
21/22-001	**Apologies for Absence**	Chair	Verbal	N/A
21/22-002	**Declaration of Interests**	Chair	Verbal	N/A
21/22-003	**Patient Story**	Chief Nurse	Video	N/A
21/22-004	**Minutes of Previous Meeting – 03 March 2021**	Chair	Paper	1
21/22-005	**Board Action Log**	Chair	Paper	11
21/22-006	**Chair's Business**	Chair	Verbal	N/A
21/22-007	**Key Strategic Issues**	Chair	Verbal	N/A
21/22-008	**Chief Executive's Report**	Chief Executive	Paper	13
Performance & Improvement				
21/22-009	**Quality and Performance Dashboards & Exception Reports**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Deputy Chief Nurse	Paper	19
21/22-010	**Reset and Recovery Plan including Clinical Validation report**	Chief Operating Officer	Presentation	46
21/22-011	**Learning From Deaths** ***(Mike Ellard to attend)***	Medical Director	Paper	71
21/22-012	**Finance Report**	Chief Finance Officer	Paper	79
21/22-013	**2021/22 Capital Allocation Report**	Chief Finance Officer and Director of Strategy	Presentation	94
21/22-014	**International Nurse Staffing**	Chief Finance Officer and Deputy Chief Nurse	Paper	129
Governance				
20/21-015	**NHS North West BAME Advisory Report** ***(Sharon Landrum to attend)***	Director of Workforce	Paper	134
21/22-016	**CQC Compliance and Action Plan**	Deputy Director of Patient Safety and Governance	Paper	151
21/22/017	**CQC Consultation on Strategy for Regulation**	Deputy Director of Patient Safety and Governance	Paper	194
20/21-018	**Monthly Safe Staffing Report**	Deputy Chief Nurse	Paper	225

20/21-019	**Change Programme Summary, Delivery & Assurance**	Director of Strategy and Partnerships	Paper	230
20/21-020	**Review of Register of Interests and Annual F&PP Declaration.**	Interim Deputy Trust Secretary	Paper	250
20/21-021	**Review of Non-Executive Director Independence**	Interim Deputy Trust Secretary	Paper	256
20/21-022	**Chair's Report – Quality Committee**	Committee Chair	Paper	261
20/21-023	**Chair's Report – Finance, Business, Performance Assurance Committee**	Committee Chair	Paper	265
20/21-024	**Chair's Report – Workforce Assurance Committee**	Committee Chair	Paper	269
20/21-025	**Chair's Report – Safety Management Assurance Committee**	Committee Chair	Paper	274
20/21-026	**Report of Trust Management Board**	Chief Executive	Paper	278
20/21-027	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	284
20/21-028	**Any Other Business**	Chair	Verbal	N/A
20/21-029	**Date of Next Meeting – 5 May 2021, 12.30 via MS Teams**	Chair	Verbal	N/A
20/21-030	**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

03 MARCH 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 12.30 and Concluding at 14.30

Present

Sir David Henshaw	Chair
Chris Clarkson	Non-Executive Director
Steve Igoe	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

Debbie Edwards	Director of Nursing & Midwifery, Women & Children's Division
Tracy Fennell	Deputy Chief Nurse
Helen Kerss*	Guardian of Safe Working
Andrea Leather*	Deputy Board Secretary
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
Eileen Hume	Public Governor
Alison Owens	Public Governor
Ann Taylor	Staff Governor
Angela Tindall	Public Governor

Apologies

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

*Denotes attendance for part of the meeting

Reference	Minute	Action
20/21 237	**Apologies for Absence**	
	Apologies were noted as reported above.	
20/21 238	**Declarations of Interest**	
	No new interests were declared. The Chair commented on the online system for declaring interests which had recently been rolled out to Directors and staff members on Band 7 and above. He reminded all concerned to complete their declarations within the stipulated timescale.	

Reference	Minute	Action
20/21 239	**Patient Story**	
	The Board viewed a video of Mr Jones who had received treatment for stroke at WUTH. Mr Jones described his experience of treatment received as excellent. He was particularly impressed with the calm nature of the staff members including how well-organised everybody was. Mr Jones recalled being seen by multiple teams including the stroke team and the physiotherapy team whom he was full of praise for. He also expressed appreciation for the opportunity to ask question and getting a response. Mr Jones described his experience when he was invited for the COVID-19 vaccination as well organised. He expressed gratitude for the opportunity for his wife to be vaccinated at the same time as himself. The Chair expressed appreciation of the Board to Mr Jones for sharing his experience.	
20/21 240	**Minutes**	
	The minutes of the meeting held on 27 January 2021 were approved as an accurate record subject to the following amendment: **Item 20/21 224 paragraph 3 Line 9**: **Change:** "Closing of doors had been re-introduced where infection was not present" **To:** "Opening of doors had been re-introduced where infection was not present"	
20/21 241	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
20/21 242	**Chair's Business**	
	The Chair reported that there had been discussions at regional level about recovery of services post-COVID-19 pandemic. Some progress had been made in terms of working together as a system. More clarity had been provided on the proposed changes to the NHS. The Chairs/Chief Executives forum had proposed to retain the independent Chair for a further six months whilst moving forward with the design of the collaborative working arrangements. **RESOLVED:** **To NOTE the Chair's Business**	
20-21 243	**Key Strategic Issues**	
	There were no additional strategic issues to report.	
20/21 244	**Chief Executive's Report**	
	The Chief Executive presented her report and highlighted that there had been a significant decline in the number of COVID-19 inpatients. The reduction had been attributed to a number of factors including reducing community prevalence, the impact of lockdown, and the successful Wirral vaccination programme which began in December. The number of red wards	

Reference	Minute	Action
	had reduced from 10 to 2 but critical care occupancy and patient acuity had however remained high. The CEO also highlighted that Planned Care activities had been restarted in line with phase 3 recovery, and were being delivered with the focus on COVID-19 safety measures. Other issues highlighted by the CEO included the Trust's vaccination programme which had received a five-star rating by the Healthwatch; WUTH's research contributions to the 'it has a name' study; two major capital delivery programmes - the New Cardiac Cather Lab and the Upgrade of Emergency Department (ED) Majors Area. There had been four serious incidents in each of the months of December 2020 and January 2021. All the incidents were being investigated under the Serious Incident Framework to identify opportunities for learning and actions to drive improvement and reduce future risk. Since the CEO's report was circulated, there had been a CQC Inspection of the Trust's Infection Prevention and Control (IPC). Initial feedback confirmed in a letter had indicated that there were no major concerns, good staff engagement and positive patient experience reported by all patients spoken to on the day. The formal report was anticipated in April. John Sullivan asked for clarification on management arrangements for the next phase of the vaccination programme. The CEO advised that support for the vaccination programme had been delivered mainly by locums, bank and agency staff. Capacity requirement was being reassessed in line with the Primary Care and Place Vaccination delivery model. It was currently difficult to predict for how long the vaccination hub would be opened for but it was anticipated that the hub would be opened for another six to nine months. Further clarification was sought on the capacity to administer the second dose of the vaccine. The CEO advised that there was a standard fixed capacity with some flexibility. The Trust was working on the assumption that the second dose vaccination would be administered for staff members. If it became necessary to continue with booster vaccinations, further assessments would be made on the level of capacity for the vaccination hub. The CEO added that administration of the vaccines was clinically led. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
20/21 245	**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. There was an observation that the dashboard data which showed a dip in 'Eligible patients having VTE risk assessment within 12 hours of decision to admit' had been pulled from a sample audit. **It was proposed and agreed that BI data which contained all patient data should be presented for this section in future reports in line with national standards.** It was noted that exception reporting had been temporarily suspended. This would resume from the April Board as part of return to business as usual.	**John H**

Reference	Minute	Action
	The COO gave explanations on why there had been a fall in the 4-hour A&E target in January 2021. Wave 3 of COVID-19 surge had peaked in January which had culminated in designating a number of wards from green to red. The situation had improved in February which had enabled one of the red wards to be moved back to green. A testing regime had been introduced to ascertain those patients that were COVID-19 positive before being admitted. The tests had helped to reduce further risks of nosocomial infection. The COO gave explanations on the recent improvements to patients' flow and how focus had returned to the 4-hour A&E target. The COO also gave explanations on the slip in Ambulance Handover target across the system and Cheshire and Mersey in January 2021. The Trust had been on top of the average turn-around time of about 40 minutes at acute hospitals across the region. North West Ambulance Service had received some support from the Ministry of Defence. With more focus and increased management oversight, Ambulance Handover at WUTH had seen a significant improvement in February 2021. Whilst there had been 158 handovers lasting more than one-hour in January, the number was only 10 in February 2021. The progress was also attributed to additional investment to create capacity in A&E through capital build. On cancer waiting times, the COO advised that all patients that could be clinically deferred had been deferred and that the number of deferrals had become smaller. The period of suspension of some of the services had become shorter which indicated that the service was recovering. There had however been a backlog of the clinically deferred patients. John Sullivan queried why the deterioration in Ambulance Handover times had lasted several months and wanted to know how confident the COO was that the recovery plans put in place would turn the situation around in the next quarter or so. The COO replied that one of the errors of the past was about trying to do too many things at the same time and that when improvement plans had been introduced, they were not sustained. The executives had been holding regular operational meetings with the divisions to ensure that improvement plans were well embedded before moving on to another one. The Board congratulated the executive team for the Diagnostic wait which had improved significantly. The Chair echoed the concern on why some improvement plans had not been sustained particularly around Discharge and requested the executives to identify if there were system problems that needed to be resolved. The Chief Nurse advised that a new service lead for the patient flow team was having a positive impact. Improvement work was underway to improve triage times as part of the Trust wide Patient Flow Programme and progress was tracked through the Programme Board. The CEO gave explanations on the daily oversight meetings at which the leadership teams were taken to account for delivery of the improvement plans in line with regional and national expectations. There was greater visibility of the service and improvements had been made to information sharing which had provided confidence that issues would be known as soon as they happened.	

Reference	Minute	Action
	The Chief Nurse drew attention to the slight rise in formal complaints and gave explanations on how they were being resolved. There would be a quarterly performance report on complaints through the Patient Safety and Quality Board (PSQB). She added that the complaints were largely around communication, care, treatments and appointments. The Director of Workforce briefed the Board on the sickness level and the plan to return to business as usual post-COVID-19. Trigger meetings would now be held with those with difficult sickness record which could not be done whilst under COVID-19. She added that some improvements in staffing level were expected on the clinical support workers over the coming months due to the successful international recruitment exercise. Advice had been received nationally to expect some fatigue and increase in sickness level as a result of what people had been through. The Director of Workforce also highlighted some of the support facilities for staff members and the flexible working programmes designed to improve staff turnover. John Sullivan commented on the high turnover rate and the need to include underline staffing issues, appraisal rates and sickness level in the COVID-19 reset and recovery plans. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard for the period to 31 January 2021.**	
20/21 246	**Month 10 Finance Report 2020/21**	
	The Chief Finance Officer (CFO) presented the month 10 financial report and highlighted the year to date surplus of £1.9m and a forecast surplus of £2m by the end of the financial year. The CFO advised that an independent sector contract on MSK had been taken over as a national contract funded directly by NHSE/I. That had effectively reduced the Trust's expenditure by £1.5m and represented a positive cash-flow position. Delivery of the capital programme had continued to progress well with current plans expected to deliver in line with the £13.2m previously reported. The CFO advised that there had been a request by the national team for NHS Trusts to carry out an assessment of the liability in relation to unutilised annual leave by staff. An assessment by the Trust had revealed a significant increase in unspent leave over the third wave of the pandemic. The value of unspent leave was estimated at about £1.5m whilst the final number of unutilised days up till the end of the financial year was being calculated by HR. It was anticipated that the full liability would be significantly more than was provided for. This was reported as a significant issue which would need to be reviewed by the auditors and the Audit Committee. Steve Ryan requested clarification on the new NHS funding model. The CFO gave explanations on the proposed 'Blended Payments' model of funding. The model involved a combination of a fixed payment, alongside financial risk-sharing elements, for example, a variable element reflecting actual activity levels, and outcomes-based payments. The CFO had not received official notification that the proposed funding model would be implemented during the 2021/22 financial year.	

Reference	Minute	Action
	RESOLVED: **That the Board NOTED the report.**	
20/21 247	**Strategic Planning Update**	
	The Director of Strategy and Partnerships made a presentation on the development of the Trust's enabling strategies, which builds on the Trust's 2021-26 Strategy. The Chief Nurse commented on the need to develop the patients experience quality safety structure in conjunction with the NEDs, governors, public and Healthwatch to ensure adequate capture of what patients want. She noted that patient feedback was a strand of CQC inspection. Steve Igoe commented on the significant work that had gone into the development of the strategy. He requested that KPI's should be tied into the six key objectives. The Director of Strategy advised that work had begun at division levels to develop respective KPIs. An executive workshop had been planned for April 2021 to define each of the divisional priorities. **RESOLVED:** **That the Board NOTED the report.**	
20/21 248	**Initial Capital Programme 2021/22**	
	The Director of Strategy presented the report and highlighted the approach for the development, prioritisation and allocation of capital funding for the 2021/22 financial year, along with the management and delivery of the capital programme across the financial year. He advised that the capital programme had been reviewed at the Capital Committee in February where it was decided that the programme should be shared with the entire Board. Amongst the issues that were further highlighted were details of the timeframes for the submission of capital bids, review and award of bids and approval by Trust Board sub-committees, including the formation of a Capital Bid Panel to review and award bids. The Board was pleased to note that a structured capital plan had been developed and looked forward to implementing the programme at the right pace to have the proposed facilities in place. Steve Ryan commented on the risk assessments that had been done for the Estates in the capital programme and queried if there was a similar assessment for the clinical and medical equipment. The Director of Strategy replied that there was a comprehensive list for equipment replacement and that each division maintained internal risks assessments for each of their equipment in line with current risk metrics. The CFO advised on the need to plan ahead for the remaining years left on the Estates as well as on the medical equipment through maintenance of a comprehensive database. **RESOLVED:** **That the Board NOTED the report.**	

Reference	Minute	Action
20/21 249	**Monthly Safe Staffing Report**	
	The Chief Nurse presented the safe staffing report and highlighted that January 2021 had been a difficult month for nurse staffing due to the negative impact of COVID-19 pandemic. She advised that data was being analysed to identify if any patient harm had occurred as a result of staff shortage despite the mitigating steps that had been taken. The first cohorts of international nurses from India had arrived in the previous week and were currently in their quarantine period. Subsequent groups will arrive during April and over the summer. The Chief Nurse requested support from the Board to undertake only one Acuity and Dependency study this year. The rationale for this was the impact of the pandemic on base wards and staff movement. This will take place in late summer. John Sullivan requested explanations for the difference in the sickness rate for nurses and care support workers; and if there was an exit plan for the nurse incentive scheme. The Chief Nurse explained that there was a plan post-COVID-19 to do an assessment with HR for a deeper understanding of the difference in sickness rates amongst staff members. In relation to the nurse incentive scheme, an exit strategy was due to be presented to the executive team the following week. From the end of March, agency nurses that had been block booked would be cancelled. The recommendation was to stop the incentive scheme as more international nurses arrived. **RESOLVED:** **That the Board NOTED the report.** **That the next Acuity and dependency report will be presented during Q3 as part of the scheduled 6 month Chief Nurse Safe Staffing report.**	
20/21 250	**Guardian of Safe Working Q3 Report**	
	Dr Helen Kerss presented the report on her role as the Guardian of Safe Working for junior doctors. The aim of the role was to ensure that both working conditions and rota of junior doctors were safe for doctors and patients. She gave explanations on how the new junior doctors' forum had been meeting virtually every six weeks to address mutual concerns and expressed appreciation to Dr Stevenson for attending the meetings and for her support. Dr Kerss gave explanations on the use of exception reports that were completed by junior doctors to highlight issues of concern and on the usefulness of the reports to the Trust as a tool for monitoring junior doctors' welfare. In answer to a question, the Medical Director gave explanations on how issues of concerns raised by the junior doctors were being resolved including issues with rota and underpayments. The Board was pleased with the progress report and requested for regular updates on how the relationship with junior doctors was developing and on the resolution of issues of concern. It was noted that the Guardian of Safe Working Report was due to the Board on a quarterly basis. **RESOLVED:** **That the Board NOTED the report.**	

Reference	Minute	Action
20/21 251	**Ockenden Review and Assurance of Maternity Services**	
	The Chief Nurse introduced the report which was presented by Debbie Edwards, Director of Nursing & Midwifery, Women & Children's Division. The report had been presented to provide evidence of compliance with the Immediate and Essential Actions (IEAs) and other recommendations that emanated from the Ockenden review of WUTH maternity services. Debbie Edwards advised that one of the recommendations from the Ockenden report was to review the midwifery staffing in line with birth-rate plus and to have a plan in place for staffing going into the new year. The staffing review was nearing completion and the outcome would form part of the regular updates to the Board on maternity services. Debbie Edwards informed the Board that NHS England was in the process of finalising perinatal quality surveillance model that would be rolled out nationally. The Trust would be required to comply with that model of quality surveillance and had submitted its statement of commitment in that regard. The Board noted the comprehensive report which had provided a good level of assurance and that the Quality Assurance Committee would be reviewing aspects of the report in greater detail. The Chief Nurse advised that direct support had been offered to the local maternity system in the design of perinatal quality surveillance model. The Medical Director acknowledged that there was good leadership team in the Children's and Women's division and noted that the implementation of the improvement plan would be done through the Divisional teams. John Sullivan asked if there was any concerns regarding outsource of aspects of the maternity services to which Debbie Edwards replied in the negative. It was agreed that the Board would receive outline report on quarterly basis to provide assurance and oversight of the maternity services. Perinatal specific report would also be coming to a future Board to provide further assurance. **RESOLVED:** **That the Board NOTED:** • **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)**	
20/21 252	**Change Programme Summary, Delivery & Assurance**	
	The Director of Strategy used the previously circulated presentation slides to highlight the progress on the Change Programme and the current areas of focus. Attentions were drawn to the 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 2021.	

Reference	Minute	Action
	Governance ratings for February 2021 had seen two of the three programmes as green rated, whilst one had attracted amber rating. For the Digital Enabler and Service Improvement projects, five were green rated whilst the remaining two were amber. Delivery ratings for February had seen only one programme green rated whilst the other two were amber rated. For the Digital Enabler and Service Improvement projects, five were green rated, one amber and one red, noting that amber rating was an indication of substantial issues. Attentions were drawn to page 121 of the meetings pack which contained details of the amber ratings for 'Improving Patients Flow' and the green ratings for the 'Perioperative Medicine Improvement'. Outpatients Improvement had been rated green for governance but amber for delivery. The COO gave explanations on the plan to further improve the performance of the Outpatient project and Patients Flow going forward. **RESOLVED:** **That the Board NOTED the report.**	
20/21-253	**Board Assurance Framework**	
	The Deputy Board Secretary presented the updated BAF and drew attention to the changes highlighted as well as the next steps. Steve Igoe commented on the need to refresh the risk process to reflect the earlier discussion on the strategic update KPIs and to build in the work being done by the Chief Nurse in her capacity as the executive lead for risks. **RESOLVED:** **That the Board NOTED the report.**	
20/21-254	**Chair's Report – Quality Assurance Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held on 15 February 2021 including the report on nosocomial coronavirus infections in patients with hip fracture; Surgical site infection (SSI) surveillance programme; concerns about risks of visual loss in patients due to delays in ophthalmology care; full compliance with WHO's surgical checklist; reduction in both formal and informal complaints; and radiology reporting quality assurance. The Chief Nurse advised that it had been agreed that report on Nosocomial infections would be tabled at the next Patients Safety and Quality Board (PSQB) and Quality Assurance Committee. **RESOLVED:** **That the Board NOTED the report.**	
20-21 255	**Communications and Engagement Monthly Report**	
	The Board received the report on the Trust's communications and engagement activities since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement.	

Reference	Minute	Action
	The Director of Communications and Engagement highlighted for further discussions, some of the issues that had attracted significant media coverage including the anniversary of the arrival of the quarantined individuals from Wuhan and nosocomial COVID-19 transmission in the North West . She also highlighted the results of staff survey, which was due to be published on 11 March 2021, the ongoing leadership briefing for staff members which had been very popular amongst staff members and the appeal in the Wirral Globe for fundraising, which had reached £150K. The Board expressed appreciation for the fundraising efforts and gratitude to all the contributors. **RESOLVED:** **That the Board NOTED the report.**	
20/21 256	**Any other business**	
	None.	
20/21 257	**Date of Next Meeting** Wednesday 7 April 2021, via MS Teams	
20/21 258	**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 – 03 March 2021
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 03.03.21						
1.	BM20-21/250	Guardian of Safe Working report to be presented on a quarterly basis.	**NS/HK**	This item has been added to the cycle of business. Q4 update is expected at the May Board.	Complete	
2.	BM20-21/251	It was agreed that the Board would receive outline report on quarterly basis to provide assurance and oversight of the maternity services. Perinatal specific report would also be coming to a future Board	**HR/DE**	This item has been added to the cycle of business. Next report is expected at the June Board.	Complete	
3	BM20-21/245	In future reports, data for 'Eligible patients having VTE risk assessment within 12 hours of decision to admit', would be compiled from BI Portal which contain all patient data.	**John H**	This request has been implemented in the quality dashboard for April Board	Complete	
Date of Meeting 02.12.20						
4	BM20-21/191	Clinical and operational teams to present their plans to the Board in the new year	**MS**	This item has been deferred to the May Board	Complete	
5	BM20-21/199	Presentation to the Board on progress with the Planned Care Control Centre	**AM**	This item has been deferred to the May Board	Complete	
Date of Meeting 04.11.20						
6	BM20-21/174	Update the Board on progress regarding work on the new strategy on Culture and Leadership	**JG/MS**		To be confirmed	This work will tie into the staff survey results and the People Plan. To commence after completion of backlog of legacy issues.
7	BM20-21/175	Seek clarification on the status of the additional license condition that was imposed by NHSI in 2018.	**JH**		May '21	Work underway as part of the System Improvement Board (SIB) to be removed from the 'Challenged Provider Programme'. Evidence pack to be submitted in April '21 with a regional decision in May '21.

Date of Meeting 04.03.20						
8	BM 19-20/237	Discussion at a future Board meeting regarding internal productivity to support financial sustainability	**CW**		Complete	2020/21 programme suspended and will be addressed through the 2021/22 financial planning.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-008

BOARD OF DIRECTORS
7 April 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 March 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
7 April 2021

Chief Executive's Report

Purpose

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

Introduction / Background

1. Reset and Recovery

Planned care activity monitoring against phase 3 national plans, is outlined below.

The Phase 3 national expectation was that plans should deliver the following %'s of activity in comparison with the same period last year but assumed no further COVID-19 waves:

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 - February	Trajectory	Actual	Variance
Outpatients	100%	95%	-5%
Daycase	90%	70%	-20%
Inpatients	90%	48%	-42%

It should be noted that during January and February non urgent routine planned care activities were stepped down to support wave 3 of COVID-19 management. However from the 8th March planned care activity has restarted in a phased approach. 2021/22 recovery planning is underway with a focus on restart, recovery and transformation in line with national planning guidance.

2. Vaccination Programme

The Clatterbridge Vaccination Centre continues to work closely with local partners to ensure that the local population is vaccinated at the earliest opportunity. As of week commencing 22nd March, first vaccination candidates are within the JCVI cohorts 1-9 which includes all front line health and social care staff, the clinically extremely vulnerable, clinically vulnerable and those aged 50 years and above.

The Pharmacy team continue to co-ordinate the vaccination of hospital inpatients where they fall within cohort. Also on behalf of the Wirral Healthcare Partners accelerated courses of vaccination required for patients who are commencing immunosuppressive treatments and specialist allergy sessions with on hand anaesthetic support for patients who have suffered an allergic response to their first dose of the COVID-19 vaccine.

Second dose vaccinations re-commenced on the 8th March. The Arrowe Park "pop up" site started on 30th March and will be open for 5 days to deliver second dose Pfizer vaccines.

The Trust Chief Pharmacist is also working as part of the Cheshire and Mersey Vaccine Command and Control structure and is supporting policy and practice decisions for the Healthcare Partnership and the movement of vaccine across the system via the national mutual aid process to avoid vaccine wastage.

3. Serious Incidents

In February five serious incidents were declared; this included one Never Event under the category of wrong site surgery, an infection control incident, a hospital acquired pressure ulcer, a CT incident and a patient fall during admission.

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

4. RIDDOR Update

One incident that reported to the HSE in accordance with RIDDOR in February 2021. This report was for a member of staff in attendance at a home birth and resulted in a cold burn to the member of staff's hand when the Entonox regulator came loose from the cylinder.

The incident was subject to a rapid review investigation which involved key stake holders; including Electronic and Biomedical Engineering (EBME) and the Manufacturers of the Entonox regulator.

5. Wirral University Teaching Hospital (WUTH) Results in the NHS Staff Survey 2020

On March 11th, together with the rest of the NHS, WUTH received its results from the **2020 NHS Staff Survey**, undertaken by independent external organisation, Quality Health. The survey took place between September and November 2020. The Trust response rate was 41% which is an improvement on the 2019 survey, which saw a response rate of 38% (2,265). The questions are grouped into ten theme areas, which give insight into staff experience of working at WUTH.

Key headlines for 2020 survey are:

- WUTH had a stable set of results in a challenging year, with no theme areas declining significantly.
- Pleasing progress in staff experiences on the theme of bullying and harassment.
- Improvements in the Equality, Diversity and Inclusion theme, reflecting our focus in this area.
- Recognition of the Trust's zero tolerance approach to violence against staff
- Improvements in 'Safety Culture' theme.
- Areas for improvement in teamwork and line management.
- Support for continuing focus on staff health and wellbeing.

Considering the year we've had with the pandemic and our ongoing work to modernise many aspects of how and where we work, this set of results represents a stabilised and improving picture for the Trust.

The Executive and I were pleased to see the significantly increased confidence from staff that bullying and harassment is tackled at the Trust and that the clear stance we've been taking on zero tolerance for violence directed at our staff is reflected in the results. We've more to do in teamwork and immediate line management; and we expect some of the action we're taking on recruiting additional nurses such as our international cohort will also begin to help with work and time pressures for staff going forward.

6. International Nurses

On March 17th, we welcomed a further seven international nurses from India who have now joined the Trust. They are among 100 international nurses who will be starting with us in April and across the summer.

This will significantly reduce our registered nurse vacancy rate by July 2021.

7. National Day of Reflection - 23 March 21

The 23rd March marked a year since the first day of COVID-19 lockdown and as a Trust we joined the national day of reflection and remembrance.

It has been an extremely challenging year for us all, but one in which we have continued to give everything we have and sometimes with great personal sacrifice, to ensure our patients are cared for.

As we marked a year since lockdown, we remembered those who have lost their lives to COVID-19, but recognised the many patients our staff helped to pull through and return to their families. We also recognised those in support functions who have worked tirelessly and their hard work has also supported colleagues on the frontline.

To mark the day, our Chaplaincy Team held multi-faith special services for staff at Arrowe Park and Clatterbridge Hospitals.

Along with other organisations in Wirral, we lit up the outside of Arrowe Park Hospital in recognition of the hard work of staff and to remember everyone affected by COVID-19 over the past year.

8. Capital Programme Delivery

In addition to the recent completion of the Upgrade of the ED Major Areas and Cardiac Cather Lab capital projects, the Trust has continued to deliver a number of other major capital projects in the last quarter of the 2020/21 financial year including:

- £1.4m upgrade of the Higher Dependency Unit (HDU) at Arrowe Park Hospital, which commenced in February 2021, improving and enhancing patient facilities in the unit.
- The construction of a Post-Operative Care Unit (POCU) at Clatterbridge General Hospital, allowing for the delivery of more complex surgery at the Hospital.
- The refurbishment of orthopaedic theatres at Clatterbridge General Hospital, supporting increases in more complex orthopaedic surgery on the campus.

- The upgrade of ventilation systems across operating theatres at Arrowe Park Hospital, improving air circulation and ventilation within the theatre complex.
- The replacement of roofing across the Arrowe Park Hospital main building

Across this last quarter, the Executive have undertaken a process to propose the allocation of capital funding across the 2021/22 financial year, working in conjunction with Divisional leadership teams. This risk based approach will support early delivery of capital projects and equipment purchases in the next financial year.

Conclusions

N/A

Recommendations to the Board

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

Agenda Item: 21/22–009

BOARD OF DIRECTORS
7 April 2021

Title:	Quality & Performance Dashboard
Author:	J Halliday Assistant Director of Information
Responsible Director:	COO, MD, CN, DoW, DoF
Presented by:	COO, MD, CN, DoW, DoF

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

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 February 2021.

Of the 45 indicators that are reported for March (excluding Use of Resources):

- 21 are currently off-target or failing to meet performance thresholds
- 24 of the indicators are on-target

Please note during the current Covid-19 pandemic some 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 the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

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	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)		
Quality and Safety of Care. Patient flow management during periods of high demand.		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
The dashboard Includes NHSI Oversight Framework metrics, considered as part of provider segmentation.		
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		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	N/a	
Background papers / supporting information	N/a	

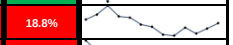
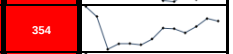
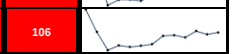
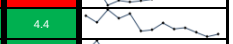
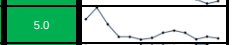
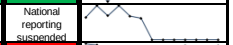
Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

March 2021
Upated 24-03-21

	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-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	0.32	0.31	0.25	0.14	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	96.2%	95.8%	96.2%	96.4%	95.8%	95.1%	95.3%	95.4%	95.1%	95.3%	94.7%	94.2%	94.9%	95.31%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.7%	97.5%	97.8%	97.8%	97.6%	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	96.6%	97.2%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	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	National reporting ceased	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	4	4	3	4	1	4	4	2	3	2	4	4	5	36	
	Never Events	Safe, high quality care	CN	0	SOF	2	0	0	0	0	0	0	0	0	0	0	0	1	1	
	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	3	6	5	5	1	4	1	5	10	8	4	7	56	
	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	9	1	7	4	6	8	5	3	7	3	1	3	6	53	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	1	0	1	0	0	0	0	0	0	0	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	100.0%	100.0%	100.0%	99.1%	99.0%	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	98.9%	99.5%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	2	0	2	0	4	0	0	1	0	1	0	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%	91%	95%	95%	98%	96%	94%	91%	93%	Not avail	Not avail	94%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	79.1%	78.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	85.0%	82.8%	80.6%	71.4%	71.8%	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	84.1%	76.7%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	86.7%	79.9%	51.5%	19.7%	19.0%	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	80.1%	80.1%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.42%	93.42%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	93.91%	94.27%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.67%	0.91%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.9%	13.9%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	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	8.9	8.9	

Quality Performance Dashboard

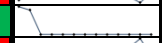
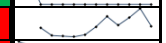
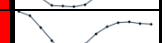
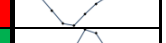
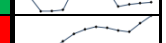
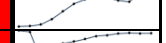
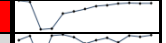
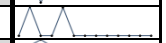
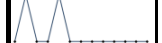
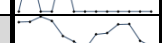
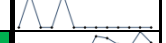
	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	96.5%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	94%	95%	93%	98%	97%	98%	98%	96%	96%	98%	97%	95%	97%	96.6%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.9%	18.8%	
	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	448	383	174	209	210	202	239	309	305	279	319	371	354	354	
	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	198	108	35	54	48	53	59	92	95	86	112	98	106	106	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	5.9	4.9	6.8	5.5	6.2	3.6	3.8	4.8	3.9	4.1	3.4	2.8	3.2	4.4	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	7.8	9.9	6.9	4.7	4.7	4.2	4.5	5.4	5.8	5.4	4.3	4.7	4.4	5.0	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	1006	827	667	870	941	1016	1012	1014	1007	992	1020	1027	938	955	
	Delayed Transfers of Care	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	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	National reporting suspended	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	71.4%	81.2%	76.5%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	2020/21	Trend
Caring	**Same sex accommodation breaches**	Outstanding Patient Experience	CN	0	SOF	14	4	2	0	2	3	5	1	0	0	3	2	0	18	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	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	87.0%	84.0%	87.0%	86.0%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	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	92.0%	91.0%	91.5%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	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	95.0%	94.0%	95.0%	94.7%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	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	80.0%	100.0%	67.0%	82.3%	

Quality Performance Dashboard

March 2021
Upated 24-03-21

	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-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	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	76.8%	76.8%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	24	21	0	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%	8.7%	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	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	67.89%	67.89%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	23,207	22,350	21,284	21,288	21,383	23,034	24,486	24,212	22,945	21,633	21,792	21,880	21,955	21,955	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	0	15	56	200	413	616	733	806	777	704	666	899	1108	1108	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	94.3%	80.5%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	97.6%	92.7%	
	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	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	94.8%	92.1%	98.0%	97.4%	97.2%	98.0%	89.5%	95.7%	
	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%	86.0%	87.4%	86.2%	82.1%	80.7%	78.6%	82.6%	82.9%	85.3%	85.4%	80.9%	79.3%	82.8%	
	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	160	125	74	99	119	143	124	183	178	161	150	196	165	145	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.10	2.70	1.30	1.50	2.80	2.10	3.40	4.20	3.80	3.20	1.32	3.80	3.56	2.82	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	86%	88%	100%	100%	100%	100%	100%	94%	100%	97%	100%	97%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	0	1	0	1	5	1	0	2	1	4	2	2	4	2	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

March 2021
Upated 24-03-21

	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	2020/21	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	CN	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	49	117	329	181	152	86	31	126	329	215	163	599	206	2417	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	84.9%	83.0%	82.9%	85.1%	77.9%	81.3%	84.3%	76.3%	73.0%	74.1%	76.2%	72.9%	74.7%	74.7%	

	Indicator	Objective	Director	Threshold	Set by	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	2020/21	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-2.929	2.377	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	-3.5	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-2.445	-0.589	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.5	0.3	-0.1	-5.3	-4.2	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	4	4	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	-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	0.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	14.9%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-17.8	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	50.7%	74.8%	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	-74.8%	

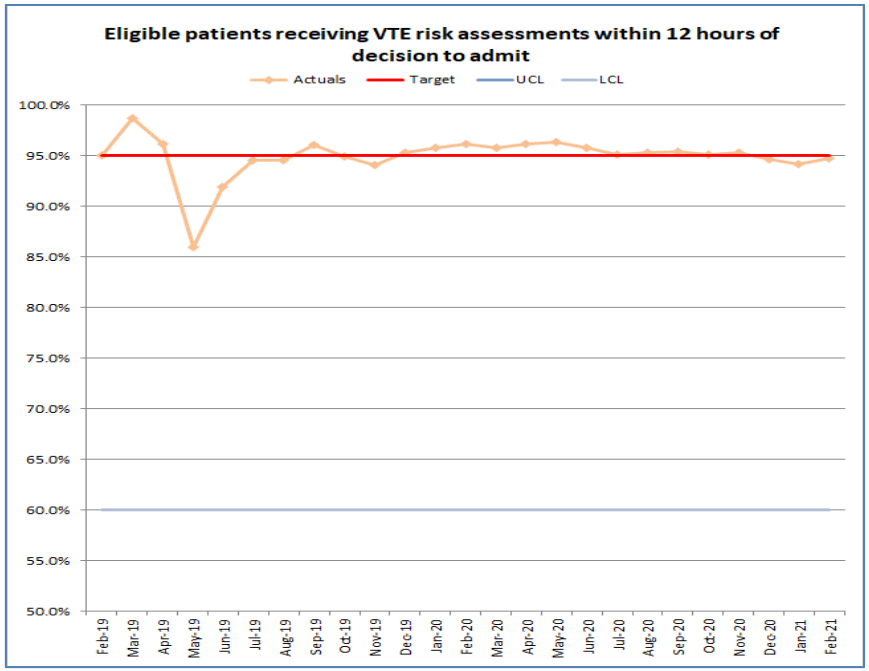
(*) Updated Metrics — **Metric Change**

(**) Updated Thresholds — **Threshold Change**

Safe Domain

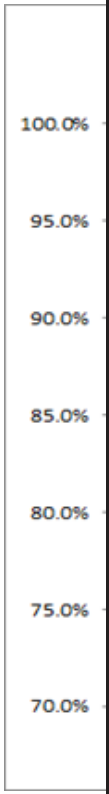
Eligible patients having VTE risk assessment within 12 hours of decision to admit

Executive Lead: Medical Director
Performance Issue: A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. Performance has regularly achieved the 95% threshold, though February was slightly below at 94.8%. The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital has been consistently met.
Action: No action needed at present, but performance will continue to be monitored to ensure that there is not a significant nor sustained deterioration in assessment.
Expected Impact:



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse
Performance Issue: WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been improving in recent months, with February 2021 at 79.1%.
Action: Protecting Vulnerable People (PVP) training is an online package that can be accessed by staff at any time. During Quarter 3 compliance was reported as less that the agreed trajectory. Compliance is still below the trajectory however December, January and February have seen a steady increase to 79.1% February. Staffing has been increasingly challenging due to the impact of COVID 19 reducing compliance in a number of staff groups. Divisions are taking a risk-based approach to release staff working with vulnerable adults and children to complete Level 1 training as a priority.
Expected Impact: There is an expectation that PVP level 1 training compliance will increase further during Q1.



Protecting Vulnerable People Training - % Compliant Level 2

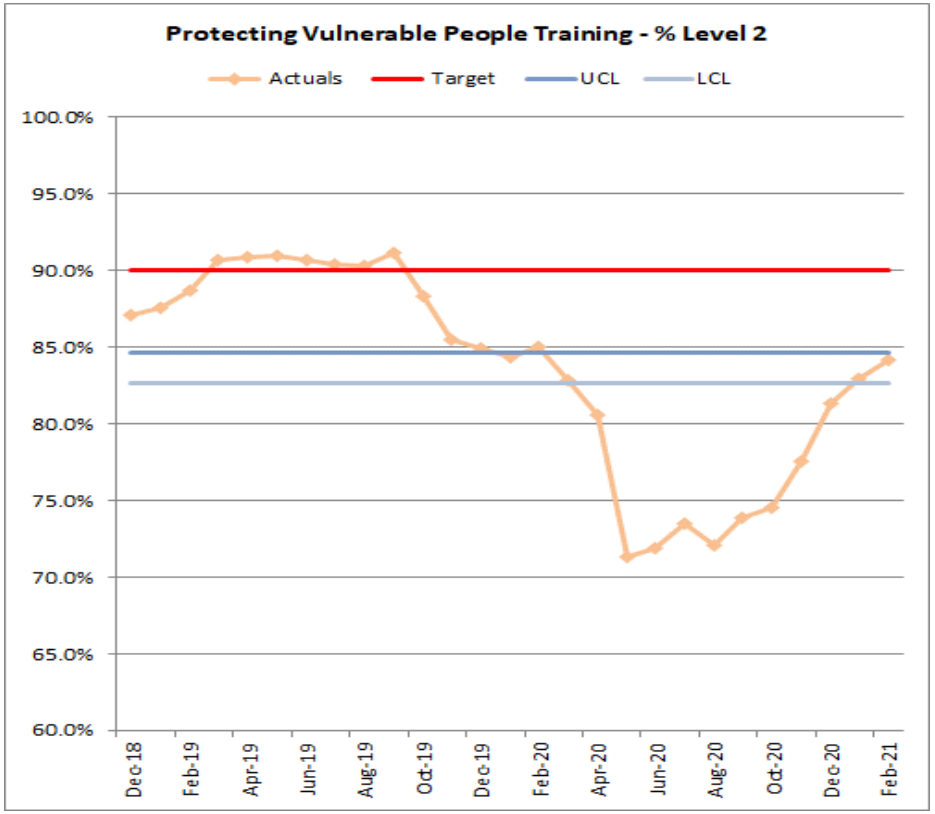
Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been improving and is up to 84.1% for February 2021.

Action:
Level 2 Protecting Vulnerable People training (PVP) is an online package that can be accessed at any time. Improvement has been noted during February however this is less than expected on the agreed trajectory's that are monitored via the Safeguarding Assurance Group reporting to Patient Safety Quality Board. The divisions continue to take a risk-based approach in improving safeguarding training compliance across the Trust. This approach results in the planned release of staff working with high risk patient groups to attend PVP training. To bridge the gap in knowledge for staff that are presently unable to access training, safeguarding awareness is being monitored through Perfect Ward. Any areas of concern identified are supported with bespoke training and practical support from the Trust Safeguarding Team.

Expected Impact:
PVP level 2 training compliance is expected to increase further in March.



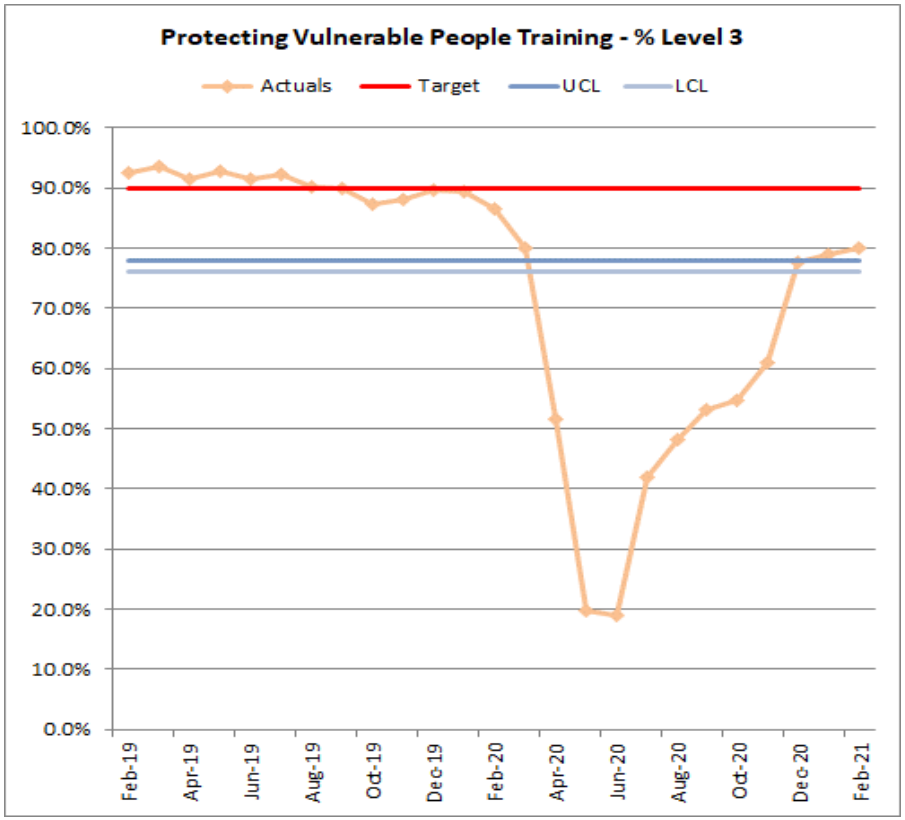
Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead:
Chief Nurse

Performance Issue:
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has not been achieved since August 2019, though February 2021 continued the improvement up to 80.1%.

Action:
There has been a continued increase in the number of staff accessing Level 3 training providing a steady improvement in compliance. This improvement is in line with the introduction of the E-Learning element of Protecting Vulnerable Adults Level 3 (PVP) training. Due to the limited availability of large venues available to host the face to face component of the training (Level 4), trajectories had been set based on available capacity (33 staff per session), compliance for February is 75.64%. Sadly, due to the COVID 19 which has reduced attendance in a number of staff groups, 'did not attend' (DNA) rates remain. The Associate Director of Safeguarding is reviewing new methods of delivery with support from the Workforce Steering Group. The Safeguarding Team continue to monitor risks in staff knowledge gaps through Perfect Ward Audits, quality monitoring of MCA applications and the Wise Spot Check Programme additional bespoke support is applied where necessary to support staff working with vulnerable adults and children.

Expected Impact:
PVP level 3 training compliance will increase month on month moving to full compliance in Q1 2021/ 22.



Staff attendance % (in-month rate)

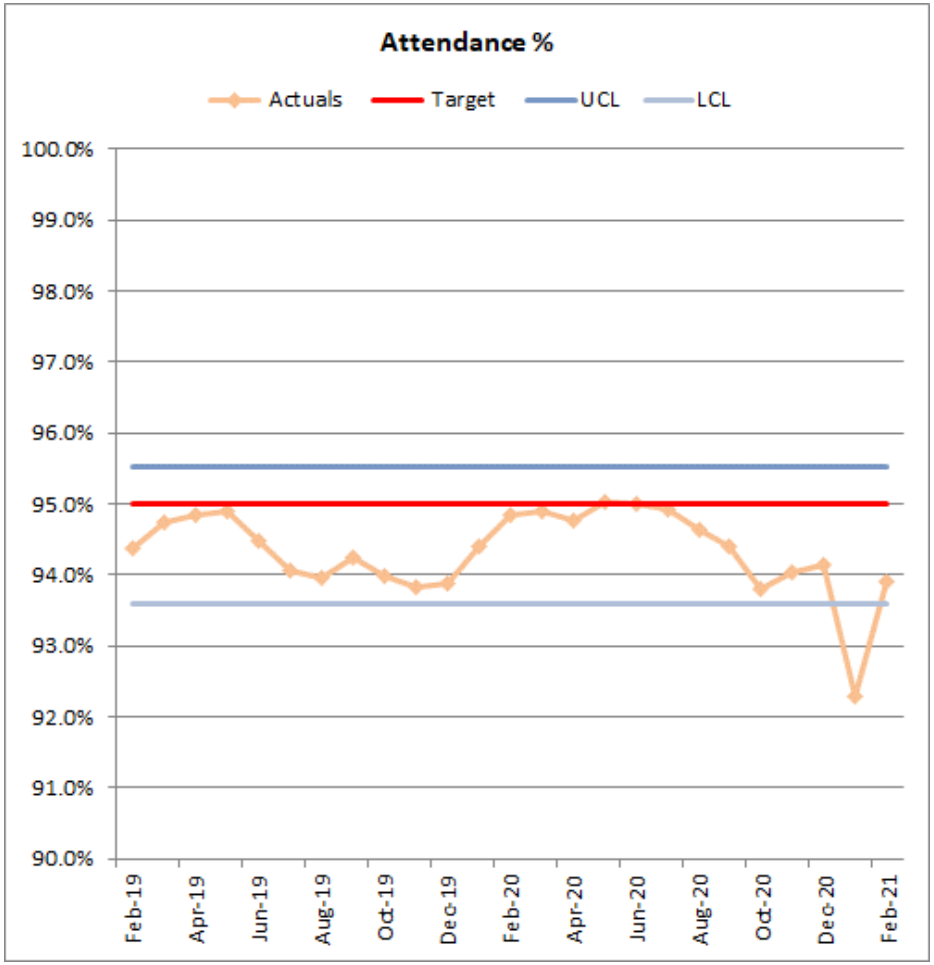
Executive Lead: Director of HR / OD

Performance Issue:
The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. Between the period of April-October 2020 sickness absence rates have been outside the tolerated threshold. In month sickness for February 21 was 6.09% and the rolling 12-month rate for the same month was 6.58%. There is an improvement when comparing to January 21 in-month sickness which was 7.70%. Similarly, the 12-month rolling rate improved from 6.52%.

It is important to provide the context however of the unprecedented Pandemic in 2020. Therefore when examining the split between Covid and non-Covid related absence to provide a true comparison to 2020 and 2019 figures, sickness in February 21 in month is 4.89% and rolling absence is 5.24%. The same period last year was 5.15% and 5.85% respectively. This demonstrates a reduction in like for like sickness absence across the two periods.

When reviewing the split of sickness absence between long and short term absence, the impact of the Pandemic is clearly evident in the data. In Between May and September 2020, long term absence is higher than short term absence. The impact of the second wave of Covid-19 has again tipped the balance in October 2020 to an increased proportion of absence being due to short term sickness however this has then reduced, which is possibly due to impact of the Covid vaccination roll out and national lockdown.

Typically, short term absence is more difficult to manage; sourcing cover to fill gaps at short notice is difficult and can feel unsettling to other members of the team. Managers are strongly encouraged to complete return to work discussions following every episode of sickness absence in order to offer a balance of support and challenge. It is proven that this valuable conversation is one of the main drivers of improved sickness



absence in an organisation.

Data evidences the variation in compliance with completion of return to work discussions across the organisation which is being mitigated by provision of regular weekly reports to Executive Directors and Divisional Triumvirates to provide check and challenge to improve the position.

When examining absence reasons data, it is clear that the sickness reason consistently giving the greatest impact on absence levels across this period was Anxiety, Stress, Depression. Reflecting the experience of the Covid-19 Pandemic, Cold, Cough, Flu is a significant contributor to overall absence levels.

Historically, Musculoskeletal (MSK) problems have been significantly higher than tolerated thresholds and additional interventions have been put in place to improve the support offering to staff. A fast referral to a MSK lead within Occupational Health has had a positive impact; this absence reason equates to 8.97% of the overall absence figure for February 2021. This shows an increase in absence levels from the previous month for this reason (6.52% in January 21). Overall, there is a pattern of significant improvement when compared to last year's data however there is still significant work to do in this area to sustain improvement.

Sickness absence due to Anxiety or Mental Health has always been a large proportion of the overall absence in the Trust. This worsened significantly over the summer months in 2020, perhaps following the first wave of the pandemic, but has subsequently improved and in January and February 2021 is better than the same period in the previous year. This could be due to the enhanced wellbeing offer available to staff as well as the roll out of the Covid vaccination programme. When viewed overall it means approximately one third of staff absence is reported as being due to mental health issues.

The Trust Employee Assistance Programme has been widely and regularly communicated to staff recently as a reminder of the support available. Additional in-house Psychology support has also been sourced. Due to the Covid-19 Pandemic and resultant impact on staff who may

experience Post Traumatic Stress Disorder (PTSD) the Trust has also commissioned support through Red Poppy so staff can be referred for specialist intervention. Information available to staff via the Intranet has been produced in the form of hard copy handbooks to enable access to awareness of support for staff who do not readily have access to PC's or laptops at work.

Action:

Across the divisions, managers are working with support from the HR Services Team to progress complex sickness absence cases. A number of long-term cases have been referred to management hearings for resolution between October and November, following delays to case management due to a national pause in processes due to the COVID-19 Pandemic.

Some service areas, for example Estates and Facilities, manage additional challenges in relation to misconduct due to non-compliance with policy. This manifests in lack of engagement by staff with managers and the Occupational Health team and this behavior is managed robustly on a case by case basis with support from the HR Services Team.

HR Business Partners are working with Divisional triumvirates and Workforce Information Hub colleagues to identify and target hot spots with a view to undertaking departmental audits and progressing recovery plans to support an improvement in sickness absence.

A star chamber approach is in place to review long term sickness absence cases <4 months on an individual basis. This seeks to map an action plan to either support staff back to work or to conclude employment in line with policy where a return to work within a reasonable timescale is not anticipated.

Workshops for staff at bands 1 and 2 and their managers took place prior to the third wave of the Pandemic, with a view to improving levels of morale and engagement, underpinning Trust values and encouraging a culture change whereby staff feel able to bring their best selves to work and can identify solutions to their health and wellbeing.

A review of the Occupational Health service has been completed to ensure the service is resilient, forward thinking and able to support staff and managers. The successful impact evidenced by the introduction of the fast-intervention service for MSK staff is being scoped out to include those absent with reasons of back pain. Staff wellbeing is also a key area of focus for the Workforce directorate with a number of initiatives in place including management coaching, wellbeing hubs/ wobble spaces for staff and debrief sessions to support staff psychological safety.

Resources have been increased within the HR Services Team to ensure appropriate support is available to managers in the divisions to manage sickness absence. One HR Business Partner is dedicated specifically to a Trust wide deep dive and review of approaches currently in place across the Trust together with examination of the policy, processes, and gap analysis to support a strategy for improvement. Divisional engagement meetings are in place to support improvement in absence levels.

The staff vaccination programme continues to be a success and we continue to strongly encourage all staff to have the vaccine to protect our teams and our patients.

The Lateral Flow Test has been superseded by the Lamp (loop-mediated isothermal amplification) test. Lamp Test Kits have gone live within Women and Children's and have been rolled out to Medicine and Acute and Surgery. So far more than 2,000 kits have been delivered to staff.

Expected Impact:
Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over the next quarter.

Staff turnover % (rolling 12-month rate)

Executive Lead: Director of Workforce

Performance Issue:
The Trust target is set as a maximum rolling 12-month turnover threshold of 10%; in February 2021 this was 13.88% which demonstrated deterioration to the tolerated threshold. Furthermore, there is a pattern of deteriorating performance between October 2020 to February 2021 of 1.29% overall.

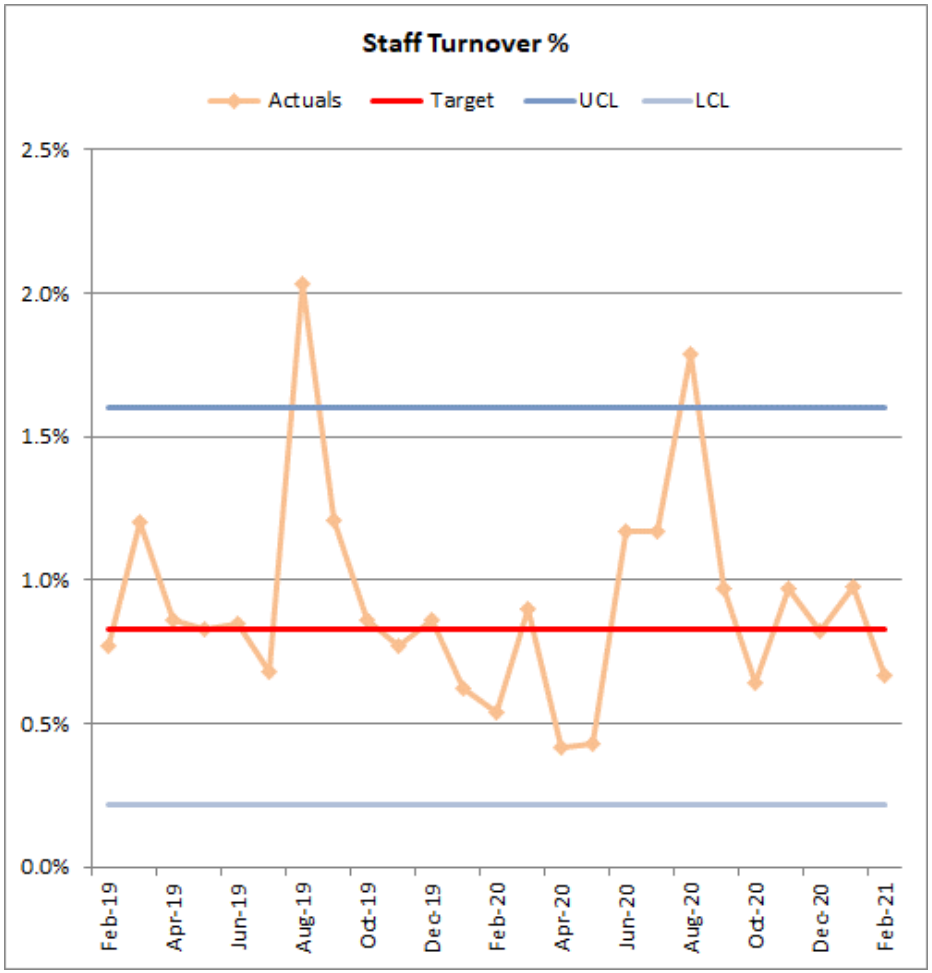
The threshold for in-month turnover is 0.83% and February 2021 reported 0.67%, which was a good improvement on the previous month which reported 0.98%

Corporate Support and Women's & Children's divisions were the most significant outliers in relation to rolling turnover threshold at 14.98% and 14.85% respectively. In month outlier was Clinical Support at 0.95%

Particular staff groups with the highest in-month turnover levels are Medical & Dental at 1.87%, Additional Professional & Technical at 1.36%, Healthcare Scientists at 0.81% and Nursing & Midwifery at 0.46%.

The impact of this turnover in real terms for nursing & midwifery is evidenced when reviewing the in-month starters and leavers. 13.15 WTE commenced in post in the month of February 2021 however in the same month 6.40 WTE left the organisation. Similarly, 4.97 WTE staff members left in February 2021 compared to those recruited (11.77 WTE) within the Additional Clinical Services workforce (Healthcare Support Workers fall into this category). For Medical & Dental, 8.50 WTE exited the Trust in February with only 5.07 WTE recruited in the same month.

This paints a clear picture of candidate attraction working well as evidenced by the number of individuals being commencing in post in-month, whereas retention is an area where the Trust needs to direct focus.



Actions
Areas of highest risk currently for the Trust are the gaps and correlating levels of turnover within the Medical and Dental, Nursing and Midwifery, Estates and Ancillary and Additional Clinical Services workforce (Healthcare

Support Workers are included in this category). All these staff groups drive the front-line activity of the hospital and for a number of reasons are where the Trust is potentially exposed.

Operational, clinical and HR staff are ensuring attention is focused on retention in line with the new Recruitment & Retention Strategy by reviewing the preceptorship programme and developing the Wirral Nurse career framework, responding at pace to staff feedback via staff side colleagues, the freedom to speak up guardian, and guardian of safe working, and maximising access to wellbeing and staff support initiatives. An additional focus for 2021/22 is planned on development and support for line managers on key skills following feedback from the national NHS Staff Survey.

Key risk areas are:

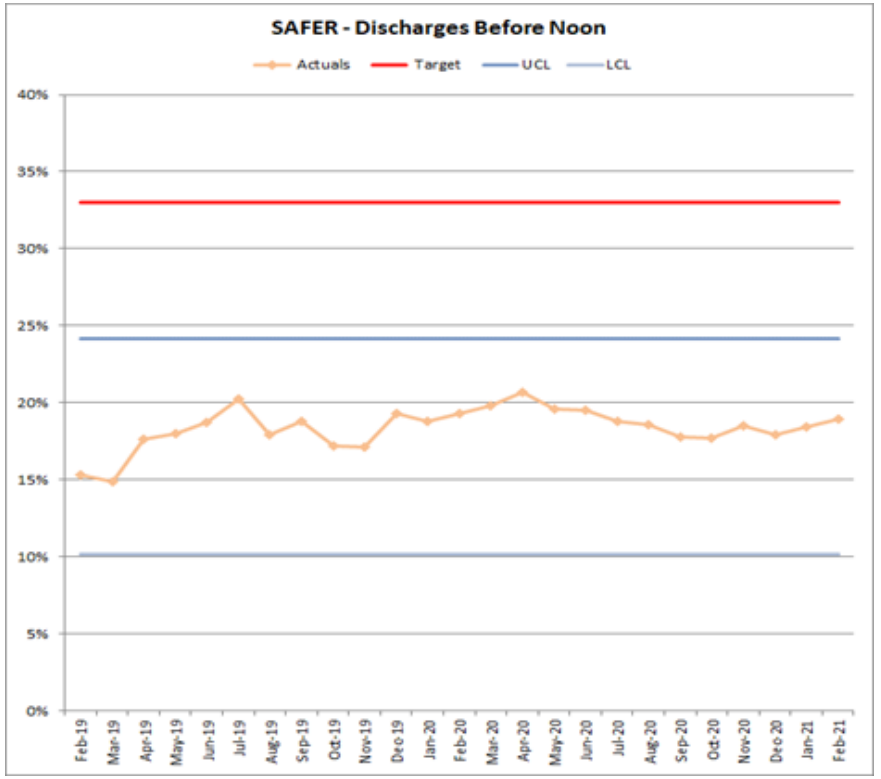
- Poor retention of key staff groups deemed hard to fill. This offers financial and performance risks to the organisation.
- Operational, clinical and HR staff are ensuring attention is focused on retention by reviewing the preceptorship programme, responding at pace to staff feedback via freedom to speak up guardian and guardian of safe working, and maximising access to wellbeing and staff support initiatives.
- Gaps are predominantly filled by use of NHS Professionals and Framework Agencies therefore risks are mitigated by standard of pre-engagement checks and stability in flexible workforce.

Expected Impact:
Embedding and benefit realisation from Recruitment & Retention Strategy and benefit from September 2021 following cohorts of managers receiving additional L&OD intervention to support them in their leadership roles.

Effective Domain

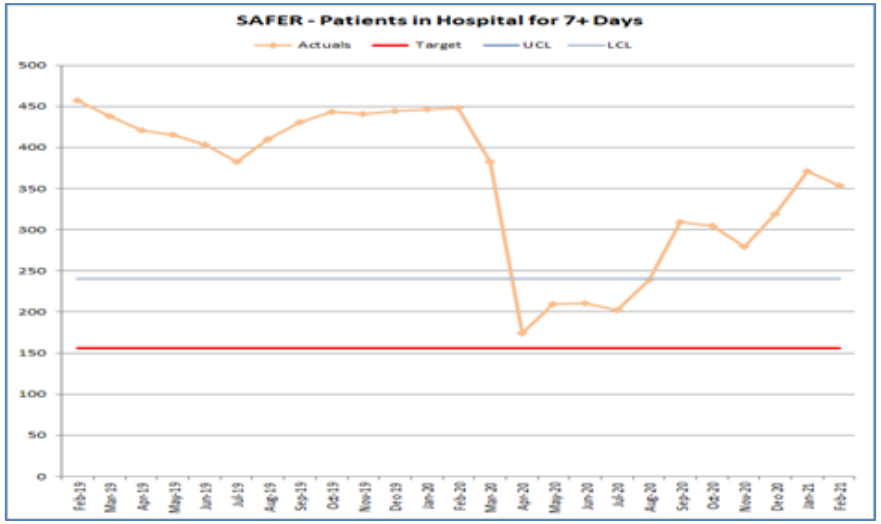
SAFER bundle: % of discharges taking place before noon

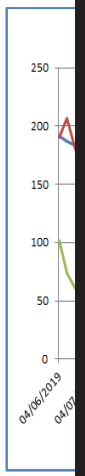
Executive Lead: Medical Director / Chief Operating Officer
Performance Issue: A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%.
Action: The patient flow improvement programme contains a key workstream around ward processing and has been implemented across a number of medical wards and has begun roll out in surgery. Operational controls have been put into place to ensure ward rounds have commenced as planned and are comprehensively staffed by senior decision makers.
Expected Impact: During February 33% of discharges were delivered by 1.55pm.



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

Executive Lead: Medical Director / Chief Operating Officer
Performance Issue: A WUTH target had been set to reduce the number of patients in hospital for seven days or more to a maximum 156. The internal target for 21 days or more has been set at the outset of Covid to a revised maximum 52.
Action: During the third wave of Covid the Wirral system enhanced its governance of complex discharges which resulted in increased discharge rates. Within the Trust, as wards have reverted back to specialty management there is focus on instilling safer standards and processes once again. The Patient Flow Improvement Group oversees the effectiveness of these interventions.
Expected Impact: The aim is to achieve no more than 90 LLOS patients.





Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. During the first wave of Covid-19 urgent planned care activities were maintained by throughput reduced. Following this the recovery and reset phase increased the rates, only to be impacted again by the third wave of Covid in January 2021. February has again seen improvement in utilisation up to 81.2%.

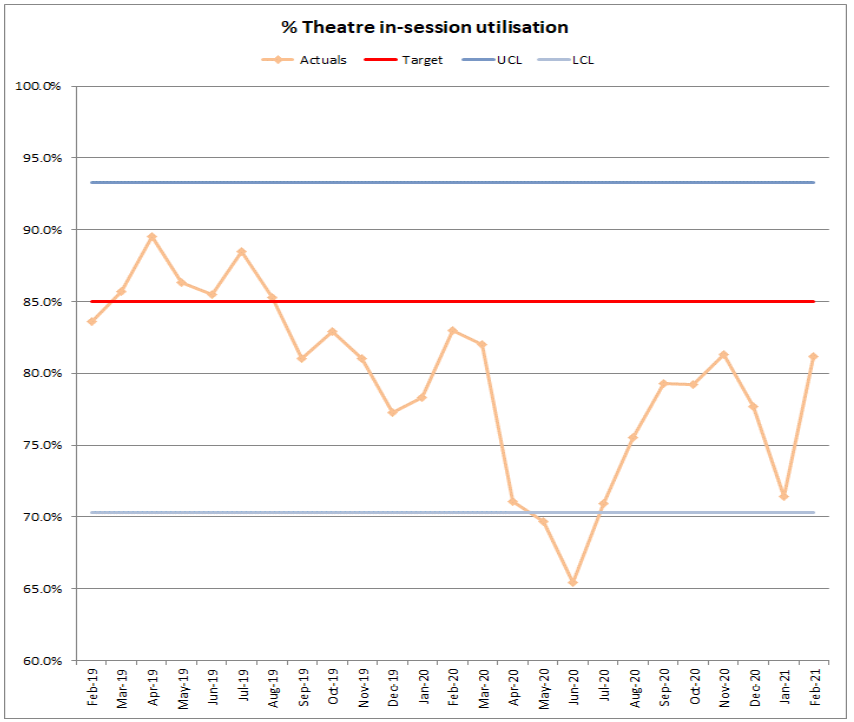
Action:

Throughout the 3rd wave of Covid non-urgent procedures were clinically deferred which impacted on this indicator.

From March 8th the Trust has restarted its non-urgent elective programme in a phased manner.

Expected Impact:

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



Responsive Domain

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

Executive Lead: Chief Operating Officer
Performance Issue: Performance during the first wave of Covid resulted in much reduced attendances, lower bed occupancy due to faster discharge and reduced elective activities creating better flow. During the third wave of Covid from January 2021, ED attendances again reduced but the number of Covid inpatients were greatly increased and so occupancy levels remained high despite the elective programme again being reduced.
Action: The functioning of the ED footprint and the assessment units has adapted to reflect the moving demand of Covid and non Covid during the downside of the third wave, and models for long term provision are being developed. The Executive triumvirate meets with the divisional and directorate teams on a weekly basis and has impressed the need to focus pathway improvement and sustained delivery before further interventions. The initial focus is on triage within 15 minutes and senior review within an hour.
Expected Impact: The above measures are targeted to improve performance and maintain a zero approach to 12-hour trolley waits.

Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

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

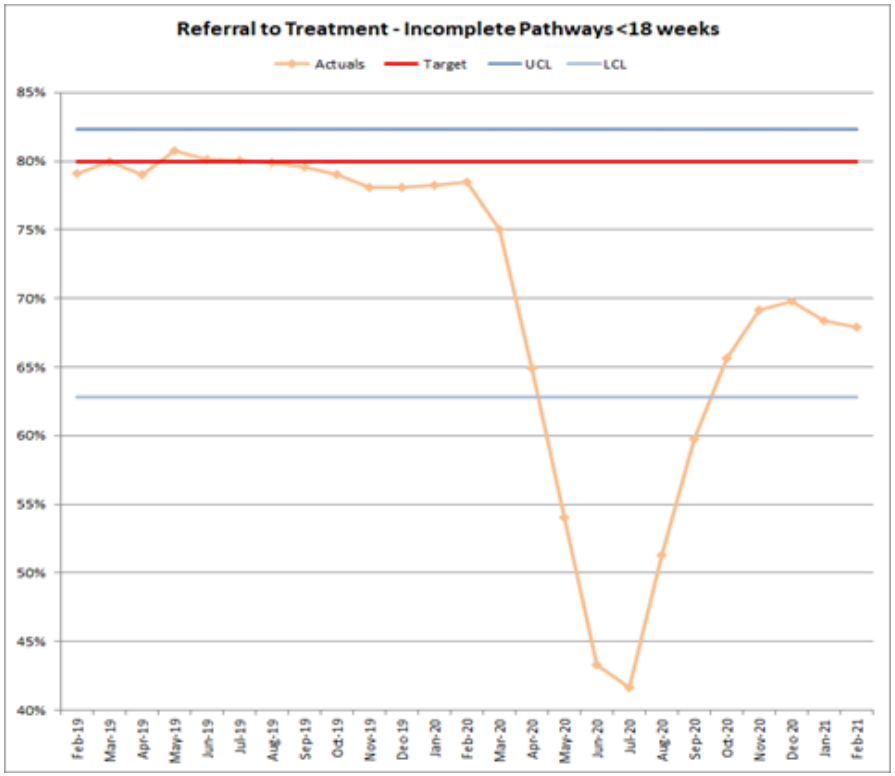
Following the directive to cease all non-urgent elective activities as part of the Covid response this metric sharply declined. The subsequent resumption of elective activity from July 2020 saw performance improve, until the onset of the Covid third wave from January 2021.

Action:

From March 8th the Trust has restarted non-urgent activities and has developed activity and performance trajectories.

Expected Impact:

It is expected that the performance will improve moderately month on month but scenarios around referral growth will be monitored closely.



Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

Performance Issue:

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

The position at the end of February 2021 was 94.3%. The steady improvement from Summer 2020 slightly stalled with the onset of the third Covid wave from January 2021.

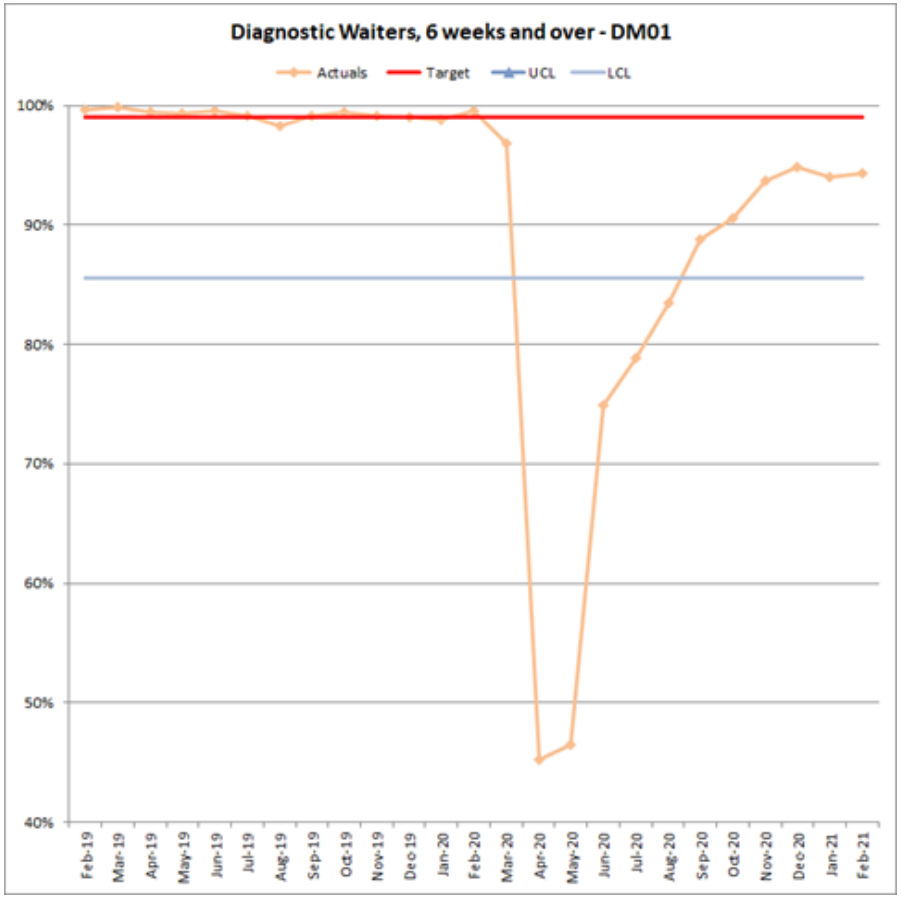
Action:

During the third wave access to diagnostics was clinically prioritised with a negative impact on clinically triaged routine waiting times.

The recovery of diagnostic backlogs is part of the overall reset and recovery programme and trajectories.

Expected Impact:

An improvement in routine referral waiting times, and a subsequent increase in this indicator.



Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse

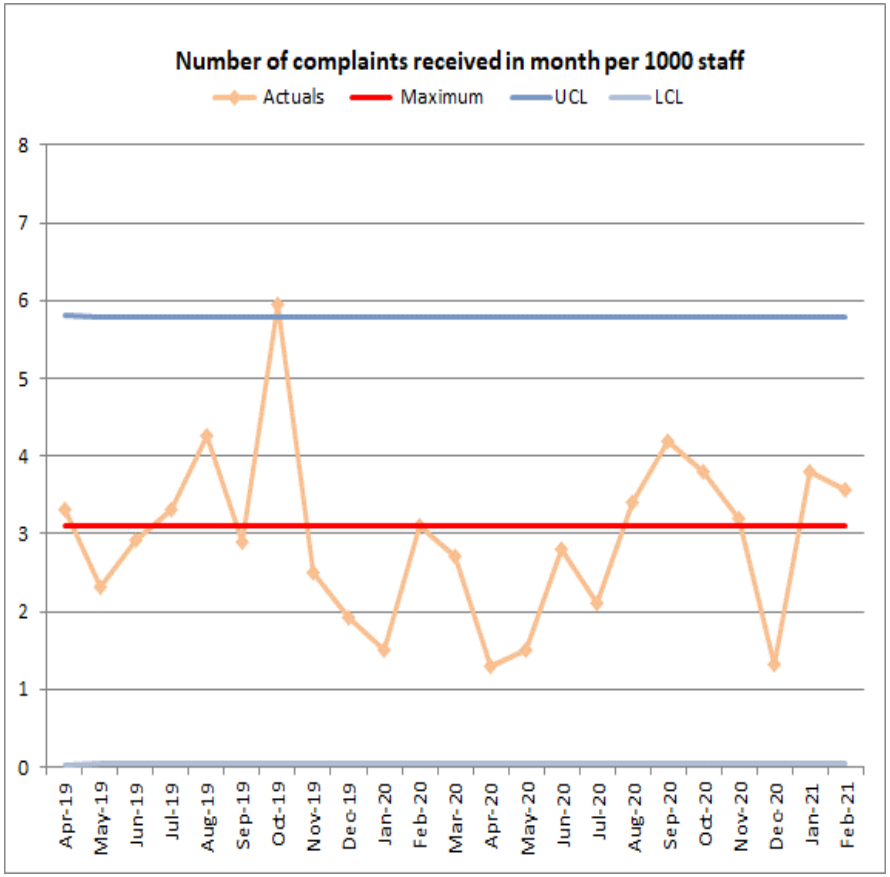
Performance Issue:

WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for February 2021 was 3.56.

Action:
The rate for February has reduced from 3.8 in January to 3.56 in February however this is above the Trust target of 3.1. This equates to 19 complaints compared with 14 for the same time-period last year. Communication remains the highest reason for complaints, often associated with the restricted visiting arrangements that have been and continue to be in place. There were two complaints received in relation to patient lost property. This is also a theme from the informal concerns and has attracted external media attention; in response a Task and Finish group has been established to address this and is being led by the Medical Division's Director of Nursing and the Head of Governance Support Unit.

Medicine and Surgery are piloting follow up calls with patients after discharge. This aims to resolve any issues early and provides opportunities for learning.

Expected Impact:
A reduction in formal complaints.



Well-led Domain

Appraisal compliance %

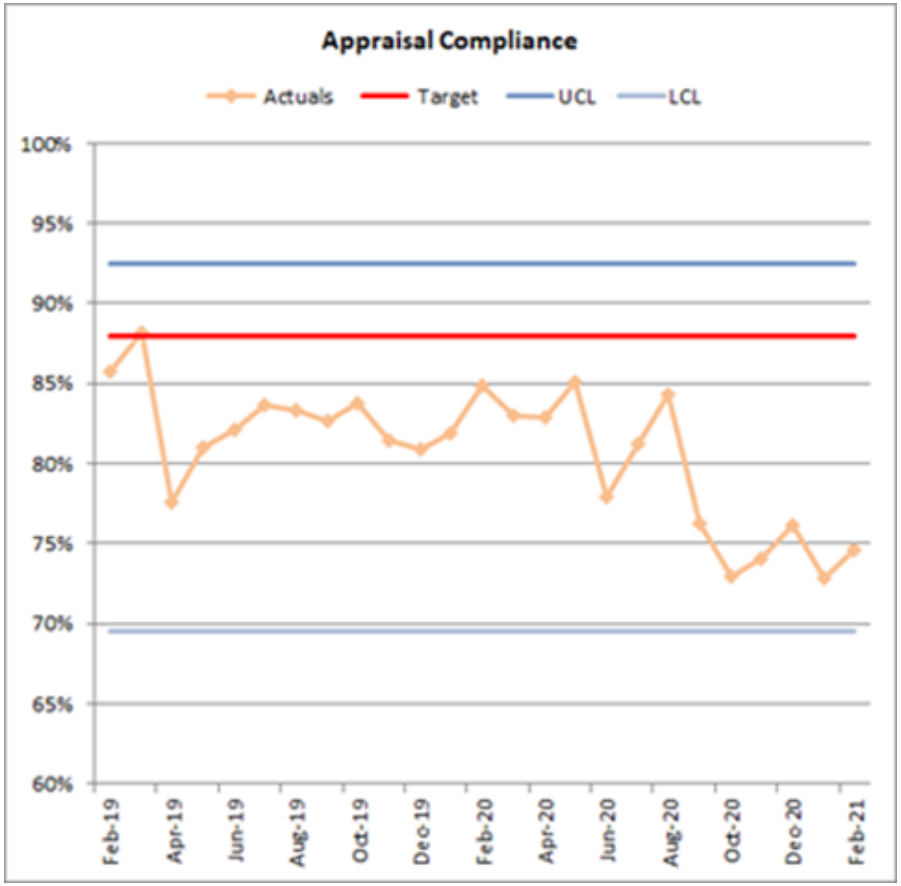
Executive Lead: Director of HR / OD

Performance Issue:

The target for staff having an annual appraisal is 88%. This standard has not been achieved since March 2019.
A significant deterioration was seen in June but subsequently improved in Jul and Aug 20. Rates dropped again to 73% in October 2020 however this was increased by 3.21% in December to 76.21%. Since December there has been a further drop in compliance to 74.66% which is 5.4% below the trust KPI.

Division	October 2020	Dec 2020	Feb 21	Focus areas to improve compliance
Clinical Support	64.39%	71.24%	72.45%	Radiology Pathology, AHP's
Corporate Support	86.47%	74.10%	69.74%	HROD, Finance, Corporate Nursing
Estates & Facilities	86.47%	88.76%	81.11%	
Medicine and Acute	72.17%	76.36%	75.70%	DME, General medicine
Surgery	76.40%	76.42%	71.59%	Surgical Division Management Gen Surgery
Women's and Children's	68.32%	71.88%	78.30%	
Overall Trust	**73.0%**	76.21%	74.66%	

Although over the last 12 months there have been significant improvements in some division's compliance such as Estates and Facilities. In Feb '21 no division achieved the trust KPI of 88% and all except Women's and Children's and Clinical support saw a decrease in compliance from the



previous report.

Surgery and Medicine/ Acute Divisions have both previously achieved above the compliance target of 88% however both dropped this month (76.42% to 71.59% for Surgery and 76.36% to 75.70% for Medicine).

Both Women's and Children's and Clinical Support have shown an ongoing improvement in their appraisal trajectories (68.32% in Oct 20 to 78.30% in Feb 21 for W&C and 64.39% in Oct 20 to 72.45% in Feb 21) however both are still some distance from achieving compliance in line with the trusts KPI.

The impact of this is that circa 25% of staff have not had the opportunity to review their performance, objectives, and development needs with their manager as a protected conversation within the expected timeframes.

It is fair to note that the operational impact of COVID-19 has significantly contributed to this reduction, which includes the number of staff who took annual leave after the first wave, the second and third waves of the pandemic and the continuation of elective activity with subsequent inability to release staff to support COVID areas. .

Action:
Workforce compliance data has been made available to managers on request via Divisions to enable them to manage complicate for their areas.

Department managers are expected to act on compliance alert reports by making arrangements for their staff appraisals to take place and by committing to a quality discussion with staff members.

The OD team and HR Business Partners will be working with the Divisional Management teams to confirm Divisional actions being taken to address low levels of compliance in specific areas, and seek the support of the HR Business Partner and OD Team in delivering against these. Check and challenge discussions take place at a divisional triumvirate and exec team level at the monthly Divisional Performance Review meetings.

Team appraisals will be promoted across the organization as an alternative, particularly for those areas with low levels of compliance.

Medical appraisals will be monitored as a priority following the national cessation of the pause for this staff group during the first wave of the Pandemic.

We are currently dovetailing the appraisal with the Wellbeing Conversation recommended as part of the People Plan.

A quality review of appraisals is underway and a review of the bespoke appraisal process developed for Estates and Facilities Division will take place in Q1.

Risks associated with non-completion of appraisals include impact on performance and finance by effective use of resources. Staff may not have clarity regarding their roles, responsibilities, personal objectives and skills and knowledge development may not be achieved to enable effective delivery of their roles. This is likely to impact on the outcome of the national staff survey in terms of the extent to which staff feel valued and supported and overall staff engagement score.

A recovery plan will be developed.

Expected Impact:

- 31/3/21 to complete the quality review and deliver recovery plan of appraisal compliance.

Wirral Recovery Activity

Trust Board of Directors
7 April 2021

1st Wave Recovery

Wirral University Teaching Hospital NHS Foundation Trust

- **Cancer**
  - Cancer Alliance backlog trajectories met
  - Access standards for 31 and 62 day pathways delivered during Q3
  - Access to Robot prioritised – Urology waits at 4 year low

- **RTT**
  - Reduction in total waiting list size month on month from September2020
  - 52 Week waiters peaked at 806 at the end of September – Month on month reduction from October through to December

- **Activity Forecasts**
  - Outpatients 100% delivery by November
  - Inpatients 100% by November
  - Daycase 96% by December

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Waiting List Management Approach

Wirral University Teaching Hospital NHS Foundation Trust

Pre COVID Prioritisation (normal capacity)

- Cancer
- Diagnostics
- RTT Chronological Management

Post Covid recovery (reduced capacity)

- Cancer
- Diagnostics
- RTT Clinical Prioritisation (P Codes) with reprioritisation for long waits

Impact

- Exponential Growth in 52ww
- Reducing RTT compliance
- Reduced GP Referrals

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1. Cancer – Management Approach

Wirral University Teaching Hospital NHS Foundation Trust

- 1847 Cancer patient all actively tracked & managed
- No patient is suspended for COVID reasons
- Harm Reviews undertaken for 31 day breaches at 73 days – All low or no harm
- Harm Reviews undertaken for 62 day breaches at 104 days – All low or no harm
- Cessation of non cancer work on robot, and prioritised by specialty
- Forecasting assumptions are based on current demand – there has been no drop in referrals during wave 3

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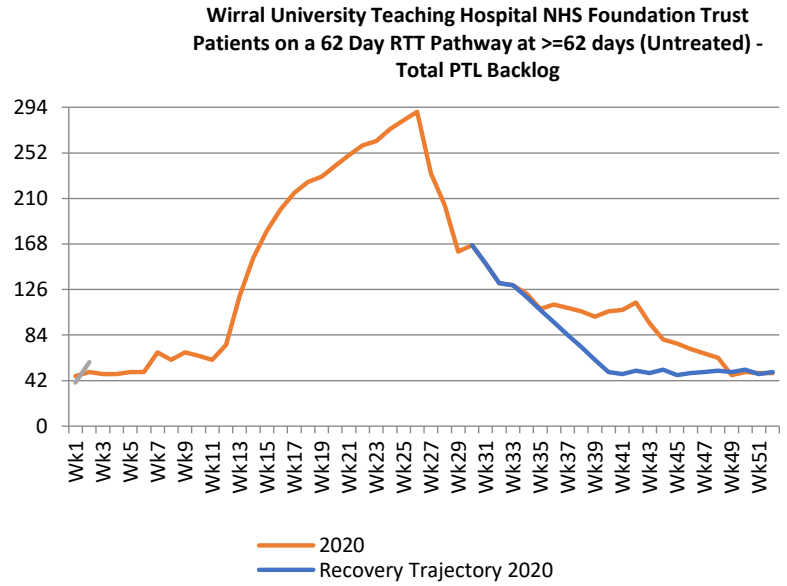
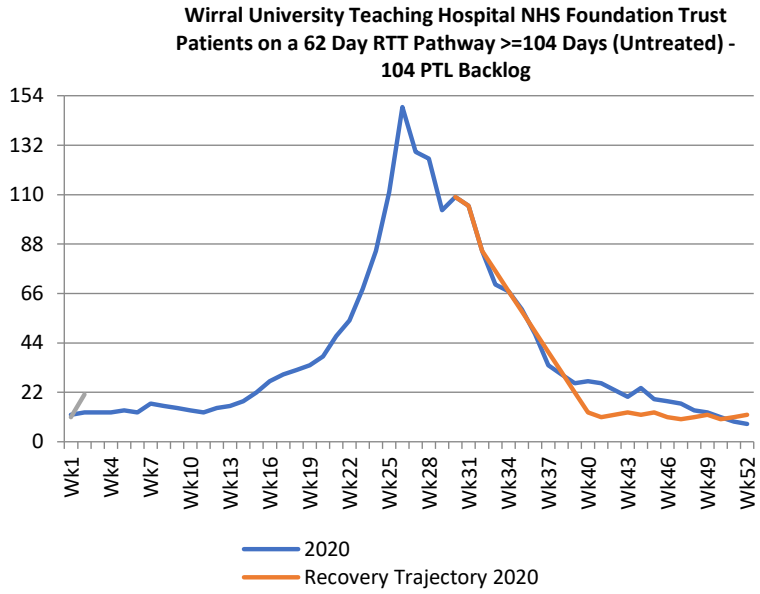
1. Cancer : 62 & 104 day Backlogs

(1st Wave Recovery)

Wirral University Teaching Hospital
NHS Foundation Trust





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1. Cancer : Forecast Delivery - 2 week standard

Wirral University Teaching Hospital NHS Foundation Trust

	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22
2 week standard (Target 93%)	93%	90%	92%	94%	94%	93%

Performance expected to be maintained during 3rd quarter and beyond

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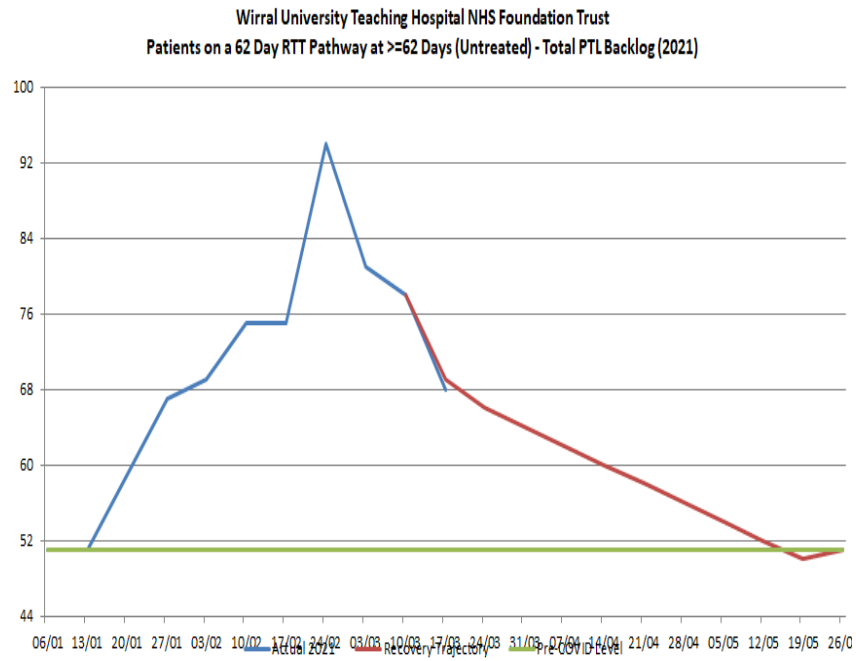
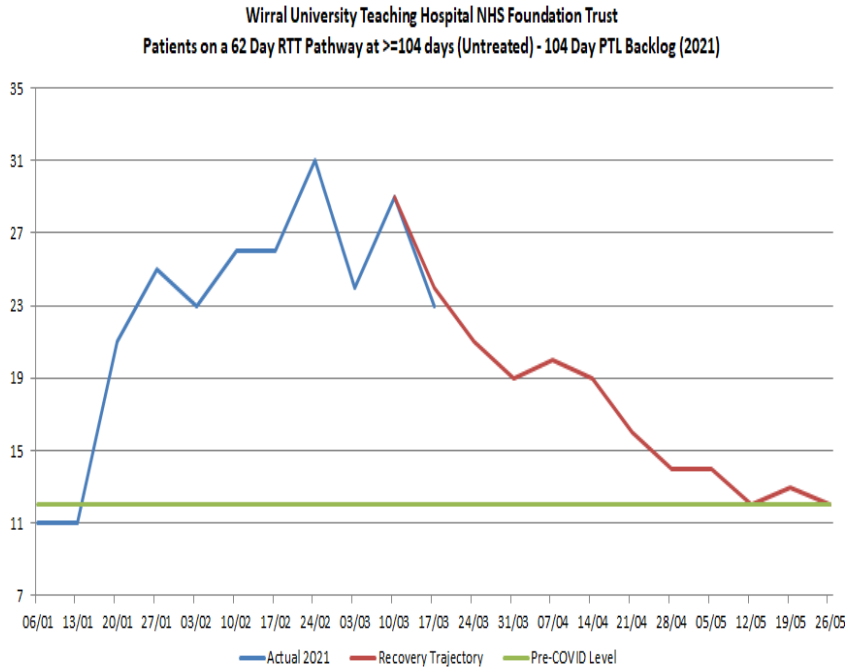
1. Cancer : 62 & 104 day Backlogs

(3rd Wave Recovery Trajectory)

Wirral University Teaching Hospital NHS Foundation Trust





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1. Cancer – 31 & 62 Day Standard

Wirral University Teaching Hospital NHS Foundation Trust

Standard	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
31 Day Standard				
62 Day Standard				

Recovery will straddle both Q4 and Q1 affecting standard delivery in aggregate.

Both standards expected to be delivered from June 2021

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2. Planned Care / RTT Management

Wirral University Teaching Hospital NHS Foundation Trust

- Clinical v Chronological Prioritisation
- All new referrals are triaged upon receipt & clinically prioritised
- Inpatient waiting lists are validated & 'P coded'
- Clinical Reviews undertaken at 40 weeks in key long wait specs and re-prioritised if required
- Harm reviews undertaken for P1 and P2 breaches
- Harm reviews undertaken for all 52 week breaches
- Regular review of patient self isolation policy linked to community prevalence
- TCI bookings made in 'P' code clinical priority order not chronologically
- WLI's authorised after DCC commitments delivered
- Insourced additional capacity in Endoscopy
- Utilisation of IS capacity maximised

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2. RTT - Referrals

Wirral University Teaching Hospital NHS Foundation Trust

Waiting List	Mar-18	Mar-19	Mar-20	Jan-21
Total List Size	24,736	27,309	22,350	21,880

Referral Source	2019 Jan to Dec	2020 Jan to Dec	% Change
GP	84,869	63,876	-24.7%
Non GP	46,135	37,702	-18.3%
Total	131,004	101,578	-22.5%

The total waiting list size has reduced by 470 since Covid, as reduced activity levels have been offset by referral reductions (see next 2 slides).

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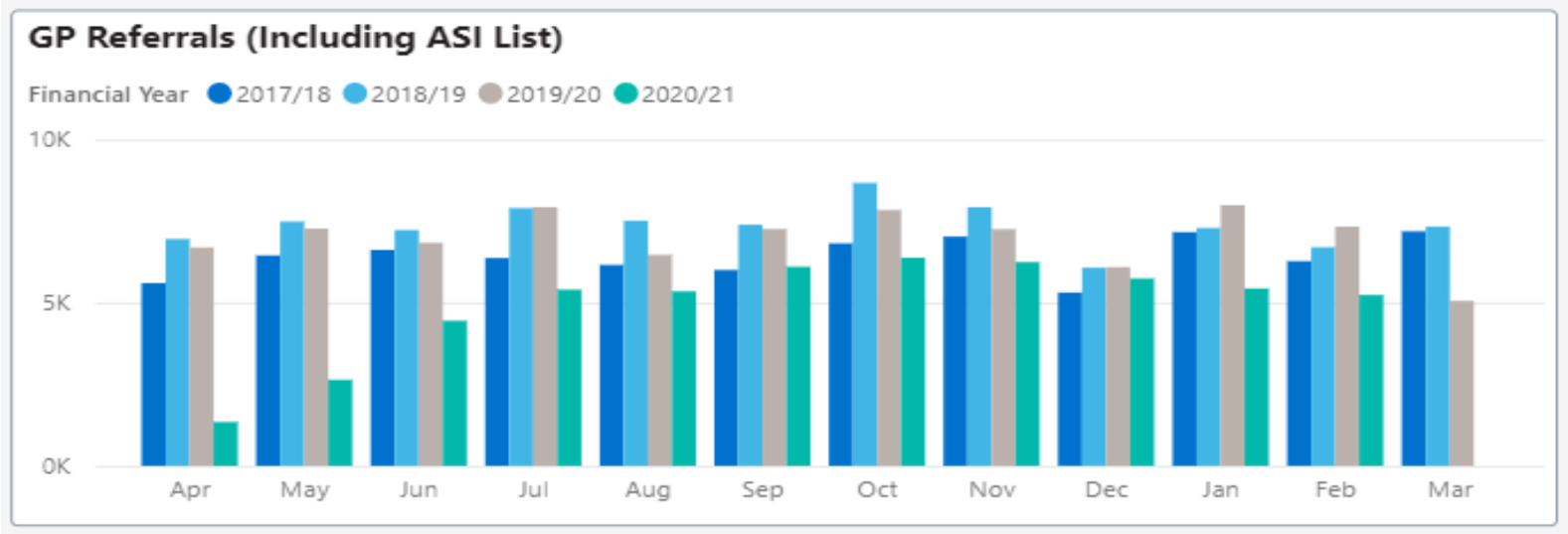
2. Referrals – GP

Wirral University Teaching Hospital
NHS Foundation Trust



Year on Year Comparison											
GP Refs	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
% of 2019/20	20%	36%	65%	68%	83%	84%	81%	86%	94%	68%	71%

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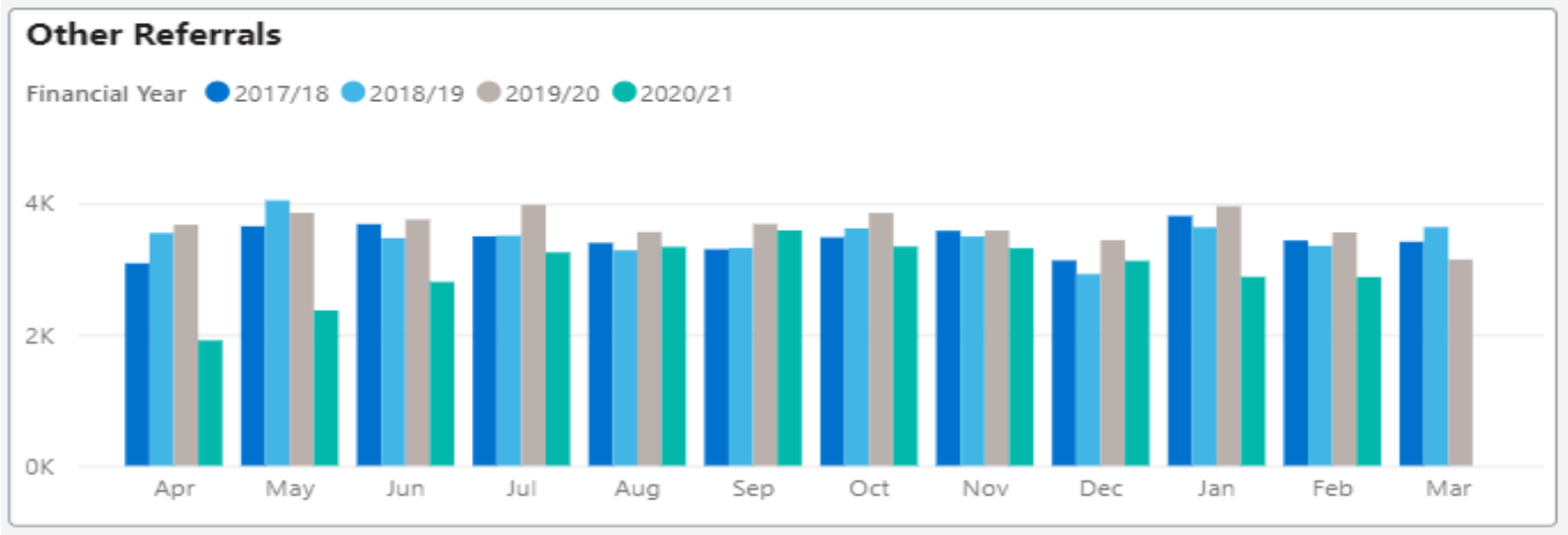
2. Referrals – Other



Year on Year Comparison											
Other Refs	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
% of 2019/20	52%	61%	75%	82%	94%	97%	87%	92%	91%	73%	81%

2. Planned Care – Outpatient Activity Forecast

Wirral University Teaching Hospital NHS Foundation Trust

Activity Type	March	April	May	June	July	August
Outpatient (New)	91 %	94 %	97 %	100%	100%	100 %
Outpatient (Follow up)	97 %	96 %	96 %	100%	100%	100 %
Total	**95 %**	**96 %**	**96 %**	**100%**	**100%**	**100 %**

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2. Planned Care – OP Activity

Wirral University Teaching Hospital NHS Foundation Trust

December	Total (New & Follow-up) Appointments Non-F2F		
Division	NHSE Target	C & M	Actual Activity Levels
Medicine & Acute	25%	29%	49%
Surgery			23%
Women & Children's			34%
Clinical Support			33%
Trust Total			**33%**

December	Follow Up Appointments Non-F2F		
Division	NHSE Target	C & M	Actual Activity Levels
Medicine & Acute	60%	31%	51%
Surgery			20%
Women & Children's			36%
Clinical Support			32%
Trust Total			**33%**

Transformation Programme Priorities

- 2020:
  - Focus on Non F2F during 2020
- 2021:
  - Patient Initiated Follow ups
  - Joint GP/Consultant review
  - Consultant sign off – Junior led appointments

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2. Planned Care – Elective Activity Forecast

Wirral University Teaching Hospital NHS Foundation Trust

Activity Type	March	April	May	June	July	August
Daycase (incl Endoscopy)	83 %	94 %	94 %	96 %	98 %	100 %
Inpatients	62 %	67 %	77 %	86 %	95 %	100 %
Total	**79 %**	**90 %**	**92 %**	**95 %**	**97 %**	**100 %**

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2. Inpatients – P2 & 3 Backlog timescales

Wirral University Teaching Hospital NHS Foundation Trust

Medicine & Acute	Month P3 Backlog cleared
CARDIOLOGY	April
CLINICAL HAEMATOLOGY	April
ENDOCRINOLOGY	April
GASTROENTEROLOGY	May
RESPIRATORY MEDICINE	April
Surgery	
ANAESTHETICS	April
COLORECTAL SURGERY	April
ENT	April
GENERAL SURGERY	May
OPHTHALMOLOGY	May
ORAL & MAXILLOFACIAL SURGERY	August
TRAUMA AND ORTHOPAEDICS	May
UPPER GASTROINTESTINAL SURGERY	September
UROLOGY	May
Women & Children	
BREAST SURGERY	April
GYNAECOLOGY	April
PAEDIATRIC SURGERY	April

- P2 : Backlog to cleared during March / April.
- P3 : Oral & Maxillofacial to be prioritised for IS access and plan for internal mutual aid for Upper GI
- Plan to address P3 backlog by end of Q1

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2. RTT – P4 / 52 week waiters

Wirral University Teaching Hospital NHS Foundation Trust

- All patients clinically reviewed at 40 weeks
- Single C&M PTL – Mutual Aid
- Priority use of IS capacity
- No further deterioration in monthly position from June 2021
  - **Forecast clearance of 52 week backlog = September 2022**
- For all patients who breach 52 weeks there is a harm review undertaken

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3. Use of Independent Sector

Wirral University Teaching Hospital
NHS Foundation Trust

- Nationally commissioned capacity maximised
- System plan for Q1 use – Local commission
  - Priority specialities :
    - Oral Surgery
    - Ophthalmology
- Trust / IS provided have single point of contact's
- Plan agreed for Endoscopy and Ophthalmology use for remainder of year

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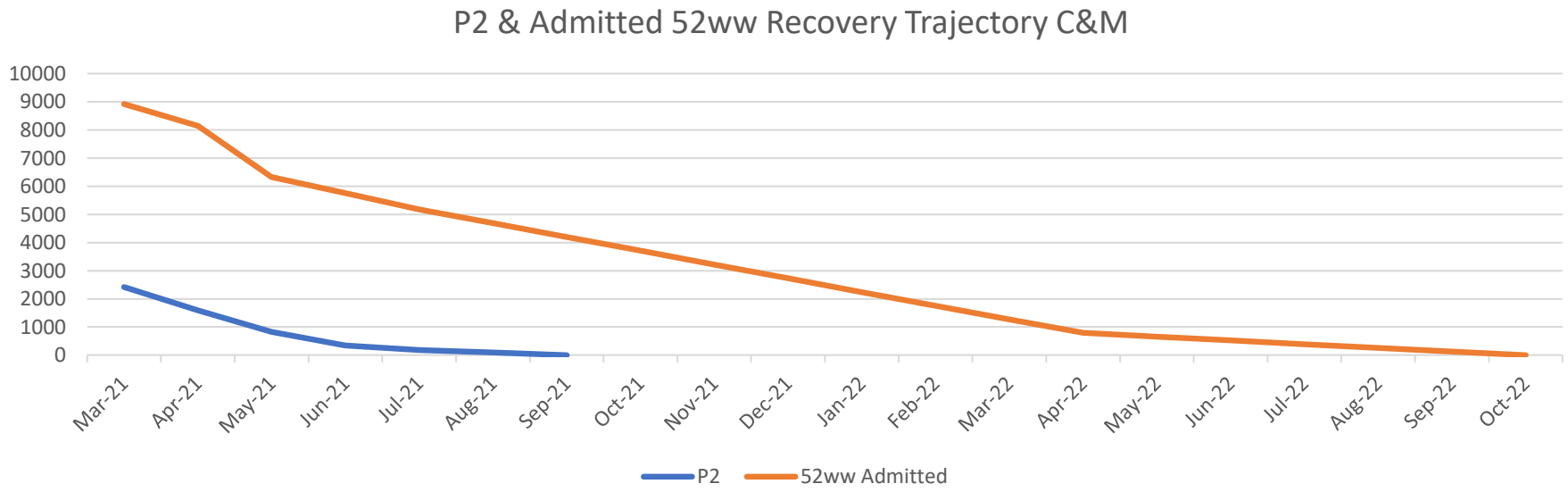
4. Cheshire & Mersey Backlog Trajectories

Wirral University Teaching Hospital NHS Foundation Trust

Majority of trusts expect get back to seeing all P2 patients within 4 weeks within the first quarter of 2021/22.

52 week restoration will take much longer and is anticipated to take us into 2022/23



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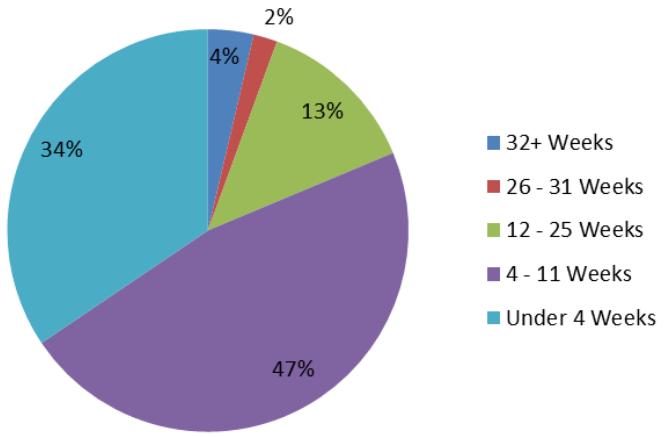
5. Workforce : Sickness / Absence (As at 03/03/21)

Wirral University Teaching Hospital NHS Foundation Trust

	All Sickness	Non Covid Sickness	Covid Sickness	Other Covid Absence
Add Prof Scientific and Technic	2.75%	2.75%	0.00%	0.78%
Additional Clinical Services	7.98%	7.13%	0.85%	3.95%
Administrative and Clerical	3.42%	2.74%	0.68%	1.03%
Allied Health Professionals	2.06%	1.80%	0.26%	1.03%
Estates and Ancillary	9.20%	7.51%	1.69%	6.03%
Healthcare Scientists	2.08%	2.08%	0.00%	2.08%
Medical and Dental	1.39%	0.93%	0.46%	0.15%
Nursing and Midwifery Registered	6.69%	5.80%	0.89%	3.20%
Students	0.00%	0.00%	0.00%	0.00%
TRUST TOTAL	**5.64%**	**4.82%**	**0.82%**	**2.81%**



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5. Workforce : Sickness / Absence

Wirral University Teaching Hospital NHS Foundation Trust

Employee Health and Wellbeing is and continues to be at the heart of WUTH's response to the pandemic.

- Strategic Approach - 'basic, better, best'
  - New Attendance / Sickness Strategy designed to achieve continuous improvement. 8 Work streams / critical success factors.
  - Audit of Sickness and Absence Reporting
  - Wellbeing Strategy – 6 key elements - Mental Health, Empowerment, Physical Health, Support Services, Digital Support and Staff Wellbeing Hubs.
  - Recruiting new Head of Health Work and Wellbeing – *greater focus on employee wellbeing & leading the Trust's Health and Wellbeing agenda.*
  - Restructure of Occ Health in response to the NHS People Plan and commitment around Health & Wellbeing. Focus on provision of a rounded and holistic approach to supporting staff wellbeing
  - Modernisation and technical investments – switch on Allocate / ESR absence module, integration between Allocate absence module and ESR
  - Business Case for Empactus

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5. Workforce : Sickness / Absence

Wirral University Teaching Hospital NHS Foundation Trust

Additional Support for Managers and Staff – a workforce that is 'healthy, well and at work'.

- In line with reset and recovery HR Services continue to support managers & Divisions with the management of sickness absence across the Trust. Championing RTWs and supporting management of all sickness cases.
- New Attendance Management Policy which strikes a balance between providing support to help employees stay in and returning to work, and taking firm action. *It has also streamlined the short and long term policies into one modern policy, clarifies expectations, removed the Bradford factor, enabled self navigation and reintroduced triggers to improve consistency and progression of cases.*
- New Health & Wellbeing Staff Information and Resources Brochure.
- Psychological Support for staff in response to C-19 and NHS People Plan – *including access to Red Poppy Company for staff suffering from PTSD intended to help employees maintain their attendance at work.*
- New staff reassignment process and workforce information tool has been introduced to bolster & best utilise staff.
- Plans to procure external support of physio services, just for staff
- Series of seminars and workshops about Health Assured (our EAP) their extensive range of services & how to access them.
- Staff Vaccination Programme
- LFD self testing and transitioning to LAMP testing
- Planned divisional Engagement Meetings with Deputy Head of WF and HR Workforce Intelligence Lead.

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6. Other Information

Wirral University Teaching Hospital NHS Foundation Trust

- Plan developed in line with NW principles
    - Reset period for staff
    - Cognisant of critical care pressures
    - C&M PTL
    - Internal Improvement programmes
    - System coordination of acute and community restart
    - Continued use of IS
    - Increased CT capacity
    - Multiple Covid testing platforms

- Capital investment in Clatterbridge theatres to increase acuity thresholds

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7. Next Steps

Wirral University Teaching Hospital NHS Foundation Trust

- Rework plan and timescales against an expected 30% growth in referrals

- Operational Planning Guidance 2021/22 Released 25th March
  - Implementation expectations and timelines being reviewed

8. Engagement – For Information

Wirral University Teaching Hospital NHS Foundation Trust

- Trust Operational Performance Committee
- Trust Medical Board
- Trust Management Board
- Trust Board of Directors
- Wirral System Restoration group
- Healthy Wirral Partners Board

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Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-011

Board of Directors
7th April 2021

Title:	Learning from Deaths Report
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director
Presented by:	Mr Michael Ellard

Executive Summary

This paper represents the Wirral University Teaching Hospitals (WUTH) *Learning from Deaths* report and reports on deaths observed in Q2 and 3 2020/21 (July - December 2020).

Key points:

- Mortality Review Group (MRG) Meetings resumed in Q2 with frequency increased from monthly to weekly with evidence of rapid learning being disseminated to teams
- The medical examiners started in Q2 and have performed 100% scrutiny of deaths
- A 10% sample of cases undergo a primary mortality review for quality assurance
- Key learning from deaths in Q2 2020/21 has been identified in relation to;
  DNCPR documentation
  Mental Capacity Assessments, Derivation of Liberty and Best Interest documentation
  Side effects of medication
  Delays in discharge
- Compliance of SJR completion with our 30 working day standard is 87.5%
- The SHMI has fallen for 3 consecutive reports from 115.11 to 112.3 (statistically as expected)
- The HSMR is 102 (statistically as expected)

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

To note medical examiner process is embedded in the organisation and progress on SHMI action plan

Which strategic objectives this report provides information about:	
Outstanding Care	**Yes** / no
Compassionate Workforce	**Yes** / no
Continuous Improvement	**Yes /** no
Our Partners	**Yes** / no
Infrastructure	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)
none
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC essential standards
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
none
Specific communications and stakeholder /staff engagement implications
Local and system learning issues
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
none
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
none

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

PATIENT SAFETY AND QUALITY BOARD
07 APRIL 2021

LEARNING FORM DEATHS REPORT (Q2 AND 3)

Purpose

To provide a summary of the mortality review process, care issues, learning and progress against the SHMI action plan.

Introduction / Background

The Learning from Deaths Guidance published in March 2017 by the National Quality Board for NHS Trusts and Commissioners in England identified the requirement for Trusts to report on the numbers and outcomes of deaths. To support Trusts the National Quality Board generated a Mortality Reporting Dashboard as a suggested tool to aid the systematic recording of deaths and learning. The Learning from Deaths Report has been adapted in line with this National Guidance and incorporates the required National Reporting Criteria.

The Medical Examiner role was to be introduced by April 2020 in acute trusts and its' introduction was delayed till August 2020 due to the COVID pandemic. The role of the medical examiners is to;

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establishing if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures

Definitions

- Primary Mortality Review (PMR) – a screening assessment tool to identify if case automatically qualifies for a Structured Judgemental Review or care issues
- Structured Judgemental Review (SJR) – an in depth analysis of all aspects of inpatient care using Royal College of Physicans proforma
- Mortality Review Group (MRG) – multidisciplinary group of clinicians that review cases and determine learning to be shared and if a case requires escalation to the serious incident (SI) review process
- Medical Examiner (ME) – senior clinicians who provide independent scrutiny of deaths

Summary of all Adult in patient deaths					
20/21	Total Adult In-patients Deaths (ME review)	Total Reviewed by Med Examiner	Total No of PMRs (concerns)	Total No of SJR and SI deaths	Total reviewed
Q1	533	0	27	20	47
Q2	383	331	79 (0)	8	87
Q3	572	572	76 (4)	8	84
Q4					

SJRs should be completed within a 30 working day timeframe. Between Q2 and 3 this was achieved in 87.5%

Learning Disability Mortality Reviews				
20/21	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care	Referred to LeDeR
Q1	4	4	1	4
Q2	2	2	0	2
Q3	0	0	0	0
Q4				

Woman and Childrens Mortality Reviews						
20/21	Total No. of Maternal Deaths	No. reviewed using Mbrrace Tool	Total No. of Neonatal Deaths	No. reviewed using Perinatal Mortality review Tool	Still Births 24+ weeks (22-23+6)	No. reviewed using Perinatal Mortality Review Tool
Q1	0	0	4	4	(2)	2
Q2	0	0	1	1	(1)	1
Q3	0	0	2	2	1(1)	2

Medical Examiners

The MEs review all deaths that have occurred at WUTH (inpatient and in A&E). They started on 16th July and have reviewed 100% of deaths. Deaths between the 1st and 15th of July all underwent a PMR to ensure there has been 100% of deaths scrutinised in Q2 and Q3.

10% of deaths undergo a PMR to provide Quality Assurance on the ME scrutiny, 4 reviews identified care issues at a system level that had not been highlighted previously by the medical examiners. No additional care issues within WUTH were identified at PMR.

28 (3.1%) cases have been escalated by the ME to the mortality review group for further consideration in the following referral categories.

Concern by Family / Carer 1 (SJR)
Deaths with Learning Difficulties / severe mental illness 2 (SJRx 2)
Deaths following elective admission 2 (SJR x 2)
Deaths where there is a significant concern on quality of care 10 (SJR x 10)
Deaths where learning will inform existing or planned improvement work (i.e. improving sepsis or end of life care) - 13 (reviewed at MRG, 1 subsequently required SJR)

Of these escalated concerns the MRG decided a SJR should be performed in 16 cases (5 automatically tiggered a SJR - learning difficulties, elective admission and family / carer concern). Themes identified included communication with family / carers, documentation (particularly in relation to DNACPR).

In only one SJR was major care issues identified (see 1st learning point) but it was not felt to have affected the overall outcome.

Grading of Care and avoidability (Perinatal in brackets)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Q1	7	3	2	0 (0)
Q2	8 (5)	0 (1)	0 (0)	0 (1)
Q3	7 (2)	1 (2)	0 (0)	0 (0)
Q4				

Learning

1. Importance of updating patient allergy status and reviewing pharmacy prescribing record when a patient suffers severe side effect of medication.
2. Mental Capacity Assessments, Best Interest Decisions and DoLs must be performed and documented when documenting a DNACPR decision
3. Patient and Family Information leaflets must be provided when having discussions on DNACPR status
4. COVID swabs should be done at the time of decision to discharge
5. Perinatal case – learning was disseminated to relevant staff groups but not included in this paper as there is risk of breaching patient confidentiality due to the low number of perinatal cases seen.

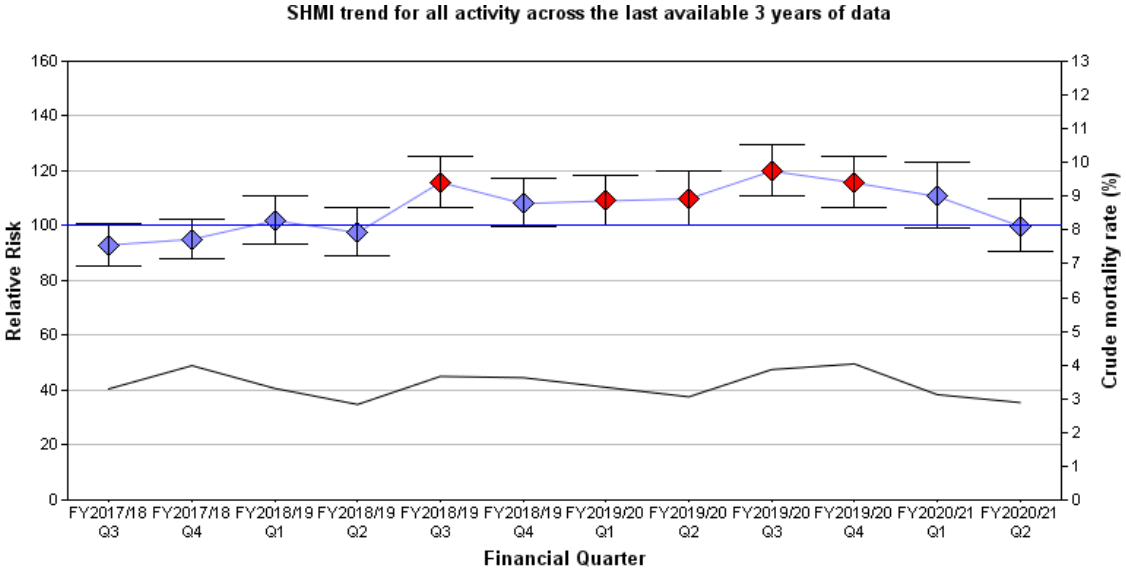
The implementation of the digital DNACPR in November 2020 addressed a large number of the medical examiner concerns for “existing or planned improvements” with DNACPR issues falling to 3, compared to 9 between July and October.

System shared learning - issues in delays to recognise deterioration in functional status resulting in admission and then delay to discharge

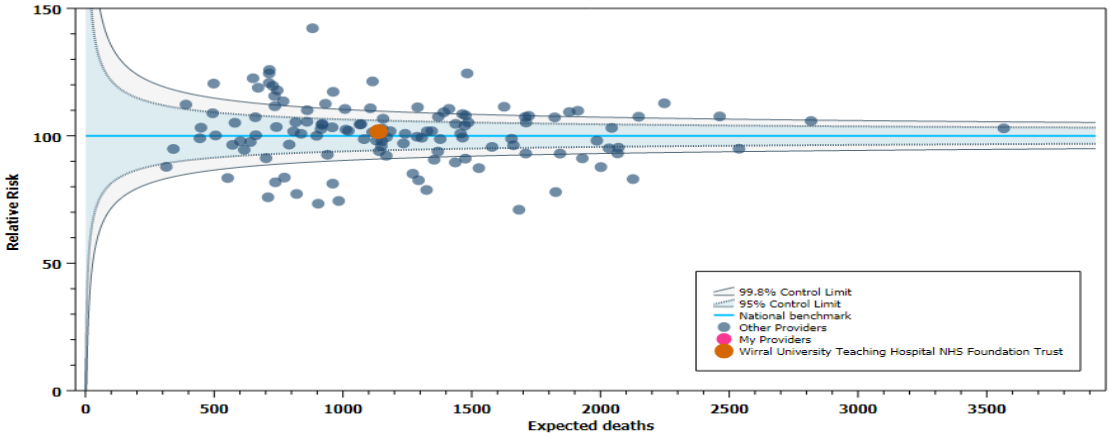
Dr Foster Data

The following data was published in February 2021 and represents the rolling 12 month data for October 2019 to September 2020

The in quarter SHMI scores have fallen and for Q2 are the lowest since Q2 2018/19. The rolling 12 month SHMI has steadily decreased from a high of 115.11 (Jun19-May20) to 112.3 (Oct 19-Sept 20)



HSMR BY PROVIDER (All acute non-specialist) for all admissions



The HSMR for Oct 19- Sept 20 is 102 (within expected range). The number of CUSUM alerts for SHMI has decreased from 4 to 2 and the exceedance values for these alerts has also decreased.

SHMI action plan

Action	Lead	Completion Date	RAG
Review of Coding Practices	H Kielty	January 21	Complete
Coders to prioritise Charlson morbidities in coding list	H Kielty	January 21	Complete
Introduce comorbidity folder on CERNER	AMDs / C Mason	May 21	Charlson changing to Elixhauser classification system and waiting to be published
Auto population of comorbidities from previous clinical episodes	M Ellard / C Mason	May 21	
Education package for clinical staff	M Ellard / H Kielty	March 21	Package completed, awaiting staff dissemination
Introduce mechanism of coding review before NHS data submission	H Kielty	January 21	Complete

Conclusions

The medical examiner role has been fully implemented in the trust and are reviewing 100% of deaths. The escalation of concerns by the medical examiner to the mortality review group is 3.1%.

87.5% of structured judgemental reviews were completed within the 30 working day timeframe

The SHMI action plan is progressing and Dr Foster SHMI data shows a month on month drop from 15.11 and is now 112.3

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-12

BOARD OF DIRECTORS

07 APRIL 2021

Title:	Month 11 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 28h February 2021 (Month 11).

The year to date (YTD) position is a deficit of £3.530m, with a movement of £5.400m in M11. This is largely attributable to the in-year increase in our annual leave accrual of £4.975m calculated in partnership with HR.

Income reflects the reduced activity in respect of patient care offset by the income guarantee funding arrangement. We received £6.256m in respect of the income guarantee in month and have now received £75.746m YTD.

Expenditure reflects reduced activity in respect of elective activity and lower than forecast COVID-19 costs offset by a significant increase in employee expenses. This relates to the annual leave accrual and increased provisions in respect of employee disputes.

We currently forecast a year end deficit of £5.054m. Without the annual leave accrual our deficit would be £0.059m,

Cash balances at the end of M11 were £52.408m. The early payment of block income ended in February 2021 so cash balances are expected to reduce in March 2021.

The Trust has recorded capital spend of £9.335m against a year to date budget of £18.524m. The full year capital forecast is currently £15.4m.

The Board of Directors are asked to note the financial position of the Trust for the period ending 28th February 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

1.1 Table 2: Financial position – M11

Month 11 Financial Position	Forecast (Mth 11)	Actual (Mth 11)	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS income - patient care	27,394	20,830	(6,564)	226,033	330,279	246,472	(83,806)
Income Guarantee	0	6,256	6,256	75,746	0	82,632	82,632
National Top-up	3,213	3,207	(6)	31,403	34,647	34,610	(37)
Additional top up	0	77	77	2,923	0	2,923	2,923
Covid 19 income	2,134	2,231	96	10,589	11,451	12,777	1,326
Non NHS income - patient care	370	360	(10)	4,035	4,693	4,285	(408)
Other income	2,093	2,700	607	23,695	28,645	25,859	(2,786)
Total Income	**35,204**	**35,661**	**457**	**374,424**	**409,715**	**409,559**	**(156)**
Employee expenses	(23,035)	(29,129)	(6,095)	(252,683)	(272,735)	(275,470)	(2,735)
Operating expenses	(10,442)	(10,009)	433	(107,956)	(124,397)	(119,958)	4,439
Covid 19 costs	(1,542)	(1,491)	51	(13,709)	(7,889)	(15,195)	(7,305)
Total expenditure	**(35,019)**	**(40,630)**	**(5,611)**	**(374,348)**	**(405,021)**	**(410,622)**	**(5,601)**
Non Operating Expenses	(326)	(440)	(114)	(3,717)	(4,515)	(4,044)	471
Actual Surplus / (deficit)	**(141)**	**(5,409)**	**(5,267)**	**(3,641)**	**179**	**(5,107)**	**(5,286)**
Reverse capital donations / grants I&E impact	23	8	(14)	111	140	132	(8)
Surplus/(deficit) - Control Total	**(119)**	**(5,400)**	**(5,282)**	**(3,530)**	**320**	**(4,975)**	**(5,294)**

1.2 The year to date (YTD) position is a deficit of £3.530m, with a movement of £5.400m in M11. This is largely attributable to the in-year increase in our annual leave accrual of £4.975m calculated in partnership with HR.

1.3 Income reflects the reduced activity in respect of patient care offset by the income guarantee funding arrangement. We received £6.256m in respect of the income guarantee in month and have now received £75.746m YTD.

1.4 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 £2.231m in M11 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.

1.5 Expenditure reflects reduced activity in respect of elective activity and lower than forecast COVID-19 costs offset by a significant increase in employee expenses. This relates to the annual leave accrual and increased provisions in respect of employee disputes.

1.6 We currently forecast a year end deficit of £5.054m. Without the annual leave accrual our deficit would be £0.059m,

1.7 Cash balances at the end of M11 were £52.408m. The early payment of block income ended in February 2021 so cash balances are expected to reduce in March 2021.

1.8 The Trust has recorded capital spend of £9.335m against a year to date budget of £18.524m. The full year capital forecast is currently £15.4m.

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.

2.2 NHSI have confirmed that Trusts will receive the financial guidance for the first 2 quarters of 2021/22 on the 26th March. We believe that the funding regime will be broadly similar to the current system but allocations are likely to reduce.

3. Dashboard and risks

3.1 Mth 11 Performance Dashboard

	Indicator	Threshold	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	2020/21
Use of Resources	I&E Performance (monthly actual)	On Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	-3.5
	I&E Performance Variance (monthly variance)	On Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.5	0.3	-0.1	-5.3	-4.3
	NHSI Risk Rating	On Plan	2	2	2	2	2	2	2	2	2	2	2	2
	CIP Performance	On Plan	0.0%	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)	On Plan	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	2.1%
	Cash - liquidity days	NHSI metric	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-17.8
	Capital Programme (cumulative)	On Plan	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	-74.8%

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.

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. We remain behind plan at M11 but significant progress is being made in March and we anticipate achieving the revised forecast position.

4. Financial Performance

4.1 Income

4.1.1 The Trust has received £374.4m YTD, a £0.5m improvement against the forecast submitted to NHSI in November.

Table 3: Income analysis for M11.

	Forecast (Mth 11)	Actual (Mth 11)	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective & Daycase	4,240	1,978	(2,262)	24,072	50,743	26,251	(24,492)
Elective excess bed days	83	10	(73)	580	993	632	(361)
Non-elective	8,419	6,711	(1,708)	73,540	101,455	80,205	(21,251)
Non-elective Non Emergency	974	985	11	10,706	11,755	11,669	(86)
Non-elective excess bed days	355	169	(186)	1,335	4,270	1,458	(2,812)
A&E	1,273	1,016	(257)	11,817	15,354	12,887	(2,467)
Outpatients	3,022	2,397	(625)	22,618	36,419	24,666	(11,754)
Diagnostic imaging	187	153	(34)	1,558	2,257	1,699	(557)
Maternity	480	450	(30)	4,858	5,787	5,298	(489)
Non PbR	7,092	5,956	(1,136)	61,251	86,416	66,697	(19,719)
HCD	1,259	1,461	202	14,463	15,327	15,722	394
CQUINs	189	189	0	2,085	2,273	2,274	1
National Top up	3,213	3,284	71	34,326	34,647	37,532	2,885
Income Guarantee	0	6,256	6,256	75,746	0	82,632	82,632
Sub-Total Board Clinical Income	30,788	31,015	227	338,954	367,697	369,621	1,924
Other patient care income	135	149	14	957	1,113	1,072	(41)
COVID-19 Income	2,134	2,231	96	10,589	11,451	12,777	1,326
Non-NHS: private patient & overseas	12	17	4	54	125	67	(58)
Injury cost recovery scheme	42	30	(11)	655	684	697	13
Total Patient Care Income	33,111	33,442	331	351,210	381,069	384,234	3,165
Other operating income	2,093	2,219	127	23,209	28,645	25,320	(3,325)
Other non operating income		0	0	5		5	5
Total income	35,204	35,661	457	374,424	409,714	409,559	(156)

4.1.2 The lower 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 this year compared to normal hospital activity.

4.1.3 COVID-19 income in M11 of £2.2m reflects the Covid envelope of £1.8m, an additional £0.3m for the vaccination programme costs incurred in February and income of £0.1m to support lateral flow testing.

4.1.4 We currently forecast income of £409.6m which is (£0.2m) below plan.

4. Financial Performance

4.2 Expenditure: Pay

4.2.1 The Trust has spent £252.7m on pay costs YTD, £6.1m higher than M11 forecast. 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 11)	Actual (Mth 11	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Consultants	(3,908)	(3,751)	157	(40,292)	(44,154)	(44,196)	(42)
Other medical	(2,508)	(2,372)	136	(27,380)	(31,676)	(29,884)	1,792
Nursing and midwifery	(6,225)	(6,097)	127	(66,521)	(73,933)	(72,621)	1,313
Allied health professionals	(1,319)	(1,420)	(101)	(14,212)	(15,473)	(15,510)	(37)
Other scientific, therapeutic and technical	(515)	(517)	(2)	(5,562)	(6,122)	(6,077)	45
Health care scientists	(1,041)	(1,090)	(49)	(11,366)	(12,381)	(12,405)	(24)
Support to clinical staff	(4,319)	(4,204)	114	(45,570)	(51,063)	(49,804)	1,259
Non medical, non clinical staff	(3,117)	(9,668)	(6,551)	(40,925)	(36,893)	(44,034)	(7,141)
Apprenticeship Levy	(83)	(9)	74	(855)	(1,039)	(939)	100
Total	(23,035)	(29,129)	(6,095)	(252,683)	(272,735)	(275,470)	(2,735)

Table 5: Pay analysis by pay type

Pay analysis (exc Covid)	Forecast (Mth 11)	Actual (Mth 11	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Substantive	(20,913)	(27,001)	(6,087)	(232,569)	(245,336)	(253,256)	(7,919)
Bank	(874)	(778)	96	(8,289)	(11,009)	(9,149)	1,860
Medical Bank	(450)	(469)	(20)	(5,051)	(7,294)	(5,500)	1,794
Agency	(715)	(873)	(158)	(5,919)	(8,057)	(6,627)	1,430
Apprenticeship Levy	(83)	(9)	74	(855)	(1,039)	(939)	100
Total	(23,035)	(29,129)	(6,095)	(252,683)	(272,735)	(275,470)	(2,735)

4.2.2 In M11 there was a £6.1m movement, the largest part of which was the £5m annual leave provision in substantive pay. This is based on an estimate of carry forward leave calculated by HR and will be finalised in M12. In addition a further £0.8m provision has been included for ongoing employment tribunals and a £0.4m pension provision adjustment. All these technical adjustments are for year end reporting requirements.

4.2.3 We currently forecast year end pay costs of £275.5m, an increase of £2.7m against the plan submitted to NHSI in November.

4. Financial Performance

4.3 Expenditure: Non-Pay

4.3.1 Non-pay expenditure YTD is £107.9m, £0.5m lower than the M11 forecast.

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

Non Pay Analysis (exc Covid)	Forecast (Mth 11)	Actual (Mth 11	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Supplies and services - clinical	(2,812)	(2,454)	358	(27,721)	(34,910)	(30,559)	4,351
Supplies and services - general	(368)	(330)	38	(3,899)	(5,065)	(4,287)	777
Drugs	(1,930)	(2,038)	(107)	(20,951)	(23,508)	(22,881)	627
Purchase of HealthCare - Non NHS Bodies	(1,158)	563	1,721	(4,366)	(7,040)	(5,246)	1,793
CNST	(1,079)	(1,079)	(0)	(11,868)	(12,894)	(12,947)	(53)
Consultancy	0	6	6	2	(411)	2	413
Other	(2,185)	(3,724)	(1,539)	(29,416)	(30,139)	(33,393)	(3,253)
	(9,532)	(9,056)	476	(98,220)	(113,967)	(109,312)	4,655
Depreciation	(910)	(953)	(43)	(9,736)	(10,430)	(10,646)	(216)
	(10,442)	(10,009)	433	(107,956)	(124,397)	(119,958)	4,439

4.3.2 M11 saw a substantial £1.7m reduction in spend with the independent sector due to the nationally agreed contract funded directly by NHSE. There was also a further £0.4m reduction in in clinical supplies across all divisions as a result of reduced elective activity.

4.3.3 The underspends above were partially offset by increased expenditure in respect of estates and other overhead costs.

4.3.4 We currently forecast year end non-pay costs of £120m, a reduction of of £4.4m against plan.

4. Financial Performance

4.4 Expenditure: COVID–19

4.4.1 We incurred a further £1.5m of COVID-19 costs in M11, with the YTD spend now £13.7m.

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	Feb (M11) £'000	Year to Date £'000
Medical Staff	(263)	(386)	(204)	(199)	(37)	(165)	(84)	(52)	(64)	(103)	(114)	(1,670)
Other Clinical Staff	(367)	(626)	(574)	(560)	(126)	(293)	(272)	(470)	(373)	(912)	(702)	(5,274)
Non Clinical Staff	(182)	(52)	(47)	(105)	(37)	(58)	(32)	(44)	(132)	(189)	(267)	(1,145)
Total Pay	(812)	(1,065)	(824)	(863)	(200)	(516)	(388)	(566)	(568)	(1,204)	(1,082)	(8,089)
Clinical Supplies	(189)	(591)	70	(99)	(122)	(68)	(42)	(207)	(177)	(366)	(221)	(2,013)
Other Non-Pay	(556)	(140)	(333)	(627)	(233)	(273)	(395)	(153)	(211)	(496)	(188)	(3,607)
Total Non-Pay	(746)	(731)	(263)	(726)	(355)	(341)	(437)	(361)	(388)	(863)	(409)	(5,620)
Total Covid Expenditure	**(1,558)**	**(1,796)**	**(1,087)**	**(1,589)**	**(555)**	**(857)**	**(825)**	**(927)**	**(957)**	**(2,067)**	**(1,491)**	**(13,709)**

4.4.2 £1.1m of our COVID-19 costs in M11 related to pay with a further £0.4m on non pay. This spends reflects the COVID-19 activity in the hospital in February.

4.4.3 The COVID-19 YTD position of £13.7m of which £0.8m is vaccination costs and £0.6m is testing costs. The latter costs are both funded centrally outside the Cheshire & Merseyside Healthcare Partnership envelope.

6. Appendices

5.1 Statement of Financial Position (SOFP)

5.1.1 The movement in total assets employed at M11 is the movement trade and other payables offset by the movement in cash and cash equivalents.

Statement of Financial Position (SoFP)

Actual as at 31.03.20 £'000		Actual as at 31.01.21 £'000	Actual as at 28.02.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	162,536	161,986	(550)	↓
14,029	Intangibles	13,022	12,922	(100)	↓
723	Trade and other non-current receivables	598	547	(51)	↓
176,244		**176,156**	**175,455**	**(701)**	↓
	Current assets				
3,991	Inventories	4,100	4,114	14	↑
24,375	Trade and other receivables	16,110	13,952	(2,158)	↓
0	Assets held for sale	0	0	0	→
5,931	Cash and cash equivalents	45,550	52,408	6,858	↑
34,297		**65,760**	**70,474**	**4,714**	↑
210,541	**Total assets**	**241,916**	**245,929**	**4,013**	↑
	Current liabilities				
(41,874)	Trade and other payables	(39,442)	(44,942)	(5,500)	↑
(3,000)	Other liabilities	(35,094)	(35,170)	(76)	↑
(85,234)	Borrowings	(1,163)	(1,180)	(17)	↑
(2,926)	Provisions	(3,321)	(4,538)	(1,217)	↑
(133,034)		**(79,020)**	**(85,830)**	**(6,810)**	↑
(98,737)	**Net current assets/(liabilities)**	**(13,260)**	**(15,356)**	**(2,096)**	↑
77,507	**Total assets less current liabilities**	**162,896**	**160,099**	**(2,797)**	↓
	Non-current liabilities				
(2,588)	Other liabilities	(2,498)	(2,489)	9	↓
(6,274)	Borrowings	(5,711)	(5,706)	5	↓
(7,304)	Provisions	(6,764)	(7,156)	(392)	↑
(16,166)		**(14,973)**	**(15,351)**	**(378)**	↑
61,341	**Total assets employed**	**147,923**	**144,748**	**(3,175)**	↓
	Financed by Taxpayers' equity				
80,106	Public dividend capital	164,888	167,122	2,234	↑
(65,492)	Income and expenditure reserve	(63,692)	(69,100)	(5,408)	↓
46,727	Revaluation reserve	46,727	46,727	0	→
61,341	**Total taxpayers' equity**	**147,923**	**144,749**	**(3,174)**	↓

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 in March 2021 and it is expected that funding flows with return to their usual timings in 2021/22.

6. Appendices

5.2 Capital Expenditure – February 2021

Capital Programme - 28 February 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	10,382	
PDC (Public Dividend Capital) - UTC	500		500	300	200	0	
PDC - COVID-19	0	925	925	925	0	925	
PDC - Critical Infrastructure Repair	0	1,434	1,434	1,434	0	1,434	
PDC - Urgent & Emergency Care	0	2,141	2,141	2,141	0	2,141	
PDC - Restoration of Cancer Services	0	792	792	792	0	792	
PDC - Critical Care	0	664	664	664	0	664	
PDC - Cyber Security	0	40	40	55	(15)	40	
PDC - Mammography Scanner	0	831	831	820	11	831	
PDC - Transport Ventilator	0	19	19	19	0	19	
PDC - COVID-19 IT	0	6	6	6	0	6	
External Funding - donations/grants	0	140	140	140	0	140	
Total funding	**11,240**	**6,992**	**18,232**	**18,036**	**196**	**17,374**	
Expenditure							
Prior year(s) capital commitments	3,526	(180)	3,346	2,710	636	2,290	420
Estates	4,383	(372)	4,011	224	3,787	166	58
Informatics	575	457	1,032	1,316	(284)	495	821
Medicine and Acute	300	186	486	681	(195)	136	545
Clinical Support and Diagnostics	369	306	675	906	(231)	716	190
Surgery	1,363	256	1,619	1,436	183	1,012	424
Women and Children's	0	67	67	441	(374)	58	383
Other	0		0	0	0	0	0
Contingency[2]	224	(228)	(4)	0	(4)	0	0
UTC / Hospital upgrade programme	500	(200)	300	257	43	249	8
COVID-19 response	0	925	925	981	(56)	981	0
Critical Infrastructure Repair	0	1,434	1,434	1,509	(75)	382	1,127
Urgent & Emergency Care	0	2,141	2,141	2,349	(208)	1,769	580
Restoration of Cancer Services	0	792	792	789	3	766	23
Critical Care	0	664	664	757	(93)	120	637
Cyber Security	0	40	40	49	(9)	49	0
Mammography Scanner	0	831	831	820	11	0	820
Transport Ventilator	0	19	19	19	0	0	19
COVID-19 IT / Rapid Testing	0	6	6	6	0	6	0
Donated assets	0	140	140	140	0	140	0
Total expenditure (accruals basis)	**11,240**	**7,284**	**18,524**	**15,390**	**3,134**	**9,335**	**6,055**
Capital programme funding less expenditure	**0**	**(292)**	**(292)**	**2,646**	**(2,938)**	**8,039**	
Capital expenditure	11,240	7,284	18,524	15,390		9,335	
NBV asset disposals	0	0	0	0		0	
Donated assets	0	(132)	(132)	(140)		(140)	
CDEL impact	**11,240**	**7,152**	**18,392**	**15,250**		**9,195**	

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

5.2.1 The BAU capital plan at M11 has increased as a result of additional PDC funding. Actual YTD spend totals £9.3m (£8.9m M10). Expenditure has been relatively low again in February, but many schemes are now reaching a conclusion and together with the capital equipment purchases which have been brought forwrad into 2020/21 we are on track to spend circa £15.4m.

5.3 Statement of Cash Flows – February 2021

Detailed cash variances through SoCF

	Month Actual £'000	Year to date Actual £'000
Opening cash	**45,550**	**5,931**
Operating activities		
Surplus / (deficit)	(5,354)	(3,641)
Net interest accrued	17	209
PDC dividend expense	424	3,255
Unwinding of discount	(1)	(13)
(Gain) / loss on disposal	0	89
Operating surplus / (deficit)	(4,914)	(45)
Depreciation and amortisation	953	9,753
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(16)	(141)
Changes in working capital	9,146	46,823
Investing activities		
Interest received	0	12
Purchase of non-current (capital) assets [1]	(550)	(10,823)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	9	141
Financing activities		
Public dividend capital received	2,234	87,017
Net loan funding	0	(84,392)
Interest paid	0	(378)
PDC dividend paid	0	(1,330)
Finance lease rental payments	(5)	(61)
Total net cash inflow / (outflow)	**6,858**	**46,477**
Closing cash	**52,408**	**52,408**

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

5.3.1 We have received £2.234m of PDC in month relating to Critical Infrastructure Repair (£1.441m) and Resoration of Cancer Services (£793k).

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).

6. Appendices

5.4 Treasury

Borrowings summary February 2021

	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 20	Loan Repayment Sept 20	Loan Balances Feb 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

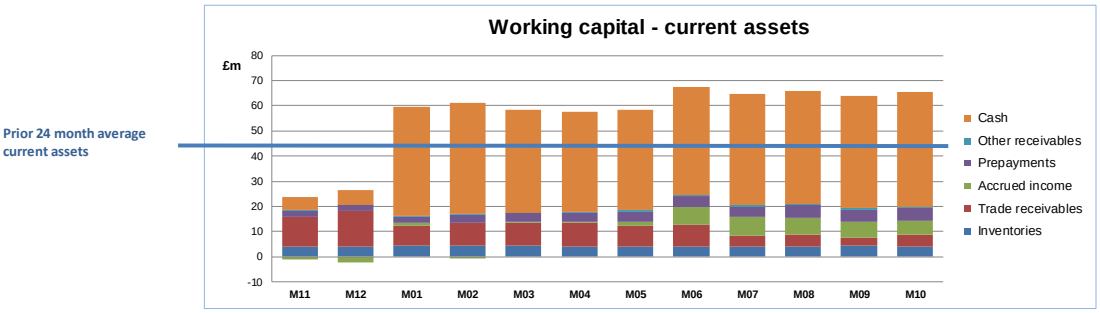
This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

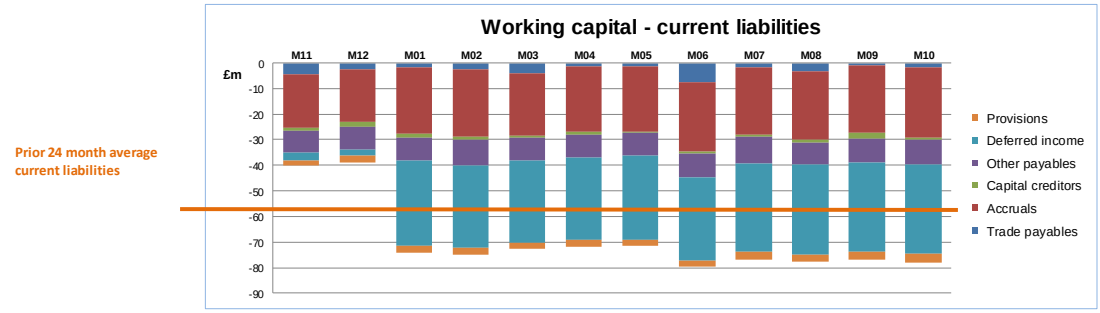
5.4.1 As part of reforms to the NHS cash regime, £83.9m of interim revenue support and working capital loans were repaid in September by the issue of additional Public Dividend Capital. Interest charges on these loans prior to repayment have also been waived in year.

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 February 2021 (M11) 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.





6. Appendices

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

Use of Resources (UoR) Rating

	Metric	Description	Weighting %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-26.5	4	-17.8	4	-30.4	4
	Capital service capacity (times)	Revenue available for capital service: the degree to w hich generated income covers financial obligations	20%	2.0	2	2.4	2	2.5	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.1%	2	0.4%	2	0.9%	2
Financial controls	**Distance from financial plan (%)**	Show s quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	0.3%	1	0.0%	1
	Agency spend (%)	Distance of agency spend against cap	20%	0.0%	1	-2.0%	1	0.0%	1
	Overall NHSI UoR Rating				**2**		**2**		**2**

5.6.1 The liquidity rating of 4 remains unchanged from 2019/20. The capital service capacity metric remains at 2 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 borrowings. The M11 UoR rating is 2 and this rating is expected to continue for the

Wirral University Teaching Hospital
NHS Foundation Trust

21/22 Capital Programme Bid Allocation

23RD March 2021

V4

Table of Contents

1. Background and Scope

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, along with dedicated financial resources to track delivery.

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.

1. Background : Historical Capital spend and trends

Wirral University Teaching Hospital NHS Foundation Trust

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.

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 percentage by type: 17/18 – 20/21

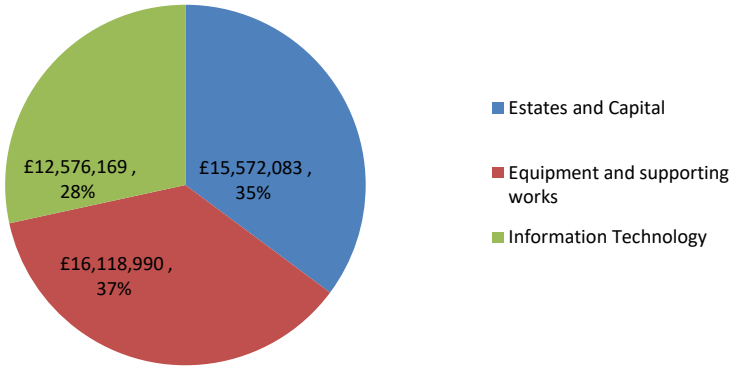
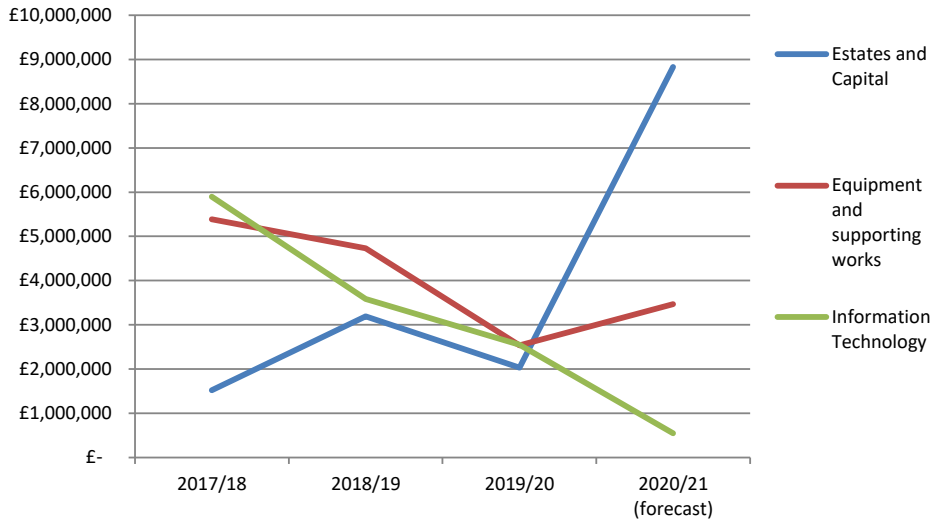


Diagram: Capital spend by type: 17/18 – 20/21



1. Background: 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**

2. Capital budget and approach

2. Approach to 21/22 Capital Programme bids

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital Programme bid approach and timeframes

- A staged approach was taken to the development and allocation of funding for the 21/22 capital programme, as detailed in the diagram below. This included the development of a methodology to assess bids, the review and assessment of bid submissions and allocation of bid funding.
- This process was managed through the Capital Bid Panel, whose membership from Finance, Operations, Strategy and Procurement.

Table: 21/22 Capital Bid Panel

2021/22 Capital Bid Panel
Director of Strategy
CFO
COO
Assistant Director of Finance
Head of Procurement

Table: 21/22 Capital available for Divisional schemes

14th January 2021	Mid-February 2021	February/March	Late March 2021
1. Kick off	2. Divisional Bid Submission	3. Bid Review	4. Bid Award
• 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 • Methodology for allocations agreed	• Divisions triumvirate sign off and submit bid submission forms and associated documentation (items over £75k) to Director of Strategy and Assistant Director of Finance, including completion of risk rating and condition rating. • Submissions collated and initial review undertaken	• Capital Bid Panel convene (CFO, COO, Director of Strategy, Head of Procurement) to review bids • Clarification sessions with Divisions held • Agreement of capital allocation	• Successful bids notified • Procurement routes agreed • 21/22 Capital Programme to be approved by Execs, Capital Committee and FBPAC , then Board

together we will

2. 21/22 Capital Programme budget and commitments

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital Programme budget and funding

- Based on recent analysis, it is estimated that the Trust will have a capital budget of £13.05m, based on depreciation estimates and capital underspends from 20/21 (table, right). The Trust is awaiting confirmation from Cheshire and Merseyside Health and Care Partnership on the use of the £3.5m cash reserves for capital projects and expects this advice by April 2021.
- This also 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.

b. 21/22 Capital funding pre-commitments

- As part of the 21/22 capital programme, there are a funding number of pre-existing commitments to the budget. These commitments are from either 20/21 scheme slippage, staffing, national NHS Digital requirements or Chief Executive requests. The table, below right, details each of these commitments, showing a total of £6.16m
- The pre-commitments also includes a 3.8% contingency to allow for flexibility within the 21/22 capital budget to address emergency equipment or repairs within the financial year.
- this reduces the remaining 21/22 capital budget to £6.9m.

Table: 21/22 Capital available for Divisional schemes

Area	Budget	
21/22 Capital Budget	£	13,050,000
21/22 Capital Commitments	£	6,160,000
21/22 Available Budget for Divisions Bids	£	6,890,000

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: Capital funding commitments : 21/22

Area	Item	Reason	Estimated spend
Information Technology	IT - GDE	NHS Digital requirement	£304,000
Information Technology	IT - Wireless Network Refresh	20/21 slippage	£80,000
Capital and Estates	Estates -Ward Refurbishment (2 wards)	20/21 slippage	£2,000,000
Capital and Estates	Estates - Hot/Cold Water Distribution	20/21 slippage	£346,000
Capital and Estates	Estates - Bleep system (ward 10)	20/21 slippage	£60,000
Capital and Estates	Estates - Carpark & traffic APH (preliminary works)	20/21 slippage	£200,000
Capital and Estates	Critical Care Upgrade (PDC)	20/21 slippage	£870,000
Capital and Estates	Capital Delivery Resource	21/22 Capital Team staffing	£200,000
Capital and Estates	Soft FM Staff changing areas	CE Prioritisation	£500,000
Sub-Total			**£4,560,000**
Capital and Estates	Contingency (3.8%) - equipment and estates	Contingency	£500,000
20/21 Scheme Slippage	theatres, ventilation, pipes, fire alarms,	20/21 slippage	£1,100,000
Total			**£6,160,000**

together we will

2. 21/22 Capital Programme allocation methodology

Wirral University Teaching Hospital NHS Foundation Trust

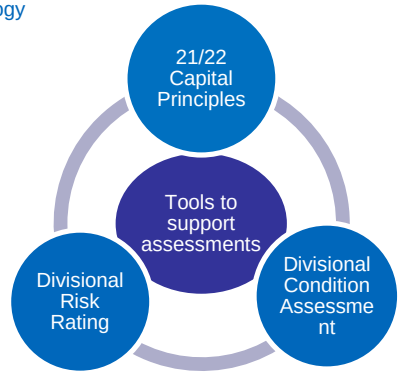
a. Allocation methodology

- As part of the review of capital bids, we developed a three component methodology, allowing for each bid to be assessed on risk, age and condition as well as alignment to capital principles. This made use of both the Trust's Risk Matrix and the NHS England Estates and Equipment Condition Assessment Tool.
- Divisions were required to assess each bid in relation to risk and condition, providing a score for each, with the Bid Panel reviewing scores and examining bids against the capital principles.

b. Key Principles for capital approvals

- Through discussions at the Bid Panel, a number of key principles emerged for prioritisation of bids:
    - Impact of current equipment or estate on patient and/or staff safety
    - Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
    - New equipment or estate supports patient flow and improvement
    - New or replacement equipment or estate supports elective recovery
    - New or replacement equipment or estate supports staff wellbeing
    - New or replacement equipment delivers in year cost reduction

Table: Allocation Methodology



Assessment Type	Completed by	Scoring method
Divisional Risk Assessment	Division	1-25
Condition Assessment	Division	A-D and X
Capital Principles Alignment	Bid Panel	Alignment to one or more principles

Table: Condition assessment (NHSE approach)

Condition Definition	Classification
Excellent/as new condition (generally less than 5 years old). Expected to perform as intended over its expected useful service life.	A
Satisfactory condition with evidence of only minor deterioration or defects. Element/sub-element is operational and performing as intended.	B
Poor condition with documented evidence of major defects Element/sub-element remains operational but is currently in need of major repair or replacement . Has reached the end of useful life.	C
Unacceptable condition. Non-operational, about to fail or failing. Impacting on patient care and/or safety.	D
New technology request. Supplementary equipment or item based on service enhancements or need.	X

3. Capital Bid Submissions

3. Summary of Bid Requests

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital Programme budget and funding

- In February, the Bid Panel received £35m of bids from Divisions, as highlighted on table, right.

- Each bid was assessed by the Division using the NHS capital and equipment rating process. The Bid Panel's evaluation of the bids showed:
  - £13m of bids with rating of D (Unacceptable condition, Non-operational, about to fail or failing, Impacting on patient care and/or safety)
  - £ 15m of bids with a rating of C (Poor condition with documented evidence of major defects, Element/sub-element remains operational but is currently in need of major repair or replacement, Has reached the end of useful life)
  - £5m of service developments and new bids

DIVISION	TOTAL BIDS
CGH ELECTIVE	£ 2,166,000
SURGERY	£ 6,373,803
ESTATES	£ 10,364,062
MEDICINE	£ 3,356,600
SOFT FM	£ 468,000
WOMEN AND CHILDRENS	£ 474,259
ED AND ACUTE	£ 330,215
CLINICAL SUPPORT AND DIAGNOSTICS	£ 7,630,372
IT CORE BIDS	£ 3,218,400
IT DIVISIONAL BIDS	£ 1,513,000
TOTAL	**£ 35,894,711**

DIVISION	TOTAL BIDS	PROJECTS NOT COSTED	PROTOCOL RANKING D		PROTOCOL RANKING C		NEW EQUIPMENT		SCHEMES ON RR WITH SCORE OF 12 OR MORE	COST	
CGH ELECTIVE	£ 2,166,000	Y - 4	£ -		£ 2,100,000	PLUS 3 UN-COSTED SCHEMES	£ 66,000		0	£ -	
SURGERY	£ 6,373,803	Y - 3	£ 1,386,962	PLUS 1 UN-COSTED SCHEME	£ 4,257,312		£ 677,612	PLUS 1 UN-COSTED SCHEMES	9	£ 1,977,035	
ESTATES	£ 10,364,062	N	£ 4,935,006		£ 5,429,055		INCLUDED IN COST		N/A	£ -	
MEDICINE	£ 3,356,600	Y - 3	£ 1,340,350	PLUS 1 UN-COSTED SCHEME	£ 1,812,712	PLUS 1 UN-COSTED SCHEME	£ 203,538	PLUS 1 UNCOSTED SCHEME	7	£ 1,828,629	PLUS 1 UN-COSTED SCHEME
SOFT FM	£ 468,000	N	£ 420,000		£ 48,000		INCLUDED IN COST		N/A	£ -	
WOMEN AND CHILDRENS	£ 474,259	N	£ 362,994		£ 60,359		£ 50,906		5	£ 370,403	
ED AND ACUTE	£ 330,215	Y - 2	£ 18,704		£ 75,236		£ 236,000		0	£ -	
CLINICAL SUPPORT AND DIAGNOSTICS	£ 7,630,372	Y - 1	£ 3,739,793	PLUS 1 UN-COSTED SCHEME	£ 148,518		£ 2,691,300		15	£ 2,293,975	
IT CORE BIDS	£ 3,218,400	N	£ 170,000		£ 1,120,000		£ 258,000		1	£ 120,000	
IT DIVISIONAL BIDS	£ 1,513,000	Y - 1	£ 648,000		£ -		£ 865,000		N/A	£ -	
TOTAL	**£ 35,894,711**		**£ 13,021,809**		**£ 15,051,192**		**£ 5,048,356**			**£ 6,590,042**	

4. Capital Funding Allocation

4. Movement of 21/22 Capital Schemes to 20/21 Financial Year

Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital schemes to be purchased in 20/21

- Following review by the Bid Panel in February 21, there was agreement for Divisions to submit requests for the purchase of equipment, from the 21/22 capital requests, by 31st March 2021, allowing for the purchases to be accounted for within the 20/21 financial year. This was due to slippage on the 20/21 Capital Programme.
- An assessment of these bids was undertaken with agreement that funding approvals would primarily be focussed on requests with a Divisional Risk rating above 12 and an condition assessment rating of 'C'/'D' or 'X'.
- The table, right, highlights the approved bids, which total £2.4m.

Table: 21/22 Capital schemes for purchase in 20/21

Type	Amount	
Stand alone divisional equipment	**£**	**876,024.13**
IT: Surgery: T&O monitors	£	215,000.00
IT: Surgery: Digital lists	£	90,503.78
Divisional equipment with IT input	**£**	**305,503.78**
IT: hardware	£	285,000.00
IT: UPS	£	170,000.00
IT: additional spend to be confirmed	£	250,000.00
IT confirmed in progress	**£**	**705,000.00**
IT: PACs - awaiting confirmation	**£**	**568,000.00**
		£ 2,454,527.91

Table: 21/22 Capital schemes for purchase in 20/21:Divisonal requests

DIVISION	NAME OF SCHEME	ESTATE OR EQUIPMENT TO BE PURCHASED	DIVISIONAL RISK REGISTER SCORE	CONDITION ASSESSMENT	ESTIMATED GROSS COSTS	
Diagnostics and Clinical Support	Replacement of a Histopathology processor	Histopathology processor	16	C	£	34,630.70
Clinical Support	M2 Blood Fridge	LABCOLD BS Blood Bank 160g bag, twin system, 3 drawer, solid door, med dev - core temperature alarm, digital lock, blood tracking connection, 12 mm access port.	16	D	£	10,894.20
Clinical Support and Diagnostics	Replacement Blood Fridge - APH Issues fridge	Equipment - Blood Fridge	12	D	£	8,836.20
Diagnostics and Clinical Support	Replacement of a Microtome	Microtomes	12	D	£	78,000.00
Surgery	Replacement of 18 Conmed Diathermy machines across all of theatres	Purchase	12	D	£	169,084.37
Surgery	Sonosite Fujifilm S-Nerve Sonosite Ultrasound (USS machine and probe)	Purchase	12	X	£	91,224.00
Surgery	Specular Microscope	Purchase	12	D	£	44,555.40
Surgery	Cyclo G6 Glaucoma Laser System	Purchase	12	D	£	21,000.00
Women & Children	Neonatal Ventilator replacement	7 x Neonatal Ventilators	12	C		211,162
Women & Children	Transport Incubator replacement	1 x transport incubator	12	D		31,000
Women & Children	Replacement of Tympanometeres	1 x Tympanometer	12	D		6,174
Medicine & Acute	Drying Cabinets		15	C	£	116,000.00
Medicine & Acute	Draeger Monitors	7 Draeger monitors	12	X	£	17,463.00
Women & Childrens	Resuscitaires x2	Resuscitaires x2	12	C	£	36,000.00
		TOTAL			**£**	**876,024.13**

4. Summary of 21/22 Capital Allocation to Divisions

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. 21/22 Capital Allocation

- Using the allocation methodology, each capital bid was assessed by the Bid Panel, in conjunction with Divisional leadership teams.
- Given the scale of bid requests, the majority of allocations were for capital (infrastructure) and equipment with a Divisional risk rating above 12 and a condition assessment rating of 'C'/'D', along with the scheme meeting one or more of the agreed principles. Some schemes with a condition assessment rating of 'X' were also included , where they supported improving patient flow or elective recovery across the Trust.
- Section 5 details each of the 21/22 capital allocations by Division.

Table: Capital funding allocations: 21/22

CAPITAL ALLOCATED		
DIVISION		**21/22 ALLOCATION**
CGH ELECTIVE	£	53,796
SURGERY	£	687,961
ESTATES	£	2,403,090
MEDICINE	£	714,970
SOFT FM	£	390,000
WOMEN AND CHILDRENS	£	236,239
ED AND ACUTE	£	-
CLINICAL SUPPORT AND DIAGNOSTICS	£	1,913,993
IT CORE BIDS	£	400,000
IT DIVISIONAL BIDS	£	-
CORPORATE - HR INFORMATICS SYSTEM (held in reserve – requiring OBC)	£	90,000
Total	**£**	**6,890,049**

Table: Capital funding allocations: 21/22 and 21/22 bids purchased in 20/21

CAPITAL ALLOCATED	21/22 Bids purchased in 20/21		21/22 Bid Allocations		Total	
CGH ELECTIVE	£	-	£	53,796	**£**	**53,796**
SURGERY	£	631,368	£	687,961	**£**	**1,319,329**
ESTATES	£	-	£	2,403,090	**£**	**2,403,090**
MEDICINE	£	116,000	£	714,970	**£**	**830,970**
SOFT FM	£	-	£	390,000	**£**	**390,000**
WOMEN AND CHILDRENS	£	284,336	£	236,239	**£**	**520,575**
ED AND ACUTE	£	17,463	£	-	**£**	**17,463**
CLINICAL SUPPORT AND DIAGNOSTICS	£	132,361	£	1,913,993	**£**	**2,046,354**
IT CORE BIDS	£	1,273,000	£	400,000	**£**	**1,673,000**
IT DIVISIONAL BIDS	£	-	£	-	**£**	-
CORPORATE - HR INFORMATICS SYSTEM (held in reserve)	£	-	£	90,000	**£**	**90,000**
Total	**£**	**2,454,528**	**£**	**6,890,049**	**£**	**9,344,577**

together we will

5. Capital Funding Allocations by Division

5. Summary of Allocation: Elective Care – CGH

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Surgical Division submitted capital bids to the value of £2.2m.
- The table below summaries the proposed allocations, with Elective Care being allocated £54k

Table: Requests

DIVISION	TOTAL BIDS
CGH ELECTIVE	£ 2,166,000

Table: 21/22 Schemes proposed for allocation

CGH ELECTIVE - TOTAL BID £2.166M		AMOUNT		RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Monitor for POCU	£	53,796	n/a	X	New or replacement equipment or estate supports elective recovery – CGH
REJECTED	One stop Urology centre at CBH	£	2,112,000	N/A	C	

5. Summary of Allocation: Surgery

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Surgical Division submitted capital bids to the value of £6.3m
- £640k of 21/22 capital schemes have been purchased in 20/21
- The table below summaries the proposed allocations, totalling £687k .

Table: Requests

DIVISION	TOTAL BIDS
SURGERY	£ 6,373,803

Table: 21/22 Schemes to be purchased in 20/21

	TYPE	AMOUNT		RISK RATING	CONDITION RATING
	Replacement of 18 Conmed Diathermy machines across all of theatres	£ 169,084		12	C,D OR X
	Sonosite Fujifilm S-Nerve Sonosite Ultrasound (USS machine and probe)	£ 91,224		12	X/A
	Specular Microscope	£ 44,555		12	D
	Cyclo G6 Glaucoma Laser System	£ 21,000		12	D
	T&O monitors	£ 224,572		12	C
	Digital lists	£ 90,504		12	X
POTENTIAL B/F SPEND	TOTAL	**£ 640,940**			

5. Summary of Allocation: Surgery

SURGERY - TOTAL BID £6.441M				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
	T&O Large Bone Power tools – CGH & APH	£	198,000	6	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+); New or replacement equipment or estate supports elective recovery
	Surgical Tray standardisation replacement programme for Head and Neck Services	£	215,000	9	X	New or replacement equipment or estate supports elective recovery
	Theatre trolleys Anetic Aid QA3 model	£	35,532	12	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Percutaneous Nephrolithotomy (PCNL) equipment for kidney and ureteral stones – CGH	£	17,520	6	X	New or replacement equipment or estate supports elective recovery
	General Medical Piezoelectric unit, Metron Flex – CGH	£	41,940	6	X	New or replacement equipment or estate supports elective recovery
FUNDED	Haag-streit Anterior Segment Camera BX900	£	76,073	8	X	New or replacement equipment or estate supports elective recovery
	Replacement theatre lights for APH Th 2, G4 and Opthal 10	£	51,980	12	C	•Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Biometer – opthalmology	£	51,916	12	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	TOTAL	**£**	**687,961**			

REJECTED	SSSD Equipment	£	1,303,121	N/A	C	
	One stop Urology centre at CBH	£	2,112,000	N/A	C	
	Oral scanner	£	30,720	N/A	X	
	Monitor for POCU – duplicate request	£	54,000	N/A	X	
	Robot	£	1,600,000	6	C	

5. Summary of Allocation: Medicine

NHS Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Medicine Division submitted capital bids to the value of £3.4m
- £116k of 21/22 capital schemes have been purchased in 20/21
- The table below summaries the proposed allocations, totalling £715k.

Table: Requests

DIVISION	TOTAL BIDS
MEDICINE	£ 3,356,600

Table: 21/22 Schemes to be purchased in 20/21

MEDICINE - TOTAL BID £3.439M				RISK RANK	NHS RANKING
POTENTIAL B/F SPEND	Drying cabinets	£	116,000	15	C

5. Summary of Allocation: Medicine

MEDICINE - TOTAL BID £3.439M				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Refurbished kitchen on OPAU and ward 30	£ 36,900		12	D	
	CPET machine	£ 67,450		8	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Equipment: Scopes	£ 444,000		8	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Equipment: Replacement machine	£ 29,028		6	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	ECG machine	£ 16,800		6	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Equipment: New chair	£ 7,992		6	X	New equipment or estate supports patient flow and improvement
	CX50 portable echo machine	£ 33,600		8	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Tilt testing equipment	£ 39,600		6	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	ETT equipment	£ 39,600		6	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	TOTAL	£ 714,970				

DEFERRED	Refurb of ward 31 – Aligned to capital ward upgrades	£ 1,236,000	12	D
	Essential maintenance work M1	£ 305,000	12	C
	Endoscopy equipment	£ 40,817	6	X
	Static echo machine	£ 148,800	8	C
	Various ward upgrades	NOT COSTED	VARIOUS	C&D
	2 Telemetry boxes	£ 51,608	12	X
	Track and trace SSSD	£ 103,121	12	X
	Dialysis equipment	£ 723,084	8	C

5. Summary of Allocation: Acute

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Acute Division submitted capital bids to the value of £330k.

- £17k of 21/22 capital schemes have been purchased in 20/21. No further allocations were approved by the Panel.

Table: Requests

DIVISION	TOTAL BIDS
ED AND ACUTE	£ 330,215

Table: 21/22 Schemes to be purchased in 20/21

ED & ACUTE - TOTAL BID £330K		RISK RANK	NHS RANKING
POTENTIAL B/F SPEND	£		
Draeger monitors	17,463	12	X

5. Summary of Allocation: Acute

NHS Wirral University Teaching Hospital NHS Foundation Trust

ED & ACUTE - TOTAL BID £330K			RISK RANK	NHS RANKING
DEFERRED	1 x ABL90 Flex Plus Point of Care Blood Gas Analysers	£ 59,263	6	X
	1 x Verathon Medical Bladder Scan Prime Plus	£ 10,254	6	X
	1 x Verathon Medical Bladder Scan Prime Plus	£ 10,254	6	X
	1 x GE Healthcare Venue Go Point of Care Ultrasound	£ 29,631	6	C
	2 x GE Healthcare Venue Go Point of Care Ultrasound	£ 56,941	6	X
	Mounting of 7 x Dräger Infinity Acute Care System patient monitors and installation of a central monitor in Green Majors	£ 17,464	6	X
	Kitchen replacement	£ 8,196	6	C/D
	Heartworks Eve TOE/TTE Echo Simulator	£ 72,000	2	N/A
	Renovation of AMU/UMAC medicines room	£ 10,098	6	N/A
	Refurbishment of 2 x WCs/shower rooms in AMU	£ 37,409	9	C/D
	Refurbishment of 1 x WC in RRU	£ 18,704	9	D
	Reconfigure footprint to provide separate ambulatory area with clinic rooms plus develop a trolley area	?	?	?
	8 x Defibrilators for Red Majors	?	?	?

5. Summary of Allocation: Women's and Children

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The W&C Division submitted capital bids to the value of £474k
- £255k of 21/22 capital schemes have been purchased in 20/21
- The table below summaries the proposed allocations, totalling £236k.

Table: Requests

DIVISION	TOTAL BIDS
WOMEN AND CHILDRENS	£ 474,259

Table: 21/22 Schemes to be purchased in 20/21

WOMEN AND CHILDREN - TOTAL BID £492K				RISK RANK	NHS RANKING
POTENTIAL B/F SPEND	Replacement of 7 x Neonatal ventilators current stock are breaking down frequently and are not longer able to be upgraded	£ 211,162		12	D
	Replacement of Oxylog 300 and neonatal transport incubator as the current one frequently breaks down and is over 20 years old	£ 37,200		12	D
	Replacement of 1 Tympanometer, all others have been replaced as part of a rolling programme. Current machine is constantley breaking down and repair costs are going up.	£ 7,409		12	C
		£ 255,771			

5. Summary of Allocation: Women's and Children

WOMEN AND CHILDREN - TOTAL BID £492K				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Conversion of an Office in Childrens Outpatients into an additonal Clinic room, current estate limited due to social distancing this would provide additonal flexibility.	£ 25,000		12	D	New or replacement equipment or estate supports elective recovery
FUNDED	Purchase of 3 x CPAP Machines to be shared between Childrens Ward and Neonates	£ 27,000		8	X	New equipment or estate supports patient flow and improvement
FUNDED	Purchase Ultra Sound Scanner to avoid delays to children who amy need to be referred to other departments or to the ward for the scan to be undertaken.	£ 23,906		8	X	New equipment or estate supports patient flow and improvement
FUNDED	2 x Neonatal incubators to be replaced as part of the rolling replacement programme, this has not been funded for the last 2 years and has been carried forward as a request.	£ 52,950		8	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
FUNDED	GE Vivid Echo	£ 107,383		12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
		£ 236,239				

5. Summary of Allocation: Clinical Support and Diagnostics

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The CS&D Division submitted capital bids to the value of £474k
- £136k of 21/22 capital schemes have been purchased in 20/21
- The table below summaries the proposed allocations, totalling £1.9m

Table: Requests

DIVISION	TOTAL BIDS
CLINICAL SUPPORT AND DIAGNOSTICS	£ 7,630,372

Table: 21/22 Schemes to be purchased in 20/21

CSD - TOTAL BID £7.558M POTENTIAL B/F SPEND			RISK RANK	NHS RANKING
Replacement of a Histopathology processor	£	34,631	16	D
M2 Blood Fridge	£	10,894	16	C
Replacement Blood Fridge - APH Issues fridge	£	8,836	12	B
Replacement of a Microtome	£	82,000	12	D
	£	136,361		

5. Summary of Allocation: Clinical Support and Diagnostics

NHS Wirral University Teaching Hospital

CSD - TOTAL BID £7.558M			RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	CT Scanner	£ 1,060,000	16	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Replacement of negative pressure isolator	£ 40,000	16	C	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Pneumatic air tube upgrade - linear coupler	£ 15,393	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Aseptic suite replacement of damaged vinyl flooring through out the aseptic suit	£ 20,000	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Digital XR equipment for OP rooms at CGH	£ 160,000	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Digital XR equipment IP room at CGH	£ 150,000	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Replacement of Aseptic services worktops through out the aseptic suit	£ 15,000	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Digital XR equipment for Ortho OP rooms	£ 300,000	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Replacement of Slidemates	£ 49,200	12	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Sarstedt POS 720	£ 96,600	16	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Replacement of Centifuge	£ 7,800	16	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	total	**£ 1,913,993**			
DEFERRED	MR Scanner	£ 1,500,000	9	D	
	Replacement of a bank of fridges in the mortuary	£ 115,000	9	B	
	Replacement platelet incubator	£ 10,920	?	C	
	Pneumatic air tube upgrade - diverters	£ 15,976	?	C	
	Removal of old autoclave, building work and benchtop steriliser	£ 18,000	N/A	X	
	Electronic Blood Tracking System	£ 108,000		X	
	Replacement of a consultant microscope	£ 24,000	6	B	
	Replacement of failing microscopes	£ 9,000	?	C	
	Medicines Storage and Security - Medicines administration rounds	£ 20,000	6	D	
	Medicines Storage and Security - Air conditioning for medicines rooms	£ 25,200	3	D	
	Medicines Storage and Security - Bedside lockers keyless access	£ 115,000	6	X	
	Medicines Storage and Security - Medicines storage upgrade	£ 2,000,000	6	X	
	Interventional Radiology Suite	£ 900,000	8	B	
	Replacement of dispensary windows	£ 25,000	?	C	
	Medicines Storage and Security - Access to medicines rooms	£ 102,000	6	X	
	Medicines Storage and Security - Access to medicines cabinets	£ 322,500	6	X	

5. Summary of Allocation: Estates and Capital

a. Divisional requests and proposed allocations

- The Estates Division submitted capital bids to the value of £10.4m
- None of 21/22 capital schemes are able to be purchased in 20/21
- The table below summaries the proposed allocations, totalling £2.4m

Table: Requests

DIVISION	TOTAL BIDS
ESTATES	£ 10,364,062

5. Summary of Allocation: Estates and Capital

NHS Wirral University Teaching Hospital NHS Foundation Trust

ESTATES - TOTAL BID £6.373M				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Phase 1: Refurbishment of Floor surfaces across Arrowe Park Hospital	£	76,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Phase 1 : Patient Bathroom Refurbishments	£	170,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Informatics Relocation and Refurbishment of Post Grad - CGH	£	450,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Pipework within plant areas mostly past replacement. Original distribution to circulation/minor areas and services to above	£	401,624	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Doors past repair, penatrations through 60min walls and damper failures likely.	£	366,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Hot & Cold Water Systems aged systems	£	51,240	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Hot & Cold Water Systems aged systems	£	57,340	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Ventilation Systems - aged systems	£	14,640	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Ventilation/Heating Systems - aged systems	£	7,686	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Deteriorated mortar joints to brickwork, presumed poor original mortar leaving large gaps between joints which in turn have been expanded due to frost heave distorting the PVC windows above	£	24,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Aged System - obsolete equipment	£	122,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Windows in uneconnomical state of repair: M1 &M3 CGH	£	360,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	Aged surfaces	£	183,000	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	High risk, beyond econonical repair. 250m main gas service pipe.	£	58,560	N/A	D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	D Sub - High Voltage Transformer	£	61,000	N/A	C/D	Equipment or estate not operating creating risk to the Trust (Category rating C-D and divisional risk 12+)
	TOTAL	**£**	**2,403,090**			

5. Summary of Allocation: Estates and Capital

NHS Wirral University Teaching Hospital NHS Foundation Trust

ESTATES - TOTAL BID £6.373M				RISK RANK	NHS RANKING
REJECTED	APH Site Water Main Replacement	£	490,147	N/A	C
	Primary Substation High Voltage Switchgear.	£	122,976	N/A	C
	Ventilation Plant 3	£	183,000	N/A	CX
	Ventilation Plant 4	£	183,000	N/A	CX
	Cal 2 Boiler	£	109,800	N/A	CX
	Gym relocation	£	488,000	N/A	D
	Medical gas systems W&C GF	£	87,840	N/A	C
	Medical gas systems W&C FF	£	98,088	N/A	C
	Medical gas sytems main block GF	£	101,016	N/A	C
	Medical gas systems main block ward areas.	£	397,849	N/A	CX
	Ronald McDonald House Electrical switchgear	£	31,110	N/A	C
	Plant/SW RMS/Hotel Services/Med Rec/Stores. Switchgear	£	62,830	N/A	CX
	Plant/SW RMS/Hotel Services/Med Rec/Stores. Distribution Boards	£	30,500	N/A	C
	Plant/SW RMS/Hotel Services/Med Rec/Stores. Wirring	£	103,700	N/A	C
	Wards 17,18/Medical Short Stay/Ambulatory Care Unit	£	18,910	N/A	C
	Drainage updrade	£	244,000	N/A	C
	Catering/Plant and switch rooms/Medical Records/Stores heating pipework	£	142,130	N/A	C
	Catering Extract Fans	£	42,700	N/A	CX
	Medical Vacuum BOC 120 compressors x2	£	117,120	N/A	CX
	Medical Vacuum BOC 70 compressors x2	£	97,600	N/A	CX
	Ward Ventilation Sytems	£	219,600	N/A	D
	Ward Wiring Systems	£	549,000	N/A	CX
	W&C Block - Fire Alarm	£	183,000	N/A	CX
	Roofing Replacement Phase 1. Part of out year planning.	£	488,000	N/A	C
	Staff Change Rooms and Rest Facilities (Phase 2)	£	366,000	N/A	C
	Integrated Pollution Prevention and Control	£	219,600	N/A	CX
	Health & Safety, infection control upgrade/improvements	£	183,000	N/A	D
	Emergency Critical asset replacements	£	610,000	N/A	C
	Improvements access control of rooms throughout the site facilities - keys	£	244,000	N/A	C
	Chilled Water System Upgrade	£	305,000	N/A	D

5. Summary of Allocation: Facilities (Soft FM)

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Facilities Division submitted capital bids to the value of £468k
- None of the 21/22 capital schemes have been purchased in 20/21
- The table below summaries the proposed allocations, totalling £390k

Table: Requests

DIVISION	TOTAL BIDS
SOFT FM	£ 468,000

SOFT FM - £390K				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Decontamination Unit Refurb and Equipment renewal	£ 120,000		12	D	•Impact of current equipment or estate on patient and/or staff safety
	Catering refurbishment at APH and CBH	£ 120,000			D	•Impact of current equipment or estate on patient and/or staff safety
	The cleaning cupboards used to store the equipment used to clean the hospital at both sites have had no investment in some cases since the Trust was built.	£ 110,000			D	•Impact of current equipment or estate on patient and/or staff safety
	Bowman's Refurbishment	£ 40,000			C	New or replacement equipment or estate supports staff wellbeing
		£ 390,000				

5. Summary of Allocation: Informatics

Wirral University Teaching Hospital NHS Foundation Trust

a. Divisional requests and proposed allocations

- The Informatics Division submitted capital bids to the value of £4.7m, including some bids which were part of the 21/22 GDE commitments.

- £1,138k of 21/22 capital schemes have been purchased in 20/21

- The table below summaries the proposed 21/22 allocations, totalling:
    - £400k – Core
    - £304k – GDE (pre-commitments)

Table: Requests

DIVISION	TOTAL BIDS
IT CORE BIDS	£ 3,218,400
IT DIVISIONAL BIDS	£ 1,513,000
TOTAL	**£ 4,731,400**

Table: 21/22 Schemes to be purchased in 20/21

IT CORE - TOTAL BID £3.380M				RISK RANK	NHS RANKING
POTENTIAL B/F SPEND	IT Equipment	£ 400,000			
	PACS	£ 340,000		8	C/D
	UPS refresh	£ 170,400		8	C/D
	Total	£ 910,400			

IT DIVSIONAL - DIVISIONAL BID £1.204M				RISK RANK	NHS RANKING
POTENTIAL B/F SPEND	PACS	£ 228,000			D

5. Summary of Allocation: Informatics : Core

IT CORE - TOTAL BID £3.380M				RISK RANK	NHS RANKING	ALIGNMENT TO PRINCIPLES
FUNDED	Cerner Domain refresh - requirement to keep Cerner solutions upto date on appropriate code instance	£ 300,000		N/A	Contractual	Contractual requirement
	PACS Implementation	£ 100,000		8	D	
	Total	**£ 400,000**				

DEFERRED	Learning Management system to provide assurance of pre-requisite clinical system skills , contextual training materials (video / play domain)	£ 60,000		9	X
	Replacement Service desk and integrated resource system Automated test script solution for development and analyst build	£ 120,000		6	C/X
	Replace current backup solution with an Imutable solution as recommended by NHSD Backup review Audit to protect against randsomware threats. Imutable storage offers change protection preventing Cyber attacks on backup storage which is a common pre attack method.	£ 150,000		10	B/X
	Forcepoint firewalls end of contract in Nov - 2022. Plan is to replace all end of contract Forcepoint firewalls in 2022 using National firewalls for advanced threat protection. APH firewalls to move to CGH and additional PaloAlto firewall purchased to make existing CoCH firewall resilient and used for APH traffic.	£ 120,000		10	C/D
	Trust has been notified by Cerner to deprecate the current PIEDW data warehouse by 2023. Solution to build an inhouse datawarehouse with requiremet for real time extraction toolsets	£ 120,000		12	X
	Network core should last between 5 - 7 years 5 years old in Sept 20 - extended support until Oct 21 and can extend 1 more year. Aim to start full review and tender process in Qtr 2/3 2021 - to award and start project replacement in Q4/Q1 22/23	£ 1,500,000		10	B/X

5. Summary of Allocation: Informatics : Divisional

IT CORE - DIVISIONAL BID £1.204M				RISK RANK	NHS RANKING
DEFERRED	Upgrade to Cerner Global PAS solution	£	220,000		X
	Bleep Replacement extended contact support (Oct 21) for over 700 bleeps - Govt mandate to commence cease use of bleeps by end of 2021.	£	420,000		D
	Replacement fetal monitoring solution	?			X
	Indicative quotes on site wide passive and active tagging solution	£	336,000		X

5. Summary of Allocation: Informatics : GDE (pre-commitment)

NHS Wirral University Teaching Hospital NHS Foundation Trust

NAME OF SCHEME	ESTATE OR EQUIPMENT DESCRIPTION AND REQUIREMENT (MAX 100 WORDS)	ESTATE OR EQUIPMENT TO BE PURCHASED	DIVISIONAL CAPITAL BID FORM OR BRIEF DEVELOPED AND ATTACHED (>£75k requests)
Oncology Solution Build	The Trust has confirmed preference to implement the Cerner Oncology Chemotherapy ePrescribing solution instead of testing the market for alternative system providers.	**Option 4: Cerner oversee 25% of the regimen rebuild = £46,000**	£46,000
Closed Loop Medicines	Capitalised staff support costs - Trust previously committed to move towards closed loop meds in 2017 GDE Programme and was funded accordingly - this is the provisional balance of capital	Capitalised staff support costs - Trust previously committed to move towards closed loop meds in 2017 GDE Programme and was funded accordingly - this is the provisional balance of capital	£45,000
ECG Cerner Interfaces	Interface solution for ECG Device output into Cerner - One Patient Record Project	Interface solution for ECG Device output into Cerner - One Patient Record Project	£63,000
Neonatal - Infusion Pump Interfaces Cerner	Interface solution for 10 workstation / pumps (software and professional services only) Indicatove Cerner costs 65k - Indicative BBraun - 85k	Interface solution for 10 workstation / pumps (software and professional services only) Indicatove Cerner costs 65k - Indicative BBraun - 85k	£150,000
	total		£304,000

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22-14

BOARD OF DIRECTORS

07 APRIL 2021

Title:	International Nurse Recruitment Update
Responsible Director:	Claire Wilson, Chief Finance Officer Hazel Richards, Chief Nurse Jacqui Grice, Executive Director of Workforce
Presented by:	Claire Wilson, Chief Finance Officer

Executive Summary

This report provides an update on the Trusts international nurse recruitment and sets out the non-recurrent costs associated with the campaign. The Trust has been successful in securing funding from NHS Improvement to fund a significant proportion of the costs but will need to contribute to this investment utilising its own revenue funding.

The Finance, Performance and Business Assurance Committee has revied the proposal and has recommended that the Board:

- Note the costs of the programme across the 3 cohorts of nursing recruits and the external funding associated with this.
- Approve the additional Trust contribution of £519k which will be funded from non-recurrent revenue funding.
- Note the proposal for benefits review in 12 months

Recommendation:

For approval.

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	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)	
Risks set out in the paper include impact on run-rate of filling nurse vacancies and need to manage other overspending budgets robustly.	
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)	
Supports reduction in agency and bank costs.	
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 review of workforce modelling assumptions underpinning the recruitment decisions.
Background papers / supporting information	NA

1. Executive Summary

1.1. This report provides an update on the Trusts international nurse recruitment and sets out the non-recurrent costs associated with the campaign. The Trust has been successful in securing funding from NHS Improvement to fund a significant proportion of the costs but will need to contribute to this investment utilising its own revenue funding

1.2. The Finance, Performance and Business Assurance Committee has revied the proposal and has supported the recommendations to the Board.

2. Background

2.1. In November a paper was taken to Trusts Management Board regarding the high vacancy rate within Nursing and recommending the recruitment of 22 nurses from overseas through NHSP. This was considered as a business case which set out a compelling case from both a quality and financial perspective of ensuring that our nursing vacancies were filled.

2.2. The paper set out the cost of recruitment and estimated that this would be £219,934, or £9,997 per nurse, which it was estimated would be paid back through savings in agency and overtime costs.

2.3. In January 2021, the Trust was informed of additional funding of £7,000 per nurse for up to 100 nurses (£700,000) so the Trust sought to utilise this funding for our initial recruitment and agreed to recruit a further 86 nurses through the Pan Mersey framework.

2.4. In addition, the Trust is to recruit a further 28 nurses prior to December 2021 using Strand B monies utilising the Pan Mersey framework. This brings the total recruitment figure to 136 international nurses.

2.5. This paper sets out the current costs of the larger programme and a proposal for how the Trust funds its share.

2.6. The Board of Directors are asked to approve the costs being borne by the Trust. It is also proposed that a benefit review is undertaken in 12 months to assess both the financial and non-financial impact of the campaign and identify any learning for future intakes.

3. Non-recurrent cost of recruitment

3.1. Nurse recruitment is a key NHS Improvement priority and funding has been provided to support a series of International recruitment campaigns. The Trust is now pursuing international recruitment within 3 separate funding arrangements where the non-recurrent costs of recruitment are funded as follows:

- 8 WTEs internally funded as an initial pilot (originally 22 WTEs but 14 WTE re-badged to winter funding)
- 100 WTE Pan Mersey collaborative funded from winter monies
- 28 WTES ‘Strand B’ monies.

3.2. The extent of the external funding per WTE is different for b) and c) above, with b) being funded at £7k per nurse and c) at approx. £2k per nurse.

3.3. The Table below sets out the total non-recurrent costs of International recruitment across the 3 cohorts.

Table 1: Non-Recurrent Cost of Recruitment of 136 International Nurses

	Total Cost	2020/21	2021/22
Costs			
NHSP Placement Fee	£364,800	£292,000	£72,800
Certificate of Sponsorship	£27,064	£21,492	£5,572
Immigration Skills Charge	£408,000	£324,000	£84,000
Migration Medical Certificate	£6,800	£5,400	£1,400
UK Visa	£63,104	£50,112	£12,992
One-Way Flight to UK and transfers	£71,200	£9,900	£61,300
3 Month Free Accommodation	£163,200	£8,800	£154,400
Welcome Package	£6,800	£1,100	£5,700
NMC Application	£19,040	£15,120	£3,920
OSCE Training	£85,600	£11,000	£74,600
COVID Testing	£28,560	£4,620	£23,940
OSCE training travel and accommodation	£13,538		£13,538
Bedding and towelling	£8,840	£7,020	£1,820
Additional NHSP charge	£2,400	£2,400	£0
OSCE Test	£107,984		£107,984
International Recruitment Pastoral Lead (B7 mid scale)	£51,227	£12,807	£38,420
Practice Education Facilitator (B6 mid scale)	£41,334		£41,334
Administrative support (B3 mid scale)	£25,909		£25,909
Total cost	**£1,495,399**	**£765,771**	**£729,629**
Funded by			
TMB approved funding [Note 1]	219934	£219,934	£0
Winter Monies [Note 2]	£700,000	£26,371	£673,629
Strand B monies [Note 3]	£56,000		£56,000
Request for additional funding [Note 4]	***£519,465***	***£519,466***	***£0***
Total funding	**£1,495,399**	**£765,771**	**£729,629**

Note 1: The initial request for £219,934 for funding was approved by TMB in November.

Note 2: Funding of £700,000 (£7,000 per nurse) is available from NHSE/I to support onboarding, quarantine and testing requirements, induction, education, health and wellbeing and OSCE training. This funding is dependent on the nurses arriving before October 2021 and passing the OSCE test before March 2022. Minimal OSCE tests will have been completed prior to 31st March so most of this funding will not be confirmed until 2021/22.

Note 3: We will receive £2,000 per nurse in respect of Strand B monies.

Note 4: Assuming that the NHSI funding is received in full, albeit on a staggered basis and subject to conditions, this leaves a funding gap of £519,465 that requires approval.

4. Financial risks and mitigations

4.1. Non-nursing overspends

The nurses being recruited will each take up a vacant position once training is complete. This means that the recurrent costs of their salaries are funded within current budgeted establishments. It should be noted that previously underspending nursing budgets will no longer be available to support overspends in other budgets and so it is important that operational overspends are robustly manged and mitigated where required. This may include reviewing wards budgets to identify any posts which were being used to compensate for nursing vacancies but are not funded.

4.2. Workforce modelling assumptions

The extent of the recruitment has been determined by workforce planning assumptions. Given the incremental nature of the IR decisions needing to be taken and the speed at which the NHSI bidding process requires responses from Trusts it is important that the Trust reviews its workforce modelling to ensure that the underpinning assumptions are robust. This exercise has been carried out and is subject to a paper being considered by Workforce Assurance Committee in March 2021 (attached in appendix 1 for information).

4.3. Changing circumstances

Given the challenging waiting list position facing the NHS post COVID-19 and the expected increase in referrals as the NHS returns to pre-pandemic levels, it is highly likely that the Trusts requirement for nursing will increase, rather than reduce, over the next 2-3 years. However, there is an informally agreed position in Cheshire and Merseyside that any nurses recruited above an individual Trusts requirement will be managed across the system to support areas where gaps exist.

5. Recommendations

The Finance, Performance and Business Assurance Committee has revied the proposal above and has recommended that the Board:

- Note the costs of the programme across the 3 cohorts of nursing recruits and the external funding associated with this.
- Approve the additional Trust contribution of £519k which will be funded from non-recurrent revenue funding.
- Note the proposal for benefits review in 12 months

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 21/22-015

Board of Directors
7 April 2021

Title:	NHS North West Black Asian and Ethnic Minority (BAME) Strategic Advisory Committee (the Assembly)
Responsible Director:	Jacqui Grice, Executive Director of Workforce
Presented by:	Sharon Landrum, Diversity and Inclusion Lead / FTSU Guardian

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

The North West NHS has established a Black, Asian and Minority Ethnic (BAME) strategic advisory committee (otherwise known as the Assembly), comprising of over 70 NHS leaders from BAME backgrounds.

They aim to bring together and harness the collective will of the system with a vision of ensuring "significant and sustained change within the NHS, based on what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism".

A letter was sent from the co-chairs of the North West BAME Strategic Advisory Committee (Assembly) on 18 November 2020 to all NHS Chairs, Chief Executives and Accountable Officers for the North West (copy attached at appendix 1).

The letter was accompanied by supporting documentation and sought to provide an overview of the newly developed assembly, including its vision and objectives and asked Trusts to provide a response and "call to action".

The Assembly asked for 3 key components:

1) A written response setting out our commitment to their mission, aims and objectives, by 18 December 20
2) For conversations to take place with Trust staff around racism issues and inequalities, using their information as a catalyst for discussions
3) For information to be shared across the Trust on the assembly itself

This report therefore seeks to provide an overview on who the BAME assembly are, what their mission and objectives are and to provide assurance on our response and commitment (appendix 2).

The assembly are hoping to work with organisations across the North West to develop action plans that leverage the collective power of the region acting together, to make a lasting change.

Recommendation: (e.g. to note, approve, endorse) *What action / recommendation is needed, what needs to happen and by when?*
Paper is for noting

Which strategic objectives this report provides information about:	
Outstanding Care	Yes
Compassionate Workforce	Yes
Our Partners	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)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
The contents of this paper support best practice to uphold Equalities legislation, public sector equality duties, commissioner and CQC requirements
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)
The contents of this paper seek to advance equality of opportunity and experiences for staff and patients.
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	Appendix 1 – letter to Trusts from the BAME Assembly Appendix 2 – Trust's response Appendix 3 – Assembly mission and objectives Appendix 4 - Cheshire and Merseyside Health and Care Partnership (CMHCP) Pledge

Board of Directors
7 April 2021

NHS North West Black Asian and Ethnic Minority (BAME) Strategic Advisory Committee (the Assembly)

Purpose

The purpose of the report is to:

1) provide an introduction to the newly established NHS North West BAME Strategic Advisory Committee (The Assembly)
2) provide members with a copy of the Trust response that was developed and submitted to the assembly in December 2020, following a "call to action".
3) Highlight work undertaken so far and further actions required to support our BAME staff and patients

Introduction / Background

The North West NHS took the decision to establish a Black, Asian and Minority Ethnic strategic advisory committee (otherwise known as the Assembly). The committee comprises of over 70 NHS leaders from BAME backgrounds and aims to bring together and harness the collective will of the system.

The committee is chaired jointly by Evelyn Asante-Mensah, Chair of Pennine Care NHS Foundation Trust and Bill McCarthy, Regional Director for NHS England-Improvement.

The Assembly's vision is "for a significant and sustained change within the NHS, based on what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism.

A smaller working group was established to identify a set of priorities, which form the basis of the committee's programme. More information about the Assembly and its mission and objectives are attached at appendix 3 and via the following links: https://www.england.nhs.uk/north-west/north-west-black-asian-and-minority-ethnic-strategic-advisory-group/ and https://youtu.be/UcQOdP7mtGw

A letter was sent from the co-chairs of the Assembly on 18 November 2020 to all NHS Chairs, Chief Executives and Accountable Officers for the North West with a response required by 18 December 2020 (copy attached at appendix 1). The Trust response is attached at appendix 2.

3 key components were asked of Trusts:

1) A written response setting out our commitment to their mission, aims and objectives
2) For conversations to take place with Trust staff around racism issues and inequalities, using their information as a catalyst for discussions
3) For information to be shared across the Trust on the assembly itself

WUTH's Current Position

The Trust has been working hard to raise awareness of the importance and significance of equality, diversity and inclusion, with a variety of work streams undertaken.

It has also put a variety of measures in place to encourage staff who shared protected

characteristics, to speak up, share lived experiences, identify challenges and barriers and encouragement to be involved in making improvements and developing new ways of working moving forwards (included within the Trust's response at appendix 2).

The Trust hasn't however previously issued any specific statements regarding racism specifically, however has integrated wider equality, diversity and inclusion messages within revised core values and continues to work on embedding these across core functions.

At WUTH we recognise that further work is required to support our BAME staff and community members and to reinforce the Trust's position with regards to racism and tackling inequalities therefore the information and support provided by the assembly should be integrated as we move forwards.

Cheshire and Merseyside Health and Care Partnership (CMHCP) Pledge

The CMHCP have recently developed a pledge that it hopes all Trusts will sign up to. Jacqui Grice, Executive Director of Workforce is one of the HR Director leads for the partnership and as such, has been involved in the development of the pledge and positive way forward. The pledge is attached at appendix 4.

The pledge calls on organisations across the North West to work collaboratively and:

a. look inwards and recognise that we all have a role in addressing these inequalities and structural racism.
b. work together with our communities across all sectors to create a better future in which everyone enjoys the same freedoms, rights and opportunities in Cheshire and Merseyside.
c. Constructively challenge one another and sometimes engage in uncomfortable conversations that enable us to arrive at better decisions for our staff and our communities.

It is hoped that as a collective partnership, pledging consistent attention and actions which are visible and practical to tackle the deep-rooted issues that lie behind systemic racial inequalities, whilst is not the complete answer, are concrete steps towards reducing inequalities, creating an atmosphere of inclusiveness in our workplaces and cultivating meaningful change for our communities.

The Trust's response to the assembly is therefore that in addition to the work already undertaken, it will work in collaboration with colleagues across the region to achieve the objectives laid out within the CMHCP Pledge.

Call to Action

WUTH, along with all organisations are being called to action to proactively take steps to eliminate racism within our workplaces and within our communities.

Whilst some great work and improvements have been seen to date, we need to consider what further action is needed and what we will do to make the changes needed.

The CMHCP pledge highlights that "it is no longer enough for us simply to stand up and condemn racism, we must be actively anti-racist".

Conclusions

The Trust has responded to the requirements of the assembly and shared its commitment to their mission and objectives, however, ensuring we fulfil this commitment and continue to take positive action to move forwards to tackle racism and inequalities is critical.

Information regarding the assembly and the Trust's commitment to being anti-racist has already started to take place, with specific declarations made by the Trust during the first ever National Race Equality Week in January 2021 and preparations made with BAME staff network members to "Show Racism the Red Card" for the International Day of the Elimination of Racial Discrimination on 21 March 2021.

The assembly information and CMHCP pledge has also been shared and the Trust's BAME staff network will be pivotal to discussions as to how best to move forwards. Network members have already been sharing thoughts and suggestions and therefore updates on progress made will be provided at subsequent meetings.

The Trust must also continue to link with community partners e.g. Wirral Change and Wirral Multi-cultural Organisation so as to further understand the needs of our BAME community and to foster relations and best practice moving forwards.

Recommendations to the Board

1) All members to review the mission and objectives of the assembly and CMHCP pledge
2) Members to review the further actions identified within the Trust's response to the assembly
3) All members to acknowledge their individual responsibilities with regards to tackling inequalities and racism and consider what if any further actions are required.

Ref BMc EA KMcB 2020-11-18

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North West Region
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Manchester
M1 3BN

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TO ALL NHS CHAIRS, CHIEF EXECUTIVES AND ACCOUNTABLE OFFICERS FOR THE NORTH WEST

By email

18 November 2020

Dear Colleagues

During this second wave of Covid-19, it is important that we learn the lessons from earlier in the pandemic for our communities and the impact on the services we provide, in order to minimise the disproportionate effect the virus has on our BAME colleagues and communities. The North West continues to be one of the regions which is most affected by the high levels of community transmission of COVID. Fourteen out of the fifteen local authority areas with the highest COVID prevalence in over 60 years are in the region: and it is not therefore surprising that hospital admissions are high and growing and pressure remains intense in all parts of our systems, including primary, community, mental health and social care.

Black History Month provided us all with an opportunity to reflect on the progress that has been taken to confront racism within our organisations and wider society and to shine a light of the contribution of our BAME colleagues to the NHS. We are clear that racism has no place in our NHS and as leaders in our organisations and our systems, we must all make sure that equality is intrinsic in everything we do. We want our NHS in the North West to be clearly and unashamedly anti-racist, which means working to dismantle the structures that mean it is difficult for our BAME communities to access services and to enter the NHS workforce and progress.

Many colleagues are tired of and frustrated by the repeated pattern they see in how the NHS approaches the issue of BAME inequalities. Action rather than just talk is an imperative. Committing consistent attention and action over the long period of time is needed to tackle the deep-rooted issues behind inequalities is a must.

As an Assembly, we want to work with our North West organisations to develop action plans that leverage the collective power of the region acting together, to make a lasting change. Our members are a group of senior BAME leaders, with invaluable collective knowledge and experience, who can provide advice and guidance on the vital steps needed to tackle the deep-rooted issues behind inequalities.

The Assembly has now developed its vision, mission and identified its priorities. We ask that you:

1. Consider the attached statement from the Assembly and provide us with a response from your organisation, setting out your commitment to supporting our vision, mission and objectives. As part of your response, describe your aspirations in terms of tackling racism and inequalities and the actions you will take. The Assembly will consider these plans and identify areas where we can focus additional support (please complete the template provided).

2. Use the statement as a catalyst to have further discussions within your own staff about the issues of racism and inequality and to inform the development of your organisation's response. We know that many of our colleagues from all backgrounds across the region want to engage and stand up to racism but are sometimes fearful of saying the wrong thing and causing offense. It is only by encouraging safe space conversations that we can shine a light on the experiences of BAME staff.
3. Share information provided about the Assembly with your staff. To support this, we have provided the following:

   - A link to a short film, which can be shared with staff
   - Content for your staff intranet sites and bulletins
   - A set of slides to guide conversations with staff

We will have a discussion on this topic at the next meeting of the Chairs' forum at the end of November. It would be good if you could come prepared to give an overview of the following:

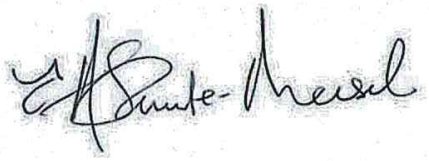
- How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities
- How you plan to link with the Assembly and its members, to support the development of your response to our statement
- How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme

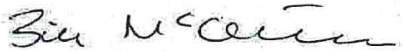
We would ask that you return your responses to our statement with us by close of play on Tuesday 22 December. We will be pulling responses from all NHS organisations together in a report for the Assembly to consider at its next meeting in January.

In the meantime, if you want to discuss anything further about our agenda, please either of us as co-chairs of the Assembly, Anthony Hassall or Raj Jain, who are also supporting the Assembly.

May we also take this opportunity to thank you for the leadership and ongoing commitment you and your teams have demonstrated to tackling inequalities. It is only through working collaboratively together as a region that we will be able to confront racism to become anti-racist and reduce health inequalities.

Yours sincerely,





Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Chair Pennine Care NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Executive Regional Director (North West)

North West Black, Asian and Minority Ethnic Strategic Advisory Committee

Response to the Assembly Statement

1. The Assembly has set out its vision, mission and objectives, to support the NHS in the North West to be anti-racist; please describe your own organisation's commitment to achieving this

Wirral University Teaching Hospital is working collaboratively with the Cheshire and Merseyside Health and Care Partnership, with Jacqui Grice, Director of Workforce acting as one of the HR Director Leads for the partnership. Our Diversity and Inclusion Lead is also actively involved in the Cheshire and Merseyside equality focused forums and together we are striving to not only improve experiences within our Trust, but the wider communities across the region and beyond.

As such, we are committed to ensuring that the pledges made across the Cheshire and Merseyside Health Care Partnership are embedded within our own organisation and that work actively takes place to not only promote these, but that actions are taken to ensure they are achieved, with ongoing monitoring and review along the way.

"As a partnership, we are collectively pledging consistent attention and actions which are visible and practical to tackle the deep-rooted issues that lie behind systemic racial inequalities" (C&M Health Care Partnership).

We have also been a part of the recent NHSE/I commissioned Inclusive Leadership Project, to not only hear the views of others and learn lessons of how we can improve, but to contribute nationally on how best to move things forwards and bring about systemic change.

Internally, we have established a BAME Staff network, with regular meetings taking place and membership growing slowly and steadily.

An Executive Partner has now been identified, with plans underway to not only further promote the network and encourage staff to be involved, but to ensure Trust affirmation and leadership on its commitment to ensuring anti-racism. Trust communications will also include the pledges of the wider C&M Health Care Partnership and information provided by the BAME Strategic Advisory Committee.

Wirral University Teaching Hospital is committed to trying to understand the views of our BAME staff and community and ensuring involvement in actions to move forwards. As such we also recognise the need for additional BAME leaders and have appointed a Freedom to Speak up (FTSU) Guardian who is also a member of our BAME staff network. We have identified and promoted additional BAME FTSU champions who are encouraging staff to speak up, get involved and share their experiences with us. They have also shared videos of encouragement to fellow BAME colleagues to promote the importance of completing health risk assessments.

Additional areas of commitment include:

i) Diversity and Inclusion Lead appointed and governance structure established so as to identify issues and suggestions to move forwards and ensure monitoring of key actions
ii) LGBT+ and disability staff networks are also established and will be further built on to explore greater levels of intersectionality

iii) Reverse mentoring agreement in place
iv) Trust values and behaviours reviewed and integrated within key processes
v) Challenging examples of poor attitudes and behaviours and conducting cultural reviews to identify key strengths and challenges within areas and;
vi) Reviews / investigations undertaken where breaches to Trust's values and behaviours exist
vii) Links made with regional and national D&I Leads and work streams that support identification of best practice and contribute to identifying improvements moving forwards
viii) The Trust has signed up to be a third party reporting centre in collaboration with "StopHateUk" and is incorporated within Safeguarding mandatory training sessions.

Further actions are also under planning, which will involve:

i) Appointment to BAME staff network leadership roles
ii) Further links with local community organisation Wirral Change to develop greater links with our BAME community members; support cultural awareness development sessions; greater employment support links; wellbeing support; raising the profile of the Trust to the BAME community and encouragement to apply for all roles including Trust Board management and greater awareness of local health inequalities.
iii) Review of capacity to ensure sufficient to deliver the actions required

2. Please share the key points from feedback you have had from staff within your organisation, which has helped you to shape this commitment

We have received feedback from our staff in a variety of ways including:

i) Workforce Race Equality Standard (WRES) reports (which includes staff survey and workforce information data)
ii) National annual survey data
iii) BAME focus group
iv) BAME staff network
v) D&I Lead – during D&I developmental sessions; within local areas or when contacted via individuals. The number of BAME staff speaking up has significantly increased this year, with staff reporting they feel more comfortable to now speak up
vi) Via Freedom to Speak Up team members, when concerns have been raised
vii) Via HR and staff side colleagues

Key points:

1) The data shows that the experience for BAME staff is less positive than non-BAME colleagues in a number of areas. Whilst this is highlighted within the data, the gap is however narrowing and the Trust has seen a number of positive improvements in the staff survey data this year.
2) The increase in the number of BAME staff speaking up and now becoming involved in the staff network allows a greater opportunity to hear the concerns of staff, to try and understand the views and experiences of others and understand how best to move forwards to address.
3) Lack of BAME representation at Board level
4) Disproportionate BAME representation between clinical / non-clinical roles and across pay grades – 9% difference between clinical and non-clinical BAME representation
5) BAME staff are less likely to speak up and seek support, raise concerns and challenge poor behaviour

3. Please give an overview of what you are going to do differently as a senior leadership team, in order to put this commitment in to action

Wirral University Teaching Hospital will be ensuring a firmer approach with regards to anti-racism and will ensure that clear messages are delivered across the organisation and led by the senior leadership team.

The Trust will continue to work with its internal staff network to build on the foundations already laid and ensure actions are taken in order to achieve the objectives and pledges agreed as part of the Cheshire and Merseyside Health Care Partnership. We will also be embarking on a cultural awareness development programme to ensure all staff are aware of not only the challenges faced but the responsibilities required of them and the Trust in order to make change.

Specific activities will include:

i) Individuals encouraged to step out of comfort zones and create listening opportunities/ reverse mentoring with BAME colleagues and strive to understand the challenges - promoting others to do the same
ii) Link with Merseycare's BAME staff network and recent cultural awareness training, for roll out of a cultural awareness developmental programme including conscious / unconscious bias training
iii) Link more with BAME specific community support organisations
iv) New senior leadership roles considered and links made with BAME communities to promote.
v) Review D&I KPI's and priorities agreed
vi) Regular updates reviewed throughout the D&I governance structure with monitoring in place to ensure achievement
vii) Capacity review to ensure sufficient capacity is in place to deliver the actions needed
viii) Link with Trust communications and engagement team to ensure heightened communications on key messages across a range of media platforms – led by the senior management team
ix) Ensure actions are taken where Trust values and behaviours appear to be breached
x) Provide support to managers across the organisation in understanding how to recognise and deal with racist actions

4. Given where we are with the second wave of the pandemic, please give an overview of how you are going to focus on some immediate challenges facing our BAME colleagues and communities i.e.:

- **The health and wellbeing of staff, in particular building on risk assessments for BAME staff**

Wirral University Teaching Hospital is committed to ensuring the health, safety and wellbeing of its staff and due to the emerging disproportionate effects of COVID-19 on BAME people, where one of the earlier Trusts to include ethnic origin on our health risk assessments.

We were also keen to ensure all available support was on offer for our BAME staff and so identified the following in addition:

i) BAME FTSU Champions
ii) Video messages from BAME colleagues to encourage completion

iii) A range of communication mechanisms to reach individuals colleague, including personal phone calls (where details known) and 1:1 support offered.
iv) Proactive response to call for action request, whereby the Trust developed an innovative programme to not only offer a free one-month supply of Vitamin D for all BAME staff, but included a Pharmacy led screening process with Vitamin D and bone profile blood test (to support additional health surveillance) was included and referral process to GP and Occupational Health Support as appropriate.
v) A range of wellbeing support options including on site wellbeing hubs, counselling and psychological wellbeing support and continuous Trust wide promotion of a range of support services

Our completion rate was the highest locally, however need to ensure we can continue to build on this with new staff and also ensuring those hard to reach staff are reached.

The health risk assessment form has been further reviewed in line with emerging guidance and Occupational Health link with BAME staff network.
Further actions include:

i) Continued monitoring of individual compliance with health and environmental risk assessments
ii) Further Trust communications to encourage staff to complete risk assessments
iii) Further promotion of our BAME FTSU Guardian and Champions as key contact points
iv) Staff network to be re-energised with promotion from new Executive Partner. Encouragement for BAME staff members to take up leadership roles and creation of BAME visible leaders
v) HWB hub established at CGH and APH with staff to support signposting to additional services as necessary
vi) Meeting scheduled with Wirral Change community organisation to ensure further links and support
vii) Continue promotion of HWB offerings including Chaplaincy and spiritual care and culturally sensitive counselling / talking therapies

- **Support for your BAME staff networks and effective communications with them in general**

As the Trust's BAME staff network is newly established, The Trust's D&I Lead is currently the chair. The D&I Lead is also the FTSU Lead Guardian and as such, seeks to offer a range of specific levels of support for the network and individuals themselves. That said, as the D&I Lead is non-BAME, open discussions have taken place with members to understand how best to ensure support and progress moving forwards.

The Trust is therefore embarking on a communications plan as detailed above, which will include encouragement for new network leads to come forward. The D&I Lead will still continue to offer support to the network and maintain the link with the wider organisation and ensure support and continuity is available.

The D&I Lead / network chair is linked in to wider local, regional and national collaboratives and as such, ensures that the network is kept up to date and also shared feedback from the network to the wider system. She is also in regular attendance at a variety of Trust senior leadership meetings and provides regular feedback and updates on progress and challenges faced.

Additional support mechanisms:

i) The D&I Lead and future network leaders will be also be linked in to the new Cheshire and Merseyside BAME Staff Network Leaders forum for personal support within the role.
ii) Links made with local BAME staff networks and joint working and support options to be explored.
iii) Trust BAME staff network mailing list to where staff can register to keep in touch and be involved on an ongoing basis.
iv) A new social media platform is also be currently explored for less formal interaction amongst members.
v) Executive Partner now linked to future network meetings and to meet regularly with the Chair
vi) Network chairs attendance at senior leadership meetings
vii) Implementation of Cultural Ambassadors is currently being explored with staff network members

- **The take up of the flu and the Covid vaccines by staff in particular BAME staff**

The Trust developed a flu plan which has been monitored and supported by a dedicated task and finish group, with a number of actions identified and completed.

The Trust has trained a series of peer vaccinators to offer flu vaccines locally along with providing a range of alternative options for staff to receive. There have been consistent Trust wide communications to promote and offer support, capturing information regarding those who have also received elsewhere.

The Trust is also proud to support one of the three chosen vaccine Hospital Hubs for Cheshire and Merseyside, and as such, are involved in the planning and delivery of COVID-19 vaccinations to our staff and community.

With particular reference to BAME staff:

i) We have currently managed to vaccinate more BAME staff than non-BAME
ii) In addition to general Trust communications, additional communications have been circulated through our D&I Steering group and specifically to our BAME staff network members. The Occupational Health Manager has attended a staff network meeting to discuss and capture any feedback or concerns
iii) Feedback from BAME staff network members captured

- **Ensuring BAME communities are not disproportionately impacted by any temporary changes to services; and that as services are brought back on line, health inequalities are not made worse**

The Trust developed and equality analysis policy in 2018 and reviewed it's processes to ensure that equality analysis / impact assessments were conducted as necessary to ensure any potential impacts were considered and actions taken to overcome or reduce any potential negative effects.
An equality analysis / impact assessment was completed during the onset of COVID-19 and has subsequently been reviewed to reflect second wave considerations. This analysis encompasses local, regional and national considerations and has been developed in conjunction with local commissioners and D&I Leads and internal staff network and D&I Steering group members. This also encompasses staff side representation.

This analysis has also been reviewed and included as part of new divisional strategic planning processes and as such, will form part of future divisional discussions.

The Trust is also planning additional work streams to further support the reduction of health inequalities. This will include a more detailed review of patient data and accessibility of services and ensure further links with BAME community members and representative organisations. We will also link further with Healthwatch Wirral so as to ensure a more detailed understanding of the needs and views of our community members. Meetings are scheduled from January 2021 to develop.

5. What are you proud of; what initiatives or programmes in place to tackle health inequalities and take positive action against racism

We are really proud of the general progress made so far in highlighting diversity and inclusion considerations as a whole; however do recognise that we still have much more to do. We are currently in discussions regarding more focused efforts moving forwards and will continue to be committed to tackling health inequalities and taking positive action against racism.

Some of the key areas completed to date are:

i) Identification and promotion of BAME leaders
   a. BAME FTSU Guardian appointed
   b. BAME FTSU Champions
ii) Continued support to developing our BAME staff network– although still in developmental stage, the group is continuing to meet and membership is growing
iii) Trust pro-active and innovative response to supplying Vitamin D for all BAME staff and additional blood and bone profile testing to offer additional levels of support (during the first wave)
iv) Individual calls made to BAME colleagues to raise awareness of risk assessment process and support completion of forms.
v) Regular D&I updates to senior management teams to raise awareness of D&I across the Trust
vi) WUTH Diversity and Inclusion Steering Group won the national Unsung Heroes Award for 2020
vii) D&I Lead now also the Lead for FTSU so agendas are closely linked
viii) Trust values and behaviours have been reviewed and relaunched with 2000+ staff involved in their development.
ix) Respect at work sessions now developed and delivered with examples of racism included for discussion. Compliance with these sessions is also now monitored to ensure completion.
x) We have also successfully launched and delivered FTSU training levels 1-3, with levels 2 and 3 developed and delivered internally. These sessions seek to encourage staff to speak up as well as providing practical support on how best to respond. Compliance with these sessions is also now monitored to ensure completion.
xi) D&I Lead a member of the NHSE/I Inclusive Leadership Project – supporting identification and transformation of inclusive leadership moving forward
xii) Purchase of additional software programmes e.g. Browsealoud so as to support greater accessibility and understanding of Trust information

North West Black, Asian and Minority Ethnic Strategic Advisory Committee

Vision

A significant and sustained change within the NHS, based on what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism.

Mission

Our ambition is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism and the health inequalities faced and experienced by people in our communities, brought into stark relief by the coronavirus pandemic.

We want our NHS in the North West to be clearly and unashamedly Anti-Racist, which means working to dismantle the structures that mean it is difficult for our Black, Asian and Minority Ethnic communities to access services and to enter the NHS workforce and progress.

We believe that we can bring about real improvements, by working with our NHS colleagues as our allies, to improve knowledge of the issues that our Black, Asian and Minority Ethnic colleagues face not just in the NHS but society in general.

We must unapologetically and purposefully identify, discuss and challenge issues of race and colour and the impact they have on our organisations, our systems, and our people and communities.
We must actively seek racism out and remove it from our great NHS. Our ambition is equality for all.

Strategic Objectives

In response to the disproportionate impact of COVID 19 and Black Lives Matter movement, a strategic advisory committee (our Assembly) has been established to lead on our drive for positive action on racism.

Our Assembly will work with its members to support our NHS system to be anti-racist, with the expectation that this will lead to real and sustained change, which will be noticed at all levels of the NHS from board level to the frontline. There will not be any place for bigotry and racism on any level.

Our Assembly brings together the collective will of our system, to make a significant and sustained change to what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism.

There are examples where organisations are making progress, however many colleagues are frustrated by what they see as the repeated pattern in some places in relation to how the NHS approaches the issue of racism and inequalities. Committing consistent attention and action to tackle the deep-rooted issues behind inequalities is an imperative.

We aim to achieve this by:

- Supporting our many colleagues of all backgrounds that want to engage and stand up to racism
- Addressing structural processes and issues that embed racism in the NHS

- Ending the “data secrecy” and being open and willing to share data that reveals inequities.

We will seek to influence decisions made at the highest level in the NHS for our region. We will develop action and strategies that dismantle racism within all aspects of the North West NHS region.

We have identified three main themes and a supportive work programme:

1. Minimise the risks posed by Covid-19 to our Black, Asian and Minority Ethnic colleagues
    - Act on information/intelligence derived from staff risk assessments
    - Support development of staff networks at an organisational level

2. Address underlying racism within our structures, which prevents our Black, Asian and Minority Ethnic colleagues from fulfilling their potential
    - Set improvement trajectories for representation at each grade in every organisation
    - Nurture the understanding of all colleagues of the depth of equality and inclusion issues

3. Tackle the inequalities of access, which mean that our Black, Asian and Minority ethnic communities have poorer health and health outcomes
    - Increase the confidence of our communities to access services and self-support
    - Utilise data points to identify inequality of service provision
    - Understanding population communities and ensuring services are meeting needs
    - Target pre employment and job opportunities at most disadvantaged
    - Challenge Reset programmes to evidence that are working on EDI agenda

Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Advisory Group
Chair, Pennine Acute NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Advisory Group
North West Regional Director, NHS England and Improvement

OUR AMBITION TO IMPROVE EQUALITY, DIVERSITY AND INCLUSION FOR BLACK, ASIAN AND MINORITY ETHNIC (BAME) STAFF AND COMMUNITIES

The Cheshire and Merseyside Health and Care Partnership is fully committed to equality, diversity and inclusion. We believe all forms of racism and discrimination are unacceptable and must not be tolerated. There is clear evidence that racism and discrimination cause health inequalities, impacting our communities, patients and colleagues.

The tragic death of George Floyd has shown inequality, racism and discrimination is still experienced by black people across the world, unfortunately, for many this is part of everyday life.

The COVID-19 pandemic has also brought into sharp focus health inequalities, social injustice and systemic discrimination, particularly that experienced by Black, Asian and Minority Ethnic (BAME) communities.

As a Partnership, we need to look inwards and recognise that we all have a role in addressing these inequalities and structural racism. Now is the time to act and do things differently. We need to harness the collective will of our system and work together to make a significant and sustained change.

We are at a juncture where we can improve things or allow them to get worse. It is no longer enough for us simply to stand up and condemn racism, we must be actively anti-racist. We must work together with our communities across all sectors to create a better future in which everyone enjoys the same freedoms, rights and opportunities in Cheshire and Merseyside.

This means creating workplaces and services in which people of all backgrounds and cultures feel included, welcomed and valued; positively striving to meet the needs of BAME staff and communities; and creating the conditions where all staff can reach their full potential.

We aspire for our Partnership to be recognised for positively promoting and delivering equality and inclusion for all groups in our leadership, our workforce and in the way that we carry out our work. However, the purpose of this statement and pledge commitment is to set out our ambition to improve equality and the inclusion specifically for BAME staff and communities.

Our goal is to create environments where we will constructively challenge one another and sometimes engage in uncomfortable conversations that enable us to arrive at better decisions for our staff and our communities.

We recognise that equality, diversity and inclusion are multifaceted issues and we need to tackle these subjects holistically. The power of our Partnership comes from our ability to influence beyond health and social care, it is within our gift to also influence the socio-economic factors that are so important to tackling inequalities such as access to employment, education and housing.

As a Partnership, we are collectively pledging consistent attention and actions which are visible and practical to tackle the deep-rooted issues that lie behind systemic racial inequalities. We acknowledge that these pledges are not the complete answer, but we believe they are important, concrete steps toward reducing inequalities, creating an atmosphere of inclusiveness in our workplaces and cultivating meaningful change for our communities.

Dr Jackie Bene
Chief Officer
Cheshire and Merseyside Health and Care Partnership

Alan Yates
Chair
Cheshire and Merseyside Health and Care Partnership

Endorsed by the Cheshire and Merseyside Partnership Board

OUR EQUALITY, DIVERSITY AND INCLUSION PLEDGES

Our leadership and governance

We commit to collectively do more as leaders to increase equality and reduce inequalities, addressing honestly and head-on the concerns and needs of our BAME employees and communities:

1. We will tackle the profound lack of understanding and knowledge of leaders on the issues that BAME people face, not just at work, or in health and care settings, but in society in general

2. We will develop strategic action plans to prioritise and drive accountability around diversity and inclusion and encourage partner organisations to do the same

3. We will ensure diverse representation on key groups, boards and in decision making processes

Our workforce

We commit to cultivating working environments where diverse perspectives and experiences are welcomed and respected and where employees feel comfortable and encouraged to discuss equality, diversity and inclusion:

4. We will encourage our staff to positively challenge when they see a lack of diversity and call out inappropriate behaviour or discrimination, even when it is uncomfortable to do so

5. We will actively support under-represented groups and take positive action to ensure our workforce, at all levels, reflects the diversity of the communities we serve

6. We will ensure that for all recruitment, including senior recruitment campaigns, we have a network of equality and diversity representatives to support our recruitment panels and ensure the panel is diverse

Our work

We commit to understanding the impact of our work on all members of our communities and for our work to reflect the diversity within these communities:

7. We will ensure that COVID-19 recovery strategies actively address the impacts on our BAME communities and reduce inequalities caused by the wider determinants of health to create long term sustainable change

8. We will actively engage with and involve BAME communities in our work, ensuring we include people from marginalised and seldom-heard groups

9. We will share best and unsuccessful practices relating to equality, diversity and inclusion initiatives. We will support all organisations to evolve and enhance their equality and diversity strategies and encourage them to share their successes and challenges with others

Agenda Item: 21/22-16

Trust Board of Directors
07/04/2021

Title:	CQC Compliance and Action Plan – Quarterly update
Responsible Director:	Hazel Richards, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
Presented by:	Christine Griffith-Evans Deputy Director of Patient Safety and Governance

Executive Summary

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

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

- overdue actions
- completed actions and level of assurance

There are currently;

- 3 must do actions overdue;
- 9 should do actions overdue;
- 24 actions embedded (the outcome of the action has been in place for >= 3 months).

Of the 107 overall requirements, 74 have all actions completed so therefore 69% of the action plan has been achieved.

44% of the 351 actions have been completed and assured

As a result of the significant pressure experienced, due to the pandemic, confirm and challenge meetings, that were being held to review progress, were suspended during the latter part of 2020. Patient Safety Quality Board was informed that these meetings will be re-established from April 2021. The meetings will also be utilised to review the relevance of the actions, in view of the passage of time and the impact of the improvement work undertaken, over the past twelve months.

The CQC are currently reviewing and consulting on how future inspections will be undertaken in a timely and responsive way, which is dynamic in nature and acts quickly on intelligence and stakeholder feedback. In view of this, work will commence to consider how the current systems and processes for monitoring ongoing compliance, with the fundamental standards are aligned and how a single evidence repository can be established to ensure a state of readiness.

Recommendation: (e.g. to note, approve, endorse) *What action / recommendation is needed, what needs to happen and by when?*	
The Board of Directors are requested to note the progress made against the CQC Action plan and the planned next steps.	
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	Yes
Digital future: be a digital pioneer and centre for excellence	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)	
PR4 Catastrophic failure in standards of safety and care PR6 Fundamental loss of stakeholder confidence	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
CQC essential standards and regulation.	
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	NA
Background papers / supporting information	This is a quarterly report to Board of Directors.

1. Executive Summary

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During the period of escalation, due to the Covid-19 pandemic, a revised process was agreed whereby progress against actions was provided, via email, by the Divisional Triumvirates. This process replaced the previous 'confirm and challenge meetings' as an interim arrangement during the period of escalation.

The CQC Evidence Review meetings were implemented in February 2021. These meetings are held on a weekly basis and are attended via Microsoft Teams by:

- Members of the Governance Support Unit
- Associate Director of Nursing; Corporate Nursing
- Deputy Chief Nurse
- Deputy Medical Director
- Head of Quality Improvement
- Associate Director of Allied Health Professionals

The purpose of this meeting is to seek assurance that the evidence submitted by Divisions meets the requirements of the CQC action plan, the action is embedded and there is evidence to demonstrate sustained improvement.

Although in its infancy, the revised process has highlighted a need for more robust evidence and as a result there is a plan is to reinstate divisional confirm and challenge meetings from March 2021.

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

- overdue actions
- completed actions and level of assurance

There are currently;

- 3 must do actions overdue;
- 9 should do actions overdue;
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Of the 107 overall requirements, 74 have all actions completed so therefore 69% of the action plan has been achieved.

44% of the 351 actions have been completed and assured

2. Background

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

a. The quality improvement action plan (for Must do's) has 122 specific actions/work-plans for implementation on or before 31st March 2021.
b. The quality improvement action plan (for Should do's) has 229 specific actions/work-plans for implementation on or before 30th April 2021

The CQC inspection report was utilised to support the Trust's consideration of which areas we need to improve.

In developing the action plan the following areas of consideration were included:-

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

Actions overdue are emailed out to the Triumvirates for a response

Divisions provide evidence against each of their actions appropriate to the stage in the cycle for that particular action.
Actions are RAG rated as follows:-

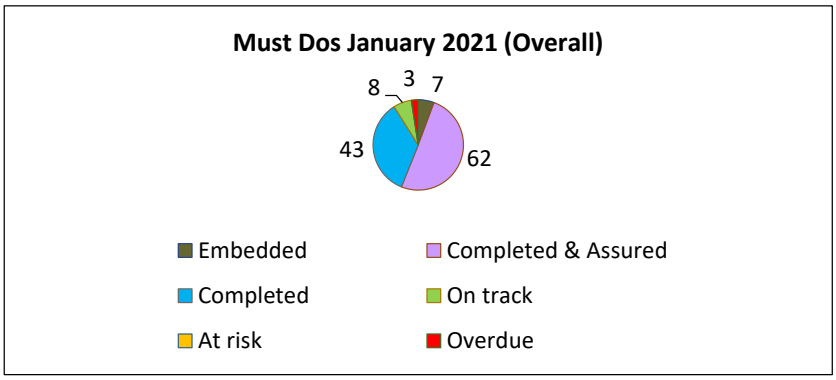
Embedded	The action has been completed and reviewed; it is embedded and there is evidence that the desired outcome has been consistently met and has been tested.
Completed & Assured	The action is completed and assurance has been given by way of evidence
Completed	Verbal assurances that action has been completed
On track	Action is on track with target date
At risk	Action is at risk of not meeting its target date
Overdue	Action is overdue

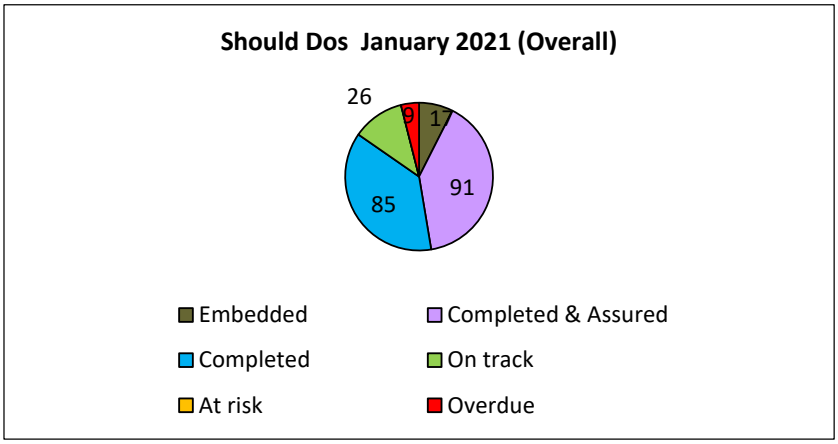
An exception report is presented each month to PSQB and a quarterly report which provides assurances against all actions is also provided

3. Key Issues/Gaps in Assurance

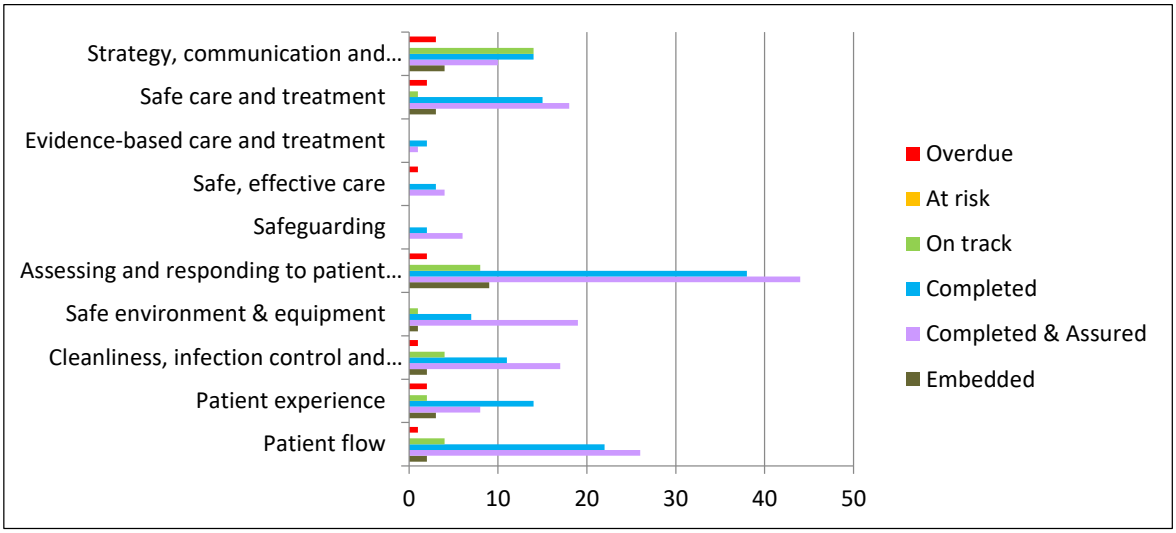
- Patient flow actions are reported as completed, however the CQC Evidence review meeting identified the sustainability of these actions need revisiting light of COVID-19 activity and impact on patient flow.
- During the recent period of escalation, limited evidence of completed actions have been submitted. Assurance that actions are being completed is a priority and a meeting has been established to progress. Areas of concern re progress will be escalated via the monthly report
- Extraction of other assurance data currently already available – see appendix 1

The graphs below summarises the current position of the CQC action plan as of 28/02/2021.





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



*It should be noted that there were a number of actions identified for each regulatory requirement. An overdue action therefore does not indicate a lack of progress but an indication that one element of the plan for that specific regulation has been delayed.

4. Next Steps

- Overdue actions to be addressed by Divisional Triumvirates.
- Evidence to be provided by Divisional Triumvirates to provide assurance that completed actions are embedded.
- Meeting to be arranged by GSU with Divisional Directors to reinstate robust arrangements to progress the CQC action plan
- Escalation process to PSQB re any areas of concern.
- Sustainability of actions, including patient flow, need to reviewed in light of COVID-19 impact.

5. Conclusion

Overall there has been significant progress made with the CQC Action Plan with 80% of all actions completed. Organisational pressures during the pandemic have impacted on progress of some actions and the submission of evidence. Reinstating robust arrangements to progress the CQC action plan is a priority.
The sustainability of actions need review in light of Covid-19 to ensure regulations will still be met.

There are currently 12 actions overdue which were due in December/January; updates will be included in the next PSQB report. Appendix 1 provides more details of actions due and assurance that has been provided so far. Governance Support Unit will address with divisions the actions that still need assurance.

6. Recommendations

Quality Committee is requested to note the progress made against the CQC Action plan

Ref	Key theme	Specific area	MUST Do/Should Do	Actions taken to meet regulation	Exec lead	Operational lead	RAG Status	Assurance
M01	Patient flow	Trustwide	The trust must ensure that improvements are taken to ensure that patients have timely access to care and treatment. Regulation 17(2)	1. Evaluate and Review Patient Flow Improvement Group (PFIG) structure and refocus with three key workstreams focusing on Assessment areas ('Front Door' w/s), Stranded patients ('Back Door' w/s) and roll-out of Capacity Manager tool ('Cap Man' w/s).	COO/ Medical Director	Divisional Director - M&A/ Interim Deputy Chief Operating Officer	**Completed & Assured**	PFIG
	Patient flow			2. Deliver all components of workstreams governed by the Transformation Programme/Patient Flow Improvement workstream with overdue actions escalated to Trust Board through PMO assurance processes			**On track**	
	Patient flow			3. Review bed management agenda and SOP to ensure OPEL actions and triggers are reviewed and appropriate responses made by the Chair of the Bed meeting and these are recorded. To be audited by Bed management matron quarterly and reported to PFIG			**Completed**	
	Patient flow			4. Integrate bed management and Bronze command functions incident command meetings to encompass whole urgent care pathway management			**Completed**	
	Patient flow			5. Utilisation of support from NHSE and ECIST to introduce a single management structure for the Integrated Discharge Team ensuring effective command and multiagency collaboration in facilitating effective flow.			**Completed & Assured**	PFIG
	Patient flow			6. Development of Weekend Discharge SOP and criteria led discharge policy to facilitate 7 day discharges			**Completed & Assured**	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual

M02	Patient flow	Trustwide	The trust must continue to work with stakeholders to improve treatment times and referral to treatment times - Regulation 17(2)	1. Introduction of system wide Command Centre during periods of exceptional demand	COO/ Medical Director	Wirral System Lead for Discharge	**Completed & Assured**	Wirral Planned Care Board
	Patient flow			2. Ensure consistent Executive presence at Wirral Planned Care Board			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			3. System Lead for discharge to be appointed and responsible for leading on collaboration and partnership working between Health and Social Care.			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			4. Development of system-wide dashboard to ensure a single source of robust capacity and demand data across the system.			**Completed & Assured**	Wirral Planned Care Board
	Patient flow			5. Introduction and evaluation of multi-agency approach to Frailty at the Front Door pilot to prevent avoidable admissions of frail patients			**Completed**	
M03	Patient flow	Urgent and emergency services	The service must reduce delays in decision to admit times (Regulation 12)	1. Integrate 'ED LaunchPoint' software into Cerner to enable the implementation of ED senior clinician decision to admit rights and ensure effective governance	COO/ Medical Director	M&A Triumvirate	**Completed & Assured**	Cerner Matrons audit
	Patient flow			2. Proposal of ED senior clinician decision rights approved and implemented			**Completed & Assured**	
	Patient flow			3. IPSS Standards being utilised (see M10)			**Completed**	
	Patient flow			4. Reinstatement of Senior multi-professional leadership hourly huddles to monitor; respond and escalate appropriately to ensure decision to admit delays are reduced			**Completed & Assured**	Matrons audit
M04	Patient flow	Urgent and emergency services	The service must improve the effectiveness of internal professional standards for patients who need a specialist review. Together with improving specialist review times. (Regulation 12)	1. Development of Intraprofessional Standards highlighting the turanround time for specialist input from referral by ED and establish monitoring arrangements to ensure adherence to the agreed turnaround times.	Medical Director	AMD - M&A	**Completed**	
	Patient flow			2. Internal ED streaming pathways agreed and rolled out for all accepting specialties.			**Completed & Assured**	ED Today Live Dashboard Bi Portal
	Patient flow			3. Establish direct access pathways to assessment areas e.g. Orthopaedic Outpatient Minor Injuries Unit; gynae assessment unit to allow increased same day emergency care and direct streaming of specialist patients from ED to improve specialist review times.			**Completed & Assured**	ED Today Live Dashboard Bi Portal Patient

	Patient flow			4. Development of an Enhanced Frailty team ED in reach pilot evaluated and established as business as usual			**Completed**	
	Patient flow			5. ED and Bed Bureau to refresh the 4 and 12 hour tracking responsibilities to ensure delays (including Mental health patient delays) are highlighted and escalated prospectively in timely manner.			**Completed & Assured**	ED Today Live Dashboard Bi Portal Patient FIRST
M05	Patient flow	Medical care services	The service must ensure patients have timely access to care and treatment.(Regulation 17)	1. Implement Divisional requirements of the Trustwide Patient Flow Improvement workstreams (see Mo1)	COO	Divisional Director - M&A	**On track**	
	Patient flow			2. Explore viability of bringing key diagnostic tests in-house e.g. Capsule Endoscopy / Cardiac MRI. Alongside developing mitigations if not viable			**Completed**	
	Patient flow			3. Review admission criteria and Implement SOP for transfer of patients to M1 Rehab, which includes collaborative approach to acceptance of appropriate patients.			**Completed**	
	Patient flow			4. Introduce CAS / RAS services in a number of specialties e.g. gastro / renal / sleep / haematology (electronic triaging system for new referrals)			**Completed & Assured**	Outpatients Transformation Action Log
M06	Patient flow	Medical care services	The service must ensure patient care is planned effectively to reduce length of stay (Regulation 17)	1. Establish IDT processes to identify delays in discharge of patients as a result of lack of suitable support packages / and availability of T2A beds and share appropriate data on a regular basis to the Commissioners to inform decisions on their commissioning intentions to procure rehabilitation and assessment bed based services from a single provider with improved KPI's on transfers of care and length of stay.	COO/ Medical Director	Wirral system lead for discharge	**Completed & Assured**	SAFER BUNDLE: % of discharges taking place before noon
M07	Patient flow	Medical care services	The service must ensure patient care is planned to effectively reduce the number of patients moved between wards at night (Regulation 17)	1. Launch of capacity management to enable clinically appropriate moves to occur within daytime hours and to allow data collection of moves overnight	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Divisional Director, M&A	**Embedded**	Capacity Management Wirral Millennium
	Patient flow			2. Increase HCC establishment to provide 24/7 support for timelier moves of patients in hours			**Completed & Assured**	
	Patient flow			3. Senior nurse late/twilight rota put into place to support out of hours.			**Completed & Assured**	Med & Acute Shared Drive

	Patient flow			4. Establish bed management process that will facilitate early pull of patients from assessment areas to base wards to create vacant capacity in assessment areas for out of hours new admissions			Overdue	
M08	Patient flow	Medical care services	The service must ensure effective discharge planning take place for patient (Regulation 17)	1. Review discharge policy to ensure all changes made as a result of improvement work are encapsulated and communicated to staff	COO	Divisional Director M&A	**Completed & Assured**	Discharge Policy KPIs
	Patient flow			2. The discharge process at APH to be rolled out to CBH site with Discharge Co-ordinator, Social Worker and Discharge Tracker working together to support the MDT in a co-ordinate approach to discharge.			**Completed**	
	Patient flow			3. Workflow in powerchart to enable medics to document if a patient is medically fit for discharge or not and outstanding actions required highlighted on board rounds.			**Completed & Assured**	Cerner/Audit
	Patient flow			4. Launch Criteria to Reside and Ready for Discharge information on Millennium			**Completed**	
	Patient flow			5. A live record of all medically optimised patients to be available on the Trust Business Intelligence portal and used by the System Lead and Integrated Discharge team as a daily discharge worklist to ensure effective discharge planning.			**Completed & Assured**	Bi Portal
	Patient flow			6. A Command and Control model to be established in the Integrated Discharge team with hourly updates reported into the Command Centre to ensure appropriate escalation of any delays to discharge.			**Completed & Assured**	Live Inpatients Bi Portal
	Patient flow			7. Implement weekly MD/COO meetings to oversee Divisional LLOS progress			**Completed**	
M09	Patient flow	Medical care services	The Service must act to reduce referral to treatment times particularly for gastroenterology, dermatology and	1. Additional Clinic Capacity for Early Inflammatory Arthritis patients to be established	COO	Divisional Director M&A	**Completed**	

	Patient flow		rheumatology services (Regulation 12)	2. Outpatient redesign to be undertaken to include booking of diagnostics pre-first attendance, patient initiated follow-up, virtual clinics.			**Completed & Assured**	Programme Board
	Patient flow			3.Triumvirate to lead a review of clinical capacity within Gastroenterology by reviewing resources available and activity plans to increase productivity and identify potential gaps.			**Completed**	
	Patient flow			4. Implement clinical assessment service for Gastroenterology			**Completed**	
	Patient flow			5. Triumvirate to lead a review of clinical capacity within Dermatology by reviewing resources available and activity plans to increase productivity and identify potential gaps.			**Completed**	
	Patient flow			6. Pilot and evaluate referral assessment service (dermatology)			**Completed**	
	Patient flow			7. Agree a system wide trajectory to achieve national RTT standards			**Completed**	
M10	Patient experience	Urgent and emergency services	The service must improve standards of privacy and dignity for patients cared for in the emergency department. (Regulation 9)	1. Minimise ED delays increasing risk of patients being accommodated in the emergency department corridors areas for extended periods of time by:- -A) Ensuring internal and external streaming in place at front door and ATN 24/7. - B) Focussing on 4 hour targets - C) Embedding huddles and ED action cards	COO/ Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director M&A/ Divisional Director Nursing M&A	**Completed & Assured**	Quality Dashboard
	Patient experience			2. Embed and sustain inter professional standards to ensure delays in ED are escalated and kept to a minimum			Overdue	
	Patient experience			3. Develop a SOP for periods of escalation that describes the standards to be maintained for safety, privacy and dignity			**Embedded**	Quality Dashboard

M11	Cleanliness, infection control and hygiene	Medical care services	The service must ensure all staff follow infection prevention and control measures and implement effective processes to prevent and control outbreaks of infection. (Regulation 12)	1. Develop and approve IPC Strategy with operational plan	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC	**Completed**	
	Cleanliness, infection control and hygiene			2. Develop and approve estates capital plan to support IPC improvements			**Completed & Assured**	IPC Annual Plan
	Cleanliness, infection control and hygiene			3. Re-establish and reinvigorate the IPC link nurses.			**Completed**	
	Cleanliness, infection control and hygiene			4. Review of Trustwide c-Diff action plan and works / equipment replacement programme and completion of all priority actions			**Completed**	
	Cleanliness, infection control and hygiene			5. Additional IPC training and guidance for matrons to support IPC management and oversight			**Completed & Assured**	IPC Report PSQB
	Cleanliness, infection control and hygiene			6. Divisional IPC meeting minutes to include evidence of tracking of IPC action plans; RCA's and themes from Exec review panel			**Completed & Assured**	Monthly IPC meeting
M12	Cleanliness, infection control	Medical care services	The service must ensure all premises and equipment are clean. (Regulation	1. Review decontamination policy and ensure all medical devices are included;	Chief Nurse, Executive Director for Midwifery and	Divisional Director of Nursing Med & Acute / Director	**Completed**	

	Cleanliness, infection control and hygiene		15)	2. Review IPC Governance arrangements to ensure that the cleanliness of all medical equipment is included and results of IPC audits are reviewed and acted upon with senior leadership oversight	Allied Health Professionals, Director of Infection Prevention & Control/ COO	of Estates & Facilities / Associate Director of Nursing for Infection Prevention & Control	**Completed & Assured**	Perfect Ward
	Cleanliness, infection control and hygiene			3. In conjunction with Hotel Services establish standardised process for cleaning of curtains and develop SOP for ward managers guidance.			**Completed**	
	Cleanliness, infection control and hygiene			4. All areas and equipment identified by CQC cleaned, repaired or included within replacement program			**Completed**	
M13	Safe environment & equipment	Medical care services	The service must ensure all premises and equipment are suitable for purpose and properly maintained. (Regulation 15)	1. Re-establish scheduled H&S audits across all wards/ department and embed escalation processes for delayed critical repairs through H&S exception reporting process.	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control /	Divisional Director of Nursing Med & Acute / Director of Estates & Facilities / H&S Manager	**Completed & Assured**	Bi Portal
	Safe environment & equipment			2. Division to carry out an audit of all bathrooms and showers and add to capital requests for consideration; ensuring the audits are embedded within matrons audits for on-going monitoring			**Completed**	
	Safe environment & equipment			3. Change ward layout with M1 to provide a designated dining / activity room where the therapists undertake group sessions on a daily basis			**Completed & Assured**	H&S Committee
	Safe environment & equipment			4. Undertake risk assessment of M1 in accordance with Workplace (Health Safety & Welfare) Regulations 1992 and ensure control measures to effectively mitigate risks are implemented to ensure safe environment for staff and patients			**Completed**	
	Safe environment &			5. M1 Temporary heating solutions deployed with additional bedding stocked on ward if required.			**Completed & Assured**	H&S Committee

	equipment							
	Safe environment & equipment			6. Revise Terms of Reference for the Medical devices and equipment group to ensure that processes are robust and assurances received that all equipment is suitable for purpose; on an appropriate maintenance and replacement schedule and that Divisions are appropriately represented			**Completed & Assured**	Clinical Procurement Group attendance
M14	Safe environment & equipment	Medical care services	The service must ensure oxygen is stored in line with health and safety best practice guidance (Regulation 15)	1. Audit medical gas cylinder usage (annual rolling programme) to identify any deficiencies in storage and implement any changes in storage requirements	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Supported by H&S manager/ Lead Director of Pharmacy/ Director of Estates & Facilities	**Completed & Assured**	Bi Portal
				2. Incorporate medical gas storage audit as part of perfect ward audits and include performance on the H and S performance dashboards			**Embedded**	Bi Portal
				3. Risk assessment and standard operating procedure to be reviewed and circulated throughout Trust to ensure all ward/ dept managers understand the requirements for storage of oxygen and process for removal of oxygen cylinders			**Completed & Assured**	Bi Portal Bulletin
M15	Safe environment & equipment	Medical care services	The service must ensure all portable equipment is tested regularly. (Regulation 15)	1. All wards and departments to carry out a check of when electrical equipment (including emergency equipment) was last checked for electrical safety and liaise with EBME to ensure PAT's are brought up to date	COO/ Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute / Director of Estates & Facilities / H&S Manager/ Head of EBME	**Completed & Assured**	
	Safe environment & equipment			2. Estates and EBME to develop a process for tracking portable equipment which will inform a schedule for when portable electrical equipment is due for testing and its location so that PAT's are carried out when required			**Completed & Assured**	H&S Committee
	Safe environment & equipment			3. Implement Standard Operating Procedure for ward managers to ensure guidance and agreed checking process for electrical safety is implemented.			**Completed & Assured**	H&S exception report

	Safe environment & equipment			4. Risk assessment and usual frequency for Portable appliance testing of equipment to be shared with all wards/ departments			**Completed**	
M16	Patient experience	Medical care services	The service must ensure the confidentiality of patients is maintained at all times in the discharge lounge. (Regulation 17)	1. The discharge to assess team to be permanently relocated out of the Discharge Hospitality Centre	COO	Divisional Director Medicine and Acute Specialties Division	**Completed & Assured**	Perfect Ward
	Patient experience			2. All staff to be reminded of the importance of confidentiality			**Completed & Assured**	Perfect Ward
	Patient experience			3. Develop a Perfect Ward audit for discharge lounge incorporating IG and confidentiality	Director of IT and Information	Divisional Director of Nursing Med & Acute	**Completed & Assured**	Perfect Ward
M17	Assessing and responding to patient risk & safety	Medical care services	The service must ensure staff complete risk assessments and associated care plans for patients. (Regulation 12)	1. Mandatory question to be added to the incident reporting module in Ulysses Safeguard to prompt staff to confirm that risk assessment has been reviewed following an incident	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Deputy Director of Nursing	**Completed**	
	Assessing and responding to patient risk & safety			2. Nutrition & Hydration specific dashboard to be uploaded to the nursing Business Intelligence (BI) portal			**Embedded**	Bi Portal
	Assessing and responding to patient risk & safety			3. Inclusion of 24 hour MUST compliance will be included in the Trust Quality Dashboard.			**Embedded**	Quality Dashboard

	Assessing and responding to patient risk & safety			4. Improvement workstream for Nutrition and Hydration group to include key improvement area of 'the quality completion of MUST and compliance of Dietitian care planning'.			**Completed & Assured**	N&H Dashboard
	Assessing and responding to patient risk & safety			5. Ward profiles for falls to be developed and targeted action plans developed for priority areas which will include targeted falls prevention training			**Completed & Assured**	Bi Portal - Falls Profile
	Assessing and responding to patient risk & safety			6. Identify all CSW's to undertake the care certificate and establish a programme of training			**Completed**	
	Assessing and responding to patient risk & safety			7. Review of harms panel to improve compliance with care bundles (including risk assessment) by increased focus on areas where trends, themes and patterns are identified and ensuring targeted action plans are developed, monitored and implemented			**Completed & Assured**	CLIPPE
	Assessing and responding to patient risk & safety			8. Raise staff awareness of personal accountability for completion of risk assessments			**Completed & Assured**	OLM

M18	Assessing and responding to patient risk & safety	Medical care services	The service must ensure that staff share key information, in line with trust policy, when handing over the care of patients who are medical outliers or moved into escalation areas.	1. Explore the option of a revised electronic handover	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director of Nursing Med & Acute/ Deputy Director of Nursing	**Completed**	
	Assessing and responding to patient risk & safety			2. Review of SBAR handover template to ensure it meets patient and service needs and re-circulate for use until electronic handover can be implemented			**Completed & Assured**	SNMT
	Assessing and responding to patient risk & safety			3. Implement and monitor compliance with intentional rounding on escalation areas			**On track**	
	Assessing and responding to patient risk & safety			4. Review Standard Operating Procedure for escalation areas to ensure handover of information and completion of risk assessments is included			**Completed & Assured**	
M19	Assessing and responding to patient risk & safety	Medical care services	The service must ensure that patients who are medical outliers or moved into escalation areas receive regular senior medical reviews. (Regulation 12)	1. Development of SOP to ensure all staff are aware of the requirements for medical review of medical outliers and patients in escalation areas and escalation processes including at weekends	Medical Director	Deputy medical Director/ AMD M&A	**Completed & Assured**	Medical Outlier audit
	Assessing and responding to patient			2. Inclusion of medical outliers in the 7 day audit to monitor appropriate senior medical reviews			**Completed & Assured**	Medical Outlier audit

	risk & safety							
	Assessing and responding to patient risk & safety			3. Ensure that all appropriate patients are admitted via assessment areas to provide a timely consultant review.			**Completed**	
	Assessing and responding to patient risk & safety			4. Review use of ward 25 (isolation ward) and ensure access to a relevant specialist consultant			**Completed**	
	Assessing and responding to patient risk & safety			5. Implement process whereby the manager of the day highlights any patient who has not been seen by the speciality team on the outlying wards/ escalation areas as per weekly medical rota for speciality teams in the outlying wards.			**Completed**	
M20	Safeguarding	Medical care services	The service must ensure there is an effective system to track and monitor deprivation of liberty safeguards applications. (Regulation 17)	1. Safeguarding team to provide divisions with daily list of patients who are subject to a Deprivation of Liberty safeguard with expiry dates, to increase ward staff awareness of delays to Local Authority approvals of DoLs and the legal framework already in place to manage this	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Associate Director of Nursing for Safeguarding	**Completed & Assured**	Daily List
	Safeguarding			2. Ward managers to identify expiry of Deprivation of Liberty at each ward Board round from the list provided by Safeguarding			**Completed & Assured**	Huddles audit
	Safeguarding			3. Develop audit process to ensure sufficient assurance regarding Safeguarding teams processes and report within Safeguarding reports to PSQB			**Completed**	
M21	Safe, effective care	Medical care services	The service must act to ensure performance is	1. Convene a joint meeting to review SNAPP results and analyse the data. Draw up plan, with staff engagement, and set review and target date.	Chief Nurse, Executive Director for	Divisional Director Nursing - M&A	**Completed**	

	Safe, effective care		monitored effectively and there are clear plans to improve patient outcomes. (Regulation 17)	2. Review Therapy Outcome Measures (TOMs) data; setting targets for improvement and linking in with SNAPP results.	Midwifery and Allied Health Professionals, Director of Infection Prevention & Control		**Completed**	
	Safe, effective care			3. Review Speech and Language Therapies service performance against local targets, exploring good practice and implementation			**Completed & Assured**	SSNAP
	Safe, effective care			4. Evaluate the robustness of governance arrangements for clinical audits and strengthen arrangements to ensure assurance as to the development and progression of action plans to address areas identified for improvement (including measures to improve patient outcomes)			**Completed & Assured**	SSNAP
M22	Safe, effective care	Surgery	The service must ensure that staff comply with all aspects of the surgical safety checklist. (Regulation 12)	1. External peer review to be arranged by AMD - Action reviewed MIAA are now doing a review	Medical Director	Divisional Director of Nursing - Surgery	Overdue	
	Safe, effective care			2. Leadership team to ensure the Trust's arrangements for Safer Surgery is strengthened, specifically including NATSSIPs; LOCSSIPs and compliance with all aspects of the safer surgery checklist.			**Completed & Assured**	WHO Safer Report to be presented at PSQB
	Safe, effective care			3. Increased observational audits to be undertaken until the required level of assurance is obtained, results of the audits to be reviewed by Clinical Service leads and appropriate actions are taken to drive improvements.			**Completed & Assured**	WHO Safer Report to be presented at PSQB
M23	Cleanliness, infection control and hygiene	Surgery	The service must ensure that it reduces its number of surgical site infections. (Regulation 12)	1.Develop strategy with CD's across the division and DIPC/IPC Team.	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Triumvirate - Surgery	**On track**	
	Cleanliness, infection control			2. Implement targeted infection prevention/wound management improvement plan for the post-operative care management in all surgical wards			**On track**	

	and hygiene							
	Cleanliness, infection control and hygiene			3. DDN/AMD to set up an MDT function to review all potential surgical site infections and ensure appropriate actions are implemented to reduce them.			**On track**	
	Cleanliness, infection control and hygiene			4. Learning to be cascaded through local quality boards and safety summits.			**On track**	
	Cleanliness, infection control and hygiene			5.Triumvirate to lead a review of clinical capacity to ensure effective audit and improvement activities for SSI's can be undertaken.			**Completed**	
	Cleanliness, infection control and hygiene			6. Extend SSI audit across all quarters to gain accurate information to inform actions to be implemented to reduce SSI's			**Completed**	
M24	Safe environment & equipment	Surgery	The service must ensure that the pre-operative assessments area is improved to make it appropriate for staff and patients. (Regulation 15)	1. Pre-operative assessment area to be re-located to a more suitable location.	COO	Associate Director of Health Care Professions- Perioperative Medicine & Critical Care; Divisional Director - Surgery	**Completed & Assured**	Programme Board
	Safe environment & equipment			2. Fit & Well Questionnaires to be rolled out reducing the demand for face to face			**Completed**	

M25	Patient flow	Surgery	The service must implement clear plans, with set timescales and actions, to improve patients access to care and to achieve their timely discharge from hospital. (Regulation 17)	1. Implement Divisional requirements of the Trustwide Patient Flow Improvement workstreams (see Mo1)	COO	Divisional Triumvirate Surgery	**On track**	
	Patient flow			2. Divisional Triumvirate to work with IT to make Estimated Discharge Date (EDD) a mandatory field within Cerner Millennium.			**Completed**	
	Patient flow			3. AMD to ensure that all Consultants agree and document EDD during ward rounds.			**Completed**	
	Patient flow			4. AMD and DDN to initiate board rounds across surgery - to be agreed with all CD's.			**Completed**	
	Patient flow			5. Establish 3 Phase recovery plan to enable the division to maintain the elective programme all year round as the day case facility will now be within the theatre recovery footprint. This will negate the need for ward 1 and reduce the number of cancelled operations			**Completed & Assured**	Periop steering group
M26	Safeguarding	Children's and young people's services	The service must comply with the national information sharing standard designed to safeguard children who were looked after or in protection. (Regulation 13)	1. Managers in ED, PAU, Children's ED, Children's ward, Maternity triage and community midwifery coordinators to identify staff requiring access to CPIS and ensure this is enacted	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Director of Nursing & Midwifery – Women's and Children's Division Associate Director of Nursing for Safeguarding	**Completed & Assured**	Safeguarding PSQB
	Safeguarding			2. Training to be delivered for all identified staff in ED, PAU, Children's ED, Children's ward, maternity triage and community midwife coordinators, which will be supported by safeguarding team and additional face to face sessions will be offered.			**Completed**	
M27	Assessing and responding to patient risk & safety	Children's and young people's services	The service must undertake the required patient risk assessments including pain, nutrition and pressure area assessments and implement a robust process for the monitoring of care and treatment received by patients.	1. Cerner awareness & navigation session to be included on the paediatric essential training day all staff to attend	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Director of Nursing & Midwifery – Women's and Children's Division; Divisional Quality & Safety Specialist	**Completed & Assured**	
	Assessing and responding to patient risk & safety			2. Create a perfect Ward Children's Harms Prevention Audit , that includes pain assessment review			**Completed & Assured**	Perfect Ward

	Assessing and responding to patient risk & safety		(Regulation 12)	3. Create an audit cycle to assess compliance with completion of mental health and wellbeing assessments of children and young people			**Completed**	
M28	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service must ensure the risk to patients of MRI induced burns is mitigated by the development and implementation of a policy or standard operating procedure for staff to follow in the event of such an incident. (Regulation 17)	1. SOP for MRI induced burns to be approved and uploaded to staff intranet	Medical Director	Associate Medical Director Clinical Support and Diagnostics; Dr Simon Lea/ Consultant Radiologist	**Embedded**	Huddle book
	Assessing and responding to patient risk & safety			2. Ensure effective communication to all relevant staff			**Embedded**	Huddle book
M29	Evidence-based care and treatment	Diagnostics	The diagnostic imaging service must ensure that policies and procedures are evidence based and where appropriate linked to relevant professional guidelines. (Regulation 17)	1. Review all policies and procedures to ensure all are evidence based and where appropriate linked to relevant professional guidelines	Medical Director	Operation and Performance Manager for Radiology	**Completed & Assured**	Intranet
M30	Safe care and treatment	Outpatients	The service must ensure that the trust standard operating	1. Process to be revised to ensure ET tubes are no longer pre-cut and remain in their original sealed packaging and placed in a sealed tray which is dated.	COO Medical Director Chief Nurse	Matron of Ophthalmology/ Associate Director of	**Completed & Assured**	Perfect Ward

	Safe care and treatment		procedure is followed when decontaminating equipment. (Regulation 12)	2. Establish Trust-wide audit and reporting process for monitoring adherence to the trust standard operating procedure for decontaminating equipment		Nursing for Infection Prevention & Control/ CSSD lead	**Completed & Assured**	Perfect Ward
M31	Safe care and treatment	Outpatients	The service must ensure that flooring in the ophthalmology department is compliant with infection control guidance. (Regulation 12)	1. Repair flooring	COO	Director of Estates & Facilities	**Completed & Assured**	Bi Portal
S01	Strategy, communication and engagement	Trust wide	The trust should ensure it takes measures to ensure executive visibility in services is increased	1. Introduction of bi-monthly listening events led by the Chief Executive and Executive Directors.	Chief Executive/Director of Workforce/Director of Strategy & Partnerships/ Medical Director/Chief Nurse/Chief Operating Officer/Director of IT and information	Communications Team	**Completed**	
				2. Posters detailing Executive Team members to be mounted on notice boards throughout the Trust			**Completed**	
				3. Executive Directors to participate in Corporate Induction sessions			**Completed**	
				4. Executive Directors to carry out regular informal walk arounds, including joining the monthly Chief Nurse visits. Visits to be recorded in a register held by the Board Secretary.			**Completed**	
S02	Strategy, communication and engagement	Trust wide	The trust should ensure that the overall five-year strategy is reviewed and refreshed where appropriate	1. Strategic Framework approach developed	Director of Strategy & Partnerships	Head of Strategic Planning	**Embedded**	Board bulletin
				2. Strategic Plan workshops held			**Embedded**	Board bulletin
				3. Drafting of 2021-26 Strategy			**Embedded**	
				4. Board approval of Trust Strategy			**Embedded**	Published In Touch Bulletin
S03	Safe care and treatmen	Trust wide	The trust should ensure that mortality reviews	1. Update 'Learning from deaths' policy	Medical Director	Deputy Medical Director	**Completed & Assured**	

	t		are undertaken in a timely way	2. Weekly Mortality review group to be established			**Embedded**	Mortality review group
				3. Strengthen timeframe for completion of SJRs to 28 days, which will be monitored and reported against			**Completed & Assured**	Learning from deaths report
				4. Weekly Mortality review group to review how best learning is to be disseminated			**Embedded**	Mortality review group
				5. Appoint Medical Examiner officer			**Embedded**	Mortality review group
S04	Strategy, communication and engagement	Trust wide	The trust should ensure that culture within the trust is improved across all services	1. New Values and Behaviours team development session offered to support teams experiencing challenges.	Director of Workforce	Deputy Director OD. Director of Communications and Engagement	**Completed & Assured**	Chris Lloyd - ensuring sessions are still taking place
				2. Ensure values and behaviours posters are available in all departments.			**Completed**	
				3. Review and refresh actions of Respect at Work Group.			Overdue	
				4. Revisit approach to 'Just Culture' and implement.			**On track**	
				5. Strengthen terms of reference for cultural reviews to ensure timeliness of actions is clear and relevant managers are accountable for timely completion of actions and feedback to staff.			**Completed & Assured**	Culture reviews
				6. Incorporate updates of cultural review action plans into Directorate/Divisional Review meetings			**Completed**	
				7. Include managers responsibility and guidance related to compassionate leadership and culture into a new managers toolkit.			**On track**	
				8. Include welcome from CEO in Corporate Induction virtual programme for 2020			**Completed & Assured**	Corporate Induction
				9. Undertake temperature check with staff to understand if we are living our values and what we need to do more of.			**On track**	
				10. Increase number of FTSU Guardians and BAME representations in FTSU structure			**Completed & Assured**	Freedom to Speak Up

				11. Review current wellbeing support, continue to provide this and engage with staff to identify what needs to be continued in medium to longer term and provide this on prioritised and value basis.			**Completed & Assured**	In Touch bulletin
				12. Review our values based annual awards with staff and improve based on feedback so that they feel valued for their contribution.			**Completed**	
				13. Establish leadership forum as Think Tanks or Alumni to work on improvements needed across services, inclusive of behaviours and how to challenge poor behaviours.			**On track**	
				14. Continue to deliver the leadership and management development framework inclusive of compassionate leadership, 360 feedback and coaching and promote this.			**On track**	
S05	Strategy, communication and engagement	Trust wide	The trust should consider ways in which engagement with the wider public is improved.	1. Increase links with Community Advisory Group run by Merseyside Police.	Director of Workforce/Chief Nurse	Deputy Director OD. Director of Communications and Engagement Deputy Chief nurse	**On track**	
				2. Host Equality Group Conferences to engage with community, building on the inaugural Transgender Conference with community groups held in 2019.			**On track**	
				3. Work with Healthwatch to focus on EDS2 requirements and Equality Analysis			**On track**	
				4. Host open days and events to support recruitment and engagement.			**On track**	
				5. Work proactively with the Divisions to gain and promote good news stories internally and externally from staff or patients and families			**On track**	
				6. Continue to work with and expand our links with local community forums such as ill-health prevention and wellbeing (including alcohol/smoking/weight/drugs related issues			**Completed**	
				7. Work with universities and colleges to support the education agenda, research activity, work experience and recruitment			**Completed**	
				8. Utilise themes from patient stories, complaints and concerns to inform service improvements			**On track**	
S06	Assessing and responding to patient risk &	Urgent and emergency services	The service should ensure there are enough suitably qualified doctors in the emergency department to meet	1. Perform ED medic staffing capacity and demand analysis utilising ECIST tool and benchmark against peers. ECIST tool undertaken to inform workforce planning - next steps agree numbers by hour.	Medical Director	Deputy divisional director and Head of Urgent Care	**Completed**	

	safety		patient need	2. Develop CESR business case			Completed & Assured	
				3. Recruit to CESR post			Completed	
				4. Develop business case for additional ED consultants to compensate for middle grade gaps			Completed	
				5. Recruit NHS ED locum consultant for 6 months in interim			Completed & Assured	
S07	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that all staff Complete mandatory training	1. Nursing - Recruit to department educator to work alongside staff and ensure mandatory training completed.	Chief Operating Officer	Deputy divisional director and Head of Urgent Care	Completed & Assured	November PSQB
				2. Ensure Nurse educator is trained in CPR for local training delivery.			Completed & Assured	November PSQB
				3. Develop trajectory to achieve mandatory training compliance.			Completed & Assured	
				4. Establish nursing workforce monthly meeting to commence with new ADN/matron to embed and sustain compliance			Completed	
				5. Ensure Consultants Complete all mandatory training.			Completed	
S08	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that all documentation is fully completed	1. Review of use of paper within the department to reduce requirement and transfer to electronic reporting where possible	Chief Nurse	Deputy divisional director and Head of Urgent Care ADN for ED	Completed & Assured	November PSQB
				2. Removal of CAS cards and ensure documented on Electronic Cerner system			Completed & Assured	November PSQB
				3. Establish process for monitoring discharge summary			Completed	
				4. Nursing documentation compliance audits carried out monthly to monitor patient risk assessments			Completed & Assured	November PSQB
				5. Launchpoint implemented (which includes patient safety checklist)			Embedded	PSQB
				6. Monitor implementation of Launchpoint and patient safety pathways			Completed & Assured	November PSQB
S09	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that records trolleys are locked when not in use	1. Remove CAS cards.	Chief Nurse	Deputy divisional director and Head of Urgent Care ADN for ED	Completed & Assured	November PSQB
				2. Install locked storage trolley in EDRU. Install lock on room that will store storage trolley			Completed & Assured	Bi Portal
				3. Install lock on room for storage trolley			Completed & Assured	Bi Portal

S10	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that patients have access to call bells at all times	1. Reconfigure department to increase number of low risk majors space.	Chief Nurse/Chief Operating Officer	Deputy divisional director and Head of Urgent Care ADN for ED	**Completed & Assured**	PSQB
				2. Implement Clinical Decisions Unit			**Completed**	
				3. Roll out of launch point and safety checklist reviewed, to ensure that call bells and reach are included.			**Embedded**	ED Safety PSQB Paper August
S11	Cleanliness, infection control and hygiene	Urgent and emergency services	The service should ensure that all areas are clean and tidy in the department	1. Improvement plan for infection control developed	Chief Nurse/Chief Operating Officer	ED Triumvirate Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Head Estates	**Completed & Assured**	November PSQB
				2. ED triumvirate commenced weekly review of department with infection control and IPC audit completed monthly to address issues			**Embedded**	Bi Portal
S12	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that all patients risk assessments are fully completed in the emergency department	1. Safety checklist to be implemented	Chief Nurse/	ADN for ED	**Embedded**	November PSQB
				2. Monitor implementation of Safety checklist			**Completed & Assured**	November PSQB
				3. Nurse educator to develop nurse competencies for risk			**Completed & Assured**	November PSQB
				4. Roll out nurse competencies for band 5			**On track**	
				5. Roll out nurse competencies for band 6			**On track**	
				6. Roll out nurse competencies for band 7			**Completed & Assured**	November PSQB
				7. Launch point rolled out to enable completion of assessment			**Completed & Assured**	November PSQB
S13	Assessing and responding to patient risk & safety	Urgent and emergency services	The service should ensure that there are effectively managed governance and performance systems in place.	1. Introduce safety huddles every 2 hours and include a Senior ops/nurse, ED sister, lead consultant. (See S17)	Chief Operating Officer	ED Triumvirate	**Completed & Assured**	November PSQB
				2. Monitor implementation/ compliance of Safety huddles process			**Embedded**	November PSQB
				3. Establish breach meetings with specialities (See S17)			**Completed & Assured**	ED Safety PSQB
				4. Each speciality to develop escalation processes which will link to the inter professional standards (See S17)			**On track**	

				5. Develop Directorate Performance Reviews to provide Division with assurance on processes. (See S17)			Completed	
				6. Urgent care action plan developed with 4 partner organisations			Completed	
				7. Monitor completion of urgent care improvement action plan			Completed	
				8. Patient breaches who are awaiting review collected and analysis for themes reviewed			Completed	
S14	Safe environment & equipment	Medical - CBH	The service should review the two wards and where appropriate set out a plan to improve the environment, equipment and space for rehabilitation services being delivered.	1. Review the environment, equipment and space for rehabilitation and identify areas for improvement.	Chief Operating Officer	ADN for rehab Estates AHP Directorate manager	Completed	
				2. Develop designated dining / activity room where the therapist undertake group sessions on a daily basis.			Completed & Assured	Activities timetable
				3. Ensure robust activities timetable in place once the unit reopens			Completed	
S15	Assessing and responding to patient risk & safety	Medical - CBH	The service should ensure that there is local ownership of risks and actions across all areas of the hospital.	1. Introduce a weekly risk meeting to discuss and review previous risks/incidents that have occurred.	Chief Nurse	Divisional governance lead Divisional ADN	Completed	
				2. Introduce monthly risk meeting to ensure risk register up to date, validate and appropriate scoring applied to incidents and ensure timely management of incidents, rapid reviews for SI Panel.			Completed	
				3. Governance lead and ADNs develop a development plan for ward managers to improve knowledge and skills regarding risk management.			Completed & Assured	
				4. Senior nurse presence (Matron or AND) at Clatterbridge site to support Ward Sisters			Completed	
S16	Patient flow	Medical - CBH	The service should ensure that there is timely access and discharge from services at the hospital	1. WUTH to work with WCCG around developing their commissioning intention to procure rehabilitation and assessment bed based services from a single provider with improved KPI's on transfers of care and length of stay	Chief Operating Officer	AHP Directorate manager	On track	
				2. Develop system Lead for D/C role to support the Divisional Triumvirate with daily monitoring of all patients with a LLoS of 20+ days (subsequently 14 and then 7 days).			Embedded	Quality Dashboard

				3. Work with healthcare economy partners to develop urgent care improvement plan.			**Completed & Assured**	Programme Board
				4. Work with healthcare economy partners to commission redesigned intermediate care model			**Completed & Assured**	Programme Board
S17	Patient experience	Medical - CBH	The service should consider how all healthcare professionals work together consistently to benefit patients	1. System Lead for D/C to support the Divisional Triumvirate with daily monitoring of all patients with a LLoS of 20+ days (subsequently 14 and then 7 days).	Chief Operating Officer	System wide discharge lead	**Embedded**	Quality Dashboard
				2. Work with healthcare economy partners to develop urgent care improvement plan.			**Completed & Assured**	
				3. Work with healthcare economy partners to commission redesigned intermediate care model			**On track**	
S18	Safeguarding	Medical - CBH	The service should consider how best to have an effective track and monitoring of deprivation of liberty safeguarding applications	1. Ensure all DOLs / MCA and best interests are contacted electronically on Cerner and subsequently followed up by the safeguarding team, contacting the ward prior to the end of the agreed Dols.	Chief Nurse	Associate Director of Nursing for Safeguarding Named Nurse Safeguarding Adults	**Completed & Assured**	Safeguarding report PSQB
				2. Develop process for DOLS being discussed at ward level daily by nurse in charge			**Completed & Assured**	Safeguarding report PSQB
S19	Patient experience	Trust wide	The service should consider the availability of information leaflets for health promotion.	1. Undertake a review of health promotion leaflets available and ensure they are available for patients and relatives to access and read throughout the Division	Chief Nurse	Divisional Nurse Director	**Completed**	
				2. Undertake review of the current guidance to authors of the Patient Information leaflets - review to include Version / Detail / Author / Intended Reader / Content and availability of health promotion leaflets			**Completed**	
				3. Development of a Trust Wide approval and distribution process (Standard Operating Procedure)			**Completed**	
				4. Promote the Trust website which has a link to all national leaflets and in electronic library suite (Ido) which complies with easy read etc.			**Completed**	
				5. Closer working with hospital library heritage system to ensure dates for information doesn't expire 25/02/21 - TF requested to delete action				

S20	Safe care and treatment	Medical - APH	The service should act to improve completion rates for mandatory training for nursing and medical staff. It should ensure relevant staff complete intermediate life support training.	1. OD Team to work with Medical and Acute Division leads and training subject leads to develop a plan to ensure they understand and act on monthly compliance reports and staff are able to access training.	Director of Workforce	M&A Triumvirate Deputy director of OD	**Completed**	
				2. M&A Division Managers to plan and allocate block of time to staff to complete mandatory training.			**Completed**	
				3. Identify staff non-compliant and any trends related to this and how this may be supported on an individual or team basis.			**Completed**	
				4. Improve mandatory training compliance to meet Trust standard of 90%.			**On track**	
S21	Safe care and treatment	Medical - APH	The service should ensure plans to provide substantive staffing numbers in the acute medical assessment unit are actioned and embedded	1. Increased establishment by recruiting to funded posts that were approved in Acute medicine nursing business case.	Chief Nurse	M&A Triumvirate	**Completed & Assured**	Quality Dashboard
				2. Implemented daily staffing meetings conducted with the Senior nursing team to ensure safe staffing levels maintained as in line with the SSOT			**Completed & Assured**	Quality Dashboard
				3. Utilise NHSP as backfill for both vacancies and sickness.			**Completed & Assured**	Quality Dashboard
S22	Safe care and treatment	Medical - APH	The service to act to minimise the number of times nursing staff are moved to cover escalation areas and areas outside of their speciality.	1. Maintain check and challenge meetings to ensure all areas are compliant with standards agreed in KPS for E -Roster and ensure actions are completed within the agreed time scale.	Chief Nurse	Senior Nursing team	**Completed**	
				2. Accountability and responsibility to be delegated to the Divisional Nurse Leadership Team to ensure all shifts have an agreed total number of staff and skill mix as shown by the establishment templates			**Completed**	
S23	Safe care and treatment	Clinical Support and diagnostics	The service should ensure sufficient allied health professional staff are deployed to ensure patients receive the right care and treatment	1. Review use of resources, pathways and implement use of electronic roster for staff to ensure staff are allocated appropriately to areas of greatest clinical need	Chief Operating Officer	AHP Directorate Manager	**Completed**	
				2. Complete business case for resources required for consideration by trust management board.			**Completed**	
				3. Development of AHP staffing resource reporting via Trust 'BI Portal' to monitor referral to assessment time and other key metrics.			**Completed & Assured**	Orthotics Dashboard
S24	Safe care and	Medical - APH	The service should ensure that all	1. Close ward 1 as escalation area.	Medical Director	AMD for Medicine	**Completed & Assured**	

	treatment		patients have their care pathway reviewed by relevant staff and consultants, especially those on escalation wards.	2. Utilise opportunity presented by reduced demand due to COVID to stop admitting to outlier wards			**Completed & Assured**	
				3. Increase weekend consultant cover to ensure all sick patients and potential discharges reviewed			**Completed**	
S27	Assessing and responding to patient risk & safety	Medical - APH	The service should ensure patients care plans reflect individual needs and preferences	1. Complete baseline assessment of care plans in all in-patient areas	Chief Nurse	Associate Director of Nursing	**On track**	
				2. Develop Options Appraisal regarding the development of a long term electronic process for care planning standardisation and assurance moving forward			**On track**	
S28	Strategy, communication and engagement	Medical - APH	The service should ensure plans to deliver the divisional strategy are robust and align with the organisational strategy	1. Review and refresh Divisional strategy following approval of Trust wide Strategy to ensure it is effective and in alignment	Chief Operating Officer	Divisional Director of Medicine	Overdue	
				2. Devise roll out plan to ensure effective communication and engagement with all staff			Overdue	
				3. Develop plans to ensure implementation			**On track**	
S29	Strategy, communication and engagement	Medical - APH	The service should act to provide opportunities for all staff to engage with the organisation and contribute to service improvement and development	1. Ensure medical staff have the opportunity to engage with Divisional management team through Directorate Performance Reviews and Senior Clinicians Forum to identify and contribute to service improvement and development	Director of Workforce	M&A Triumvirate Director of Communications and Engagement	**Completed**	
				2.Develop future leaders, with quality improvement skills, through utilising WUTH's Top Leader's Programme.			**Completed & Assured**	Directorate performance review
				3. Establish registered nurse and Clinical Support worker forums to engage with staff group and encourage involvement with improvement and development work			**Completed & Assured**	Forums
				4. Development of link nurse programmes to support awareness and involvement of staff in improvement and development initiates			**On track**	
				5. Establish schedule of away days which incorporate a focus on service improvement and development			**Completed & Assured**	

S30	Cleanliness, infection control and hygiene	Surgery	Surgery should ensure that staff adhere to infection prevention control practices	1. Matrons to undertake infection control training to enable them to work alongside the infection prevention and control team to monitor standards across all clinical areas, supporting and educating staff. (See M23)	Chief Nurse	Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Divisional ADN	**Completed & Assured**	IPC PSQB Report
				2. Increased auditing to be introduced including weekly ward manager hand hygiene audits, matrons in undertake twice monthly opposed to monthly in all clinical areas. (See M23)			**Embedded**	Bi Portal
				3. Isolation area for patients presenting with infections incorporated in the new 3 stage recovery. (See M23)			**Completed**	
				4.'I am clean stickers' to be applied to all equipment following decontamination (See M23)			**Completed & Assured**	
S31	Cleanliness, infection control and hygiene	Surgery	The service should continue to develop its surveillance of surgical site infections	As per CQC 'must do' action plan -M23	Chief Nurse	Divisional ADN	**On track**	
S32	Assessing and responding to patient risk & safety	Surgery	Surgery should review the reasons for increasing sickness rates within the nursing teams and develop a long-term action plan	1. Monthly sickness review meetings with the HR Manager; ADN, Matron and Ward Managers, to be established. Ensuring that staff sickness is managed in line with Trust policy.	Director of Workforce/Chief Operating Officer	Divisional ADN	**Completed & Assured**	Quality Dashboard
				2. Surgical Matron to hold staff surgeries enabling staff to discuss any work related concerns, professional development and progression.			**Completed & Assured**	Vacancy data
				3. Continued promotion and awareness of Employee Assistance Programme. Use of Staff support group to provide themes for addressing.			**Completed**	
S33	Assessing and responding to patient	Surgery	The service should review the reasons for the increasing turnover rates and vacancy rates for	1. A proactive plan to be developed to fill any gaps with known vacancies submitted to panel at least 3months in advance with over recruitment if possible.	Medical Director	Divisional Director of Ops, Associate Medical Director	**Completed**	
				2. Short term gaps to be filled by additional hours where appropriate with agency staff			**Completed**	

	risk & safety		medical staff and develop a long term action plan	3.For persistent gaps, the division will skill mix and appoint Advanced Nurse Practitioners or Specialist Nurses.			**Completed**	
S34	Assessing and responding to patient risk & safety	Surgery	Surgery should consider introducing a standardised agenda for safety huddles which includes specific opportunities to discuss incident, complaints or compliments.	1. Pilot a new standardised patient safety huddle template within the Division	Chief Nurse	Divisional ADN	**Completed & Assured**	Safety Huddle
				2. Evaluate the pilot to ensure the standardised template meets the improvement objectives and is approved for roll out across the Division			**Completed & Assured**	
				3. Roll out of agreed standardised patient safety huddle template to be completed.			**Completed & Assured**	
S35	Assessing and responding to patient risk & safety	Surgery	The service should ensure that staff complete nutritional and hydration assessments	1. Completion of risk assessments (including MUST) to be added to the standardised patient safety huddle to be used in conjunction with the M Page on Wirral Millennium.	Chief Nurse	Divisional ADN	**Completed & Assured**	Quality Dashboard
				2. Compliance of fluid balance for specific patients to be undertaken			**Completed & Assured**	
				3. Nutrition and hydration fluid balance metrics to be reviewed as standing agenda item of nutrition and hydration working group			**Completed**	
				4. Trust wide compliance of fluid balance for specific patients to be undertaken			**Completed**	
				5. Each division to have a nutrition and hydration lead			**Completed**	
				6. Development of new hydration training package			Overdue	
				7 .Additional safety huddle to be undertaken at 15:00 to ensure that all identified actions have been completed.			**Completed & Assured**	
S36	Safe care and treatment	Surgery	The service should continue to discuss ways to improve patient outcomes	1. Cross reference with GIRFT Review recommendations for ENT and Urology, (recognising Urology is a Regional Cancer Centre)	Medical Director	Associate Medical Director	**Completed**	

				2. Review laparotomy audit results and associated action plan			**Completed & Assured**	Audit forward plan
				3. Benchmark of Orthopaedic readmission from the national Joint Registry			**Completed & Assured**	
				4. Use of the laparotomy audit to identify areas of concern for General Surgery.			**Completed & Assured**	Audit forward plan
S37	Patient experience	Surgery	The service should improve the patient and family room areas to provide more information regarding health promotion and services for people at the hospital and within the community	1. A health promotion topic of the month to be introduced across the division led by a Matron. Schedule to be agreed through the divisional quality board in line with national events such as 'smoking cessation', nutrition & hydration week.	Chief Nurse/Medical Director	Divisional ADN	**Completed**	
				2. Additional information regarding health promotion and services available for people at the hospital and within the community to be available in the patient and family room			**Completed**	
S38	Assessing and responding to patient risk & safety	Surgery	The service should continue to monitor adherence with Deprivation of Liberty Safeguards documentation requirements	1. DOLs documentation and expiry dates to be included in the new standardised patient safety huddle template.	Chief Nurse	Divisional ADN	**Completed & Assured**	
S39	Assessing and responding to patient risk & safety	Surgery	The service should consider ways to make the surgical wards more dementia friendly.	1. Dementia lead identified for the division (Matron).	Chief Nurse	Divisional ADN Matron dementia	**Embedded**	
				2. Baseline audit and gap analysis to be undertaken to identify improvements required against national standards and development of an approved action plan.			Overdue	
S40	Strategy, communication and engagement	Surgery	Surgery should continue to monitor staff adherence to the trust's values and behaviours	1. Review of staff survey results for the Division and development of action plan to ensure continued improvement and monitoring of staff's adherence to the Trust's values and behaviours	Director of Workforce	Surgery Triumvirate, Director of Communications and Engagement	**Completed**	

S41	Safe care and treatment	Children's and young people's services	Children and young people services should take steps to improve staff compliance with mandatory training and ensure that staff are provided with adequate training to undertake their role effectively.	1. Improve compliance of mandatory training to 90% for nursing and medical staff	Director of Workforce	W&C Triumvirate	Overdue	
				2. Mandatory training compliance reviewed as part of appraisal for medical staff, APNP's and ANNP's. Ensure medical staff appraisals are completed within the frame of 12 months.			**Completed**	
				3. Specific Children's training day to be co-ordinated and all Children's nursing staff to attend, review compliance with same and ensure compliance >90%.			**Completed & Assured**	Eroster
				4. Send the training spreadsheets/compliance reports to CL's and CD's to action and oversee compliance with mandatory training.			**Completed & Assured**	Divisional Dashboard
S42	Cleanliness, infection control and hygiene	Children's and young people's services	Children and young people services should improve the standard of infection, prevention, control and cleanliness within it.	1. PW Audit (IPC) to be undertaken monthly in NNU with IPC Team	Chief Nurse	W&C Triumvirate, Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC	**Completed & Assured**	Perfect Ward
				2. Divisional IPC Meetings with Nurse & Consultant IPC Lead to review IPC audits			**Completed & Assured**	Divisional IPC meetings
				3. Introduction of revised dashboard for NNU to include incidents of infection with umbilical lines/other lines; staff compliance with ANNT and other care metrics.			**Completed & Assured**	
				4. All staff to attend IPC mandatory training with review of compliance monthly to >90%.			Overdue	
				5. NNU Leads (Matron and CL) to undertake monthly walkabout of NNU to identify any concerns re environment and to ensure progress with IPC improvement plan.			**Completed & Assured**	Improvement plan
				6. IPC Team on the NNU to include Practice Development Lead who will lead on improvement including improvement work on CLABSI (Reducing the rate of line infections in the neonate)			**Completed & Assured**	Improvement plan
				7. Recruitment of a Practice Development Nurse Lead.			**Completed**	
S43	Safe environment & equipment	Children and young people	The service should ensure that routine equipment checks are undertaken consistently, the safe storage of supplies within the neonatal area and the service	1. Finalise plan for potential expansion of the NNU, aligned to the Divisional Strategy and identify Exec lead.	Chief Nurse/Chief Operating Officer	W&C Triumvirate, Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC	**On track**	
				2. Weekly audit of equipment checklist in PAU to ensure compliance.			**Completed & Assured**	Bi Portal
				3. Undertake a review of stock requirements and ensure only stock required is located on wards to enable effective storage			**Completed & Assured**	

			continues to work towards meeting the national guidance on minimum cot space.			Estates		
S44	Safe environment & equipment	Children's and young people's services	The service should review the provision of resuscitation equipment between the neonatal and maternity departments and ensure that availability of resuscitation equipment is in line with expectations	1. Undertake a review of the provision of resuscitation equipment between neonatal and maternity department	Chief Operating Officer	W&C Triumvirate	**Completed & Assured**	
				2. Ensure all staff are aware that the adult defibrillator is stored for use on Delivery Suite in the event of an adult collapse.			**Completed & Assured**	
S45	Assessing and responding to patient risk & safety	Children's and young people's services	The service should seek to fill medical vacancies within the neonatal department.	1. Undertake a review with Neonatal ODN to identify future service models	Director of Workforce/Medical Director	W&C Triumvirate	**On track**	
				2. Review of MTI workforce to ensure full compliance with competencies and training compliance.			**Completed**	
				3. Review of ANNP workforce and ensure clear progression to Tier 1 and Tier 2 Medical staff rotas.			**Completed**	
S46	Safe care and treatment	Children's and young people's services	Children and young people services should continue to work in reducing the occurrence of medicine errors.	1. Thematic review of medication errors to be undertaken and action plan developed to address any issues highlighted presented at September MSOP	Chief Nurse/Medical Director	Divisional Pharmacist Lead	**Completed**	
				2. Spot Check and Audits to be undertaken to review compliance with expectations for medication administration via Perfect Ward		W&C Triumvirate	**Completed**	
				3. Standardise the process for managing medication incidents across neonatal and children's services			**Completed & Assured**	CIF meeting
				4. Embed the PCIF into the medication incident investigations			**Completed**	
				5. Encourage medical trainees and junior nurses to attend CIF meeting to encourage reporting of incidents and embed the systems approach to incident management			**Completed & Assured**	CIF meeting

S47	Evidence-based care and treatment	Children's and young people's services	Children and young people services should look at ways to improve achieving the standards of the National Paediatric Diabetes Audit such as annual test for albuminuria and thyroid function.	1. Diabetes Audit - Gap analysis to be undertaken against audit standards	Chief Nurse/Medical Director	W&C Triumvirate/Governance Lead	**Completed**	
				2. Establish monthly CG Meeting with attendance from all areas to ensure sufficient engagement and effective implementation of improvement plan			**Completed**	
S48	Patient flow	Children's and young people's services	The service should look at ways of reducing patients re-admitted following an emergency admissions and multiple readmissions of diabetic and epileptic patients	1.QI Project to be undertaken specifically focussing on reducing readmissions in Diabetes (Linked to action S47)	Chief Nurse/Medical Director	Directorate Lead for QI project	**Completed**	
				2. Development of epilepsy passport to support with epilepsy management			**Completed**	
S49	Strategy, communication and engagement	Children's and young people's services	The service should work in collaboration with other providers to ensure appropriate assessment of children and young people attending with symptoms of acute mental health illness.	1. Ensure staff and service users have opportunity to be involved in strategy development which will include key areas within the service such as mental health of children and young people.	Medical Director	W&C Triumvirate in conjunction with ED	**Completed**	
				2. Liaise with ED to ensure the process of mental health assessments for Children and Young people attending ED, but are not admitted, is child appropriate and robust			**Completed**	
				3. Reference M27 must do action plan '3. Create an audit cycle to assess compliance with completion of mental health and wellbeing assessments of children and young people '			**Completed**	
S50	Patient experience	Children's and young people's services	The service should consider ways to improve support and advice given to children and young people to lead healthier lives.	1. Snapshot audit to be completed for children and young people/parents on benefits of the voice of the child group and the best way to receive feedback	Chief Nurse	Deputy nurse W&C Triumvirate	**Completed & Assured**	

				2. Fabio Frog (patient feedback tool) will be further utilised to inform improvement plan including COPD as an area of consideration.			**Completed**	PFEG
				3. Gap Analysis of CQC patient survey to be undertaken and is reviewed for compliance with progress at divisional governance meeting with oversight at PFEG			**On track**	PFEG
S51	Patient experience	Children's and young people's services	The service should consider tailoring the entrance to the women's and children's department to the needs of children accessing its service.	1. Undertake a review of the main entrance to W&C Hospital to consider whether it can be tailored to the needs of children accessing its service	Chief Operating Officer	W&C Triumvirate	**Completed**	
				2. Review the entrance to the children's ward to determine whether any further changes required to ensure it meets the needs of children accessing its service and implement changes			**Completed**	
				3. Ensure specific information and directions are detailed in the entrances for children and that this is child friendly			Overdue	
S52	Safe care and treatment	Children's and young people's services	The service should continue with plans to recruit additional play specialists to increase the establishment within the service	1. Business cases to be completed to increase the number of play specialists in the hospital to support OPD out of the W&C Hospital	Chief Nurse	ADN for Children's Service W&C Triumvirate	Overdue	
S53	Patient experience	Children's and young people's services	The service should review the suitability of all areas used by children and young people within the hospital outside of the dedicated children's service and ensure it has oversight of these patients	1. Development of an improvement plan that incorporates all areas outside of the W&C Hospital where children visit for appointments.	Chief Nurse	ADN for Children's Service W&C Triumvirate	**Completed**	
				2. Ensure those area leads are involved in TWISCH to ensure that such areas are child focused.			**Completed**	
				3. Ensure attendance by all divisions at TWISCH meeting.			**Completed**	
				4. Gap analysis of Facing the Future standards to be discussed at the TWISCH and CG meeting and progress regarding W&C improvements noted within improvement plan to be monitored			**Completed**	
S54	Patient experience	Children's and young people's services	The service should review the format and language availability of patient information offered	See also S19 1. Review of patient information leaflets currently available and identify those for translation	Chief Nurse	ADN for Children's Service W&C Triumvirate Deputy chief nurse	**Completed**	PFEG

S55	Assessing and responding to patient risk & safety	Children's and young people's services	The service should ensure that all children are reviewed by a consultant within 14 hours of admission.	1. Gap Analysis of rota (medical) to identify shortfall in staffing to ensure that all children are reviewed by a consultant with 14 hours of admission.	Medical Director/Chief Nurse	W&C Triumvirate	**Completed**	
				2. Pathways developed to standardise care of those patients who do not require a 14 hour review by Consultant but will be monitored by Junior Doctors and ANPS.			**Completed**	
				3. Risk Register to be utilised to ensure oversight of any non-compliance of the Division.			**Completed**	
				4. Identify robust process to ensure escalation of instances where a consultant review hasn't taken place in 14 hours and appropriate response framework including undertaking harms reviews.			**Completed**	
				5. Ensure changes to the rota to support compliance - where this is not possible review risk of non-compliance and ensure on the Divisional Risk Register for review and monitoring			**Completed**	
S56	Assessing and responding to patient risk & safety	Children's and young people's services	The service should ensure initial health assessments for looked after children are undertaken within the designated timeframes.	1. Deep dive auditing to capture compliance of internal processes and identify gaps/breach in statutory timeframes	Chief Nurse	Associate Director of Nursing for Safeguarding	**Completed & Assured**	Safeguarding report PSQB CQC Wirral CLAS Review Progress Action Plan
				2. Development of live dashboard to provide real time assurance			**Completed & Assured**	Safeguarding report PSQB CQC Wirral CLAS Review Progress Action Plan
S57	Safe care and treatment	Children's and young people's services	Children and young people services should continue to consider ways to resolve issues with transitional pathways for patients with complex care needs	1. Transition policy to be reviewed with CCG and Local Authority	Chief Operating Officer	W&C Triumvirate	**Completed**	
				2. Review of Transition Policy at AHCH to identify good practice and gaps in service provision at WUTH.			**Completed**	

S58	Strategy, communication and engagement	Children's and young people's services	The service should find ways to include the patient voice, community groups, and relevant stakeholders in developing its strategy and services.	See actions for S50/51	Chief Nurse	W&C Triumvirate	**On track**	
S59	Strategy, communication and engagement	Children's and young people's services	Children and young people services should ensure all staff have an understanding of and know how to access guardians such as freedom to speak up and Caldicott.	1. Staff to have increased awareness of FTSU guardians and training	Director of Workforce	W&C Triumvirate	**Completed & Assured**	Training compliance
				2. Ensure actions from 2019 cultural survey are implemented and evaluated			**Completed & Assured**	Cultural review action plan
S60	Assessing and responding to patient risk & safety	Children's and young people's services	On h	1. Undertake audit of compliance with the sepsis pathway	Medical Director	W&C Triumvirate	**Completed**	
				2. Develop an electronic version of the Sepsis pathway on Cerner			**On track**	
				3. Child health representation on Trust wide Sepsis steering group			**Completed**	
S61	Cleanliness, infection control and hygiene	Surgery	The service should follow standard operating procedures when using cleaning products	1. Install COSHH cupboards in treatment room / laser room	Chief Nurse	Divisional AD N	**Completed & Assured**	
				2. Ensure guidance displayed for suitable PPE and training given to those who utilise it			**Completed & Assured**	
				3. Product representative to attend unit for training			**Completed & Assured**	
S62	Safe care and treatment	Outpatients	The service should continue to maintain paper record security whilst in the main outpatient department	1. Communicate with staff to remind them of their responsibilities in regards to security of patient records whilst working towards becoming paperless.	Director of IT and Information	OPD Manager	**Completed & Assured**	Outpatients Transformation Action Log
				2. Establish paperless outpatient project group to reduce reliance on paper records within the Outpatient Department.			**Completed & Assured**	Outpatients Transformation Action

S63	Patient experience	Surgery	The service should consider installing a hearing loop at the ear, nose and throat clinic	1. Install additional hearing loop in clinic	Chief Nurse	Divisional ADN	**Completed & Assured**	
S64	Safe environment & equipment	Surgery	The service should follow trust process for maintaining equipment in ophthalmology.	1. Review PAT testing schedule in line with electrical safety guidelines.	Chief Operating Officer	Director of Estates & Facilities	**Completed & Assured**	Policy KPIs
				2. Develop and maintain an equipment record, including PAT testing information, and store locally			**Completed & Assured**	Eye department inventory
				3. Alert estates to any due PAT testing			**Completed & Assured**	Policy KPIs
S65	Patient flow	Outpatients	The service should continue to monitor and improve referral to treatment times for all specialities within outpatients.	1. Develop an action plan around the RTT standards in line with Executive Led Transformational Change Programmes for Outpatients and perioperative medicine which are progressing.	Chief Operating Officer	Surgery / D&CS Divisional Director	**Completed & Assured**	Programme Board
S66	Cleanliness, infection control and hygiene	Outpatients	Outpatients should address the infection risk of assessing patients in a room with a sluice hopper.	1. Remove sluice hoppers from patient assessment rooms.	Chief Operating Officer	OPD Manager Estates	**Completed**	
S67	Safe environment & equipment	Diagnostics	The diagnostic imaging service should ensure that standard MRI safety labels are used on equipment within the MRI unit to identify equipment that is MRI Safe or MRI Not Safe.	1. Ensure MRI safety labels are placed on equipment in use within the MRI unit to indicate if equipment is MRI safe or not safe.	Chief Operating Officer	Radiology services manager Health & Safety	**Completed & Assured**	Health and Safety walk around

S68	Patient experience	Diagnostics	The diagnostic imaging service should consider the benefits of providing more distraction toys or books for children in the waiting areas	1. Risk assess toy provision within the Radiology waiting room in line with IPC guidance, to inform decision to purchase this equipment.	Chief Nurse	Radiology services manager	**Completed & Assured**	Environmental meeting
S69	Safe environment & equipment	Diagnostics	The diagnostic imaging service should, in line with evidence-based practice and the requirements for the control of substances hazardous to health, ensure that sluice rooms and cleaning cupboards are kept locked when not in use.	1. Ensure sluice rooms and cleaning cupboards are kept locked when not in use, communicate and remind staff of the importance of this.	Chief operating officer	Radiology services manager	**Completed**	
S70	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider the benefits of having regular band seven experience scheduled on night shifts.	1. Undertake a review of the current staffing rota in line with service requirements.	Chief Nurse	Radiology services manager	**Completed & Assured**	Safe staffing oversight
S71	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should ensure that appropriate changing facilities are in place so that patients are not left alone in controlled areas when not undergoing a scan	1. Undertake a review of the facilities available within the CT department to identify any areas/rooms potentially suitable to re-purpose as designated changing facilities for patients.	Chief Operating Officer	Radiology services manager, Health & Safety		
				2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal.			**Completed & Assured**	Complaints/Incidents

S72	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider the benefit of including awareness of Gillick competency Guidelines in relevant mandatory training.	1. Training needs analysis of diagnostic imaging staff to be undertaken to review specifically consent treatment	Medical Director	Radiology services manager	**Completed & Assured**	ESR consent /safeguarding training
S73	Safe, effective care	Diagnostics	The diagnostic imaging service should consider if there would be any benefits in implementing quality assurance sampling of a percentage of images and reports to support the early identification of discrepancies or quality concerns	1. Design and implement formal QA programme	Chief Nurse/Medical Director	Radiology services manager	**Completed**	
S74	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider how it could minimise the risks of delayed identification of deteriorating persons in the MRI waiting room	1. Review feasibility of camera or other mechanism to provide visibility of waiting room for outpatient attendees	Chief Nurse/Chief Operating Officer	Radiology services manager, Health & Safety	**Completed**	
S75	Patient experience	Diagnostics	The diagnostic imaging service should consider how it can improve the privacy and dignity for patients in the CT	1. Amend CT appointment letters to include an instruction to patients not to attend wearing clothing which contains any metal. In rare cases where this instruction is not followed, Radiographers will continue to ensure the privacy & dignity of patients is maintained by locking the 'public access' door to the scanning room, and closing the blinds on the control room window to allow patients to change in private.(See S71)	Chief Nurse/Chief Operating Officer	Radiology services manager, Divisional ADN Health & Safety, Estates	**Completed & Assured**	Risk assessments

			changing/inpatient waiting area.	2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal. (See S71)			**Embedded**	Incidents
S76	Assessing and responding to patient risk & safety	Diagnostics	The diagnostic imaging service should consider how it can effectively support the further reporting development of radiographer staff in reporting on common types of CT scans	1. Continue to develop reporting Radiographers through rolling programme of plain image reporting to release Radiologists to undertake more complex reporting images.	Chief Nurse	Radiology services manager	**Completed & Assured**	Monthly training development committee

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: BM21/22-017

BOARD OF DIRECTORS
07 APRIL 2021

Title:	Briefing on Care Quality Commission Proposed Strategy for Regulation
Responsible Director:	Hazel Richards, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention and Control.
Presented by:	Tracy Fennell, Deputy Director of Nursing

Executive Summary
CQC published a consultation in January 2021: The World of Health and Social Care is Changing. So are We. The consultation proposes a new approach to regulation and inspection with more focus on feedback from patients and stakeholders as a driver to monitor compliance with the fundamental standards and quality and safety. The consultation closed on 4 March 2021. This briefing report outlines the keys areas for proposed change and considerations for the organisation.

Recommendation: (e.g. to note, approve, endorse)
To receive, review and discuss the briefing and consider any additional actions required.

Which strategic objectives this report provides information about:	
Outstanding Care: Provide the best care and support	**Yes** / no
Compassionate Workforce: Be a great place to work	Yes / no
Continuous Improvement: Maximise our potential to improve and deliver best Value	**Yes** / no
Our Partners: Provide seamless care 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)

Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
Compliance with CQC fundamental standards and associated trust overall ratings. NHSI Use of Resources assessment and segmentation rating	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
None	
Specific communications and stakeholder /staff engagement implications	
Once new framework for monitoring and inspection has been confirmed, awareness for staff across the Trust will be essential.	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
None	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
None	
Previous considerations by the Board / Board sub-committees	None
Background papers / supporting information	 20200111_cqc-consultation_doc_new_str

BOARD OF DIRECTORS
07 APRIL 2021

Briefing Report

Care Quality Commission Consultation: The World of Health and Social Care is Changing. So are We.

1. Purpose

The briefing paper aims to provide the Board with an overview of the proposed changes to CQC's approach to monitoring, inspection and rating formulation of Health and Social Care services in the future. In addition, the report considers implications for the Trust on the proposed approach.

2. Background

Over the past twelve months, the way in which health and social care is delivered has seen significant change and transformation; including an increase is remote consultations and the use of digital technology in care. The use of clinical resources across local health and care systems, to ensure and maintain safe delivery of care, has been further developed. In addition the pandemic has highlighted inequalities, within populations, in relation to both access and high quality and safe services. In view of this the Regulator has restated their commitment to reducing inequalities, eliminating discrimination, advancing equality, and protecting human rights and aim to utilise the new strategy to help health and social care providers to achieve this.

CQC has recognised that the approach to delivering care as a 'system' is significantly different to that of a 'single provider service model', which it was established to oversee. In the future they will assess both individual services and how local systems work together. Furthermore they have identified the need to review their current approach to regulation, with the aim of developing more flexibility to manage risk and uncertainty in a dynamic and responsive way. This will be based on both intelligence arising from data and patient/families/staff and stakeholder experience. There will also be increased focus on what local populations want and need from their local systems. The overarching role and purpose of CQC will continue to be ensuring safe, compassionate/responsive, effective and high quality care along with supporting improvement. However they have indicated that there will be an ongoing focus on safety along with the drive for openness and transparency.

3. CQC Proposal

The proposed strategy, which will be implemented over a five year period, is centred around four themes:

- **People and communities**: Focus on what matters to the public and to local communities, when they access, use, and move between services
- **Safety through learning**: Expectation that learning and improvement will be the primary response to all safety concerns
- **Smarter regulations**: Smarter with data resulting in targeted and focused visits.
- **Accelerating improvement:** Improvement within individual services, and in the way a local system work together

The proposal includes a move away from a fixed schedule of inspections and from utilising only onsite inspections, with the new approach using broader intelligence. Whilst on-site inspections may be used, this will not be required to change ratings and ratings may change more frequency. This approach will offer the opportunity to reflect "what is known now" about an organisation. More staff interviews will be undertaken remotely along with off-site analysis.

Whilst CQC will continue to inspect and rate core services, there is a proposal to move away from aggregation of core service level ratings to formulate the overall rating for an organisation; this will be replaced with a rating based on current assessment of the well led key questions. Further work will be undertaken to consider core services assessments and how these relate to the well led domain. In addition there will be more time between core service inspections to allow improvement.

There will be increased focus on people's experiences of services and CQC plans to develop further its mechanisms for receiving and analysing feedback. There will be an increased focus on feedback people who are the most disadvantaged within society, those who have had distressing or traumatic experiences, and therefore are more likely to experience poor outcomes and inequalities.

CQC will work with providers, other regulators and partners to coordinate data collections with the aim of reducing duplication and workload for providers. There is a stated commitment to only ask for the information that we can't be obtained elsewhere and to enhance the digital interfaces with services. CQC also plan to share data and information, they hold, with voluntary and other organisations in order to help them in their own work to improve people's care.

There will be a move away from long reports, written after inspections, with plan to provide information and data targeted to an audience, which is easy to understand and is in an accessible format.

4. Considerations for the Trust

As a provider of services, the Trust should welcome a smarter and more responsive approach to regulation, which is anticipated to be less burdensome and the intention of CQC to base their judgements on a more rounded picture of quality.

Further information on the new thresholds that CQC will utilise, to decide when to inspect Trusts will be needed to bring more clarity. In addition, consideration by the regulator will be needed in relation to the complex context in which providers operate, the need to balance person-centred care with wider national policy imperatives and the constraints on the financial envelope, along with workforce challenges. There will also be potential for duplication across regulators, in the proposed work relating to support for continuous improvement.

In relation to review of local systems, this will be dependent, in part, on the relationships developed between Trusts, their commissioners and STP. Clear lines of responsibility, accountability and decision making will be essential as the Cheshire and Merseyside local system develops further.

The proposed strategy and the its key aims and focus, aligns with the Trust priorities for 2021 – 2026, which encompasses aims to deliver intimate and personal patient experience, embedding a culture of safety improvement that improves outcomes, investing in staff to support continuous learning and delivering system partnerships to

improve outcomes for our population

In order to deliver our priorities and continue to meet the expectations and requirements of both our local population and regulators we will need to:

- Continue to welcome and listen to feedback and involvement from patients and their loved ones, in the pursuit of delivering safe care, continuous improvement and as a mechanism for monitoring that we are meeting the "needs and wants" of our population.
- Triangulate feedback from patients and their loved ones with internal data arising from staff feedback, quality monitoring, mortality reviews, incidents and clinical audit to identify areas for improvement work.
- Continue to develop our safety and just culture and support psychological safety within our staff. In addition, develop capability in safety investigations, in line with the emerging Patient Safety Incident Response Framework, to enable the true causes of safety errors to be identified and therefore support improvement.
- Continue to work, putting aside self-interest, with partners, to meet the needs of our population in pursuit of integrated pathways in pursuit of seamless integrated care and reducing health inequalities.
- Continue to develop our mechanisms for self-assurance.

A revised quality strategy will be developed this year incorporating patient experience patient safety and clinical effectiveness. In addition, a work programme to support ongoing assurance of compliance with the fundamental standards will be established via Task and Finish Group.

5. Conclusions

The Trust will be well placed to respond to the new strategy and regulatory approach once finalised. This recognises that further development work particularly in relation to patient engagement and experience is required to strengthen our position to be "fit for regulation" in the coming months and years.

6. Recommendations to the Board

To receive, review and discuss the briefing and consider any additional actions required.

Care Quality Commission

The world of health and social care is changing.

So are we.

We want to hear what you think of our new strategy.

We'll change how we regulate to improve care for everyone

We were established as an independent regulator with a clear purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve.

We'll always be committed to this purpose, it's as vital as ever. But the world in which we regulate has changed significantly since we were created. The COVID-19 pandemic has accelerated that change: new and innovative types of service started up using digital channels, and new restrictions have changed how services can deliver care.

In this new world, we must also transform. We need to make changes to the way we regulate so that it's more relevant and has positive outcomes for everyone, as people's expectations of care have changed. We need to be more flexible to manage risk and uncertainty. We've learned a lot from our response to the pandemic, and we're using this to put us in a better place for the future and support services to keep people safe.

We have a responsibility to change people's lives for the better.

As people get older, they often have multiple, long-term conditions. Delivering care is increasingly complex. The organisation of health and social care services is evolving rapidly, and many are working in partnership across different sectors. The crisis has emphasised just how vital this is. It's now more important than ever for health and care services to work together as a system to deliver care – to meet the needs of the local population and of each individual person.

But the approach of delivering care as a 'system' is very different to the 'single provider service model' that CQC was set up to oversee in 2009.

> **It's not enough to look at how one service operates in isolation.**

It's essential that people who use services, those who work in them, and health and care organisations work together as a system to design and deliver care. It's **how** services work together that has a real impact on people's outcomes. We need to adapt to this. Our assessment of people's care must look at every stage of their journey through the health and care system, looking at both individual services and across different providers and organisations.

The way people receive care has also changed – powered and supported through new technology. The growth of artificial intelligence, advances in data analytics and the increase in mobile communication all point to a future of care built on a dynamic partnership between health and care services and the people who use them. We need to understand where digital services can meet people's needs and improve their outcomes – and change the way we regulate them.

> **The pandemic has renewed the focus on inequalities in health and care.**

We've seen inequalities across different areas of the country and different groups of people. Reducing inequalities in people's outcomes is a fundamental part of our new strategy. We want everybody to have access to safer and better-quality care and we will champion this in everything we do. We want to understand why there's such variation across the country in how people get the care they need, so we can help to tackle it.

We're committed to reducing inequalities, eliminating discrimination, advancing equality, and protecting human rights. We want our new strategy to help health and social care providers and systems to do this.

Our strategy is built on four themes that together determine the changes we want to make. Running through each theme is our ambition to improve people's care by looking at how well health and care systems are working and how they're acting to reduce inequalities.

Our aim is to implement our new strategy over the next five years. To enable us to be as flexible as possible and adapt to changes in health and care, we'll review it when we need to.

People and communities

We want to be an advocate for change, with our regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership, we have an opportunity to help build care around the person: we want to regulate to make that happen.

Listening and acting

People need to clearly understand how their voice can make a difference to the safety and quality of the services they use. We'll transform how we encourage and enable people to share their experiences of care with us in a way that works for them. We'll transform how we capture, use and analyse people's feedback. We want to build trust with the public and motivate people to share their experiences by showing how we've acted on what they told us.

- We'll enable people to give feedback in different ways that work for them – whether that's giving information to us directly, or speaking with our Experts by Experience, our inspectors, Mental Health Act Reviewers, Local Healthwatch or our local voluntary and advocacy partners. We'll also make it easier for people to give feedback using digital channels.

- We'll develop the skills and tools that we need to enable all people to share their experiences. But we'll have a specific focus on people who are the most disadvantaged in our society, have had distressing or traumatic experiences, and are more likely to experience poor outcomes and inequalities. This includes people with a learning disability, people with communication needs, people living in poverty, those whose voices are seldom heard, those who are detained under the Mental Health Act, and those who are at risk of abuse or other human rights breaches.

- A priority will be improving our capacity and capability to get the most out of feedback. We'll identify more and better ways to gather experiences from a wider range of people. We'll change the way we record and analyse people's feedback, so it's easier for us to quickly identify changes in the quality of care – both good and bad. This means building systems that enable us to track and prioritise people's experiences throughout our regulatory and other processes. We'll be clear about the value and weight we give to quantitative and qualitative information when using it with other evidence. This includes the stories that people tell us about their experiences of services and pathways of care.

People and communities want us to act on their feedback and understand how we've acted on it – and we want people to know how much we value their feedback.

- When we publish information about quality, we'll be clearer about how we've used people's experiences, and the action that we and others have taken as a result.

- When people take the time to share their experiences with us we'll provide a response to them that clearly explains how we've acted on what they tell us and how it has informed our view of how a service is performing. We'll provide our response in the way people need it.

We know that people are often afraid to speak up. We want to help build a new understanding among the public, health and care providers, and our partners, that welcomes, values and acts on feedback to improve care for all.

- We'll improve the way we assess how services encourage and enable people who use their services to speak up, and how they act on this feedback. It will be unacceptable if providers are not doing this. We'll also focus on this when we look at how local systems are listening to their local communities so they can improve access to services that meet people's needs.

People are empowered

To help empower people to drive change, it's important for them to know who we are and understand what we do. We want to put people at the centre of all conversations about the quality of care they receive. Having an agreed and shared view of quality will enable a joined-up approach that's applied to individual services, corporate providers, and across system boundaries in both health and social care. It will empower people to have more control in their care and encourage services to improve.

- We'll proactively raise public awareness of CQC and be clear about our role as a regulator. We'll invest in the most effective ways to do this within different population groups.

- We'll be clear what standards people can expect from their health and care services, and how their feedback can drive change. To do this, we'll provide a clearer definition of what good and outstanding care looks like, based on what people say matters to them. Everybody will be able to easily access, understand, and use these definitions. We'll use them as the basis for assessing services and the information that we collect as evidence.

We'll encourage people to use our information in ways that are relevant to their lives. Our up-to-date view of the quality of care in a service will help people and their families make informed decisions when they are choosing where to go for their care. This means they can be confident in the knowledge that our information reflects the quality of care that they can expect, on the day they receive it.

Providing independent, trusted and high-quality information about the quality of care is a fundamental part of our work.

We'll change how we provide information so that it's more relevant, up to date, and meaningful for people who use services, and reflects their experiences. We'll ensure people have access to information in the way they need it, through improved communication channels, and using clear and accessible language.

Prioritising people and communities

We know care is better when it's developed through the eyes of people who use services and delivered in partnership with them. We think the same of regulation. We want to regulate to drive more personalised and coordinated care.

We'll work closely with people who use services and those that represent them to understand their needs, and to co-design and develop how we work and the services we provide to the public. Any changes we make will start with understanding what people expect and need from care services and pathways, and from CQC. We want to involve people in a meaningful way, so we'll encourage and enable people to do this in ways that work for them.

Local health and care services and commissioners need to understand the diverse needs of their populations. They need to work together as a system to meet these needs and improve health and wellbeing. We need to ensure that services in local areas are working with other parts of their community to enable better outcomes and reduce inequalities.

When we assess services, we'll look at how they work with each other, and in partnership with communities, to make improvements. We'll look at how effectively they involve people in designing and improving services. We'll look at how they embed equality, diversity and inclusion, and corporate social responsibility in everything they do to benefit local health and wellbeing, society, the economy, and the environment.

- As well as assessing individual services, we'll assess how they work together as a system in an area. It will be unacceptable for services not to be working in this way. We'll focus on how well systems perform against the things that matter to people and communities and the outcomes for people in that community – important things such as being able to move easily between different services.

- We'll hold local care systems to account for the quality of care in their area and clearly call out issues when we see them. At the same time we'll highlight good practice.

We will identify and call out unwarranted variation and inequalities in health and care. We know that a person's health and wellbeing is significantly affected by factors outside health and care services.

- We'll support local systems to understand the needs of their local populations, especially those that face the most barriers to accessing good care or those with the poorest outcomes, enabling them to respond positively to inequalities.

- We'll work with other agencies, voluntary and community organisations, system partners and other regulators to develop a shared understanding of the factors that contribute to inequalities, and the levers that we and they can use to tackle them.

What do you think?

1a. To what extent do you support the ambitions set out in this theme?

1b. Please give more details to explain why you chose this answer.

Smarter regulation

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

We'll regulate in a more dynamic and flexible way so that we can adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate and efficient regulator.

Targeted and dynamic

We now have a baseline understanding of quality across health and social care. We know that the quality of care can vary from day to day. We want to provide a more consistent, up-to-date, and accurate picture of quality; using the best information will help us to keep people safe and to protect, respect and uphold people's human rights.

- We'll have a more dynamic approach to regulation. Inspections are not the only way to assess quality: we want to move away from relying on a set schedule of inspections to a more flexible, targeted approach. Site visits are a vital part of performance assessments and essential in some settings to observe the care people receive. But we want to use all our regulatory methods, tools, and techniques to assess quality continuously, rather than relying only on scheduled all-inclusive on-site inspection visits. We want our local teams to have a regular view of the services they manage, based on their continuous knowledge and not on a particular date in the calendar.

- We'll use our powers to visit services when we need to respond to risk, when we need specific information, when we need to observe care, and when sampling to check that our view of quality is reliable.

We want everyone we work with to benefit from our regulation. The way we regulate will become more relevant – using what we know to help services to tackle problems early and providing up-to-date, high-quality information and ratings.

- We'll use the best information we can get about a service to keep ratings and our information about quality up-to-date, rather than relying on the outcome of periodic all-inclusive inspections to change them. This includes a better understanding of people's feedback and experiences of care. We'll use this alongside a combination of targeted inspections, national and local data from other organisations and partners, insight from our relationships with providers and partners, providers' own self-assurance, and accreditation.

- We'll change our assessments to be more dynamic, and update ratings more often, so that everybody will have an up-to-date view of quality.

We now have IT systems that can handle large amounts of data, which will enable us to use artificial intelligence and innovative analysis methods. This replaces more manual handling of data and will ensure we interpret data in a more consistent way.

- We'll use our regulatory powers in a smarter, more proportionate way so we take the right action at the right time. Based on the best information available, and enabled by technology, we'll be proactive in using innovative analysis, including data science techniques, to support robust and proportionate decision-making. Combined with the experience, knowledge, and professional judgement of our inspectors, this means we'll be alert and ready to act quickly in a more targeted way and tailor our regulation to individual services and circumstances.

- We'll share the data and information we hold on services with voluntary and other organisations where it will help them in their own work to improve people's care.

Making it easier to work with us

We all have a common drive to improve people's care. From the point of registration, we want to develop ongoing, collaborative relationships with services, built on openness and trust. We want this to enable effective and proportionate regulation so we can focus our regulatory work where quality needs to improve. Digital channels will make it easier for services to work with us and other partners. Our aim is to gather information differently and reduce the duplication of requests by developing how we work with others. This will help staff to focus on providing care safely and finding opportunities to improve.

- We'll work with providers and other regulators and partners to coordinate data collections. To reduce the duplication and workload for providers in collecting and submitting data to us, and to other organisations, we'll only ask for the information we need and that we can't get elsewhere. We'll use information from other sources and share the information we gather ourselves through data-sharing agreements. We'll collect data once and use it many times.

- We want to explore how we can improve our digital interfaces with services. Where we do need to collect information directly, this will make it easier for services to give us the information we need and simpler to update what they've already told us. We'll also make it easier for services to access more of the information we hold about them by having it in one place.

- Being smarter with data will enable our regulation to be more proportionate and consistent. We'll have regular contact with services through our ongoing relationships, and spend more time monitoring and analysing data using technology. This means our visits will be more targeted and effective, with a sharper focus on what we need to look at. So, rather than spending time looking at paperwork when we're on site, we'll have better conversations with people who use services and care staff, and we'll have more time to observe how a service is delivering care.

Future proof and focused on what matters most

Like the services we regulate, we're evolving to adapt to changing models of care, such as integrated systems and digitally-enabled care. The move to looking at how services work together in a local system is a change in our approach; we think this is a smarter way to regulate. We'll work with providers and partners to understand how care is changing, ensuring that our regulatory model keeps pace with changes.

- The way we register services will allow us to make organisations more accountable for people's care. We'll expand our definition of what we consider to be a provider of care and what it means to carry on a regulated activity. This will make sure that we register all the parts of an organisation that are responsible for directing or controlling care; importantly, this will make sure they can be held accountable.

- We'll look at how services meet their social and ethical responsibilities, such as environmental sustainability.

- Our assessments will always focus on what matters to people as they access, use, and move between services. We'll also look more closely at aspects that we know have a positive effect on quality such as the culture of a service, how it works with other services in a local system, and how it drives improvement.

- We'll focus our assessments on how providers are working together to ensure fair access to health and care services for everyone. The information we gather will enable us to better understand risk relating to inequalities in people's health outcomes and we'll take action where we see a need for improvement.

- We'll add to our existing knowledge and experience, and build capability and capacity in our people, our systems, and our processes. We want to learn and improve to be a flexible and responsive regulator, while staying true to our purpose.

Relevant for all

We want our ratings and information to help people to make informed choices about their care, and to give services an assessment of their performance to encourage them to improve.

- We'll evolve our ratings. As well as ensuring they provide an up-to-date view on quality, we want to make ratings reflect how people experience care so they're more meaningful and focus on what matters most to them.
- We'll move away from long reports written after inspections, and instead provide information and data targeted to an audience. Information for the public will be easier to understand and more accessible. We want people to be able to get information in ways that suit them.
- We'll regulate in a smarter way by providing a clearer definition of quality and the standards people can expect, which is based on what people say matters to them. Everybody will be able to understand and use it as a reference for what good and poor care looks like. We'll explain clearly how we use this to assess the quality of services and the information that we collect as evidence. This definition will be at the heart of our regulatory processes and will help us improve consistency in what we do, so people can be confident that good means good wherever they are in the country and whichever service they are using.

What do you think?

2a. To what extent do you support the ambitions set out in this theme?

2b. Please give more details to explain why you chose this answer.

Safety through learning

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments.

It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

The importance of culture

We know that the right organisational culture is crucial to safety. A strong safety culture needs everyone working in health and care and people who use services to play their part. In a strong safety culture, risks aren't overlooked, ignored, or hidden – and staff can report concerns openly and honestly, confident that they won't be blamed. In this type of culture, it's accepted that all incidents – positive, negative, and wholly avoidable – provide opportunities to learn and improve. We want this approach to be universal with leaders, staff and people using services all involved. Safety must be a top priority for all – regardless of seniority or role.

- There's no national agreement on what we mean by safety in different health and care sectors and services. We'll work with others to agree and establish a definition and language that explains what we mean by safe care and how this could apply in different services. This will create a better understanding of risk across all health and care – so that we know what's not acceptable – and therefore help to minimise harm. More clarity will enable services to prioritise the essentials and have clearer expectations when we assess them. When we talk about safety we'll make sure it reflects what's most important to people when they use services.

- Our assessments of safety will have a sharper focus on checking for open and honest cultures. We'll be looking for cultures that have learning and improvement at their core.

- We can do more to help services improve safety by sharing the insights, learning, and exemplary practices that we've identified. We'll use our independent voice to highlight the changes and improvement that services have made as a direct result of our regulatory action. We'll highlight trends and patterns across health and care so that services have the information they need to improve.

Building expertise

Knowledge is crucial to having the right safety cultures, but there are different levels of knowledge and expertise in different types of service and sectors. Shifts in safety culture won't happen without the right expertise at all levels across health and social care – including at CQC. Changing a safety culture also needs good leadership to make it happen. We all need to understand why safety is important at a practical level and how we can each individually improve it in our area of work, and to create an excitement and movement around it that motivates people every day to improve.

- When we assess services, we'll be looking at the type and levels of expertise in services. We'll check how they assure themselves that they have the right balance, and how they are investing in improving safety, including training, support and how they use data.

- We'll improve and increase our own safety expertise to ensure our approach is in line with the latest safety thinking – whether from health and care in England, from elsewhere, or from other industries and sectors. Together with our unique data and insight, this will enable us to challenge and highlight failures in services and in systems.

Involving everybody

People have a right to expect safe health and care services. We think that making sure people experience the safest care is everyone's job. To do this, leaders, their staff, and the people using their services all need to be involved. People should influence the planning and prioritisation of safety and be truly involved as equal partners in their care at all levels. This means that services need to actively take into account people's rights and their unique perspectives on what matters to them in the way they choose to live their lives and manage risk. This collaborative approach has the potential to transform safety and to ensure that people's human rights are upheld.

- In our assessments we'll look for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and the impact this has on their outcomes. We'll check that people have the information they need to help them be equal partners in their care and play a part in their own safety.

Regulating safety

We know that some of the greatest safety risks – both physical and psychological – happen when people struggle to access the right care, when they're transferred between services or after they're discharged. We also know that some services are more likely to have greater safety risks than others. Sometimes the care system works against health and care staff, making it hard to take the right and safest action.

With new ways of delivering care and more services working as part of a local system, we will change how we regulate safety in all services.

We'll focus more on the types of care setting where there's a greater risk of a poor culture going undetected. We'll develop ways to understand what's happening in these services as, we know that people are often unable to speak up for themselves, and more likely to be failed by a poor culture.

- Learning and improvement must be the primary response to all safety concerns in all types of service. Where we have concerns, we will directly make services respond and show us – and the people who use their service – what action they'll take to show they are learning and improving. We'll share this information with the public as part of our up-to-date view of quality.

- We'll review how effectively we are assessing and monitoring safety – from registration through to enforcement. We'll use our improved safety expertise to assure ourselves that we're taking the right approach. As part of this, we'll review how we gather data to ensure greater consistency across sectors regardless of who is responsible for reporting or receiving the information.

- Where we identify risks to people using a service, we'll intervene more quickly. If we have evidence of risks, including what people are telling us, we'll take action earlier to make sure that services are focusing on protecting people before they experience poor care and avoidable harm. This includes protecting people's human rights. To do this, we'll make better use of people's feedback on services. Key to this will be having the best comparable data and ensuring we are sharing it with our partners.

- Services that are not open to learning can't be safe. We'll use our powers and act quickly where improvement takes too long, or where change isn't sustainable. We'll take action where services are unable to identify systemic issues in their own organisational culture or fail to learn lessons from widely publicised failures happening across health and care.

- We'll check how well services work together – those that are truly focused on safety will be determined to ensure a safe journey of care for people moving between services.

- Where we see systemic safety issues in a local area, we'll speak out to encourage meaningful change. We'll share the learning from our insight on themes, trends, and best practice to help services and systems improve their safety. We'll also share our data and information about safety in health and care systems with regional organisations, to support their oversight of safety in a local area.

Consistent oversight and support

To improve safety, service providers may need support and guidance. In some sectors, there's a national team of experts who provide guidance and alerts about safety. But this type of national support and oversight doesn't exist in all sectors. Although there are bodies who might provide support or receive data about safety incidents, this oversight or champion role isn't joined up, meaning these sectors risk being left behind. It's crucial that all health and care services have consistent access to the right support and insight to help them on their journey to build strong safety cultures, learn from safety incidents, and improve their practice.

- We want to understand where there is a lack of support and expertise for safety. We'll work with others to develop solutions to ensure that all services have support and leadership during difficult times, and that they have the right tools to always provide safe care. We'll need to understand where this oversight is best placed and develop the right frameworks as needed.

- We'll use our insight and independent voice to promote a national conversation on safety across health and care sectors and systems. We can use this to drive improvements in safety cultures and reduce harm.

What do you think?

3a. To what extent do you support the ambitions set out in this theme?

3b. Please give more details to explain why you chose this answer.

Accelerating improvement

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

We want to empower services to help themselves, while retaining our strong regulatory role. The key to this is by collaborating and strengthening our relationships with services, the people who use them, and our partners across health and care.

Collaborating for improvement

We want to see improvement within individual services, and in the way that they work together to make sure people get the care they need. Services and local areas that want to improve should get the support they need to make this happen.

Where individual services or a local health and care system need to improve, it's essential to get this right for the people who use and rely on them. This is important so that improvement happens in ways that people can recognise: easier movement between services and pathways of care, equal access to the most appropriate services at the right time, reduced inequalities, fewer avoidable mistakes, and better experiences and outcomes – all delivered by a diverse workforce that is thriving.

The support that's available to help services improve the quality of their care varies between and within health and care sectors and across England. Some services have limited access to support; we want all sectors to have equal and consistent access to the support they need to improve. We want to play a much more active leadership role in driving improvement, advocating for the issues that matter to people who use services.

- We want to establish and facilitate national sector-wide improvement coalitions with a broad spectrum of partners within both health and care, including those representing people who use services. These coalitions would work collaboratively to improve the availability of support, focusing on areas where there are gaps, both nationally and at a local system level. We'll champion consistent access to direct, tailored, hands-on support for all providers who need it.

- We'll encourage our national partners to offer support to local systems to help them improve. We'll also strengthen our ongoing relationships at a local level to promote collaboration on improvement across areas, working with partners from the relevant improvement coalitions. The aim is to ensure all parts of a local system are focused on improvement, including addressing health inequalities.

Making improvement happen

As health and care evolves, what was considered good a few years ago isn't good enough today; what is good today won't be good enough in the near future. People have higher expectations about safe, high-quality care – and so do we.

We'll do more to make improvement happen, taking action in priority areas that need support the most. We will hold improvement conversations with services and offer a range of resources to support them.

- We want to encourage continuous improvement in quality. We'll be clearer on the standards that we, and people who use health and care services, expect. We'll set a higher bar for what we expect of services rated as good, which should match what the public expects. As part of this, we'll expect services to keep on improving so that they remain good. We'll also expect services to contribute to improvement in their local health and care system.

- We'll identify the areas that need to improve as a priority – both at a local and national level. We'll work with partners to make change happen through programmes of activity based on evidence of what works. This will include using our independent voice to share good practice and examples of the factors that drive improvement, and the findings from our in-depth reviews. We'll prompt action through events and workshops, and by publishing guidance, tools, and frameworks that support improvement.

- We'll develop collaborative relationships with services, helping them to find their own route to improvement by pointing them to sources of guidance, best practice, and other providers and organisations that can offer advice and support. We'll hold improvement conversations with services to support them to decide for themselves the best way forward rather than 'telling them what to do'. This will enable us to help services who want to improve, while retaining our core regulatory role, which means using our powers to act where we see poor care.

- We'll empower providers and local systems to improve themselves by offering analysis and benchmarking data. This will enable them to self-assess how they're performing against similar services and areas, so they can use this to target improvements themselves. Our benchmarking information will also show us where we need to focus our work to drive improvement.

Encouraging innovation

Innovative practice and technological change present an opportunity for rapid improvement in health and care, but services don't always understand it or implement it well. Our regulation will keep pace with these changes and promote innovation that will improve people's care.

- We'll make sure we understand changes being developed to the way services deliver care. We'll then work with health and care services and

other stakeholders to understand how these can improve the quality of people's care. When we do this, we'll consider where using new technology might disadvantage some people and what services need to do so that nobody is left behind.

- We'll work in partnership with services and other stakeholders to develop a coordinated, effective, and proportionate approach to regulating new innovations and technology. We will encourage and champion innovation and technology-enabled services where they benefit people and where the innovation results in more effective and efficient services. We know the path to innovation is difficult; we want to use what we know as a regulator to create an environment where services can try new ways to deliver safe, high-quality care. We'll aim to support their efforts to innovate through clear advice and guidance.

An approach based on evidence

We have valuable knowledge and insight about improvement – we want to use this to inform our regulatory approach. Through all our work, we want to promote an improvement culture across health and social care.

This activity will be based on evidence about what really works.

- Through our assessments of services and local systems, and across all our work, we'll identify and investigate the things that are most important to ensuring good quality of care. We'll use the evidence we collect to support improvement.
- We'll invest in research and make better use of external evidence to have a better understanding of the conditions that drive quality improvement, including evidence and best practice from other industries.
- We'll use the best available evidence to inform our approach to regulation. We'll further develop and embed a culture of learning in CQC to maximise our impact on the quality of care and people's outcomes.

What do you think?

4a. To what extent do you support the ambitions set out in this theme?

4b. Please give more details to explain why you chose this answer.

Our core ambitions

In each of the four themes in this strategy, we have an ambition to improve people's care by:

- assessing how well health and care services work as a local system
- looking at how services and local systems are acting to reduce inequalities.

5a. To what extent do you support our ambition to assess health and care systems?

5b. Please give more details to explain why you chose this answer.

6a. To what extent do you think the ambitions in the strategy will help to tackle inequalities?

6b. Please give more details to explain why you chose this answer.

Measuring the impact on equality

We need to consider equality and human rights in all our work, so we've produced a **draft equality and human rights impact assessment**. It identifies the opportunities and risks for doing this through our new strategy. Importantly, it identifies the actions we'll take to minimise the risks and make positive change happen.

7. We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our draft equality impact assessment. For example, you can tell us your thoughts on:

- Whether the ambitions in the strategy will have an impact on some groups of people more than others, such as people with a protected equality characteristic.
- Whether any impact would be positive or negative.
- How we could reduce or remove any negative impacts.

How to respond to this consultation

Thank you for taking the time to tell us what you think about our proposals for our future regulation. It's important to get your feedback and thoughts so we can make our strategy work for everyone.

Please respond by 5pm on 4 March 2021.
The quickest and easiest way to respond is through our online form:

www.cqc.org.uk/Strategy2021

If you can't use the online form, you can respond by email to:
strategydevelopment@cqc.org.uk

Or you can post your response free of charge to:

Freepost RSLS-ABTH-EUET
Strategy 2021 Consultation
Care Quality Commission
Citygate
Gallowgate
NEWCASTLE UPON TYNE
NE1 4WH

Please contact us if you would like a summary of this document in another language or format.

CQC-468-012021

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 21/22-018

Board of Directors
7 April 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

There has been a reduction in CSW vacancies and improvements in RN and CSW sickness rates. There has also been a positive reduction of the number of RN red shift impacts on care that have been reported in this period via the Safe Staffing Oversight Tracker (SSOT). These improvements were seen in all categories with the exception of falls that has noted an increase.

The Trust remains on track with the International Recruitment Programme expecting 107 RNs to arrive before end of April 2021.

During Q1 of 21/22 CSW vacancies should reduce to zero plus any subsequent turnover. Band 5 RN vacancies are expected to reduce to 4.5% by July once all the international RNs have passed their exams and have their registration.

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 / 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.
- The Trust has maintained NHSP RN fill rates at 54% through the use of the nurse incentive scheme despite an increase in requested hours during Q3 and Q4.
- 107 international nurses that are expected to arrive in the Trust before the end of April 2021
- The Trust has supported 36 3rd year nursing students to supplement the workforce who finish end April 2021.

Gaps.

- The Trust has seen an increase in the use of agency nurses utilised to fill RN staffing gaps to 7% (M11)

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	Nurse incentive scheme review 13 October 2020 and 21 December 2020 (EMT).

Executive Management Team
21 March 2020

Monthly Safe Nurse Staffing Report.

Purpose

This report provides the Board of Directors with information regarding safe nurse staffing and the actions to improve the vacancy rates.

1 Current position: areas to note

1.1 Vacancies

The Trust has seen a reduction in CSW vacancies in M11 to 5.94% from 6.79% in M10. Band 5 RN vacancies currently remain static at 19%.

1.2 Sickness

The Trust has seen a reduction in RN sickness to 7.14% (M11) from 9.17% (M10) and CSW sickness reduce to 9.47% (M11) from 12.34% (M10).

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M11 the SSOT reported a lower number of shifts that fell below minimum staffing levels for RNs. There were no “red” shifts when assessed using professional judgement, as appropriate controls and mitigations were put in place ahead of such shifts.

1.4 Impact on Care

The impact on care of reduced staffing noted a reduction in M11 with the exception of falls that increased to 36 (M11) from 26 (M10). Falls improvement work has already begun and will be tracked through our system for quality improvement and PSQB.

2. Actions to mitigate risks

The Trust remains on track with the international recruitment of 107 RNs to arrive before end of April 2021. The first cohort of 14 nurses arrived from India on 24 February 2021; these nurses are expected to be working on the wards as RNs in April 2021 following successful completion of the Objective Structured Clinical Examinations (OSCE). Further groups are due to arrive in March and April 2021.

WUTH is currently running active recruitment campaigns, interviewing weekly for registered nurses and care support workers. The Trust has now provided enough CSW offers to reduce vacancies to zero during Q1 2021/22.

During the Covid-19 wave 3 of the pandemic the Trust has also utilised 36 third year students to support the workforce. These are due to finish end April expecting to increase the vacancy pressure slightly during May 2020.

The impact of the nurse incentive scheme has proved successful in increasing registered and non-registered nurse fill rates during times of pressure; this has been extended to June following approval from the Executive Management Team on 16 March 2020.

4. Conclusions

Despite M11 remaining challenging for nurse staffing the Trust has been able to more suitably staff wards during M11 than previous months. This is due to reducing sickness and the pressures of the COVID 19 pandemic starting to ease at the end of the month. In addition the benefit of the nurse incentive scheme and the use of block booked agency nurses have reduced the impact of the 19% band 5 RN vacancies.

A number of actions are underway to reduce the vacancy factor these are expected to impact from Q1. These include active continuous weekly RN and CSW recruitment, international recruitment.

To bridge the gap the nurse incentive scheme has been extended until June 2021 to encourage increased NHSP fill rates of vacant duties.

5. Recommendations to the Board

The Board of Directors are requested to note the contents of report

Appendix 1 – Safe staffing dashboard July 2020- February 2021

	Safe Staffing Board Assurance Dashboard 2020 /21									
Data Source	Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total		9.6	8	8.5	10.1	9.5	8.1	8.9	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses		4.8	3.8	4.1	5.2	4.8	4	4.3	
Corporate Nursing	Care Hours Per Patient Day - CSW's		4.2	3.5	3.7	4.1	3.8	3.4	3.7	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	79%	81%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	86%	91%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	77%	84%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	95%	71%	
Corporate Nursing	Trust Occupancy Rate	57.20%	66.90%	79.50%	79.50%	76.10%	79.30%	83.50%	80.20%	
Corporate Nursing	Occupancy Rate - APH	63.10%	72.10%	81.50%	79.10%	76.00%	80.30%	82.30%	80.30%	
Corporate Nursing	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	50%	50%	
Workforce	Vacancy Rate (Band 5 RN's)	18.46%	18.05%	16.94%	16.61%	17.66%	18.10%	19.42%	18.81%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.57%	20.16%	18.73%	17.11%	17.72%	18.49%	19.89%	19.01%	
Workforce	Vacancy Rate - All RN (All grades)	9.81%	9.90%	9.40%	8.67%	9.79%	9.57%	10.79%	10.03%	
Workforce	Vacancy Rate (CSW's)	5.89%	5.86%	7.86%	7.77%	8.11%	6.28%	6.79%	5.94%	
Workforce	Sickness Rate - RN	5.69%	6.12%	6.38%	6.80%	6.95%	6.49%	9.17%	7.14%	
Workforce	Sickness Rate - CSW	10.46%	9.58%	10.09%	8.82%	7.59%	8.18%	12.34%	9.47%	
Workforce	Absences Rate - RN	4.84%	2.36%	2.60%	1.55%	1.76%	1.50%	2.39%	1.78%	
Workforce	Absences Rate- CSW	4.96%	3.33%	3.17%	1.55%	2.17%	1.56%	2.64%	2.71%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	0	0	
Corporate Nursing	Number of RN Red Shifts		359	445	454	243	499	689	430	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	26	36	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	0	1	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	2	1	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	1	2	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	33	6	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	38	2	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	119	34	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	278	31	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	237	72	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	46	23	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	299	88	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	1	1	0	
Corporate Nursing	Total Number of staffing incidents	30	53	80	75	25	90	102	42	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	0	1	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	1	0	
Complaints team	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	0	
Corporate Nursing	Staff Moves		232	329	140	164	172	TBC	TBC	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	43952	35299	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	42759	33056	
NHS Professionals	% of requested filled RN's	67.80%	62.80%	61.70%	60.20%	72.70%	58.90%	57.50%	54.60%	
NHS Professionals	% of requested CSW filled	86.30%	80.20%	76.50%	71.10%	85.30%	68.10%	62.80%	68.00%	
NHS Professionals	% of Agency staff used RN	3%	3%	3%	2%	6%	1%	2.30%	7.00%	
NHS Professionals	% of Agency staff used CSW	0	0	0	0	0%	0%	0%	0%	

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21- 019

BOARD OF DIRECTORS
07 April 2021

Title:	**Change Programme Summary, Delivery & Assurance**
Author:	Clare Jefferson, Head of Service Improvement
Responsible Director:	Matthew Swanborough, Director of Strategy and Partnerships
Presented by:	Matthew Swanborough, Director of Strategy and Partnerships

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

The Programme Board of 17th March 2021 received the assurance evidence and that evidence (coupled with attendance at the programme meetings) forms the basis of this assurance report to the Board of Directors.

One of the previously tracked Digital Enabler projects has been completed and no longer subject to assurance; this project was reporting Green ratings for both Governance and Delivery in February.

The table below give a summary of the assurance ratings in March in comparison to February.

	Governance				Delivery			
Month	Red	Amber	Green	Suspended	Red	Amber	Green	Suspended
Feb-21	0	3	7		1	3	6	
Mar-21	0	4	5		0	5	4	

The ratings for the 3 priority programmes have improved this month with two attracting both Green for Governance and Delivery.

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** / ~~No~~
Compassionate workforce: Be a great place to work	~~Yes~~ / **No**
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)	
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	
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
7 April 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

At the Programme Board of 17th March 2021 the members received a presentation on the Improvement teams: Service Improvement, Quality Improvement and Productivity and Efficiency/PMO. Members, as usual, received full update presentations on the priority programmes of Patient Flow, Perioperative Medicine and Outpatients Transformation. The Programme Board also received the assurance evidence and that evidence (coupled with attendance at all the programme meetings) forms the basis of this assurance report to the Board of Directors.

Conclusions

1.1. Governance Ratings

For March, two of the three programmes were Green rated for Governance, with one attracting an Amber rating (no change from the February ratings). For the Digital Enabler and Service Improvement projects, three were Green rated with the remaining three Amber.

1.2. Delivery Ratings

March saw two programmes Green rated for Delivery with just one Amber rated (this is an improvement from the February ratings where two rated Amber with just one Green). For the Digital Enabler and Service Improvement projects, two were Green rated, four Amber (two of which are to flag milestone extensions which have now been approved by the SRO).

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.

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.

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.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

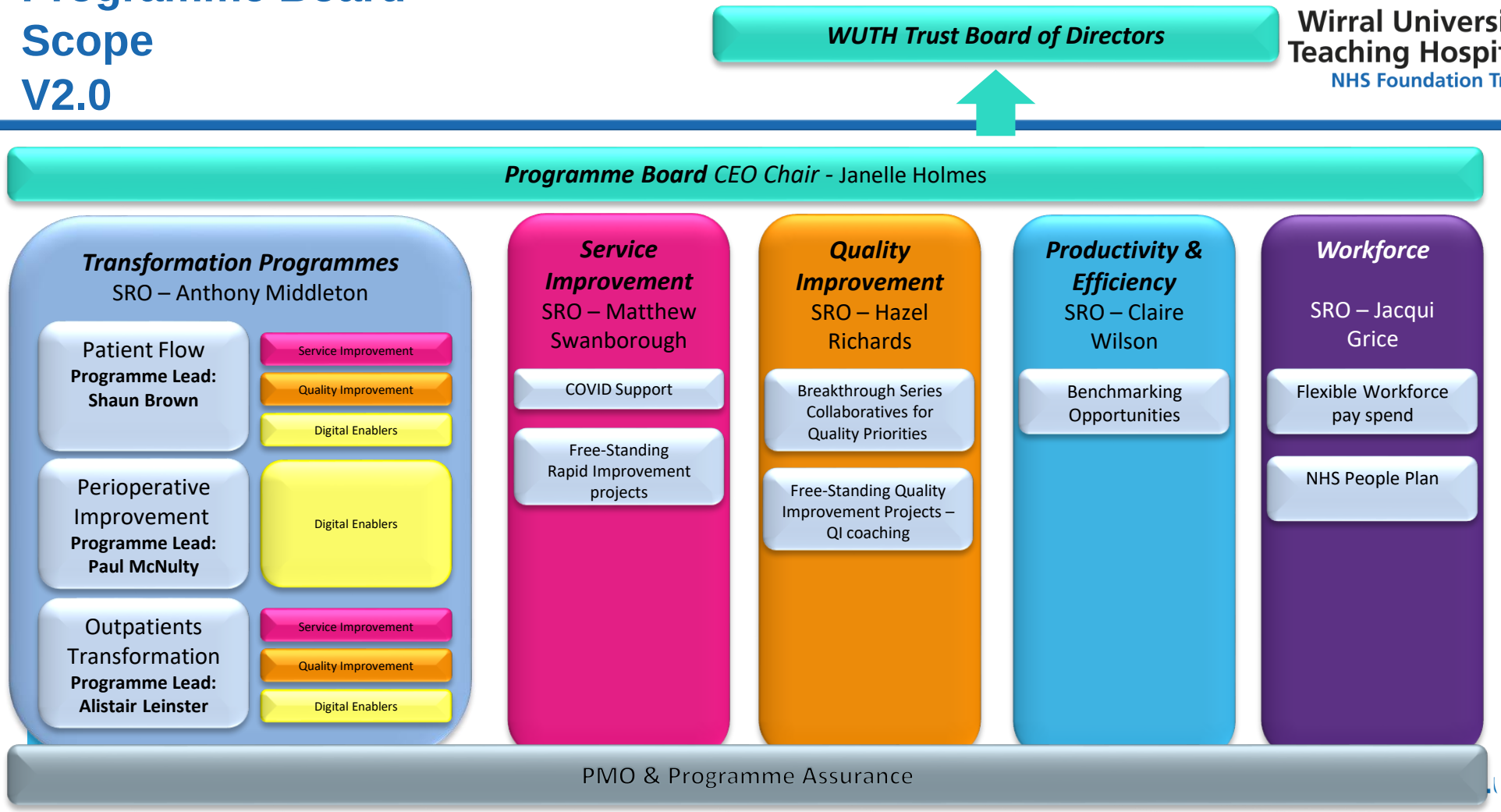
Change Programme Summary

Programme Assurance
March 2021

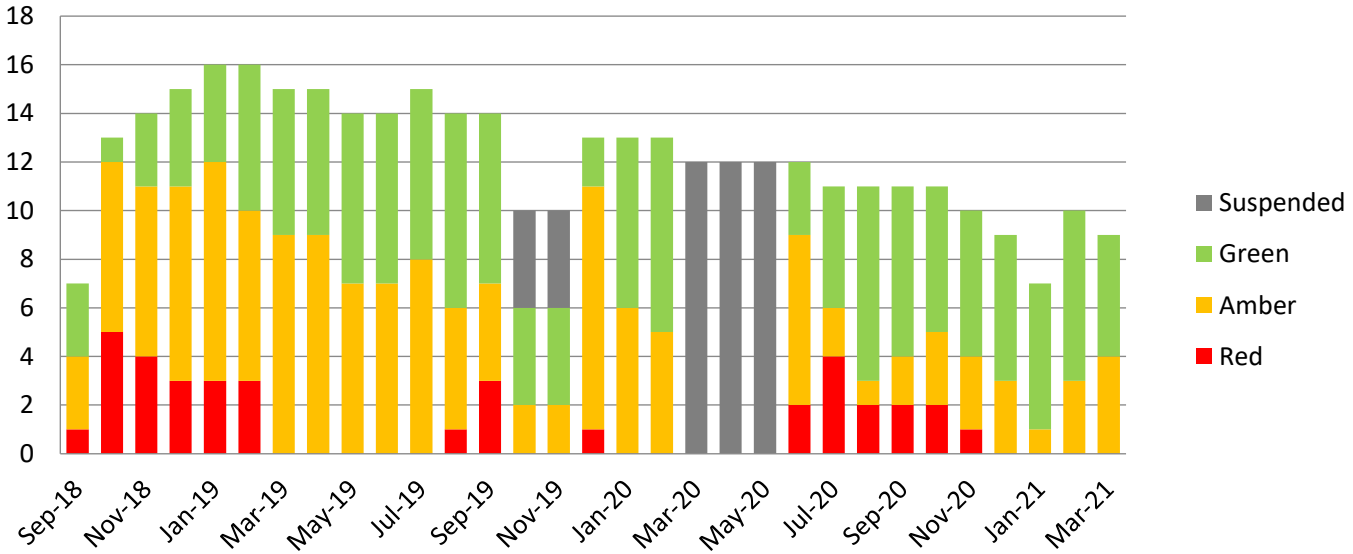
wuth.nhs.uk

Programme Board Scope V2.0

Wirral University Teaching Hospital NHS Foundation Trust



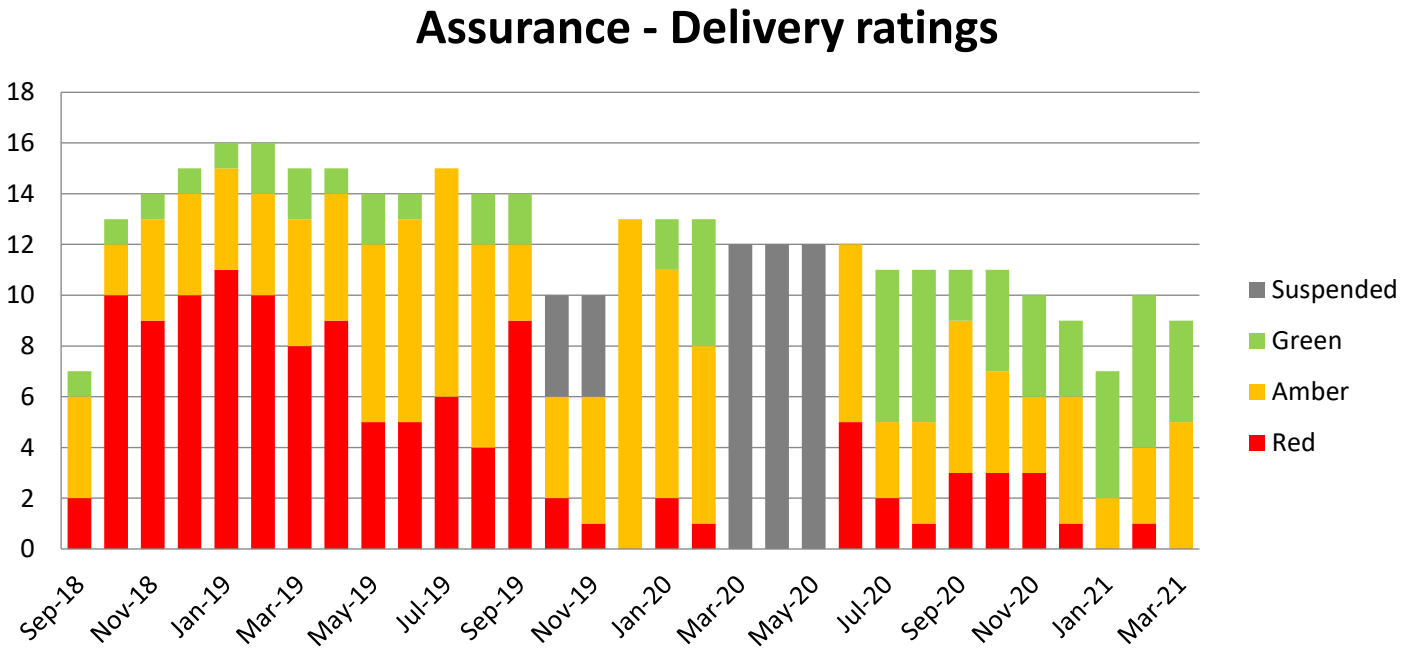
Assurance - Governance ratings



Change Programme Assurance Report - Trust Board Report - March 2021

Assurance

Wirral University Teaching Hospital NHS Foundation Trust



together we will

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NHS
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NHS Foundation Trust

Programme Assurance Ratings

10 March 2021

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

Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Improving Patient Flow	Governance	Amber	Delivery	Amber

- The scope of the Patient Flow Programme has been narrowed to focus improvement work on a small number of key standards in the Flow Vision during Q1 21/22.
- The reported Metrics will be those directly linked to active improvement projects: Discharge Before Midday, ED Triage within 15 Minutes, Bloods & ECG in ED within 30 minutes.
- **A plan is in development to identify the improvement projects which will contribute to an increase in the number of Discharges before Midday and the ED Performance KPIs as described above, 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.
- Only Digital Enabler projects remain within the Scope of this Transformation Programme; therefore Programme Management responsibility will transfer from Service Improvement to Informatics as of 01/04/2021 *(approved by Programme Steering Group 08/03/2021)*
- **The KPIs declared by the programme, as agreed by the Programme Board, continue to be monitored through the Programme Board.**

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

Programme Assurance

Wirral University Teaching Hospital
NHS Foundation Trust

Outpatients Improvement	Governance	Green	Delivery	Green

Overall Aim: The Outpatients programme was re-focussed (Programme Board on 18th March 2020) 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 2021's figures have been 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 January at **38%** (was 33% in December); the **60%** 'follow-up' non-F2F target was not achieved, but the trajectory (36%) target was exceed in January **39%** (was 33% in December). **The revised QIA/EIA has been now been signed off at Clinical Executive level.**

Compliance and Exceptions: The programme team is in the process of setting up a Non -F2F project group to identify barriers to Non-F2F consultations and increase the adoption of Video Consultations.

Note 1: The programme cites Simon Stevens - 3rd Phase of NHS response to Covid letter, dated 31 Jul 2020: Overall 25% Non-F2F, FU appts 60% Non-F2F.

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Improving Patient Flow - Programme Assurance Update – 10 March 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. PSG 8 Mar 21 approved the revised Programme Scope now v3.1 which focuses on the delivery of 4 KPIs from the Flow Dashboard. **2.** Action Tracker available up to meeting of 2 Mar 21. **3.** ToR updated Oct 20 is uploaded to PM3. **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 managed in PM3 however detailed Milestone Plans are still to be populated. **7.** The Programme has chosen 4 KPIs from the Flow Dashboard to Focus and report on for Q1; they have a revised dashboard for these but are yet to developed a plan for 'how much, by when'. **8. & 9.** Programme risks and issues are managed in PM3 and were reviewed by the Patient Flow Steering Group 2 Mar 21.

Most recent assurance evidence submitted 10 Mar 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 specific flow standards in the Flow Vision	Anthony Middleton		●	●	●	●	●		●	●	●	●

SERVICE IMPROVEMENT: 111 First Phase 2 - Project Assurance Update – 10 March 2021

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

Independent Assurance Statement

1. Project Proposal v0.1 is attached in PM3 and was approved in principle by the project group Dec 20 awaiting clinical input. Project paused after Week 1 due to Covid. Project restart meeting scheduled for 12 March 2021 where rescoping and potential amends to proposal will take place. **2.** The Project team is defined, however no meetings since the launch have taken place. Project meeting scheduled 12 March 2021.
6. The PM3 milestone tracker shows a revised end date for the project due to the project pause which should now be discussed by the Project Team and agreed.
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 7 Mar 21.
8. & 9. System identified risks and issues have been added to PM3 but these have not been reviewed by the Project Team.
Most recent assurance evidence submitted 10 Mar 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 – 10 March 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. PSG 8 Mar 21 approved the revised Programme Scope. **2.** As well as the Steering Group 2 Mar 21, there is a monthly Project meeting for the Digital Enablers - evidence by log 9 Mar 21. **3.** The Perioperative Steering Group has ToRs revised in Jan 20 in supporting documents which needs to be reviewed before the next assurance assessment. **4.** There is a Comms Plan in place which is tracked last updated Jan 2021 - this should be reviewed ahead of next assurance. **5.** The renewed QIA signed off Dec 20 is evidenced in PM3. **6.** Programme and associated Projects are effectively managed in PM3. **7.** KPIs are defined and on track. **8. & 9.** Programme risks and issues are managed in PM3 (all reviewed in March Steering Group).

Most recent assurance evidence submitted 10 Mar 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
3.1	**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: Electronic Booking Form- Project Assurance Update – 10 March 2021

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

Independent Assurance Statement

1. It appears that the PID has been revised, undated report from PM3 CPO 1514 evidenced in Teams folder for Project. No Evidence of approval. **2.** The Perioperative Digital Enabler projects are discussed at the Perioperative Digital Enablers Project Meeting, evidence of meetings on 9 Mar 21.
6. Milestone plan on PM3 shows all to be on track. **8. & 9.** Project Risks and Issues are managed in PM3; 1 open risks recorded and reviewed 05/03/2021. 2 open issue last updated 05/03/21 and 10/03/21 .
Most recent assurance evidence submitted 10 Mar 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 – 10 March 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. Draft PID submitted to Periop Steering meeting 2 Mar 21, still to be agreed and signed off. Milestone for this is 12 Mar 21. **2.** Electronic Consent is discussed as part of the Perioperative Digital Enablers meeting, evidence this meeting took place 9 Mar 21 . However there is not yet an effective project team with clinical representation in place.
6. The milestone plan has been updated in PM3 to reflect revised dates for the initiation stage; all currently on track.
8. & 9. Project risks and issues documented in PM3 updated by project manager 09/03/2021 but all require review by the project team once established.
Most recent assurance evidence submitted 10 Mar 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 – 10 March 2021

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

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. PSG 8 Mar 21 approved the revised Programme Scope now v5.0. **2.** As well as the Outpatients Transformation Steering Group meeting last held 3 Mar 21, there is comprehensive evidence of project meetings taking place in Mar 21. **3.** Programme ToR has been updated (v3.0) awaiting sign off; this needs to be reviewed before the next assurance assessment.
4. There is a tracked Comms Plan in place and a supporting stakeholder matrix. **5.** Programme EIA/QIA now signed 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 (Achieving total non-f2f target for January (25%) at 38%, but not achieving follow-up target (60%) at 39%) the Programme has initiated a Vision and KPI RI project to identify additional KPIs to monitor a draft of which was presented to PSG 8 Mar 21.
8. & 9. Programme risks and issues are managed in PM3 (all reviewed in steering meeting 3 Mar 21).
Most recent assurance evidence submitted 10 Mar 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 – 10 March 2021

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

Independent Assurance Statement

1. The project is defined in the PID v2.0 dated 3 Jul 20. **2.** Project meeting held 25/02/2021 (agenda and action log evidence). ToR updated DRAFT v3.0 and circulated to reflect change in frequency of meetings and that the Operational Lead post is currently vacant; to be reviewed before the next assurance assessment.
6. The PM3 milestone plan shows revised dates for 7 milestones - most notably extension to 'paper documentation to be made electronic' 30/04/21 to 25/06/21 due to Analyst resource this was escalated and accepted by PSG 8 Mar 21
8. & 9. Project risks and issues are managed in PM3 (all reviewed Feb/ Mar 21).
Most recent assurance evidence submitted 10 Mar 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 – 10 March 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. The Non-F2F Consultations Project Meeting held 04/03/2021 was only attended by VS and MM to finalise the **Closure Report which was approved at PSG 08 Mar 21.**
6. PM3 shows 2 remaining milestones (FAQ Video Consultation Workshop revised date 23/03/2021 and Post Implementation Review scheduled for 07/05/2021).
8. & 9. Project risks and issues are managed in PM3 (Evidence of review in Feb/ Mar 21.
Most recent assurance evidence submitted 10 Mar 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 – 10 March 2021

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

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 03 Mar 21.
6. An 6-week project extension was approved at PSG 08 Mar 21; the milestone plan has been updated to reflect this. **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 4 open risks logged on PM3 and these were last reviewed on 8 Mar 21. No issues have been raised to date.
Most recent assurance evidence submitted 10 Mar 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: 21/22 –020

BOARD OF DIRECTORS

07 APRIL 2021

Title:	Declaration of Interests and Fit & Proper Person Annual Check
Author:	Oyetona Raheem, Interim Deputy Trust Secretary
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Oyetona Raheem, Interim Deputy Trust Secretary

Executive Summary

This report presents the Declaration of Interests by all serving directors and persons holding director-equivalent positions, in line with Section 28 of the Trust's constitution and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Details of individual declarations are attached as Appendix A.

The report also contains the result of the Fit and Proper Person annual checks which was undertaken by the Trust Secretariat. The checks include those of the Register of Disqualified Directors and the Insolvency and Bankruptcy register. The annual check was undertaken on 25 March 2021 and a summary of the findings is attached as Appendix B.

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	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)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential

standards, competition law)	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
NA	
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	Trust Board on 1 April 2020
Background papers / supporting information	

BOARD OF DIRECTORS
07 April 2021

Declaration of Interests and Fit & Proper Person Annual Check

Purpose

To present the declaration of interests and the results of the Fit and Proper Persons Annual Check for 2020/21. The last report was presented to the Board on 01 April 2020.

Introduction / Background

NHS Trust Boards are required to present a report on declarations of interest and the Fit and Proper Persons Annual Check under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and CQC Regulation 5: Fit and proper persons: directors – Information for NHS bodies.

Key Issues/Gaps in Assurance
There are no matters to report.

Next Steps
The information provided in the report would be used to update the register of interests published on Trust website and the Fit and Proper Persons declarations held centrally by the Trust Secretariat.

Conclusions

All directors and director-equivalent posts are compliant with the requirements of the Fit and Proper Persons test.

Recommendations to the Board

- the Board to note the individual declaration of interests
- the Board to note the content of the Fit and Proper Persons Annual Check report.

Appendix A

Declaration of Interests 2021

The following Declarations of Interests have been made by Board members through the Civica online declaration system that is maintained by the Trust.

Name	Declaration
Chris Clarkson	None
Jayne Coulson	• Experian – Director of Service
Sir David Henshaw	• Chair – National Museums Liverpool • Trustee – North Wales Heritage Trust • Chair – Natural Resources, Wales • Chair – Sir David Henshaw Partnership Ltd • Chair – Liverpool World Heritage Task Force
Janelle Holmes	• Spouse is a Senior manager in NHS at Salford Royal NHS Trust • Spouse Employed as UK Director at Ortivus which is a Swedish Medical equipment company selling into Healthcare
Steve Igoe	• Deputy Vice Chancellor – Edge Hill
Sue Lorimer	• Alpha (RSL) Ltd – Board member
Steve Ryan	Sole trader providing professional advisory services in healthcare - typically to the NHS
Anthony Middleton	None
Hazel Richards	• Spouse is Group Chief Executive of Northern Care Alliance NHS Group • Step daughter is on rotation to WUTH as an ST4.
Nikki Stevenson	• Spouse is Mersey and Cheshire Critical Care Network Lead & Consultant in ITU at RLUH
John Sullivan	None

Matthew Swanborough	None
Claire Wilson	• Healthcare Financial Management Association - Trustee • Spouse is Executive Lead for Investment, Greater Manchester Health & Social Care Partnership
Jacqui Grice	None

Appendix B

Fit and Proper Persons Annual Check - 2021

	CC	JC	DH	JH	SI	SLo	SR	AM	HR	NS	JS	MS	CW	JG
Is the individual recorded as being a disqualified director on the Insolvency Service Register?	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is the individual recorded as being a disqualified director by Companies House?	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is the individual recorded as insolvent or bankrupt on the Insolvency and Bankruptcy Register?	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 21/22 –021

BOARD OF DIRECTORS

07 APRIL 2021

Title:	Review of Non-Executive Director Independence
Author:	Oyetona Raheem, Interim Deputy Trust Secretary
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Oyetona Raheem, Interim Deputy Trust Secretary

Executive Summary
In line with NHSI good governance guideline, an assessment of independence of the serving Non-Executive Directors have been conducted. The Board of Directors is also required to identify the Directors that are considered to be independent in the Annual Report. The outcome of the independence assessment for 2020/21 is attached as Appendix A.

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

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	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)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
NHS FT Code of Governance
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
NA
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	Trust Board on 24 June 2020
Background papers / supporting information	

BOARD OF DIRECTORS
07 April 2021

Review of Non-Executive Director Independence

Purpose

To present the outcome of the independence assessments of the Non-Executive Directors for 2020/21.

Introduction / Background

Under section B.1.1 of the NHS FT Code of Governance, There is a requirement for the Board of Directors to identify in the annual report, each non-executive director it considers to be independent. The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement.

The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director:

- has been an employee of the NHS foundation trust within the last five years;
- has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;
- has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;
- has close family ties with any of the NHS foundation trust's advisers, directors
- or senior employees;
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or
- is an appointed representative of the NHS foundation trust's university medical or dental school.

For the purpose of the 2020/21 Annual Report, self-declarations have been obtained from serving Non-Executive Directors to facilitate the independence assessments.

Key Issues/Gaps in Assurance
There are no matters to report.

Next Steps
A declaration of the Non-Executive Directors independence will be included in the Annual Report & Accounts for 2020/21.

Conclusions

NA

Recommendations to the Board

To agree that the Non-Executive Directors are independent.

Wirral University Teaching Hospital NHS Foundation Trust

Balance and Independence of Non-Executive Directors – 2020/21

	DH	JS	SI	SL	JC	CC	SR
Has been an employee of the NHS foundation trust within the last five years;	N	N	N	N	N	N	N
Has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;	N	N	N	N	N	N	N
Has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance- related pay scheme, or is a member of the NHS foundation trust's pension scheme;	N	N	N	N	N	N	N
Has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;	N	N	N	N	N	N	N
Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;	N	N	N	N	N	N	N
Has served on the board for more than six years from the date of their first appointment;	N	N	N	N	N	N	N
Is an appointed representative of the NHS foundation trust's university medical or dental school.	N	N	N	N	N	N	N

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22 –22

BOARD OF DIRECTORS
07 APRL 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 22nd March 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)
Principle BAF Risk 4: Catastrophic Failure in Standards of Care
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC standards on safety and effectiveness
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 on 22 March 21
Background papers / supporting information	Learning from Deaths report will be presented separately

BOARD OF DIRECTORS
7th April 2021

Report of the Quality Assurance Committee
Held on 22nd March 2021

Purpose

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 22nd March 2021.

Introduction / Background

1. Learning from Deaths

The Committee received the quarterly Learning from Deaths report, which is also presented to this Board of Directors meeting. The Committee noted the significant improvement in the scope and quality of the report over the last year. The report will incorporate the latest update on the Summary Healthcare Mortality Indicator (SHMI). The committee were assured on the effective embedding of the medical examiners, with 100% of patient deaths being scrutinised by the examiners.

2. CQC Compliance and Action Plan

The Committee received a detailed update and noted the progress with actions. It was noted that a small number of outstanding "must do" items related to areas of high focus and complexity such as emergency patient flow. The Trust is taking significant strategic action on these areas as part of its Change Programme. The Committee noted that improvements in the mechanism of assurance on the action plan are being developed through planned enhancements to confirm and challenge process.

3. CLIPPE Report

The Committee received the "Complaints, Claims, Incidents, Patient-concerns, and Experience (CLIPPE) Report", for Quarter 3. It was agreed that the report would be further developed to emphasise the quality and timeliness of the Trust's responsiveness to patients when things went wrong, and the quality and embedding of learning for staff. It was noted a small number of claims related to vaginal mesh implants had been received.

4. Emergency Department safety

The Patient Safety and Quality Board (PQSB) had reported that further improvement had been seen in metrics of coverage of components of the digital patient safety checklist in the Emergency Department. The Committee will receive a detailed report on progress at the next quarter.

5. Potential harm from extended waiting times

The Committee discussed the risks to patients from elective care backlogs due to

restrictions of scheduled care related to the pandemic. It noted the increasing numbers of patients recorded as having waited >52 weeks or treatment (typically surgery) on the Performance Dashboard. Noting the scale of this challenge the Committee agreed that PQSB planning to review the process of harm reviews was an important and timely action. The significant call on clinician time required for the harm review process was noted.

6. Review of Board Assurance Framework

The Committee reviewed items of the Board Assurance Framework (BAF), referring to PR4 –'Catastrophic failure in standards of safety and care'. It noted updates to controls, gaps in controls, and plans to improve gaps and improve assurance. The Committee agreed the principle risk rating should remain unaltered. The committee felt that in addition to reviewing the BAF it should have sight of high-level risks from the Divisional risk registers. The process to achieve this will be developed.

Conclusions

The Committee received appropriate and detailed documentation in relation to the items it considered on 22nd March and was able to scrutinise this and note areas of progress, areas for development and areas of risk, receiving relevant assurance on actions to meet the objective of providing outstanding care

Recommendations to the Board

The Board is requested to note this report.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 21/22-023

Board of Directors

7th April 2021

Title:	Report of the Finance Business Performance and Assurance Committee
Responsible Director:	Claire Wilson, Chief Finance Officer Sue Lorimer, Non-Executive Director
Presented by:	Sue Lorimer, Non-Executive Director

Executive Summary
This report provides a summary of the work of the FBPAC which met on the 31st March 2021. The Committee recommends that Board of Directors: • Approve the international recruitment non-recurrent investment which is subject to a separate paper on the Board agenda. • Support the 2021/22 capital programme

Recommendation:
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	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)
The committee considered that the following risks should be reflected in the Trust

risk register: - Risk to recovery of elective programme plan if the Trust experienced another surge of COVID-19. - The level of annual leave untaken by staff at the year-end has been accounted for financially but could present a staff wellbeing and/or operational pressure during 2021/22.
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)
Supports assurance processes in relation to financial performance.
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	Paper reports on the activities of Board sub-committee.
Background papers / supporting information	NA

Report of the Finance, Business, Performance and Assurance Committee (FBPAC)

This report provides a summary of the work of the FBPAC which met on the 31st March 2021.

1. Finance Report for the period ending 28th February 2021

The Committee received the month 11 finance report and noted the overall position of a £3.5m deficit with a forecast deficit of £5m. This position includes £4.98m relating to an annual leave accrual which is not considered in assessing financial performance of the Trust, and without this, the Trusts position is forecast to be breakeven. The committee noted this as a very positive position which reflected the hard work across the Trust during a challenging year.

2. Financial planning for 2021/22

The Chief Finance Officer shared a series of slides which updated the Committee on the approach to financial planning for 2021/22. The financial planning guidance and system funding envelopes were issued on 29th March 2021. Envelopes for the first half of 2021/22 (H1) are consistent with the levels of resource available to the NHS in the second half of 2020/21 (H2). Work is now being done by the Executive Team to pull together a draft operational plan for the deadlines required which will align operational plans with finance and workforce.

The NHS will be required to deliver on efficiency requirements again in the second half of 2021/22. The Committee asked that an update on our approach and progress towards our plans to be presented at its next meeting.

3. Capital allocation report 2021/22

The committee received a presentation from the Director of Strategy on the proposed capital plan for 2021/22. The committee received assurance on the process undertaken to prioritise requirements and the work undertaken with the divisions to generate the programme. It was noted the final capital envelope for the Trust still needed to be approved by The Cheshire and Merseyside ICS and a decision was imminent. The committee were supportive of the proposed programme which will be presented to the Board of Directors for final approval in its April 2021 meeting.

4. International Nurse Recruitment

The Committee reviewed a paper which set out the financial implications of the International Recruitment campaign for nurses. The non-recurrent costs were reviewed together with the financial risks and mitigations associated with the programme. The committee supported the investment set out in the paper and supported the approval of the recommendations by the Board of Directors.

5. Quality Performance Dashboard report

The Quality Performance Dashboard report for month 11 was reviewed. A&E performance continues to be a key pressure for the Trust and a discussion took place on the work ongoing as a system to address these challenges. It was recognised that the Elective programme recovery performance is going well and performance in February and March against expected trajectories is strong.

6. Wirral Elective Recovery Plan

The committee received an update on the Elective recovery plan which is also being presented to the Board. The committee discussed the arrangements in place to support cancer and RTT performance trajectories in line with planning requirements and reviewed quarterly performance forecasts for 2021/22.

7. Risk Register

The committee considered that the following risks should be reflected in the Trust risk register:

- Risk to recovery of elective programme plan if the Trust experienced another surge of COVID-19.
- The level of annual leave untaken by staff at the year end has been accounted for financially but could present a staff wellbeing and/or operational pressure during 2021/22.

8. Recommendations to the Board

The Committee recommends that Board of Directors:

- Approve the international recruitment non-recurrent investment which is subject to a separate paper on the Board agenda.
- Support the 2021/22 capital programme

Agenda Item: BM21/22 – 024

BOARD OF DIRECTORS

7 April 2021

Title:	Report of Workforce Assurance Committee
Author:	John Sullivan, Non-Executive Director
Responsible Director:	Jacqui Grice, Executive Director of Workforce
Presented by:	John Sullivan, Non-Executive Director

Executive Summary
This report provides a summary of business conducted during a meeting of the Workforce Assurance Committee held on 24 March 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	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)
PR2 – 'Critical shortage of workforce capacity & capability'
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)
NA
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	NA
Background papers / supporting information	

Wirral University Teaching Hospital NHS Foundation Trust

BOARD OF DIRECTORS

7 April 2021

Report of Workforce Assurance Committee

Purpose

To provide a summary of business conducted during a meeting of the Workforce Assurance Committee held on 24 March 2021.

Introduction / Background

1. Chair's business

The meeting took place on Wednesday 24 March 2021 via Microsoft Teams. The meeting duration was revised to 2 hours from the pandemic impacted 1 hour meetings of 2020.The Chair stressed that the Workforce Assurance Committee (WAC) should seek to add value to other Workforce meetings and not duplicate discussions on performance which are adequately covered in other regular meetings. Our focus should be longer term, more anticipatory and oversee a strategic view (2-5 years) for Workforce. For example, future meetings will include discussions on the Workforce impacts of Integrated Care System formation (recent Government White Paper) and associated Provider Collaboratives going forward.

As the updated WUTH Workforce Strategy is developed, this committee will be particularly interested in Triumvirate organisational development with a focus on greater divisional accountability for Workforce, improved compliance to Workforce processes and procedures while building organisational resilience.

2. Reports from Workforce Steering Boards held 17 Dec 2020 and 17 Feb 2021.

The reports were received. The following risks were discussed and noted.
Pressure that staff are under due to the number of COVID related meetings that are held on a daily basis. This overload and excessive use of email is impeding getting 'the day job' done and reducing staff productivity significantly. Business Process Re-Engineering is one way forward but any meaningful changes will require a Board Secretary level review to take place so a thorough review of the Trust meeting cycles can take place.

Mandatory Training Records accuracy and robustness requires an ESR based solution and staff buy in which has not been forthcoming previously. A 2021 pilot is planned for Maternity Services. Work is also ongoing to progress compliance with individual areas.

Patient safety risks were identified in the Freedom to Speak Up (FTSU) Guardian 2020/21 Q3 Update Report, assurance was given that these have been addressed.
Risk to the organisation with regards to Employee Relations cases.

3. Workforce Performance Report

Divisional accountability for workforce performance and in particular compliance with workforce procedures and policies (e.g. return to work discussions) was again discussed.
The progress on sickness absence management processes and staff Covid vaccination roll out was noted.
The comprehensive and detailed reporting now in place was commended.

4. Pandemic Health & Wellbeing Provision Update

The Committee requested a future report on how the impacts of staff well-being programmes are being measured. The interest of CQC in this area was noted.
Further employee feedback activities were agreed to support direction of travel and to ensure activities have the maximum positive impact on staff.

5. NHS North West Black Asian and Ethnic Minority (BAME) Strategic Advisory Committee (aka The Assembly)

The assembly are hoping to work with NHS organisations across the North West to develop action plans that leverage the collective power of the region acting together, to make a lasting change. The WUTH Board have committed the organisation to be anti-racist in words and actions. Wirral NHS is represented by the Community Trust on The Assembly.

6. International Nurse Recruitment update.

The recent interrogation of data used for the purposes of workforce modelling between ESR and the Financial Ledger gave assurance and confidence in the accuracy of the data used as the basis for the business case for international nurse recruitment. The rigor of the analysis was commended by the committee.

The recruitment campaigns currently underway are making good progress and it is anticipated that WUTH will deliver the full projected numbers of successful recruits as well as unlock the regional funding attached to a number of the campaigns.

7. Communications and Engagement report

The report covered the Trust's communications and engagement activities since the last Committee meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement.
The recent positive coverage of WUTH in local and national media was noted. The committee thanked all those involved in the projection of the positive external image of WUTH.

8. Workforce Priorities.

The following 3-12 month Workforce improvement priorities were discussed and agreed by the committee:

- Staff wellbeing (NHS People Plan)
- Local community links for future recruitment
- Workforce planning as a system (ICS and Wirral)
- Legacy controls and extraordinary Audit Committee action plans
- Diversity and inclusion, BAME patient access and employer behaviours
- Learning and development for first line and middle managers and triumvirate teams development
- Medical engagement e.g. job planning and Acute / ED staff.

- It was agreed that the updated Workforce Strategy road map is required before August 2021. Building organisational resilience will be included in the strategy work.

9. Flexible Workforce

Ideas to improve the employee offering to include more flexible working will form part of the Workforce strategy update in 2021. It will include proposals to make staying employed after retirement more attractive to our clinical staff.

10. Board Assurance Framework (BAF).

The Workforce risk section of the updated BAF was reviewed.
PR 2: Critical shortage of workforce capacity & capability risk scores were agreed and an assurance rating of Amber: Inconclusive Assurance was assigned to all three Strategic Threats that make up the Principal Risk PR2.

11. Items for the Risk Register

The following risks were discussed as appropriate to be included on the WUTH Workforce Risk Register (if they are not already included):

- Unplanned loss of staff due to early retirement at age 55+
- Staff overload due to excess numbers of meetings and emails.

12. Any Other Business

The Committee requested that the Workforce implications of the recent external review of Estates be presented at a future WAC.

Conclusions

N/A

Recommendations to the Board

The Board is asked to note the report

John Sullivan
Chair of Workforce Assurance Committee
April 2021

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22 – 25

BOARD OF DIRECTORS
7 APRIL 2021

Title:	Report of the Safety Management Assurance Committee
Author:	Steve Igoe, Non-Executive Director
Responsible Director:	Hazel Richards, Chief Nurse
Presented by:	Steve Igoe, Non-Executive Director

Executive Summary
This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee on 22nd March 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)
NA
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)
NA
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	NA
Background papers / supporting information	

BOARD OF DIRECTORS
7 APRIL 2021

Report of the Safety Management Assurance Committee

Purpose

This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee on 22nd March 2021

Introduction / Background

1. Meeting schedule

This was the first of the re-convened meetings with the schedule now being to meet on a Bi monthly basis.

2. Health and Safety Management Committee chairs report

The Committee were updated on the discussions in the Trust's Health and Safety Management Committee in December 2020, January 2021 and February 2021.That report confirmed that:

- There had been an increase in RIDDOR events as a result of the impact of COVID19
- Divisional exception reports were presented to ensure risks were being acted upon and monitored appropriately
- Work was continuing in terms of ensuring appropriate PPE and fit testing as necessary
- Reports were received and discussed in relation to Water Safety and Ventilation.

Discussion took place in relation to the number of assaults on staff and the work being done to try to manage these issues. The Trust does have a Violence and aggression prevention group and work is ongoing to seek to reduce risks in this area.
The Committee noted that as at the time of writing the report, the Trust was recording 494 staff still requiring individual COVID19 Health Assessments. It was felt that this was not an accurate figure and that further work was required to both resolve any outstanding assessments and ensure a more accurate figure.

3. Health and Safety Performance activity and Dashboard update

A report was provided to the Committee to update on relevant data and progress against actions previously identified. The Committee noted:

- The Trust recorded a total of 24 RIDDOR events of which 16 were COVID related.
- There had been a significant decrease in non-clinical incidents from 1723 py to 1034 (20/21). The reasons for this will be reviewed. The most significant set of issues here relating to violence and aggression comprising over 38% of such issues reported.

- 14 duty of care notices had been issued relating to improper disposal of sharps. This compares with 16 reported across the same period last year.
- There are 44 risks relating to Health and Safety on the risk register. There is one significant risk relating to Legionella water safety risk which continues to be monitored and proactively addressed as much as possible given the Environmental constraints.

4. Health and Safety Improvement plan

The appointment of a new Deputy Director of Patient Safety and Governance has enabled a detailed review of the Trust progress in the H&S area to be undertaken along with a further review of the original Arcadis external H&S audit. A more detailed and updated plan on all work streams will be brought back to the Committee for review and to enable the Committee to better monitor ongoing activity in this area.

5. Divisional Exception Tracker

The Committee received a high-level summary of the matters being managed at a Divisional level. The detailed Divisional plans will be presented to the Committee at the next meeting in May

Conclusions

N/A

Recommendations to the Board

The Board is requested to note this report.

S J Igoe
Chair of Safety Management Assurance Committee
24th March 2021

Agenda Item: 21/22-26

BOARD OF DIRECTORS

07 APRIL 2021

Title:	Report of the Trust Management Board
Responsible Director:	Janelle Holmes, Chief Executive
Author:	Andrea Leather, Deputy Board Secretary
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
To provide a summary of the Trust Management Board held on 30th March 2021 via Microsoft Teams.

Recommendation: (e.g. to note, approve, endorse)
To note the Report of the Trust Management Board.

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)
Across all BAF priorities.
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)
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

FOI status	Document may be disclosed in full	✓
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

BOARD OF DIRECTORS MEETING IN PUBLIC
7th April 2021

REPORT OF THE TRUST MANAGEMENT BOARD

Purpose

To provide a summary of the Trust Management Board held on 30th March 2021 via Microsoft Teams.

Introduction / Background

A summary of the topics covered is provided below:

- **Quality and Performance Dashboard**

The Quality Performance Dashboard was presented and acknowledged that it had been reviewed in detail at the Operations & Performance Committee (OPC) and likewise at Quality Committee. TMB advised that at future OPC meetings the dashboard would be presented at Divisional level with feedback from the respective teams.

Whilst it was noted that thresholds have now been identified for all indicators, the appropriate governance groups to review these and revise where necessary.

- **Finance Update**

The TMB received the month 11 finance report and noted the financial position of the Trust for the period ending 28th February 2021. The potential adverse impact on the Trust forecast of annual leave liabilities for the staff was noted. The capital programme is progressing well with activity in March moving at pace with the expectation to deliver in line with capital forecast.

The Chief Finance Officer advised that planning guidance has been published and an update was to be provided at the next meeting.

- **Workforce Dashboard**

The workforce dashboard provided TMB with an overview of performance against the Workforce KPI Dashboard, comprising 21 indicators of which 16 had identified either a national or local standard. These are subject to external scrutiny by regulators or have been identified by the Board of Directors as key to delivering it's strategy. Over the coming months it is anticipated that the dashboard will be expanded to include other priority areas.

HR business partners are to work with each Division to develop improvement plans and trajectories to improve performance and compliance with sign off and monitoring via the Workforce Steering Group.

- **Wirral Recovery Activity**

TMB considered the presentation outlining the approach to re-establishing activity including: cancer management, planned care and referral to treatment.

The recovery plans and trajectories have now been submitted to Cheshire & Mersey up to and including March 2022 for both planned care activity and cancer, with a detailed breakdown being provided. It was noted that the use of the independent sector including insourcing would continue for some specialities, namely Endoscopy and Ophthalmology for the remainder of the year.

It was reported that work was underway to rework the plan and timescales against an expected 30% bounce back growth in referrals. The Operational Planning Guidance 2021/22 was released on 25th March and implementation expectations and timelines are being reviewed.

- **Clinical Services Strategies – Acute Medicine**

TMB reviewed and considered the Clinical Service Strategies for the Acute Division that encompassed Acute and Emergency medicine along with Frailty. Each of the services outlined their priorities against the six strategic priorities contained in the Trust Strategy.

It was noted that each Division is producing a 'plan on a page' summarising their priorities for consideration by the Board.

- **Risk Management Committee – Key Issues**

The meeting reviewed the report of the Risk Management Committee meeting held on 9th March 2021 summarising the key quality initiatives.

TMB noted the reduction in the number of significant and high risks, with a corresponding increase in the number of moderate risks. The Chief Nurse emphasised the need to continually monitor all risks and mitigations and informed TMB that the revised Risk Management Strategy and training plan was to be discussed at the forthcoming Risk Management Committee.

- **Operational Performance Committee**

TMB reviewed the report of the Operational Performance Committee meeting held on 25th March 2021 summarising the key quality initiatives:

  - Quality & Performance Dashboard
  - Reset & Recovery
  - Clinical Harm Reviews / P Code compliance
  - MSK
  - Business cases: Haematology Pharmacist and Substantive consultant cover ward 33.

TMB reviewed and approved the Haematology Pharmacist business case with the expectation that the additional £37.5k investment would need to be found from further Divisional efficiencies.

- **Divisional Updates**

The TMB noted the key issues in the previously circulated updates from each Division including:

Surgery

- Focus on Reset & Recovery following the 3rd wave, with enhanced Divisional A&P meetings and Theatre Scheduling meetings. To aid the recovery effort, continuation to outsource to Spire (Ophthalmology, ENT, Orthopaedics and Gen Surgery). Insourcing is also being actively pursued particularly in Ophthalmology for Outpatients.
- Ophthalmology Service Risks are being reduced weekly, through thrice weekly reassurance meetings and patient level validation. Training of staff has commenced, and validation continues to prevent future risks reoccurring.
- Several Capital Building works underway to support the development of the CGH site including formation of the Post-Operative Enhanced Monitoring Unit (located within Ward M2 Surgery) the upgrade and expansion of theatre 4 for support increasing more complex orthopaedic surgery.

Medicine

- Reset & Recovery activity:
  - Division on plan for delivery of Outpatients new, follow-up and electives target for March.
  - Endoscopy: 2nd lowest waiting list (now back to pre-COVID levels) and long waiters in Cheshire & Merseyside; activity levels 2nd highest in region. Faecal Immunochemical Testing (FIT) testing commenced for surveillance patients.
  - Heart failure ambulatory service started on ward 1.
- Capital estates work due to start imminently and a tender process for the Arrowe Park Hospital Dialysis Unit equipment has closed and the Division are evaluating submissions.
- Divisional focus post April is the implementation of the Respiratory Support Unit and commencement of monitoring speciality's operational priorities progress report through Divisional Performance Review meetings.

Acute

- Trust wide COVID-19 escalation plan was implemented to support patient flow, with zero 12 hour trolley breaches throughout this period and significant improvement in NWAS handover delays with zero tolerance approach for delays over 60mins.
- Patient flow plan being implemented with Patient Flow tool kit to be operational by end of April.
- New red majors area capital plan implemented and operationalised within timescales in January 2021.

Women and Children's

- The CQC to conduct a core service review of Maternity Services at WUTH under their Transitional Regulatory Framework, the review is likely to take place towards the end of April 2021.
- Cheshire & Merseyside (C&M) Women & Children's Partnership is separating into Women's Services including the Local Maternity System (LMS) which will continue as Women's and LMS Transformation Programme Board. Children

and Young People (CYP) will form the C&M CYP Transformation Programme Board.
- The Neonatal consultancy tender has been evaluated and a preferred bidder recommended to the Executive Team. The service review will commence in April for a period of 12 weeks.
- Division reviewing the 'The First Do No Harm' report authored by Baroness Cumberlege with consideration of the approach to the impact of historical transvaginal mesh surgery for our patients.

Diagnostics and Clinical Support

- PACS Steering Board established to deliver change to Carestream viewer rather than Skyview (easier to use) and change in PACS archive to Carestream (improve timeliness of scans being available for reporting). This will help start to align WUTH Radiology to the wider regional position.
- During the downtime of CT1, inpatient, ED, urgent and cancer work is prioritised. Mobile scanner due to be commissioned by 02/04/21, with additional staffing being sourced to support recovery of outpatient scans. Divisional Team are liaising with the manufacturer on upgrade to CT1 to bring it back on line. Procurement work for new CT scanner (to replace older scanner) has commenced.
- COVID-19 testing activity reported, TMB advised that the Pathology Team continue to liaise with suppliers and the regional team to maximise the number of test kits available to the Trust. Work being undertaken to develop longer term COVID-19 testing strategy.

Estates and Facilities

- Capital programme of works - significant number of schemes affecting most divisions across the Trust. Scope includes site wide fire alarm installation and HDU refurbishment programme underway and moving at pace to create alternative temporary accommodation.
- Service Improvement projects being undertaken: Medical Equipment Library to provide a 24/7 service and Hotel Services using the access control system to clock staff in and out instead of signing paper timesheets.
- A detailed summary of areas of focus for both Estates and Facilities was provided.

IT & Information

- Strategy development continues, collaborative workshops held for Digital Foundations and Digital Education elements.
- Move to off-site storage for case notes to release prime APH & CGH locations has commenced.

Recommendations to the Board

The Board of Directors is requested to review and note this report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-27

BOARD OF DIRECTORS
7th April 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:	
Providing the best care and support	Yes
Be a great place to work	Yes
Maximise improvement and deliver best value	Yes
Digital pioneer and centre for excellence	Yes
Work seamlessly with partners to deliver care	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)
Board Assurance Framework risks PR2 (staff engagement) and PR 6 (stakeholder confidence)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Workforce 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 of the team's activity 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, unless reputation risks manifest in an unforeseen way	
Previous considerations by the Board / Board sub-committees	Monthly reports to Board and WAC
Background papers / supporting information	Report attached with appropriate links embedded.

BOARD OF DIRECTORS
7th April 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

- The team supported a number of national campaigns and events like disease awareness days, months and weeks. These provide important opportunities to inform the public on healthcare topics and issues like mental health.

- These included International Women's Day on March 8th featuring women across the Trust illustrating this year's theme 'Choose to challenge' (Wirral University Teaching Hospital (@wuthnhs) / Twitter

- We promoted the range of careers available in healthcare sciences and diagnostics during Healthcare Science Week and also supported the Trust's recruitment campaigns.

- Other important awareness raising activities were produced in support of World Kidney Day, Child Exploitation Awareness Day, Ovarian Cancer Awareness Month and highlighting the work of our midwives on Mothers' Day.

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 investment in our new cardiac catheter lab, which was covered in 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.
- Along with the rest of the country we joined the National Day of Reflection marking one year since the start of the first lockdown. We provided staff comments to the Wirral Globe and for Wirral Council's COVID-19 stories. - Wirral Globe Supplement (from page 28) and Matron Marg Davies on the role of the Family Support Team
- Other positive news stories were that WUTH was performing significantly better than average for breast cancer referrals and the community support continued with stories about gifts in memory and with thanks for care https://www.wirralglobe.co.uk/news/19114296.family-donates-tvs-hospital-staff-alans-memory/
- The Globe featured a positive story of a mother who is an artist and has donated her skills to produce murals in thanks for her care in the Women and Children's Hospital, thanking WUTH for her IVF treatment and the birth of her daughter; and the care she received from Consultant Dr Mike Ellard. Mum who underwent IVF paints mural in same maternity unit | Wirral Globe

Media Statements

- We provided a response from Dr. Nicola Stevenson to an enquiry from The Liverpool Echo on nosocomial COVID-19 infections arising from issues covered in the December 2020 public report to the Board on Infection Prevention and Control.
- We provided a response to the Liverpool Echo following a complaint from the daughter of a deceased patient about lost property. The issue is being followed up at Arrowe Park Hospital.

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.
- We have placed significant emphasis in communications to encourage staff to have the COVID-19 vaccination.
- 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 received really positive feedback from the sessions and staff find them informative, they keep staff working at home in touch with the Trust and they are helping our Executive been more accessible and visible.

- We received the national Staff Survey results, **2020 NHS Staff Survey** on 11th March 2021. Communication of the results and action planning will follow the publication of the survey results.All staff were invited to a briefing with Quality Health, the provider of WUTH's NHS Staff Survey.
- 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.
- The first two cohorts of new international nurses were publicised within the Trust and WUTH charity provided wellbeing welcome gifts in their rooms.
- We supported to roll out of the new system for Declarations of Interest, staff vaccinations and overcoming vaccine hesitancy in staff and the community; and communicated the roll out of the new LAMP testing for staff.
- We marked the International Day for the Elimination of Discrimination and Racism with social media posts and Trust-wide communications. Hazel Richards with colleagues from our Black, Asian and Ethnic Minorities Staff Network, Staff Side and colleagues

WUTH Charity update

- On the COVID-19 support fund, the local appeal has now exceeded £150,000. The final application to the national funds for £143,000 has been submitted and we expect to receive confirmation of these funds in April.
- In developing corporate support, Vauxhall have confirmed the Trust will benefit from a volunteer day in April. The Head of Fundraising is in regular discussions with Industrial Fragrances regarding a further donation in April. Early discussions are also being had with Barclays bank to support Tiny Stars neonatal appeal.
- A 3 year strategy is being developed and will be presented at the next Charitable Funds Committee, the focus of this is the successful completion of the Tiny Stars neonatal appeal, increased visibility of WUTH Charity on both sites and the stewardship of the new support WUTH Charity has gained in the last year.
- As restrictions are eased the Charity is scoping safe activity, initially outdoors, which can be resumed. These include raffles, stalls, collections and events such as the Charity Golf Day and Abseil.
- Tri4life Everest Challenge Tri4Life is a Wirral based charitable enterprise. A group of friends brought together in remembrance, friendship and a collective love of adventure and physical endeavour whilst raising funds for charities close to their hearts and promoting active, healthy lifestyles to today's youth. Our own Dr Martin Pritchard-Howarth, Consultant Geriatrician is a member of this group. The group have chosen WUTH Charity and Community Action Nepal to jointly benefit from this inspiring challenge.
- Martin has committed to an arduous three year training programme in preparation for the final challenge of attempting to reach the summit of Everest in May 2022. Subject to COVID-19 restrictions allowing, in the next 12 months Martin intends to complete the following challenges and is also considering launching his year with our Parachute Jump!

- The Head of Fundraising is currently working with the Directors of Community Action Nepal to develop a plan for the next 12 months to support Martin and the team with this exceptional year of challenges.

    - Ironman UK
    - Ultraman UK
    - London Marathon
    - Himlung Himal 7000m Himalayan climbing trip
    - Everest

Stakeholders

- We shared Healthwatch's Bulletin with our staff and continue to work collaboratively with them.
- .We have worked with system partners on vaccine communications, promoting the vaccination hub and other community options to have the vaccine. We are also sharing Cheshire and Merseyside's campaign materials aimed at addressing issues of vaccine hesitancy either from groups in society or for specific concerns like fertility and pregnancy.
- We joined with system partners in Cheshire and Merseyside and on the Wirral for the National Day of Reflection on 23/3/2021 and provided content to Wirral Council for their website.

Conclusions:

N/A

Recommendations to the Board

The Board IS asked to note the report.