Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

04 August 2021

together we will

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors in Public
13.30 - Wednesday 04 August 2021
Via Teams
AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
21/22-099	**Apologies for Absence**	Chair	Verbal	N/A
21/22-100	**Declaration of Interests**	Chair	Verbal	N/A
21/22-101	**Patient Story**	Chief Nurse	Video	N/A
21/22-102	**Minutes of Previous Meeting – 07 July 2021**	Chair	Paper	1
21/22-103	**Board Action Log**	Chair	Paper	9
21/22-104	**Chair's Business**	Chair	Verbal	N/A
21/22-105	**Key Strategic Issues**	Chair	Verbal	N/A
21/22-106	**Chief Executive's Report**	Chief Executive	Paper	10
Performance & Improvement				
21/22-107	**Quality and Performance Dashboards & Exception Reports**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	17
21/22-108	**Finance Report for Month 3**	Chief Finance Officer	Paper	42
Strategy and Development				
21/22-109	**Digital Strategy**	Interim Director of IT and Information	Paper	62
21/22-110	**Infection Prevention and Control (IPC) Strategy**	Chief Nurse / DIPC	Paper	95
Governance				
21/22-111	**CQC Compliance and Action Plan**	Chief Nurse	Paper	115
21/22-112	**Monthly Safe Nurse Staffing Report**	Chief Nurse	Paper	194
21/22-113	**Infection Prevention & Control Annual Report 2020/21**	Chief Nurse	Paper	203
21/22-114	**a) Workforce Race Equality Standard (WRES)** **b) Workforce Disability Equality Standard (WDES)**	Interim Director of Workforce	Paper	256
21/22-115	**Change Programme Summary, Delivery & Assurance**	Director of Strategy and Partnerships	Paper	298
21/22-116	**Chair's Report – Safety Management & Assurance Committee**	Committee Chair	Paper	340

21/22-117	**Chair's Report – Workforce Assurance Committee**	Committee Chair	Verbal	N/A
21/22-118	**Chair's Report – Finance, Business Performance & Assurance Committee**	Committee Chair	Paper	357
21/22-119	**Chair's Report – Quality Assurance Committee**	Committee Chair	Paper	361
21/22-120	**Report of Trust Management Board**	Chief Executive	Paper	365
21/22-121	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	371
21/22-122	**Any Other Business**	Chair	Verbal	N/A
21/22-123	**Date of Next Meeting – 01 Sept 2021**	Chair	Verbal	N/A
21/22-124	**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

07 JULY 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 10.00 and Concluding at 12.30

Present

Sir David Henshaw	Chair
John Sullivan	Non-Executive Director/Vice Chair
Chris Clarkson	Non-Executive Director
Steve Igoe	Non-Executive Director
Sue Lorimer	Non-Executive Director
Steve Ryan	Non-Executive Director
Janelle Holmes	Chief Executive
Nicola Stevenson	Medical Director / Deputy CEO
Hazel Richards	Chief Nurse / DIPC
Claire Wilson	Chief Finance Officer
Matthew Swanborough	Director of Strategy and Partnerships
Debs Smith	Interim Director of Workforce

In attendance

Debbie Edwards*	Director of Nursing & Midwifery (W&C)
Jonathan Lund	Associate Medical Director
Molly Marcu	Interim Director of Corporate Affairs
Oyetona Raheem	Board Secretary
Sally Sykes	Director of Communications & Engagement
Philippa Boston	Staff Governor
Eileen Hume	Public Governor
Allen Peters	Public Governor
Angela Tindall	Public Governor
Irene Williams	Public Governor

Apologies

Jayne Coulson	Non-Executive Director
Kathryn Brodbelt	Associate Medical Director
Chris Mason	Chief Information Officer
Simon Lea	Associate Medical Director

*Denotes attendance for part of the meeting

Reference	Minute	Action
21/22 079	**Apologies for Absence**	
	Apologies for absence were noted as reported above. Steve Igoe gave advance apologies for having to leave at 2pm.	
21/22 080	**Declarations of Interest**	
	No interests were declared.	
21/22 081	**Patient Story**	
	The Board viewed a video from Mr P, about his and his wife's experiences at APH that were less positive. A number of very valid points were made to the Board including the use of jargon and abbreviations by staff members and complaints about the 'tiny chairs' in the waiting rooms that were very difficult to sit in for someone with mobility issues. Mr P also highlighted a number of issues to do with communications, use of disabled car parking area and service responsiveness.	

Reference	Minute	Action
	The Board received explanations on steps that had been taken to address all the issues raised by Mr P. The Chair on behalf of the Board expressed gratitude to Mr. P for sharing his experience.	
21/22 082	**Minutes**	
	The minutes of the meeting held on 02 June 2021 were approved as an accurate record.	
21/22 083	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
21/22 084	**Chair's Business**	
	The Chair informed the meeting that more national guidance had been received on ICS development but there remained areas to be resolved amongst the key stakeholders. Further updates would be provided in due course. **RESOLVED:** **That the Board NOTED the Chair's Business**	
21/22 085	**Key Strategic Issues**	
	There were no additional strategic issues to report.	
21/22 086	**Chief Executive's Report**	
	The Chief Executive presented her report and highlighted that community prevalence of COVID-19 had continued to increase with an incidence of 182 per 100,000 over 7 days. The number of inpatients had also increased but not at the rate witnessed during the 3rd surge. Staff members were being encouraged to participate in LAMP testing, in addition to vaccination and infection, prevention and control practices whilst hospital visiting remained restricted with few exceptions. The Trust had delivered against its trajectory for reset and recovery during May 21 and was on course for the increased expectation during June 21 with the exception of Daycase, due to breakdown issues within the endoscopy unit. The issues had now been resolved. The Trust trajectories had continued to exceed the national expectation of 80%. The national vaccination programme had been opened to all adults age 18 years and over. The vaccination centre had continued to deliver the vaccines in collaboration with local partners. Other issues highlighted by the CEO included the appointment of Tilbury Douglas Construction Ltd (Interserve) as the principal supply chain partner for the design and construction of the urgent and emergency care upgrade project (UECUP) at Arrowe Park Hospital; quality visit by the University of Liverpool during which positive steps taken by the Trust in the delivery of simulation training and improvements to educational governance structure had been acknowledged; preparations for the COVID-19 pandemic Public Inquiry; and a series of planned Board development sessions, which	

Reference	Minute	Action
	commenced earlier in the day. There had been three serious incidents reported in the month of May 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. One RIDDOR incident was also reported to HSE in relation to staff injury. Lastly, the Chief Executive reported that Board seminars would be incorporated within the schedule of Board days as part of a regular programme of Board development. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
21/22-087	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard up to end of May 2021 for their respective areas. The Medical Director highlighted the slight fall in the Trust's threshold for VTE compliance within 12 hours of admission which was being monitored through internal governance processes. She added that there had been no patient safety issues as a consequence and that Trust's overall VTE performance for patients admitted to hospital had remained above national threshold. The Chief Nurse highlighted the improvement in Protecting Vulnerable People (PVP) training levels 3 and 4. The Chief Executive advised that ED performance had remained challenged due to increased level of non-elective attendance across the NW region. This had impacted on turn-around times for ambulances. Questions were being asked at regional level about how much of the surge in ED attendance was potentially being driven by access to primary care. Occupancy rate had remained high due to a number of significant long lengths of stay. Agreements had been reached with Wirral Place to re-establish the frequency of the discharge cell meetings. The main priority area was around Pathways 1 and 2. The Chief Executive added that the elective recovery programme had been going well but there was a nationally recognised risk that if there was no reduction in the non-elective attendances at EDs, it might impact on elective recovery. The Trust was above trajectory against delivery for cancer performance, which was monitored on monthly and quarterly basis. Sue Lorimer commented on the benefits of the bed management model which had been presented to the Finance Committee recently and wanted to know when those benefits would translate into improvements in ED performance data. The CEO explained the significance of processing patients through ED promptly, which had helped to avoid 12-hour breaches. The Medical Director gave explanations on the multi-factorial issues affecting ED performance, one of which was issues with medical staffing. The ED performance required further improvements and was being monitored by the Executives teams. The Interim Director of Workforce highlighted the deterioration in staff	

Reference	Minute	Action
	attendance for May 2021 which was below the 95% target. Sickness absence was at 5.68% compared to the target of 5%. However this was a significant improvement compared to the position earlier in the year in January when sickness absence was at 7.82%. The Interim Director of Workforce gave explanations on steps that had been taken to improve attendance including return to work meetings and participation in a pilot programme by NHSI/E on leadership programme on organisation and staff well-being culture. John Sullivan asked if there was a system in place to monitor the impact of Test and Trace on staff attendance. The Interim Director of Workforce advised that staff isolation as a result of Test and Trace would be recorded as sickness absence and therefore not included in the figures presented. The Interim Director of Workforce did confirm that the figures were reported through Bronze Command on a daily basis to support the operational management of staffing levels. John Sullivan also asked if there was going to be a policy change on people who have been double vaccinated not needing to self-isolate in the future. The Interim Director of Workforce advised that policy changes would be considered when national guidance is received in that regard. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard and the Exception Reports for the period to 31 May 2021.**	
21/22-088a	**Month 2 Finance Report**	
	The Chief Finance Officer (CFO) presented the Month 2 finance report and highlighted a surplus of £0.268m at M2, which represented a positive variance against plan of £0.360m. She added that the Trust expected to perform in line with plan for a break-even position in the first half of the 2021/22 financial year (H1). The CFO also highlighted the areas of efficiency savings that have been achieved in order to deliver against efficiency requirements in the second half of the year including recent appointment to consultant positions which had previously been staffed through locum arrangements. The CFO advised that the capital spend currently stood at £0.78m which was behind plan but expected to be back on track over the coming months. **RESOLVED:** **That the Board NOTED the report.**	
21/22-088b	**2021/22 (H1) Financial Plan Update**	
	The CFO talked the Board through the update on the financial planning process for the first half of 2021/22 (H1). She highlighted a number of changes that had been made to support the delivery of a balance plan for Cheshire and Merseyside. The CFO gave explanations on the redistribution of monies within the system and a reduction of funding for WUTH of approximately £8.6m, £4.6m of which was offset against the Trust's original planned surplus. The adjustments to	

Reference	Minute	Action
	the original plan had been reviewed by the Finance, Business, Performance and Assurance Committee which had recommended it to the Board for approval. In response to a question from Sue Lorimer, the CFO advised that 3% CIP would translate to an £11m CIP which would need to be delivered as both cost reduction and productivity improvements. Sue Lorimer asked if the CIP team had been initially working on a target of £8m to which the CFO replied in the affirmative. 2% CIP was originally anticipated with a caution that this could increase based on national guidelines. The Chair expressed concern that one or two Trusts were capable of creating issues for other Trusts within the Cheshire and Mersey system due to an imbalance between those that exceeded their budgets and those that stayed within budget. **RESOLVED:** **That the Board SUPPORTED the changes to the financial plan and the risks and mitigations set out in the paper.**	
21/22-089	**Maternity Services Quarterly Update**	
	Debbie Edwards presented the Maternity Services quarterly update during which she highlighted evidence of full compliance with the Immediate and Essential Actions (IEAs) from the last inspection, which had now been submitted to NHSI. Other areas of the report that were highlighted included details of the Maternity Incentive Scheme (MIS) which had been re-commenced by NHS Resolution. MIAA have undertaken an internal audit to review and test our evidence against the 10 MIS standards. The draft report details strong evidence and compliance, along with management recommendations for further improvement. The C&M Clinical Outcome / Outlier report identified a shortfall in elective capacity for caesarean section. The remedial action taken was the introduction of an additional elective caesarean section list which had reduced risks associated with undertaking emergency caesarean sections out of normal working hours. Debbie Edwards provided detail of the neo-natal deaths and the Board of Directors was assured that independent external scrutiny had occurred as appropriate and in line with national processes. Steve Ryan commented on his role as the Non-Executive Safety Champion and the requirement to provide updates at least quarterly to the Board with escalation of any concerns in between the dates, should the need arise. The Chair congratulated the maternity services team for the significant progress. **RESOLVED:** • **That the Board NOTED the content of the Perinatal Clinical Surveillance Quality Assurance Report and the Outlier report.**	

Reference	Minute	Action
	• **That the Board NOTED the Trust compliance to the Safety Actions that link to the Maternity Incentive Scheme.** • **That the Board APPROVED the signing of the declaration form to NHSR before the 15th July 2021 deadline.**	
21/22-090	**Monthly Safe Nurse Staffing Report**	
	The Chief Nurse presented the report which provided information regarding safe nurse staffing and the actions to improve the vacancy rates. The Board noted the reduction in RN band 5 vacancies to 13.97% in Month 2 due to the success of the International Recruitment Programme and the anticipated arrival of 42 delayed international nurses in July 2021. Other RN and CSW vacancies detailed in the report were duly noted together with interim cover arrangements and the local recruitment drives. John Sullivan requested clarification on how falls in care standards due to staff shortages are monitored. The Chief Nurse advised that standards are monitored through observations, Perfect Ward audits and through concerns that had been raised on the wards. **RESOLVED:** **That the Board NOTED the report.**	
21/22-091	**System Improvement Board (SIB) Update**	
	The CEO presented the paper which provided an update on the Trusts challenged provider status which was recently reviewed by NHS Improvement regional team. Following submission of evidence to the Wirral System Improvement Board (SIB), the regulators had removed the Trust from challenged provider status and future SIB meetings had been stood down. The Chair noted that the Trust had been under intense scrutiny for some time prior to his joining the Trust. Whilst noting that more work needed to be done around OD culture and financial stability, in order to attain outstanding status, the Board congratulated the executive team and all those who have worked hard to bring about the improvements. **The Communications team was requested to communicate the positive development to all the stakeholders.**	**SS**
21/22-092	**Change Programme Summary, Delivery & Assurance**	
	The Director of Strategy and Partnerships made a presentation to highlight the progress on the Change Programme and the current areas of focus. The Chair sought to know the reasons behind reports that some 111 appointments were not handled properly in the ED. The CEO gave explanations on the creation of queues which had made it difficult to manage the calls. Many of the calls were those that ED considered to be low risk which should be handled at the Walk-in centres. She gave explanations on the collaborative work with the GP practices to resolve the problem at regional level.	

Reference	Minute	Action
	The Director of Strategy and Partnerships advised that **a revised assurance framework would be coming to the Board in September 21** which would align to the new PM3 project management software that had been acquired. **RESOLVED:** **That the Board NOTED the report.**	**MS**
21/22-093	**Chair's Report – Finance, Business Performance & Assurance Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held on 24 June 2021 including: • The Committee received a detailed report of Month 2 finance together with CIP updates. • The Committee had been pleased to note the permanent recruitment into consultant positions which had previously been staffed by locum arrangements. • The Committee also received a presentation on the benefits of investments in the patient flow system and noted the key metrics for success. • Questions had been asked about when the successes achieved through the patient flow programme would translate into improved ED performance data to which satisfactory responses had been received. **RESOLVED:** **That the Board NOTED the report.**	
21/22-094	**Report of Trust Management Board**	
	The Medical Director presented the TMB Chair's report and highlighted some of the key issues discussed at the meeting held on 22 June 2021 including: • A review of the Month 2 finance report which had shown £0.268m positive variance against plan of £0.360m and the expectation to break even at end of H1. • The Committee had reviewed the Workforce Assurance key issues report and noted amongst others, the appointment of Jayne Coulson as the Non-Executive Director for Wellbeing Guardian. • Risk Management Committee key issues report had also been reviewed during which a decrease in the current live risks had been noted. The Chief Nurse briefed the Board on a new high scoring risk had been added to the risk register, which incorporates the current pressures on the Trust with increasing numbers of patients presenting and requiring an acute mental health admission, both children and adults. The Chief Nurse and Medical Director have established as Mental Health Transformation Group, which includes relevant partners. • Detailed explanations had been received on the continuing efforts to improve the quality of care in the ED, noting the current surge in ED attendance. **RESOLVED:** **That the Board NOTED the report.**	
21/22-095	**Communications and Engagement Monthly Report**	

Reference	Minute	Action
	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. The Director of Communications and Engagement highlighted campaigns supported by her team including awareness Cervical Screening Awareness, Breastfeeding Celebration, Men's Health, Nutrition and Hydration as well as Learning Disability Week, Carers Week and Volunteers' Week. **RESOLVED:** **That the Board NOTED the report.**	
21/22-096	**Any other business**	
	None	
21/22-097	**Date of Next Meeting** 4 August 2021 (Physical or via MS Teams TBC)	
21/22-098	**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 is 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 – 07 July 2021
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 07.07.21						
1	**BM21-22-091**	**The Communications team to communicate the removal of the Trust from the Challenged Provider status, to all the stakeholders.**	**SS**	**This information has been publicised widely as directed.**		Complete
2	**BM21-22-092**	**Present a revised programme assurance framework to the Board in September 21.**	**MS**	**This item has been added to the Board cycle of business for Sept 21**		Complete
3	**BM21-22/066**	**Divisions to be asked to present their individual plans to the Board**	**MS**	**Divisional plans has been scheduled for the Board in September 2021**		**Complete**

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-106

BOARD OF DIRECTORS
04 August 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 July 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

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

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

BOARD OF DIRECTORS
04 August 2021

Chief Executive's Report

Purpose

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

Introduction / Background

1. COVID-19 Update

The community prevalence of COVID-19 continues to increase with an incidence of 482 per 100,000 over 7 days at the time of writing. The number of inpatients has increased significantly to a total of 40 patients, with currently 9 of these patients in critical care. The majority of inpatients are unvaccinated. With the increase in admissions we have seen pressure on urgent and critical care. Escalation plans are in place should we require further Covid-19 beds to be opened. It may be necessary to curtail some elective activity over the short to medium term to help with staffing in critical care, and this is reviewed on a daily basis.

Staff members are being encouraged to participate in LAMP testing, in addition to vaccination and infection, prevention and control practices. The Trust has put in place a process to enable staff who are self-isolating to return to work with daily covid-19 testing in line with recent national guidance. Hospital visiting remains restricted with exceptions for birth partners, end of life care and those patients who may require additional support such as people with dementia. These actions will reduce the risk of nosocomial transmission. There is a pro-active communication plan in place for all wards across the Trust to ensure that families and friends receive regular updates in the absence of visiting

2. Reset and Recovery

The target for recovery was reset from 85% to 95% by the national team in July. Current performance for July is below the required standard.

Activity - July	Trust Target	Actual to Date	Variance
Outpatients	100%	92%	-8%
Day Case	98%	68%	-30%
Inpatients	95%	74%	-21%

There are a number of reasons for this, including:

- Endoscopy washer emergency replacement programme
- Staff absence due to self-isolation
- Non elective demand

The impact on Elective recovery is being mirrored across Cheshire & Mersey and

the North West as a whole. Regional monitoring and support is in place, for all Providers, alongside understanding any potential System financial impacts.

3. Vaccination Hub

The vaccination programme continues across the local health economy. To 20th July 2021, 417,630 vaccinations have been given across Wirral place in GP practices, PCN local vaccination sites, the WUTH vaccination centre in pop up clinics and using the vaccination bus.

The Clatterbridge Vaccination Centre's move to the national booking system as part of the national hospital hub plus scheme has been successful and has increased bookings at the centre. In addition the Trust team supported a "pop up" clinic in Birkenhead, in a centre for care leavers aged 18-25.

Interim guidance for the autumn booster programme has been issued and it is expected that the hospital centre continues to play a role in the system delivery programme for patients as well as staff for the flu and Covid programme. More detailed guidance is expected shortly.

The Trust Chief Pharmacist continues to provide pharmaceutical support to the Cheshire and Mersey Vaccine Silver Command and Control structure and the WUTH hosted Medicine Delivery Driver continues to move vaccine across Cheshire and Mersey footprint to support the national mutual aid process to avoid vaccine wastage.

4. Serious Incidents

The Trust declared 9 serious incidents (SI) in the month of June 2021. Eight incidents relate to care provided within the Trust and one relates to care provided in a service commissioned by the Trust. This is an increase over the previous months, however the SI review panel agreed that it is beneficial to report and investigate under the "Serious Incident Framework" and then the learning can be identified. If at that stage it is deemed as not meeting the SI criteria, a request to the CCG can be made to step it back. There were no common themes or areas identified from the reported incidents, which spanned areas of the trust, including the Emergency Department, Surgery, and Women's and Children's.

Duty of Candour is being undertaken in line with legislation and national guidance.

5. RIDDOR Update

During June 2021, two RIDDOR events were reported to the HSE, both of which related to Slips, Trips and Falls.

6. New Quarterly Staff Survey

The People Plan 2020/21 set out an intention to enhance activities to better understand employee experience, which included the introduction of a quarterly survey. On 29 June 2021 NHS England and NHS Improvement (NHSE/I) announced that a National Quarterly Pulse Survey will replace the paused Staff Friends and Family Test (SFFT) and published guidance to enable Trusts to meet the expectation that the survey is implemented in July 2021. The survey consists of the nine engagement theme questions which are the same as those included in the National NHS Staff Survey, and measures motivation, advocacy, and involvement.

NHSE/I recommended that Trusts utilise the People Pulse to run the National Quarterly Pulse Survey. The People Pulse was already in use in this Trust and therefore has been used for the National Quarterly Pulse Survey in Q2. This will be reviewed in Q3 ahead of the next required Pulse Survey n Q4 (n.b. the National Quarterly Pulse Survey is not required in Q3 as the National NHS Staff Survey is run in those months).

7. Wirral Millennium Downtime

Following previous approval at Silver command, on the evening of Wednesday July 21st at 10pm planned work commenced on Wirral Millennium Electronic Patient Record (EPR) to upgrade the operating systems on Cerner managed hardware. After the upgrade, performance problems in the system were reported. The technical issues were immediately escalated to Cerner via established processes.

As these issues were impacting the reliability of the Electronic Patient Record a decision was made by the Executive Team to take the system off line until the issues could be resolved. In line with EPRR process a Level 2 Critical Incident was declared and staff moved to downtime paper processes to deliver patient care from that point onwards. Technical teams from both Cerner and WUTH informatics worked through the night to troubleshoot and rectify the problems. Eventually at approximately 3:30pm on Friday July 23rd systems were brought back up and released to users in a staggered manner, enabling a structured approach to recovery.

Following the return of the EPR system there was further work required to realign to the system capacity manager (the live patient flow module). From 15:45 on Saturday July 24th the internal incident and command centre was stood down with normal services resumed.

A full IT technical de-brief will take place w/c July 26th followed by a Trust-wide debriefing session organised for w/c August 2nd. Further planned system work is required in the coming months to complete the process of moving to new hardware, this will be planned in line with Trust governance procedures and will include a full risk assessment.

8. 2021 Governor Elections

Governor elections are underway to fill 13 governor vacancies as from the 1st of July 2021 till the 29th of September 2021. Vacancy and constituency details are summarised in the table below:

Public: Bebington & Clatterbridge
Public: Liscard & Seacombe
Public: Birkenhead, Tranmere and Rock Ferry
Public: West Wirral
Public: Bidston & Claughton
Public: North West & North Wales
Public: Greasby, Frankby, Irby & Upton
Public: Leasowe, Moreton & Saughall Massie
Public: Oxton & Prenton
Staff: Medical & Dental
Staff: Nurses & Midwives (APH)
Staff: Nurses & Midwives CBH & other sites
Staff: Other Healthcare Professionals

The outcome of the votes will be announced at the Annual Members' Meeting on 30th September 2021. In the meantime all staff and public members are being encouraged to vote for their preferred candidates by the 12th of August 2021 through the wider communication channels.

9. Extension of Chair's and Senior Independent Director's Tenure of Office

I am pleased to report that on the 19th of July 2021, the Council of Governors ratified an extension to the Chairman's term of office by an additional three years with effect from February 2022.

Steve Igoe, our Senior Independent Director's appointment has also been extended for a three year term with effect from 2nd of October 2021.

Both these appointments substantially enable stability and continuity of Board capability and capacity at a stage where the Board is starting to realise key benefits from the enhanced leadership, such as the lifting of the challenged provider status by NHSI/E last month.

10. Cheshire & Merseyside Health & Care Partnership

Pending permanent substantive appointments, it has been confirmed that David Flory, Chair of Lancashire and South Cumbria ICS, has been appointed Acting Chair for the Cheshire & Merseyside ICS. David will continue his role at Lancashire and South Cumbria ICS during this appointment. Furthermore, Sheena Cuminsky, Chief Executive at Cheshire and Wirral Partnership NHS Foundations Trust, has agreed to step into the post of Chief Officer on an interim basis for a period of three months.

11. SIREN Study Research

Dr Susan Hopkins, Chief Investigator for the SIREN study, has written to the Trust, expressing thanks and congratulations to our SIREN study research team and the 215 study participants here at WUTH.

The purpose of this study is to understand whether prior infection with SARS-CoV2 (the virus that causes COVID-19) protects against future infection with the same virus. Recruitment to the study ended on 31st March 2021.

A recently published paper from the SIREN study shows that previous infection with SARS-CoV-2 induces effective immunity to future infections in most individuals.

Following positive feedback from participants and sites, an amendment has just been approved to extend SIREN follow-up for a further 12 months. Funding has been approved across England until at least the end of March 2022.

The next key outputs will focus on the durability of the immune response to SARS-CoV-2 from both vaccination and natural infection and will support planning and preparedness for the next phases of the pandemic.

Agenda Item: 21/22–107

BOARD OF DIRECTORS
4 August 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 June 2021.

Of the 46 indicators that are reported for April (excluding Use of Resources):

- 26 are currently off-target or failing to meet performance thresholds
- 20 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

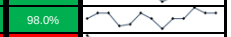
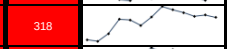
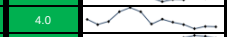
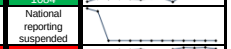
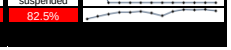
Quality Performance Dashboard

July 2021
Upated 26-07-21

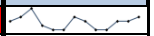
	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16	0.10	0.20	0.10	0.10	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.8%	95.1%	95.3%	95.4%	95.1%	95.3%	94.7%	94.2%	94.9%	94.0%	94.4%	94.5%	94.7%	94.70%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.6%	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	96.6%	96.2%	96.4%	96.6%	96.6%	96.6%	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	1	4	4	2	3	2	4	4	5	4	5	4	8	17	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	1	0	0	1	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	0	1	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	5	1	4	1	5	10	8	4	7	6	5	7	5	5	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 63 for financial year 2021-22, with a varying trajectory of a maximum 5 or 6 cases per month	WUTH	6	8	5	3	7	3	1	3	6	6	3	5	7	7	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	1	0	0	0	0	0	0	0	0	0	0	1	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99.0%	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	99.2%	99.2%	99.0%	99.0%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	2	0	4	0	0	1	0	1	0	0	0	0	1	1	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	95%	95%	98%	96%	94%	91%	93%	Not avail	Not avail	96%	96%	96%	95%	95%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	71.6%	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	79.1%	79.9%	84.3%	85.9%	87.5%	87.5%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	71.8%	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	84.1%	82.3%	83.0%	83.6%	83.9%	83.9%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	19.0%	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	80.1%	67.0%	69.5%	70.8%	72.3%	72.3%	
	Attendance % (12-month rolling average)	Safe, high quality care	DoW	≥95%	SOF	94.25%	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.42%	93.48%	93.79%	93.90%	93.95%	93.95%	
	Attendance % (in-month rate)	Safe, high quality care	DoW	≥95%	SOF	95.01%	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	93.91%	94.71%	94.62%	94.32%	94.32%	94.32%	
	Staff turnover % (in-month rate)	Safe, high quality care	DoW	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.67%	0.77%	0.95%	0.72%	0.79%	0.79%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DoW	≤10%	WUTH	11.1%	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.9%	13.0%	13.5%	13.2%	13.3%	13.3%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	National reporting suspended	National reporting suspended	9.9	8.0	8.5	10.1	9.5	8.1	8.9	9.0	8.7	8.3	8.8	8.8	

Quality Performance Dashboard

July 2021
Upated 26-07-21

	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%	98.4%	98.3%	98.3%	98.3%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	97%	98%	98%	96%	96%	98%	97%	95%	97%	97%	99%	98%	98%	98.0%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	19.5%	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.9%	18.0%	18.0%	17.7%	18.4%	18.4%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	210	202	239	309	305	279	319	371	354	341	323	329	318	318	
	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	48	53	59	92	95	86	112	98	106	88	96	85	99	99	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	6.2	3.6	3.8	4.8	3.9	4.1	3.4	2.8	3.2	3.1	3.6	3.3	3.5	3.5	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	4.7	4.2	4.5	5.4	5.8	5.4	4.3	4.7	4.4	4.2	3.8	4.0	4.0	4.0	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	941	1016	1012	1014	1007	992	1020	1027	938	1097	1149	1131	1084	1084	
	Delayed Transfers of Care	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	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	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	65.4%	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	71.9%	81.3%	84.9%	84.5%	85.5%	82.5%	82.5%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	2	3	5	1	0	0	3	2	0	0	2	2	3	3	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	87.0%	84.0%	87.0%	85.0%	84.0%	83.0%	82.0%	82.0%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	TBC	92.0%	91.0%	92.0%	94.0%	95.0%	95.0%	95.0%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	95.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	80.0%	100.0%	67.0%	94.0%	99.0%	95.0%	93.0%	93.0%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	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	90.0%	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	76.8%	77.8%	76.1%	73.5%	78.0%	78.0%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	76.4%	78.0%	71.4%	64.8%	64.9%	71.4%	69.6%	65.3%	77.8%	78.8%	73.4%	68.1%	73.4%	73.4%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	0.6%	0.6%	0.7%	2.7%	4.3%	3.1%	4.3%	6.7%	2.3%	1.6%	1.7%	2.6%	2.3%	2.3%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	3.5%	3.2%	4.2%	8.3%	13.8%	9.2%	13.2%	18.0%	8.7%	9.1%	11.0%	13.0%	9.3%	9.3%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	43.29%	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	67.89%	69.26%	69.61%	72.57%	75.64%	75.64%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,980 for WUTH by March 2021	National	21383	23034	24486	24212	22945	21633	21792	21880	21955	23444	24774	25873	26671	26671	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	413	616	733	806	777	704	666	899	1108	1168	874	633	526	526	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	74.9%	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	94.3%	97.4%	97.7%	98.5%	96.8%	96.8%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	98.3%	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	97.6%	98.8%	96.9%	97.6%	97.2%	97.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	90.2%	–	–	92.48%	-	-	94.20%	-	-	97.64%	-	-			
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	97.1%	90.7%	94.8%	92.1%	98.0%	97.4%	97.2%	98.0%	93.0%	93.5%	94.7%	96.6%	95.5%	95.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	98.6%	–	–	92.44%	-	-	97.55%	-	-	94.73%	-	-			
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	82.1%	80.7%	78.6%	82.6%	82.9%	85.3%	85.4%	80.9%	82.1%	84.1%	84.5%	84.1%	87.5%	85.4%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	85.3%	–	–	80.68%	–	–	84.60%	-	-	82.56%	-	-			
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	119	143	124	183	178	161	150	196	165	170	157	156	145	145	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	2.80	2.10	3.40	4.20	3.80	3.20	1.32	3.80	3.56	4.07	4.09	2.56	4.04	4.04	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	100%	94%	100%	97%	100%	95%	100%	93%	95%	95%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	5	1	0	2	1	4	2	2	4	4	0	2	1	1	

Quality Performance Dashboard

July 2021
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	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	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	Under review	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 21/22 (ave min 59 per month until year total achieved)	National	152	86	31	126	329	215	163	599	206	87	16	16	65	97	
	% Appraisal compliance	Safe, high quality care	DoW	≥88%	WUTH	77.9%	81.3%	84.3%	76.3%	73.0%	74.1%	76.2%	72.9%	74.7%	77.0%	81.0%	81.3%	82.7%	82.7%	

	Indicator	Objective	Director	Threshold	Set by	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	-0.6	-0.4	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.8	-0.4	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.02%	3.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-32.4%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-10.4	-10.4	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	52.8%	62.9%	12.0%	12.0%	

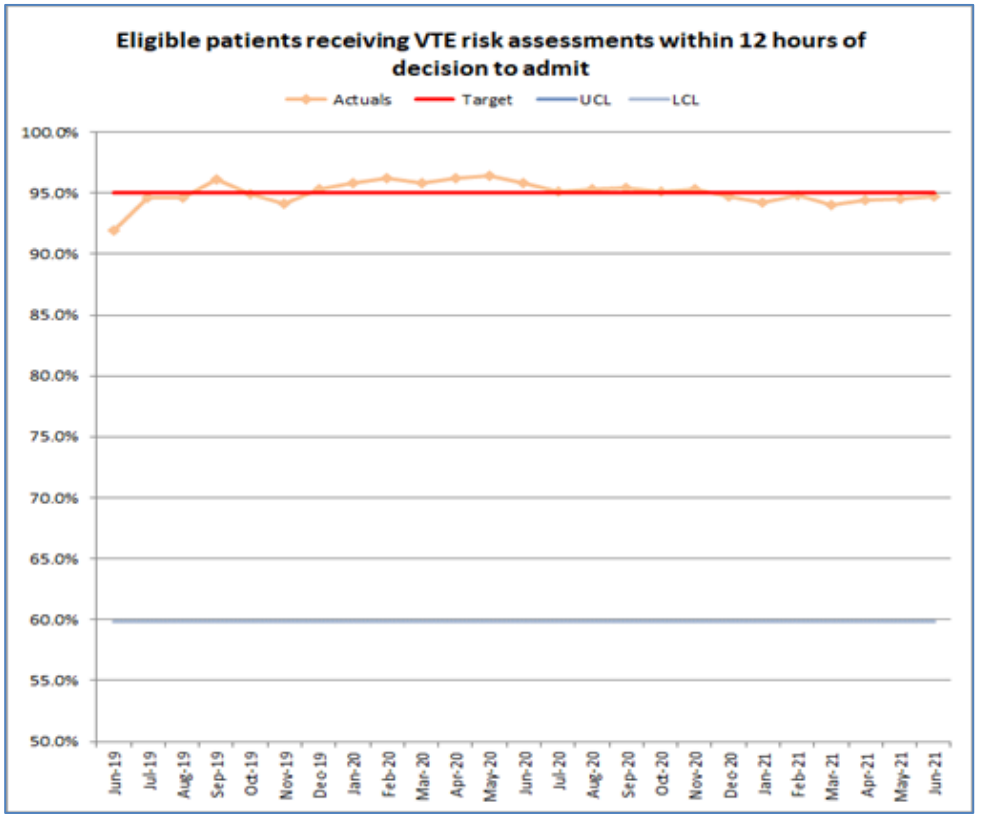
(*) Updated Metrics

(**) Updated Thresholds

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. June performance was again slightly below at 94.7%. The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital has been consistently met.
Action: VTE compliance in each division is tracked through divisional governance reports to PSQB. Some data quality issues are being addressed. Performance will continue to be closely monitored to ensure that there is not a significant nor sustained deterioration in assessment and that there are no patient safety issues.
Expected Impact:



Gram Negative Bacteraemia

Executive Lead: Chief Nurse

Performance Issue:

The Trust maximum threshold for 2021-22 is set at 63, with a varying trajectory of a maximum 5, 6 or 7 cases per month.
There were 7 cases in June, with the cumulative number to the end of June 2021 being 15 cases, which is just in line with the overall trajectory.

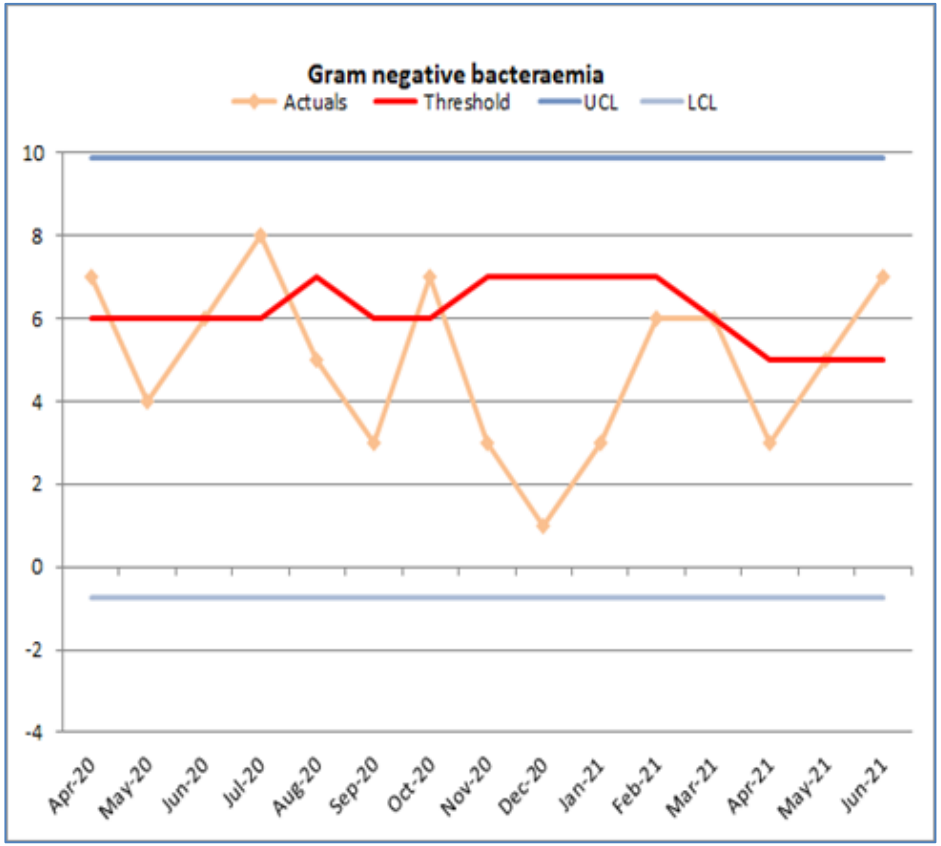
Action:

MDT investigations are completed following the incidence of a Gram–Negative bacteremia. The investigations are presented at the weekly harms panel, where areas for improvement and common themes are identified and action plans agreed. Lessons learnt are shared at local ward safety huddles.

Divisional Infection Prevention Control meetings monitor delivery of action plans along with compliance with High Impact Interventions. Training, education and policies are also in place to ensure staff are supported to reduce further incidence. Summaries of each incident are fed back at the monthly IPCG meetings to ensure trust wide learning.

Expected Impact:

Reduction in the number of Gram-Negative Bacteremia's to ensure the monthly threshold is not exceeded.



MRSA Bacteraemia – hospital acquired

Executive Lead: Chief Nurse

Performance Issue:

Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA Bloodstream Infections. All MRSA blood stream infections are subject to a Post Infection Review (PIR).

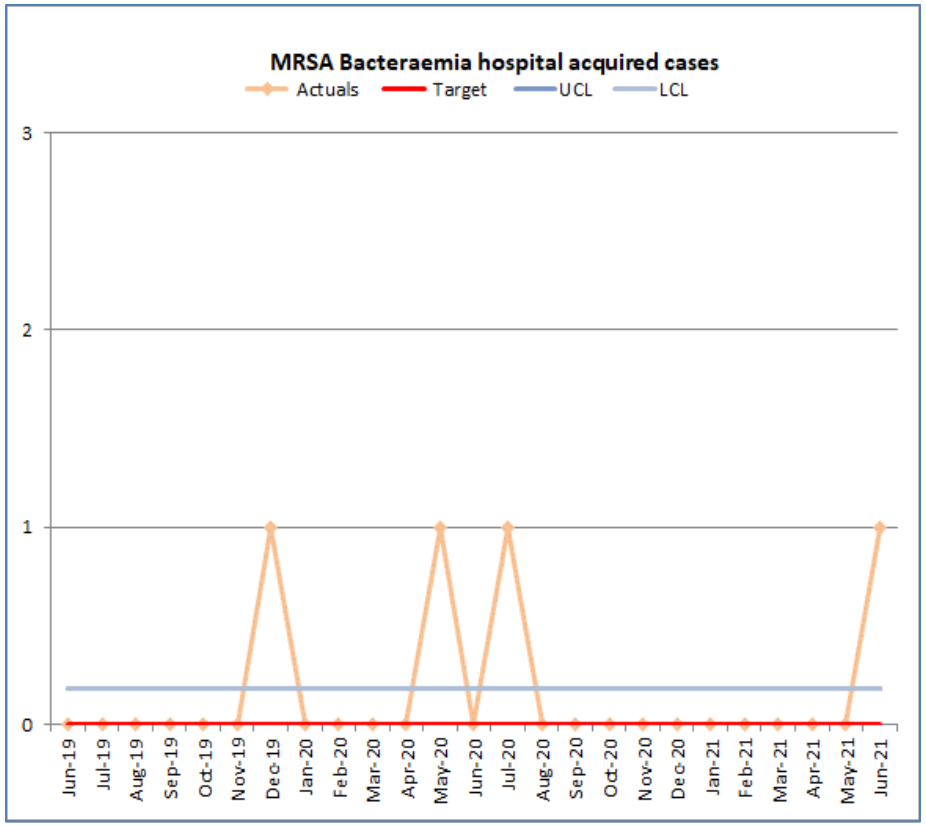
WUTH reported 1 MRSA bacteraemia in June this year, with the most recent case before that being in July 2020.

Action:

A Post Infection Review (PIR) has taken place. Whilst the MDT investigation revealed that there appeared to be no lapses in care leading to the bacteremia there was some incidental lessons learnt which were presented at the Divisional IPC meeting along with the resulting action plan**.** Lessons learnt are also shared at local safety huddles and Trust wide at the monthly IPCG.

Expected Impact:

Targeted interventions will help to reduce the risk of MRSA bacteraemia.



Pressure Ulcers – hospital acquired category 3 and above

Executive Lead:

Chief Nurse

Performance Issue:

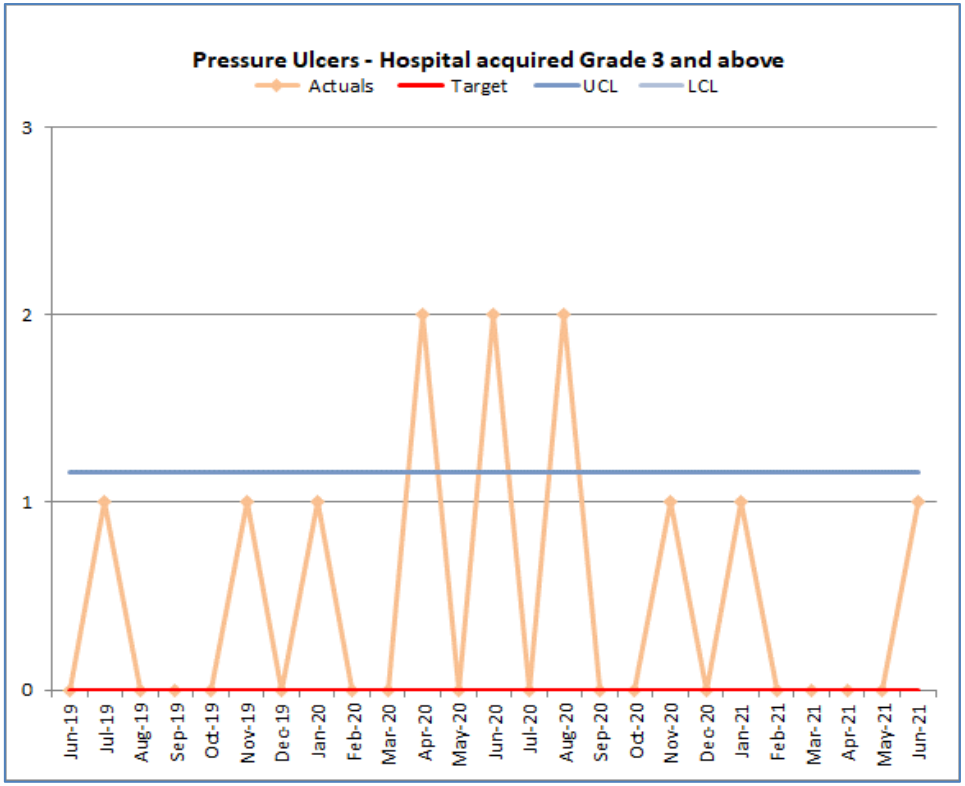
WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above.

Action:

There was a single case in June 2021, a full review of the incident has been undertaken. All risk assessments were completed including MUST and Braden and appropriate pressure relieving equipment was in place. The patient was known to have capacity but declined support with pressure relieving care which was fully documented. The review concluded all actions were taken to prevent skin deterioration and therefore was classified unavoidable. Tissue viability work continues, and the trust has seen a significant reduction in grade 2 pressure ulcers, particularly in ED and Medicine.

Expected Impact:

There will be a reduction in the number of patients with hospital acquired pressure damage.



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse

Performance Issue:

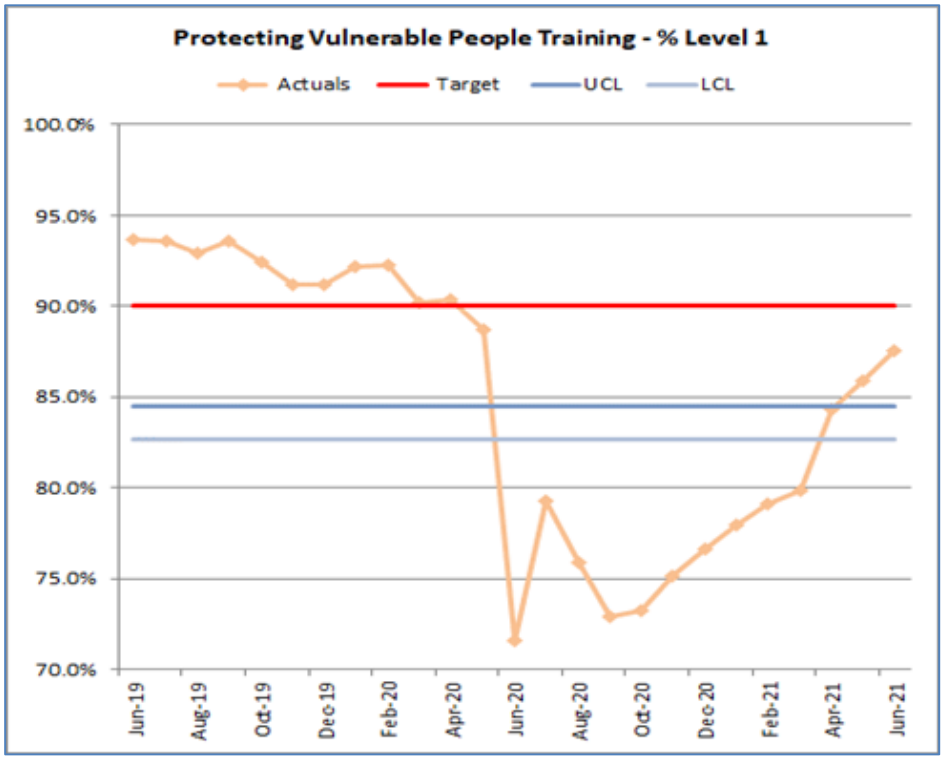
WUTH has a target set at 90% or above of relevant staff being compliant with training. Performance against this standard has been improving in recent months, with June at 88.5%.

Action:

Level 1 PVP is completed online and therefore can be accessed at any time.
Improvements continue to be noted following a targeted focus on non–compliance by the Divisions. Compliance for PVP level 1 has been achieved for Medicine and Acute (91.26%) and Women's and Children's (94.44%) with the other divisions also seeing significant improvements.
The Associate Director of Nursing for Safeguarding continues to provide regular monthly compliance reports highlighting areas requiring further focus and improvement. Assurance regarding divisional actions to improve compliance is reported to Safeguarding Assurance Group.
Perfect ward audit remains in use that assesses staff knowledge in relation to all areas of safeguarding. Any clinical areas requiring improvements are supported by the safeguarding team through additional bespoke training.

Expected Impact:

Level 1 PVP compliance is expected to continue to increase to the required mandatory 90% and above during Q2.



Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:

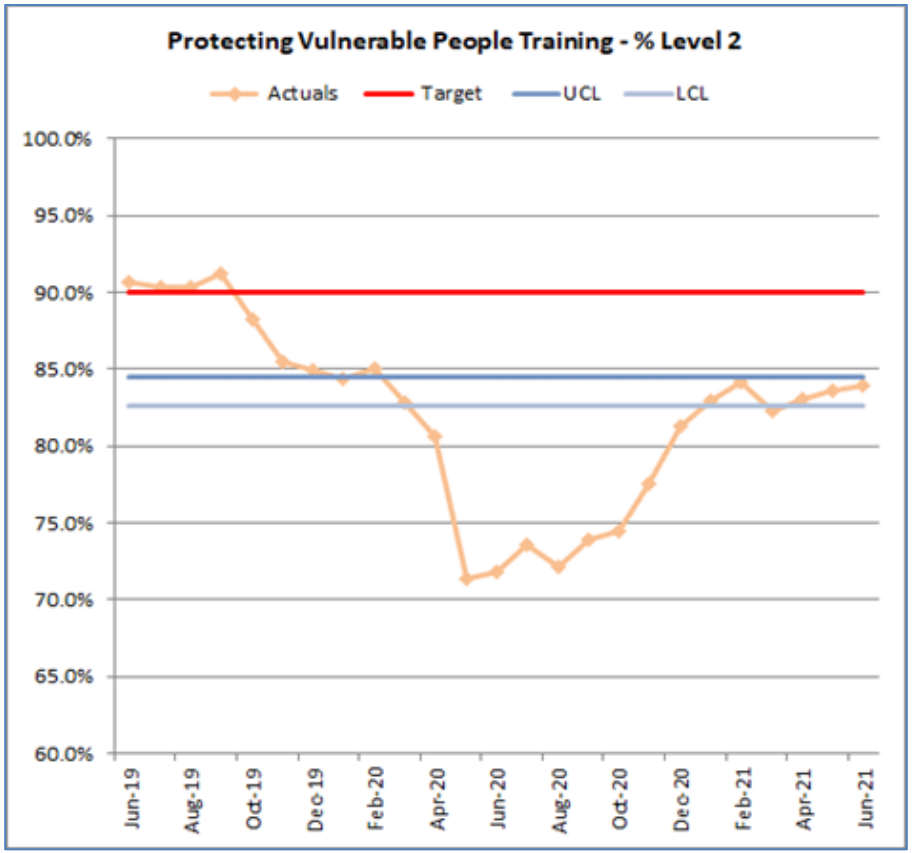
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been improving with a further increase in June 2021 to 83.9%.

Action:

Level 2 PVP is an eLearning package completed via ESR which can be accessed by staff directly and therefore can be completed at any time. Overall Trust compliance remains marginally the same since May with an increase of only 0.24%. The largest divisional increase in compliance for level 2 PVP has been noted in surgery who are now 89.49% complaint. The Associate Director of Nursing for Surgery continues to provide detailed monthly breakdown of compliance enabling a targeted focus by divisions. This is reported via the Safeguarding Assurance Group.

Expected Impact:

Level 2 PVP training is expected to continue to increase to the mandatory 90% and above mark during Q2.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

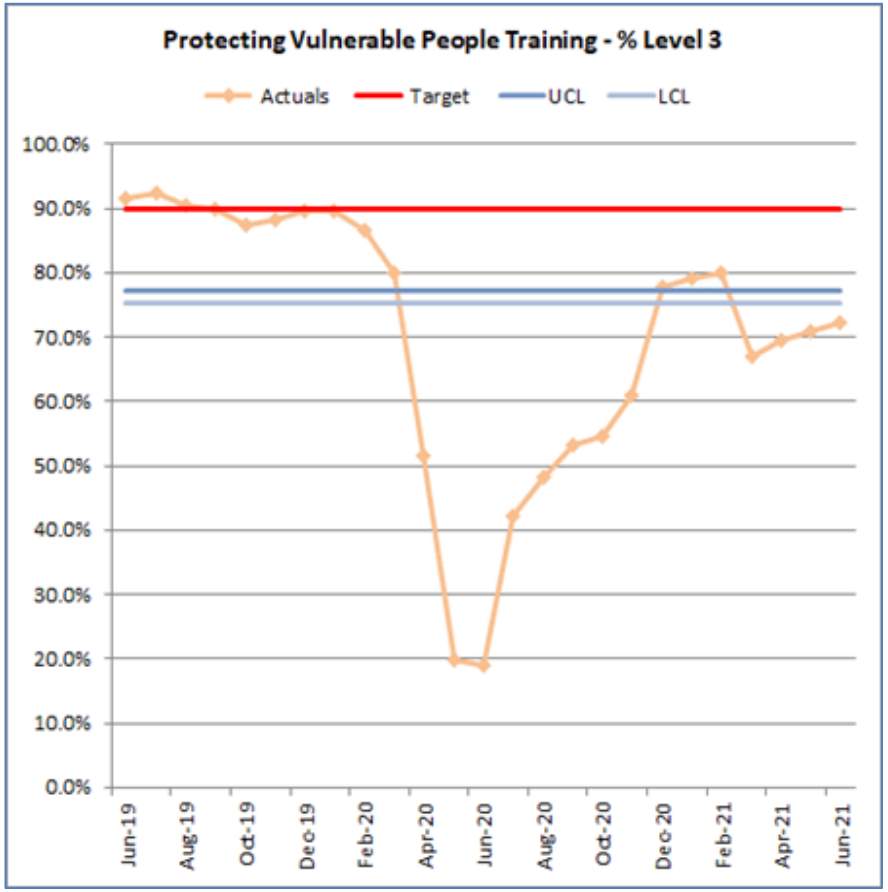
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been steadily improving, with June compliance increasing to 72.3%.

Action:

Trust wide compliance has improved by 5.24% in the previous month. Part of the Level 3 PVP is an eLearning package completed via ESR therefore can be completed by staff at any time. Monthly compliance reports are provided by the Associate Director of Nursing for Safeguarding to enable triumvirates to take a targeted approach to non-compliant staff to ensure further improvements are made.
Compliance for the face-to-face element of Level 3 has significantly improved form Q1 (59.17%) to Q2 (70.85%) an overall improvement of 11.68% across the quarter.
Lecture Theatre Capacity (33) had provided challenges for the face-to-face element of PVP training. In addition, DNAs have been high due to operational and staffing pressures. These sessions have now been arranged via teams to ensure there is enough capacity in place throughout the year to ensure compliance can be achieved.
Perfect ward audits remain in place to assess staff knowledge in relation to all areas of safeguarding. The Safeguarding Team are providing additional support for areas of concern with additional bespoke training.

Expected Impact:

Level 3 safeguarding training is expected to continue to increase to the mandatory 90% and above mark by Q2.



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.

Community prevalence of COVID-19 continues to increase. Unsurprisingly sickness absence levels continue to be above the Trust's 5% target, both for in-month sickness and over a rolling 12-month period.

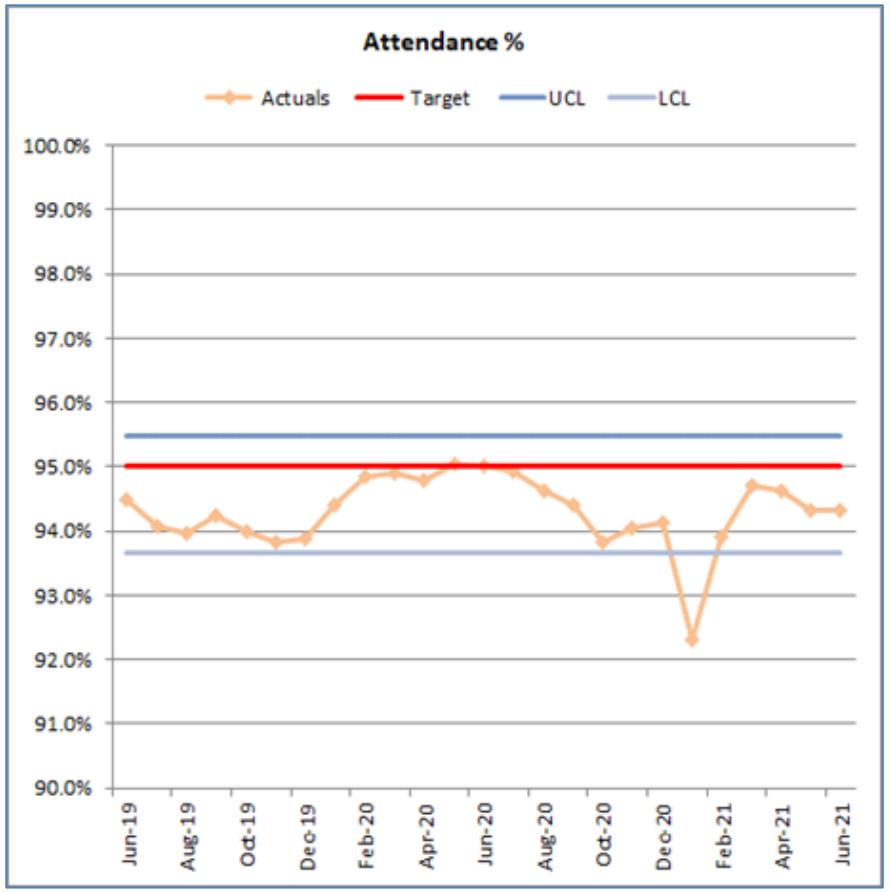
The Trust has experienced significant staff shortages caused by test and trace notification which has placed additional pressures on our workforce. Also, there has been a rise in staff absence as a result of COVID-19 cases affecting their children in schools, resulting in short term needs for staff to arrange childcare for children sent home from school.

Despite this in-month sickness in June 2021 remained static at 5.68% which was the same as May 2021 and slightly higher than April 2021 which was 5.38%. All months are significant improvement from the position in January 2021, which was 7.82%.

The rolling 12-month figure in June 2021 was 6.05% which was an improvement on last month from 6.10%.

4 Divisions and the Vaccination Hub have exceeded the 5% KPI in June 2021;

- Covid-19 – Vaccination Hub (8.22%)
- Estates and Hotel Services (7.77%)
- Women and Children's (6.21%)
- Medicine and Acute (5.94%)
- Surgery (5.91%)



In June 2021 there were 312 episodes of long-term sickness (28 days+) across the Trust which accounted for 29.02% of total sickness. There were 763 episodes of short-term sickness which accounted for 70.98%.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence at 36.86% (115 episodes), followed by Musculoskeletal Health at 12.18% (38 episodes).

Gastro problems were the highest reported reason for short term sickness absence at 22.28% (170 episodes) followed by Anxiety, Stress and Depression at 10.75% (82 episodes).

Action:

Extensive work is being undertaken strategically, operationally and locally. Employee health and wellbeing is and continues to be at the heart of the Trust's response to the ongoing pandemic.

Managing Sickness Absence

Work continues strategically and operationally from HR Services to support Divisions and managers to manage sickness absence effectively. HRBPs and HR Managers are focusing on supporting managers locally to conclude a number of complicated protracted long term sickness cases and to target specific areas requiring improvement.

Attendance management forms an important aspect of Triumvirate performance meetings and discussions take place on a case-by-case basis with relevant managers. Regular sickness review meetings and hearings are being undertaken across the Trust. The HR Managers are undertaking departmental audits to ensure (i) compliance with the new policy and (ii) quality assurance.

Supporting and Promoting Wellbeing

Divisional Triumvirates, with support from their HR Business Partners, are delivering against their Staff Survey Action Plans which are heavily focused on Health, Wellbeing and Attendance. Delivery against the plans is monitored via the Divisional Performance Reviews.

There continues to be a significant amount of wellbeing activity and promotions across the Trust. The Health Risk Assessment Form has been updated to include questions around COVID-19 vaccination and LAMP testing participation. Active promotion of LAMP Testing for all Trust staff continues as COVID-19 is increasing in the community. More general health and wellbeing initiatives include work such as the launch of Lower My Drinking app. During the COVID-19 pandemic harmful drinking has risen significantly, consequently impacting on people, communities, and services.

North West Attendance Deep Dive

Work continues on the North West Attendance Deep Dive pilot with the NHSEI North West People Team. The task and finish group have identified some possible areas of focus including:

- Policy (inclusion of further good practice)
- Policy Audit (review of our audit form against other Trusts)
- Staff Group Focus (Nursing & Midwifery and Estates & Ancillary Staff Groups)
- Age Focus (absence rates for those under 40 are comparatively high at WUTH)
- Staff Survey (focus on two themes Staff Engagement and Team Working) Occupational Health (improvements in referral to appointment times and time between appointment and the issuing of the management report).

The operational work of this group will be overseen by the Workforce Steering Board.

Expected Impact:

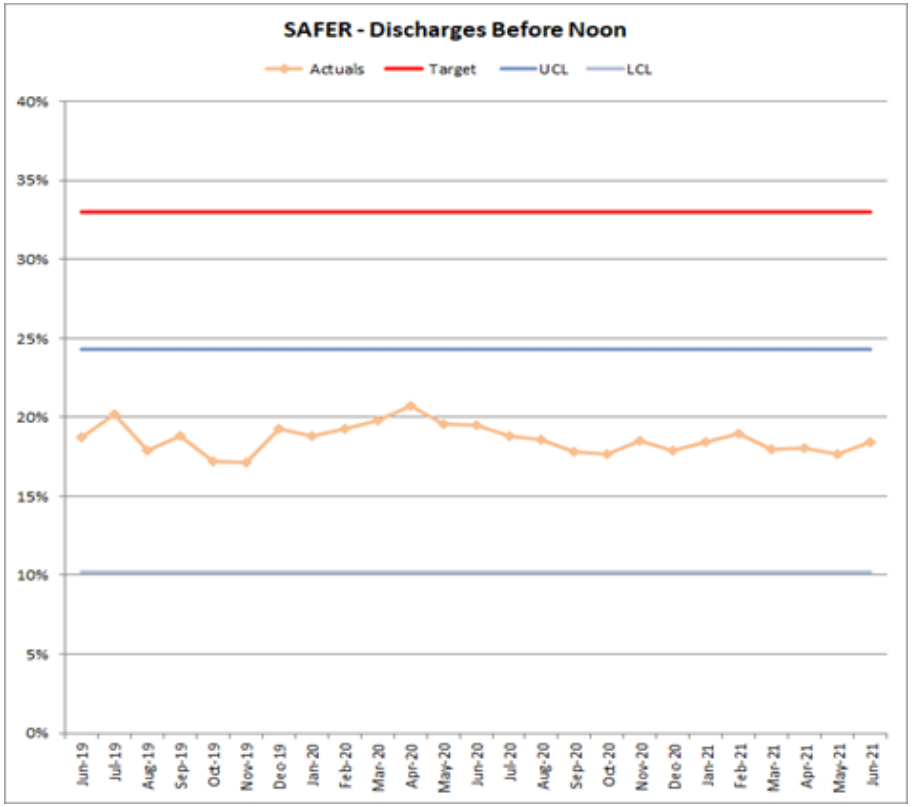
The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety.

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.

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 is comprehensively staffed by senior decision makers.
Expected Impact: During June 33% of discharges were delivered by 2.00pm.



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. June reduced to 82.5% in part due to the impact of increased Covid-19 related late cancellations.

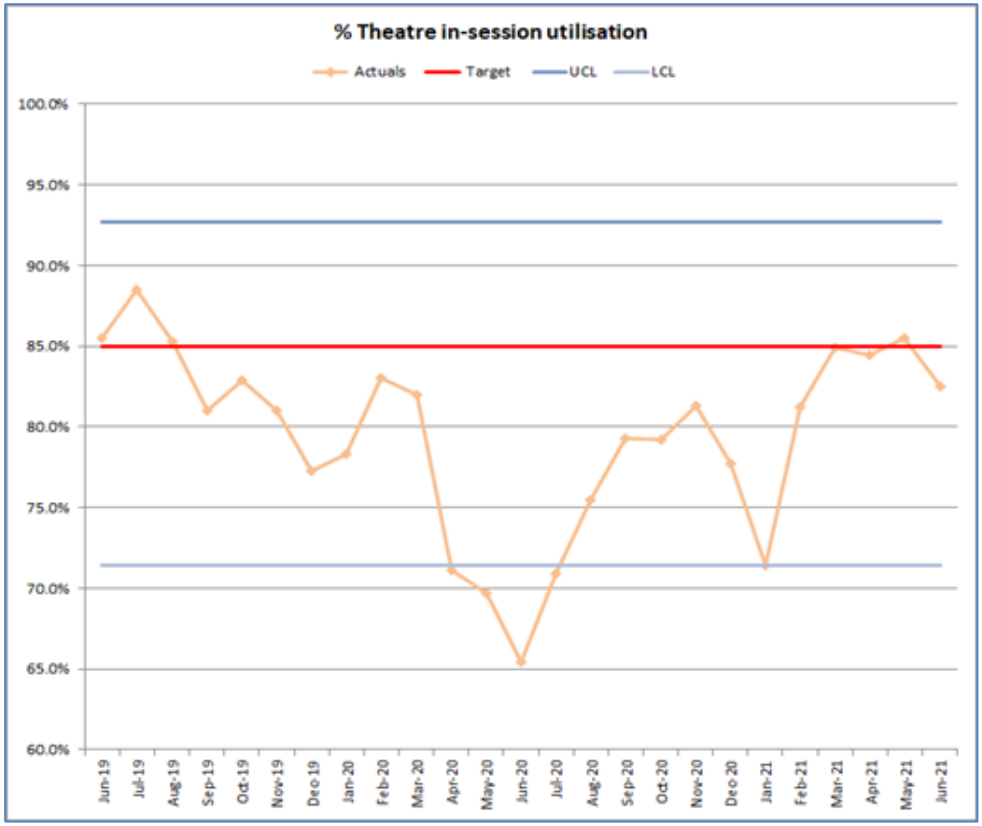
Action:

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. Monthly theatre activity has increased to typical pre-pandemic levels.

Expected Impact:

The increase in utilisation rates is expected to continue as activity returns to pre-pandemic levels on a consistent basis.



Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should not have mixed-sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

WUTH mixed sex breaches are largely due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 3 such breaches in June 2021.

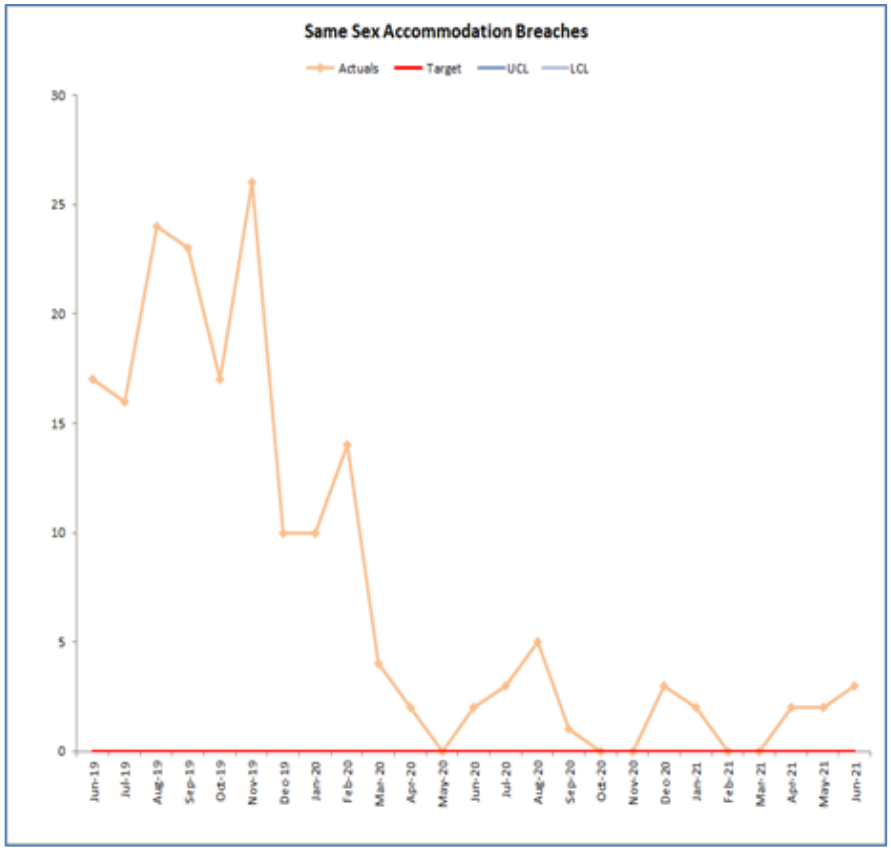
Action:

This month due to unexpected increases in ED attendances and admissions there were 3 mixed sex breaches. The management of mixed sex breaches is considered as high priority and is managed via Bed Capacity and Bronze Command Meetings to ensure actions are taken to address these timely. The Critical Care Matron attends the bed meetings to ensure focus remains high on any patients that are at risk or reported as mixed sex breeches.

These reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed capacity was available at this time. Patient's privacy and dignity needs are met whilst in critical care and the team ensures their specialty care is not compromised due to a lengthened critical care stay.

Expected Impact:

There will be a reduction in same sex accommodation breaches.



Responsive Domain

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

Executive Lead: Chief Operating Officer

Performance Issue:

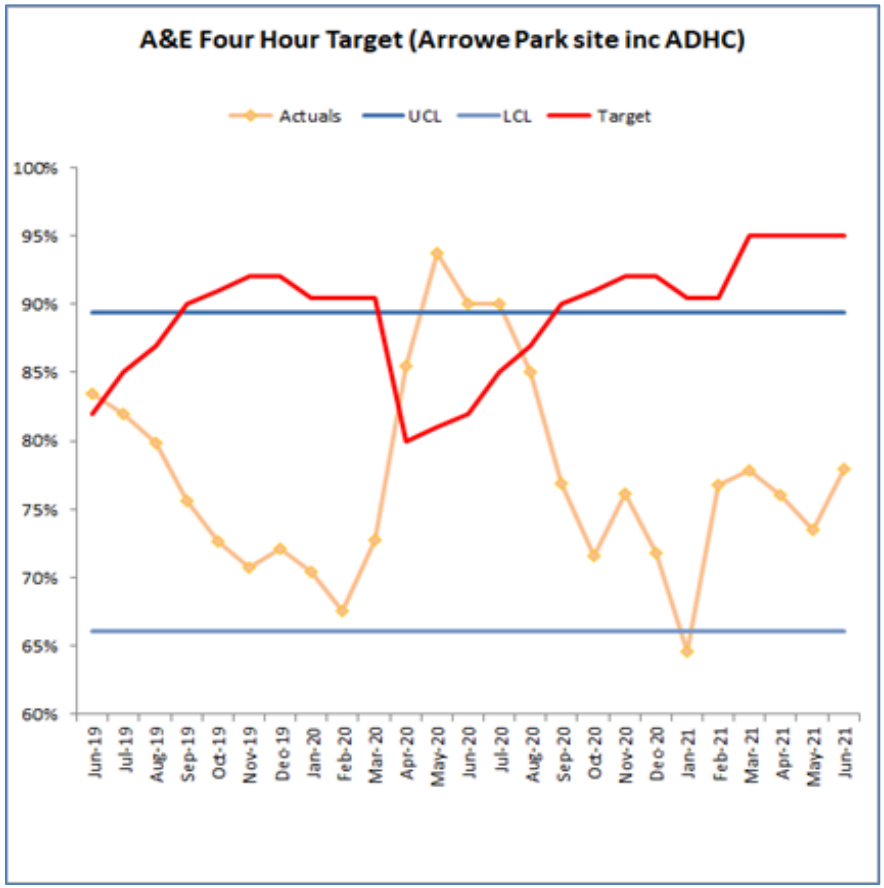
Performance during the first wave of COVID resulted in much reduced attendances, lower bed occupancy due to faster discharge and reduced elective activities creating better flow. During the third wave of Covid from January 2021, ED attendances again reduced but the number of Covid inpatients were greatly increased and so occupancy levels remained high despite the elective programme again being reduced. Since late March attendances have continued to exceed pre-covid levels.

Action:

There have been demonstrative improvements in breaches related to bed availability and the focus is now on delays within the ED itself.
A focus on triage times and the time taken for initial assessment is the focus of the improvement plan and is tracked through the transformation agenda.
The weekly performance framework is now focused on ED and there are weekly Exec led meetings with the Department and a further trust wide meeting to address issues and track progress.

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 had 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.

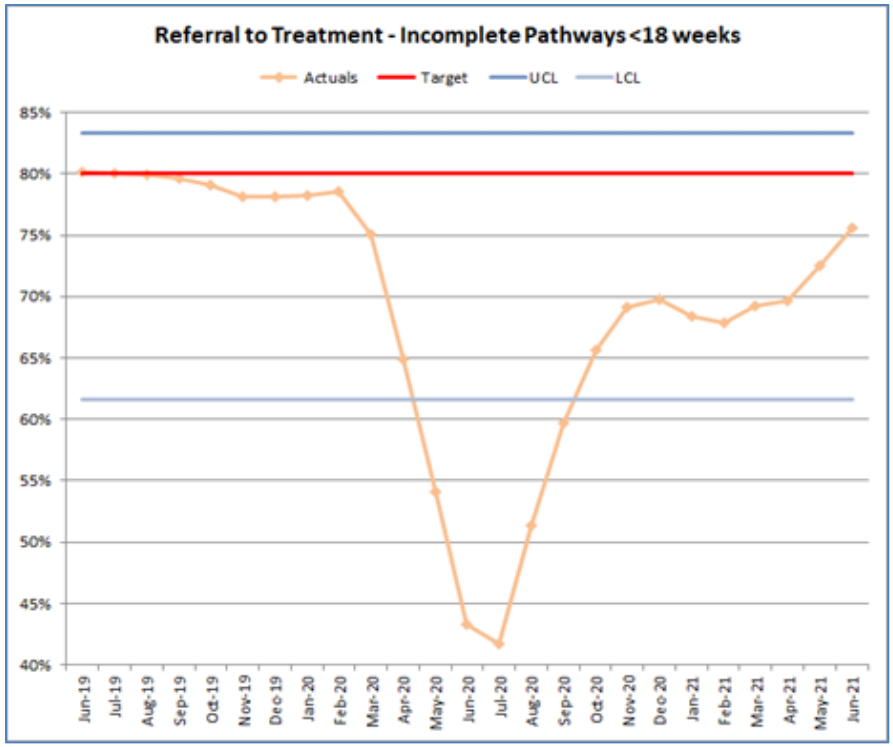
Following the directive to cease all non-urgent elective activities as part of the COVID response this metric sharply declined. The subsequent resumption of elective activity from July saw performance improve, until the onset of the Covid third wave from January 2021.

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 June 2021 was 96.8%.

Under national waiting time rules, patients waiting for medically planned investigations are excluded. However, if they wait beyond their expected waiting time, they should become active waiters and included.

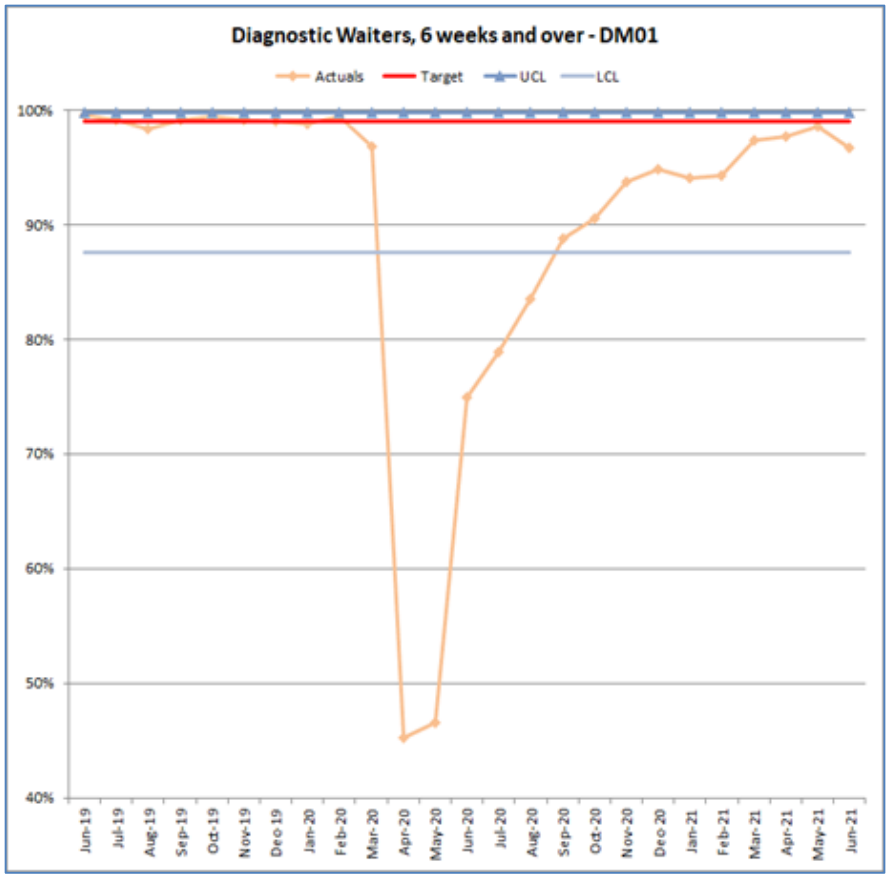
WUTH have a number of planned pathways where patients are now waiting beyond the time to be seen, and those waiters are now included in the total position – hence the deterioration since the end of May.

Action:

The recovery of diagnostic backlogs is part of the overall reset and recovery programme and trajectories, including the clinical validation of priority.

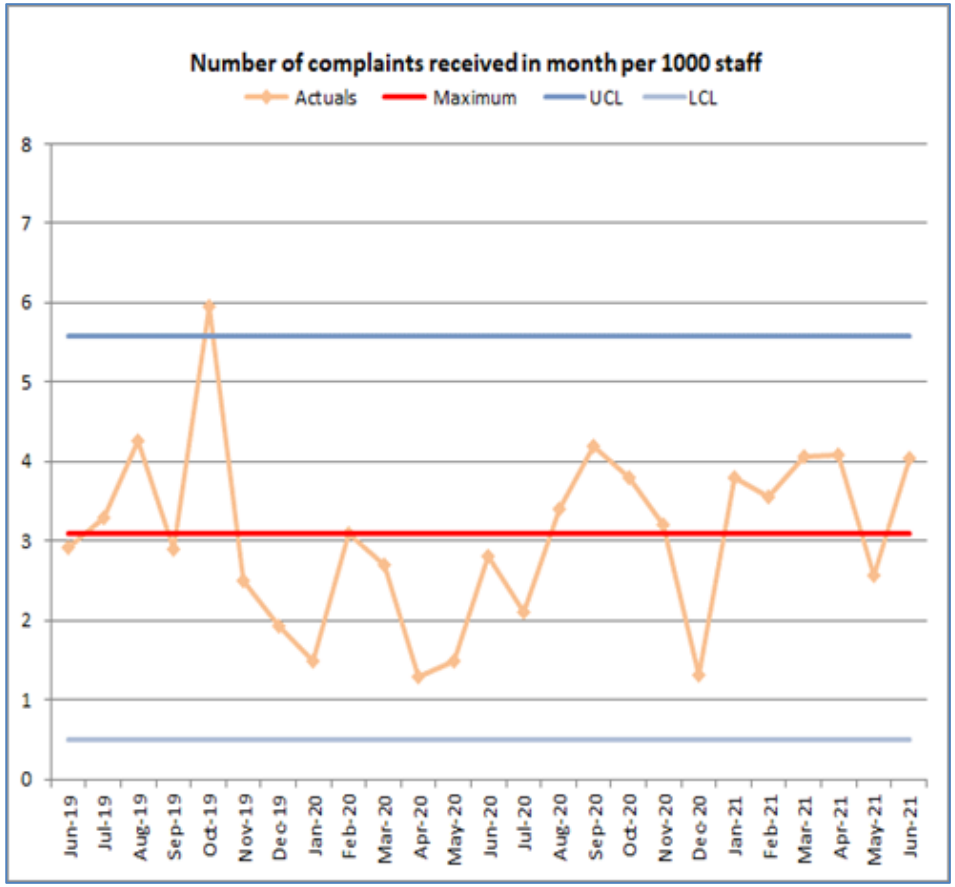
Expected Impact:

The ongoing inclusion of 'overdue' planned cases is expected to further deteriorate the Trust position in July, with subsequent improvement through the reset and recovery programme



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 June 2021 was 4.04.
Action: As previously observed, the number of complaints received does fluctuate seasonally, with contributing factors that are outside of the Trust's direct control (e.g., the social or clinical effects of a pandemic and winter). In June 2021, 22 formal complaints were logged, compared with 17 in 2020 and 15 in 2019. Communication remains the largest component of formal complaints at 41%, (in line with level 1 concerns). Following the first meeting of the Trust's Complaints and Claims Management Group in June, increased focus has been placed on the Divisions to try to resolve concerns in a timelier manner at a local level.
Expected Impact: Actions are expected to reduce the number of formal complaints being logged (although not necessary the overall number of informal concerns being raised).



Well-led Domain

Appraisal compliance %

Executive Lead: Director of HR / OD

Performance Issue:

The target for annual appraisal compliance is 88%. Compliance at the end June 2021 was 82.66%. Although this standard has not been achieved, there has been sustained improvement since February 2021.

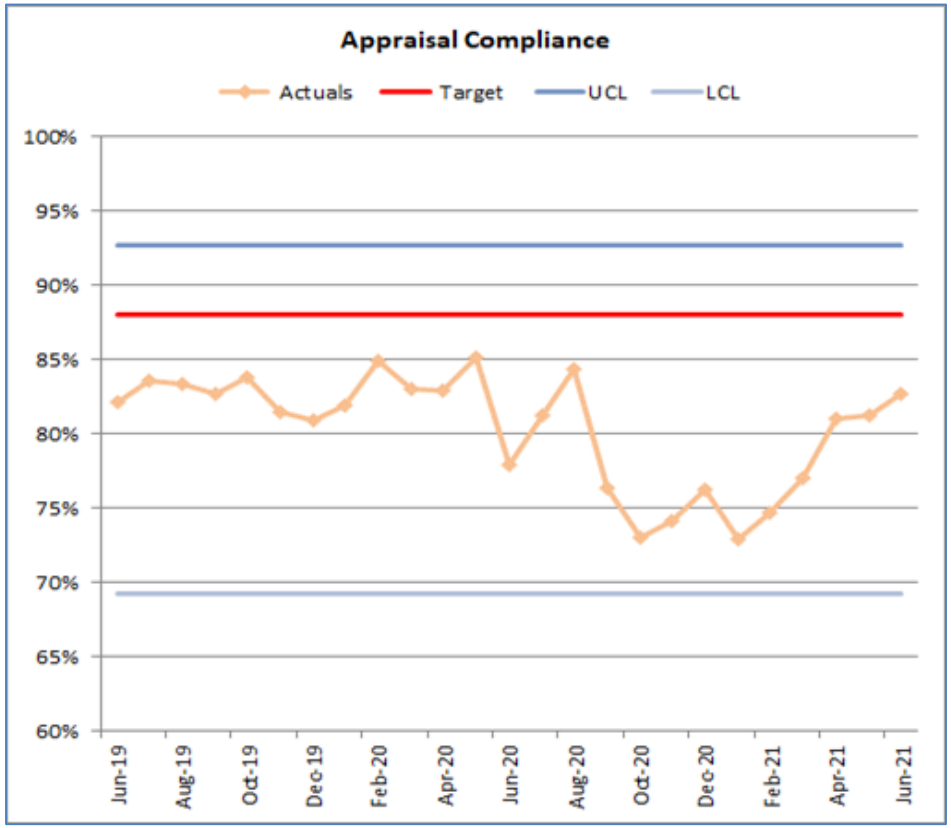
All divisions have increased compliance in month, with the exception of Women's and Children's, which reduced slightly to 87.34%.

Corporate Division continues to be area of challenge at 73%.

Action:
Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas and alerts of appraisals due are generated via the ESR system.

Detailed compliance reports are received by the Education Governance Group and the OD team and HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas.

Managers within the Corporate Support Division are continuing to deliver improvement plans against the detailed compliance reports, this is evidenced by the in-month increase.



Check and challenge discussions take place at a divisional triumvirate levels and recommencement of divisional performance review meetings will see this challenged further.
Expected Impact: Improvement in trajectory as the Trust returns to business as usual.

Agenda Item: BM21/22-108

BOARD OF DIRECTORS

04 August 2021

Title:	M3 Finance Report
Responsible Director:	Claire Wilson, CFO
Author:	Robbie Chapman, Deputy CFO
Presented by:	Robbie Chapman, Deputy CFO

Executive Summary

The Trust is reporting a surplus of £0.023m at M3, an adverse variance against plan of £0.032m.

Income from the Elective Recovery Fund (ERF) is yet to be confirmed and will not be received until M4 at the earliest. The figure represents a prudent estimate of our activity against national trajectories and is subject to change. NHSI have now confirmed that the trajectories in re-spect of ERF will increase to 95% for the remainder of H1. This will significantly reduce the amount of income the Trust will receive for M4-6.

Total employee expenses excluding COVID-19 were £70.534m at M3, this represents an overspend against our budget of £0.179m. However, this figure includes a significant overspend of budget in respect of Medicine and Acute offset by underspends in other parts of the Trust.

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

Board is asked to note the report.

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	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.	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)		
PR3: failure to achieve and/or maintain financial sustainability.		
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)		
Summary of financial performance at M3 with implications for 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	N/A	
Background papers / supporting information	N/A	

Contents

1. Executive summary

1.1 **Table 1: Financial position – M3**

Month 3 Financial Position	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	31,034	31,163	129	92,601	92,777	177
Covid 19 income	2,566	1,118	(1,448)	5,708	5,560	(148)
Non NHS income - patient care	409	398	(12)	1,228	1,219	(10)
Other income	2,135	2,478	344	6,455	6,968	513
Total Income	**36,144**	**35,157**	**(987)**	**105,992**	**106,524**	**532**
Employee expenses	(23,524)	(23,342)	182	(70,355)	(70,534)	(179)
Operating expenses	(10,829)	(11,197)	(368)	(32,552)	(33,143)	(591)
Covid 19 costs	(1,264)	(498)	766	(1,886)	(1,728)	158
Total Expenditure	**(35,616)**	**(35,037)**	**579**	**(104,793)**	**(105,405)**	**(612)**
Non Operating Expenses	(381)	(365)	16	(1,144)	(1,096)	48
Actual Surplus / (deficit)	**146**	**(246)**	**(392)**	**55**	**23**	**(32)**
			0			0
Surplus/(deficit) - Control Total	**146**	**(246)**	**(392)**	**55**	**23**	**(32)**

1.2 The Trust is reporting a surplus of £0.023m at M3, an adverse variance against plan of £0.032m. Despite this small variance we expect to perform in line with our plan for a break-even position in H1.

1.3 Total income was £103.524m at M3. This reflects the revised 'block' contract arrangements with CCGs with the reduced income compared to draft plans, confirmed values in respect of specialist and direct commissioning and ERF income of £2.888m.

1.4 The figure accrued in respect of ERF has yet to confirmed and will not be received until M4 at the earliest. The figure represents a prudent estimate of our activity against national trajectories and is subject to change. NHSI have now confirmed that the trajectories in respect of ERF will increase to 95% for the remainder of H1. This will significantly reduce the amount of income the Trust will receive for M4-6.

1.5 We have received £6.968m in other income, a positive variance of £0.513m. This is attributable to funding we received in respect of Teledermatology and Elective care programme and larger than expected income from Clatterbridge Cancer Centre for SLAs due to their continued use of the site. Both of these are offset by increased expenditure.

1.6 Total employee expenses excluding COVID-19 were £70.534m at M3, this represents an overspend against our budget of £0.179m. This figure includes a significant overspend of budget in respect of Medicine and Acute offset by underspends in other parts of the Trust. Employee expenses can be broken down as follows:

Table 2: Pay cost analysis

1. Executive summary

Pay analysis (exc Covid)	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,663)	(21,008)	655	(64,624)	(63,016)	1,608
Bank	(729)	(1,029)	(300)	(2,205)	(3,206)	(1,001)
Medical Bank	(444)	(379)	65	(1,332)	(1,522)	(190)
Agency	(604)	(828)	(224)	(1,945)	(2,518)	(574)
Apprenticeship Levy	(83)	(98)	(15)	(250)	(272)	(22)
Total	(23,524)	(23,342)	182	(70,355)	(70,534)	(179)

1.7 Operating expenses were £33.143 at M3, an overspend of £0.591m. This reflects lower spend against clinical supplies and services than budget offset by increased expenditure on drugs, estates and education and training.

1.8 Cash balances at the end of M3 were £16.5m.

1.9 The Trust has recorded capital spend of £1.76m at M3 in line with plan.

2. Background

2.1 The Trust resubmitted our financial plan to NHSE/I on the 22nd June. As anticipated this did not result in any material movement in the plan and the Trust is still expected to break even in H1.

2.2 All Divisions have now received full details of their budget for H1.

2.3 The funding arrangements for H2 have yet to be confirmed but it is likey that we will have to undertake a second planning procress ahead of the 2nd half of the year.

3. Dashboard and risks

3.1 **Table 3: M3 Performance Dashboard**

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2021/22
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	-0.6	-0.4
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.8	-0.4
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.02%	3.0%
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-32.4%
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-10.4	-10.4
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	2.0%	5.0%	12.0%	12.0%

3.1.1 Although thresholds have yet to be confirmed for 2021/22, we have reported against the most recent thresholds.

3.1.2 The performance in respect of I&E performance is explained by the adjustments made due to the redistributions of funding since M1 and increased pressure in clinical areas, most notably in respect of Medicine & Acute.

3.1.3 Agency spend is above threshold. This is discussed in more detail at 4.2.3.

3.1.4 Despite significant improvement over the last year, the Trust's liquidity days measure is below threshold. This is based on net current liabilities compared against operating expenses. Steps are being taken to reduce historic accruals which will serve to improve this measure.

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

3.2.1 Risk 1 – Failure to manage financial position

- The H1 financial envelope has now been confirmed and our ability to operate within this envelope will be dependent on effective cost management alongside the delivery of activity trajectories, the management of COVID activity and the centrally funded vaccination and testing programmes. This report demonstrates that, as of M3, we are managing this position within envelope.

3.2.2 Risk 2 – Failure to deliver CIP

- The confirmed H1 CIP target is £1m and this has been incorporated into our plans submitted to NHSE/I. This figure will likely increase in H2 and work has already begun to identify schemes for the period.

3.2.3 Risk 3 – Failure to complete capital programme

- Our capital programme target for 21/22 is £14m which contains work carried forward from the previous financial year and significant work throughout the Trust. M3 performance is in line with plan.

4. Financial Performance

4.1 **Income**

4.1.1 The Trust has received £106.524m at M3.

Table 4: Income analysis for M3

	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	4,066	4,086	20	11,420	11,720	300
Elective excess bed days	131	62	(70)	284	186	(98)
Non-elective	7,871	8,311	440	24,461	25,087	626
Non-elective Non Emergency	1,046	1,302	256	3,199	3,490	290
Non-elective excess bed days	273	90	(183)	962	514	(448)
A&E	1,289	1,520	230	3,941	4,261	320
Outpatients	3,116	3,652	536	9,146	9,983	837
Diagnostic imaging	263	295	32	779	768	(11)
Maternity	420	422	2	1,367	1,307	(60)
Non PbR	5,819	5,898	79	17,651	16,737	(914)
HCD	1,244	1,604	360	3,790	4,484	694
CQUINs	190	190	(0)	570	570	(0)
National Top up	3,363	2,260	(1,103)	9,705	8,118	(1,587)
Other	1,018	1,233	215	3,055	3,124	69
Sub-Total Board Clinical Income	30,110	30,925	815	90,330	90,348	18
Other patient care income	1,240	558	(681)	3,219	3,408	189
COVID-19 Income	2,566	1,118	(1,448)	5,708	5,560	(148)
Non-NHS: private patient & overseas	29	38	9	87	74	(13)
Injury cost recovery scheme	64	39	(25)	192	166	(27)
Total Patient Care Income	34,009	32,679	(1,330)	99,537	99,556	19
Other operating income	2,135	2,478	344	6,455	6,968	513
Other non operating income		0	0			0
Total income	36,144	35,157	(987)	105,992	106,524	532

4.1.2 Clinical income in M3 was in line with forecast. The lower patient care activity income in respect of non-PbR activity and non-elective excess bed days was offset by strong performance in respect of outpatients, elective and daycase and non-elective care.

4.1.3 Total patient care income was also in line with plan. The budget submitted to NHSE/I on the 22nd of June included the costs associated with COVID testing and vaccination these no longer cause a variance.

4.1.4 Other Operating income was £6.968m at M3, a positive variance of £0.532m. This is attributable to additional funding we received in respect of our telederm initiative and larger than expected income from Clatterbridge Cancer Centre for SLAs due to their continued use of the site. Both of these are offset by increased expenditure.

4. Financial Performance

4.2 **Expenditure: Pay**

4.2.1 The Trust has spent £70.534m on pay costs at M3. Table 5 details pay costs by staff group and Table 6 details pay costs by pay category type.

Table 5 Pay costs by staff type (excluding COVID-19)

Pay analysis (exc Covid)	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(3,901)	(3,280)	621	(11,663)	(11,305)	358
Other medical	(2,644)	(2,704)	(60)	(7,931)	(7,970)	(38)
Nursing and midwifery	(6,299)	(6,492)	(193)	(18,731)	(19,125)	(394)
Allied health professionals	(1,355)	(1,347)	8	(4,018)	(4,109)	(91)
Other scientific, therapeutic and technical	(570)	(503)	67	(1,710)	(1,501)	209
Health care scientists	(1,060)	(1,085)	(26)	(3,178)	(3,263)	(85)
Support to clinical staff	(4,507)	(4,492)	15	(13,315)	(13,114)	201
Non medical, non clinical staff	(3,105)	(3,341)	(236)	(9,559)	(9,876)	(317)
Apprenticeship Levy	(83)	(98)	(15)	(250)	(272)	(22)
Total	(23,524)	(23,342)	182	(70,355)	(70,534)	(179)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,663)	(21,008)	655	(64,624)	(63,016)	1,608
Bank	(729)	(1,029)	(300)	(2,205)	(3,206)	(1,001)
Medical Bank	(444)	(379)	65	(1,332)	(1,522)	(190)
Agency	(604)	(828)	(224)	(1,945)	(2,518)	(574)
Apprenticeship Levy	(83)	(98)	(15)	(250)	(272)	(22)
Total	(23,524)	(23,342)	182	(70,355)	(70,534)	(179)

4.2.2 Total pay costs in M3 were £70.534m, an overspend of £0.179m. This hides under-spends on staff across most of the Trust, with an overspend of £2.192m in Medicine & Acute.

4.2.3 This is largely driven by the Nurse Incentive Scheme, additional demand for agency support within ED at junior doctor level and additional support required to meet the surge in activity since March. The Nurse Incentive Scheme finished at M3, additional support to cover for junior doctors should remain high until the appointment of new trainees after the summer. However, the support required to meet demand is likely to continue for some time.

4. Financial Performance

4.3 **Expenditure: Non-Pay**

4.3.1 The Trust has spent £33.143m on non-pay operating expenditure at M3.

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

Non Pay Analysis (exc Covid)	Budget (Mth 3) £'000	Actual (Mth 3) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Supplies and services - clinical	(3,174)	(2,738)	436	(9,359)	(8,386)	973
Supplies and services - general	(417)	(381)	36	(1,259)	(1,122)	136
Drugs	(1,936)	(2,396)	(460)	(5,802)	(6,745)	(943)
Purchase of HealthCare - Non NHS Bodies	(928)	(719)	208	(2,548)	(2,109)	439
CNST	(1,152)	(1,152)	(0)	(3,455)	(3,453)	2
Consultancy	(11)	(18)	(7)	(33)	(119)	(86)
Other	(2,259)	(2,855)	(596)	(7,244)	(8,387)	(1,143)
Sub-Total	(9,876)	(10,258)	(382)	(29,700)	(30,322)	(622)
Depreciation	(953)	(941)	12	(2,852)	(2,823)	30
Impairment	0	2	2	0	2	2
Total	(10,829)	(11,197)	(368)	(32,552)	(33,143)	(591)

4.3.2 The overspend in respect of non-pay is being driven by pressure in respect of higher than expected costs for high cost drugs, non-capital pressures in estates and an increase in expenditure around education and training offset by a reduction in spend in respect of supplies and services due to high levels of stock.

4.3.3 Expenditure on high cost drugs was historicaly offset by additional funding from commissioners but this is no longer the case. Increased expenditure on high cost drugs is an issue across all clinical divisions and is explained in more detail within the appendices.

4.3.4 The Trust has seen increased costs in respect of estates most notably in respect of support from architects, project management consultants and maintenance costs. It is possible that some of these costs will be capitalised in due course.

4.3.5 NHS Improvement are no longer directly funding independent sector spend through the nationally agreed contract. This is currently below budget but we expect this to increase in the second half of H1.

4. Financial Performance

4.4 **Expenditure: COVID–19**

4.4.1 The Trust spent £1.728m on Covid-19 costs at M3, with £0.915m on pay and £0.813m on non-pay.

Table 9: YTD COVID-19 revenue costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Year to Date £'000
Medical Staff	(35)	(14)	(24)	(73)
Other Clinical Staff	(343)	(172)	(183)	(698)
Non Clinical Staff	(72)	(49)	(22)	(144)
Total Pay	(450)	(236)	(229)	(915)
Clinical Supplies	(101)	(207)	(230)	(539)
Other Non-Pay	(106)	(129)	(39)	(274)
Total Non-Pay	(208)	(337)	(269)	(813)
Total Covid Expenditure	**(658)**	**(572)**	**(498)**	**(1,728)**

4.4.2 The vaccination costs were £0.431m at M3 which was in line with plan and is funded centrally.

4.4.3 The testing costs were £0.4m at M3 and is funded centrally so offset in income.

4. Financial Performance

4.5 CIP Performance

4.5.1 The Trust's YTD target for CIP was £0.25m with £1m for the whole of H1. As at M3 the Trust has achieved £0.428m of CIP, of which £0.397m is recurring and £0.031m is non-recurring.

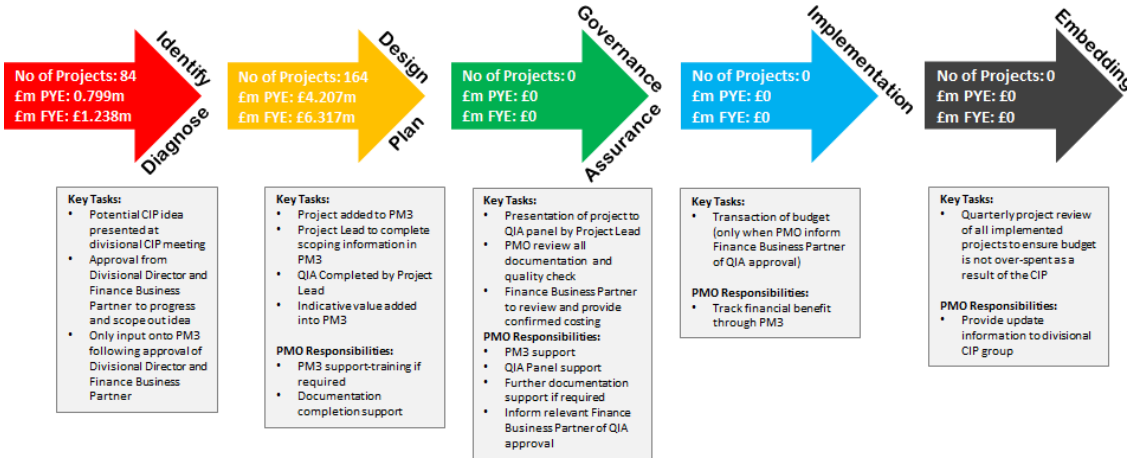
4.5.2 Plans are in place for to achieve a further £1.063m in CIP in H1 of which £0.741m is recurrent and £0.322m is non-recurrent.

4.5.3 The target for the remainder of the year (H1 and H2) has yet to be confirmed but, as at the 15th July, 248 opportunities have been identified with a recurrent value of £5.006m in year expenditure and £7.555m full year expenditure (including the values listed at 4.5.1 and 4.5.2. A breakdown by division can be seen in Table 10 below:

Table 10: IYE and FYE breakdown by Division

Division	IYE Identified £m	FYE Identified £m
DCS	1.093	2.660
M&A	1.574	2.204
Surgery	1.226	1.484
W&C	0.407	0.598
Corp	0.706	0.609
Total	**5.006**	**7.555**

4.5.4 A CIP gateway framework has been developed to track progress of CIP opportunities from proposed to delivery:



4.5.5 84 projects with a value of £0.799m have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.5.6 164 projects with a value of £4.207m have progressed to design & plan (gateway 2), meaning documentation is now being completed on PM3 with indicative costings.

4.5.7 The tracking, monitoring and reporting of CIP projects through the gateways, will be done through PM3. PM3 is the new project management software used at WUTH. This is used for all Projects and Programmes, including the three Priority Transformation Programmes, Quality Improvement, all CIP projects and Strategies. The Productivity and Efficiency team offer continued support to CIP project leads to ensure project documentation is inputted into PM3 to support governance and reporting.

4.5.8 Trust wide and divisional position statements will be reported through divisional CIP meetings and FPBAC to provide over sight of progress and any issues arising. These reports will also include divisional CIP performance against plan and forecast adjustments.

4. Financial Performance

4.6 Divisional performance

Table 11: IYE and FYE breakdown by Division

Division	Budget Variance (£000)	WTE Variance (inc bank)	Agency spend (£000)	CIP YTD (£000)	CIP Forecast H1 (£000)
M&A	-2,690	-31.47	1,543	52	165
Surgery	-301	-15.01	311	80	256
DCS	50	22.23	266	206	412
W&C	474	6.12	105	16	63
EHS	-540	33.60	63	0	0
Corporate	-433	42.87	230	44	241

4.6.1 The table above sets out 5 key metrics in regard to divisional performance: variance from YTD budget, variance from budgeted establishment including bank but excluding agency, agency spend, YTD CIP and the total forecast for CIP in H1.

4.6.2 At M3 Medicine & Acute has an adverse variance against budget of £2.690m The Division has employed on average 31.47 more people than was allowed for within the budget in addition to £1.543m of agency costs. CIP performance YTD is small in the context of the size of the budget but progress has been made in terms of reducing agency costs and run rate through the permanent recruitment of doctors in cardiology, haemotology and gastroentonology.

4.6.3 At M3 Surgery has an adverse variance against budget of £0.301m The Division has employed on average 15.01 more people than was allowed for within the budget in addition to £0.311m of agency costs. CIP performance YTD centres around the reduced cost in respect of orthopaedic hip and knee implants. In addition to this the renewal of the coloplast contract on improved payment terms will contribute savings for the remainder of the year.

4.6.4 At M3 DCS has a positive variance against budget of £0.050m The Division has employed on average 22.23 fewer people than budget but has paid £0.266m of agency costs YTD. CIP performance YTD centres around the reduced cost in respect of clinical supplies, reduced bedding costs and increased income in respect of SLAs.

4.6.5 At M3 Women's & Children's has a positive variance against budget of £0.474m. The Division has employed on average 6.12 fewer people than budget but has paid £0.105m of agency costs YTD. CIP performance YTD centres around reductions in budgeted establishment and changes in skills mix resulting in reduced costs.

4.6.6 At M3 Estates and Hotel Services has an adverse variance against budget of £0.540m. The Division has employed on average 33.60 fewer people than budget and has paid only £0.063m of agency costs YTD. No CIP has been achieved in respect of Estates and Hotel Services YTD and none has been identified for the remainder of H1.

4.6.7 At M3 Corporate has an adverse variance against budget of £0.433m. The Division has employed on average 42.87 fewer people than budget and has paid £0.230m of agency costs YTD. CIP in respect of Corporate achieved YTD and identified for the

remainder of H1 all relates to procurement. This includes corporate contract reviews and the MSC tender dialysis unit on APH and CGH sites.

4.6.8 This is the first time that a summary of divisional performance has been included within the main body of the report for Board. We would be interested to have members feedback on this section and whether there were any specific risks beyond the information listed that you would like to be addressed in future reports.

5. Financial Position

5.1 **Statement of Financial Position (SOFP)**

5.1.1 The movement in total assets employed at M3 is minimal.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 31.05.21 £'000	Actual as at 30.06.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	162,676	162,738	62	↑
12,864	Intangibles	12,655	12,620	(35)	↓
869	Trade and other non-current receivables	885	897	12	↑
177,293		**176,216**	**176,255**	**39**	↑
	Current assets				
4,788	Inventories	4,356	3,971	(385)	↓
16,848	Trade and other receivables	17,513	24,449	6,936	↑
0	Assets held for sale	0	0	0	→
21,294	Cash and cash equivalents	22,227	16,538	(5,689)	↓
42,930		**44,096**	**44,958**	**862**	↑
220,223	**Total assets**	**220,312**	**221,213**	**901**	↑
	Current liabilities				
(44,124)	Trade and other payables	(42,982)	(43,049)	(67)	↑
(4,622)	Other liabilities	(5,869)	(6,982)	(1,113)	↑
(1,090)	Borrowings	(1,114)	(1,125)	(11)	↑
(7,256)	Provisions	(7,170)	(7,235)	(65)	↑
(57,092)		**(57,135)**	**(58,391)**	**(1,256)**	↑
(14,162)	**Net current assets/(liabilities)**	**(13,039)**	**(13,433)**	**(394)**	↑
163,131	**Total assets less current liabilities**	**163,177**	**162,822**	**(355)**	↓
	Non-current liabilities				
(2,479)	Other liabilities	(2,461)	(2,452)	9	↓
(5,193)	Borrowings	(5,193)	(5,193)	0	→
(7,318)	Provisions	(7,144)	(7,044)	100	↓
(14,990)		**(14,798)**	**(14,689)**	**109**	↓
148,141	**Total assets employed**	**148,379**	**148,133**	**(246)**	↓
	Financed by Taxpayers' equity				
171,121	Public dividend capital	171,121	171,121	0	→
(64,220)	Income and expenditure reserve	(63,982)	(64,227)	(245)	↓
41,240	Revaluation reserve	41,240	41,240	0	→
148,141	**Total taxpayers' equity**	**148,379**	**148,134**	**(245)**	↓

5. Financial Position

5.2 **Capital Expenditure – June 2021**

Capital Programme - 30 June 2021

	Full Year Budget			Full Year Forecast		YTD
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Funding						
Total Internally Generated Funding	12,738	0	12,738	12,738	0	12,738
PDC (Public Dividend Capital) - UTC	1,300	0	1,300	1,300	0	1,300
External Funding - donations/grants	0	552	552	552	0	552
Total funding	**14,038**	**552**	**14,590**	**14,590**	**0**	**14,590**
Expenditure						
Pre-commitments 20/21	5,007	283	5,290	5,290	0	1,068
Estates	2,671	0	2,671	2,671	0	1
Informatics	784	0	784	784	0	69
Medicine and Acute	715	(104)	611	611	0	403
Clinical Support and Diagnostics	1,914	20	1,934	1,934	0	0
Surgery	688	66	754	754	0	101
Women and Children's	236	0	236	236	0	99
Other	90	0	90	90	0	7
Contingency[2]	633	(265)	368	368	0	0
Donated assets	0	552	552	552	0	
UEC	1,300	0	1,300	1,300	0	9
Total expenditure (accruals basis)	**14,038**	**552**	**14,590**	**14,590**	**0**	**1,757**
Capital programme funding less expenditure	**0**	**0**	**0**	**0**	**0**	**12,833**
Capital expenditure	14,038	0	14,038	14,038		1,750
NBV asset disposals	0	0	0	0		0
Donated assets	552	0	552	552		7
CDEL impact	**14,590**	**0**	**14,590**	**14,590**		**1,757**

[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 Spend in M3 is in line with plan. Divisions have made progress with replacement equipment purchases and over the next few months the number of capital works schemes will increase.

5. Financial Position

5.3 Statement of Cash Flows – June 2021

Detailed cash variances through SoCF

	Month Actual £'000	Year to date Actual £'000
Opening cash	**22,227**	**21,294**
Operating activities		
Surplus / (deficit)	(246)	23
Net interest accrued	17	50
PDC dividend expense	351	1,054
Unwinding of discount	(3)	(8)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	120	1,118
Depreciation and amortisation	941	2,823
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	0	(7)
Changes in working capital	(5,717)	(3,467)
Investing activities		
Interest received	0	2
Purchase of non-current (capital) assets [1]	(1,028)	(5,210)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	0	0
Financing activities		
Public dividend capital received	0	0
Net loan funding	0	0
Interest paid	0	(1)
PDC dividend paid	0	0
Finance lease rental payments	(5)	(16)
Total net cash inflow / (outflow)	**(5,689)**	**(4,757)**
Closing cash	**16,538**	**16,537**

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

5.2.1 There has been a 25% reduction in cash balances in month which is offset by a 40% increase in receivables. At M3 the Trust has £17.5m of accrued income which is an increase of £5.5m or 46% in month.

5. Financial Position

5.4 Treasury

Borrowings summary June 2021

Borrowings summary

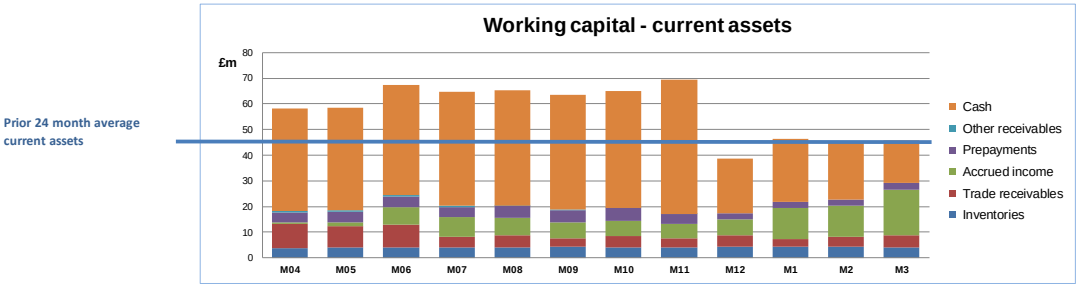
	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar21	Conversion to PDC Sept20	Forecast Repayment 20/21	Forecast Closing Balance Mar21
	£'000	Years	%	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	0	(750)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	0	(265)	3,583
3. Interim revolving working capital support	23,289	5	3.50	23,289	(23,289)	0	0
4. Uncommitted interim revenue support	40,389	3	1.50	40,389	(40,389)	0	0
5. Uncommitted interim revenue support	20,206	3	3.50	15,700	(15,700)	0	0
	97,884			86,601	(79,378)	(1,015)	6,208

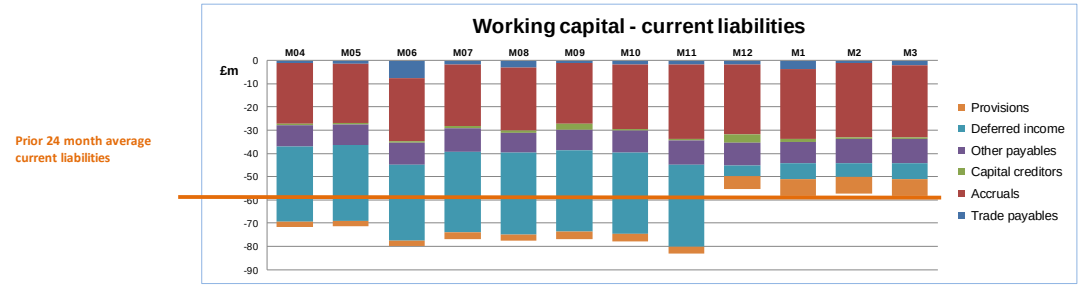
This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

5.4.1 The Trust's borrowings, comprising capital loans, will be repaid at a level of £1m per year.

5.5 Working capital profiles by month

5.5.1 2021/22 working capital profiles below show June 2021 (M3) working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.





5. Financial Position

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

Use of Resources (UoR) Rating

Summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-10.3	3
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	2.4	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	1.4%	1
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-50.0%	4
	Overall NHSI UoR rating				**2**

5.6.1 The liquidity rating of 3 is a slight improvement in month. The capital service capacity metric remains at 2 which again is in line with 2020/21. The I&E margin reflects the YTD surplus. Agency spend is higher than anticipated and is therefore rated as a 4. The overall UoR rating of 2 is expected to continue for the remainder of the year.

Agenda Item: 21/22-109

BOARD OF DIRECTORS
4th August 2021

Title:	Digital Strategy
Responsible Director:	M Swanborough, Director of Strategy & Partnerships
Author:	M Swanborough, Director of Strategy & Partnerships Chris Mason, Interim Director for IT & Information Helen Walker, Strategy & Business Planning Manager
Presented by:	M Swanborough, Director of Strategy & Partnerships

Executive Summary
Our Digital Strategy forms 1 of 7 enabling strategies, through which Our 2021-2026 Strategy will be delivered. Our Digital Strategy sets out our commitment to creating a culture that embraces digital technology to enable us to provide the best acute hospital services to the communities we serve. Our Digital Strategy is broken down into 4 domains aligned to Our Strategy 2021-2026, Digital Future strategic objective: Digital Foundations, Digital Innovations, Digital Education and Digital Intelligence. During a series of Digital Strategy development workshops, engagement sessions and through utilising a patient questionnaire, priorities were identified for each of the 4 Digital Strategy domains and mapped out over the next 5 years. Digital Future strategic objective priorities developed by our clinical teams have also been drawn out of our Clinical Service Strategy 2021-2026 to inform our Digital Strategy. Our Digital Strategy outlines the development approach undertaken, sets out our current organisational digital position, identifies key priorities and areas for improvement over the next 5 years and details how progress in delivering our priorities will be monitored.

Recommendation: (e.g. to note, approve, endorse)
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	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

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		
FOI status	Document may be disclosed in full	X
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	Trust Management Board on 27 July 21	
Background papers / supporting information		

Digital Strategy

2021 to 2026

Wirral University Teaching Hospital NHS Foundation Trust

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Foreword

"I am delighted to welcome you to our Digital Strategy which is a bold and dynamic statement of our ambition to ***deliver digitally enabled Best Care for Everyone.***

There has been a clear shift in our approach to digital transformation because we have realised that in order to deliver outstanding care for our patients, our focus must be directed towards the needs of our patients and staff rather than the traditional model of being technology and IT driven. Therefore, this strategy has been developed by asking our clinical teams how IT can help them to deliver their clinical service strategy priorities through innovations and also by asking our patients to tell us about their experiences in accessing healthcare services using technology and how we can best support them to do so in the future.

It is important that we remember delivering improvements to benefit our patients and staff is all of our responsibility and IT forms only part of any transformation. Therefore, we must work together to take our Digital Strategy forward"

Dr Nicola Stevenson,
Medical Director and Deputy Chief Executive

Opening Words

"Our Digital Strategy is our commitment to digital transformation over the next 5 years and will support the delivery of Our Strategy 2021-2026 objectives and vision. This document clearly sets out our intensions that IT will no longer be directing the future of digital innovations. Instead our digital vision is that IT acts as the enabler for our clinical teams, with technological advancements being driven by our clinicians who understand our patient and service needs, so together we ***deliver digitally enabled Best Care for Everyone****.*

Our Digital Strategy evidences how we will build on our impressive foundations, using a set of underpinning principles to drive operational efficiency and clinical excellence by equipping the organisation with the latest digital tools and adoption of industry best practice. Working with our healthcare partners at both a local and regional level we will strive to provide seamless care to all of our patients through the use of appropriate technologies.

Due to the level of engagement with our clinicians, nurses, AHPs, operational management, support functions and patients during development, Our Digital Strategy is owned by all and key priorities identified by our staff and patients will be delivered through a ***digitally enabled and clinically led*** *approach. I would like to take the opportunity to thank all of those who attended our strategy development workshops and engagement sessions because there is clearly a positive drive within the organisation for digital transformation".*

Chris Mason,
Interim Director for IT and Information

Contents

Wirral University Teaching Hospital NHS Foundation Trust

Introduction

Our journey to deliver the best quality and safest care to the communities we serve

Our Digital Strategy forms 1 of 7 enabling strategies, through which Our 2021-2026 Strategy will be delivered. Our Digital Strategy sets out our commitment to creating a culture that embraces digital technology to enable us to provide the best acute hospital services to the communities we serve.

Our Digital Strategy is user centred to address the most important needs of patients, service users and staff. The aim of our Digital Strategy for our patients is to deliver outstanding care through our staff having the best tools and the necessary knowledge and skills to use them. The aim of the Digital Strategy for our workforce is to provide simplified and efficient work processes within our digitised organisation.

Our Digital Strategy is broken down into 4 domains aligned to Our Strategy 2021-2026, Digital Future strategic objective: Digital Foundations, Digital Innovations, Digital Education and Digital Intelligence. During a series of Digital Strategy development workshops, engagement sessions and through utilising a patient questionnaire, priorities were identified for each of the 4 Digital Strategy domains and mapped out over the next 5 years.

In the past our Informatics and Information teams have tried to support all requests received from end users. However, the volume of requests led to a lack of strategic focus and direction for our Informatics colleagues and demand outstretched resources. Therefore, moving forward our Informatics and Information teams will instead focus their efforts upon the key priorities put forward by our patients and staff outlined within this document that will provide maximum benefits across our organisation. Through this approach we will also adopt best practice solutions and stop building WUTH bespoke solutions which impact integration and our ability to keep up with the national IT agenda. This is of particular importance when considering our alignment to national and regional integrated care system digital priorities.

This document outlines how the Digital Strategy was developed, sets out our current position, identifies key priorities and areas for improvement over the next 5 years and details how progress in delivering our priorities will be monitored.

Background

Developing Our 2021-2026 Strategy

Our previous strategic focus was upon our top three priorities: patient flow, outpatients and peri-operative medicine. Our Clinical Divisions aligned their operational plans to support improvements in each of these three areas. However, clear strategic objectives for all to work towards, aimed to ultimately deliver our vision were not defined. Therefore, our Trust Board decided further work was needed to create a new, clear and meaningful strategic direction.

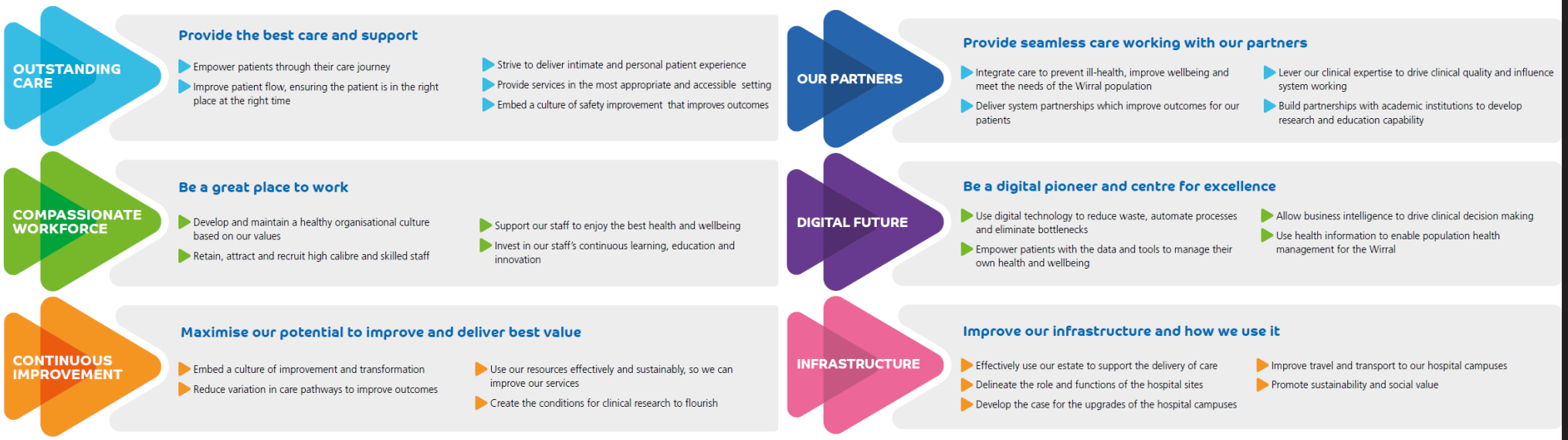
Our journey to develop our new strategic direction began early 2020, through a robust process of research and engagement as described.

Our 2021-2026 Strategy launched October 2020 outlining our intensions and setting out our specific strategic objectives to focus progress over the next five years.

Our 2021-2026 Objectives and Priorities

Wirral University Teaching Hospital NHS Foundation Trust

Our six strategic objectives and priorities demonstrate our intension to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. We will be a Hospital Trust that patients, families and carers recommend and staff are proud to be part of.



Strategic Framework

Our Enabling Strategies

Our 2021-2026 Strategy will be delivered through seven enabling strategies as shown.

This Digital Strategy details our IT and information priorities for the next five years aligned to our Digital Future strategic objective, to ensure we are all working towards the same goal in delivering Our 2021-2026 Strategy.

The Digital Strategy is integrated with the other enabling strategies, as an enabler to wider transformation. Digital Future strategic objective priorities developed by our clinical teams have also been drawn out of our Clinical Service Strategy 2021-2026 to inform our Digital Strategy.

Developing Our Digital Strategy

2021 to 2026

Wirral University Teaching Hospital NHS Foundation Trust

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Our Digital Journey Over the Past 5 Years

Where we are now and where we want to be?

Our digital strategic intension over the past 5 years was to be a digital exemplar. Now we have some of the best technology available to us within our digitised organisation, our strategic focus is shifting towards a new patient focused digital vision;

Delivering digitally enabled Best Care for Everyone

In order to achieve our digital vision we need to firstly understand our starting point by reflecting upon our digital journey over the past 5 years and recognising the key milestones achieved, following financial investment received through programmes such as Global Digital Exemplar, Safer Hospital and Safer Ward. We also recognise through acknowledging our lessons learnt over the past 5 years that there is a requirement for a strategic priority within this Digital Strategy to demonstrate how we will support our staff to best use our technology, to aid clinical decision making and provide safe, outstanding care for our patients.

The 4 domains of our Digital Strategy which are introduced within this section of the document, encompass all required elements to enable us to progress from where we are now to where we want to be over the next 5 years, through alignment to our Digital Future strategic objective priorities and our Clinical Service Strategy 2021-2026.

Key Digital Achievements Over the Past 5 Years

Reflection to shape the Development of Our Digital Strategy 2021-2026

Historically our organisation has always been at the forefront from a technology perspective, being one of the first UK Trusts to deploy elements of Cerner Millennium back in 2010.

Over the past 5 years our digital journey has gained momentum, with significant investments having been made into our infrastructure and software solutions - aided greatly by central funding from the Global Digital Exemplar Programme. In 2018 the College of Healthcare Information Management Executives (CHIME) named Wirral University Teaching Hospital as one of the “most wired” hospitals in the world.

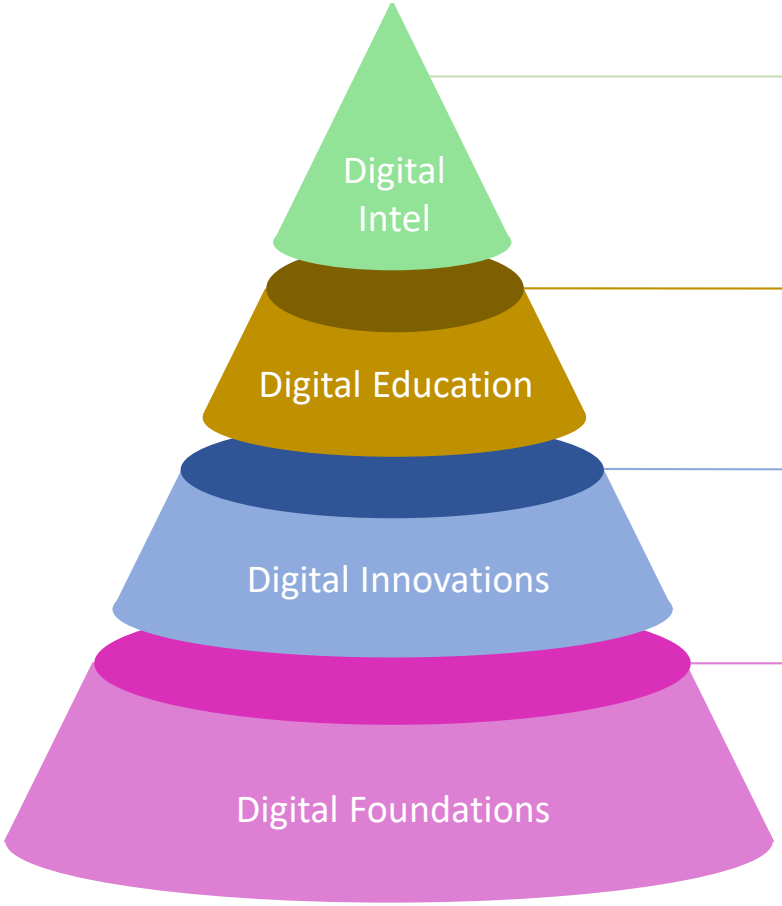
We are now in the enviable position where we have a high level of digital maturity and our organisation is functionality rich. Our latest technologies help us to deliver safe, high quality care and we need to ensure our staff and patients have the knowledge to utilise those tools to their full potential. Here are some of our key digital achievements over the past 5 years:

- **Medical Device Integration** with SECA scales, digital ECG and Vitalslink observation monitors all feeding information real-time into our electronic patient record (EPR)
- **Our real-time bed management system** gives a minute by minute account of the patient flow situation within our hospitals
- **Patient Portal** is proving invaluable in caring for our cancer patients
- **Business Intelligence portal** provides access to Divisional and specialty level clinical and operational data
- **Wirral Care Record** draws information from our local healthcare partners and allows care providers and commissioners in Wirral to know our population, identify risks and apply clinical recommendations to keep our community and patients healthy
- **Electronic documentation** can be sent directly to GPs to enhance communication and support continued patient care

The 4 Domains of Our Digital Strategy

Developing Our Digital Strategy 2021-2026

Wirral University Teaching Hospital NHS Foundation Trust



Embedding Business Intelligence to drive clinical decision making at WUTH & across the wider health economy through collaboration with our healthcare partners.

Enabling staff and patients with the digital skills to utilise our digital tools to their full potential, delivering the highest levels of safe & effective care.

Using Digital Innovation to streamline processes, increase efficiency & improve quality across Clinical & supporting functions within WUTH and as part of the wider health economy

Provision of a safe and secure digital infrastructure, protecting the Trust data and it's assets.

Digital Foundations

Digital foundations focusses upon the necessary technical elements required to ensure safe, secure and continued clinical and operational service delivery. Digital foundations is broken down into the following 5 elements:

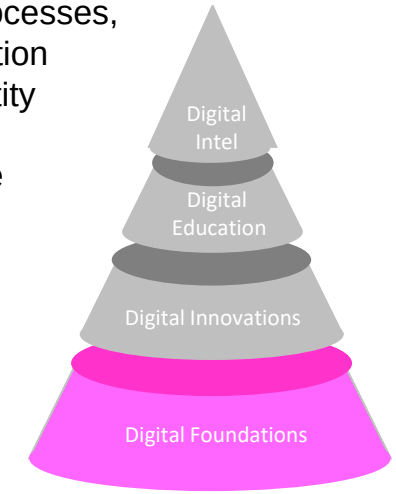
End user computing
Devices and associated peripherals delivering capability to clinical and operational services

IT Service Continuity and Recovery
Data back-up, storage, archive, recovery and critical systems testing to minimise operational disruption due to loss of service. Environmental risk assessments of data centres and equipment maintenance to protect assets and ensure continued service provision.

Networking and Communications
Focus on providing WUTH with telecommunications capability, infrastructure and services which enable the safe, secure and efficient operation of the organisation and increasingly focuses on the growing importance to deliver better patient and integrated health economy connectivity.

Security
Cyber security controls to protect infrastructure across WUTH and partners, including data within the system and assets. Capture of security incidents and monitoring of trends to identify learning, responsibilities and improvements.

Governance and Risk Management
Structured policies across WUTH and partners, review of existing processes, risk identification and stratification and assurance reporting. Identity management and associated access control at infrastructure level.



Digital Innovations

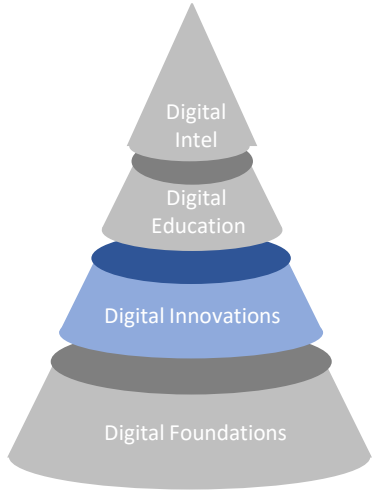
Digital innovation opportunities are continuously evolving as are our patient, service user and staff needs. Therefore, we recognise that our Digital Innovations Strategy needs to provide the future direction for our digital transformation projects but also allow us flexibility to take advantage of new opportunities.

Our aim through engaging with our Clinical Divisions and service teams was to develop a set of digital innovations priorities we will follow to guide all of our digital, technology and data transformation work over the next 5 years.

Our priorities will be the foundations to delivering our digital innovations intention; to use digital innovation to streamline processes, increase efficiency & improve quality across clinical & supporting functions within WUTH and as part of the wider health economy.

A pre-existing established digital innovations priority is to deliver one electronic patient record across our organisation which will remain at the forefront of our enabling objectives over the next 5 years.

In addition to our major innovations programme we will also be embarking on an optimisation journey. Re-examining and re-designing workflows, horizon scanning the technology landscape and identifying further opportunities for the deployment of the latest Cerner tools to drive efficiencies in a structured and strategic approach.



Digital Education

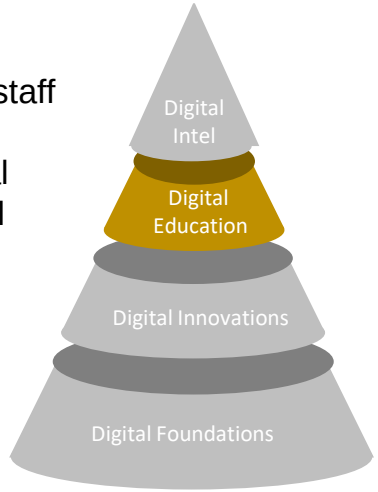
Reflecting upon our digital journey over the past 5 years highlighted that digital education is an area which has previously been lacking. Therefore, digital education focusses upon supporting our workforce to have the required digital skills and knowledge to provide high quality and safe care, within our digitally enabled organisation. Digital education also encompasses how we provide information to our patients to enable them to access digital healthcare services across the Wirral system. Digital education is broken down into 3 elements:

Digital Workforce
How digital training is delivered to meet the needs of our staff to enable them to have the knowledge and skills to best use our digital tools to deliver quality and safe care. Core and supplementary training for new staff to the Trust, staff moving to a new role, staff who are in developing roles and refresher training. How we measure the success of digital training and monitor competencies.

Digital Patient
Working collaboratively with other NHS organisations in Wirral to enable our patients to access digital health information and use digital healthcare services.

Implementation of New Digital Technologies
The process in which new digital technology is introduced to enable technology adoption, manage priorities, ensure sustainability and cost efficiency.

During engagement sessions our staff showed clear interest and drive to focus efforts upon improving digital education and subsequently digital literacy within our digitised organisation, to benefit our patients and clinical services.



Digital Intelligence

Our Digital Intelligence Strategy forms part of the overall Digital Strategy. The importance of Business Intelligence to support our staff to aid clinical and business decision making was recognised within our Clinical Service Strategy 2021-2026, with a clear priority being to "*develop business intelligence dashboards with real time data, for each specialty, to drive clinical decision making and improve the care we provide*".

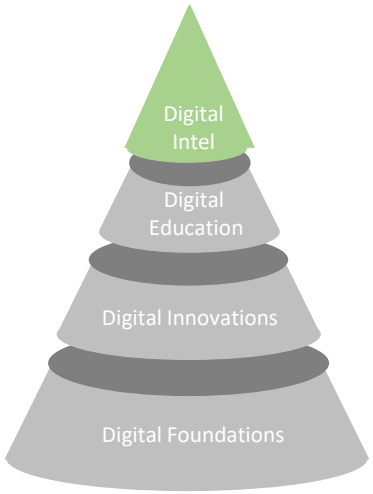
Using the Clinical Service Strategy to inform our Digital Intelligence Strategy, digital intelligence has been broken down into the following elements and focusses upon embedding Business Intelligence to drive clinical decision making at WUTH and across the wider health economy through collaboration with our healthcare partners:

Operational
Real time command and control intel that is needed to run our services for patients and aid clinical decision making.

Performance
Data analysis to enable us to review how we did.

Benchmarking
Data analysis that enables us to review how we performed compared to our peers.

Predictive Analytics
The ability to model future demand and the impact upon operational requirements and performance, to aid future planning.



Strategic Alignment

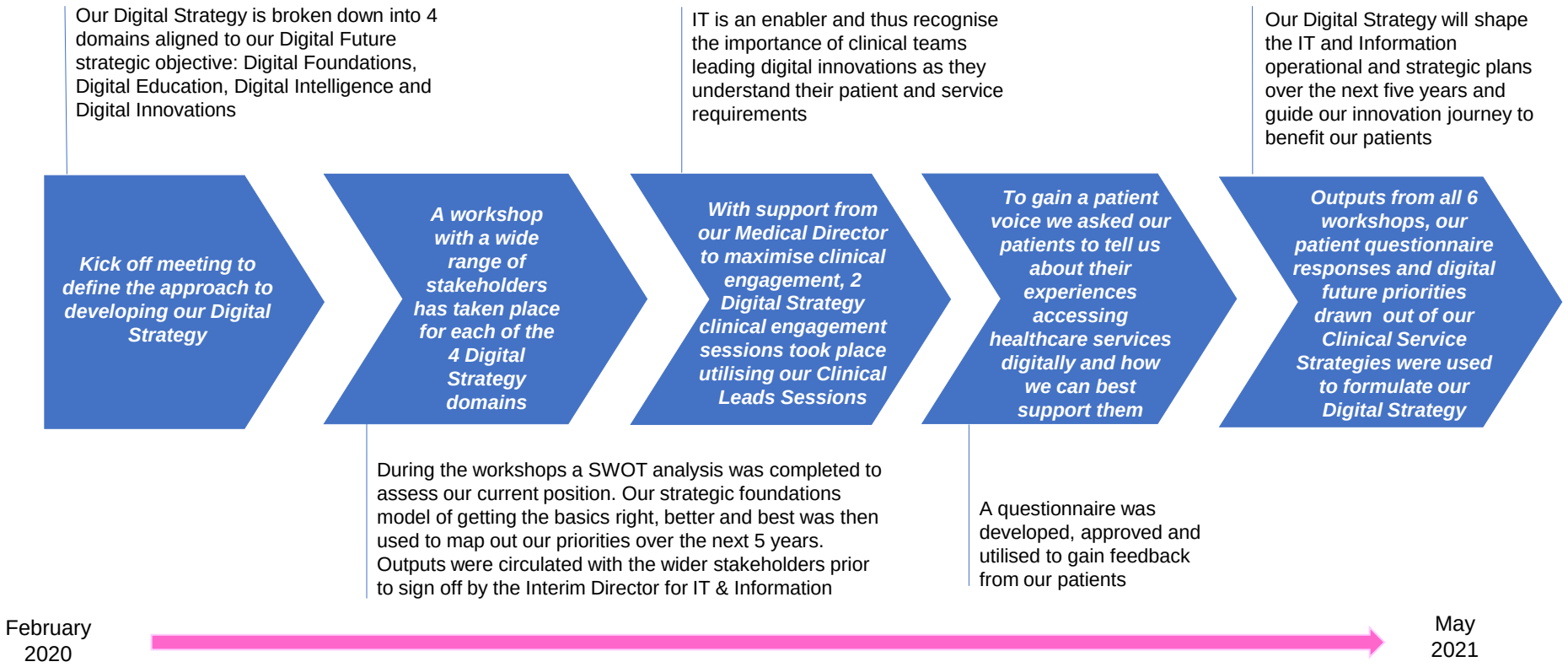
The 4 Domains of Our Digital Strategy
Aligned to Our Digital Future Strategic Objective

Wirral University Teaching Hospital NHS Foundation Trust

	Digital Future Be a digital pioneer and centre for excellence			
	Use digital technology to reduce waste, automate processes and eliminate bottlenecks	**Empower patients with the data and tools to manage their own health and wellbeing**	**Allow business intelligence to drive clinical decision making**	**Use health information to enable population health management for the Wirral**
Digital Intelligence	✔		✔	✔
Digital Education	✔	✔	✔	✔
Digital Innovations	✔	✔	✔	✔
Digital Foundations	✔			

Engagement with our Patients and Staff

Wirral University Teaching Hospital NHS Foundation Trust



Patient Engagement

"*There are 12.6 million people in the UK who don't have basic digital skills and these people are those who are most likely to be suffering from poor health*" (NHSE, 2016)

To help us shape our future healthcare services, we asked our patients to tell us about their experiences accessing healthcare services using technology and how we can best support them to do so in the future, to promote patient convenience, aid the reduction of digital exclusion and health inequalities. A questionnaire was developed, approved and utilised to gain patient feedback. We received a return rate of 42% (patient questionnaire, results and report can be found in appendix 1).

The patient questionnaire results have confirmed that patients find accessing healthcare services using technology convenient but our patients wish to be given the choice to opt out and offered a face to face if they prefer or if it is more clinically appropriate. Further work is required to roll out technology innovations across our organisation to benefit our patients as there was a clear interest from our patients in accessing video appointments in the future.

Recommendations have been made following feedback from our patients; we will provide digital education to support our patients in accessing and using our digitally enabled healthcare services, during every patient contact we will advise patients about the digitally enabled services available and signpost them to available support and registration. However, our staff firstly require education to ensure they are aware of the digitally enabled services available within our organisation and across Wirral. Patient feedback was used to inform our digital education and innovation strategy domains.

Clinical Staff Engagement

During the stakeholder workshops all staff groups were well represented, including: medical, nursing, AHPs, operational and support functions. However, as this Digital Strategy is focussed upon the clinical agenda and prioritising what is best for our patients by supporting our clinicians to provide outstanding care, it was felt important to reach the wider medical audience. With the support of our Medical Director, during two Clinical Lead sessions the following questions aligned to the 4 domains of the Digital Strategy were asked:

1. **How can IT help you deliver your clinical service strategy priorities through innovations?**
2. **How can IT support our staff to have the required digital skills?**
3. **How can Business Intelligence further support you in delivering patient care?**
4. **What should IT be focussing on as our priorities for the next five years?**

A strong appreciation of the benefits of CERNER Millennium came across, with praise for our digital capabilities and functionalities. However, the following key areas were identified for further development and improvement over the next 5 years, which cumulatively will support the **delivery of digitally enabled Best Care for Everyone.**

Digital Strategy
Key Priorities

2021 to 2026

Wirral University Teaching Hospital
NHS Foundation Trust

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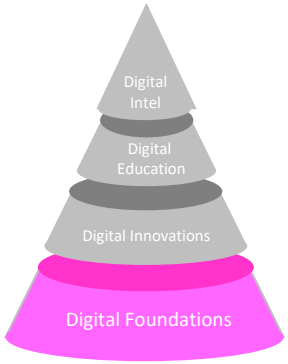
Key Priorities

The 4 domains of our Digital Strategy 2021-2026

Here we reveal our key priorities of focus for the next 5 years to achieve maximum benefits across our organisation, to benefit our patients and staff. The priorities are broken down into the 4 domains of our Digital Strategy which are aligned to deliver our Digital Future strategic objective priorities and our Clinical Service Strategy 2021-2026.

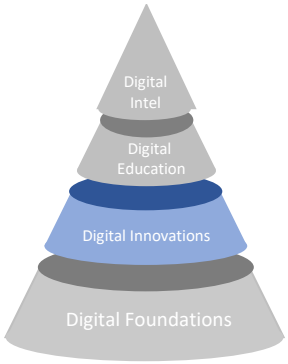
The detailed outputs from each of the Digital Foundations, Digital Innovations, Digital Education and Digital Intelligence strategy development workshops which include a SWOT analysis to assess our current position and a comprehensive list of priorities put forward from a wide range of stakeholders can be found in Appendix 2.



Digital Foundations Priorities

Being a digital pioneer and centre for excellence we will:

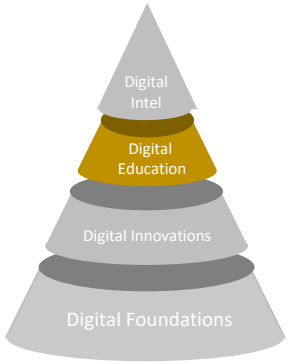
- Deliver a technical refresh programme of our end user computing estate on a 3-5 year life cycle, ensuring all equipment is fit for purpose across our organisation.
- Migrate in-house developments/data warehouse to cloud based solutions.
- Refresh both the wired and wi-fi estate across our organisation ensuring its ability to support all of our applications and communication tools.
- Re-design our network and provide segmentation for medical devices, improving security and network access to provide a robust Cyber defense.
- Deliver business efficiencies following implemented Telephony and Office 365 solutions.
- Strengthen our support offering through the deployment of self-service portals, allowing users to resolve their basic issues in a timely manner, without the need for human interaction.



Digital Innovations Priorities

Being a digital pioneer and centre for excellence we will:

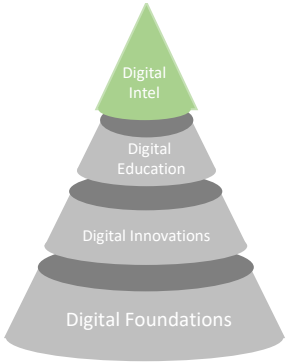
- Provide one Electronic Patient Record (EPR) including extensive device integration, delivering complete and accurate clinical information at the point of care, enabling better clinical decision making to provide outstanding care for our patients.
- Embark on a system-wide optimisation of our EPR, deploying the latest technologies to innovate and standardise our processes and systems in line with industry standards and adopting best practice to drive effectiveness and efficiency through the organisation.
- Expand our patient portal offering with the latest technologies to provide our patients with access to patient centred digitised healthcare advice and services to support our patients to optimise their healthcare.
- Work with our Health and Social Care partners to develop:
  - Integrated care systems delivering extended access to healthcare information across the region, providing a rich clinical picture to improve care for our patients
  - Analytical capabilities improving access to information and appropriate information sharing to further enable population health management.



Digital Education Priorities

Being a digital pioneer and centre for excellence we will:

- Improve our training delivery model through the implementation of a learning management system and virtual learning environment, giving flexibility for staff to access a full suite of learning modules at their convenience.
- Introduce a competency framework for all roles, keeping knowledge current and relevant by ensuring compliance against competency-based assessments for all staff on a regular cycle.
- Create an in-context training platform to offer support to clinical and operational staff, providing targeted support as and when they need it in their daily working lives.
- Support our clinical teams in the delivery of bespoke knowledge transfer, helping empower our patients through increased usage of our patient facing applications.



Digital Intelligence Priorities

Being a digital pioneer and centre for excellence we will:

- Provision of a new Trust Data solution to produce a holistic data model, by including clinical and non-clinical data.
- Develop a single offering for Business Intelligence platforms, providing near real-time operational information to drive clinical and operational decision-making.
- Embed benchmarking analysis into the Business Intelligence portal, providing analysis against external comparators, identifying potential clinical and operational opportunities.
- Deliver the ability to model future demand predicting impact upon operations and performance, to assist in business planning. Working with our healthcare partners to provide a consistent source of information across Wirral and the Cheshire and Merseyside region.

Next Steps

Implementation, Monitoring and Review

Our Informatics and Information teams are the enablers to wider organisational transformation. The Digital Future strategic objectives will apply innovative, digital technologies to support the delivery of our Clinical Divisions and corporate services 2021-22 operational and strategic priorities.

Moving forward our Digital Future strategic priorities will be carefully selected through robust governance processes involving all key stakeholders across the organisation as part of an annual planning cycle. This will ensure our Digital Future priorities remain relevant to the evolving needs of our patients, support the development of clinical services and apply the latest technologies in an ever-changing digital landscape.

Our Informatics and Information teams will then translate the Clinical Divisions annual Digital Future strategic priorities into their annual operational and strategic priorities, to provide a clear work plan for the subsequent 12 months and deliver our 2021-2026 Digital Strategy.

Delivery of the operational and strategic priorities will be driven and monitored through existing comprehensive governance structures, providing organisational transparency whilst ensuring the delivery of quality digital transformation, within agreed timescales and cost constraints.

Appendix 1: Patient Questionnaire and Results
Appendix 2: Outputs from our Digital Strategy Development Workshops

Wirral University Teaching Hospital NHS Foundation Trust

together we will

Appendix 1: Patient Questionnaire and Results

Microsoft Word Document

Appendix 2: Outputs from our Digital Strategy Development Workshops

Wirral University Teaching Hospital NHS Foundation Trust

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Agenda Item: BM21/22-110

BOARD OF DIRECTORS
4th August 2021

Title:	Infection Prevention and Control Strategy 2021.23
Responsible Director:	Hazel Richards, Chief Nurse / Director of Infection Prevention and Control (DIPC)
Author:	Jay Turner-Gardner, Associate Director of Nursing - Infection Prevention & Control / Deputy DIPC
Presented by:	

Executive Summary

The prevention and control of healthcare associated infections (HCAI) remains a high priority both locally and nationally with a continued focus on reducing HCAI's and improving and sustaining the quality of care provided by NHS Trusts. This underpins the Care Quality Commission (CQC) Outcome 8 (Regulation 12): Cleanliness and Infection Control, this requires all providers to comply with the Health and Social Act 2008, Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance.

This three year strategy will ensure the Trust has clearly defined objectives for infection prevention and control. This is based upon the Infection Prevention Society's mission of "informing, promoting and sustaining evidence based infection prevention policies and practices to create a health and care system where no persons health and wellbeing is harmed by preventable infection".

Annual work plans will set out the actions required to achieve our objectives.

The objectives focus on continuing to reduce HCAI, to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe.

In doing so the Trust will develop existing work and projects and initiate the development of leading edge work, aspiring to be national leaders for the reduction of HCAI's.

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

To note N.B This IPC strategy 2021-2023 has been to the IPCG in June 21 and the PSQB and QAC in July 21.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	no
Digital future: be a digital pioneer and centre for excellence	no
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)		
None identified		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
CQC essential standards and recommendation from the CQC IPC inspection in 2021. Compliance to the Hygiene code.		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
None		
Specific communications and stakeholder /staff engagement implications		
None		
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		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

BOARD OF DIRECTORS MEETING IN PUBLIC

Infection Prevention and Control Strategy 2021-23

Purpose

This three year strategy will ensure the Trust has clearly defined objectives for infection prevention and control.

Annual work plans will set out the actions required to achieve our objectives.

The objectives focus on continuing to reduce HCAI, to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe.

Introduction / Background

The prevention and control of healthcare associated infections (HCAI) remains a high priority both locally and nationally with a continued focus on reducing HCAI's and improving and sustaining the quality of care provided by NHS Trusts. This underpins the Care Quality Commission (CQC) Outcome 8 (Regulation 12): Cleanliness and Infection Control, this requires all providers to comply with the Health and Social Act 2008, Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance.

Conclusions

The IPC 3 year strategy will develop existing work and projects and initiate the development of leading edge work, aspiring to be national leaders for the reduction of HCAI's.

Recommendations to the Board

For noting

Infection Prevention & Control Strategy

2021-2023

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

together we will

Contents

Introduction

Our journey to deliver the best quality and safest care to the communities we serve

The prevention and control of healthcare associated infections (HCAI) remains a high priority both locally and nationally with a continued focus on reducing HCAI's and improving and sustaining the quality of care provided by NHS Trusts. This underpins the Care Quality Commission (CQC) Outcome 8 (Regulation 12): Cleanliness and Infection Control, this requires all providers to comply with the Health and Social Act 2008, Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance.

The Code of Practice, also known as the Hygiene Code, was initially launched to help NHS Trusts plan and implement actions around the prevention and control of HCAI's, setting out criteria with which Trusts must comply.

The CQC, independent regulator of health and adult social care services in England, monitors the Trusts compliance against the Code of Practice through formal visits and the implementation of enforcement actions where necessary.

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This three year strategy will ensure the Trust has clearly defined objectives for infection prevention and control. This is based upon the Infection Prevention Society's mission of "informing, promoting and sustaining evidence based infection prevention policies and practices to create a health and care system where no persons health and wellbeing is harmed by preventable infection".

Annual work plans will set out the actions required to achieve our objectives.

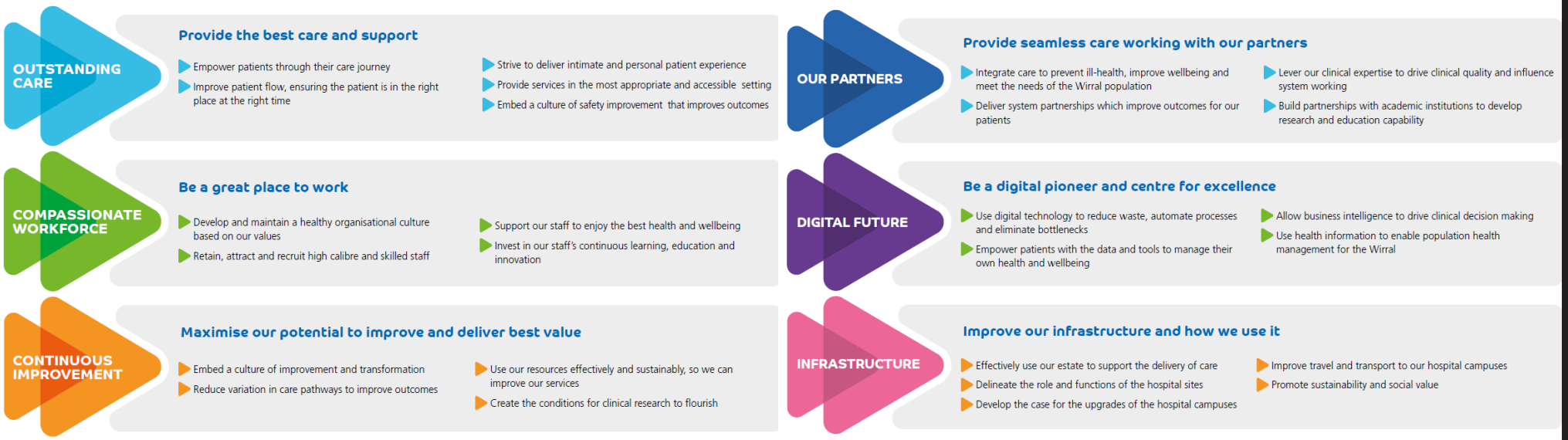
The objectives focus on continuing to reduce HCAI, to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe.

In doing so the Trust will develop existing work and projects and initiate the development of leading edge work, aspiring to be national leaders for the reduction of HCAI's.

Our 2021-2026 Trust Objectives and Priorities

Wirral University Teaching Hospital NHS Foundation Trust

Our six strategic objectives and priorities demonstrate our intention to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. We will be a Hospital Trust that patients, families and carers recommend and staff are proud to be part of.

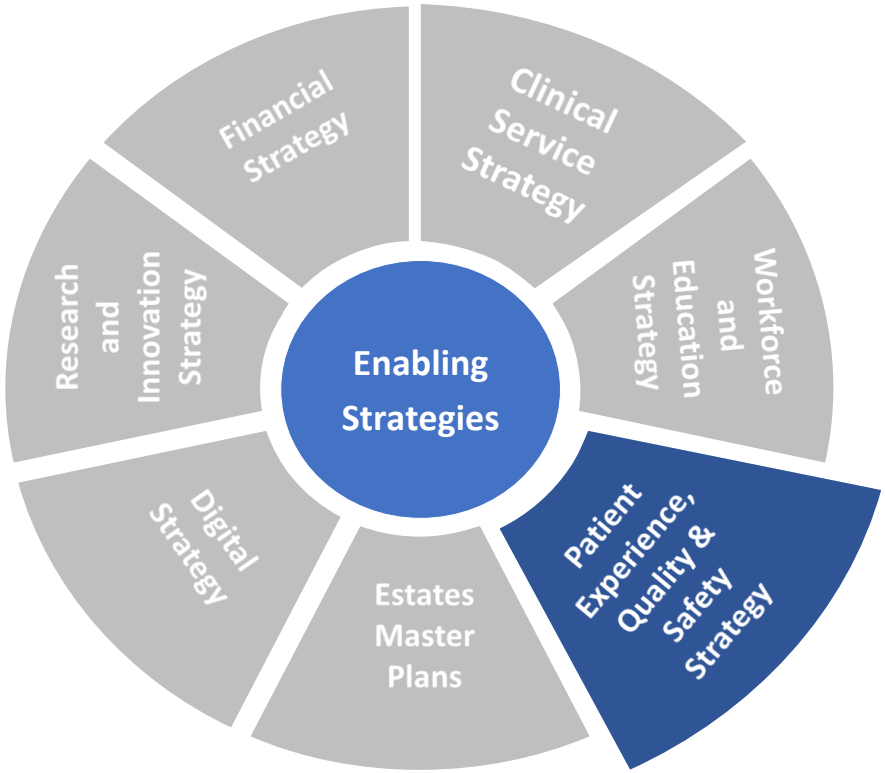


Strategic Framework

Our Enabling Strategies

Our 2021-2026 Strategy will be delivered through seven enabling strategies as shown.

This IPC Strategy underpins our Patient Experience and Quality & Safety strategies. Our IPC Strategy outlines our intention to continue to reduce HCAI, embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe. Achieving our IPC intentions will support us to deliver our vision; together we will deliver the best quality and safest care to the communities we serve.



Our IPC Journey

In 2018 the CQC reported that the Trust had not always controlled infection risks well and that the environment and equipment was visibly dirty in some areas.

In 2018-19 the Trust reported a large protracted Outbreak of *Clostridium difficile* infections across many wards.

In 2019 there was a re-focus on infection prevention. This was critically important during 2020 when the COVID 19 pandemic arrived.

By 2021 the CQC reported that the Trust had a clear vision and plan for continuously improving practices related to infection prevention and control and that there were effective processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment.

The CQC recognised that leaders had worked to decrease the number of healthcare associated infections and a result saw that reportable infections had reduced considerably over the last 2 years.

The CQC stated that the innovative infection prevention campaign 'Keep it Simple' was an example of outstanding practice that engaged staff in IPC awareness activities to communicate key messages to staff, patients and visitors.

The Trust must continue this hard work to maintain this continuous improvement.

Roles and Responsibilities

Wirral University Teaching Hospital NHS Foundation Trust

Infection prevention and control is everybody's responsibility; staff, patients and visitors.

A key challenge for the prevention and control of healthcare associated infections is to ensure that practices are in place to reduce the risk of acquiring such infections.

All staff are responsible for establishing, maintaining and supporting a coordinated approach to infection prevention in all areas of their work. This includes complying with Trust infection prevention policies and procedures and attending mandatory infection prevention training.

Staff should be proactive in identifying and addressing infection risks in their area of work; this may include the environment, resources and behaviours.

The Director of Infection Prevention and Control (DIPC) is responsible for the development and implementation of this strategy.

The Board of Directors will approve the strategy and monitor its progress. In doing so, it will ensure sufficient resources are available and key strategies are aligned to support the effective delivery of the IPC objectives.

Senior managers and clinicians have the responsibility to ensure adherence to IPC policies and procedures; this includes investigating all incidences of HCAIs and outbreaks to establish a root cause and learning.

Our IPC Strategic Objectives

2021-2023

Wirral University Teaching Hospital NHS Foundation Trust

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Strategic Alignment

Our IPC Strategic Objectives Aligned to Our 2021-26 Trust Strategic Objectives

Wirral University Teaching Hospital NHS Foundation Trust

	WUTH Strategic Objectives & Priorities 2021-2023					
IPC Strategic Objectives 2021-2023	**Outstanding Care** *Provide the best care and support*	**Compassionate workforce** *Be a great place to work*	**Continuous Improvement** *Maximise our potential to improve and deliver best value*	**Our Partners** *Provide seamless care working with our partners*	**Digital Future** *Be a digital pioneer and centre for digital excellence*	**Infrastructure** *Improve our infrastructure and how we use it*
Training & Education	✔	✔	✔	✔		
Audit & Surveillance	✔	✔	✔	✔	✔	✔
Policies & Procedures	✔	✔	✔	✔	✔	✔
Care Environment	✔	✔	✔			✔
Communications & Information	✔	✔	✔	✔	✔	
Research & Innovation	✔	✔	✔	✔	✔	
Antimicrobial Stewardship	✔	✔	✔	✔		

Objective 1 - Training and Education

Regulation 12 & 7 (CQC) , Criterion 1,6 & 10 (The Hygiene Code)

Wirral University Teaching Hospital NHS Foundation Trust

WUTH places strong emphasis on the need for all health care staff to understand, be competent and discharge their roles and responsibilities in relation to IPC.

A training and education programme aimed at developing lPC expertise at all levels of staff will be developed.

We will also determine how we better educate our patients and visitors in relation to IPC.

We will:

Ensure our staff are trained and competent in IPC practices
Develop a competency framework to reflect the IPC requirements for different roles
Develop our “link roles” as a way of constantly reinforcing best practice through education
Improve the ‘paper less’ recording of training activities
Introduce further e-learning packages relating to IPC topics

Objective 2 - Audit & Surveillance
Regulation 9, Criterion 4

Wirral University Teaching Hospital NHS Foundation Trust

IP surveillance data plays a central role in providing the information needed to underpin our IPC strategic objectives as well as informing priorities and focus for day to day operations. Infection reduction programmes can only be demonstrated as being effective if accurate rates of infections are known. Incorporation of an effective surveillance programme with regular feedback of results to clinical staff is recognised as crucial to the development of action plans to facilitate reductions in the incidence of HCAI.

Clinical audit provides an important tool to monitor the implementation of policies and operational performance. It can also provide insight into problems highlighted by surveillance. Infection prevention audits will be reviewed and strengthened to reflect national standards.

We will:

Complete timely and accurate reporting of mandatory surveillance of all Alert organisms (Infections)
Develop an overarching IPC annual audit programme reflecting current national guidance
Support the development of an SSI strategy
Work in collaboration with WUTH teams to ensure local care & management audits reflect national guidance

Objective 3 - Policies & Procedures
Regulation 12, Criterion 1 & 9

Wirral University Teaching Hospital NHS Foundation Trust

Policies are decision orientated and made to support the strategies while Procedures are helpful in the implementation of programmes because they are action orientated. Local infection prevention polices should reflect national guidance. Policies need to be thoroughly accepted by the people who are influenced by them so it is essential to have an education programme around the development and implementation of new policies.

We will:

Develop a suite of IPC policies in line with the requirements set in the Health and Social care Act 2008
Work with the divisions to strengthen existing procedures developed from national guidelines
Work with the corporate teams to strengthen and support the review and implementation of the High Impact Interventions where appropriate

Objective 4 - Care Environment
Regulation 15, Criterion 2 & 7

Wirral University Teaching Hospital NHS Foundation Trust

There is a strong recognition between the cleanliness of the hospital environment and infection. There has been great emphasis placed on getting the basics right and delivering high quality care in clean and safe environments. The revised NHS Standards of Cleanliness has just been released (May2021) and the trust will be adopting these standards which will provide a structured approach to defining the environmental cleanliness requirements that will aid the successful delivery of this strategy. Whilst the responsibility for providing the cleaning and maintenance of the estate lies with the Estates and Facilities department; the ward /departmental manager has responsibility for ensuring that the high standards of hygiene and maintenance is achieved.

Support from the Estates Department is essential for ensuring that the fabric of the environment is suitable for meeting the needs of patients, carers' visitors and staff. It is essential that audits of ward cleanliness are reviewed with the IPC Team frequently and that the IPC team independently audit ward cleanliness on a regular basis.
Any plans for capital schemes and planned preventative maintenance must be brought to the attention of the IPC team at the first stage of planning to ensure that IPC is designed in and risks mitigated as much as possible.

We will:

Work in collaboration with Estates Teams regarding all schemes and projects to ensure the provision of a safe and appropriate environment.

Ensure that the built environment meets all HTM/HBN requirements

Work in collaboration with Facilities to introduce and educate staff regarding the new National standards of cleanliness (April 2021)

Objective 5 - Communications & Information
Regulation 17, Criterion 5

Wirral University Teaching Hospital NHS Foundation Trust

Effective information and engagement with staff, patients, service users and carers is essential to support the reduction of HCAIs.

By ensuring that patients and staff are provided with clear, easy to understand information about infections and taking the time to talk them through it and answer questions is an important step towards helping staff and patients to make the best choices with regards to the management of infection prevention and control.

We will:

Support the development of a BI portal page for timely reporting of IPC data

Review and update staff, patient and visitor information leaflets/posters reflecting national guidelines

Produce monthly newsletters reflecting local patient safety issues relating to IPC

Objective 6 - Research & Innovation
Criterion 9

Wirral University Teaching Hospital NHS Foundation Trust

Research and innovation is essential to improve clinical practice. In order to deliver our vision and prevent avoidable infections we will promote and work in collaboration with our teams and partner organisations to become involved in programmes of research and quality improvements to underpin the delivery of high quality infection prevention practice; with the potential to foster improvements in experience, safety and effectiveness of patient care

We will:

Develop a quality improvement project for Infection Prevention to move us from “Good” to “Great”. This will form part of the patient safety work plan.

Review and evaluate IPC innovations for their suitability for WUTH.
Participate in relevant research.

Objective 7 - Antimicrobial Stewardship
Regulation 12, Criterion 3 & 9

Wirral University Teaching Hospital NHS Foundation Trust

Alarmingly, the prevalence of antimicrobial resistance (AMR) has risen over the last 40 years, and there have been few truly novel antimicrobials developed. As a result this has led to an increased pressure on existing antibiotics and thus greater challenges in treating patients. Inappropriate use of antimicrobials increases the risk to patients of colonisation and infection with resistant organisms and subsequent transmission to other patients. Criterion 9 of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the standards for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. The updated Code of Practice places greater emphasis on antimicrobial resistance and stewardship. The Code states: “Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors”.

We will :

- Maintain an audit programme of adherence with antimicrobial prescribing policies, responding effectively when areas for improvement are identified.
- Consolidate the work of the ward-based antimicrobial stewardship service for inpatient clinical areas.
- Work towards national targets for quality indicators associated with antimicrobial prescribing and reductions in antimicrobial consumption

Next Steps

Implementation, Monitoring and Review

Development and sign off of the 3 year IPC Strategy aligned to the Trust Strategic objectives.
The IPC strategy translated into the 2021-2023 IPC Annual plan

Key performance indicators for infection prevention and control .i.e. infection rates, audit results and cleaning standards will be discussed at the monthly Divisional IPC and governance meetings with a focus on outcome, exceptions will be monitored via the Monthly IPCG meeting

Key to the success of this IPC strategy is the ability to adhere to the underlying principles of Infection prevention practice whilst meeting the changing demands of the population we serve

IPC Strategy objectives will be reviewed as part of annual operational and strategic planning to ensure they remain relevant to our evolving patient needs and maintain delivery momentum.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: BM21/22-111

BOARD OF DIRECTORS
4 August 2021

Title:	CQC Action Plan 2020 – 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

The TMB received a quarterly report in March 2021, on progress made against the actions arising from the CQC Inspection, undertaken in late 2019, with the report published on 31 March 2021. The position in March 2021 was that, of the 107 overall requirements (Inclusive of Must Do and Should Do overarching actions), 74 were reported as completed and 69% of the action plan reported as having been achieved.

Following this, it was agreed to undertake a deep dive into each of the actions associated with the Must Do's and Should Do's to ascertain:

- If the actions remain relevant in view of the passage of time and the impact of the ongoing pandemic. As a result of the deep dive a number of action have been amended
- Where actions have been reported as completed and evidenced, have these had the desired impact (in line with the CQC report) and is there evidence to support this.

The position in July 2021 is that of the 107 overall requirements (Inclusive of Must Do and Should Do overarching actions), 95 were reported as completed and 88% of the action plan reported as having been achieved.

There are a total of 352 individual actions within the action plan. Currently 220 (62.5%) actions are completed and assured or embedded.

Recommendation:

The Board of Directors are requested to note the progress made against the CQC Action plan and be informed that the PQSB agreed the proposals within this report.

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

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.

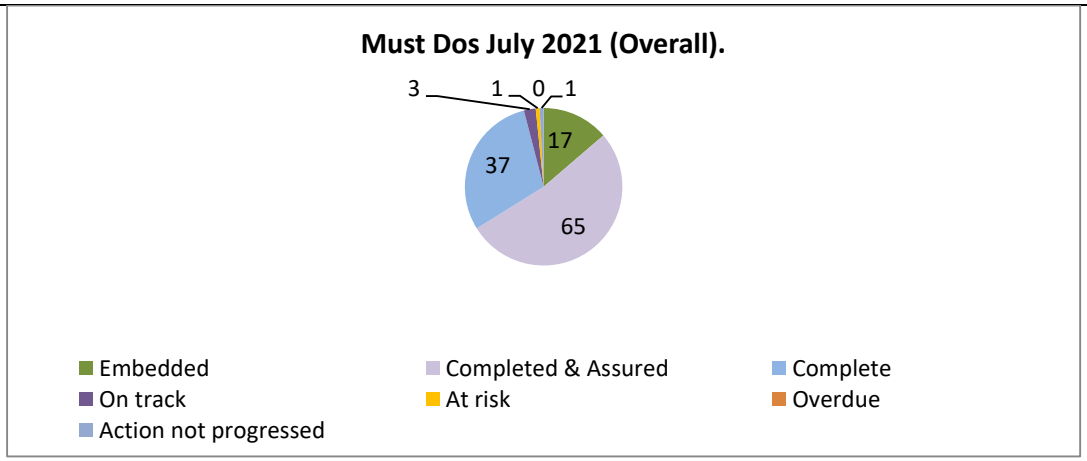
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

<table>
<tr><td colspan="3">Potential as some actions may require investment</td></tr>
<tr><td colspan="3">Specific communications and stakeholder /staff engagement implications</td></tr>
<tr><td colspan="3">None</td></tr>
<tr><td colspan="3">Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)</td></tr>
<tr><td colspan="3">Failure to meet the CQC fundamental standards may negatively impact on both patients and staff</td></tr>
<tr><td colspan="3">Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)</td></tr>
<tr><td colspan="3">None</td></tr>
<tr><td>FOI status</td><td>Document may be disclosed in full</td><td>Yes</td></tr>
<tr><td></td><td>Document includes FOI exempt information</td><td>No</td></tr>
<tr><td></td><td>Entire document is exempt under FOI</td><td>No</td></tr>
<tr><td>Previous considerations by the Board / Board sub-committees</td><td colspan="2">Ongoing review by PSQB/Quality Assurance Committee on a quarterly basis and quarterly reporting to TMB.</td></tr>
<tr><td>Background papers / supporting information</td><td colspan="2">As above</td></tr>
</table>

BOARD OF DIRECTORS
4 August 2021

CQC Action Plan Update Report

1.	**Introduction** The TMB received a quarterly report in March 2021, on progress made against the actions arising from the CQC Inspection, undertaken in late 2019, with the report published on 31 March 2021. The position in March 2021 was that, of the 107 overall requirements (Inclusive of Must Do and Should Do overarching actions), 74 were reported as completed and 69% of the action plan reported as having been achieved. Following this, it was agreed to undertake a deep dive into each of the actions associated with the Must Do's and Should Do's to ascertain: • If the actions remain relevant in view of the passage of time and the impact of the ongoing pandemic. As a result of the deep dive a number of action have been amended • Where actions have been reported as completed and evidenced, have these had the desired impact (in line with the CQC report) and is there evidence to support this. There are a total of 352 individual actions within the action plan. Currently 220 (62.5%) actions are completed and assured or embedded. A further 106 (30.1%) are reported as completed however evidence to support this is awaited. Work is ongoing to complete the deep dive with Divisions for their associated actions, as well as for actions that are considered to be Trust wide. As a result of the Deep Dive, some actions have resulted in a change of RAG ratings. This report provides a summary of the current position and makes recommendations for the Board to consider. It should be noted that some Divisions underwent a deep dive in April 2021 and further actions may have been taken since, however updates have not been received by the Governance Support Unit. In addition within the Medical Division, the deep dive has only partially been undertaken and further information has been requested to support updates on the remaining actions. Details of progress against each individual actions can be found in Appendix One of this report.
2.	**Must Do Actions** The Table below shows the progress against the 124 actions associated with the 31 Must Do areas highlighted by CQC**:**



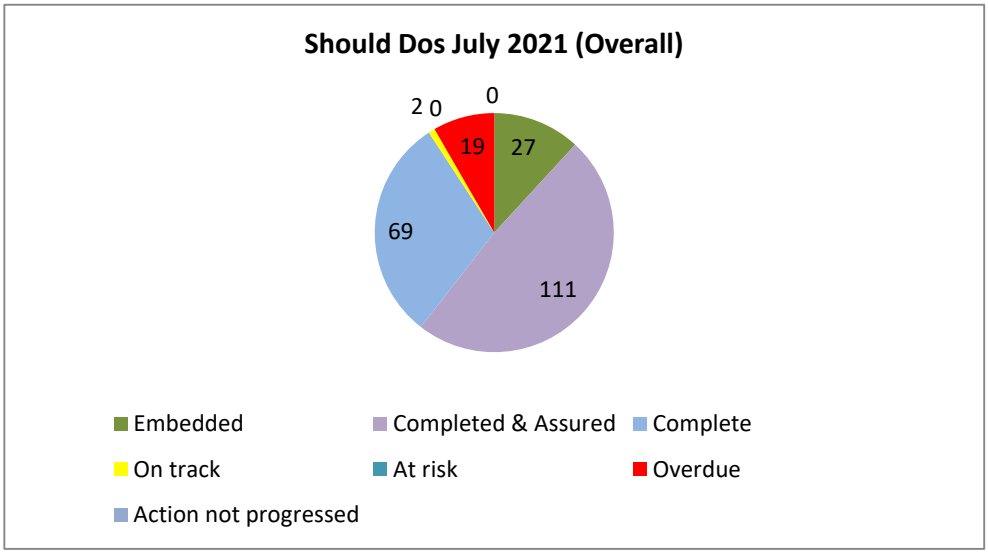
82 (66.1%) actions are either completed and assured or embedded
37 (29.9%) actions are reported as completed however evidence is awaited to confirm assurance
3 (2.4%) actions are on track for completion
1 (0.8%) is at risk, which relates to the Medical Services

- Establish IDT process to identify delays in discharge as a result of a lack of suitable support packages. (Awaiting evidence of impact).

There are no overdue Must Do actions.

3. Should Do Actions

The Table below shows the progress against the 228 actions associated with the 76 Should Do areas highlighted by CQC**:**



138 (60.5%) actions are either completed and assured or embedded
69 (30.3%) actions are reported as completed however evidence is awaited to confirm assurance
2 (0.9%) actions are on track for completion
19 (8.3%) actions are overdue:

Trust wide

- Review and Refresh sections of Respect at Work Group (awaiting Update)
- Revisit approach to "Just Culture" and implement (Awaiting update)
- Include managers responsibility and guidance related to compassionate leadership and culture into new managers toolkit (Awaiting update)
- Establish Leadership Forum as Think Tanks or Alumni to work on improvements needed across services inclusive of behaviours and how to challenge poor behaviours (Awaiting Update)
- Continue to develop the leadership and management development framework inclusive of compassionate leadership, 360 feedback and coaching (Awaiting Update)
- Increase Links with Community Advisory Group run by Merseyside Police (Awaiting Update)
- Host Equality Group Conference to engage with community (Awaiting update)
- Work with Healthwatch to focus on EDS2 requirements and equality analysis (Awaiting Update)
- Host open days and events to support recruitment and engagement (Awaiting update)
- Work proactively with the Division to gain and promote good news stories internally and externally from staff or patients and families (Awaiting update)
- Utilise themes from patient stories, complaints and concerns to inform service improvements. (Awaiting further work)

Urgent and Emergency Care

- Roll out nurse competencies for band 5 (Awaiting update)
- Roll out nurse competencies for band 6 (Awaiting update)
- Each specialty to develop escalation processes which link to professional standards (Awaiting update)

Medical Division

- Improve mandatory training compliance to meet Trust standard of 90% (Awaiting Update)
- Complete baseline assessment of care plans in all inpatient areas (Awaiting update)
- Develop options appraisal regarding the development of a long term electronic process for care planning

Women and Childrens

- Finalise plan for potential expansion of the NNU, aligned to the Divisional Strategy and identify Exec Lead (Awaiting update)
- Ensure specific information and directions are detailed in the entrances for children and that this is child friendly (Awaiting update)

4. Discussion

Progress continues to be made in relation to the action plan; however there is a need for further evidence of completion and impact for a number of actions. In addition there are a number of actions rated as overdue, due to the need for updates regarding progress; however please note that some of these have not had a full deep dive at the time of writing this report.

It is well recognised that compliance with CQC fundamental standards requires ongoing

	engagement and scrutiny by each and every team across the organisation to ensure they are considered and embedded within everyday practice. It is proposed that moving forward: • The Divisional Triumvirates continue to monitor those actions, related to their Division, which have been completed and assured or embedded. Divisions should report ongoing compliance through their reports into PSQB. Divisions should also consider reporting against broader compliance with the CQC fundamental standards, which should be being monitored through their governance structures. • The Governance Support Unit continues to monitor those actions that are reported as completed, on track, at risk or overdue. A quarterly update on progress against these will continued to be presented to PSQB. PSQB members are requested to approve the above proposals.

Appendix One

Ref	Specific area	MUST Do/Should Do	Actions taken to meet regulation	Actual completion date	Exec lead	Operational lead	RAG Status	Comments	Deep Dive Progress
M01	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). PFIG structure has been revamped to concentrate on delivery of Patient Flow Vision standards. This currently primarily focuses on improving performance against ward based Patient Flow vision standards through 'Barriers to Discharge' project and ED PF Vision standards through PDSAs	Complete	COO/ Medical Director	Divisional Director - M&A/ Interim Deputy Chief Operating Officer	**Embedded**	28/04/21 -Structure has been renewed - now focussing on rapid transfer projects in ED to improve performance in KPIs. SB has updated action, sent PM3 and SIT milestone plans **Action has been changed to reflect this**	Deep Dive completed
			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.	28/04/2021			**Completed & Assured**	28/04/21 - Structure is in place there is a clear governance route, Capacity management roll out, reduction in stranded patients, updated set of priorities, initial action completed, new action ongoing for new projects. Ongoing transformation programme. **Now added as action 3.**	Deep Dive completed
			3. Ongoing transformation programme with project continually updating and refreshing and new projects being added.				**On track**	This is an ongoing programme	Deep Dive Completed

			4. 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	Complete			**Completed & Assured**	28/04/21 - Bed management structure action plan and embedded into PFIG. Standard item on agenda. **To send sample of minutes and transformation governance structure.**	Deep Dive Completed
			5. Integrate bed management and Bronze command functions incident command meetings to encompass whole urgent care pathway management	30/06/2020			**Completed & Assured**	Assurance has been provided	Deep Dive Completed
			6. 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. New guidance has been issued following Covid so this is no longer applicable	Complete			**Completed & Assured**	28/04/21 - Do not have single management structure, unlikely to be going down that route, changed since Covid with the guidelines re pathways, amend action no longer applicable, **JF to send a copy of guidance and to embed into action plan**	Deep Dive Completed
			7. Development of Weekend Discharge SOP and criteria led discharge policy to facilitate 7 day discharges Changed weekend on call structure, Now have 7 day working for all wards and strengthened ward rounds.	01/09/2020			**Completed & Assured**	28/04/21 - JC - changed weekend oncall structure, Now have 7 day working for all wards, strengthened ward rounds so all Oncall doctors see patients, not applicable, SB to update action	Deep Dive Completed
M02	Trustwide	The trust must continue to work with stakeholders to improve treatment times	1. Introduction of system wide Command Centre during periods of exceptional demand	Complete	COO/ Medical Director	Wirral System Lead for Discharge	**Completed & Assured**	Evidence obtained from Wirral Planned Care Board Need to ask for Terms of Reference	Deep Dive Completed

		and referral to treatment times - Regulation 17(2)						**Paul Mcnulty to provide up to date evidence on planned care - any reports for operational groups?**	
			2. Ensure consistent Executive presence at Wirral Planned Care Board	Complete			**Completed & Assured**	Evidence obtained from Wirral Planned Care Board	Deep Dive Completed
			3. System Lead for discharge to be appointed and responsible for leading on collaboration and partnership working between Health and Social Care.	Complete			**Completed & Assured**	Evidence obtained from Wirral Planned Care Board	Deep Dive Completed
			4. Development of system-wide dashboard to ensure a single source of robust capacity and demand data across the system.	Complete			**Completed & Assured**	Evidence obtained from Wirral Planned Care Board	Deep Dive Completed
			5. Introduction and evaluation of multi-agency approach to Frailty at the Front Door pilot to prevent avoidable admissions of frail patients	Complete			**Completed**	**EC to ask Clare Jefferson for Programme Updates**	Deep Dive Completed
M03	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	Complete	COO/ Medical Director	M&A Triumvirate	**Completed**	The division have confirmed this action is complete and huddles are available on the shared drive. Evidence has not been provided.	Deep Dive Completed
			2. Proposal of ED senior clinician decision rights approved and implemented	29/09/2020			**Completed**	29/09/20 - Proposal has been approved at CAG and implemented Division have confirmed complete and is line with IPS. Evidence has not been provided.	Deep Dive Completed
			3. IPSS Standards being utilised (see M10)	29/01/2021			**Completed**	**28/04/21 - Need more work on assurance, IPSS to be resent and**	Deep Dive Completed

								refreshed	
			4. Reinstatement of Senior multi-professional leadership hourly huddles to monitor; respond and escalate appropriately to ensure decision to admit delays are reduced	Complete			**Completed & Assured**	04/11/20 - Allie Knowles - The huddles can be found: S Drive Medicine and Acute Specialty Division A&E ED Huddles	Deep Dive Completed
M04	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 turnaround time for specialist input from referral by ED and establish monitoring arrangements to ensure adherence to the agreed turnaround times.	25/08/2020	Medical Director	AMD - M&A	**Completed**	**28/04/21 - There are streaming pathways in conjunction with ECIST, JF to summarise for evidence.**	Deep Dive Completed
			2. Internal ED streaming pathways agreed and rolled out for all accepting specialties.	Complete			**Completed**	28/04/21 - Pilot suspended, don't have internal streaming for every cohort of patients - Orthopaedics. Pathways identified but need evidence of this. **JF to summarise for evidence. Meet with ED on regular basis. Reported as assured but no evidence to support completion.**	Deep Dive Completed
			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.	Complete			**Completed**	15/06/20 - complete, EDToday Live dashboard on Biportal 28/04/21 - **JF to summarise for evidence. Reported as assured but no evidence to support completion.**	Deep Dive Completed

			4. Development of an Enhanced Frailty team ED in reach pilot evaluated and established as business as usual	29/09/2020			**Completed**	28/04/21 - Increase Consultant resource which has been delivered. **To share summary of further information**	Deep Dive Completed
			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.	Complete			**Completed & Assured**	28/04/21 - No 12 hour breaches, 4 hours are all tracked in ED. **JF to send revised guidance before embedding.**	Deep Dive Completed
M05	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) Ongoing transformation programme with project continually updating and refreshing and new projects being added.		COO	Divisional Director - M&A	**Complete**	15/06/20 - see Mo1 28/04/21 - Initial action completed, further actions ongoing. No evidence provided.	Deep Dive Completed
			2. Explore viability of bringing key diagnostic tests in-house e.g. Capsule Endoscopy / Cardiac MRI. Alongside developing mitigations if not viable Develop Access and Performance programme schedule to provide assurance on delivery of Elective and Outpatient standards	25/08/2020			**Completed**	28/04/21 - Did not develop capsule endoscopy or Cardiac MRI due to capacity in house so decided to continue with original pathway. Additional actions have been undertaken to meet requirement. **SB – action has been revised PcNulty to send evidence and SB.**	Deep Dive Completed
			3. Review admission criteria and Implement SOP for transfer of patients to M1 Rehab, which includes collaborative approach to acceptance of appropriate patients. Divisional weekly A&P in place with documented specialty submissions of performance against access standards	Complete			**Completed**	**28/04/21 - NM to send SOP, SB - update action and supply information 18/06/21 - No SOP supplied**	Deep Dive Completed

			4. Introduce CAS / RAS services in a number of specialties e.g. gastro / renal / sleep / haematology (electronic triaging system for new referrals)	Complete			**Completed & Assured**	13/11/20 - SB - we have non F2F clinics in all specialities and have RAS in place in renal & cardiology, Virtual triage in place in respiratory. ASI review is in place but not fully formalised at present within Gastro. **Alistair Lenister/SB to be asked about evidence.**	Deep Dive Completed
M06	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.	25/08/2020	COO/ Medical Director	Wirral system lead for discharge	**At risk**	28/04/21 - National guidance for complex patients have changed, there is now established pathways. Much better offer in Community. **JF- To change what the action is for Community and add in revised guidance. Quality Dashboard. Data suggests length of stay is red in 3 out of 5 indicators, Inform JF and SB. Provide with data around Clatterbridge length of stay.**	Deep Dive Completed
M07	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	Complete	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention &	Divisional Director of Nursing Med & Acute/ Divisional Director, M&A	**Embedded**	Embedded	Deep Dive Completed
			2. Increase HCC establishment to provide 24/7 support for timelier moves of patients in hours	Complete			**Embedded**	15/06/20 - complete 28/04/21 - Now embedded	Deep Dive Completed

			3. Senior nurse late/twilight rota put into place to support out of hours.	Complete	Control		**Embedded**	15/06/20 - complete evidence on Med & Acute shared drive (cross division) 28/04/21 - Did introduce late rota	Deep Dive Completed
			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	28/04/2021			**Completed**	23.03.21- SB- Patient Flow transformation programme restarted in March. Barriers to discharge project to launch in April: this will review a ward's performance against the Patient Flow Vision KPIs(including ability to deliver early pull of patient's from assessment areas) and then develop PDSAs to support improvement. Ward 11,18,21 and 36 to be the first wards assessed. Bed Bureau Improvement Plan which will integrate use of Live Flow reports into Bed Bureau flow management and redefine and implement Hospital Co-ordinator Working Practices (both of which should support flow out of the assessment areas) restarted in March with deadlines for full implementation end of April. **To ask for an**	Deep Dive Completed

								update.	
M08	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	10/09/2020	COO	Divisional Director M&A	**Completed & Assured**	**02/05/21 - Julie Reid - The discharge policy is done and live on the intranet**	Deep Dive Completed
			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.	Complete			**Completed**	28/04/21 - NM - there is a tracker based at Clatterbridge, beds have reduced from 40 to 20.	Deep Dive Completed
			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.	Complete			**Completed & Assured**	Assurance has been provided	Deep Dive Completed

			4. Launch Criteria to Reside and Ready for Discharge information on Millennium	25/01/2021			**Completed & Assured**	25/01/21 - CTR and RFD launched on Cerner 28/04/21 - Online dashboard shows utilisation, BI Portal	Deep Dive Completed
			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.	Complete			**Completed & Assured**	17/11/20 - Amanda Pattullo has sent over a bank copy of the RFD worklist as requested	Deep Dive Completed
			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.	Complete			**Embedded**	16/11/20 - Amanda Pattullo - The Command and Control model in IDT involves a twice daily meeting (via Teams) in the morning and afternoon to run through the IDT worklist by pathway. There is no formal agenda for this meeting as it is a routine task for the IDT team 28/04/21 - Embedded	Deep Dive Completed
			7. Implement weekly MD/COO meetings to oversee Divisional LLOS progress	Complete			**Completed**	**28/04/21 - Need to review long length of stay meetings now there are zones. There was a plan for an Exec sponsor but did not get established.**	Deep Dive Completed

M09	Medical care services	The Service must act to reduce referral to treatment times particularly for gastroenterology, dermatology and rheumatology services (Regulation 12)	1. Additional Clinic Capacity for Early Inflammatory Arthritis patients to be established	Complete	COO	Divisional Director M&A	**Completed & Assured**	15/06/20 - complete impact from covid outpatient redesign programme board productivity meetings to support loads of evidence and for trustwide level operational productivity group well established governance all outputs captured within programme board **22/06/21 - Routine waiting times: Rheumatology: 4 weeks**	Deep Dive Completed
			2. Outpatient redesign to be undertaken to include booking of diagnostics pre-first attendance, patient initiated follow-up, virtual clinics.	25/08/2020			**Completed & Assured**	**28/04/21 - Embedded virtual clinics which can be evidenced by proportion of non-face to face compliance, patient initiated follow up hasn't been rolled out yet. - Ask AL and SB. Need evidence.**	Deep Dive Completed

			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.	25/08/2020			**Completed**	28/04/21 - There is a clear understanding of where gaps are in Gastro and do not have significant waits. Comparatively good to other specialities. **22/06/21 - Routine waiting times:** Gastro (luminal): 20 weeks, Gastro (HPB): 18 weeks (post pandemic this had been 52 weeks)	Deep Dive Completed
			4. Implement clinical assessment service for Gastroenterology	25/08/2020			**Action Not Progressed**	25/08/20 – Completed 22/06/21 – Phil Raymond - The Clinical Assessment Service was trialled in gastro but not formally implemented	Deep Dive Completed
			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.	25/08/2020			**Completed & Assured**	**22/06/21 - Routine waiting times:** Dermatology: 6 weeks	Deep Dive Completed
			6. Pilot and evaluate referral assessment service (dermatology)	06/07/2020			**Completed**	15/06/20 -programme board The RAS in Dermatology is to continue; the direction the Trust is moving in via it's Outpatient Transformation Group is to establish clinical triage for OP referrals to ascertain most appropriate first appointment e.g. face-to-face (F2F), non F2F or diagnostics. A RAS	Deep Dive Completed

								supports this. Dermatology, as part of their response to COVID has introduced a RAS and it is now an essential part of their OP pathway.	
			7. Agree a system wide trajectory to achieve national RTT standards	31/07/2020			**Completed & Assured**	Graeme Hancock has sent over summary data. Howard has also developed some really useful reports on his reports page https://aph-ma-sqlpi/reports.htm This will include snapshot positions updated daily and you can find summary numbers on the RTT Return Summary report	Deep Dive Completed
M10	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	29/06/2020	COO/ Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention &	Divisional Director M&A/ Divisional Director Nursing M&A	**Completed & Assured**	Assurance has been provided	Deep Dive Completed

			2. Embed and sustain inter professional standards to ensure delays in ED are escalated and kept to a minimum		Control		Complete	updated 25.04.21 • Continue to embed – ED trackers supporting • Data to be shared with specialties, once agreed how to capture 30 minute – may require specialties to standardise where they document • Standard from referral • ED trackers are now in situ. Escalation of IPS standards in real time being developed between ED department and the patient flow team and will be monitored through capacity meetings daily and escalated real time to manager of the day. Breaches of these standards will be reported daily to specialties and divisions and monitored through Patient Flow Improvement Group 13.7.21 IPS in place and monitored through huddles, escalated to patient flow and through to manager of the day. Any delays monitored through 4 hour breach validation. Patients can transfer to base wards if breach has occurred and are safe to move, via	Deep Dive Completed

								escalation process	
			3. Develop a SOP for periods of escalation that describes the standards to be maintained for safety, privacy and dignity	31/07/2020			**Embedded**	31/07/20 - NM sent EC escalation SOP Assurance processes for delivery of reliable safe care within Emergency Department at WUTH PSQB report saved	Deep Dive Completed
M11	Medical care services	The service must ensure all staff follow infection prevention and control measures and implement effective processes to prevent and control outbreaks	1. Develop and approve IPC Strategy with operational plan	02/09/2020	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention &	Divisional Director of Nursing Med & Acute/ Associate Director of Nursing for Infection Prevention	**Completed & Assured**	02/09/20 - The 3 year IPC Strategy has been presented in draft format to IPCG and agreed, the annual plan on how this will be achieved has been included within the 2019/20 IPC annual report.	Deep Dive Completed

		of infection. (Regulation 12)	2. Develop and approve estates capital plan to support IPC improvements	Complete	Control	& Control/Deputy DIPC	**Completed & Assured**	Evidence provided – assurance through latest CQC inspection	Deep Dive Completed
			3. Re-establish and reinvigorate the IPC link nurses.	25/08/2020			**Completed & Assured**	02/09/20 - This has been rolled out across the trust and the first session has taken place	Deep Dive Completed
			4. Review of Trustwide c-Diff action plan and works / equipment replacement programme and completion of all priority actions	25/08/2020			**Completed & Assured**	15/06/20 - on track updates provided through PSQB 02/09/20 - Trust wide CDI action plan has been reviewed and updated and submitted to MIAA	Deep Dive Completed
			5. Additional IPC training and guidance for matrons to support IPC management and oversight	04/08/2020			**Completed & Assured**	15/06/20 - on track updates provided through PSQB 17/07/20 - NM to get update - EC asked NM 31/07/20 - NM is sending the Matron training for IPC dates to GSU	Deep Dive Completed
			6. Divisional IPC meeting minutes to include evidence of tracking of IPC action plans; RCA's and themes from Exec review panel	17/09/2020			**Completed & Assured**	17/09/20 - monthly IPC meeting, do share action plans and have divisional BAF. On agenda quarterly presented to Hazel. KJ tracks action plan and on shared drive. Taken to weekly meeting too. Minutes go to IPCG.	Deep Dive Completed
M12	Medical care services	The service must ensure all premises and equipment are clean. (Regulation 15)	1. Review decontamination policy and ensure all medical devices are included;	28/08/2020	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals,	Divisional Director of Nursing Med & Acute / Director of Estates &	**Completed**	**28/08/20 - Pat Peers - The Decontamination Policy was recently reviewed. We have generic Medical Devices listed within the policy.**	**Deep Dive in progress**

			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	17/09/2020	Director of Infection Prevention & Control/ COO	Facilities / Associate Director of Nursing for Infection Prevention & Control	**Completed & Assured**	02/09/20 - The audit of the cleanliness of patient shared equipment is included in the audit programme on perfect ward. Following incidence of HCAI audits are completed by the IPC team and fed back to the ward staff for improvements where required. 17/09/20 - monthly divisional IPC audits do discuss cleanliness. BAF covers perfect ward results.	**Deep Dive in progress**
			3. In conjunction with Hotel Services establish standardised process for cleaning of curtains and develop SOP for ward manager's guidance.	Complete			**Completed**	**24/09/20 - TMB - Cleanliness working group now established. Ask JTG for a SOP**	**Deep Dive in progress**
			4. All areas and equipment identified by CQC cleaned, repaired or included within replacement program	Complete			**Completed**	15/06/20 - complete	**Deep Dive in progress**
M13	Medical care services	The service must ensure all premises and equipment is 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.	25/08/2020	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**	15/06/20 - JR to liaise with Andre - monitored through Bi Portal 17/07/20 - JR reported all on track 25/08/20 - AB - they are being sent to KJ Item requiring critical repairs by Estates are included within the Divisional Exceptions reports presented at H&SMC and SMAC 24/09/20 - TMB - Environmental Safety	**Deep Dive in progress**

								Matron selected	
			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	11/06/2020			**Completed**	**SB - Need to get approval, check area when open not being used for anything else**	**Deep Dive in progress**
			3. Change ward layout with M1 to provide a designated dining / activity room where the therapists undertake group sessions on a daily basis	Complete			**Completed & Assured**	15/06/20 - complete	**Deep Dive in progress**
			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	Complete			**Completed**	15/06/20 - complete	**Deep Dive in progress**
			5. M1 Temporary heating solutions deployed with additional bedding stocked on ward if required.	Complete			**Completed & Assured**	15/06/20 - complete	**Deep Dive in progress**
			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	17/06/2020			**Completed & Assured**	15/06/20 - complete and assured A Clinical Procurement Group has been established which replaces the former MEDPREG group. The Clinical Procurement Group has established ToR which include appropriate membership and standing agenda-	**Deep Dive in progress**

M14	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	Complete	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**	15/06/20 - complete and assured, evidence on Bi Portal	**Deep Dive in progress**
			2. Incorporate medical gas storage audit as part of perfect ward audits and include performance on the H and S performance dashboards	26/06/2020			**Embedded**	15/06/20 - add to perfect ward audit - on house keeper audit **complete** EC and CB have liaised with Health & Safety regarding Dashboard for results can pull from Bi Portal for every division	**Deep Dive in progress**
			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	17/07/2020			**Completed & Assured**	30/10/20 - Safety Bulletin saved	**Deep Dive in progress**
M15	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	24/06/2020	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**	EBME do not perform PAT tests but assurance has been given that all medical devices have had the appropriate Medical Testing as required by law. Estates have confirmed all registered Electrical devices are up to date. Additional assurances relating to managers instructions, policy and process have been sought.	**Deep Dive in progress**

			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	26/08/2020			**Completed & Assured**	15/06/20 - check process at Health & Safety Committee	**Deep Dive in progress**
			3. Implement Standard Operating Procedure for ward managers to ensure guidance and agreed checking process for electrical safety is implemented.	22/07/2020			**Completed & Assured**	SOP developed and shared Completed 22/07/20 – Electrical safety SOP incorporating Estates and EBME processes for portable electrical equipment agreed at the H&SMC	**Deep Dive in progress**
			4. Risk assessment and usual frequency for Portable appliance testing of equipment to be shared with all wards/ departments	22/07/2020			**Completed**	Estates have been asked to provide supportive evidence for the decision to PAT test every 18 months. Estates have been asked to review and update Trust policy to reflect current practice. 17/07/20 Updated SOP approved at Health & Safety Committee - July 12/11/20 EC has asked Dave Hatch for an update	**Deep Dive in progress**
M16	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	Complete	COO	Divisional Director Medicine and Acute Specialties Division	**Completed & Assured**	15/06/20 - complete	**Deep Dive in progress**
			2. All staff to be reminded of the importance of confidentiality	Complete			**Completed & Assured**	15/06/20 - complete	**Deep Dive in progress**

			3. Develop a Perfect Ward audit for discharge lounge incorporating IG and confidentiality	30/07/2020	Director of IT and Information	Divisional Director of Nursing Med & Acute	**Completed & Assured**	30/07/20 - NM has sent audit to GSU but to note that will not go onto Perfect ward straight away as there is an issue with a licence but is saved on the s drive for evidence until ready.	**Deep Dive in progress**
M17	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	01/07/2020	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**	**26/08/20 - It's been done but just for falls at the moment – need to assess with this is working as an action**	**Deep Dive in progress**
			2. Nutrition & Hydration specific dashboard to be uploaded to the nursing Business Intelligence (BI) portal	13/08/2020			**Embedded**	CB to review Nutrition paper to PSQB - July timescale included in quality dashboard capacity affecting BI BUILD	**Deep Dive in progress**
			3. Inclusion of 24 hour MUST compliance will be included in the Trust Quality Dashboard.	Complete			**Embedded**	GSU have now saved Trust Quality Dashboard as evidence	**Deep Dive in progress**
			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'.	Complete			**Completed & Assured**	15/06/20 - complete	**Deep Dive in progress**
			5. Ward profiles for falls to be developed and targeted action plans developed for priority areas which will include targeted falls prevention training	Complete			**Completed & Assured**	15/06/20 - complete - ask Johanna and Marg	**Deep Dive in progress**

			6. Identify all CSW's to undertake the care certificate and establish a programme of training	25/08/2020			**Completed & Assured**	01/11/20 - Helen Patterson - The care certificate has been aligned against staff roles for compliance to be reported. The first report was issued 2 weeks ago.	**Deep Dive in progress**
			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	26/08/2020			**Completed & Assured**	Contact Corporate Nursing for Harms Panel/CLIPPE	**Deep Dive in progress**
			8. Raise staff awareness of personal accountability for completion of risk assessments	15/06/2020			**Completed & Assured**	15/06/20 - linking with SI's including on practice educator programme of work NM to send programme of work for practice educator through to GSU Fortnightly huddles - one for risk assessments as staff sign	**Deep Dive in progress**
M18	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	29/09/2020	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**	29/09/20 - discussed at SNMT, paper version, trying to roll out to obtain good compliance. mark as complete. Need to add to Ward Accreditation. 20/11/20 - EC has asked NM if SBAR is now electronic	**Deep Dive in progress**
			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	15/06/2020			**Completed & Assured**	15/06/20 - Complete NM has sent copy of SBAR handover NM to raise at senior nurse meeting so is	**Deep Dive in progress**

								reflected Trust wide	
			3. Implement and monitor compliance with intentional rounding on escalation areas				**On track**	29/01/21 - Matron is currently reviewing rounding process on corridors, to engage with Royal ED Senior Nursing Team and observe their process. Meeting with Junior Sisters in department planned to engage re rounding, set expectations and develop assurance process as audits have shown rounding is not consistently bring carried out	**Deep Dive in progress**
			4. Review Standard Operating Procedure for escalation areas to ensure handover of information and completion of risk assessments is included	Complete			**Completed & Assured**	23/11/20 - Escalation pro-forma has been sent	**Deep Dive in progress**
M19	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	13/08/2020	Medical Director	Deputy medical Director/ AMD M&A	**Completed & Assured**	EC asked NM and KL for an update as SB is on leave - request an action review as KL has sent over a roster which shows which team look after which area.	**Deep Dive in progress**
			2. Inclusion of medical outliers in the 7 day audit to monitor appropriate senior medical reviews	30/09/2020			**Completed & Assured**	**29/09/20 - GSU has sent audit to Triumvirate**	**Deep Dive in progress**

			3. Ensure that all appropriate patients are admitted via assessment areas to provide a timely consultant review.	17/07/2020			**Completed**	15/06/20 - on track	**Deep Dive in progress**
			4. Review use of ward 25 (isolation ward) and ensure access to a relevant specialist consultant	17/07/2020			**Completed**	17/07/20 - Use of Ward 25 is being reviewed at CAG next week	**Deep Dive in progress**
			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.	Complete			**Completed**	25/11/20 - EC has sent medical outliers audit to Triumvirate to discuss	**Deep Dive in progress**
M20	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	Complete	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Associate Director of Nursing for Safeguarding	**Embedded**	15/06/20 - complete - Safeguarding PSQB Report 04/05/21 - PSQB report for Q3 and DoLS section of the Safeguarding Assurance Oversight report that was presented to SAG on 22 April 21.	Deep Dive Completed
			2. Ward managers to identify expiry of Deprivation of Liberty at each ward Board round from the list provided by Safeguarding	15/06/2020			**Embedded**	15/06/20 - safeguarding audit on huddles for documented expired DOLS Kal Shaw reviewing Complete - Safeguarding PSQB Report	Deep Dive Completed
			3. Develop audit process to ensure sufficient assurance regarding Safeguarding teams processes and report within Safeguarding reports to PSQB	25/08/2020			**Completed & Assured**	15/06/20 - on track 25/08/20 - Kal Shaw has given assurance through PSQB	Deep Dive Completed

M21	Medical care services	The service must act to ensure performance is monitored effectively and there are clear plans to improve patient outcomes. (Regulation 17)	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.	03/07/2020	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Director Nursing - M&A	**Completed**	15/06/20 - NM to liaise with Stroke Lead and Therapy Lead 24/11/20 - EC has asked Ruth Davies, Tony Probbing and NM for evidence	**Deep Dive in progress**
			2. Review Therapy Outcome Measures (TOMs) data; setting targets for improvement and linking in with SNAPP results.	03/07/2020			**Completed**	15/06/20 - NM to liaise with Stroke Lead and Therapy Lead 03/07/20 - Ruth Davies - there are plans for a meeting with therapy to review latest SSNAP figures - Dr Gott and Graeme Lambert plan to meet	**Deep Dive in progress**
			3. Review Speech and Language Therapies service performance against local targets, exploring good practice and implementation	03/07/2020			**Completed & Assured**	15/06/20 - NM to liaise with Stroke Lead and Therapy Lead	**Deep Dive in progress**
			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)	25/08/2020			**Completed & Assured**	15/06/20 - on track 25/08/20 - SNAP audit, **will ask Tony Probbing and Ruth Davies**	**Deep Dive in progress**
M22	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	**Complete**	MIAA audit arranged for Sept 2021	Deep Dive Completed
			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.	28/08/2020			**Embedded**	Lee Bennett - Paper for audit results to be presented to Divisional Quality Board Education team being recruited to support	Deep Dive Completed

								education and increased audit capacity further.	
			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.	22/06/2020			**Completed & Assured**	28/08/20 - Lee Bennett - Policies being updated Increased in assessments prior to covid – reduced during COVID and restarted audits. August report can be provided next week and will be presented to DQB (I can send it next week once the last bits of data are through and formulated into the report)	Deep Dive Completed
M23	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.	22/04/2021	Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control	Divisional Triumvirate - Surgery	**Completed and Assured**	22/04/21 - Dylan - Strategy is completed just not formally approved yet. Evidence of strategy provided	Deep Dive Completed
			2. Implement targeted infection prevention/wound management improvement plan for the post-operative care management in all surgical wards	22/04/2021			**Completed & Assured**	22/04/21 - Over reported in 2018. Dylan - for quarter 3 under 1% infection rate T&O, now undertaking with Colorectal. Working with new TVN Matron looking at new formulary. Original data indicated 8% but was a problem with data accuracy. Completed. Medical engagement still an issue. Evidence provided	Deep Dive Completed

			3. DDN/AMD to set up an MDT function to review all potential surgical site infections and ensure appropriate actions is implemented to reduce them.	22/04/2021			**Completed and Assured**	22/04/21 - Dylan - There is now an MDT process for any suspected infections and the learning just need medical engagement now. Only had 1 meeting so far. **To send minutes over.** Actions will be monitored through DQB. Evidence provided.	Deep Dive Completed
			4. Learning to be cascaded through local quality boards and safety summits.	22/04/2021			**Completed**	22/04/21 - SSI paper is being presented at IPCG and DQB and will be a standing item. Asked for it to be fed into PSQB. As now developing into other specialities can now proceed with SSI bundle and to audit against it. Surveillance to be undertaken all year round. **No evidence supplied.**	Deep Dive Completed
			5. Triumvirate to lead a review of clinical capacity to ensure effective audit and improvement activities for SSI's can be undertaken.	05/10/2020			**Completed**	22/04/21 - nationally there is a minimum requirement for 1 quarter and at least 1 specialty, gold standard is other specialities. **No evidence supplied.**	Deep Dive Completed
			6. Extend SSI audit across all quarters to gain accurate information to inform actions to be implemented to reduce SSI's	05/10/2020			**Completed**	05/10/20 - Alison Tinkler undertaking SSI audit - Q4 (T&O only) Audit is reported externally 22/04/21 - To take to Quality Board for a broader role out	Deep Dive Completed

								No evidence supplied	
M24	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.	17/09/2020	COO	Associate Director of Health Care Professions-Perioperative Medicine & Critical Care; Divisional Director - Surgery	**Completed & Assured**	05/10/20 - Re-located to Clinic 9 from the temporary location. Staff currently working out at CGH for COVID swabbing, but facility ready for use. **21/06/21 -** the service has been relocated now and is in clinic 9 at APH along with CGH which has continued as is. The concern was APH pre-op location.	Deep Dive Completed
			2. Fit & Well Questionnaires to be rolled out reducing the demand for face to face	19/08/2020			**Completed**	22/06/20 - on track 19/08/20 - DE - questionnaires are taking place and in 3 months if reduced need for pre op for assurance	Deep Dive Completed
M25	Surgery	The service must implement clear plans, with set timescales and actions, to improve patient's access to care and to achieve their timely discharge from hospital. (Regulation 17)	1. Implement Divisional requirements of the Trustwide Patient Flow Improvement workstreams (see Mo1)		COO	Divisional Triumvirate Surgery	**Complete**	Twice weekly length of stay meetings attended by directorate with IDT - go through any delay with discharge.	Deep Dive Completed
			2. Divisional Triumvirate to work with IT to make Estimated Discharge Date (EDD) a mandatory field within Cerner Millennium.	26/02/2021			**Completed**	26/02/21 - DE - Completed **22/04/21 - To produce a snapshot audit, no evidence supplied.**	Deep Dive Completed

			3. AMD to ensure that all Consultants agree and document EDD during ward rounds.	05/10/2020			**Completed**	05/10/20 - Manual trawl of each patient to check with missing EDDs picked up at the afternoon Board round. Twice weekly LLOS meetings embedded and led by ADNs. All patients now have an EDD - ADNS working with Paul Jones in IT to pull data onto patient board to enable Matrons to check EDD's daily. Board rounds working well in T&O. Heather leading on board rounds across other specialties. **No evidence supplied - request an audit**	Deep Dive Completed
			4. AMD and DDN to initiate board rounds across surgery - to be agreed with all CD's.	19/08/2020			**Completed & Assured**	19/08/20 - works well on ward 11, twice weekly long length of stay meetings, not robust yet. Matrons are feeding back to DE that there have been improvements and more engagement. **Evidence supplied**	Deep Dive Completed
			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	Complete			**Completed & Assured**	GSU to look at programme board minutes - **Paul McNulty**	Deep Dive Completed
M26	Children's and young people's services	The service must comply with the national information sharing	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	Complete	Chief Nurse, Executive Director for Midwifery and	Director of Nursing & Midwifery – Women's	**Completed & Assured**	16/06/20 - CPIS already in place all band 6 only across all areas Safeguarding PSQB report	Deep Dive Completed

		standard designed to safeguard children who were looked after or in protection. (Regulation 13)	ensure this is enacted		Allied Health Professionals, Director of Infection Prevention & Control	and Children's Division Associate Director of Nursing for 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.	16/06/2020			**Completed & Assured**	16/04/21 - Contact Nicky Denton, band 6s that have had the training, no incidents have been received, DE to include at SAG	Deep Dive Completed
M27	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. (Regulation 12)	1. Cerner awareness & navigation session to be included on the paediatric essential training day all staff to attend	Complete	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	**Embedded**	16/06/20 - Training in place and compliance, attendance monitored 12/03/21 - Anne Marie confirmed now embedded, **does it cover pain, nutrition and pressure area assessments? More up to date data**	Deep Dive Completed
			2. Create a perfect Ward Children's Harms Prevention Audit , that includes pain assessment review	Complete			**Embedded**	16/06/20 - Good compliance on Perfect Ward 12/03/21 - Anne Marie confirmed now embedded	Deep Dive Completed
			3. Create an audit cycle to assess compliance with completion of mental health and wellbeing assessments of children and young people	21/07/2020			**Completed and Assured**	25/08/20 - **DE and NP will ask Anne Marie to send audits through to GSU and for planned cycle to continue, incorporate in annual audit cycle, look at actions from PSQB.** Evidence provided.	Deep Dive Completed
M28	Diagnostics	The diagnostic imaging service must ensure the risk to patients of	1. SOP for MRI induced burns to be approved and uploaded to staff intranet	Complete	Medical Director	Associate Medical Director Clinical	**Embedded**	24/05/21 - confirmed embedded	Deep Dive Completed

		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)	2. Ensure effective communication to all relevant staff	Complete		Support and Diagnostics; Dr Simon Lea/ Consultant Radiologist	**Embedded**	30/06/20 - been communicated through safety huddles and email **LN has sent over evidence**	Deep Dive Completed
M29	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	28/07/2020	Medical Director	Operation and Performance Manager for Radiology	**Embedded**	24/05/21 - assured at governance meetings	Deep Dive Completed
M30	Outpatients	The service must ensure that the trust standard operating procedure is followed when decontaminating equipment. (Regulation 12)	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.	Complete	COO Medical Director Chief Nurse	Matron of Ophthalmology/Associate Director of Nursing for Infection Prevention & Control/ CSSD lead	**Completed & Assured**	**Jay has been contacted for any recent audit data**	Deep Dive Completed
			2. Establish Trust-wide audit and reporting process for monitoring adherence to the trust standard operating procedure for decontaminating equipment	28/08/2020			**Completed & Assured**	28/08/20 - Pat Peers - Sterile Service Department is audited by an external Notified body to ISO 13485;2016 and MDD 93/42/EEC. Endoscopy Decontamination Unit in APH is audited to JAG standards. There is an audit within perfect ward app that looks at cleaning Patient	Deep Dive Completed

								shared equipment and this standard is audited on a regular basis, results of which are discussed at the monthly divisional IPC meetings and exceptions escalated to IPCG.	
M31	Outpatients	The service must ensure that flooring in the ophthalmology department is compliant with infection control guidance. (Regulation 12)	1. Repair flooring	Complete	COO	Director of Estates & Facilities	**Embedded**	30/06/20 - Surgery outpatients, assurance from Bi Portal Andre and Glen	Deep Dive Completed

Ref	Specific area	MUST Do/Should Do	Actions taken to meet regulation	Actual completion date	Exec lead	Operational lead	RAG Status	Comments	Deep Dive Progress
S01	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.	30/10/2020	Chief Executive/Director of Workforce/Director of Strategy & Partnerships/ Medical Director/Chief Nurse/Chief Operating Officer/Director of IT and	Communications Team	**Completed**	30/10/20 - Cathy McKeown - A series of Executive Director listening events as a Covid Debrief were held throughout Sept and October. Report being written up for early next week.	**Deep Dive in progress**
			2. Posters detailing Executive Team members to be mounted on notice boards throughout the Trust	30/10/2020			**Completed & Assured**	30/10/2020 - Sally Sykes - This is included in phase 2 vision and values along with ward	**Deep Dive in progress**

					information			photo boards. Approved at Execs 3 weeks ago and are now being implemented.	
			3. Executive Directors to participate in Corporate Induction sessions	30/10/2020			**Completed**	30/10/2020 - Corporate Induction is now virtual with the inclusion of a video from CEO	**Deep Dive in progress**
			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.	30/10/2020			**Completed**	30/10/2020 - Jill Hall - This is taking place, with the Covid-19 restrictions in place NED walkabouts have not continued. We will be looking at alternative ways of holding virtual walk arounds.	**Deep Dive in progress**
S02	Trust wide	The trust should ensure that the overall five-year strategy is reviewed and refreshed where appropriate	1. Strategic Framework approach developed	Complete	Director of Strategy & Partnerships	Head of Strategic Planning	**Embedded**		**Deep Dive in progress**
			2. Strategic Plan workshops held	Complete			**Embedded**		**Deep Dive in progress**
			3. Drafting of 2021-26 Strategy	27/07/2020			**Embedded**	27/07/20 - MG - Draft strategy completed, it has been shared with the Council of Governors and will be going to TMB for sign off 30th July.	**Deep Dive in progress**
			4. Board approval of Trust Strategy	05/08/2020			**Embedded**	26/08/20 - Messages from the Board - The Trust's 2021-2026 Strategy was reviewed and approved by the Board, with the document to be published in October 2020.	**Deep Dive in progress**

S03	Trust wide	The trust should ensure that mortality reviews are undertaken in a timely way	1. Update 'Learning from deaths' policy	16/07/2020	Medical Director	Deputy Medical Director	**Completed & Assured**	**Mike Ellard**	**Deep Dive in progress**
			2. Weekly Mortality review group to be established	16/07/2020			**Embedded**	Minutes and information in GSU shared drive 25/08/20 - W&C also involved in process and do external mortality reviews	**Deep Dive in progress**
			3. Strengthen timeframe for completion of SJRs to 28 days, which will be monitored and reported against	26/08/2020			**Completed & Assured**	Yes complete – we have a tracker in place – not many on at moment but does show within 28 days completion	**Deep Dive in progress**
			4. Weekly Mortality review group to review how best learning is to be disseminated	25/08/2020			**Embedded**	Minutes and information in GSU shared drive	**Deep Dive in progress**
			5. Appoint Medical Examiner officer	22/07/2020			**Embedded**	Minutes and information in GSU shared drive	**Deep Dive in progress**
S04	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.	29/07/2020	Director of Workforce	Deputy Director OD. Director of Communications and Engagement	**Completed & Assured**	29/07/20 - Kate Armitage - We offer a 1 hour values and behaviours session to teams. This is intended for a manager to invite us in at lunch etc. and talk about the importance of v & b. It's largely about message giving. This might be requested if a team are experiencing some challenges. In addition we offer a 1.5 hr session which is a more exploratory bespoke package addressing	**Deep Dive in progress**

								particular issues that have been raised that are impacting on team performance and behaviour. 30/09/20 - EC requested any evidence from Cathy McKeown and Kate Armitage - Sent	
			2. Ensure values and behaviours posters are available in all departments.	06/10/2020			**Completed & Assured**	06/10/20 - Lyndsay Young - We gave out all the posters that were printed but can print more if anyone needs them, they just need to request them from us. 03/11/20 - Lyndsay Young has sent over different formats of the posters	**Deep Dive in progress**
			3. Review and refresh actions of Respect at Work Group.				Overdue	10/02/21 - Victoria Robinson-Collins - Norm as chair of staff side and I met 4th Jan to discuss and agree next steps: View was that the scope/ terms of reference and attendees needed to be reviewed and group relaunched/ reset as it had changed over time which I agreed to progress and feed back to Norm, including sharing the NHSI culture and leadership methodology which I feel would be a useful	**Deep Dive in progress**

								framework for us to use. • Methodologies and examples of use in other Trusts has been shared with Norm/ complete • Draft ToR and attendees aim to complete end Feb 21 to allow stakeholders to input, with a view to relaunch the group as part of re-set and recovery 1st April 21.	
			4. Revisit approach to 'Just Culture' and implement.				Overdue	Awaiting update from HR	**Deep Dive in progress**
			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.	04/08/2020			**Completed & Assured**	04/08/2020 - Cathy McKeown - Terms of reference reviewed and updated. Now available for next new Cultural review in 2020	**Deep Dive in progress**
			6. Incorporate updates of cultural review action plans into Directorate/Divisional Review meetings	05/10/2020			**Completed**	05/10/20 - Completed. Cathy McKeown has agreed with divisions a process of feedback via Divisional DON or HR Business Partner to Divisional meetings.	**Deep Dive in progress**
			7. Include managers responsibility and guidance related to compassionate leadership and culture into a new managers toolkit.				Overdue	Awaiting update from HR	**Deep Dive in progress**
			8. Include welcome from CEO in Corporate Induction virtual programme for 2020	26/08/2020			**Completed & Assured**	26/08/20 - Cathy McKeown - Completed	**Deep Dive in progress**

			9. Undertake temperature check with staff to understand if we are living our values and what we need to do more of.				**Overdue**	.09/02/21 - Main survey publication date has been set for March so will go to April Board. There's lots of data in the staff survey at question level (there are over 100 questions) that can be used as indicators for aspects of culture and engagement but I recommend we use the overall engagement index as a measure. Early data show this moved from 6.84 in 2019 to 6.88 in 2020 (out of 10). The change is not statistically significant and is in the bottom quartile of our benchmark group of 61 acute sector and community trusts. The engagement index is derived from a weighted aggregate of 9 questions that measure Advocacy, Motivation and Involvement. I would recommend that the index is used as the measure to track year on year staff engagement.	**Deep Dive in progress**
			10. Increase number of FTSU Guardians and BAME representations in FTSU structure	26/08/2020			**Completed & Assured**	26/08/20 - Cathy McKeown - Completed with an additional FTSU Guardian of BAME origin.	**Deep Dive in progress**

			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.	26/08/2020			**Completed & Assured**	26/08/20 - COVID Debrief sessions to be held with staff Sept/October 2020 and also via a survey. This is expected to capture feedback on wellbeing support. Charitable funds secured for staff wellbeing and Charity Team and Director of Communications and Engagement working with Executive Team to agree spend. 12 month psychologist post being recruited to for onsite post covid support. This is in addition to the availability of the Employee Assistance programme.	**Deep Dive in progress**
			12. Review our values based annual awards with staff and improve based on feedback so that they feel valued for their contribution.	08/01/2021			**Completed**	04/02/21 - When awards can be planned as an in person celebration in 2021, we will continue to theme them around our values. All staff received a thank you card and small gift at Christmas with a message from the CEO and Chair. Further vision and values work has continued with additional visual branding installed on lift doors at Arrowe Park Hospital. An 'Employee of the month scheme' is	**Deep Dive in progress**

								also being developed. We promoted the Annual Members' Meeting via and advert in the Wirral Globe and members of the public attended to receive an annual review from the Chair and CEO. The presentation and video for this meeting were promoted on social media afterwards via the trust's public website. Volunteers received a thank you Christmas Card and recognition voucher from the CEO and Chairman in December 2020 and the annual long service awards will take place virtually in February 2021	
			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.				**Overdue**	Awaiting update from HR	**Deep Dive in progress**
			14. Continue to deliver the leadership and management development framework inclusive of compassionate leadership, 360 feedback and coaching and promote this.				**Overdue**	Awaiting update from HR	**Deep Dive in progress**
S05	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	**Overdue**	Awaiting update from HR	**Deep Dive in progress**
			2. Host Equality Group Conferences to engage with community, building on the				**Overdue**	Awaiting update from HR	**Deep Dive in progress**

			inaugural Transgender Conference with community groups held in 2019.			Deputy Chief nurse			
			3. Work with Healthwatch to focus on EDS2 requirements and Equality Analysis				**Overdue**	09/02/21 - Sharon Landrum - Requires some engagement work and links too with the new lead in patient experience.	**Deep Dive in progress**
			4. Host open days and events to support recruitment and engagement.				**Overdue**	Awaiting update from HR	**Deep Dive in progress**
			5. Work proactively with the Divisions to gain and promote good news stories internally and externally from staff or patients and families				**Overdue**	Awaiting update from HR	**Deep Dive in progress**
			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	12/01/2021			**Completed**	12/01/21 - We are reviewing our portfolio of leaflets on health promotion but more proactive engagement with groups is paused due to COVID-19 third wave. We are working with Healthwatch and Maternity Voices as stakeholders on health promotion issues and patient feedback for their respective remits.	**Deep Dive in progress**
			7. Work with universities and colleges to support the education agenda, research activity, work experience and recruitment	12/01/2021			**Completed**	12/01/21 - We continue to work with universities and colleges to deliver the education agenda and ensure the Learning and Development Agreement contractual obligations are met for students and undergraduates in the workplace	**Deep Dive in progress**

			8. Utilise themes from patient stories, complaints and concerns to inform service improvements				**Overdue**	Awaiting updates from HR	**Deep Dive in progress**
S06	Urgent and emergency services	The service should ensure there are enough suitably qualified doctors in the emergency department to meet patient need	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.	Complete	Medical Director	Deputy divisional director and Head of Urgent Care	**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			2. Develop CESR business case	Complete			**Completed & Assured**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			3. Recruit to CESR post	29/01/2021			**Completed**	19/11/20 - SB - consultant in post to cover gap Set trigger point?	**Deep Dive in progress**
			4. Develop business case for additional ED consultants to compensate for middle grade gaps	29/01/2021			**Completed**	29/01/21 - JF - Business case completed – 3 locums in post currently – awaiting decision of TMB to move to formal advertising of the post. All 3 locums expressed interest in long term posts.	**Deep Dive in progress**
			5. Recruit NHS ED locum consultant for 6 months in interim	Complete			**Completed & Assured**	Awaiting updates from Triumvirate	**Deep Dive in progress**
S07	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.	Complete	Chief Operating Officer	Deputy divisional director and Head of Urgent Care	**Completed & Assured**	ED assurance paper for PSQB 24/09/20 - TMB - Educator role has had a positive impact	**Deep Dive in progress**
			2. Ensure Nurse educator is trained in CPR for local training delivery.	Complete			**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			3. Develop trajectory to achieve mandatory training compliance.	Complete			**Completed & Assured**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			4. Establish nursing workforce monthly meeting to commence with new	17/07/2020			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**

			ADN/matron to embed and sustain compliance						
			5. Ensure Consultants Complete all mandatory training.	Complete			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
S08	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	Complete	Chief Nurse	Deputy divisional director and Head of Urgent Care ADN for ED	**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			2. Removal of CAS cards and ensure documented on Electronic Cerner system	Complete			**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			3. Establish process for monitoring discharge summary	Complete			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			4. Nursing documentation compliance audits carried out monthly to monitor patient risk assessments	Complete			**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			5. Launchpoint implemented (which includes patient safety checklist)	Complete			**Embedded**	ED assurance paper for PSQB - July	**Deep Dive in progress**
			6. Monitor implementation of Launchpoint and patient safety pathways	17/09/2020			**Completed & Assured**	17/09/20 - Been launched - PSQB ED Safety Paper	**Deep Dive in progress**
S09	Urgent and emergency services	The service should ensure that records trolleys are locked when not in use	1. Remove CAS cards.	Complete	Chief Nurse	Deputy divisional director and Head of Urgent Care ADN for ED	**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			2. Install locked storage trolley in EDRU. Install lock on room that will store storage trolley	Complete			**Completed & Assured**	Bi Portal	**Deep Dive in progress**
			3. Install lock on room for storage trolley	Complete			**Completed & Assured**	Bi Portal	**Deep Dive in progress**
S10	Urgent and emerge	The service should ensure that patients have access to call	1. Reconfigure department to increase number of low risk majors space.	Complete	Chief Nurse/Chief Operating	Deputy divisional director and	**Completed & Assured**	ED Safety PSQB November	**Deep Dive in progress**

	ncy service s	bells at all times	2. Implement Clinical Decisions Unit	10/11/2020	Officer	Head of Urgent Care ADN for ED	**Completed**	10/11/20 - Anthony Middleton - agreed and launched, tracking on a weekly basis, clinical team reviewing on a daily basis.	**Deep Dive in progress**
			3. Roll out of launch point and safety checklist reviewed, to ensure that call bells and reach are included.	31/07/2020			**Embedded**	Update through PSQB in August/ assurance	**Deep Dive in progress**
S11	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	Complete	Chief Nurse/Chief Operating Officer	ED Triumvirate Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Head Estates	**Completed & Assured**	IPC Paper and ED assurance paper to PSQB 25/11/20 - Annual Plan has been sent over	**Deep Dive in progress**
			2. ED triumvirate commenced weekly review of department with infection control and IPC audit completed monthly to address issues	Complete			**Embedded**	IPC Paper and ED assurance paper to PSQB	**Deep Dive in progress**
S12	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	17/07/2020	Chief Nurse/	ADN for ED	**Embedded**	ED assurance paper for PSQB	**Deep Dive in progress**
			2. Monitor implementation of Safety checklist	17/09/2020			**Completed & Assured**	17/09/20 - Been launched - PSQB ED Safety Paper, audited monthly, link with Emma Maxwell	**Deep Dive in progress**
			3. Nurse educator to develop nurse competencies for risk	17/07/2020			**Completed & Assured**	ED assurance paper for PSQB 24/09/20 - TMB Paper	**Deep Dive in progress**

			4. Roll out nurse competencies for band 5				Overdue	29/09/20 - Done basic competencies, launched level 2 and band 7s all signed off, cant roll out band 5 until band 7 are signed off. **NM will obtain an update. Split action for band 5 and band 7.**	**Deep Dive in progress**
			5. Roll out nurse competencies for band 6				Overdue	20/11/20 - The competency booklet for band 6s will be rolled out in December with a timeframe of completion by April 2021 - extension provided	**Deep Dive in progress**
			6. Roll out nurse competencies for band 7	29/09/2020			**Completed & Assured**	08/10/20 - NM - The band 7 has been rolled out	**Deep Dive in progress**
			7. Launch point rolled out to enable completion of assessment	17/07/2020			**Completed & Assured**	ED paper PSQB November	**Deep Dive in progress**
S13	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)	Complete	Chief Operating Officer	ED Triumvirate	**Completed & Assured**	ED assurance paper for PSQB	**Deep Dive in progress**
			2. Monitor implementation/ compliance of Safety huddles process	26/08/2020			**Embedded**	ED assurance paper for PSQB	**Deep Dive in progress**
			3. Establish breach meetings with specialities (See S17)	Complete			**Completed & Assured**	24/11/20 - Karen Stephens - Breach analysis is done weekly	**Deep Dive in progress**

			4. Each speciality to develop escalation processes which will link to the inter professional standards (See S17)				Overdue	19/11/20 - John Foley is discussing solution with IT and is meeting with Chris Mason, EC has clarified with JF on status of this. 29/01/21 - Paused due to Covid demands	**Deep Dive in progress**
			5. Develop Directorate Performance Reviews to provide Division with assurance on processes. (See S17)	Complete			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			6. Urgent care action plan developed with 4 partner organisations	Complete			**Completed**	**07/10/20 - EC has asked Karen Stephens**	**Deep Dive in progress**
			7. Monitor completion of urgent care improvement action plan	17/07/2020			**Completed**	**07/10/20 - EC has asked Karen Stephens**	**Deep Dive in progress**
			8. Patient breaches who are awaiting review collected and analysis for themes reviewed	Complete			**Completed**	**07/10/20 - EC has asked Karen Stephens**	**Deep Dive in progress**
S14	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.	17/07/2020	Chief Operating Officer	ADN for rehab Estates AHP Directorate manager	**Completed**	JR requested assurance in 2 months that area is fit for purpose for use	**Deep Dive in progress**
			2. Develop designated dining / activity room where the therapist undertakes group sessions on a daily basis.	Complete			**Completed & Assured**	Activities timetable	**Deep Dive in progress**
			3. Ensure robust activities timetable in place once the unit reopens	17/07/2020			**Completed**	JR requested assurance in 2 months that area is fit for purpose for use	**Deep Dive in progress**
S15	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.	Complete	Chief Nurse	Divisional governance lead Divisional ADN	**Completed & Assured**	03/11/20 - EC has asked KJ and NM for evidence Weekly Risk Management meeting	**Deep Dive in progress**
			2. Introduce monthly risk meeting to ensure risk register up to date, validate and appropriate scoring applied to incidents and ensure timely	Complete			**Completed & Assured**	03/11/20 - EC has asked KJ and NM for evidence – Quality Board	**Deep Dive in progress**

			management of incidents, rapid reviews for SI Panel.						
			3. Governance lead and ADNs develop a development plan for ward managers to improve knowledge and skills regarding risk management.	30/07/2020			**Completed & Assured**	30/07/20 - NM sent over risk plan for ward manager training	**Deep Dive in progress**
			4. Senior nurse presence (Matron or AND) at Clatterbridge site to support Ward Sisters	Complete			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
S16	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	Completed	WCCG have commissioned new D2A bed base on single site (CGH) with single provider (WCT). New commission due to start 01/09/21	**Deep Dive in progress**
			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).	Complete			**Embedded**	Amanda Pattullo Quality Dashboard	**Deep Dive in progress**
			3. Work with healthcare economy partners to develop urgent care improvement plan.	17/07/2020			**Completed & Assured**	Programme Board	**Deep Dive in progress**
			4. Work with healthcare economy partners to commission redesigned intermediate care model	Complete			**Completed & Assured**	Programme Board	**Deep Dive in progress**
S17	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).	Complete	Chief Operating Officer	System wide discharge lead	**Embedded**	Programme Board	**Deep Dive in progress**
			2. Work with healthcare economy partners to develop urgent care improvement plan.	Complete			**Completed & Assured**	Programme Board	**Deep Dive in progress**

			3. Work with healthcare economy partners to commission redesigned intermediate care model				Overdue	Awaiting updates from Triumvirate	**Deep Dive in progress**
S18	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.	Complete	Chief Nurse	Associate Director of Nursing for Safeguarding Named Nurse Safeguarding Adults	**Completed & Assured**	Safeguarding report PSQB	**Deep Dive in progress**
			2. Develop process for DOLS being discussed at ward level daily by nurse in charge	Complete			**Completed & Assured**	Safeguarding report PSQB	**Deep Dive in progress**
S19	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	25/02/2021	Chief Nurse	Divisional Nurse Director	**Completed**	02/09/20 - Sally Sykes - Leaflets will be supplied from a number of sources – WUTH and from other agencies like PHE and local public health programmes like 'Keep Wirral Well'. Recommend a clinically led audit of current stocks and topics as these are likely to cross Divisions and specialties. 29/09/20 - TF to send leaflets via SNMT 25/02/21 - Health promotion leaflet presented to PFEG 13/11/20 and British Heart Foundation suite approved. Other PHE resources also being evaluated from the 'Better You' series to fill any gaps in BHF information. Target completion year end.	**Deep Dive in progress**

								Completed suite of leaflets approved - Les	
			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	25/02/2021			**Completed**	25/02/21 - Task and Finish Group established, expert consultant resource secured, project plan drawn up and on track – target completion April 2021, completed	**Deep Dive in progress**
			3. Development of a Trust Wide approval and distribution process (Standard Operating Procedure)	29/09/2020			**Completed**	29/09/20 - TF - policy and SOP agreed so all process in place but struggle with capacity so business case has been approved to undertake piece of work.	**Deep Dive in progress**
			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.	25/02/2021			**Completed**	25/02/21 - BrowseAloud meets Accessible Info Standard and accessible information standard compliance is built into Task and Finish Leaflets overhaul project above. complete	**Deep Dive in progress**

			5. Closer working with hospital library heritage system to ensure dates for information doesn't expire 25/02/21 - TF requested to delete action					02/09/20 - Sally Sykes - Need to establish the nature of the links, responsibilities and management of versions and expiry dates, plus single point accountability on the clinical side. 25/02/21 - Part of the project and SoP refresh – delete action	**Deep Dive in progress**
S20	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.	17/07/2020	Director of Workforce	M&A Triumvirate Deputy director of OD	**Completed**	Review in 3 months' time 22/12/20 - EC has requested evidence from NM and SB	**Deep Dive in progress**
			2. M&A Division Managers to plan and allocate block of time to staff to complete mandatory training.	17/07/2020			**Completed**	Review in 3 months' time	**Deep Dive in progress**
			3. Identify staff non-compliant and any trends related to this and how this may be supported on an individual or team basis.	17/07/2020			**Completed**	Review in 3 months' time	**Deep Dive in progress**
			4. Improve mandatory training compliance to meet Trust standard of 90%.				Overdue	25/01/21 - Dec position 85.17% (improvement of 0.5% from November position)	**Deep Dive in progress**
S21	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.	Complete	Chief Nurse	M&A Triumvirate	**Completed & Assured**	Safe staffing report to Board	**Deep Dive in progress**
			2. Implemented daily staffing meetings conducted with the Senior nursing team to ensure safe staffing levels maintained as in line with the SSOT	Complete			**Completed & Assured**	Safe staffing report to Board	**Deep Dive in progress**
			3. Utilise NHSP as backfill for both vacancies and sickness.	Complete			**Completed & Assured**	Safe staffing report to Board	**Deep Dive in progress**

S22	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.	17/07/2020	Chief Nurse	Senior Nursing team	**Completed**	Evidence from Tracey Davies - e-roster	**Deep Dive in progress**
			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	17/07/2020			**Completed**	Evidence from Tracey Davies - e-roster	**Deep Dive in progress**
S23	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	01/09/2020	Chief Operating Officer	AHP Directorate Manager	**Completed**	01/09/20 - Tony Probbing - Staff rota currently utilised to review demand. Teams have been restructured into teams based on floors rather than speciality reducing the number of teams thus increasing the capability of the new larger teams to deal with short term sickness and annual leave. AHP leads working with Sue Heyes on a Joint nursing and AHP bits for improved e-roster offer. Paper submitted last week. 24/05/21 - working with HR team about ERoster	Deep Dive Completed

			2. Complete business case for resources required for consideration by trust management board.				**Completed**	29/09/20 - Business case has been submitted but not approved yet 25/11/20 - to allocate a trigger point for April/May, temporary funding has been provided, complete. **24/05/21 - AL to provide an update**	Deep Dive Completed
			3. Development of AHP staffing resource reporting via Trust 'BI Portal' to monitor referral to assessment time and other key metrics.	01/09/2020			**Completed & Assured**	01/09/20 - Tony Probbing -AHP BI portal now in place with live referral and activity numbers. This will be xref with E-roster once implemented.	Deep Dive Completed
S24	Medical - APH	The service should ensure that all patients have their care pathway reviewed by relevant staff and consultants, especially those on escalation wards.	1. Close ward 1 as escalation area.	Complete	Medical Director	AMD for Medicine	**Completed & Assured**	Ward 1 is closed	**Deep Dive in progress**
			2. Utilise opportunity presented by reduced demand due to COVID to stop admitting to outlier wards	Complete			**Completed & Assured**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			3. Increase weekend consultant cover to ensure all sick patients and potential discharges reviewed	Complete			**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
S27	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	Overdue	29/01/21 - Emma - continue to await IT support. Matron to develop working group to develop standardised documentation templates for interim	**Deep Dive in progress**
			2. Develop Options Appraisal regarding the development of a long term electronic process for care planning standardisation and assurance moving forward				Overdue	29/01/21 - Emma - continue to await IT support. Matron to develop working group to develop standardised	**Deep Dive in progress**

								documentation templates for interim	
S28	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	**Completed**	23.03.21- SB deadline for Division to submit operational priorities for 21/22 is 26/03/21. Trust planning a strategy session to review outputs from Division's strategy work in May. 15/07/21- Divisional strategy approved at Trust planning session	**Deep Dive in progress**
			2. Devise roll out plan to ensure effective communication and engagement with all staff				**Completed**	23.03.21- SB- Once all Trust level sign offs have occurred as per S28 1. Most recent update then it will be communicated with staff 15/07/21 Divisional strategy shared with management leads	**Deep Dive in progress**
			3. Develop plans to ensure implementation				**Completed**	29/09/20 - to be extended until March 5/07/21- Directorate Performance Reviews and Divisional performance reviews track progress against operational priorities derived from Divisional strategy	**Deep Dive in progress**

S29	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	Complete	Director of Workforce	M&A Triumvirate Director of Communications and Engagement	**Completed**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			2. Develop future leaders, with quality improvement skills, through utilising WUTH's Top Leader's Programme.	Complete			**Completed & Assured**	Awaiting updates from Triumvirate	**Deep Dive in progress**
			3. Establish registered nurse and Clinical Support worker forums to engage with staff group and encourage involvement with improvement and development work	25/08/2020			**Completed & Assured**	25/08/20 - NH - now completed and TOR has been completed - will forward to GSU	**Deep Dive in progress**
			4. Development of link nurse programmes to support awareness and involvement of staff in improvement and development initiates				Completed	29/01/21 - Link nurses identified for key subjects in ED - work streams to be agreed and tracked through nurse performance group 15/07/21- Covered in RN and CSW forum	**Deep Dive in progress**
			5. Establish schedule of away days which incorporate a focus on service improvement and development	17/09/2020			**Completed & Assured**	17/09/20 - NM - had away days and TOR saved	**Deep Dive in progress**
S30	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)	10/09/2020	Chief Nurse	Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC Divisional ADN	**Completed & Assured**	02/09/20 - Jay Turner - Gardner Matrons development plan has been introduced and the first session completed	Deep Dive Completed
			2. Increased auditing to be introduced including weekly ward manager hand hygiene audits, matrons in undertake twice monthly opposed to monthly in all	Complete			**Embedded**	Evidence can be obtained from Bi Portal	Deep Dive Completed

			clinical areas. (See M23)						
			3. Isolation area for patients presenting with infections incorporated in the new 3 stage recovery. (See M23)	Complete			**Completed & Assured**	25/11/20 - EC has asked for evidence from Jay Turner Gardner, TF and SH – evidence supplied	Deep Dive Completed
			4.'I am clean stickers' to be applied to all equipment following decontamination (See M23)	Complete			**Completed & Assured**		Deep Dive Completed
S31	Surgery	The service should continue to develop its surveillance of surgical site infections	As per CQC 'must do' action plan -M23	22/04/2021	Chief Nurse	Divisional ADN	**Completed and Assured**		Deep Dive Completed
S32	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.	22/07/2020	Director of Workforce/Chief Operating Officer	Divisional ADN	**Completed & Assured**	22/04/21 - Workforce meetings are back up and running	Deep Dive Completed
			2. Surgical Matron to hold staff surgeries enabling staff to discuss any work related concerns, professional development and progression.	22/07/2020			**Completed & Assured**	Meeting has been sent over for evidence from DE	Deep Dive Completed
			3. Continued promotion and awareness of Employee Assistance Programme. Use of Staff support group to provide themes for addressing.	22/07/2020			**Completed**	22/07/20 - on track, NF - new workplace dashboards to be rolled out 22/12/20 - EC has requested evidence from DE and PM	Deep Dive Completed
S33	Surgery	The service should review the reasons for the increasing turnover rates and vacancy rates for medical staff and develop a long term action plan	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.	05/10/2020	Medical Director	Divisional Director of Ops, Associate Medical Director	**Completed**	22/04/21 - Turnover rates are being monitored, all ward level vacancies have been filled, had a closer look at Colorectal. Still gaps for medical vacancies	Deep Dive Completed

								which are Junior level. Exit interviews have been sent for Colorectal staff that have left to go to either Theatre Recovery or SEAL because of complexity of ward. **To send any themes to Quality Board going forward. Can use intelligence from staff survey to drill down to areas.**	
			2. Short term gaps to be filled by additional hours where appropriate with agency staff	05/10/2020			**Completed**	05/10/20 - Complete - exception is when gaps aren't filled by O/T, NHSP or Agency in which case we flex roles to ensure safe staffing	Deep Dive Completed
			3. For persistent gaps, the division will skill mix and appoint Advanced Nurse Practitioners or Specialist Nurses.	27/11/2020			**Completed**	27/11/20 - PM - Workforce planning will follow job planning which will inform capacity and demand requirements. Any gaps will be assessed as to the clinical requirement and adverts made for appropriate clinicians. If we are unable to appoint, locums will be sourced to fill the gap until ANPs/SpNs can be appointed. In chronic pain the gap is covered by locums until we have skill mix signed off for advert. The Urology and EGS gap has been	Deep Dive Completed

								appointed to, but there are two gaps in Ophthal (one covered by a locum), one in colorectal and one pending in January for Upper Limb and Oral Surgery. These are deemed a Consultant only suitable so a SpN wouldn't suffice. We will be reviewing all specialties as part of the reinvigorated workforce plans, but the above is the current status.	
S34	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	Complete	Chief Nurse	Divisional ADN	**Completed & Assured**	Safety Huddle evidence	Deep Dive Completed
			2. Evaluate the pilot to ensure the standardised template meets the improvement objectives and is approved for roll out across the Division	22/07/2020			**Completed & Assured**	22/07/20 - introduced template and Med and Surg will review for Trust standard, DE - drew up evaluation sheet.	Deep Dive Completed
			3. Roll out of agreed standardised patient safety huddle template to be completed.	22/07/2020			**Completed & Assured**	22/07/20 - Ward Manager has assurance and working well, Matrons have been doing spot checks	Deep Dive Completed
S35	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.	22/07/2020	Chief Nurse	Divisional ADN	**Completed & Assured**	**22/04/21 - Regular automated reports of MUST outstanding have not been coming through so DE will check To be addressed at Quality Board**	Deep Dive Completed
			2. Compliance of fluid balance for specific patients to be undertaken	30/06/2020			**Completed & Assured**	Quality Strategy	Deep Dive Completed

			3. Nutrition and hydration fluid balance metrics to be reviewed as standing agenda item of nutrition and hydration working group	05/10/2020			**Completed & Assured**	DE - N&H Dashboard fluid balance metrics are ongoing, pulled from Bi Portal. **JR - split action into 2.** DE - each division to have a lead 05/10/20 - MUST 96-98% consistently month on month	Deep Dive Completed
			4. Trust wide compliance of fluid balance for specific patients to be undertaken	02/12/2020			**Completed**	Actions split into 3 **02/12/2020 - Audit completed – paper to be presented to PSQB in January 2021.**	Deep Dive Completed
			5. Each division to have a nutrition and hydration lead	26/02/2021			**Completed**	26/02/21 - DE - Completed	Deep Dive Completed
			6. Development of new hydration training package				**On track**	06/04/2021 - • QI project currently being developed corporately. Training matrix provided to the new QI lead. Anthony Probbing leading project.	Deep Dive Completed
			7 .Additional safety huddle to be undertaken at 15:00 to ensure that all identified actions have been completed.	22/07/2020			**Completed & Assured**	22/07/20 - taking place 3 times of the day and is documented, recorded session	Deep Dive Completed
S36	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)	26/02/2021	Medical Director	Associate Medical Director	**Completed & Assured**	25.02.2021 – Outcomes for improving patient outcomes are discussed at business meetings and both specialities work in conjunction with the cancer alliance for Cheshire and Merseyside to improve patient pathways and outcomes. Recent Workshops for	Deep Dive Completed

								both Cancer Groups pre COVID 22/04/21 - GIRFT reviews were positive Evidence provided	
			2. Review laparotomy audit results and associated action plan	25/08/2020			**Completed & Assured**	On audit forward plan	Deep Dive Completed
			3. Benchmark of Orthopaedic readmission from the national Joint Registry	14/01/2021			**Completed & Assured**	08/02/21 - Evidence has been saved	Deep Dive Completed
			4. Use of the laparotomy audit to identify areas of concern for General Surgery.	25/08/2020			**Completed & Assured**	On audit forward plan	Deep Dive Completed
S37	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.	26/02/2021	Chief Nurse/Medical Director	Divisional ADN	**Completed & Assured**	26/02/21 - Health promotion board ordered for day rooms and staff rooms. Theme for March 2021 is smoking cessation 02/03/21 - DE has sent over schedule 22/04/21 - Tied into national campaigns There is now a Quality Matron - Sarah Pickstock Can link in with population health	Deep Dive 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	31/01/2021			**Completed and Assured**	02/12/2020 - Matron Gassab is currently working on a health promotion programme for the division. Commencement has been delayed due to operational pressures and COVID-19. 31/01/2021 - Les Porter - Although Leaflets aren't the best solution at present we may need some in outpatient areas, however I believe that the link would be very helpful. Sally is adding in the NHS Better Health link to our patient facing website https://www.nhs.uk/better-health/ Evidence provided	Deep Dive Completed
S38	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.	22/07/2020	Chief Nurse	Divisional ADN	**Embedded**	04/05/21 - Go through expiry dates as part of safety huddle, to bring up at SAG meeting, to have a Trustwide audit. Kal Shaw - Trustwide audit already completed and is being monitored via perfect ward from Q1 now. It's all covered in my safeguarding Assurance reports to PSQB and safeguarding oversight reports in SAG.	Deep Dive Completed

S39	Surgery	The service should consider ways to make the surgical wards more dementia friendly.	1. Dementia lead identified for the division (Matron).	Complete	Chief Nurse	Divisional ADN Matron dementia	**Embedded**	Domingas Silverio	Deep Dive Completed
			2. Baseline audit and gap analysis to be undertaken to identify improvements required against national standards and development of an approved action plan.	04/05/2021			**Completed and Assured**	04/05/21 - Action plan is in progress by Sarah Pickstock along with Domingo - DE to send over to be monitored at Divisional Quality Board. Evidence provided	Deep Dive Completed
S40	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	05/10/2020	Director of Workforce	Surgery Triumvirate, Director of Communications and Engagement	**Completed and Assured**	05/10/20 - Complete - There is evidence of adherence to core values and managing poor behaviours. This can be seen in appraisals, investigations, Divisional Triumvirate monthly meetings, visits to clinical areas, Manager attendance and engagement at clinician meetings. 04/05/21 - To look at staff survey, values and behaviours can be reflected at divisional meetings. **Incidents can be used as evidence - Kath Brodbelt**. Safety culture can help with evidence too. Evidence provided	Deep Dive Completed

S41	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	01/04/2021	Director of Workforce	W&C Triumvirate	**Completed and Assured**	01/04/21- COVID measures have interrupted the delivery and attendance of face to face mandatory training, the training plan for 21/22 has been better adjusted to facilitate covid measures and should therefore increase compliance. The current overall position as of 15th March 2021 is that Children's directorate is at 96.96% compliant. 16/04/21 - minutes from Divisional Management meeting - DE to send over Evidence provided	Deep Dive Completed
			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.	12/02/2021			**Completed**	16/04/21 - Put on hold due to Covid, look in a couple of months, data goes to DMB	Deep Dive 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%.	23/09/2020			**Completed & Assured**	Anne-marie White - Attendance is mandatory & records are maintained by practice educators - staff don't choose when they attend, their attendance is allocated working in collaboration with ward managers and facilitated through ERoster.	Deep Dive Completed

			4. Send the training spreadsheets/compliance reports to CL's and CD's to action and oversee compliance with mandatory training.	25/08/2020			**Embedded**	25/08/20 – completed Divisional Dashboard	Deep Dive Completed
S42	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	25/08/2020	Chief Nurse	W&C Triumvirate, Associate Director of Nursing for Infection Prevention & Control/Deputy DIPC	**Completed & Assured**	25/08/20 - audits are being undertaken and improvement plan ongoing for neonates, exception reports that go to IPCG. More robust. Completed, GSU will look at perfect ward	Deep Dive Completed
			2. Divisional IPC Meetings with Nurse & Consultant IPC Lead to review IPC audits	25/08/2020			**Completed & Assured**	25/08/20 - taking place, minutes go to IPCG, anything of a concern is recorded	Deep Dive Completed
			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.	25/08/2020			**Completed & Assured**	25/08/20 - do record on all line infections, improved monitoring, compliance with ANNT is very good, DE to send over copy of dashboard.	Deep Dive Completed
			4. All staff to attend IPC mandatory training with review of compliance monthly to >90%.				Completed and Assured	06/04/21 - COVID measures have interrupted the delivery and attendance of face to face mandatory training, the training plan for 21/22 has been better adjusted to facilitate Covid measures and should therefore increase compliance. Report shows that level 1 compliance is green at 100% and level 2 is 88.43% compliance. Further focus indicated that the medical staff is	Deep Dive Completed

								pulling down the overall total. 3/07/21 - Infection control Level 1 and 2 is currently above 90% compliance	
			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.	25/08/2020			**Completed & Assured**	25/08/20 - in improvement plan	Deep Dive Completed
			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)	25/08/2020			**Completed & Assured**	17/09/20 - Anne-Marie White has sent over updated NNU CLABSI action plan	Deep Dive Completed
			7. Recruitment of a Practice Development Nurse Lead.	29/09/2020			**Completed and Assured**	Sarah Weston.	Deep Dive Completed
S43	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 continues to work towards meeting the national guidance on minimum cot space.	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 Estates	Overdue	16/04/21 - An neonatal options appraisal has been commenced at Arrowe Park which includes relevant stakeholders. The recommendations from this appraisal will be submitted to the Medical director/exec board. Await outcome of review. The storage of equipment has improved since the last inspection, minimised which equipment is needed.	Deep Dive Completed

			2. Weekly audit of equipment checklist in PAU to ensure compliance.	21/07/2020			**Completed & Assured**	21/07/20 - Complete, GSU has obtained audit from Bi Portal	Deep Dive Completed
			3. Undertake a review of stock requirements and ensure only stock required is located on wards to enable effective storage	Complete			**Completed & Assured**	14/12/20 - EC has requested evidence from NP, DE and Anne-Marie White for this to be embedded – evidence supplied	Deep Dive Completed
S44	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	Complete	Chief Operating Officer	W&C Triumvirate	**Embedded**	16/04/21 - Confirmed at check and challenge meeting that is still being sustained	Deep Dive Completed
			2. Ensure all staff are aware that the adult defibrillator is stored for use on Delivery Suite in the event of an adult collapse.	Complete			**Embedded**	16/04/21 - Confirmed at check and challenge meeting that is still being sustained	Deep Dive Completed
S45	Children's and young people's services	The service should seek to fill medical vacancies within the neonatal department.	1. Undertake a review with Neonotal ODN to identify future service models		Director of Workforce/Medical Director	W&C Triumvirate	Completed	16/04/21- External review recommended 7 Consultants in place to keep it safe which are in place, currently reviewing job planning and Neonatal service review. 13/07/21 - Request evidence from Medical Staffing	Deep Dive Completed
			2. Review of MTI workforce to ensure full compliance with competencies and training compliance.	12/02/2021			**Completed**	29/09/20 - Active work ongoing 17/11/20 - being looked at	Deep Dive Completed
			3. Review of ANNP workforce and ensure clear progression to Tier 1 and Tier 2 Medical staff rotas.	12/02/2021			**Completed**	17/11/20 - DE - reviewed a different model of workforce - will send email to Execs and will	Deep Dive Completed

								add to Board report Consultancy coming in, MTI workforce all up to speed up to Tier 2	
S46	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	29/09/2020	Chief Nurse/Medical Director	Divisional Pharmacist Lead	**Completed and Assured**	29/09/20 - Neil Caldwell, improvement plan has been developed - will send over Evidence provided	Deep Dive Completed
			2. Spot Check and Audits to be undertaken to review compliance with expectations for medication administration via Perfect Ward	01/09/2020		W&C Triumvirate	**Completed**	**16/04/21 - Medicines audit, CD that goes to MSOP - Julie Simms Pharmacy**	Deep Dive Completed
			3. Standardise the process for managing medication incidents across neonatal and children's services	01/09/2020			**Completed & Assured**	04/12/20 - Anne-marie White has sent Neonatal and Acute paediatric CIF attendance sheets that demonstrate that ward managers from different teams have attended alternative team's CIF meetings. The rationale behind this was to standardise the process of managing medication incidents.	Deep Dive Completed
			4. Embed the PCIF into the medication incident investigations	29/09/2020			**Completed**	**29/09/20 - Neil Caldwell, improvement plan has been developed report monthly at DMB.**	Deep Dive Completed
			5. Encourage medical trainees & junior nurses to attend CIF meeting to encourage reporting incidents & embed systems approach to incident management	01/09/2020			**Completed & Assured**	01/09/20 - Attendance is recorded which will better demonstrate MTD and junior staff	Deep Dive Completed

S47	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	29/09/2020	Chief Nurse/Medical Director	W&C Triumvirate/Governance Lead	**Completed & Assured**	29/09/20 - gap analysis has been undertaken and plan went to governance - will send over Evidence provided	Deep Dive Completed
			2. Establish monthly CG Meeting with attendance from all areas to ensure sufficient engagement and effective implementation of improvement plan	29/09/2020			**Completed & Assured**	16/04/21 - still being met, Clinical Effectiveness Committee	Deep Dive Completed
S48	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)	12/02/2021	Chief Nurse/Medical Director	Directorate Lead for QI project	**Completed**	12/02/21 - report has all admissions on weekly basis 16/04/21 - to be on forward audit plan, nothing has been flagged	Deep Dive Completed
			2. Development of epilepsy passport to support with epilepsy management	12/02/2021			**Completed & Assured**	12/02/21 - There is a paper version of the epilepsy passport available at the moment	Deep Dive Completed
S49	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.	25/08/2020	Medical Director	W&C Triumvirate in conjunction with ED	**Completed & Assured**	16/04/21 - Children and young people's voices partnership has been set up and part of STP work. Evidence provided	Deep Dive 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	25/08/2020			**Completed**	**16/04/21 - setting up of task and finish group for incidents that have been received**	Deep Dive 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 '	25/08/2020			**Completed & Assured**	16/04/21 - to be on forward audit plan. Evidence provided	Deep Dive Completed

S50	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	31/07/2020	Chief Nurse	Deputy nurse W&C Triumvirate	**Completed & Assured**	12/02/21 - temperature check audit undertaken back in July for service users, did not want a voice of the child group, interested in social media, snapshot audit to be sent over	Deep Dive Completed
			2. Fabio Frog (patient feedback tool) will be further utilised to inform improvement plan including COPD as an area of consideration.	17/11/2020			**Completed**	17/11/20 - DE - not seen any reports for PFEG but has gone live. Will complete, **DE to send over evidence**	Deep Dive Completed
			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	16/04/2021			**Completed**	**16/04/21 - A report is being completed to be addressed at PFEG and Anne-Marie will send over evidence**	Deep Dive Completed
S51	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	Complete	Chief Operating Officer	W&C Triumvirate	**Completed & Assured**	Evidence confirmed at confirm and challenge	Deep Dive 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	Complete			**Completed & Assured**	Evidence confirmed at confirm and challenge	Deep Dive Completed
			3. Ensure specific information and directions are detailed in the entrances for children and that this is child friendly				Overdue	06/04/21 - Estates have been contacted to request support and contact with signage company however due to Covid works the response has been delayed.	Deep Dive Completed

S52	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	16/04/2021	Chief Nurse	ADN for Children's Service W&C Triumvirate	**Completed**	06/04/21 - TWISCH meetings have been postponed due to 2nd surge of Covid, the team has been increased by 0.4 WTE this has been enabled by review of current vacancies within current establishment, the team are also in the process of further increasing by 0.32 WTE, some support is now being offered to other children's outpatient services across the trust.	Deep Dive Completed
S53	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.	12/02/2021	Chief Nurse	ADN for Children's Service W&C Triumvirate	**Completed & Assured**	12/02/21 - completed, to be sent over Evidence supplied	Deep Dive Completed
			2. Ensure those area leads are involved in TWISCH to ensure that such areas are child focused.	29/09/2020			**Completed**	**16/04/21 - Ophthalmology and Max Fax - Surgery**	Deep Dive Completed
			3. Ensure attendance by all divisions at TWISCH meeting.	29/09/2020			**Completed**	No evidence supplied	Deep Dive 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	29/09/2020			**Completed**	29/09/20 - Gap analysis has been done and going to TWISCH for updates but some gaps are being taken outside of meeting. Meeting feeds into Children's governance meetings and any issues escalated to PSQB. Awaiting evidence.	Deep Dive Completed

S54	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	16/09/2020	Chief Nurse	ADN for Children's Service W&C Triumvirate Deputy chief nurse	**Completed**	**16/04/21 - SEND work, check with TF and Sally-Sykes. Awaiting evidence.**	**Deep Dive in progress**
			2. IT to undertake a review of the ethnic minority/languages spoken by service users in determining which languages to use for the translated documents. 25/02/21 - TF requested to delete action					17/11/20 - TF - ISS group, ask for a breakdown of translation services, new provider, looking at sub contract, JR and TF to reword action to receive feedback - PFEG	**Deep Dive in progress**
S55	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.	Complete	Medical Director/Chief Nurse	W&C Triumvirate	**Completed**	No evidence supplied	Deep Dive 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.	29/09/2020			**Completed**	29/09/20 - no business case yet but is identified, includes ED too. Will feed into PSQB. Take out this action to be changed for standardised pathways	Deep Dive Completed
			3. Risk Register to be utilised to ensure oversight of non-compliance of Division.	29/09/2020			**Completed**	Evidence not supplied	Deep Dive 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.	29/09/2020			**Completed**	29/09/20 - DE - 80% compliance, looking at improvements in handovers. JL - spoken to RM, standard SOPS designed by Consultants and tick box pathways standardising care for children that don't need 14 hour reviews.	Deep Dive Completed
			5. Ensure changes to the rota to support compliance - where this is not possible review risk of non-compliance and	29/09/2020			**Completed**	Evidence not supplied	Deep Dive Completed

			ensure on the Divisional Risk Register for review and monitoring						
S56	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	21/07/2020	Chief Nurse	Associate Director of Nursing for Safeguarding	**Completed & Assured**	21/07/20 - links in with safeguarding Helen Brislen, SAG committee, reports are quarterly. GSU to link in with safeguarding for assurance. Delays can come from social care but is being monitored. Safeguarding report PSQB	Deep Dive Completed
			2. Development of live dashboard to provide real time assurance	21/07/2020			**Completed & Assured**	25/08/20 - Safeguarding report PSQB	Deep Dive Completed
S57	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	17/11/2020	Chief Operating Officer	W&C Triumvirate	**Completed & Assured**	17/11/20 - updated transition policy, a bid for funding for transitional nurse, linking with LD nurse.	Deep Dive Completed
			2. Review of Transition Policy at AHCH to identify good practice and gaps in service provision at WUTH.	17/11/2020			**Completed & Assured**	17/11/20 - complete in new policy and involves local authority. Being ratified at Policy Review Group - Feb	Deep Dive Completed
S58	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	See actions for S50/51	Chief Nurse	W&C Triumvirate	**Completed & Assured**	16/04/21 - Strategy has been revised, links to Children's voices partnership group	Deep Dive Completed
S59	Children's and young	Children and young people services should ensure all staff have an	1. Staff to have increased awareness of FTSU guardians and training	07/09/2020	Director of Workforce	W&C Triumvirate	**Completed & Assured**	**DE can send divisional training compliance**	Deep Dive Completed

	people's services	understanding of and know how to access guardians such as freedom to speak up and Caldicott.	2. Ensure actions from 2019 cultural survey are implemented and evaluated	25/08/2020			**Completed & Assured**	07/09/20 - Chris Lloyd has sent over dates of culture sessions and a summary - see email 14/09/20 - Anne-marie White - Neonates do have a record of attendance if needed	Deep Dive Completed
S60	Children's and young people's services	On h	1. Undertake audit of compliance with the sepsis pathway	17/11/2020	Medical Director	W&C Triumvirate	**Completed & Assured**	17/11/20 - audit has been undertaken, to be sent over. Evidence provided	Deep Dive Completed
			2. Develop an electronic version of the Sepsis pathway on Cerner				**Completed and Assured**	17/11/20 - in testing domain, look to include in Sepsis dashboard 12/02/21 - On hold due to Covid. Is now on CERNER and evidence provided	Deep Dive Completed
			3. Child health representation on Trust wide Sepsis steering group	Complete			**Completed**	16/12/20 - Paula Clare - This has not been happening during covid but it is in our plans for the New Year.	Deep Dive Completed
S61	Surgery	The service should follow standard operating procedures when using cleaning products	1. Install COSHH cupboards in treatment room / laser room	Complete	Chief Nurse	Divisional AD N	**Embedded**	Perfect Ward 04/05/21 - Not had any issues with PPE, COSHH and risk assessments are up to date	Deep Dive Completed
			2. Ensure guidance displayed for suitable PPE and training given to those who utilise it	Complete			**Embedded**	Perfect Ward	Deep Dive Completed
			3. Product representative to attend unit for training	Complete			**Embedded**	Evidence supplied	Deep Dive Completed
S62	Outpatients	The service should continue to maintain paper record security whilst in the main	1. Communicate with staff to remind them of their responsibilities in regards to security of patient records whilst working towards becoming paperless.	Complete	Director of IT and Information	OPD Manager	**Completed & Assured**	Look at CAG 24/05/21 - moved to paperless outpatients	Deep Dive Completed

		outpatient department	2. Establish paperless outpatient project group to reduce reliance on paper records within the Outpatient Department.	Complete			**Completed & Assured**	Outpatient Transformation Action Log	Deep Dive Completed
S63	Surgery	The service should consider installing a hearing loop at the ear, nose and throat clinic	1. Install additional hearing loop in clinic	Complete	Chief Nurse	Divisional ADN	**Embedded**	Completed 04/05/21 - Now embedded	Deep Dive Completed
S64	Surgery	The service should follow trust process for maintaining equipment in ophthalmology.	1. Review PAT testing schedule in line with electrical safety guidelines.	26/08/2020	Chief Operating Officer	Director of Estates & Facilities	**Completed & Assured**	04/05/21 - Sister has a folder and record of all PAT Testing, stored locally in the unit.	Deep Dive Completed
			2. Develop and maintain an equipment record, including PAT testing information, and store locally	26/08/2020			**Completed & Assured**	19/08/20 - DE - PAT testing is in place, all equipment is listed in book, JR - all areas to do the same	Deep Dive Completed
			3. Alert estates to any due PAT testing	26/08/2020			**Completed & Assured**	SOP and Policy has been provided	Deep Dive Completed
S65	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.	01/09/2020	Chief Operating Officer	Surgery / D&CS Divisional Director	**Completed & Assured**	01/09/20 - action plan goes to programme board **24/05/21 - to send to Surgery**	Deep Dive Completed
S66	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.	29/09/2020	Chief Operating Officer	OPD Manager Estates	**Completed & Assured**	24/05/21 - confirmed assured	Deep Dive Completed

S67	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.	Complete	Chief Operating Officer	Radiology services manager Health & Safety	**Embedded**	24/05/21 - Confirmed all labels have been placed on equipment, Health and Safety monitoring for ongoing checks to ensure stickers stay on.	Deep Dive Completed
S68	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.	28/07/2020	Chief Nurse	Radiology services manager	**Completed & Assured**	24/05/21 - no children wait in waiting room, they go straight into the rooms as they are prioritised. **A SOP to be created for evidence.**	Deep Dive Completed
S69	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.	Complete	Chief operating officer	Radiology services manager	**Completed & Assured**	24/05/21 - part of health and safety checklists, HC to develop local Health and Safety meetings in Radiology for review of checks for each of the modalities so they are escalated. Currently they are escalated in real time but need to ensure this is written on the checklist.	Deep Dive Completed
S70	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.	Complete	Chief Nurse	Radiology services manager	**Embedded**	24/05/21 - Undertaken a review, had no causes of concern so happy with structure. Didn't feel there was a need for band 7s overnight.	Deep Dive Completed

S71	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	**On track**	24/05/21 - changing rooms have been risk assessed however this action is no **to be reviewed, part of broader plan, looking at infrastructure**	Deep Dive Completed
			2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal.	28/07/2020			**Embedded**	28/07/20 - completed, document available via Cerner template 14/01/21 - EC has asked the Complaints team if any complaints have been received	Deep Dive Completed
S72	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	29/09/2020	Medical Director	Radiology services manager	**Completed & Assured**	29/09/20 - send emails to all staff and in safety huddles which have formal agendas - can provide this. For new staff will have to add on local induction form. 24/05/21 - don't consent for children, in newsletters	Deep Dive Completed
S73	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	22/12/2020	Chief Nurse/Medical Director	Radiology services manager	**Completed & Assured**	22/12/20 - SOP for the QA programme has been sent by LN which will commence the first week of January 24/05/21 - Quarterly report is presented at clinical governance meeting	Deep Dive Completed

S74	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	28/07/2020	Chief Nurse/Chief Operating Officer	Radiology services manager, Health & Safety	**Completed**	24/05/21 - Do have CCTV camera in MRI waiting room which has 2 monitors, 1 in Reception office and other in control room. There are signs which inform patients of this.	Deep Dive Completed
S75	Diagnostics	The diagnostic imaging service should consider how it can improve the privacy and dignity for patients in the CT changing/inpatient waiting area.	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)	25/11/2020	Chief Nurse/Chief Operating Officer	Radiology services manager, Divisional ADN Health & Safety, Estates	**Completed & Assured**	25/11/20 - telling patients via letter, LN - looking at relocating Ultrasound department but will be a long term solution subject to funding. LN - Action to be redrafted for a proposed change and then can be closed. No complaints have been received.	Deep Dive Completed
			2. Amend appointment letters to include instruction for patients to attend the department wearing appropriate clothing which does not contain metal. (See S71)	28/07/2020			**Embedded**	28/07/20 - completed, document available via Cerner template 12/01/2021. There is nothing around CT in there; just 2 incidents reported which are different areas completely.	Deep Dive Completed
S76	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.	Complete	Chief Nurse	Radiology services manager	**Completed & Assured**	24/05/21 - do have an active programme and have advanced radiographers, list of people that do report, do have highest rate of reporting in region	Deep Dive Completed

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: BM21/22-112

BOARD OF DIRECTORS
4 August 2021

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

Executive Summary

The RN band 5 vacancy rate has reduced further to 11.47% (M3) due to the benefits of the International Recruitment Programme. The international nurses previously delayed due to the travel restrictions have now arrived in the Trust, and will sit the Objective Structured Clinical Examination (OSCE) in August.

The Trust has commenced local RN recruitment utilising the "We are WUTH" branding across a number of channels to further reduce RN vacancies. The Trust is also currently recruiting cohort 11 (16 nurses) as part of the Pan Mersey Collaborative International Recruitment Programme in line with agreed plans.

CSW sickness has reduced slightly enabling the Trust to maintain fill rates for CSW at 100% days and 98% for nights with the additional support of NHSP staff.

2 shifts had a professional judgement of red in M3 (risk of care standards falling below expected levels) despite additional mitigations being put in place.

3 falls resulting in harm occurred when Ward 38 had less than expected levels of RN staff. These shifts were also supported by an additional CSW and a supernumerary international nurse.

In M3 there was an increase in the number of incidents reported that related to midwifery staff shortages. All incidents have been reviewed to ensure escalation policies have been followed.

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	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)
BAF references 1,2,4,6. Positives. • RN vacancies have reduced to 11.47% • Local RN recruitment planned for July / August • CSW fill rate 100% days , 98% nights • RN sickness has reduced • International recruitment plans are progressing as planned following lifting of flight restrictions. Gaps. • 2 shifts had a professional judgement of red in M3 • 3 falls resulted in harm in M3 on shifts with lower than expected staffing levels • There has been an increase in the number of maternity incidents in M3 • There is an increase in the number of staff isolating due to COVID community prevalence rising.
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	

BOARD OF DIRECTORS
4 August 2021

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 RN band 5 vacancy rate has reduced to 11.47% (M3) due to the benefits of the International Recruitment Programme.

The 42 nurses previously delayed due to the travel restrictions have now arrived in the Trust, these nurses have now commenced their training programme. They will take the Objective Structured Clinical Examination in August 2021.

Further cohorts of international nurses are expected to arrive in August, September and October 2021. Numbers will depend on the approval of visa applications and the ability to secure flight bookings however the earliest dates are being sourced.

The Trust has also commenced local RN recruitment utilising the “We are WUTH” branding. Advertisements will be shared in local newspapers, social media and other channels from mid-July through to mid- August 2021. This will be evaluated for impact.

The Trust utilised an increased number of agency nurses on Ward 18, AMU, Ward 33 and Ward 38 during the month to bridge the gap caused by the delays in the International Recruitment Programme.

In M3 there was an increase in the number of incidents reported that related to midwifery staff shortages and an increase in the number of births booked is causing pressures on maternity services across the region. Midwifery staffing is being monitored daily and plans are in place both locally and regionally (NHSE) to monitor impact. NHSE are leading weekly Situation Report Meetings and providing enhanced scrutiny of divert processes.

1.2 Sickness

RN sickness has reduced overall to 5.51% (M3) from 5.92% (M2).

CSW sickness has reduced slightly to 9.89% (M3) from 10.04% (M2).

A total of 688 nursing (325) and CSW (363) staff have reported episodes of sickness during M3.108 episodes are relating to long term sickness such as malignancy, stress, musculoskeletal or respiratory illness.

All divisions have held focused sickness clinics in M3 supported by HR colleagues to ensure sickness is managed in line with policy. The number of staff on long term sickness continues to decrease as a result. Health and wellbeing initiatives continue along with the Staff Support Team to provide on-going reassurance and support to staff.

Despite CSW sickness the Trust has been able to maintain fill rates for CSW at 100% for days and 98% for nights due to the improvements in CSW vacancies over previous months and improved NHSP CSW fill rates.

The Trust has seen an increase in staff isolating following an increase in community COVID prevalence creating greater challenges maintaining staffing levels due to higher numbers of short notice absence.

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M3 the SSOT reported the number of shifts that fell below minimum RN staffing levels as 446 a slight increase on 427 (M2). In M3, 2 shifts were assessed by the Senior Nursing Team as a professional judgement of red (high risk of care standards falling below expected levels). These shifts related to lower than expected staffing with a higher than expected acuity of patients (1 shift on Ward 22 and 1 shift on Ward 27). On review, there were delays in care but no reported moderate or serious harm to patients during these shifts.

1.4 Impact on Care

19 falls occurred in M3 when staffing levels were less than expected. 3 falls resulted in harm on Ward 38 when the ward was experiencing high acuity running 2 high visibility bays for patients known to be high risk of falls.

On review of the 3 falls incidents, 1 RN lower than expected was reported each shift. An additional supernumerary international nurse and additional CSW were noted to working on the area to alleviate the risk.

Serious incident investigations are underway to identify learning points.

Ward 26, Ward 32 and Ward 18 saw an increase in the number of episodes where care standards fell below expected levels.

- Ward 26 was due to an increase in acuity levels and the impact of short term sickness.

- Ward 32 was due to challenges covering late sickness/absence.

- Ward 18 related to high vacancies and long term sickness gaps, these have been supplemented with agency staff in anticipation of international nurses commencing on the ward in August and September 2021.

2. Actions to mitigate risks

The Trust is also currently recruiting cohort 11 (16 nurses) as part of the Pan Mersey Collaborative International Recruitment Programme in line with agreed plans. Full oversight of the International Recruitment Programme will be reported to the Workforce Assurance Committee in September 2021.

The Trust is progressing with the "falls coaching collaborative" as part of the overarching Quality Improvement Programme. The project has agreed aims and an approved driver diagram, improvement work is expected to commence from August 2021. The falls QI work is overseen by Programme Board, a recent update was provided to Programme Board on 21 July 2021.

3. Maternity staffing.

In M3 there was an increase in the number of incidents reported that related to midwifery staff shortages. In M3 the Trust had 6% (7.7 WTE) midwife vacancies; all have been recruited to and are going through recruitment processes. Sickness for M3 was noted at 8.73% for the Women's and Children's Division, and COVID isolation was reported at 2.72%.

To fill gaps incentives are in place for staff as well as a pool of staff recruited to NHSP that are now picking up regular shifts; sickness is managed in accordance with WUTH policy and monitored through divisional sickness clinics held monthly.

There has been a steady increase in the number of maternity bookings towards the end of 2020. This increase is anticipated to impact on the birth rate and also acuity on the Maternity Unit.

In addition number of women requiring induction of labour in line with the current NICE guidance (2008) has increased. This is due to due an increase of women within society that have complex needs such as raised BMI, gestational diabetes mellitus or a small gestational age foetus. Monthly statistics are currently reporting figures of 38-42%, this is a steady increase in line with national improvement requirements such as CNST and Saving Babies Lives 2 which have been successfully implemented at WUTH. This is having a significant impact on both workload and acuity. Midwifery staffing is being monitored daily and plans are in place both locally and nationally (NHSE) to monitor impact. NHSE are leading weekly Situation Report Meetings and providing enhanced scrutiny of divert processes.

On review 21 incidents were reported in M3 compared to 11 incidents in M1 and 8 incidents in M2.

From the incidents reported in M3

- 5 incidents identified the escalation process were followed accordingly and safely to continue to provide care with no divert/closure required.
- 4 of the incidents related to inter unit transfer requests, on review these were not deemed appropriate at the time of request due to acuity and to maintain safe staffing levels. For all cases the decision was made with inclusion of both the obstetric and neonatal consultant as policy.
- 9 incidents reported a delay of induction of labour as the cause; these incidents are reviewed daily on the maternity unit by the Multi-Disciplinary Team assessing any potential harm and action required. For these incidents all patients had foetal monitoring and safe observations whilst the delays occurred.

The remaining incidents were noted to be duplicated incidents.

4. Conclusions

M3 was noted to be an increasingly challenging month for staffing in both adult and maternity services due to increased patient acuity, sickness and staff absence due to staff isolating because of the increase in COVID community prevalence.

These challenges have led to increase in the number of incidents such as falls with harm and delays in induction of labour.

All areas have mitigations in place through the use of enhanced staffing monitoring, escalation processes, NHSP, agency staffing and sickness monitoring processes. In addition successful recruitment initiatives remain on-going.

Despite mitigations, M4 is expected to have increased staffing challenges due to the rising community COVID prevalence. This is expected to increase staff absence further and create an increase in acuity due to increased births, increased positive COVID cases and a rise in RSV cases that is also predicted in the forthcoming months. Resilience planning is on-going locally and regionally to ensure plans are in place ahead of the predicted pressures over the forthcoming months.

4. 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 - 2021/2022													
Data Source	Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total		9.6	8	8.5	10.1	9.5	8.1	8.9	9	8.7	8.3	8.8	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses		4.8	3.8	4.1	5.2	4.8	4	4.3	4.4	4.1	4.1	4.4	
Corporate Nursing	Care Hours Per Patient Day - CSW's		4.2	3.5	3.7	4.1	3.8	3.4	3.7	3.8	3.5	3.5	3.6	
Corporate Nursing	Number of ward below 6.1 CHPPD		0	2	0	0	0	1	1	0	1	4	1	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	79%	81%	83%	84%	83%	84%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	86%	91%	91%	92%	93%	100%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	77%	84%	78%	84%	80%	82%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	95%	71%	101%	98%	99%	98%	
Informatics	Trust Occupancy Rate	57.20%	66.90%	79.50%	79.50%	76.10%	79.30%	83.50%	80.20%	80.80%	81.40%	83.90%	82.30%	
Informatics	Occupancy Rate - APH	63.10%	72.10%	81.50%	79.10%	76.00%	80.30%	82.30%	80.30%	83.50%	83.90%	86.70%	85.00%	
Informatics	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	50%	50%	52%	55%	55%	53%	
Workforce	Vacancy Rate (Band 5 RN's)	18.46%	18.05%	16.94%	16.61%	17.66%	18.10%	19.42%	18.81%	18.57%	15.92%	13.97%	13.10%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.57%	20.16%	18.73%	17.11%	17.72%	18.49%	19.89%	19.01%	17.92%	15.35%	12.59%	11.47%	
Workforce	Vacancy Rate - All RN (All grades)	9.81%	9.90%	9.40%	8.67%	9.79%	9.57%	10.79%	10.03%	9.69%	8.26%	7.47%	7.15%	
Workforce	Vacancy Rate (CSW's)	5.89%	5.86%	7.86%	7.77%	8.11%	6.28%	6.79%	5.94%	5.97%	5.82%	2.99%	3.08%	
Workforce	Sickness Rate - RN	5.69%	6.12%	6.38%	6.80%	6.95%	6.49%	9.17%	7.14%	6.01%	5.96%	5.92%	5.51%	
Workforce	Sickness Rate - CSW	10.46%	9.58%	10.09%	8.82%	7.59%	8.18%	12.34%	9.47%	8.11%	8.46%	10.04%	9.89%	
Workforce	Absences Rate - RN	4.84%	2.36%	2.60%	1.55%	1.76%	1.50%	2.39%	1.78%	2.24%	0.07%	0.03%	0.30%	
Workforce	Absences Rate- CSW	4.96%	3.33%	3.17%	1.55%	2.17%	1.56%	2.64%	2.71%	2.47%	0.05%	0.14%	0.50%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	0	0	0	0	0	2	
Corporate Nursing	Number of RN Red Shifts *		359	445	454	243	499	689	330	383	323	427	446	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	26	36	16	16	21	19	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	0	1	1	0	0	3	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	2	1	27	2	2	1	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	1	2	0	0	1	2	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	33	6	14	14	9	4	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	38	2	3	1	10	2	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	119	34	41	42	71	57	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	278	31	126	75	248	74	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	237	72	286	90	226	120	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	46	23	58	15	43	44	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	299	88	193	55	199	79	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	1	1	0	1	0	0	0	
Corporate Nursing	Total Number of staffing incidents	30	53	80	75	25	90	102	42	57	48	93	80	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	0	1	0	0	1	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	1	0	1	0	0	1	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	0	0	0	1	1	
Corporate Nursing	Staff Moves		232	329	140	164	172	606	337	337	288	341	302	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	43952	35299	34182	24465	24192	24382	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	42759	33056	30218	24122	24171	23421	
NHS Professionals	% of requested filled RN's	67.80%	62.80%	61.70%	60.20%	72.70%	58.90%	57.50%	54.60%	62.80%	64.50%	68.22%	65.90%	
NHS Professionals	% of requested CSW filled	86.30%	80.20%	76.50%	71.10%	85.30%	68.10%	62.80%	68.00%	75.00%	77.60%	84.20%	86.20%	
NHS Professionals	% of Agency staff used RN	3%	3%	3%	2%	6%	1%	2.30%	7.00%	7.00%	5.00%	1.70%	4.80%	
NHS Professionals	% of Agency staff used CSW	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

** The National Safe Staffing submission reports the total actual hours filled against the agreed funded establishment. RN Red shifts are defined as shifts that are below both the agreed funded establishment and below the agreed minimum staffing model.*

*Blue text denotes where an amendment to the previous figures has been made following a review of establishment figures. These figures are correct at the time of the divisional sign off process at the beginning of each month for the retrospective month

Agenda Item: BM21/22-113

BOARD OF DIRECTORS
4th August 2021

Title:	Infection Prevention and Control Annual report 2020-21
Responsible Director:	Hazel Richards, Chief Nurse / Director of Infection Prevention and Control (DIPC)
Author:	Jay Turner-Gardner, Associate Director of Nursing - Infection Prevention & Control / Deputy DIPC
Presented by:	

Executive Summary

The purpose of this Annual report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2006, (updated 2008, 2012 and 2015): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code).

In early March 2020, in response to the spread of the COVID-19 virus across the world, the NHS declared a Level 4 incident. As such the NHS was placed in a "command and control" environment, where all activity was directed from NHSE / NHSI Incident Management Team. Regional and Trust level incident command structures were established to co-ordinate the response to the pandemic and oversee all daily functions including the centralisation of governance, the development and delivery of a COVID clinical model, the reconfiguration of wards and beds, the expansion of staff wellbeing systems and the reduction of elective surgery and transformation of outpatients.

During this time the IPC team along with the wards and departments worked tirelessly to promote the health, safety and well-being of not only patients and visitors but also themselves in order to deliver clean, safe and effective care.

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and best.

The Trust has now started to report its quarterly mandatory laboratory data for the first time since 2015 and the surgical division has developed a surgical site infection surveillance strategy, which includes an increase in their SSI surveillance frequency.

The Infection Prevention team has enrolled in a quality improvement project to take proactive action to sustain and maintain the improvements in 2020/21 particularly as COVID rates reduce. This requires a review of the successful work undertaken during COVID in order to embed this good practice across the Trust to promote continuous improvement and reduction in our infection rates.

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

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Risk 609- Patients may acquire COVID-19 during inpatient stay. RATE 5 Risk 798 - Current vacancies within the Infection Prevention team will impact on the Trust wide IPC support that is available. RATE 8 Risk 799 - Outbreaks of COVID-19. RATE 6
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC essential standards Compliance to the Hygiene code.
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
None
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

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

BOARD OF DIRECTORS MEETING IN PUBLIC

Infection Prevention and Control Annual report 2020-21

Purpose

This report provides information regarding the Infection prevention and Control activities of WUTH within the last year.

Introduction / Background

The purpose of this Annual report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2006, (updated 2008, 2012 and 2015): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code).

Conclusions

During this time the IPC team along with the wards and departments worked tirelessly to promote the health, safety and well-being of not only patients and visitors but also themselves in order to deliver clean, safe and effective care during the COVUD pandemic.

As a result of this hard work we have seen a dramatic reduction in many of the mandatory reportable Infections for the first time in several years

Recommendations to the Board

For noting

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2020/2021

Contents

1.0 Executive Summary

The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2006, (updated 2008, 2012 and 2015): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code).

In early March 2020, in response to the spread of the COVID-19 virus across the world, the NHS declared a Level 4 incident. As such the NHS was placed in a "command and control" environment, where all activity was directed from NHSE / NHSI Incident Management Team. Regional and Trust level incident command structures were established to co-ordinate the response to the pandemic and oversee all daily functions including the centralisation of governance, the development and delivery of a COVID clinical model, the reconfiguration of wards and beds, the expansion of staff wellbeing systems and the reduction of elective surgery and transformation of outpatients.

During this time the IPC team along with the wards and departments worked tirelessly to promote the health, safety and well-being of not only patients and visitors but also themselves in order to deliver clean, safe and effective care.

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and best.

In spite of the challenges that COVID has brought this year we have reduced the rate of *Clostridium difficile* infections by 30%, this is a reduction of 27 from the previous year and is an outstanding achievement.
There has been a dramatic reduction in gram negative bacteraemia this year; reporting 59 cases which was a reduction of 32 (35%) compared to 2019/20 finishing the year 18 cases under trajectory. This is the first year we have achieved our target figure.
Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 2 MRSA bacteraemia in 2020/21 which is an increase of 1 on the previous year. There is no national objectives for MSSA bacteraemia and no local initiatives however the trust reported 18 in 2020/21, this was a reduction of 25% from the previous year, and CPE bacteraemia remain stable.

The Trust has now started to report its quarterly mandatory laboratory data for the first time since 2015 and the surgical division has developed a surgical site infection surveillance strategy, which includes an increase in their SSI surveillance frequency.

The Infection Prevention team has enrolled in a quality improvement project to take proactive action to sustain and maintain the improvements in 2020/21 particularly as COVID rates reduce. This requires a review of the successful work undertaken during COVID in order to embed this good practice across the Trust to promote continuous improvement and reduction in our infection rates.

In conclusion, I would like to acknowledge the hard work of the IPT and the divisions; together we have shown commitment in the delivery of excellent infection prevention practices by managing our infection risks together in a caring and competent manner. Over the next 12 months we will continue to work hard and keep a focus on prevention of infections and compliance with good working practice collaborating with partners across the whole health economy.

Hazel Richards,
Chief Nurse/Director of Infection and Prevention and Control (DIPC)

2.0 Description of Infection Prevention

2.1 Nursing Team

The Chief Nurse / DIPC has overall responsibility for the Infection Prevention Team, which is in the Corporate Nursing Directorate.

Jay Turner-Gardner, Associate Director of Nursing / deputy DIPC, is managed by and professionally accountable to the DIPC and deputises in her absence for matters relating to Infection Prevention.

The Band 8a Infection Prevention Matron has managerial responsibility for the Infection Prevention Team.

The Infection Prevention Nursing Team establishment consists of:

- 3 x band 7 (3.0 WTE) Senior Infection Prevention Specialist Nurses.
- 3 x band 6 (3.0 WTE) Infection Prevention Specialist Nurses
- 1 x band 5 (1.0 WTE) Analyst
- 1 x band 3 (1.0 WTE) Infection Prevention assistant
- 1 x band 3 (1.0 WTE) Secretary.

During 2020/2021 there have been several vacancies within the nursing team, and as a result two infection prevention support nurses were seconded to the Team at the beginning of 2021 for 6 months to support the team during the ongoing recruitment process.

The challenges experienced with COVID resulted in the appointment of an exciting new role of 'Environmental Safety Matron' in the autumn. This new and high profile role became key to strengthening the existing relationship between infection prevention, the Clinical Teams and Estates and Facilities and involved collaborative working with key clinicians and stakeholders to develop and support the programme of change that COVID has required.

2.2 Medical Staff

The IPC team is supported by the consultant microbiology team of which there are 1.9 WTE consultant microbiologists. This includes the infection control doctor (3 PAs). There is one 1 WTE consultant vacancy, following the retirement of Dr John Cunliffe who has worked for the Trust for over 25 years, this vacancy is currently filled by 0.4 WTE locum. The post has now been converted to 2 x fixed time speciality doctor posts for 12 months and has now been recruited to it. They will start later in the year 2021

There are 2 WTE clinical scientists in the department, one of whom is the lead for environmental microbiology.

Out of hours consultant microbiologist support is available on call from 5pm – 9am, including weekends and bank Holidays for Microbiology and IPC advice.

2.3 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is the Medical Microbiology laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is located in Bromborough, Wirral. It provides the majority of the lab diagnostics for WUTH including routine cultures, Infection screening tests (MRSA, VRE screens) and molecular testing for organisms such as Influenza , C. difficile , Norovirus , CPE and SARS-CoV -2.

A combination of on-site and off-site testing capabilities for SARS-CoV -2 testing has been implemented over the last 12 months On-site testing capacity includes POCT for COVID with FLU A /B and Samba in blood sciences lab on APH site . Off-site services included tests done in CWMS and some referrals to Liverpool clinical laboratories

2.4 Infection Prevention on-call

The Infection Prevention Nursing Service is available Monday to Friday from 8am - 5pm and there is an on – call service from 5pm - 9am, including weekends and bank holidays. The on call is covered by the band 7 and band 6 nurses, in 2021 the AND-IPC joined the rota to support the team during the recruitment process as there was a lack of experienced staff within the team at that time.

2.5 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**

2.6 The Infection Prevention and Control Group

This group meets monthly and each directorate provides representation at the IPCG. The group is chaired by the DIPC; the deputy chair is the ADN – IPC. Its purpose is to provide a two way communication channel between the Trust Board via the Patient Safety and Quality Board (PSQB).The IPCG has an assurance/ management role and is authorised to approve Infection Prevention policies and to formulate recommendations for Infection Prevention and Control conveying these to the PSQB.

The Trust Infection Prevention & Control Terms of Reference can be found in **Appendix 2**. These are reviewed annually.

2.7 Departmental/Divisional Infection Prevention and Control groups

The following groups meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG).

- Medicine and Acute Specialties
- Orthopaedics
- Specialist Surgery
- Surgery

- Theatres
- Women's and Children's
- Diagnostics

2.8 The Infection Prevention Team

The Team meets weekly with the IP Doctor and together they provide the Infection Prevention service to the Trust. The ADN - Infection Prevention & Control is responsible for producing the 3 year IP strategy and delivering the Infection Prevention annual plan and annual audit plan on behalf of the DIPC, who reports to the Trust Board on behalf of the Infection Prevention & Control group.

2.9 The weekly 'DIPC review meeting'

This Exec led meeting was chaired by the Director of Nursing and was accountability based reviewing all incidences of CDI from the previous 10 days, concentrating on lessons learnt during the review of the patient pathway and how these were documented and their implementation progressed. As a result of the last 12 months COVID pandemic this has now become the HCAI oversight meeting and is chaired by the deputy DIPC on behalf of the DIPC and now includes all nosocomial COVID incidents.

3.0 Reports to the Trust - Summary

Reports written and/or coordinated by the ADN- IPC include

- Daily Outbreak and Surveillance summary for the Senior management and nursing teams detailing any areas under increased surveillance due to an increase in prevalence of any specific organism.
- Daily Outbreaks in the community which could have an impact on our service by the WCT.
- Monthly Infection prevention data summary of activities for the IP divisional meetings and the IPCG.
- Monthly IPC chairs reports and updates for the PSQB
- Annual Infection Prevention Report once per year which includes the Annual Infection Prevention plan and Annual Infection Prevention audit plan.
- Add hoc updates in relation to the Infection prevention board assurance framework
- Creation of an IPC BI portal

4.0 Budget Allocation to Infection Prevention

4.1 Microbiology and Laboratory Services

The medical microbiologists are funded from the Pathology Directorate, which is within the Division of Clinical Support. Funding for microbiology laboratory services (including outbreaks of infection) is covered by the service level agreement between the Trust and Public Health England (PHE).

4.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

4.3 The Infection Prevention Nursing Team (IPT)

The IPC Team are funded from corporate nursing administration and the ADN – Infection prevention is the budget holder for the Infection prevention service, the budget funds the nursing team and also any Infection prevention initiatives identified during the year. This includes Infection Prevention signage, posters, study days and campaigns.

4.4 Investments in Infection Prevention

In the year 2020/21 the Trust continued in its investment of

- MRSA screening for all admissions
- CPE and VRE screening for all Orthopedic patients
- Hydrogen Peroxide Vapor (HPV) 'fogging' following incidences of CDI and COVID
- Ongoing HPV programme
- EvaluClean - This simple system uses a UV marker which is invisible to the human eye, to mark objects , following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process
- Adenosine triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) to measure the level of and effectiveness of cleaning
- Purchase of 5 Isolation pods
- Increased cleaning in addition to the base line clean to meet COVID requirements
- PVC curtains
- Disposable curtains
- Improved paper towels to support hand hygiene protocols

5.0 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Meticillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (C. difficile) and more recently COVID – 19.

HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS. The 3 year IP strategy and annual plan for 2021/2022 focuses on revising and updating present arrangements, strengthening and building on the work that has already been achieved in the previous year and planning for the new and continuing challenges ahead.

6.0 Surveillance/ Mandatory reporting

The Health and Social Care Act 2008, updated 2015 (Code of practice on the prevention and control of infections) clearly identifies criteria to ensure that patients are cared for in a clean environment, which minimises the risk of acquiring a HCAI. Public Health England's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of:

- Meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA
- Meticillin sensitive *Staphylococcus aureus* bacteraemia (MSSA)
- *Clostridium difficile* infections
- COVID - 19

Gram negative bacteraemia

- *Escherichia coli (E.coli)* bacteraemia
- *Klebsiella* spp bacteraemia
- *Pseudomonas aeruginosa* bacteraemia

Carbapenemase Producing *Enterobacteriaceae* (CPE) bacteraemia are reported locally as are VRE bacteraemia.

The monthly quality check of the data prior to it being 'signed off' by the DIPC on behalf of the Chief Executive continues.

6.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia

The NHS have made it clear that they consider it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting .The Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) published new guidance, 'Implementation of modified admission MRSA screening guidance for NHS (2014)', these new guidelines outlined a more focused, cost-effective approach to MRSA screening whilst concentrating on reducing infections and improving patient health. The WUTH guidelines were last reviewed in 2019 and the decision made at that time to continue to complete screening for MRSA as per existing local policy, however this policy now requires further review to reflect the 2014 guidelines to ensure the best cost effective approach whilst continuing to promote patient safety.

6.2 Reporting and monitoring arrangements for MRSA Bacteraemia

It is mandatory for the Trust to report all incidents of MRSA bacteraemia onto the data capture system (DCS) and to subsequently complete a Post Infection Review. There is no longer a requirement to enter these investigations reports via the DCS reporting system. Completed PIR reports are shared with the local clinical commissioning group (CCG) and cases are discussed at their quality meetings. The contractual sanction that can be applied to each case of MRSA bacteraemia is £10,000 in respect of each incidence in the relevant month.

Following a laboratory confirmed result of MRSA bacteraemia a Multi-disciplinary Team, incorporating the patients clinician, Microbiologist, ADN-IPC, Matron and Pharmacist meet to complete the investigation to determine the attribution of the MRSA bacteraemia and a local action plan is developed which is the responsibility of the directorate to achieve. Causation is determined once the information is gathered.
MRSA Bacteraemia are apportioned according to the DOH guidelines, example

- Day 0 = Day of admission community attributed (pre day 2)
- Day 1 = community attributed (pre day 2)
- Day 2 = Trust attributed (on or post day 2)

This year there was 2 MRSA bacteraemia reported on or after day 2 of admission (post) and 0 reported pre day 2.

6.3 The incidence of MRSA Bacteraemia since 2014/15.

*Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15*

Table 1

The incidence of MRSA Bacteraemia since 2014/15							
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Pre day 2 for WCT	4	5	3	0	3	2	0
Post day 2 for WUTH	3	1	1	2	3	1	2
Total for Wirral CCG	7	6	4	2	6	3	2

6.4 Themes from Post Infection review

There has been a 50% increase in the incidence of MRSA bactereamia with the Trust reporting 2 hospital onset, hospital associated cases.

The first MRSA bacteraemia was detected in a patient who had actually been screened for MRSA on admission, which was negative. The patient also had no cross over with any other patient during their stay that was known to be colonised with MRSA, therefore it is unclear how the patient acquired MRSA. The patient required proning (nursing on their stomachs to aid breathing) which impacted on the ability to provide general care which may have resulted in the inability to provide thorough hibiscrub washes. This incidence was deemed to be a contaminant as MRSA only grew in one blood culture bottle; the patient did not display signs of a true bacteraemia and responded well to treatment. Therefore no patient harm was caused

The second MRSA bacteraemia was detected in a patient who was known to be colonised with MRSA and suffered from an auto immune skin condition. It was concluded that the bacteraemia had caused harm to the patient and a number of issues were identified:

- Antimicrobial prescribing – use of quinolones increased risk of MRSA infection
- Hibiscrub antiseptic skin wash may have had a detrimental effect on patient's fragile skin
- Multiple indwelling devices that required ongoing care. i.e. PICC lines and Urinary catheter.

- Delay in removing urinary catheter as recommended by medical team

6.5 Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia

All Acute NHS trusts report information on MSSA bacteraemia on the Data Capture System (DCS) in a similar fashion to the present collection of data on MRSA bacteraemia. *Staphylococcus aureus* that are sensitive to meticillin are termed meticillin sensitive *Staphylococcus aureus* (MSSA). There are no national or local objectives set against these at present and many are related to skin and soft tissue infections.

*Table 2 below provides a breakdown of **MSSA bacteraemia** by year and month.*

Table 2

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18

The Trust has reduced its incidence of MSSA bacteraemia by 25% from the previous year.

6.6 *Clostridium difficile* Infection (CDI)

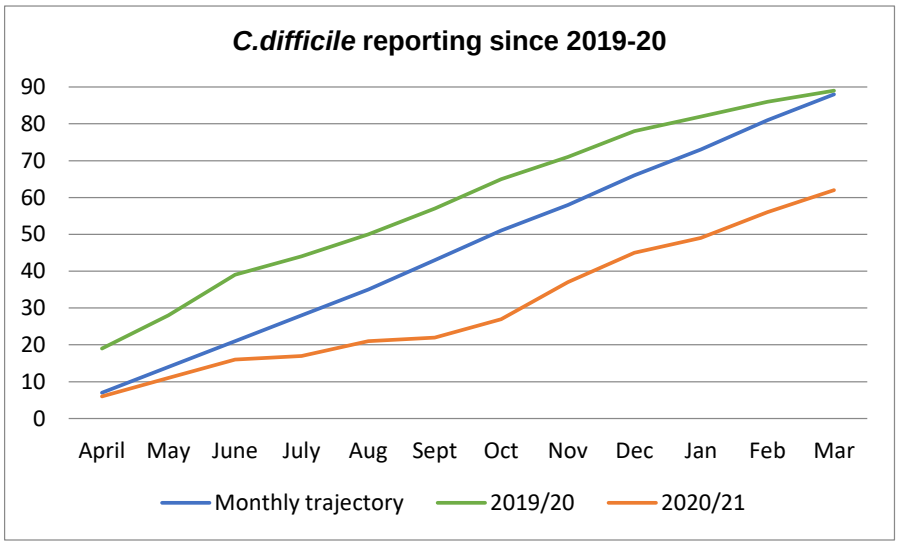
Clostridium difficile (C. difficile) is a bacterium that's found in people's *intestines.* It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies). C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows C. difficile to grow to unusually high levels. It also allows the toxin that some strains of C. difficile produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea. C. difficile can lead to more serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis). C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients. You can become infected with C. difficile if you ingest the bacterium (through contact with a contaminated environment or person). People who become infected with C. difficile are usually those who've taken antibiotics, particularly the elderly and people whose immune systems are compromised.

6.7 Surveillance of *Clostridium difficile*

Following the instigation of the CDI action plan in 2019-20 which was developed as a result of the large protracted outbreak of CDI in the previous year 2019-2020 was the closest the Trust had become to meeting their CDI target for 6 years. This has now been superseded by the Trusts achievements in 2020-21.

*Graph 1 below provides **Clostridium difficile** reported infections since 2019/20 as a comparison against 2020/21 and annual trajectory.*

Graph 1



In 2020/21 we have reported 62 *Clostridium difficile* infections. This is a reduction of 27 (30%) when compared to 2019/20. We were 26 cases under our cumulative trajectory for 2020/21.

6.8 Local reporting /investigating arrangements for CDI in 2019/20

Following the previous review of WUTH management of CDI and as a result of the COVID pandemic a more succinct system has been introduced. This process continues to follow the recommendations from NHSI/E who encourage organisations to assess each CDI case in order to determine whether it was linked to a lapse in the quality of care provided to patients.

All hospital apportioned cases continue to be discussed at a weekly senior review of HCAI which is now chaired by the deputy DIPC.

The Clinical Commissioning Group (CCG) continue to be able to consider the results of these assessments and exercise discretion in deciding whether any individual case of CDI affecting a patient under its contract should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated. For 2020/21, the contractual sanction that can be applied to each CDI case in excess of an acute organisation's objective remains £10,000.

As a result of the COVID pandemic, CDI objectives for acute organisations (and CCGs) have yet to be determined for 2021-22; these are expected at the beginning of Q2.

Objectives for last year were declared to remain as the previous year and the data was annualised with a count of cases calculated for each CCG and NHS acute provider using the case assignment definitions:

- **Hospital onset healthcare associated**: cases that are detected in the hospital two or more days after admission.
- **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

6.9 Themes from CDI RCA investigation

Although it is not always possible to ascertain the cause, some of the common themes and learning outcomes from the RCAs are listed below:

- Staff not identifying the need for isolating a patient with diarrhoea until a positive sample result was known
- Environmental cleaning, although this has improved with additional cleaning during the COVID-19 pandemic
- Delay in the start of treatment due to multiple reasons:
  - Delay in prescribing treatment following report of positive result
  - Stat doses not prescribed
  - Medication not dispensed from pharmacy in a timely manner
  - Staff unaware of escalation process for critical medication
- Antimicrobial prescribing not in line with Trust Formulary
- Clinicians not attending or supporting the RCA process

6.10 Gram-negative bloodstream infections (BSIs)

Gram-negative bacteria - *Escherichia coli (E. coli)*, *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella* spp.) are the leading causes of healthcare associated bloodstream infections. The current national ambition is to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values).

As a result of this data initially there was a primary focus on reducing healthcare associated *E. coli* bloodstream infections because they represented 55% of all Gram-negative BSIs reported, previously WUTH have not achieved this target.

E.coli

*Table 3 below provides a breakdown of **E-coli bacteraemia** by year and month.*

Table 3

E.coli bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	4	2	6	7	2	4	5	4	3	8	4	4	53
2019/20	6	3	3	4	7	2	5	6	6	8	9	1	60
2020/21	6	3	4	6	4	2	3	2	0	3	6	5	44

In 2020-21 WUTH has seen its first reduction in E-*coli* bacteraemia reporting 44; this is a reduction of 16 (17%) when compared to 2019/20.

Klebsiella

*Table 4 below table provides a breakdown of **Klebsiella bacteraemia** by month.*

Table 4

Klebsiella bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	0	2	3	3	3	1	1	0	0	2	0	1	16
2019/20	4	3	1	2	1	1	1	4	3	2	0	0	22
2020/21	0	1	1	1	0	0	2	1	1	0	0	1	8

In 2020/21 we have reported 8 Klebsiella bacteraemia. This is a reduction of 14 (64%) compared to 2019/20.

Pseudomonas

*Table 5 below table provides a breakdown of **Pseudomonas bacteraemia** by month.*

Table 5

Pseudomonas bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	0	1	0	2	0	3	0	0	0	0	1	0	7
2019/20	1	1	1	1	1	2	0	1	0	0	0	1	9
2020/21	1	0	1	1	1	1	2	0	0	0	0	0	7

In 2020/21 we have reported 7 Pseudomonas bacteraemias. This is a reduction of 2 (22%) when compared to 2019/20.

Gram Negative cumulative

*Table 6 below provides a breakdown of **all** gram negative **bacteremia** by year and month.*

Table 6

Gram- Negative bacteraemia since 2017/18													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total/ *Trajectory
2017/18	2	5	5	12	6	10	13	7	6	8	7	3	84
2018/19	4	5	10	12	5	8	6	4	2	11	5	6	78
2019/20	11	7	5	7	9	5	6	11	9	10	9	2	91
2020/21	7	4	6	8	5	3	7	3	1	3	6	6	59
2021/22 (25% reduction)													63*
2022/23													52*
2023/24 (50% reduction)													42*

In 2020/21 we have reported 59 Gram Negative bacteraemia. This is a reduction of 32 (35%) when compared to 2019/20 and 18 cases under our cumulative trajectory for 2020/21.

6.11 Themes from Gram negative RCA investigation

Email notifications are sent to the Divisions to request for the RCA investigation to be undertaken for all hospital onset Gram negative BSIs. These are then required to be presented and monitored at the Divisional monthly IPC meetings. During 2020-2021 not all RCAs were completed due to the impact of the COVID-19 pandemic. Below are the themes that have been identified from the completed investigations.

- PICC line – gaps in record keeping to confirm on going care to avoid complications
- Poor documentation related to invasive devices, particularly urinary catheters and peripheral cannulas and wounds
- Delay removing invasive devices when no longer required, especially urinary catheters
- Delayed blood culture and urine collection resulting in failure to diagnose and treat in a timely manner
- Not always clear if staff who undertook blood collection had received training and been assessed as competent
- Patients requiring multiple cannulas to be inserted for ongoing IV treatment not always being referred to the IV access team.

In order to meet the 25% reduction in gram negative bacteraemia by 2021/22 and 50% reduction in 2023/24, the Trust needs to focus on investigating all incidences and introducing measures learnt from the resulting action plans to meet these objectives and promote the health and safety of our patients. A new process will be implemented to ensure that all hospital onset Gram negative BSIs are presented to the Harms Panel.

6.12 Carbapenemase-producing Enterobacteriaceae (CPE)

The spread of antibiotic resistance in Gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

*Table 7 below provides a breakdown of **all** CPE **bacteremia** by year and month.*

Table 7

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1

As a result of the COVID pandemic the review of the current arrangements and introduction of a CPE policy, reflecting the national guidance was put on hold, this will now be part of the annual plan for 2021.22.

6.13 Mandatory Glycopeptide resistant Enterococci (VRE) bacteraemia

There have been 1 incidences of VRE bacteraemia reported at WUTH during the period April 2020 - March 2021. This is a reduction of 4 from the previous year. Unlike other organisms under mandatory surveillance, Public Health England (PHE) employs a reporting year which runs from October – September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

*Table 8 below provides a breakdown of VRE **bacteremia** by month.*

Table 8

The incidence of *VRE bacteraemia since 2019/20*													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2019/20	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*1*	*0*	*0*	*1*	*0*	*5*
2020/21	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*

6.14 Quarterly Mandatory Laboratory Reporting (QMRL)

The Quarterly Mandatory Laboratory Reporting data requires laboratories to submit data to the Public Health England Health Care Associated Infection (HCAI) Date capture system.
This data includes:

- Total number of blood culture sets examined
- Total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- Total number of positive blood culture sets
- Total number of S. aureus positive blood culture sets
- Total number of Clostridioides difficile toxin positive reports in people aged 2 - 64 years
- Total number of Clostridioides difficile toxin positive reports results in people aged >=65 years
- Total number of stool specimens tested for diagnosis of C. difficile infection.
- Total number of stool specimens examined
- Total number of faecal specimens and rectal swabs taken for carbapenemase-producing Enterobacteriaceae (CPE) screening

After a period of non-reporting (since 2015), the QMRL data is now being submitted with the following now completed:

- 2019 – Q1-3
- 2020 – Q1-Q4
- 2021 – Q1

Years 2015-2018 will be added retrospectively.

6.17 Coronavirus (COVID-19)

Coronavirus disease,(COVID-19) is an infectious disease caused by a newly discovered Coronavirus and was first encountered in November 2019 in Wuhan, China.

Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes. People over 70 and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

Effective monitoring and surveillance is central to understanding COVID-19 transmission within our hospital, providing transparency on performance and supporting a focus on continuous improvement.

Definitions for Nosocomial COVID-19 infections were released within the '*North West Hospital Onset COVID Infection Standard Operating Procedure* 'on 5th June 2020.

There are three categories for determining Hospital Onset COVID-19 infections:

- Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA) – First positive specimen date 3-7 days after admission to trust
- Hospital-Onset Probable Healthcare-Associated **(HO-pHA)** – First positive specimen date 8-14 days after admission to trust
- Hospital-Onset Definite Healthcare-Associated **(HO-dHA)** – First positive specimen date 15 or more days after admission to trust.

From 5th June onwards probable **(HO-pHA)** and definite **(HO-dHA)** cases underwent a rapid Root Cause Analysis (RCA) to establish how the transmission occurred and whether there were any other linked cases that might indicate ongoing transmission within an area.

The table 13 below provides a breakdown of COVID-19 by month

Table 13

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month 2020/21	1-2 days	3-7 days	8-14 days	15+ days	
Apr-20	272	28	26	34	360
May-20	83	10	27	29	149
Jun-20	13	0	2	2	17
Jul-20	17	6	1	2	26
Aug-20	3	1	1	0	5
Sep-20	6	1	0	0	7

Oct-20	61	6	8	12	87
Nov-20	135	19	21	13	188
Dec-20	76	17	14	28	135
Jan-21	71	24	26	28	149
Feb-21	279	52	76	85	492
Mar-21	52	9	4	7	72
Apr-21	16	2	0	0	18
Total	1084	175	206	240	

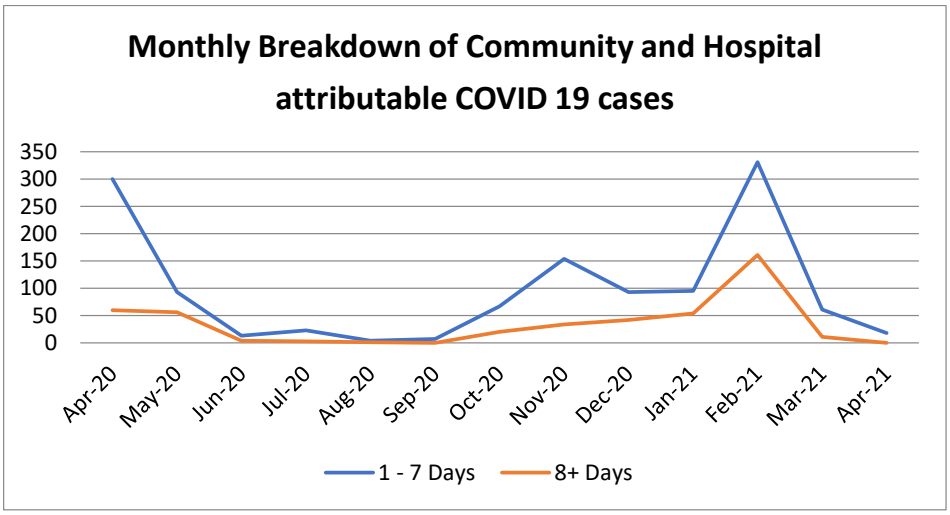
The emerging evidence base on COVID-19 has rapidly evolved and daily updates since England declared its first lockdown in March 2020 continue via the PHE and other government web sites.

By 31st March 2021 there had been 4,345,788 reported positive COVID-19 test results, this is the number of people who have had at least one positive COVID-19 test result either lab-reported or lateral flow device (England only). Positive rapid lateral flow test results are confirmed with PCR tests taken within 72 hours. If the PCR test results are negative, these are not reported as cases. People tested positive more than once are only counted once.

Updates regarding vaccine uptake, staff testing and incidences of COVID positive results in staff and patients are reported back at weekly meetings and not included in this report due to a lag in reporting accuracy. Papers and local SOPs developed following PHE guidance are readily available on the Trust intranet for staff to use.
Across England the number of COVID-19 vaccinations given by 31st March 2021 that were entered on the relevant system at the time of extract was 627,008, this figure includes all vaccines (both first and second dose) that were given up to and including 31/03/2021. The total percentage of people aged 18 and over who have received a COVID-19 vaccination 1st dose 59.1 % and 2nd dose 8.6 %.

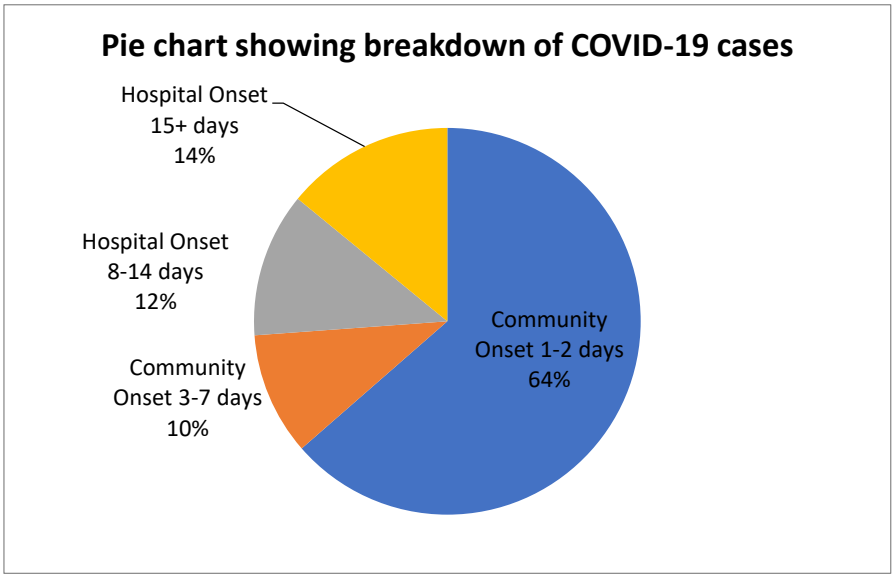
Graph 2 below shows the incidence of patient COVID-19 results in 2020/21.

Graph 2



The Pie chart 1 below provides a breakdown of COVID-19

Pie chart 1



The safety of staff has remained paramount in the approach that WUTH had to the global pandemic of COVID-19 and concentrated on ensuring staff had the personal protection equipment (PPE) they needed.

As a result local risk assessments were put in place very early on in the pandemic along with a health risk assessment tool to ensure that risks were minimised for staff, visiting restrictions were introduced, over 550 staff moved to remote working and all non –urgent elective activity as well as out-patient activity was postponed.

Effective infection prevention and control has remained fundamental in the way in which WUTH rapidly adapted to the response to the COVID pandemic and the three waves of the disease encountered so far. Ongoing improvements and initiatives have continued throughout 2020/21 to strengthen IPC practices across the trust; this activity is captured in the Infection Prevention & Control Board Assurance Framework (IPC BAF) which was introduced at the beginning of the pandemic and is now on version 1.6. This assurance document is updated to reflect current Trust guidelines and is reviewed by the Quality Committee as delegated by the BoD on a quarterly basis. Local improvements throughout 2020/21 have included:

- The launch of the 6 week 'Keep It Simple' infection prevention campaign which CQC gave accolade as 'Outstanding achievement'
- Recruitment of a new infection prevention environmental safety matron, who works in collaboration with Facilities, Corporate Nursing and the Infection Prevention Team.
- Ongoing fit testing for staff of FFP3 masks.
- Add hoc training session for donning and doffing of PPE..

- COVID Screening for all patients on the day of admission and thereafter at day 3, 6 and then every 7 days of admission.
- Creation of a Vaccination hub which opened in Dec 2020 to enable the roll out of the newly introduced COVID vaccine for all staff and the wider Wirral community at the Clatterbridge site.
- Introduction of twice weekly LFD testing for staff which then became weekly LAMP testing
- Bespoke leadership meetings to enable clinicians to discuss the control and management of COVID in the hospital based on PHE guidelines i.e Bronze/Silver/Gold and the clinical advisory group (CAG).
- Frequent updates via the communications team in all manners of media including e-mails, team briefs, messages of the day and posters.

6.16 Seasonal Influenza

WUTH participates in the Unify2 Influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU).

The table 11 below shows the summary of Influenza Cases Reported through Unify2 Surveillance Scheme since 2019/2020

Table 11

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
April 2019 - March 2020	3	4	3	0	0
April 2020 - March 2021	0	0	0	0	0

-

6.15 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to Public Health England (PHE) comprising of at least 1 quarter per year and 1 surgical specialty at a minimum. The Trust historically has submitted data for 1 quarter only and focused on Trauma & Orthopaedics in isolation as per the minimum requirement. The Trust was contacted by PHE on the 16th November 2020 highlighting that no SSI data had been submitted by WUTH for 2019/20. It was the Trust's understanding that SSI was reported by calendar year rather than financial year and therefore, when data was collected and submitted during January – March 2019; it was reported at Q1. PHE have now confirmed that the data submitted in 2019 related to the period 2018/19 (Q4).

Data was last collected for the October to December 2020 (PHE Q4) period and was reported in the March 2021 IPCG.

The last year reporting has seen a reduction in reported infections for all categories. Within the period October to December 2020 (Q3) 221 patients were reviewed:

Hip Replacement	93
Reduction in long bone fracture	57
Repair of neck of femur	71

Of these 221 patients two cases of postoperative surgical site infection were confirmed, this equals to 0.9%.

In response to the CQC 2019 report an action plan was developed and the surgical division has now produced an SSI strategy and recruited an SSI Surveillance nurse. In support of ongoing SSI surveillance the surgical division has also nominated a Matron to complete SSI training with the plan to enroll the clinical educator on future training.

SSI Surveillance is now completed for all quarters for repair of fractured Neck of Femur and hip replacement with the addition of SSI commencing for small bowel surgery in Q1.

A monthly SSI MDT review meeting has been introduced to review incidents of SSI and identify learning, an SSI RCA process has also been developed and implemented to be completed by clinical area of identified SSI, this is then fed into divisional IPC for assurance.

7.0 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of possible outbreaks which enables control measures to be instigated early to avoid escalation. The senior IPC team arrange outbreak meetings with the divisional teams for all outbreaks detected and continue this ongoing collaboration to give support and advice until the outbreak is determined to be closed.

7.1 Norovirus

The Trust reported no wards/inpatient facilities that were restricted between April 2020 and March 2021. There were no confirmed cases of Norovirus identified in the Acute Trust.

7.2 *Clostridium difficile*

Five CDIs were linked to an outbreak on Ward 22 during December 2020 and January 2021; all patients were identified as having the virulent 027 strain. An improvement plan was implemented and a clean and HPV of the ward was undertaken.

7.3 COVID-19

In May 2020 it became mandatory to report all outbreaks of COVID-19, since this date the IPC Team have reported 43 outbreaks of which 12 were staff only outbreaks, 1 was a patient only outbreak and 30 involved both staff and patients. Overall this equates to 376 patients and 230 staff.

8 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the infection, presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff staff have been exposed to a specific infection eg scabies, Group A Streptococcus, as identified by either the IP&CT or PHE which results in the need for either staff and Pt screening / treatment or both. When these situations have been identified the IP&C team support the ward teams to complete contact screening, if exposed patients / staff are identified immunisation records are

checked by pts clinician and occupational health for verification of immunity and vaccination offered as required.

8.1 Group A *streptococcus*

1 patient was diagnosed with group A strep.

9.0 Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable in the near future and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

NHS England and regulatory bodies such as the Care Quality Commission (CQC) expect secondary care organisations to be able to demonstrate adherence to guidance such as Start Smart Then Focus, a toolkit for antimicrobial stewardship in secondary care. Additionally they must be able to demonstrate good performance against other measures of effective antimicrobial stewardship such as consumption as well as the relevant indicators of the Commissioning for Quality and Innovation (CQUIN) framework.

9.1 Programme of audit and results

9.2 Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit (monthly)

The ASPIRE audit is undertaken monthly by the Pharmacy Stewardship Team for 5 patients selected at random on each ward. It aims to audit compliance against national standards mandated in Start Smart, Then Focus. The results are displayed as a dashboard demonstrating performance Trust wide as well as at a Divisional and Directorate level.

Results from 2020-21 demonstrate that average performance across the year had improved from 2019-2020

	2019-2020	2020-2021
Documentation of indication for antibiotics on prescription	94%	98%
Stop / review date on antibiotic prescription	98%	99%
Compliance with antibiotic formulary	97%	99%
Antibiotic clinical review undertaken within 72 hours of initiation	95%	96%

9.3 Antibiotic Point Prevalence audit (6 monthly)

The point prevalence audit is undertaken on a single day in July and January each year and includes every patient on antibiotics in the hospital on the day of audit. It aims to audit the standards mandated in Start Smart, Then Focus and to enable identification of trends in antibiotic use.

Results demonstrate the average performance across the year compared to last year

	2019-2020	2020-2021
Documentation of allergy status	100%	100%
Documentation of indication for antibiotics on prescription	88%	88%
Stop / review date on antibiotic prescription	95%	96.5%
Compliance with antibiotic formulary	96%	95%
Antibiotic clinical review undertaken within 72 hours of initiation	98%	97%

The outcomes of the clinical review

	2019-2020	2020-2021
Stop antibiotic	3%	5%
Continue antibiotic	85%	77%
Switch to oral treatment	10%	11.5%
Change antibiotic based on clinical picture	3%	6%
Discharge on OPAT	0%	1%

The most common indications for use of antibiotics were;

- Respiratory infections (32% in July 2020 and 35% March 2021)
- Skin, bone and joint infections (14% July 2020, 14% March 2021)
- Sepsis (13% July 2020 and 10% March 2021)
- UTI (13% July 2020 and 13% March 2021)
- Gastrointestinal infections (13% July 2020 and 9% March 2021)

The most common antibiotics used were;

- Co-amoxiclav (28% in July 2020, 28% March 2021)
- Quinolones (8% July 2020, 8% March 2021)
- Narrow-spectrum penicillins (3% in July 2020, 8% in March 2021)
- Metronidazole (8% July 2020, 9% March 2021)
- Tazocin® (8% July 2020, 8% March 2021)
- Glycopeptides (8% July 2020, 4% March 2021)
- 2nd/3rd generation cephalosporins (8% July 2020, 8% March 2021)

Since 2019, the proportion of Tazocin® usage has been stable so it is reassuring that usage has not increased significantly following the addition to the antibiotic formulary for escalation in COVID pneumonia.

Quinolone use has reduced compared to previous years in part to the safety alert around fluoroquinolones which was well publicised throughout the Trust and chapters of the antibiotic formulary were reviewed to try and reduce usage

9.4 Surgical Prophylaxis Audit (annual)

The annual surgical prophylaxis audit aims to ascertain antibiotic formulary compliance and specifically concentrates on use of single dose prophylaxis. Results from 2020-2021 demonstrated that 86% (171) of surgical prophylaxis was prescribed as recommended in the antibiotic formulary; this is a 2% improvement from the previous year. The various specialities had differing levels of performance. Inappropriate prescribing regarding incorrect dose was most often seen with inappropriate omission of antibiotics and incorrect antibiotics prescribed for procedures next, all non-conformities having no documentation for their deviation to formulary. Results were fed back by the Lead Divisional Pharmacist for Surgery.

9.5 Clinical appropriateness of piperacillin / tazobactam (Tazocin®) during COVID pandemic

During the COVID pandemic Tazocin® use increased proportional to bed occupancy and it was added to the antibiotic formulary for escalation for secondary bacterial pneumonia in COVID; thus, to ensure use was clinically appropriate, the Pharmacy Antimicrobial Stewardship Team completed monthly point prevalence audits from April 2020 to July 2020. All live prescriptions for Tazocin® on a single day in the month were audited for clinical appropriateness, course length of Tazocin® and total course length of antibiotics.

In total there were 77 patients prescribed Tazocin® across all 4 months. Of these, all but 6 were deemed clinically appropriate, prescribed in line with the antimicrobial formulary. However, a further 12, whilst clinically appropriate, had not been recommended by Microbiology which is a requirement of restricted antibiotic use.

The average course length of prescriptions for Tazocin® excluding patients who passed away prior to completion of course, was 7.1 days. This is consistent with the baseline audit from May 2019 (7.4 days).

The average course length of all antibiotics in the treatment course (including other antibiotics before or after Tazocin®) was 9.2 days.

9.6 Clinical appropriateness of meropenem during COVID pandemic

To provide ongoing assurance of antimicrobial stewardship during COVID-19 the pharmacy antimicrobial stewardship team commenced monthly meropenem point prevalence audits to ensure clinical appropriateness from May 2020 to July 2020. Meropenem was added to the antibiotic

formulary as escalation for secondary bacterial pneumonia in COVID-19 patients. All live prescriptions for meropenem on a single day in the month were audited for clinical appropriateness, course length of meropenem and total course length of antibiotics.

In total there were 40 patients audited across the 3 months, all but 2 were clinically appropriate and recommended by a Consultant Microbiologist or as per Trust wide antimicrobial formulary guidance. The majority of prescriptions were for pneumonia and neutropenic sepsis, followed by urinary tract infections.

The average course length of prescriptions for meropenem was 7.8 days, excluding patients who passed away.

The average treatment course length for total antibiotics (including other antibiotics before or after meropenem) was 11 days.

9.7 Audit of antibiotic usage in COVID patients

Antibiotic use was reviewed in COVID-19 patients over a 3 week period from 8th April to 29th April 2020.

In total, 227 patients were SARS CoV-2 positive within the data collection period. Of those, 161 patients were an inpatient for 3 days or more (inpatient for <3days were not included to provide a comparable baseline for implementation of procalcitonin testing). Of 161 patients, 152 (94%) received antibiotics to cover for possible chest infection.
The average initial total course length of all antibiotics was 7 days for 152 patients. Sadly, 29 (18%) patients passed away prior to completion of their antibiotic course or had their antibiotics stopped due to palliation. Excluding these 29 patients increased the total course length of antibiotics to 7.3 days for remaining 123 patients.
34% of patients received more than 7 days of antibiotics, with the longest course length being 19 days for a patient on critical care and only 4% received 3 days or less of antibiotics.

The proportion of antibiotic treatment days that were parenteral was 58%. 25% of patients were escalated to Tazocin®, meropenem or fosfomycin as per formulary.

9.8 Procalcitonin Implementation

Clinical Advisory Group (CAG) approved the use of procalcitonin testing in COVID positive patients in May 2020 with the aim of reducing antibiotic use in COVID patients. The project team, consisting of Respiratory, Critical Care and Microbiology clinicians, recommended undertaking PCT tests to inform antibiotic decision making for COVID-19 patients. If the PCT level was <0.25ng/ml on day 3 of antibiotics, bacterial infection is unlikely and antibiotics could be reviewed to stop.

Of the first 100 patients who received a PCT test, 59 patients had a level of <0.25ng/ml. For these 59 patients, this resulted in;

- 96 antibiotic days saved due to cessation of antibiotic therapy, calculated from the original course length prescribed; this excludes potential escalations or extensions of treatment that would have been avoided due to the PCT result.
- A reduction in total antibiotic course length of 1.7 days to 5.6 days.
- A10% increase in patients whose antibiotics stopped at or before day 3
- A 4% reduction in antibiotic course lengths in excess of 7 days.

In total, 96 antibiotic days have been saved at a cost saving of approximately £785. The cost of testing was approximately £1419, each procalcitonin test costs ~£11 but clinicians carried out repeat tests whilst becoming more familiar with the diagnostic test.

A business case is required for wider use of procalcitonin and further audit to look at antibiotic usage following the first 100 patients.

The project received Highly Commended in the Diagnostic Stewardship category at the 2020 Antibiotic Guardian Shared Learning & Awards ceremony.

9.9 Evidence based Antimicrobial Prescribing Guidelines

SSTF suggests Trusts should have up to date, evidence based guidance for antibiotic use, taking into account local resistance patterns. They should cover diagnosis and treatment of common infections and prophylaxis of infections. At WUTH the Trust wide Antimicrobial Formulary is available on the intranet that includes aspects of treatment mandated by Start Smart Then Focus such as agent, dose, course length, advice when resistant organisms are present. It also includes specific sections for;

- Prudent use of antibiotics
- Antibiotic treatment in adults
- Antibiotic treatment in children
- Surgical and Medical antibiotic prophylaxis
- Therapeutic Drug Monitoring with specific sections for gentamicin and vancomycin
- IV to oral switch guidance

Each chapter is reviewed every 3 years but updated prior to that when required. In 2020-21 the following chapters were updated;

- Sepsis (previously septicaemia)
- Respiratory chapter
- *Pneumocystis Jirovecii* Pneumonia (PCP) treatment- new chapter
- Obstetrics

- Gynaecology
- ENT chapter
- Skin chapter
- Secondary bacterial pneumonia in COVID
- Medical prophylaxis- hepatic indications
- Eye chapter
- Restricted antibiotic list

There has previously been consideration given to housing this on an app but the widespread availability of hardware to access the intranet, alongside reliance on staff manually updating apps and maintain good IPC practices around sanitising mobile phones, meant that the decision was made to remain with an intranet based formulary.

The following guidelines were also updated and approved during 2020-21:

- Antimicrobial Stewardship At Ward Level
- Antibiotic Use In Patients With Infection Alerts
- Sepsis- Antibiotic Administration in Adults

New antibiotics are agreed via application to the Drug and Therapeutics Panel, in 2020-21 there were no new antimicrobials approved for use.

9.10 Education and Training

There is education and training in place on induction for all clinical staff as part of the Infection Prevention and Control (IPC) presentation as well as specialist annual training for F1s, F2s, ANPs and pharmacists which is delivered by the CMM and AMS pharmacy team.

9.11 Antimicrobial Consumption

SSTF requires Trusts to have an understanding of their antibiotic consumption patterns. Antibiotic consumption is measured as defined daily doses (DDDs) which is the standard dose of that agent for an adult in a single day. Antibiotic consumption data is skewed by hospital occupied bed days and to introduce consistency is often measured by DDDs per 1000 admissions. This data is hard to access and there is inevitably a lag in its availability and thus Trust wide data discusses actual consumption whilst national data discusses consumption per 1000 admissions. National calculations are available on the RXInfo DEFINE and PHE Fingertips websites.

The target in the NHS Standard Contract SC21.4 is to reduce total antibiotic consumption, measured as Defined Daily Doses (DDDs) per 1000 admissions, by 2% by the end of March 2021 against the baseline figure of consumption in calendar year 2018. This was not met in 2020/21.

In 2020-21 there were a total of 344,049 antibiotic DDDs consumed within the Trust, compared to 2018 baseline data as supplied by NHSE (436,501 DDDs) this is a reduction of 21% in actual antibiotic consumption.

When this is calculated as a proportion per 1000 admissions, data from DEFINE website indicates that there has been a slight reduction in antibiotic consumption from 4558 to 4539 DDDs per 1000 admissions in financial year 2020/21, compared to 2019/20, this is a 0.5% reduction. The baseline from calendar year 2018 according to DEFINE website was 4209 DDDs per 1000 admissions, and so the Trust has not met the 2% reduction for the NHS Standard Contract. Despite this, the Trust remains in the 2nd lowest quintile of total antibiotic usage when benchmarked nationally against other teaching Trusts, following a brief move into the middle quintile in Q1 20/21 during the first wave of COVID-19. The Trust is still below the England average (data from fingertips website and correct to end of Q3 20-21.

9.12 CQUIN Performance

9.12.1 Treatment of community acquired pneumonia (CAP) in line with BTS care bundle

The CQUIN required all of the following to be completed correctly to achieve a 'pass' for the patient
.
1. Perform a chest x-ray within 4 hours of hospital arrival time;
2. Pneumonia severity score (CURB65) calculated and documented in the medical notes during the ED and/or acute medical clerking;
3. Receive antibiotics within 4 hours of hospital arrival time;
4. Antibiotic prescription is concordant with severity score and in line with CG191 or local guidelines.

The Trust did not submit data for this CQUIN due to reduced resource during the COVID pandemic. However, the requirements of the AMS team were met following an update to the CAP antibiotic formulary chapter in line with NICE guideline 138 and inclusion of the CURB-65 scoring parameters.

9.13 Appropriate antibiotic prescribing for UTI in adults aged 16+

This CQUIN required all of the following to be completed correctly to achieve a 'pass' for the patient.
1. Documented diagnosis of specific UTI based on clinical signs and symptoms;
2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all Catheter Associated UTI (CAUTI);
3. Empirical antibiotic regimen prescribed following NICE / local guidelines;
4. Urine sample sent to microbiology as per NICE requirement; and,
5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.
The Trust did not submit data for this CQUIN due to reduced resource for data collection and IT resource to implement an IT solution which would have enabled appropriate documentation and prescribing of UTIs. This decision was made in conjunction with the clinical lead for the CQUIN due to resource availability during the pandemic.

However, the following steps were taken to improve the treatment of UTIs during 2020/21:

- Education for F1s, pharmacists and new NMPs by Antimicrobial Pharmacist about the diagnosis treatment of UTIs.
- Discussions with IT about implementing a Cerner powerform and UTI bundle to aid the completion of the requirements
- Communications throughout the Trust during World Antimicrobial Awareness Week 2020.
-

9.14 Electronic Review Updates

Updates and fixes to the tool to increase usage and to aid optimal antibiotic reviews are still required and a SCR form was submitted in October 2020 for these changes. These include fixing the numbers that appear on the doctors' worklist indicating that an antibiotic review is due.

Discussions between other hospitals using Cerner are planned to discuss AMS solutions. These discussions are being facilitated by the Associate CCIO (Medicines) at NHSX and the National Pharmacy and Prescribing Clinical Lead at NHSE and aim to share good practice in electronic solutions to support the AMS agenda in Cerner sites.

9.15 Ward – focused Antimicrobial Stewardship Team

The ward focused antimicrobial stewardship team consists of a CMM and a specialist antimicrobial pharmacist. Together they undertake antimicrobial stewardship ward rounds with aim of providing patient specific clinical plans but also provision of case based teaching to the MDT. The wards rounds occur in the following areas;

- Gastroenterology ward (weekly)
- Elderly Care wards x 2 (weekly)
- Respiratory Unit (weekly)
- Orthogeriatric wards/T&O x 3 (weekly)
- Older Persons Assessment Unit (weekly)
- Acute Care (three times weekly)
- Critical Care (daily)

The AMS ward rounds have reached capacity due to reduced resource and are not covered during periods of staff absence. Several additional areas have requested commencement of AMS ward rounds but there is insufficient CMM or pharmacist capacity to undertake these. In March 2021, clinical scientists along with the antimicrobial pharmacist initiated a bacteraemia ward round on Thursdays depending on availability and they will continue to backfill for the shortage of microbiologists. Appointment of a new Lead Antimicrobial Pharmacist in July 2021 should allow increased resource for ward rounds with clinical scientists.

Due to the COVID pandemic the AMS ward rounds ceased from the end of March to mid-June but the remote Microbiology advice line was still available for ward staff with any queries.

10.0 Decontamination

10.1 Decontamination Arrangements

The Care Quality Commission and the Health and Social Care Act 2008 requires healthcare organisations to keep patients and visitors safe by having procedures and systems in place to ensure that all reusable medical devices are properly decontaminated prior to use, and that all single use devices are not re-used.(Criterion 9).

Effective decontamination of reusable medical devices and equipment (including surgical instruments), is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection and sterilisation) in order to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.'

WUTH has a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment is directed to Infection Control or the Decontamination Lead and if escalation is required this is by means of discussion at Decontamination Group meetings. where possible actions/resolutions are agreed with the support of the Trust Microbiology representative, AE(D) and other group members. In the event that actions remain unresolved it may be necessary to escalate to IPCG.

The Decontamination Group has increased its frequency to bi-monthly in 2020/21 and has the responsibility to report on progress of Trust wide decontamination issues and recommendations in relation to high risk medical devices i.e. for example those which come in to contact with mucous membranes. I.e. Scopes; the group minutes are tabled on the agenda of the IPCG and reports by exception.

The ToR for the Decontamination group have been reviewed and agreed during 2020/21.

10.2 Sterile Services

The Arrowe Park Hospital Sterile Service Department sits within Estates and Facilities and provides a decontamination service both to Wirral University Teaching Hospital NHS Foundation Trust and to private customers. The service includes washing, decontamination, assembly, packing and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external to the organisation.

The unit conforms to the requirements of the Quality System Standard BS/EN/ISO 13485: 2016 and relevant requirements of European Directive 93/42/EEC through effective implementation of the department procedures.

The unit updates and reviews their protocols on a regular basis to ensure improvements in quality and customer service and their effectiveness is monitored through internal audits, complaints and non-conformities.

11.0 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a Domestic Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement and review of cleanliness services in hospitals and our cleanliness standards are governed by the following legislation:

- National Specifications for Cleanliness in the NHS 2007
- The Revised Healthcare Manual 2009
- PAS 5748 specification 201

11.1 Management arrangements

The Facilities Department is committed to the provision of a clean healthcare environment that facilitates safe care and meets the needs of patients and staff. This is achieved by delivering the 'baseline clean'. The baseline clean is completed within all identified areas within the Trust that require cleaning services, each of the areas are risk rated depending on the frequency of clean (high, medium or low), with all domestic tasks , called 'elements' cleaned using approved methodology as per national standards of cleanliness. As a result of the COVID pandemic the cleaning policy has been reviewed this year and all areas now receive cleaning twice per day, areas identified with patients that have a known or suspected infection are cleaned above this frequency.

11.2 Cleaning Programme

Domestic Services Team continues to provide a comprehensive range of cleanliness services to support the Trusts IPC agenda. These services include:

- Rapid Response
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme

Over the past 12 months there has been a significant impact on the continuity and standard of cleanliness achieved due to a more focused scrutiny on the outcomes. Improvements in the overall condition, appearance and maintenance of the environment and improved responsibility and collaboration across the multi-disciplinary groups has resulted in progress that has now started to show results across the hospitals.

During the unprecedented challenges of the COVID-19 pandemic the cleanliness service remained adaptable and high quality. We recognised the requirement for further development of systems and processes to manage the impact of COVID-19 and to maintain safe cleanliness standards throughout the pandemic and winter period. Therefore we put in measures to support the organisation with the significant challenges ahead and provided assurance of cleanliness outcomes during 2020/21 which was as follows:

- Maximise staffing capacity to provide flexibility to meet the demand and needs of operational service delivery.
- Allocation of Domestic hours to support additional COVID-19 enhanced cleaning throughout the Trust.
- Increased cleaning frequency twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.
- Cleaning frequencies of the Care environment in COVID-19 care areas were enhanced and single rooms, cohort areas and clinical rooms cleaned twice daily.
- Introduction of Perspex curtains for clinical areas.

11.3 Performance Monitoring

To support the assurance of our cleanliness standards the Facilities Department use an industry approved MiC4C auditing software. It provides our quality control in the form of a visual inspection audit that monitors the quality of cleanliness of all our functional areas across all the responsibility groups of Domestics, Nursing and Estates. These technical audits involve the scoring of 50 elements within each area assessed and generate a score reflecting the standard of cleanliness achieved.

The Facilities Department have recruited and introduced in November 2020 two dedicated cleanliness auditing staff across all 77 functional areas on the Arrowe Park site. The deliver a two tier role that consists of the auditing process as well as the collaboration across responsibility groups to support rectification times, reporting outcomes and data and trend analysis for service improvement.

External monitoring

11.4 Patient-Led Inspection Programme (PLACE)

The Patient-led assessment of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'.

Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

In 2020 NHS Digital confirmed that the regular national PLACE collection would not be going ahead in 2020. Approval to amend the position for 2020 was granted by Sir Simon Stevens. It was felt that this is the best way forward given the risk to patient assessors and staff in undertaking the full assessment programme during the Covid-19 pandemic.

11.5 New cleaning standards

Release of the new National Standards of Healthcare Cleanliness are still awaited, previously being released as a draft, they primarily will encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around: being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results.

The final document, once released will be an update on the previous available guidance and will provide a new framework within which healthcare establishments set out details for providing cleaning services and assessing 'technical' cleanliness. This will ensure that Wirral University Teaching Hospital has a sustainable, effective healthcare cleaning service that will:

- be patient focused
- be achieved through collaboration of all responsibility groups
- provide clarity for all cleanliness responsibility groups to ensure our healthcare environment is clean and safe
- be consistent with infection prevention and control standards and requirements
- have clear objectives that will provide a good foundation for service improvements
- provide a culture of continuous improvement
- provide an agreed and recognisable auditing and monitoring framework

Compliance with these standards will enhance quality assurance systems, meet the requirements of CQC outcome standard Regulation 15, provide benchmarks and output indicators and offer a recognisable auditing and monitoring system and more importantly will be future proof. As an Acute Trust, once received it is anticipated that we will be given two years to implement the new standards.

11.6 New initiatives

New Hand Towel Dispensers for the Trust

The hands of healthcare workers play a major role in the transmission of micro-organisms which is why hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HCAI).

Everyone has a vital part to play in improving patient safety and as a result of this all Trust employees are expected to be compliant with the hand hygiene guidelines at all times, to support staff with this it is essential that we provide the best possible products for staff to enable them to practice frequent and effective hand hygiene.

In 2019 the Trust introduced new hand soap, alcohol based hand gel and hand cream and whilst the COVID pandemic prevented any further improvements at the beginning of 2021 plans were made to introduce a new hand towel.

This Rolled Hand Towel Dispenser delivers the latest in hygiene innovation offering advanced protection against cross-contamination as it allows the user to pull a paper towel/s out without touching the dispenser or other paper towels.

The new compact dispenser has a smooth design and no dirt traps which allows for easy, one-wipe-cleaning. Plus, a never-run-out feature ensures a continuous rolled towel supply.

The installation of the new dispensers is due to start in April 2021.

Blue Disposable curtains

The Trust is replacing all material curtains with disposal curtains starting in April 2021.The initial set of curtains is being funded by Domestic Services but then after this the wards and departments will be ordering from their own budget.

Clear Perspex curtains

During the pandemic the importance of social distancing of at least 2m was recognised as a key factor in helping to prevent transmission of COVID, in recognition of this all of the ward and assessment areas were reviewed to determine if patient beds were 2m distanced. The measurement was taken from the middle of each patient's bed. Whilst all areas met this requirement the delivery of patient care activities often reduced the distance and as a result PVC curtains were the obvious option in many areas to create a barrier between bed spaces but still allow vision between the beds to ensure that patient's safety would be maintained. When privacy and dignity is required the disposable curtains can be pulled across.

11.7 Reporting arrangements

The cleaning audit scores are provide to the divisions on a monthly basis and also reported to the IPCG along with requested ad-hoc cleaning requests including terminal cleaning and requests for HPV cleaning.

Facilities are reviewing the format of their report for 2021 to ensure that they are complying with the reporting arrangements as outlined within The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

11.8 Water Safety Group (WSG)

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology and Infection Prevention met monthly to undertake commissioning and development of the Trust Water Safety Policy and Trust Water Safety Plan (WSP). The WSP is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The WSP encompasses all areas of potential risk with regard to water safety; potable waters, hot and cold water systems (*Pseudomonas aeruginosa* and Legionella), endoscopy waters (AER final rinse waters), hydrotherapy pool and birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continue to give advice on remedial action when required where water systems or outlets are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extra ordinary meeting to trouble shoot and instigate remedial actions to reduce risks to patients and staff. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.9 Ventilation Safety Group (VSG)

Ventilation systems provide thermal comfort to patients and staff, enable removal of pollutants and odours, provide protection from infection for vulnerable patients and also reduce the risk of spread of infection.

Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves in order to contain, control and reduce hazards to patients and staff from airborne contaminants. This includes; operating departments, intensive treatment units, isolation suites, pharmacy and sterile supply departments and laboratories.

The sophistication of ventilation systems in healthcare premises is increasing and their importance has been further highlighted since the beginning of the COVID-19 pandemic. Patients and staff have a right to expect that it will be designed, installed, operated and maintained to standards that will enable it to fulfil its desired functions reliably and safely.

As a result a multidisciplinary Ventilation Safety Group (VSG) comprising of Estates & Facilities in conjunction with Microbiology and Infection Prevention meet monthly to look at the legal and mandatory requirements of ventilation systems in healthcare premises, this includes the design, maintenance and the operation of ventilation systems. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

The Water & Ventilation safety groups promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes; 1) Systems to manage and monitor the prevention and

control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

12.0 Training Activities

12.1 Infection Prevention Link Practitioners

There was a plan to reintroduce the IPC Link Practitioner programme and the introduction session was held in September 2020. Unfortunately due to the challenges faced by the IPC Team and the difficulty releasing ward and departmental staff during the COVID-19 pandemic this was unable to be continued. The full programme is planned to re-start again in 2021-2022.

12.2 Matrons Developmental Programme

A Matrons Development programme was planned for 2020-2021 to provide training for matrons to support them in their daily leadership role. Two sessions where held, one in June and one in July that introduced the IPC mandatory reporting of alert organism and the importance of learning from RCA investigations to ensure learning outcomes are captured and changes introduced to prevent further infections. Both sessions were positively received, the programme will be re-commenced in 2021-2022.

12.3 Student Nurse Training

There were no spoke placements arranged for student nurses during 2020-2021 due to the COVID pandemic, ad hoc training continued to be provided on the wards when requested or indicated.

12.4 Mandatory Training for Trust Staff

Infection prevention training is mandatory every 18 months for all WUTH staff based in the hospital and the community. Training is accessed on line via the learning hub, which includes an e-learning Infection Prevention package for completion by all staff, clinical and non-clinical staff. The e-Learning package covers general principles of infection prevention, hand hygiene, the use of PPE and also decontamination. The clinical package identifies more detailed information regarding alert organisms and standard precautions.

IPC participated in the Market Place as part of the induction for new staff at WUTH to provide basic IPC information. As a result of the COVID pandemic the Trust moved away from face to face training and as a result IPC produced a 3 minute video for new staff to the Trust to watch as part of their virtual induction.

The IPC team has continued to provide ad hoc training when visiting wards and departments as required ensuring that the hands.face.space concept continues.

The IP annual training programme comprises of:

Care support worker training
This has continued throughout the year and takes place once per month with reduced numbers in the clinical skills lab maintaining the hands.face.space concept. This is a 2 day programme of Clinical Support Workers Core Skills Course, which is part of the National Care Certificate. The session is an hour which covers general IPC update, hand hygiene, swab and specimen collection, diarrhoea management and mattress check.

The F1 induction programme
This was supported once during 2020-2021

Developmental programme for all newly qualified RGNs
This was reduced to once per month with reduced numbers in the clinical skills lab maintaining the hands.face.space concept.

Clinical champion training
As a result of the COVID pandemic in collaboration with clinical skills this has been reduced to quarterly.

Donning and doffing of PPE
Ad-hoc bespoke training targeted at WUTH's COVID response for this has been provided for all wards and departments on a weekly basis and more frequently as and when requested.

Evidence of completion of Infection Prevention and Control mandatory training is confirmed at appraisal and monitored at the Monthly IP performance meetings and reported to the Trust Board.

12.5 Specific Training

12.5.1 Hand Hygiene and Aseptic Protocols

Hand hygiene is fundamental to prevent HCAI's and the Trust is committed to striving for and maintaining high standards of hand hygiene from all WUTH employees. All staff receive hand hygiene refresher/update in the mandatory infection prevention training.

The Trust continues to be committed to the:

- Implementation of the 'Bare below the Elbows' initiative.
- Emphasis on the '5 moments for hand hygiene at the point of care' model from the World Health Organisation.
- Daily/weekly/Monthly monitoring of hand hygiene compliance via local departmental audits comprising hand hygiene technique with alcohol gel and liquid soap and water as well as monitoring compliance to hand hygiene opportunities, as per WHO 5 Moments.
- Targeted hand hygiene audits and teaching by members of the IP team, where an increased risk of infection has been identified: a hand hygiene compliance audit is completed by the Infection Prevention Team following the report of a *Clostridium difficile* infection.
- Bespoke hand hygiene training which includes hands on practical training using the light box for specific staff groups such as volunteer groups and non-clinical staff.

Hand hygiene compliance remains a monthly KPI

12.5.2 Aseptic Non Touch Technique (ANTT)

The ANTT framework provides a clinical guideline for aseptic technique and is based on a theoretical evidence-based framework (Rowley 2001). Its purpose is to standardise practice and raise clinical standards. It can be applied to any aseptic procedure, such as intravenous therapy, wound care and urinary catheterisation.

ANTT is recognised as the 'gold standard' for aseptic practice and is followed throughout WUTH by members of staff who are required to undertake invasive clinical procedures, including those members of staff who work in the community.

Compliance to mandatory training of ANTT is monitored by Directorates at their monthly IPC meetings and reported monthly at the IPCG.

The table 13 below shows the results of the ANTT training in 2020/21.

Table 13

Training	Number of staff trained 2020/21	Method of delivery
ANTT Train The Trainer	40	Face to Face training- 3 hour session
ANTT theory	817	e. Learning video
ANTT practical	742	Practical training either in Clinical Skills or on wards via Train the Trainers- e.g. 50 mins for theory & practical and demonstration on DP programme
Blood cultures	18	Face to face training 2 hrs
Catheterisation	90	Face to face training 3 hrs

13.0 Audit

13.1 Audit programme for 2020/21

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015) and Saving Lives (2011):

13.2 IPC Environmental audit

Due to competing priorities with the COVID-19 pandemic and vacancies within the IPC Team only 16 audits were completed by the Team with 13 wards and departments audited, results ranged from 53.5% to 88.4%. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC directorate meeting.

13.3 Commode audit

Owing to the COVID pandemic a Trust wide commode audit has not been undertaken during 2020-2021, however audits are completed on a regular basis via the perfect ward app. Ad hoc audits are done following a patient diagnosed with *C.difficile* toxin or a CD equivocal result. All results are reported to the Divisions for monitoring at the monthly IPC meetings.

13.4 Sharps audit

Undertaken by WUTH sharps bin supplier 'Daniels' in March 2021:

- 105 wards/departments were visited and 487 sharps containers were audited
- No sharps containers had protruding sharps, 11 were not properly assembled and none were more than three quarters full
- 3 containers had the wrong lid on the wrong base
- 26 sharps containers were found on the floor or at an unsuitable height
- 48 containers were not signed or dated after being assembled
- 38 containers had inappropriate contents
- No containers did not have the temporary closure in place when left unattended

13.5 Audits via perfect ward app

Hand Hygiene audits – undertaken weekly and increased to daily as required
CPE Checklist – as required
Personal Protective equipment – at least monthly
Quick COVID-19 Assessment – as required

13.6 'Saving Lives' High Impact Interventions (HII's)

High Impact intervention care bundles are improvement tools used for monitoring the management of invasive devices and procedures that are associated with a risk of infection, for example peripheral vascular cannulation, urinary catheterisation. These are audited at least monthly in all applicable clinical areas involved. The IPT also undertake spot checks in clinical areas where specific concerns are raised. Compliance to each bundle is monitored by Directorates at local IPC meetings and reported by exception at the monthly IPCG.
The High Impact Interventions on Perfect Ward will be reviewed to ensure all key elements are included to maintain standards.

14.0 External Assurance Assessments

14.1 Care Quality Commission

An unannounced Care Quality Commission (CQC) focused inspection took place at the Trust in February 2021 and found 'outstanding practice'. The inspection focused purely on infection prevention and control (IPC) at the Trust's Arrowe Park Hospital site

Inspectors praised the Trust's Infection Prevention and Control Campaign, titled 'Keep it Simple', which was a strong clinically-led campaign which explained all aspects of infection prevention and control, not just COVID-19, earning it the accolade of 'outstanding practice'.

The six-week campaign, which ran across the Trust's sites including Arrowe Park Hospital, Clatterbridge Hospital and Wirral Women and Children's Hospital, used simple messages to communicate information about infection prevention and control to staff, patients and visitors. This included brightly coloured posters, information leaflets, pull-up banners at hospital entrances, videos of hospital staff and an interactive 'design a bug' competition for staff, all aimed at articulating key IPC priorities.

During their visit, CQC inspectors found that there was an improvement in healthcare associated infections. The CQC report highlighted that the Trust had a clear vision and plan for continuously improving practices related to IPC and it had an annual plan that was aligned with the wider healthcare system. It found that staff felt respected, supported and valued. The Trust was highlighted as having an open culture where staff felt safe to raise concerns with a variety of ways in doing so, all with a focus on the needs of the patients. Inspectors also found that leaders understood and managed priorities, well and that they were visible and approachable to staff and patients alike.

Staff were clear about their roles and who was accountable for patient safety. Communication and learning supported patient safety across the Trust. Improved IPC measures implemented at the Trust included separate staff and patient entrances to allow for social distancing; volunteers at entrances to direct people to hand sanitiser and Fluid repellent surgical face masks, which are mandatory on entering the hospital, as well as social distancing signage on floors and walls.

The CQC report found that the Trust collected reliable data and staff could easily access information they needed. Its IT systems worked well and were secure. Patient records were clear and accurate with regards to COVID-19 tests and results. Leaders collaborated with partner organisations to improve services for patients. Trust staff were committed to continually learning and improving services. It had processes in place to achieve this and promoted a continuous improvement culture around IPC.

Delivering excellent IPC has enhanced a really difficult experience for patients and has helped to keep both patients and families safe.

There were areas highlighted by inspectors to help the Trust improve and are being worked upon. These included the need to finalise its draft IPC strategy; a requirement for staff to assess the risk of infection transmission for patients nursed in single rooms that have other risk factors other than IPC and ensuring all staff are aware of personal protective requirements regarding eye protection in specific settings.

All of these issues have now been addressed.

15.0 Policy Development

There were no policies ratified by IPCG in 2020-2021 due to ongoing COVID activity. There are currently 6 policies which are out of date and will be prioritised for review in 2021.

Specific policies relating to Micro-organisms are the responsibility of the Infection Prevention Dr/ Microbiologists to review whilst the Infection prevention 'procedures' policies are the responsibility of the nursing team. All policies are ratified at the monthly IPCG.

16.0 Quality Improvement.

At the beginning of 2021 IPC joined the quality improvement programme with a project entitled 'Create a health and care system where no person's health and wellbeing is harmed by a preventable infection'. The project lead is the Deputy DIPC and the Executive sponsor the Chief Nurse/DIPC. Whilst we reported a significant reduction in hospital acquired infections in 2020-21, we recognised that there is a need to continue to take proactive action to sustain and maintain this, particularly as COVID rates reduce. This requires a review of the successful work undertaken during COVID in order to embed this good practice across the Trust to promote continual improvement and reduction in our infection rates. Training for key stakeholders will be delivered by AQuA and the IPC project charter will be signed off and reviewed by the IPCG

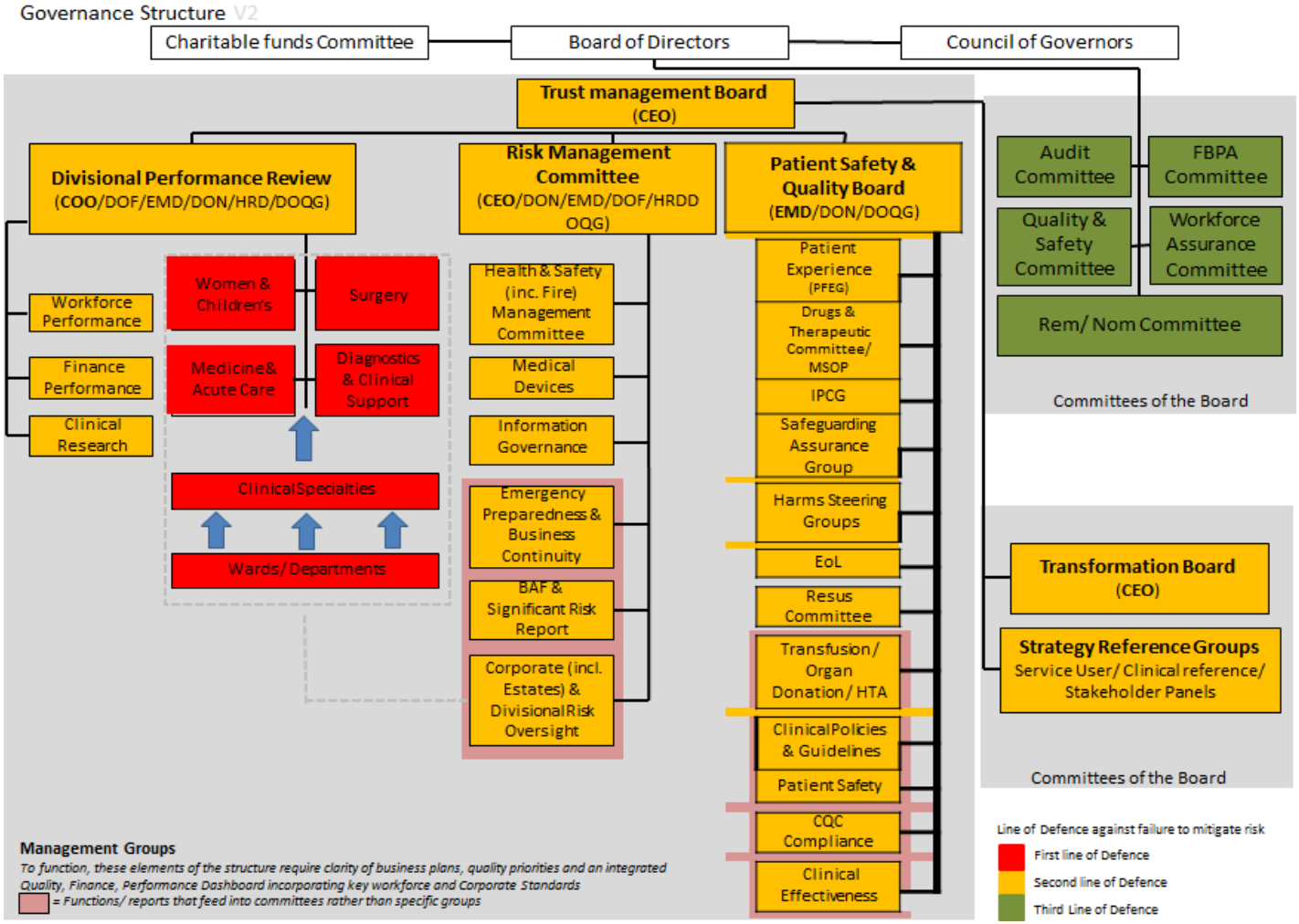
17.0 Conclusion

The above report details annual infection prevention & control activities in 2020/21 and the forward Infection Prevention & Control plan for 2021/22. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest Department of Health (DH), Public Health England or other relevant strategy and regulations.

Jay Turner-Gardner
Associate Director of Nursing - Infection Prevention & Control
Deputy Director of Infection and Prevention and Control

APPENDIX 1

Governance Structure



APPENDIX 2

Infection Prevention and Control Group
Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via PSQB to the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Associate director of Nursing –Infection Prevention and Control who is also the deputy DIPC.

2. CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (Chair)
- Associate Director of Nursing – Infection Prevention & Control/Deputy DIPC
- Consultant Microbiologist/Infection Control Doctor
- Clinical Scientist – Environmental microbiology
- Infection Prevention and Control data analyst
- Divisional Directors of Nursing
- Occupational health representative
- Antimicrobial Pharmacist
- Associate Director of Governance
- Director of Estates and Facilities
- Trust Decontamination lead
- Consultant in Public Health (PHE)
- Wirral Community Health and Care NHS Foundation Trust representative (WCHC)

CLINICAL LEADS FROM DIVISIONS

- Surgery Representative
- Women & Children representative
- Medicine and Acute representative
- Diagnostics and Clinical support representative

3. QUORUM

In order for decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 6 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor and the Associate Director of Nursing Infection Prevention and Control, including 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month. (12 times Per year)

6. OVERVIEW

The Infection Control Group is a sub –Committee of the Patient Safety and Quality Board (PSQB) and develops and monitors the core Infection Prevention and Control strategic objectives. The core objectives are agreed by the Trust Board and are based on WUTH organisational priorities. The Trust IPCG will oversee and monitor the operational IPC programme.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive with relevant information and advice.

Interpret and advise on national Infection Prevention and Control policy, relating it to the local situation.

Ensure NHS core standards and Department of Health recommendations on infection prevention and control are implemented

Review infection surveillance data, monitor performance and make recommendations for further action

Introduce, maintain and approve infection prevention and control policies and guidelines that promote a safe quality patient experience

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment, e.g. Health Act 2008.

Ensure that training and supervision systems regarding Infection Prevention and Control are in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams

Recommend an annual infection prevention and control programme; monitor and review the progress of the programme and produce an annual report Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary

perspectives and have considered the impact across all of the Directorates and departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

Members have a responsibility to Present to the IPCG divisional/departmental progress with reducing directorate/ departmental risks.

8. ORGANISATION

The IPCG is serviced by the Associate Director of Nursing – Infection Prevention and Control's Secretary /Admin support who organises the meetings.

The Associate Director of Nursing – Infection Prevention and Control / Deputy DIPC will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A quarterly chairs report will be submitted to the PSQB prepared by the deputy DIPC and an assurance report submitted monthly.

The Minutes of the Decontamination group, Antimicrobial Stewardship group, Ventilation safety group and Monthly Divisional IP&C meetings will be considered at each meeting.

Estates & Facilities will provide Quarterly summaries regarding activities as Stated in criterion 1 and 2 of the Health and Social Care Act 2008

The ToR for the group will be review annually.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	

11. DOCUMENT OWNER

Infection Prevention and Control Secretary / Team Administrator

APPENDIX 3

Annual Infection Prevention Audit Programme
2021/2022

Delivery of this audit plan is to support the Trust in meeting the NHS Commissioning Boards delivery of 'zero tolerance on MRSA bloodstream infection' and provider objectives for *Clostridium difficile* as set out in the *Clostridium difficile* infection objectives for NHS organisations in 2019/20 and guidance on sanction implementation. It also supports local compliance with the Health Act (2012), *'Saving Lives'* (2011) and Care Quality Commission standards.

	Audit topic	*Frequency*	*Where identified*	*Where reported*	*Responsibility*	*Lead*
1	Hand Hygiene (compliance & technique)	At least Monthly, Daily during COVID	IP Audit plan Directorate Action Plan Perfect ward app	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma	Directorate	Ward/ Departmental Managers
2	Environmental audit	Annual by IPC As required by Directorate	IP Audit plan Directorate Action Plan Perfect ward app PLACE	Directorate Governance meetings Monthly Infection Prevention Control group meetings *Clostridium difficile* , Bacteraemia & COVID RCA proforma	IPC and Directorate	Ward/ Departmental Managers
3	Patient shared equipment	Monthly	IP Audit plan Directorate Action Plan Perfect ward app PLACE	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma	Directorate	Ward/ Departmental Managers
4	Food safety	Monthly	IP Audit plan Perfect ward app PLACE	Monthly Infection Prevention performance meetings Directorate Governance meetings	Directorate	Ward/ Departmental Managers

5	*'Saving Lives'* High Impact Interventions Numbers 1-7	Monthly/as and when required	IP Audit plan Directorate Action Plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma as appropriate	Directorate	Ward/ Departmental Managers
6	Antimicrobial point prevalence audit	Monthly	IP Audit plan Directorate Action Plan Antimicrobial audit plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings	Pharmacy	Antimicrobial pharmacist
7	Commode audit	Annual	IP Audit plan Directorate Action Plan	Directorate Governance meetings Monthly Infection Prevention & Control group meeting *Clostridium difficile* RCA	Infection Prevention Team	Infection Prevention Team
9	Blood culture contamination audit	Quarterly	IP Audit plan Directorate Action Plan	Infection Prevention & Control group meeting Directorate Governance meetings	Microbiology	I P Doctor & IPC analyst
10	MRSA screening compliance	Monthly	IP Audit plan Directorate Action Plan	Infection Prevention & Control group meeting Directorate Governance meetings	Infection Prevention Team	IPC Analyst
11	COVID screening compliance	Daily/ Monthly	IP Audit plan Directorate Action Plan	Infection Prevention & Control group meeting Directorate Governance meetings	Infection Prevention Team	IPC Analyst
12	Mattress audit	Weekly /Following discharge of a patient	Perfect ward	Infection Prevention & Control group meeting Directorate Governance meetings	Directorate	Ward/ Departmental Managers

APPENDIX 4

Infection Prevention Annual Plan 2021/2022

The 2021-2022 IPC annual plan describes the methods that will be used to accomplish the objectives as set out in the newly developed 3yr IPC strategy which reflects the

i) The Health and social care act – Code of practice on the prevention and control of infections and related guidance, which sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations

ii) National and local objectives.

Strategic objective	Action
Objective 1 Training and Education Regulation 12 & 7 (CQC) , Criterion 1 (The Hygiene Code)	• Develop link nurse programme • Annual IPC campaign • Monthly newsletter • Develop Matron Education programme • Develop role of Environmental safety Champion • Develop and launch an IPC training matrix for all levels of staff Trust wide to reinforce best practice through education
Objective 2 Audit & Surveillance	• Complete mandatory surveillance of Infection • Provide timely information to divisions of alert organisms to monitor infections and detect potential outbreaks. • Support timely and effective RCAs • Work with the surgical division to develop SSI strategy and establish an SSI group to develop surveillance of SSI

Regulation 9, Criterion 4	programme • Facilitate screening compliance reports to the divisions to promote improvements • Work in partnership with commissioners/providers across Wirral to reduce the incidents of Gram Negative Blood Stream Infection by 50% by March 2023 • Review IPC audit tools within perfect ward to ensure they reflect national standards
Objective 3 Policies & Procedures Regulation 12, Criterion 1 & 9	• Develop a Carbapenemase producing *enterobacteriaceae* (CPE) policy based on new national guidance and operational v risk based benefits to patients • Review the existing MRSA policy to ensure that it meets with the current national guidelines • Review and update the CDI policy • Provide a policy review update to the IPCG bi-monthly • Collaborative working with key stakeholders in Wirral to develop a Wirral wide Flu plan
Objective 4 Care Environment Regulation 15, Criterion 2 & 7	• Monthly meetings with Estates and Facilities • Review environmental cleaning audit process • Attend water and Ventilation safety groups. • Ensure appropriate IPC representation at all schemes meetings • Ensure appropriate IPC representation at the Decontamination meeting

Objective 5 Communications & Information Regulation 17, Criterion 5	• Review the IPC patient information leaflets • Work with the communications team to ensure IPC updates are communicated trust wide • IPC representation at IPC Divisional meetings • Work with information to develop the IPC BI portal
Objective 6 Research & Innovation Criterion 9	• To review and investigate any IPC innovations that can be introduced to support the teams with IPC improvements • Support the introduction of new technologies • Work in collaboration with procurement to promote cost effective care delivery. • Develop a quality improvement project for Infection Prevention
Objective 7 Antimicrobial Stewardship Regulation 12, Criterion 3 & 9	• Support attendance at the antimicrobial sub – committee • Review antimicrobial practice as part of the CDI RCA programme • Weekly contribution to the CDI meeting

Agenda Item:BM21/22-114a

BOARD OF DIRECTORS

4 August 2021

Title:	Workforce Disability Equality Standards Report
Responsible Director:	Debs Smith, Interim Executive Director of Workforce
Presented by:	Sharon Landrum, Diversity and Inclusion Lead

Executive Summary

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

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

Overall, the experiences of our disabled staff are less positive than compared to non-disabled colleagues however, a number of positive improvements can be seen this year particularly with regards to staff survey feedback.

Staff survey data shows a positive improvement in 8 out of the 9 indicators, with significant progress made in some areas (improvement of 5% or more) >8.2% since 2018. All except 2 indicators are now above the national average.

It is particularly pleasing to see an increase in the number of disabled staff who reported if they had experienced bullying, harassment or abuse in the last 12 months (from 46.6% last year to 49.2% this year), as this was identified as an area of concern in the 2019/20 report.

Recruitment data also identifies an improvement in the likelihood of disabled applicants being appointed compared to non-disabled staff, with an improvement from 2:14 to 1:17.

A particular area of concern this year however is the number of disabled staff who feel their work is valued by the Trust, has unfortunately reduced from 32.5% last year to only 30.1% this year and falls significantly lower than the national average of 37.4%

Work has been taking place to ensure improvements for our disabled staff with our staff network involved in identifying and shaping the actions taken. It is felt that this may have contributed to the improvements seen so far and it is therefore hoped that the findings of this report will continue to direct areas of focus and provides opportunities to recognise and celebrate areas of improvement.

An action plan has been developed to ensure continuous improvements are made, however action moving forward are currently under review in line with the wider diversity and inclusion action plan, so as to ensure a more streamlined approach.

Appendix 1 is the full report that contains data required for national submission by 31 August 2021 and the report to be uploaded to the public section of the Trust's website by 31 October 2021.

Recommendation
• To note improvements made and areas for attention and approve data for national submission by 31 August 2021

Which strategic objectives this report provides information about:	
Compassionate Workforce	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)		
None		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
Required to uphold Equality Act 2010, Public Sector Equality Duties, CQC well led domain and actions contained within Trust's standard contract		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
None		
Specific communications and stakeholder /staff engagement implications		
None		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Seeking to provide positive improvements for those with disabilities and long-term health conditions		
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)		
None		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

Board of Directors
4 August 2021
Workforce Disability Equality Standards Report

Purpose

To provide an update on the Trust's position against the 10 national Workforce Disability Equality Standards WDES metrics and to further understand the experiences of our disabled staff compared to our non-disabled staff. This report also compliance with the national WDES reporting and WUTH's standard contract requirements.

Introduction / Background

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

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

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

Trusts are therefore required to ensure data for all ten metrics is uploaded to a government portal by no later than 31 August 2021 and a detailed report, including an action plan to address any differences is made public by no later than 31 October 2021.

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

Conclusions

Whilst the experiences of our disabled staff is less than our non-disabled in many areas, the gap has narrowed and a number of significant improvements can be seen within the data this year and over the last 2 years.

The Trust's disabilities staff network has been extremely proactive, identifying and supporting the development of a number of new initiatives.

Trust communications have increased in this area, with national and international awareness days promoted more, with WUTH staff sharing their experiences and offering support locally.

The full report is attached at appendix 1 with data that will be uploaded to a national portal by 31 August 2021 and the report to be uploaded to the public facing section of the Trust's website.

Updates on the 2019/20 action plan are also included within the report at appendix B, however all diversity and inclusion related action plans are currently under review so as to ensure greater streamlining and will be included within the final version of the report for uploading.

WDES staff survey summary data is attached at appendix C.

Recommendations to the Board

Appendix 1
Data has not been uploaded to the national data portal as yet and therefore members are asked to note the improvements made and also the areas still requiring attention.

Members are asked to approve the data for national submission.

Wirral University Teaching Hospital
NHS Foundation Trust

Appendix 1

Workforce Disability Equality Standards (WDES) Report

July 2021

Sharon Landrum, Diversity and Inclusion Lead

Contents

Background

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

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

Full details of the metrics are attached at Appendix A.

Executive Summary

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

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

Overall, the experiences of our disabled staff are less positive than compared to non-disabled colleagues however, a number of positive improvements can be seen this year particularly with regards to staff survey feedback.

Staff survey data shows a positive improvement in 8 out of the 9 indicators, with significant progress made in some areas (improvement of 5% or more) >8.2% since 2018. All except 2 indicators are now above the national average.

It is particularly pleasing to see an increase in the number of disabled staff who reported if they had experienced bullying, harassment or abuse in the last 12 months (from 46.3% last year to 49.2% this year), as this was identified as an area of concern in the 2019/20 report.

Recruitment data also identifies an improvement in the likelihood of disabled applicants being appointed compared to non-disabled staff, with an improvement from 2:14 to 1:17.

A particular area of concern this year however, is the number of disabled staff who feel their work is valued by the Trust. The results have unfortunately deteriorated this year from 32.5% last year to only 30.1% this year and falls significantly lower than the national average of 37.4%

It is important to note however that recruitment reporting data for 2018/19 is not directly comparable as TRAC was implemented in October 2018 and so annual data for that year was not complete. Backlogs also existed in completing the process on TRAC for those who had been appointed, with appointed applicants and their demographics not fully up to date for 2019/20 data.

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

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

Since the launch of the WDES, work has been taking place ensure improvements for our disabled staff and it is therefore hoped that the findings of this report will continue to direct areas of focus and provides opportunities to recognise and celebrate areas of improvement.

Work will continue to take place to ensure actions are taken forward in these areas and are updates monitored by the Diversity and Inclusion Steering Group and through the workforce governance structure.

Metric 1

Staff breakdown for 2020/21 (all staff)

As at the 31st March 2021, the self-reporting rate for those staff with a disability within WUTH is 2%.

A total of 131 staff have identified they have a disability, with 86 staff in a clinical role and 45 staff in a non-clinical role.

Numbers of staff who have declared a disability have increased over the last couple of years; however %'s are still small, with a large number of staff still remaining unspecified within ESR.

Breakdown of disability declaration categories by clinical and non-clinical

	Total Clinical Staff 2021	% of Clinical 2021	% of Clinical 2020	Total Non-Clinical Staff 2021	% of non-clinical 2021	% of non-clinical 2020	Combined 2021	% overall 2021	% overall 2020
Disabled	86	2.0	1.8	45	2.1	1.9	131	2.0	1.9
Non-disabled	2721	63.0	60.5	1150	53.4	48.4	3871	59.8	56.6
Not declared	196	4.5	4.1	109	5.1	5.3	305	4.7	4.5
Prefer not to answer	1	0.0	0.0	0	0.0	0	1	0.0	0
Unspecified	1316	30.5	33.5	850	39.5	44.4	2166	33.5	37.1
TOTAL	4320	100.0	100.0	2154	100.0	100	6474	100.0	100

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

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

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

		Clinical				Non- Clinical				Total Headcount	Total WTE	Total % of Row	Total % of Column
WDES Cluster	Disability	Headcount	WTE	% of Row	% of Column	Headcount	WTE	% of Row	% of Column				
Cluster 1	No	858	728.27	52.39%	19.47%	922	661.78	47.61%	39.77%	1780	1390.05	100.00%	25.72%
Bands 1-4	Not Declared	63	47.56	43.11%	1.27%	97	62.77	56.89%	3.77%	160	110.32	100.00%	2.04%
	Unspecified	381	317.23	36.04%	8.48%	737	562.91	63.96%	33.82%	1118	880.14	100.00%	16.29%
	Yes	30	26.05	54.57%	0.70%	29	21.69	45.43%	1.30%	59	47.74	100.00%	0.88%
Cluster 2	No	1380	1215.03	89.22%	32.49%	151	146.88	10.78%	8.83%	1531	1361.91	100.00%	25.20%
Bands 5-7	Not Declared	98	73.22	89.86%	1.96%	9	8.27	10.14%	0.50%	107	81.49	100.00%	1.51%
	Unspecified	771	648.61	89.10%	17.34%	85	79.35	10.90%	4.77%	856	727.97	100.00%	13.47%
	Yes	49	41.82	81.25%	1.12%	10	9.65	18.75%	0.58%	59	51.48	100.00%	0.95%
Cluster 3	No	115	107.99	72.38%	2.89%	42	41.20	27.62%	2.48%	157	149.19	100.00%	2.76%
Bands 8a & 8b	Not Declared	10	8.98	74.97%	0.24%	3	3.00	25.03%	0.18%	13	11.98	100.00%	0.22%
	Unspecified	68	61.34	74.76%	1.64%	21	20.71	25.24%	1.24%	89	82.04	100.00%	1.52%
	Yes	2	2.00	28.57%	0.05%	5	5.00	71.43%	0.30%	7	7.00	100.00%	0.13%
Cluster 4	No	11	10.43	27.85%	0.28%	28	27.01	72.15%	1.62%	39	37.44	100.00%	0.69%
	Not Declared	3	3.00	100.00%	0.08%			0.00%	0.00%	3	3.00	100.00%	0.06%
8c - 9 & inc VSM	Unspecified	4	4.00	39.99%	0.11%	7	6.00	60.01%	0.36%	11	10.00	100.00%	0.19%
	Yes			0.00%	0.00%	1	1.00	100.00%	0.06%	1	1.00	100.00%	0.02%
Cluster 5	No	181	171.27	100.00%	4.58%			0.00%	0.00%	181	171.27	100.00%	3.17%
	Not Declared	15	14.38	100.00%	0.38%			0.00%	0.00%	15	14.38	100.00%	0.27%
Consultants	Unspecified	71	67.51	100.00%	1.81%			0.00%	0.00%	71	67.51	100.00%	1.25%
	Yes	2	2.00	100.00%	0.05%			0.00%	0.00%	2	2.00	100.00%	0.04%
Cluster 6	No	82	71.09	100.00%	1.90%			0.00%	0.00%	82	71.09	100.00%	1.32%
	Not Declared	5	4.11	100.00%	0.11%			0.00%	0.00%	5	4.11	100.00%	0.08%
Career Grades	Unspecified	21	16.53	100.00%	0.44%			0.00%	0.00%	21	16.53	100.00%	0.31%
Cluster 7	No	94	92.10	100.00%	2.46%			0.00%	0.00%	94	92.10	100.00%	1.70%
	Not Declared	2	2.00	100.00%	0.05%			0.00%	0.00%	2	2.00	100.00%	0.04%
Trainee Grades	Prefer Not To Answer	1	1.00	100.00%	0.03%			0.00%	0.00%	1	1.00	100.00%	0.02%
	Yes	3	2.60	100.00%	0.07%			0.00%	0.00%	3	2.60	100.00%	0.05%
Other	No			0.00%	0.00%	7	7.00	100.00%	0.42%	7	7.00	100.00%	0.13%
Grand Total		4320	3740.14	69.21%	100.00%	2154	1664.22	30.79%	100.00%	6474	5404.36	100.00%	100.00%

Key Findings:-

The number of staff identified as disabled have increased over the last couple of years, however are still significantly low and fall below the national average of 3%. The number of staff remaining unspecified are therefore still high with 33.5% of staff still unspecified and therefore work is needed to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

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

Metric 2

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

A new TRAC Recruitment system was introduced for use with all posts with effect from 1 September 2018. Data comparisons to 2018/19 are therefore unfortunately not directly comparable.

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

	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Outcome: Recruited	Outcome: Recruited (%)
None disabled	15958	93.2	10470	94.1	946	84.2
Disabled	766	4.5	517	4.6	40	3.6
Do not wish to disclose / unstated	390	2.3	144	1.3	137	12.2
Total	17114	100	11131	100	1123	100

Annual Comparison

	% applied			% shortlisted			% appointed		
	2019	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020***	**2021**
None disabled	94.8	93.9	93.2	95.3	94.1	94.1	91.9	87	84.2
Disabled	3.1	4.1	4.5	3	4.7	4.6	1.4	2	3.6
Do not wish to disclose / unstated	2.1	2	2.3	1.7	1.2	1.3	6.7	11	12.2

Guaranteed Interview Scheme

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

Guaranteed Interview Scheme data

	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Outcome: Recruited	Outcome: Recruited (%)
None disabled	8643	50.5	5391	48.4	621	55.3
Disabled	526	3.1	367	3.3	11	1
Not stated	7945	46.4	5373	48.3	491	43.7
Total	17114	100	11131	100	1123	100

Guaranteed Interview Scheme Annual Comparison

	% applied			% shortlisted			% appointed		
	2019	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
No	13.2	23.3	50.5	11	21.4	48.4	22.3	26.5	55.3
Yes	1.9	3	3.1	2	3.5	3.3	0.5	1.3	1
Not Stated	84.9	73.8	46.4	87	75.1	48.3	77.2	72.1	43.7

Key Findings

Of the 17,114 total applications received via TRAC, 766 applications (4.5%) were from disabled applicants, 15,958 applications (93.2%) from non-disabled applicants and 390 (2.3%) did not wish to disclose or were unstated as to whether they had a disability or not.

11,131 (65%) applications were shortlisted and of those, 517 were disabled (4.6%), 67.5% of the disabled applicants who applied (69.2% in 2019/20). 10,470 shortlisted applications were from non-disabled applicants (65.6% of those that applied) and 137 applications did not wish to disclose this information or were unstated (35.1% of those who applied).

1123 (6.6%) were appointed, 40 applicants (3.6%) were disabled, 946 applicants (84.2%) were non-disabled and 137 applicants (12.2%) did not wish to disclose or were unstated.

The data highlights a 1:17 likelihood that disabled applicants will be appointed compared to non-disabled applicants which has also significantly improved from last year at 2.14.

Further discussions and planning are already underway to review recruitment processes and therefore this area should be reviewed as a focus area for 2020/21.

Metric 3

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

For the 2 year rolling period ending 31 March 2021, 3 people entered the formal capability process, and none were disabled.

National NHS Staff Survey Findings

The next 4 metrics are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination. A summary overview can also be found at appendix C

Metric 4

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

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months (chart 1)
   ii) Managers (chart 2)
   iii) Other colleagues (chart 3)

Chart 1

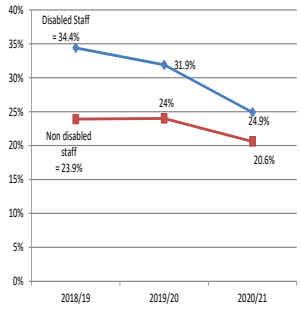


Chart 2

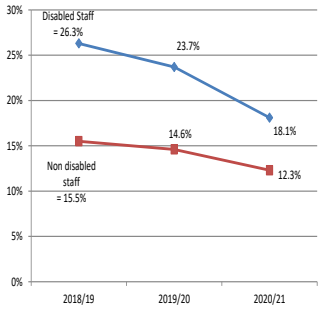
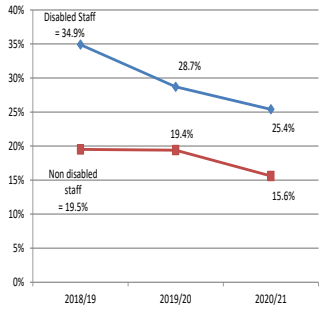


Chart 3



Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months		2018/19	2019/20	2020/21	National Average 2020/21
	Disabled staff	34.4%	31.9%	24.9%	30.9%
	Non-disabled staff	23.9%	24.0%	20.6%	24.5%

Percentage of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months		2018/19	2019/20	2020/21	National Average 2020/21
	Disabled staff	26.3%	23.7%	18.1%	19.3%
	Non-disabled staff	15.5%	14.6%	12.3%	10.8%

Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months		2018/19	2019/20	2020/21	National Average 2020/21
	Disabled staff	34.9%	28.7%	25.4%	26.9%
	Non-disabled staff	19.5%	19.4%	15.6%	17.8%

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

% of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it		2018/19	2019/20	2020/21	National Average 2020/21
	Disabled staff	55.3%	46.6%	49.2%	47.0%
	Non-disabled staff	43.8%	45.4%	43.1%	45.8%

There has been an increase from 46.6% last year to 49.2% this year, of disabled staff who said that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. This is compared to only 43.1% of non-disabled staff which unfortunately reduced this year from 45.4% last year.

This was an area of concern last year and it is therefore good to see positive improvements in this area, with results now above the national average and better than that of non-disabled colleagues.

Key findings

Significant improvement can be seen in the data this year with less disabled staff reporting that they have experienced harassment, bullying and abuse this year, in each of the indicators.

Improvements can also be seen in the number of disabled staff who reported the last time they experienced bullying, harassment or abuse, which is significant, particularly as the numbers for non-disabled staff has reduced.

Metric 5

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

	2018/19	2019/20	2020/21	National Average 2020/21
Disabled staff	75.9%	76.0%	77.5%	79.6%
Non-disabled staff	85.4%	86.5%	87.2%	86.3%

Whilst results for disabled staff are still significantly lower than non-disabled staff in this area, improvements can be seen again this year with result improving from 76.0% to 77.5% of disabled staff believing that the Trust offers equal opportunities for career progression or promotion. The results continue to fall below the national average.

Metric 6

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

	2018/19	2019/20	2020/21	National Average 2020/21
Disabled staff	39.9%	35.1%	30%	33%
Non-disabled staff	26.8%	23.4%	27.6%	23.4%

Significant improvements can be seen in the results for disabled staff this year, with results reducing from 35.1% last year to 30% this year. Results now also fall below the national average. Whilst results continue to still be higher than non-disabled staff, the improvements are extremely positive, particularly as results for non-disabled colleagues have increased this year and are now unfortunately above the national average.

Metric 7

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

	2018/19	2019/20	2020/21	National Average 2020/21
Disabled staff	29.1%	32.5%	30.1%	37.4%
Non-disabled staff	40.8%	44.1%	44.3%	49.3%

Unfortunately the results have decreased in this area this year, with less disabled staff feeling valued than last year and continuing to fall below the national average and below that of non-disabled colleagues.

Metric 8

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

	2018/19	2019/20	2020/21	National Average 2020/21
Disabled staff	66.5%	72.9%	75.4%	75.5%

There has been a further improvement in the results this year with 75.4% of staff feeling that the Trust has made adequate adjustment(s) to enable them to carry out their work. This has seen significant improvements since 2018/19 and now falls only 0.1% below the national average.

Metric 9

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

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

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

Staff Engagement Scores

	2018/19	2019/20	2020/21	National Average 2020/21
Disabled staff	6.3	6.4	6.5	6.7
Non-disabled staff	6.8	6.9	6.9	7.1
WUTH	6.7	6.8	6.8	

In terms of part a) whilst scores for disabled colleagues fall below that of non-disabled colleagues, scores have increased again this year and now fall just 0.1 below the national average. This is also significant when the scores for non-disabled colleagues have remained the same and also fall below the national average.

Part b

Yes – the Trust has taken a number of actions to facilitate the voices of disabled staff within the Trust to be heard.

The Trust's disability and long-term health condition staff network (WUTH Sunflowers), was established in 2018 and continues to meet regularly. The group provides an opportunity for staff to meet up and support each other, but to also listen to the experiences of others, share information, advice and guidance with each other and contribute to shaping the actions that the Trust moves forwards with and providing feedback on areas such as WDES.

2020/21 has seen a wide variety of support, engagement, awareness raising and promotional opportunities including:

- New disability policy and reasonable adjustment documentation
- Launch of the hidden disabilities sunflower badge/lanyard initiative
- Awareness sessions – delivered by experts in the field – Remploy
- Staff experiences, shared across the Trust in a variety of ways
- Staff trained to be mentors to colleagues across the Trust

Staff are signposted to a training programme to raise awareness of the sunflower "hidden disabilities" initiative and how to recognise and support patients and colleagues who may be wearing one.

Regular communications are produced to raise awareness of key national and international awareness days and links made to areas for consideration, action needed and support services available for both staff and patients e.g. staff recently reminded of some top tips to remember as part of Deaf Awareness week on how to communicate better using masks, how to wear masks with hearing aids and the importance of looking after patient hearing aids! WUTH sunflowers continues to be offered as a support network for staff, with staff encouraged to get involved as much or as little as people feel able.

Metric 10

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

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

As at 31 March 2021, the Trust had 13 voting members of the board.

There are 16 executive members of the Board altogether, 1 of whom is disabled.

Conclusion

The Trust has been working hard on trying to improve the experiences of our disabled staff and therefore it is pleasing to see a number of significant improvements within the staff survey data metrics this year.

That said, experiences are still lower than those of non-disabled colleagues in the majority of areas and so work must continue in order to ensure improvements continue.

It is particularly pleasing to see improvements in the areas of concern from 2019/20 however focus should now be placed on understanding further work that could be done to ensure our disabled staff feel the work they do is valued.

Self-reporting rates continue to be low and so whilst COVID has impacted on the ability to engage locally with staff in areas, it is hoped that alternative methods can be used and engagement opportunities utilised as soon as COVID restrictions permit.

Efforts to ensure that the voices of staff with disabilities or long-term health conditions continue, however further Trustwide promotion of the staff network must take place, with management encouragement and support for staff to attend.

WDES Metrics

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

WDES Metrics

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

WDES Action Plan Update – July 2021

No.	Objective	Actions	Lead	By	Progress	Comments
1	Increase disability self-reporting rates on ESR	• Continuation of additional drop in sessions to support staff access to ESR • Further Trustwide communications campaign to promote importance of self-reporting • Trustwide communications campaign • Sharing of staff stories and importance of self-reporting • Guidance documents on how to self-report your disability status • Targeted focus on key areas	ESR Team/ D&I Lead	Mar 21	Amber	Additional ESR drop in sessions held in 2019/20 however due to COVID, face to face sessions halted. Trust wide comms increased with regards to promotion of disabilities however no specific campaign launched regarding self-declaration rates. Questionnaire developed for use at wellbeing / engagement events to request central update of ESR information – usage delayed due to COVID and face to face meetings
2	Improve % of staff who feel the employer has made reasonable adjustments	• Survey of staff to uncover key priorities in improving awareness of reasonable adjustments and potential gaps or barriers • Support for managers in understanding their responsibilities to provide reasonable adjustments and what support is available • Sharing of staff stories who have received reasonable adjustments • Trustwide communications to promote support available	D&I Lead / HWB Lead	Mar 21	Green	Improvement achieved in last staff survey however a number of actions still to complete. New disability policy developed with new reasonable adjustment documentation and monitoring process. Increased staff experiences shared, linked with national and international awareness days.
3	Increase the staff engagement of disabled staff	• Further promotion of the disability and long-term health condition staff network and support mechanisms available for staff • Drop in opportunities for staff to access additional advice and support • Consider potential development opportunities aimed at disabled staff • Continue to promote new Trust values and behaviours and ensure all staff are monitored against the standards required • Trustwide communications to promote key areas.	D&I Lead / HWB Lead	Mar 21	Green	Staff engagement score improved. Staff network continues to be promoted with promotion via a variety of methods. Wellbeing event scheduled for March with community organisations, however cancelled due to COVID-19.
Additional Actions Required for 2020/21						
1	Ensure improvements are sustained	• Continue with actions identified above	D&I Lead	Mar 21	Green	Continued focus placed on support and a number of significant improvements seen with WDES 2020/21 data
2	Improve diversity	• Review Board level recruitment processes • Consider positive action required including links with community	D&I Lead / Director	Mar 21	Amber	Board level diversity increased Community engagement postponed

	representation at senior management levels	organisations to promote the Trust and opportunities	of Workforce			due to COVID

Summary of WDES Staff Survey Results From 2017/18 to 2020/21

Question		WUTH score 2017/18	WUTH score 2018/19	WUTH score 2019/20	Nat. Average 2019/20
% staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a LTC or illness	34.4%	31.9%	24.9%	30.9%
	Staff without a LTC	23.9%	24.0%	20.6%	24.5%
% staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a LTC or illness	26.3%	23.7%	18.1%	19.3%
	Staff without a LTC	15.5%	14.6%	12.3%	10.8%
% staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	Staff with a LTC or illness	34.9%	28.7%	25.4%	26.9%
	Staff without a LTC	19.5%	19.4%	15.6%	17.8%
% of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it	Staff with a LTC or illness	55.3%	46.6%	49.2%	47.0%
	Staff without a LTC	43.8%	45.4%	43.1%	45.8%
% staff believing that the organisation provides equal opportunities for career progression or promotion	Staff with a LTC or illness	75.9%	76.0%	77.5%	79.6%
	Staff without a LTC	85.4%	86.5%	87.2%	86.3%
% of staff who have felt pressure to come to work, despite not feeling well enough to perform their duties	Staff with a LTC or illness	39.9%	35.1%	30%	33%
	Staff without a LTC	26.8%	23.4%	27.6%	23.4%
% staff satisfied with the extent to which the organisation values their work	Staff with a LTC or illness	29.1%	32.5%	30.1%	37.4%
	Staff without a LTC	40.8%	44.1%	44.3%	49.3%
% of staff with a long lasting health condition or illness saying that their employer has made adequate adjustment(s) to enable them to carry out their work	Staff with a LTC or illness	66.5%	72.9%	75.4%	75.5%
Staff engagement score	Staff with a LTC or illness	6.3	6.4	6.5	6.7
	Staff without a LTC	6.8	6.9	6.9	7.1

Appendix 1

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: BM21/22-114b

BOARD OF DIRECTORS

4 August 2021

Title:	Workforce Race Equality Standard Report
Responsible Director:	Debs Smith, Interim Director of Workforce
Author:	Sharon Landrum, Diversity & Inclusion Lead
Presented by:	Sharon Landrum, Diversity & Inclusion Lead

Executive Summary

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

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

The results this year provide a mixture of positive and negative areas, with the following positives seen:

- Overall increase in BAME workforce (from 7.2% last year to 7.6% this year)
- Increase in the number of BAME staff feeling the Trust offers equal opportunities for career or promotion and
- Reduced number of BAME staff reporting harassment, bullying and abuse from patients and visitors

That said however, particularly concerning results are that negative increases can be seen in

1) the number of BAME staff who have experienced bullying, harassment or abuse from staff
2) BAME staff reporting experiencing discrimination from their manager, team leader or other colleagues
3) Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants

Appendix 1 highlights the summary of all indicator results, compared with NHS Trusts in England and appendix 2 provides the full report.

Work has been undertaken within 2020/21 to further support our BAME staff and understand their experiences, capture ideas for improvement and ultimately to offer additional support. The Trust reconvened its BAME staff network in June 2020, which continues to meet regularly and is growing slowly, but steadily.

Network members now feel able to share their experiences more widely and to be part of wider cultural awareness / competence support programmes and to support colleagues in a variety of new ways e.g. mentorship programmes.

An Executive Partner, Hazel Richards, was identified for the staff network and the Trust have made efforts to improve Trust wide communications and anti-racist messages

however there is recognition that there is opportunity to do more. A review is currently being undertaken of the overarching actions required within this and the wider diversity and inclusion agenda, along with the resources required to ensure effective delivery.

Recommendation
1) To note and approve the attached data and report 2) Members to consider actions required in order to seek assurance that improvements can be seen

Which strategic objectives this report provides information about:	
Compassionate workforce: be a great place to work	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)		
None		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
Required to uphold Equality Act 2010, Public Sector Equality Duties, CQC well led domain and actions contained within Trust's standard contract		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
None		
Specific communications and stakeholder /staff engagement implications		
None		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Seeking to provide positive improvements for those with disabilities and long-term health conditions		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
None		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information	Summary of results per indicator, compared to NHS Trust in England attached at appendix 1	

Appendix 1

Board of Directors
4 August 2021

WORKFORCE RACE EQUALITY STANDARDS REPORT 2021

Purpose

This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment standard contractual requirements and the public sector equality duty as set out in the Equality Act 2010.
The aim of the WRES is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS. The group is asked to note the key findings and approve the data and report.

Introduction / Background

Since 2014, the NHS Equality & Diversity Council decided to implement a workforce race equality standard within the standard contract. The standard requires NHS organisations to demonstrate progress against a number of indicators of workforce equality.

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

Each Trust is required to prepare and submit an annual report containing data relating to BAME staff in the workforce and progress towards improvement. Data must be shared via a national portal by 31 August 2021 and the final report should be published by 31 October 2021 and shared with commissioners.

The full report is attached with details for each metric required, with the exceptions of one area that is unfortunately still awaiting data to be ratified (indicator 4). It is anticipated that this information will be submitted to August's Workforce Steering Board for ratification before the national reporting deadline of 31 August. Annual comparative data is also provided so as to monitor trends and an update on last year's action plan is also included.

A review of all workforce related diversity and inclusion action plans is currently underway, with a view to compiling a more integrated approach. Key actions required for ensuring improvements with the WRES data will be included within the new plan and submitted for approval through the workforce governance structure.

Conclusions

Whilst there are some positives within the report, there have been a number of negative results and therefore actions must be taken in order to ensure that improvements can be achieved.

A review is currently being undertaken of the overarching actions required within this and the wider diversity and inclusion agenda, along with the resources required to ensure effective delivery.

Recommendations

1) To note and approve the attached data and report
2) Members to consider actions required in order to seek assurance that improvements can be seen

Appendix 1

WRES Indicator Summary table for NHS trusts in England compared to WUTH

WRES Indicator			NHS Trusts in England 2019/2020	WUTH 2019/2020	WUTH 2020/2021
1	% of BAME Staff	Overall	21.0%	7.2%	7.6%
		VSM	6.8%	0.0%	0.0%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants		1.61	3.19	3.28
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff		1.16	0.31	2.39* under review
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff		1.14	0.89	Awaiting data
5	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BAME	30.3%	30.1	22.3
		White	27.9%	25.4%	21.4%
6	% of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BAME	28.4%	25.5%	29.7%
		White	23.6%	29.4%	23.9%
7	% of staff believing that the Trust provides equal opportunities for career progression or promotion	BAME	71.2%	70.5%	71.1%
		White	86.9%	85.3%	86.3%
8	% of staff personally experiencing discrimination at work from a manager, team leader or other colleagues	BAME	14.5%	10.0%	13.4%
		White	6.0%	5.0%	5.3%
9	BAME Board membership		10.0%	0.0%	0.0%

Appendix 2

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Race Equality Standards (WRES)

Report and Action Plan

July 2021

Sharon Landrum, Diversity and Inclusion Lead

together we will

wuth.nhs.uk

Contents

Background

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

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

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

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

Executive Summary

The key findings from our WRES analysis for 2020/21 are as follows:-

The results this year provide a mixture of positive and negative areas, with the following positives seen:

- Overall increase in BAME workforce (from 7.2% last year to 7.6% this year)
- Increase in the number of BAME staff feeling the Trust offers equal opportunities for career or promotion and
- Reduced number of BAME staff reporting harassment, bullying and abuse from patients and visitors

That said however, particularly concerning results are that negative increases can be seen in

- the number of BAME staff who have experienced bullying, harassment or abuse from staff
- BAME staff reporting experiencing discrimination from their manager, team leader or other colleagues
- Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants

Work has been undertaken within 2020/21 to further support our BAME staff and understand their experiences, capture ideas for improvement and ultimately to offer additional support. The Trust reconvened its BAME staff network in June 2020, which continues to meet regularly and is growing slowly, but steadily.

Network members now feel able to share their experiences more widely and to be part of wider cultural awareness / competence support programmes and to support colleagues in a variety of new ways e.g. mentorship programmes.

An Executive Partner was identified for the staff network and the Trust have made efforts to improve Trust wide communications and anti-racist messages however there is recognition that much more still needs to be done.

Results are disappointing and concerning and therefore actions must be taken in order to ensure that improvements can be achieved.

A review is currently being undertaken of the overarching actions required within this and the wider diversity and inclusion agenda, along with the resources required to ensure effective delivery.

Total Staff by Ethnicity 31 March 2021

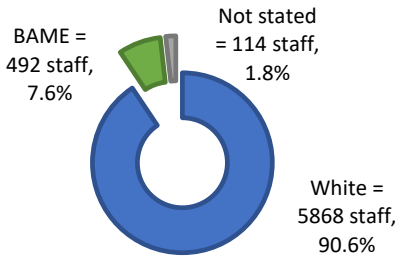
At 31 March 2021, a total of 6474 staff were employed by WUTH. Of these, 492 (7.6%) were BAME and 5868 (90.6%) were white. 114 staff however, (1.8%) were unstated for their ethnicity.

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

% Employed by Ethnicity

Ethnic Group	2021	2020	2019	2018	2017
White	90.6%	91.3%	91.5%	91.7%	96.8%
BAME	7.6%	7.2%	6.9%	6.8%	6.7%
Unknown	1.8%	1.5%	1.6%	1.5%	1.7%

Staff Employes as at 31 March 2021 by Ethnic Group



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

The WRES Standard Indicators

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

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

2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* **Note:** *this indicator will be based on data at 31 March.*
4	Relative likelihood of BAME staff accessing non-mandatory training and CPD.
National NHS Staff Survey findings (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff.	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	Percentage believing that trust provides equal opportunities for career progression or promotion.
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) manager/team leader or other colleagues
Boards representation indicator For this indicator, compare the difference for White and BAME staff	
9	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WUTH as a whole workforce for 2020/21.

Key Findings:-

- The percentage of BAME staff employed at WUTH has increased from 7.2% last year to 7.6% this year, with increases seen across the majority of pay bands.
- The percentage of BAME staff employed at WUTH (7.6%) is greater than the population of Wirral as a whole (5.5%, *2011 Census*), although the percentage is significantly higher in some areas e.g. medical and dental staff, bands 5 and 8d (although numbers within this pay band are only small). Levels are also higher within registered nursing and midwifery and healthcare scientist roles.
- The number of BAME clinical staff is significantly higher than non-clinical BAME staff with 10.7% of BAME staff being clinical and only 1.4% non-clinical.

Staff breakdown for 2020/21 (clinical and non-clinical combined)

Pay Band	White	BAME	Not Stated	Grand Total	% in Band 2021	% in band 2020	% in band 2019
Band 1	194	2	5	201	**1.0%**	0.8%	1.3%
Band 2	1668	70	23	1761	**4.0%**	3.8%	4.0%
Band 3	683	18	7	708	**2.5%**	2.7%	2.8%
Band 4	424	10	12	446	**2.2%**	2.2%	1.5%
Band 5	1045	131	15	1191	**11.0%**	10.0%	9.3%
Band 6	767	62	19	848	**7.3%**	6.7%	6.2%
Band 7	486	19	9	514	**3.7%**	2.4%	3.3%
Band 8A	172	14	5	191	**7.3%**	6.9%	5.0%
Band 8B	73	1	0	74	**1.4%**	1.5%	3.2%
Band 8C	28	0	1	29	**0.0%**	0.0%	0.0%
Band 8D	3	1	0	4	**25.0%**	28.6%	12.5%
Band 9	4	0	0	4	**0.0%**	0.0%	0.0%
M&D – Career Grade	55	47	6	108	**43.5%**	33.2%	33.2%
M&D – Consultant	170	89	10	269	**33.1%**	45.7%	46.0%
M&D – Trainee	70	28	2	100	**28.0%**	26.2%	34.1%
Other Incl VSM	26	0	0	26	**0.0%**	0.0%	0.0%
Grand Total	5868	492	114	6474	**7.6%**	7.2%	6.9%

Staff breakdown for 2020/21 (by Clinical and non-Clinical staff group)

Clinical/Non-Clinical	Staff Group	White	BAME	Not Stated	Grand Total	% BAME in group
Clinical	Add Prof Scientific and Technic	237	16	3	256	**6.3%**
	Additional Clinical Services	1211	81	12	1304	**6.2%**
	Allied Health Professionals	362	20	11	393	**5.1%**
	Healthcare Scientists	128	14	4	146	**9.6%**
	Medical and Dental	295	164	18	477	**34.4%**
	Nursing and Midwifery Registered	1523	166	23	1712	**9.7%**
	Students	29	0	3	32	**0.0%**
Non- Clinical	Administrative and Clerical	1142	22	23	1187	**1.9%**
	Estates and Ancillary	941	9	17	967	**0.9%**
Grand Total		5868	492	114	6474	**7.6%**

Clinical staff breakdown for 2020/21 (by pay band)

Pay Band	White	BAME	Not Stated	Grand Total	% BAME in band
Band 2	777	59	8	844	**7.0%**
Band 3	296	12	1	309	**3.9%**
Band 4	166	7	6	179	**3.9%**
Band 5	927	130	15	1072	**12.1%**
Band 6	705	58	12	775	**7.4%**
Band 7	424	18	9	451	**4.0%**
Band 8A	132	11	5	148	**7.4%**
Band 8B	45	1	0	46	**2.2%**
Band 8C	13	0	0	13	**0.0%**
Band 8D	1	1	0	2	**50%**
Band 9	2	0	0	2	**0.0%**
M&D – Career Grade	55	47	6	108	**43.5%**
M&D – Consultant	170	89	10	269	**33.1%**
M&D – Trainee	70	28	2	100	**28%**
Other Incl VSM	2	0	0	2	**0.0%**
Grand Total	3785	461	74	4320	**10.7%**

Non-clinical staff breakdown for 2020/21 (by pay band)

Pay Band	White	BAME	Not Stated	Grand Total	% BAME in band
Band 1	194	2	5	201	**1.0%**
Band 2	891	11	15	917	**1.2%**
Band 3	387	6	6	399	**1.5%**
Band 4	258	3	6	267	**1.1%**
Band 5	118	1	0	119	**0.8%**
Band 6	62	4	7	73	**5.5%**
Band 7	62	1	0	63	**1.6%**
Band 8A	40	3	0	43	**7.0%**
Band 8B	28	0	0	28	**0.0%**
Band 8C	15	0	1	16	**0.0%**
Band 8D	2	0	0	2	**0.0%**
Band 9	2	0	0	2	**0.0%**
Other Incl VSM	24	0	0	24	**0.0%**
Grand Total	2083	31	40	2154	**1.4%**

Indicator 2

This indicator relates to the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. The following chart provides the data for each of the recruitment phases, broken down into ethnicity.

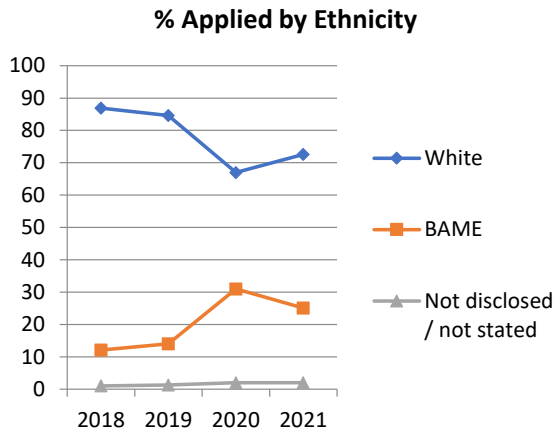
Summary of Data at Various Recruitment Stages

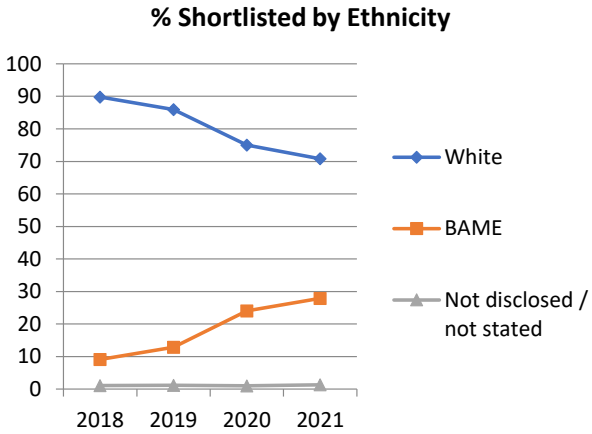
	All applications	All applications (%)	Shortlisting: All	Shortlisting: All (%)	Interview: All	Interview: All (%)	Outcome: Recruited	Outcome: Recruited (%)
White	12445	72.6	7885	70.8	2974	84.4	923	82.2
BAME Total	4322	25.1	3098	27.9	499	14.2	96	8.8
Not disclosed / not stated	347	2	148	1.3	54	1.5	104	9.3
Total	**17114**	**99.7**	**11131**	**100**	**3527**	**100.1**	**1123**	**100.3**

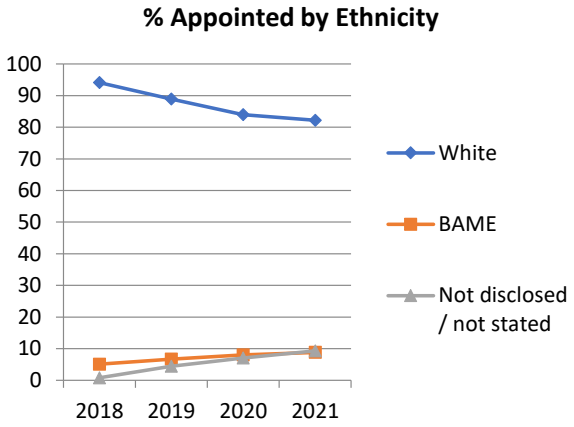
2018 to 2021 Data comparisons

	% applied				% shortlisted				% appointed			
	2018	**2019**	**2020**	**2021**	**2018**	**2019**	**2020**	**2021**	**2018**	**2019**	**2020**	**2021**
White	86.9	84.6	67	72.6	89.8	85.9	75	70.8	94.1	88.9	84	82.2
BAME	12.1	14	31	25.1	9.1	12.9	24	27.9	5.1	6.7	8	8.8
Not disclosed / not stated	1	1.3	2	2	1.1	1.2	1	1.3	0.8	4.4	7	9.3

Important Note: A new TRAC recruitment system was introduced for use with all posts with effect from 1 September 2018 and therefore 2018/19 data is therefore not directly comparable. The 2019/20 report also highlighted issues regarding a backlog of data for completed applicants and therefore data for % appointed was incomplete. Following a service review however, data provided is now identified as accurate.







Key Findings

Findings identify a reduction in the number of BAME applicants this year however an increase can be seen in the number of BAME applicants who have been shortlisted and also appointed.

That said, however, compared with the number of white applicants, the likelihood of white applicants being appointed from shortlisting compared to BAME applicants has increased this year from 3.19 to 3.28.

As noted above, appointment data is unfortunately not directly comparable with last year, therefore close monitoring in this area is required. There is also in increase in the number of those appointed who have chosen not to disclose their ethnicity and therefore this is an area that could be explored further as to potential reasons why this data has increased.

It is also important to note that whilst applicant data does appear to have reduced this year, 2019/20 data saw a significant increase in BAME applicants from 14% in 2018/19 to 31% in 2019/20, therefore data in this area must be continued to be monitored closely so as to identify any additional concerns.

Indicator 3

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

Key Finding:

Within 2020/21, 24 people entered the disciplinary process. 2 staff were BAME (0.4% of workforce numbers), 10 were white (0.2% of overall non-BAME workforce numbers) and 12 individuals have not disclosed their ethnicity (10.5% of not disclosed workforce numbers).

The data this year therefore currently identifies that BAME staff are more likely to enter the formal disciplinary process than compared to white staff. The data for not disclosed workers is significantly higher this year however and so further review of the data and links with ESR are currently being undertaken.

Indicator 4

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

Still awaiting final data

Key Findings

To be confirmed.

National NHS Staff Survey Findings

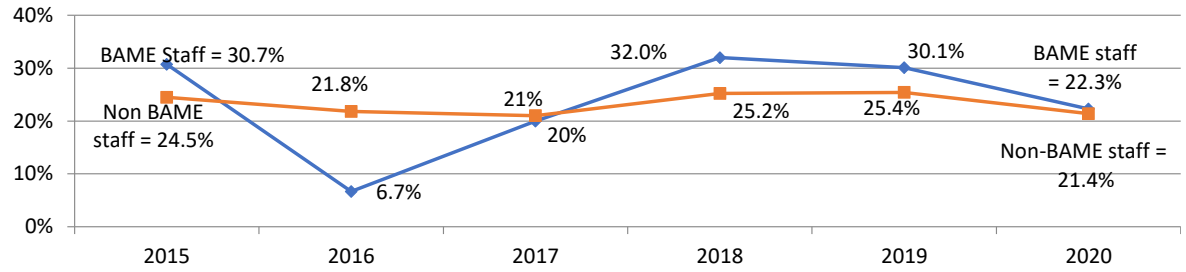
The next 4 indicators are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

Indicator 5

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

	2015	2016	2017	2018	2019	2020	National Average 2020
BAME Staff	30.7%	6.7%	20.0%	32.0%	30.1%	22.3%	28.0%
Non BAME colleagues	24.5%	21.8%	21.0%	25.2%	25.4%	21.4%	25.4%

Annual Data Comparison



Key Finding:

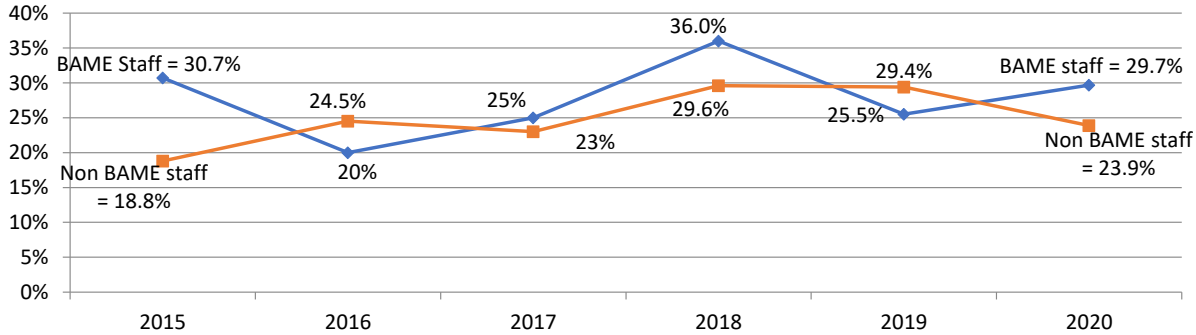
The Trust's score for this question has significantly improved this year from 30.1% to 22.3%.and is now below the national average of 28%. Whilst this still remains higher than for non-BAME colleagues the difference has reduced this year, with non-BAME colleagues at 21.4%.

Indicator 6

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

	2015	2016	2017	2018	2019	2020	National Average 2020
BAME Staff	30.7%	20.0%	25.0%	36.0%	25.5%	29.7%	29.1%
Non BAME colleagues	18.8%	24.5%	23.0%	29.6%	29.4%	23.9%	24.4%

Annual Data Comparison



Key Findings:

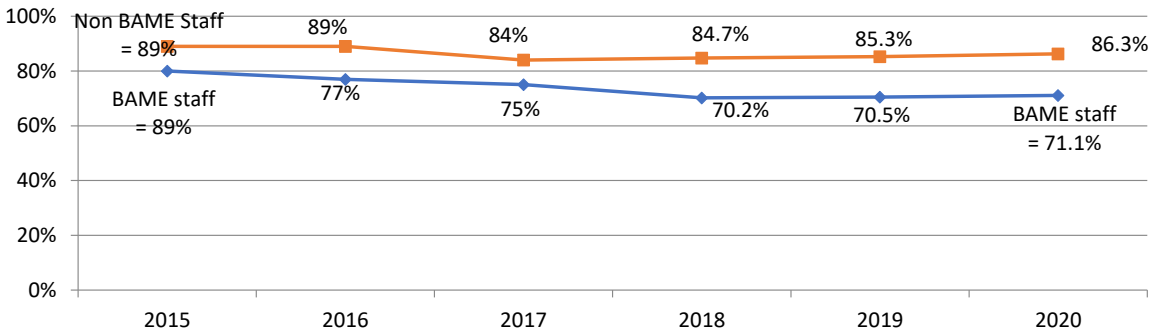
The Trust results have deteriorated this year increasing from 25.5% in 2019 to 29.7% this year. The results also now fall just above the national average of 29.1% and are higher than that of non-BAME colleagues at 23.9%.

Indicator 7

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

	2015	2016	2017	2018	2019	2020	National Average 2020
BAME Staff	80%	77%	75%	70.2%	70.5%	71.1%	72.5%
Non BAME colleagues	89%	89%	84%	84.7%	85.3%	86.3%	87.7%

Annual Data Comparison



Key Finding:

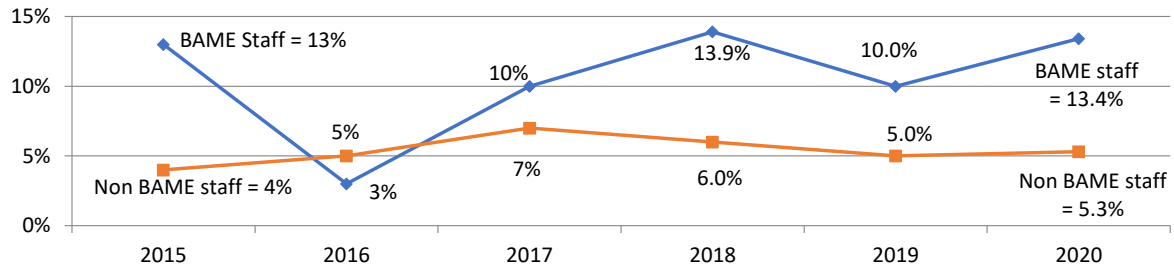
There has been an increase in BAME staff believing that the Trust offers equal opportunities for career progression or promotion (from 70.5% in 2019 to 71.1% this year).Whilst the results have increased, they are still significantly lower than that of non BAME colleagues and both still remain below the national average.

Indicator 8

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

	2015	2016	2017	2018	2019	2020	National Average 2020
BAME Staff	13%	3%	10%	13.9%	10.0%	13.4%	16.8%
Non BAME colleagues	4%	5%	7%	6.0%	5.0%	5.3%	6.1%

Annual Data Comparison



Key Finding:

Results for all staff highlight a negative increase this year; however the experience for BAME staff has increased more and is significantly higher than that of non-BAME colleagues. That said, both results are below the national averages.

Indicator 9

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

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

Key Finding:

As at 31 March 2021, the Trust had 13 voting members of the board, none of whom were BAME.

There are 16 executive members of the Board altogether, none of whom are BAME.

This gives a percentage difference for both the Trust boards voting and executive membership and its overall workforce of - 7.6% (for 2019/20 it was – 7.2%).

Conclusion

Whilst there are some positives within the report, the results are disappointing and concerning this year and therefore actions must be taken in order to ensure that improvements can be achieved.

A review is currently being undertaken of the overarching actions required within this and the wider diversity and inclusion agenda, along with the resources required to ensure effective delivery and our BAME staff network colleagues will continue to be involved.

WRES Action Plan Update – July 2021

Links	Lead	Actions	By	RAG	Comments
metrics 1, 2, 4, 7 and 8	D&I Lead	• Continue to explore ways of supporting BAME colleagues through network groups • Encourage staff to validate their own data via ESR self-service • Consider support programmes including RCN Cultural Ambassadors programme to offer specific expert support with a target of five cultural ambassadors to be identified locally.	Mar 21	Amber	LIA engagement event held followed by an NHS Wirral BAME focus group held on 5 July 2018. A new NHS Wirral BAME staff network group established Dec 18 and monthly meetings held however stalled since March 19 due to potential rotation across Wirral. WUTH launched its own network however more concentrated efforts required to sustain. Further work undertaken and new network re-established June 20. Meeting regularly since then. Cultural Ambassador programme considered however delayed due to COVID and changes within RCN. Discussions held with staff network members and included within People Plan actions and dates now being considered
metrics 2, 7 and 9	Head of Recruitment	• Encourage the recruitment conversion and progression rates of BAME staff; specifically:- • Continue to exercise robust recruitment and selection processes • All jobs to be recruited via new TRAC system so as to ensure robust recruitment data to be made available	Dec 18	Green	R&S monitoring data obtained for first time in 2018 so baseline data could be established. New TRAC system introduced from 1 Sep 19 and WRES report to contain new data which will support enhanced monitoring moving forwards. New Recruitment and selection masterclass session launched with D&I slot included. Significant improvements seen in number of BAME staff applying and being shortlisted and improvements seen in numbers being appointed although this could be improved further.
metric 3	L&D Manager / Deputy Director of Workforce	• Ensure that managers' training in disciplinary, capability and absence training to include aspects relating to Diversity, Inclusion and Human Rights (DIHR) • HR Managers will ensure that cases will only be progressed the rough formal disciplinary processes unless it is appropriate that they should do so.	Dec 18	Green	HR processes now have monitoring process in place to more robustly monitor cases by ethnicity. Reliant however on accuracy of ESR data D&I included on new effective manager development programme
metric 4	L&D Manager	• Continue to take steps to ensure our staff appraisal rates meet our 88% target	Mar 20	Amber	Steps taken to try and achieve compliance with 83.58% compliance rate as at 31 July 2019. Appraisal process reviewed with links to new Trust values and behaviours and training sessions under review so as to ensure meaningful appraisals take place. Documentation reviewed in line with new values and behaviours however trust couldn't achieve compliance target
metric 5	Head of Patient Experience	• Raise awareness of zero tolerance of harassment, bullying or abuse of BAME staff by patients, relatives or the public. • Provide guidelines to ward staff as to how to deal with patients who refuse to be assisted by staff (including BAME staff) or who are in other ways abusive	Dec 19	Green	Trustwide campaign launched to promote awareness of B&H and includes examples relating to BAME staff. Zero tolerance in place across the Trust however no specific guidelines issued, however 2021 staff survey data highlights improvements now in this area. B&H comms and education and training campaign commenced with various methods used to highlight B&H and how to report and deal with it. Further refresh of key messages and posters is also underway (July 21) FTSU training included within role specific matrix with higher levels for managers and senior Trust management. BAME FTSU Champions identified and promoted within the Trust. BAME FTSU Guardian appointed, however has since left and replacement to be considered

metric 4, 6 and 8	Learning and Development Manager	• Continue to offer training and coaching to managers to enable them to better equip them to deal with performance, behaviour and attendance issues in a positive and supportive way. • Consider leaflets and posters raising awareness of DIHR and bullying and harassment • Increase the use of the e-learning programme to improve data captures	Nov 18	Green	As with the previous metric. WUTH Leadership development framework and WUTH course directory updated and circulated to all areas to highlight suite of options available to all staff. Senior leadership development programmes in place along with monthly leadership masterclasses. E-learning programmes promoted more widely and one to one support sessions offered for staff to ensure sign up. D&I session included on new effective managers programme. Reverse mentoring proposal agreed and will include BAME staff moving forwards. Corporate comms refreshing B&H materials (July 21) and FTSU Guardians and Champions in place with 3 identified as BAME
Metric 1 and 7	D&I Lead	• Continue to include elements relating to DIHR and, specifically, conscious and unconscious bias in recruitment training	Aug 19	Green	Included on induction programme and e-learning for all staff. New recruitment masterclasses available with a DIHR slot. Face to face sessions offered to hard to reach areas e.g. hotel services. Unconscious bias training session held for Consultants Nov 2019. D&I session included on new effective managers programme. D& I Training provision currently under review with options to include cultural awareness / competence to be introduced
Metric 1 and 2	D&I Lead	• Establish links with local community groups supporting BAME communities • Identify pro-active ways to support staff and potential new recruits	Mar 21	Amber	D&I Lead signed up to the Red Heart Campaign with Wirral Change. Linked with Wirral Community Advisory Group to create greater links and offer opportunities to work with external organisations and quarterly meetings held (prior to COVID) in a variety of locations e.g. Multicultural Centre and Wirral Deen Centre. Engagement needs more focus however since COVID and further work required in this area
Metric 9	D&I Lead / Director of Workforce	• Review senior management recruitment processes • Link with community organisations to promote senior opportunities • Consider additional developmental opportunities for senior BAME colleagues • Consider recommendations from NHSE/I Model Employer guide to increasing black and minority ethnic representation at senior levels across the NHS	Mar 21	Amber	Discussions underway with BAME staff network regarding Cultural Ambassador training Links made with NHSLA regarding Ready now and Stepping Up Programmes for BAME colleagues. Programmes delayed due to COVID however discussions now underway regarding planning for 2021/22 Review underway of actions required to support NHSE/I inclusive recruitment and Model Employer Goals with new D&I action plan under development to support enhanced focus on key areas Positive received feedback received regarding BAME disparity ratios for staff progression within WUTH.
Metric 1	D&I Lead / Head of Recruitment	• Review recruitment and selection data to identify any areas of concern • Audit recruitment processes to identify any areas of potential bias • Consider positive action initiatives with community organisations involved where possible • Cultural Ambassador roles to be considered for recruitment as well as disciplinary processes • Review data available to highlight demographics of staff progression • Review retention rates for BAME staff	Mar 21	Amber	Recruitment data reviewed and initial areas for concern identified Action plan in development to ensure effective and achievable inclusive recruitment goals Cultural Ambassador role included within people plan actions Discussed with BAME staff network and Trust moving forwards to identify dates for 2021/22 Further links still to be made with community organisations

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22- 115

BOARD OF DIRECTORS
04 August 2021

Title:	**Change Programme Summary, Delivery & Assurance**
Author:	Hope Lightfoot, Head of Productivity, Efficiency & PMO 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 21st July 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.

This report contains the current assurance process and the proposed adapted assurance.

The current assurance has been adapted to reflect programme delivery.

Two Service Improvement projects were closed following the last assurance review 11 June 2021 and thus have been removed from the assurance scope in July (under the current assurance process).

Three Service Improvement projects have been introduced in July

- 111 First Phase 2: Implementation attracting Green ratings for Governance and Delivery
- Barriers to Discharge Phase 2 attracting Green for Governance and Amber for Delivery due to project extension and not yet achieving project KPI trajectories
- PIFU Phase 2 attracting Green ratings for Governance and Delivery

The Governance ratings for the three priority Transformation Programmes through the adapted assurance are as follows:

- Patient Flow-Amber
- Perioperative-Amber
- Outpatients-Green

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	

FOI status	Document may be disclosed in full	X
	Document includes FOI exempt information	
	Entire document is exempt under FOI	

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

BOARD OF DIRECTORS MEETING IN PUBLIC
04 August 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 21st July 2021, the members received an update on the 111 First project summarising outputs from the identification phase. Members, as usual, received full update presentations on the priority Transformation programmes; 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.

The proposed adaptation on the current assurance will produce no further work for the project and programme managers and has been designed with a focus on delivery, whilst ensuring key project governance is adhered to. The areas covered in the current assurance will continue to be assured through the framework and documented in PM3.

The proposed adaptation will also facilitate Trust wide programme reporting and allow clear visibility on programme progress e.g the number of programmes across the Trust with their correlating RAG status.

The assurance process will be centrally managed within the PMO and lead by the Head of Productivity, Efficiency & PMO.

Conclusions

1.1. Governance Ratings

For July, all three Transformation Programmes were Green rated for Governance in addition to all the Digital Enabler and Service Improvement projects achieving a green rating.

1.2. Delivery Ratings

Two of the three Transformation Programmes were reduced to an Amber Delivery rating in July due to trajectories not being met (Patient Flow Programme) and delays to project closure/ extensions requested (Perioperative Programme). Narrative supporting the ratings can be found in the supporting documents.

2. Programme Assurance - Ratings

The attached current assurance report has been undertaken by the Head of Service Improvement and provides a detailed oversight of assurance ratings per programme / project.

The attached proposed adapted assurance report has been undertaken by the Head of Productivity, Efficiency & PMO.

Both reports 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 to recognise the impact the current staffing situation within the organisation and the competing priorities within clinical and operational teams has had on the delivery of key projects.

The Board of Directors is also asked to review the proposed adapted assurance approach with the intention of the adapted assurance being implemented from August onwards.

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Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

Programme Assurance
July 2021

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Programme Board Scope V5.0

WUTH Trust Board of Directors

Wirral University Teaching Hospital NHS Foundation Trust

Programme Board *CEO Chair* - Janelle Holmes

Transformation Programmes
SRO – Matthew Swanborough

- Patient Flow **Programme Lead: Shaun Brown**
  - Service Improvement
  - Digital Enablers
- Perioperative Improvement **Programme Lead: Paul McNulty**
  - Digital Enablers
- Outpatients Transformation **Programme Lead: Alistair Leinster**
  - Service Improvement
  - Digital Enablers

Service Improvement
SRO – Matthew Swanborough

- Free-Standing Rapid Improvement projects

Strategy & Partnerships
SRO – Matthew Swanborough

- Service Reviews Design & Plan
- Service Reviews Implementation

Quality Improvement
SRO – Hazel Richards

- Breakthrough Series Collaboratives for Quality Priorities
- Free-Standing Quality Improvement Projects – QI coaching

Productivity & Efficiency
SRO – Claire Wilson

- Benchmarking Opportunities
- CIP Plan
- CIP Delivery

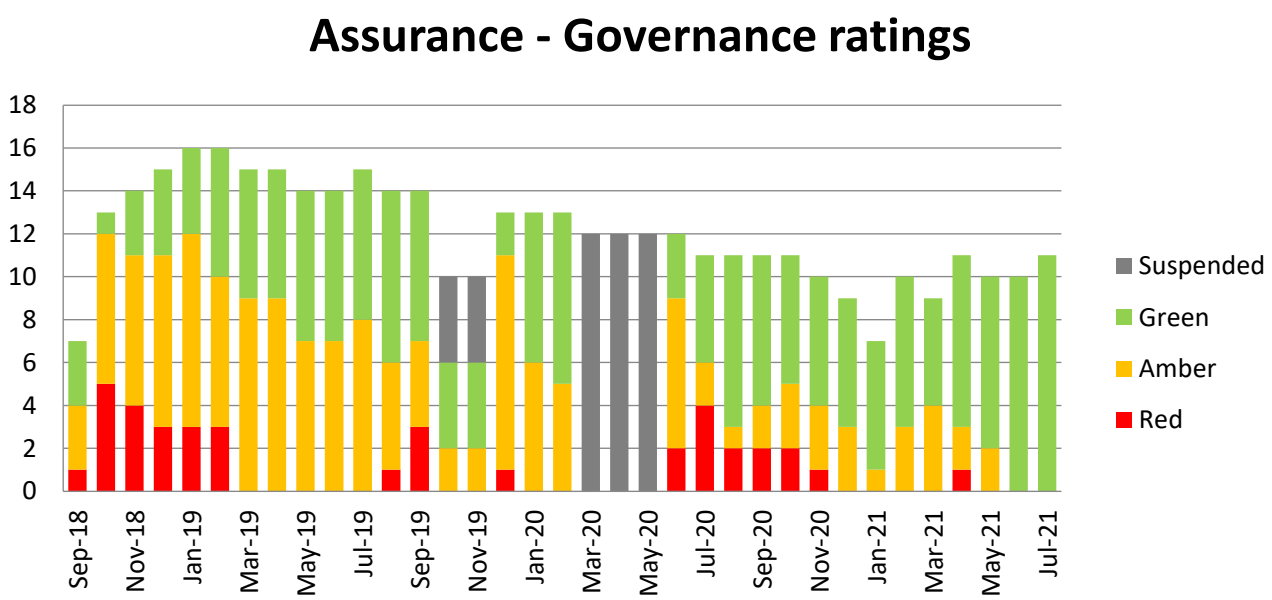
Workforce
SRO – Debs Smith

- Flexible Workforce pay spend
- NHS People Plan

PMO & Programme Assurance

Assurance – Governance ratings

Wirral University Teaching Hospital
NHS Foundation Trust



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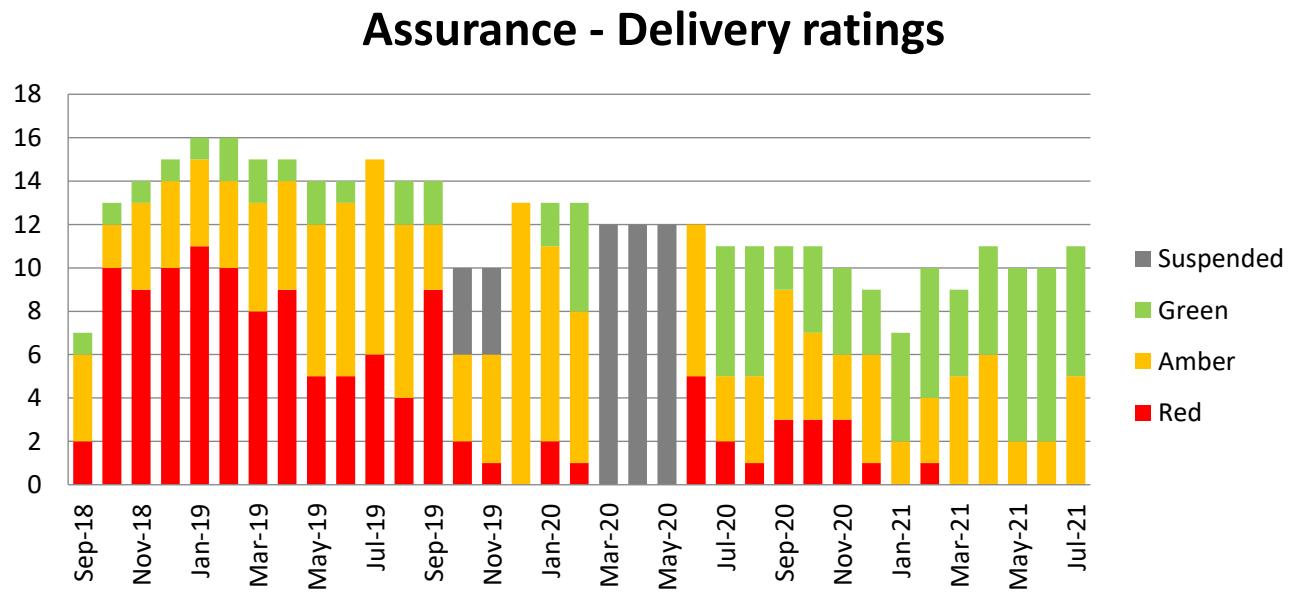
Assurance – Delivery ratings

Wirral University Teaching Hospital NHS Foundation Trust



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Programme Assurance Ratings

15 July 2021

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Change Programme Assurance Report - July 2021
Top 3 Priority Projects - Summary

Wirral University Teaching Hospital
NHS Foundation Trust

Improving Patient Flow	Governance	Green	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 Q2 21/22.
- The reported metrics are those directly linked to active improvement projects: Discharge Before Midday, ED Triage within 15 Minutes, Bloods & ECG in ED within 30 minutes.
- The improvement projects in scope aim to 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. Trajectories have been developed and are being measure against but are not yet being achieved.

Perioperative Medicine Improvement	Governance	Green	Delivery	Amber

- 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 transferred from Service Improvement to Informatics as of 01/04/2021 *(approved by Programme Steering Group 08/03/2021).* These projects have delayed the closure of the Programme and further extensions to delivery timescales due to resource have been requested and agreed.
- 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 - July 2021
Top 3 Priority Projects - Summary

Wirral University Teaching Hospital
NHS Foundation Trust

Outpatients Improvement	Governance	Green	Delivery	Green

Overall Aim: The aim of the Outpatients Transformation Programme is to contribute towards and act as an enabler for whole system transformation of elective Outpatient services. Building on the substantial amount of evidence and best practice available nationally we have aligned the transformation programme to the NHS long term plan around the following key themes:

- First Contact Services - services accessible through self-referral in primary/community setting
- Advice & Guidance - for primary care and health professionals
- Standardised Referral Pathways & Templates across the Wirral System
- Virtual Assessment and Virtual Appointments – video/telephone consultations & virtual care
- Deliver Outpatient care in the right place with the most appropriate health care professional
- Patient Initiated Follow Up (PIFU) – self-management and patient empowerment

Overall Progress: The Programme is achieving the total non-f2f target for May (25%) at 30%, but not achieving total target where no procedure is recorded (40%) at 32%. Following on from the 2021/22 Operational & Financial Guidance it was agreed by Programme Steering Group to focus Outpatient Improvement efforts initially on initiatives that will support delivery against the challenges for outpatient services. These initiatives have been identified as Advice & Guidance, Patient-Initiated Follow Up, Electronic Referral Triage & Outpatients One Patient Record (Paperless). The Outpatients Programme is working with the Divisions to identify any underlying reasons as to why there has been a decrease in Non-F2F performance in Q1.

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Improving Patient Flow - Programme Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Service Improvement Programme Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Shaun Brown	Ian Lightfoot	Implementation	Green	Amber

Independent Assurance Statement

The Approved 'Vision for Patient Flow' is uploaded to PM3. PSG 12 July 21 reviewed the Programme Scope v5.4_9th July 21. 2. Action Tracker available up to meeting of 06 July 2021. 3. ToR updated Oct 20. 4. There is a Comms Plan attached in PM3 and associated milestones have been added to the Programme Project; the plan runs out at the end of July - it is currently being refreshed and will be reviewed by Flow Steering Group in August. 5. Approved QIA 11/06/21 in PM3.
6. Programme and associated Projects are effectively managed in PM3 (any delays in the RI projects: '111 First Phase 2: Development' and 'Barriers to Discharge: Phase 2' are RAG rated separately for that project line).
7. KPI's were reviewed at PSG 12 July 21 - trajectories for projects are not being achieved, this is reflected by the amber delivery rating, all are being managed and monitored at project and programme level.
8. & 9. Programme risks and issues are managed in PM3 and were reviewed by the Patient Flow Steering Group 06 July 21.
Most recent assurance evidence submitted 15 July 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	Matthew Swanborough		●	●	●	●	●		●	●	●	●

SERVICE IMPROVEMENT: 111 First Phase 2: Implementation - Project Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Shaun Brown	Rob Jewsbury	Implementation	Green	Green

Independent Assurance Statement

1. Project defined. Proposal in PM3.
2. Project team is in place and feeds into Wirral System group weekly.
6. Project is effectively managed in PM3; all milestones on track.
7. KPI's defined and being monitored by project group and wider system group.
8 & 9. Risks and Issues in PM3; last reviewed 01 July 21

Most recent assurance evidence submitted 15 July 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
2.1c	**111 First Phase 2: Implementation** (NEW Service Improvement Project)	Implement 111 First Pre-Arrival Implement On the Door 111 ED Streaming Implement 111 slots for direct booking into assessment units and speciality clinics by the 111 and the Wirral CAS service.	Matthew Swanborough		●	●					●	●	●	●

SERVICE IMPROVEMENT: Barriers to Discharge: Phase 2 - Project Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Shaun Brown	Sarah Towey	Implementation	Green	Amber

Independent Assurance Statement

1. Project extension granted PSG 12 July 21. Revised proposal shared with project group for agreement (project meeting to take place 15/07).
2. Project Team in place. Last meeting 07/07, next meeting 15/07.
6. Milestone plan to be updated following sign off at project meeting (15/07).
7. KPI's defined and monitored weekly by project group - not all currently on track
8 & 9. Risks and Issues documented in PM3. Monitored by project group last updated June/ July 21

Most recent assurance evidence submitted 15 July 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
2.1d	**Barriers to Discharge: Phase 2** (NEW Service Improvement Project)	Support & train staff on Wards 10, 20, 24 and 26 To understand the issues and barriers the Wards face when discharging patients. To trial and investigate various improvements in the issues faced by Wards. To assess the true impact of both phase 1 and 2 of this project.	Matthew Swanborough		●	●					●	●	●	●

Perioperative Medicine Improvement – Programme Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Informatics Programme Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Paul McNulty	Nickee Smyth	Implementation	Green	Amber

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 20. PSG 12 July 21 approved Programme Scope now v5.1 9th July 21.
2. Action Tracker available up to Steering meeting of 06 July 21.
3. The Perioperative Steering Group revised ToRs were signed off at the May steering group meeting (04 May 21) and are attached in PM3.
4. Comms Plan updated now V2.0 signed off by Programme Lead 07 May 21. 5. The renewed QIA signed off Dec 20 is evidenced in PM3
6. Programme and associated Projects are effectively managed in PM3; two out of the three active projects have not met their project closure dates: extension to the Pre-op project was granted last month. Extension to the Electronic Booking Form project approved PSG 12 July 21
7. KPIs are defined and reviewed at PSG 12 July 21. 8 & 9.Programme risks and issues are managed in PM3 (all reviewed in July Steering Group).

Most recent assurance evidence submitted 15 July 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.	Matthew Swanborough		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Electronic Booking Form- Project Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Paul McNulty	Katherine Hanlon	Implementation	Green	Amber

Independent Assurance Statement

1. Project defined by the PID v1.0. 6-week project extension requested - exception report was approved by PSG 12 July 21.
2. Good attendance at Project meetings evidence of meetings reviewed.
6. Milestones have been updated to reflect agreed extension as of PSG 12 July 21. Rated Amber this month to highlight the extension to original timeframes.
8. & 9. Project Risks and Issues are managed in PM3 evidence of review in July 21.

Most recent assurance evidence submitted 15 July 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)	Revise processes to enable clinicians to order procedures directly in Millennium in the patients record Remove paper request forms for surgery. Perioperative processes have been recognised by the Trust as a Transformational priority. Following work by the transformation team over the past year and the introduction of improvement managers within the Division a number of issues have been identified with the perioperative processes. Requests have been made to Informatics to review and develop the IT systems to help support process improvement. This project forms a part of this work.	Matthew Swanborough		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Consent - Project Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Paul McNulty	Nickee Smyth	Implementation	Green	Green

Independent Assurance Statement

1. Project defined by the PID v1.0.
2. Good attendance at Project meetings evidence of meetings reviewed.
6. The milestone plan in PM3 is on track.
8. & 9. Project Risks and Issues are managed in PM3 evidence of review 30/06/21.

Most recent assurance evidence submitted 15 July 21

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EAQuality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is 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 solution within Wirral University Hospital Trust, one which does not rely on paper. Currently the consent process is paper based, forms are scanned into the patients electronic medical record, these are then viewed and verified electronically at the point of visit. Whilst the current process is fully mapped out it is not without risks, it has yet to have a SOP formally signed off by the Trust Consent Lead. This project will deliver a clear consistent process for consent which will minimise clinical risk and ensure that patients are well informed about their procedures.	Matthew Swanborough		●	●					●		●	●

DIGITAL ENABLEMENT: Pre-Op Assessment - Project Assurance Update – 15 July 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Matthew Swanborough	Paul McNulty	Katherine Hanlon	Implementation	Green	Green

Independent Assurance Statement

1. Project defined by the PID v1.0.
2. Good attendance at Project meetings evidence of meetings in July 21.
6. Milestone plan in PM3 has been updated to reflect the project extension last month and shows all to be on track.
8. & 9. Project risks and Issues are documented in PM3 all reviewed July 21.

Most recent assurance evidence submitted 15 July 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
3.2d	**Pre-Op Assessment** (Digital Enablement)	To deliver IT improvements to support more effective management of the preoperative assessment stage. Specifically, to improve tracking of the patient's readiness for surgery in order to ensure that the process is as efficient as possible and optimise utilisation of surgical resources by minimising late cancellations of surgical procedures. The project includes the display of such information within theatres to provide detail of daily operating lists but also patient level detail to support 'safety huddles' prior to surgery.	Matthew Swanborough		●	●					●		●	●

Outpatients Improvement - Programme Assurance Update – 15 July 2021

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

Independent Assurance Statement

1. Outpatient PID 5.0 approved at Outpatient Transformation Steering Group 10/05/21. The key benefits are defined therein. PSG 12 July 21 approved Programme Scope now v7.1 9th July 21. 2. Action Tracker available up to steering meeting held 07 July 21, Divisional workshops held May/June 21.
3. Programme ToR v3.0 and Divisional Workshop ToR v1.0 approved at steering meeting 01 Apr 21. 4. There is a tracked Comms Plan in place and a supporting stakeholder matrix. 5. Programme EIA/QIA signed off at Clinical Executive Level.
6. Programme and associated Projects are effectively managed in PM3 (any delays in the assured Digital Enabler or Service Improvement projects are RAG rated separately for that project line). 7. KPI dashboard updated June/July 21.
8. & 9. Programme risks and issues are managed in PM3 - all reviewed in steering meeting 07 July 21.
Most recent assurance evidence submitted 15 July 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.	Matthew Swanborough		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Outpatients One Patient Record - Project Assurance Update – 15 July 2021

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

Independent Assurance Statement

1. The Project is defined in the PID v2.0 dated 3 Jul 20.
2. Project discussed at Divisional workshops, steering group and individual meetings.
6. Milestones are tracked in PM3; the Milestone relating to BI taking over the monitoring of case notes has not been met. This is not expected to impact the delivery date of the project at this stage.
8. & 9. Project risks and issues are managed in PM3; all reviewed June/July 21

Most recent assurance evidence submitted 15 July 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.	Matthew Swanborough											

SERVICE IMPROVEMENT: Advice and Guidance: Phase 1 - Project Assurance Update – 15 July 2021

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

Independent Assurance Statement

1. Scope & Approach defined; 6 week extension approved at PSG 10 May 21
2. Regular catch ups taken place throughout benchmarking process. Options Appraisal and Project has been discussed at the Outpatient Transformation Steering Group and PSG in July
6. Project is effectively managed in PM3; Milestone Plan rated Amber as delay due to PSG reviewing Options Appraisal in more detail. If no comments/concerns raised Phase 1 to close
7. KPIs defined as part of Outpatient Dashboard. Consultant Connect data is being collated and evidenced
8. & 9. Risks and Issues documented in PM3. Last updated at a minimum 07/07/2021 at Outpatient Transformation Steering Group.

Most recent assurance evidence submitted 15 July 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
4.3b	**Advice and Guidance - Phase 1** (Service Improvement Project)	The purpose of this project is to implement a standardised Advice & Guidance process within Wirral University Teaching Hospital. Advice and Guidance services will provide primary care with continued access to specialist clinical advice, which will enable a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity. Phase 1 will identify which Options the Trust wish to utilise moving forwards whilst Phase 2 will specifically oversee implementation.	Matthew Swanborough		●	●					●	●	●	●

SERVICE IMPROVEMENT: Patient Initiated Follow Up (PIFU): Phase 2 - Project Assurance Update – 15 July 2021

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

Independent Assurance Statement

1. Scope & Approach defined (Proposal available in PM3)
2. Pilot Specialties have now been identified and implementation meetings due to start shortly. Regular catch ups have been taking place throughout the first weeks of the project
6. Milestone plan up to date (Delay on reporting/recording but not estimated to impact on overall Project Delivery & Timescales)
7. KPIs defined as part of Outpatient Dashboard
8. & 9. Risks and Issues documented in PM3. Last updated at a minimum 07/07/2021 at Outpatient Transformation Steering Group

Most recent assurance evidence submitted 15 July 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
4.3c	**PIFU - Phase 2** (NEW Service Improvement Project)	The purpose of this project is to begin to implement Patient-Initiated Follow Up across the Trust. Patient-Initiated Follow Up (PIFU) provides patients and their carers the opportunity to initiate their own appointments as and when they need them. In line with the NHSE personalised care agenda, PIFU can play a key role in enabling shared decision-making and supporting patients with self-management by helping them know when and how to access clinical input. PIFU will help manage the patient's care at the most appropriate time – avoiding unnecessary Outpatient activity and can be seen as a useful tool for provider recovery	Matthew Swanborough		●	●					●	●	●	●

WUTH improvement

NHS Wirral University Teaching Hospital NHS Foundation Trust

programme management office

Assurance Framework

Hope Lightfoot
Head of Productivity, Efficiency & PMO
July 2021

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Current Assurance

NHS Wirral University Teaching Hospital

Identified Areas for improvement

- The current process is a manual exercise with limited automation. As a result data, is copied out of PM3 and inputted into Excel.
- The RAG rating is a manual input.
- The process has a focus on the initiation phase of a programme with limited reporting and oversight on project delivery (with the exception of Digital Enablers)
- Opportunity to improve consistency across all programme reporting.

Outpatients Improvement - Programme Assurance Update – 12 May 2021

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

Independent Assurance Statement

1. Outpatient PID 5.0 approved at Outpatient Transformation Steering Group 10/05/21. The key benefits are defined therein. PSG 10 May 21 approved the revised Programme Scope now v7.0. **2.** Action Tracker available up to steering meeting held 05 May 21, Divisional workshops planned w/c 17/05. **3.** Programme ToR v3.0 and Divisional Workshop ToR v1.0 approved at steering meeting 01 Apr 21. **4.** There is a tracked Comms Plan in place and a supporting stakeholder matrix.
5. Programme EIA/QIA signed off at Clinical Executive Level. **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the assured Digital Enabler or Service Improvement projects are RAG rated separately for that project line). **7.** KPI dashboard presented at PSG 10 May 21 illustrating the Outpatient KPIs to be tracked and monitored ahead of improvement implementations; it was agree that the Non-F2F measures will undergo monitoring to ensure no slippage.
8. & 9. Programme risks and issues are managed in PM3 - all reviewed in steering meeting 05 May 21.
Most recent assurance evidence submitted 12 May 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
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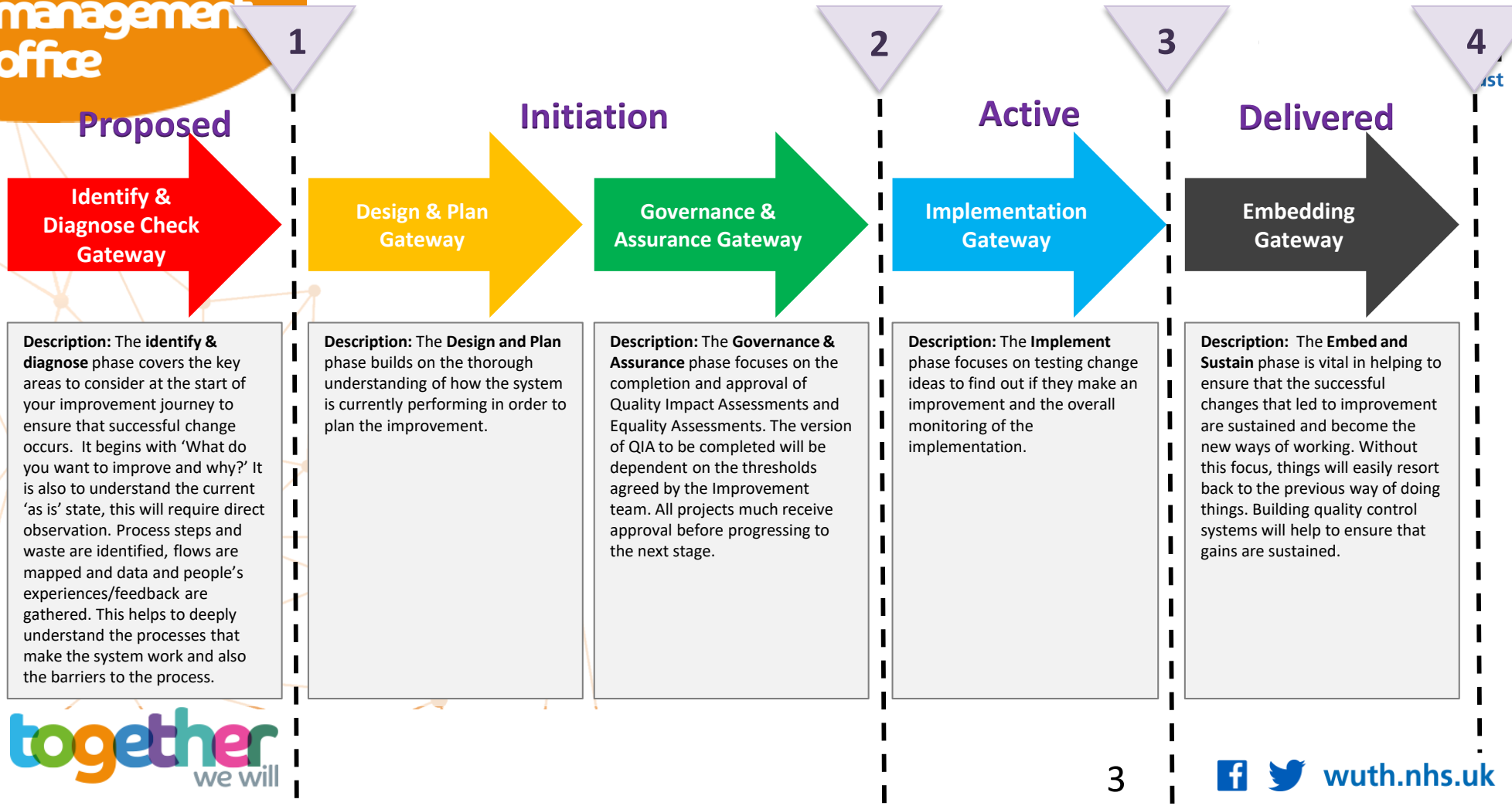
Trust Wide Programme Governance Framework

programme management office



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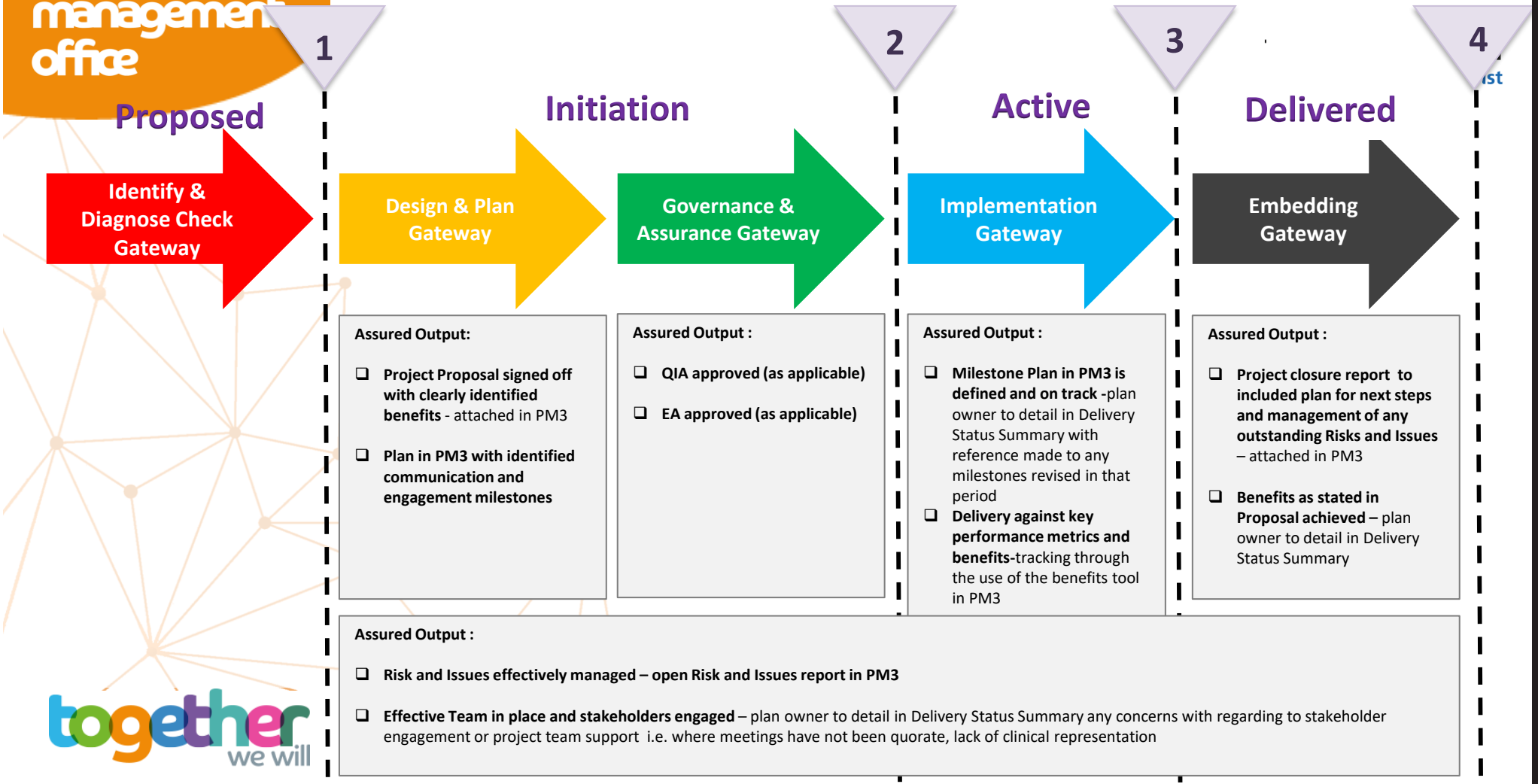
SIT Framework for Transformation Programmes



Delivery Status Summary RAG Criteria

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NHS Wirral University Teaching Hospital NHS Foundation Trust

Status	RED	AMBER	GREEN
Progress Progress against agreed delivery dates of project plan	Completed 1 week post deadline	Completed up to 1 week post deadline	Completed to deadline
Risk = / >10 Delivery of mitigation / avoidance plan by approved deadline	Completed 1 week post deadline	Completed up to 1 week post deadline	Completed to deadline
Issues = / >10 Delivery of contingency / resolution plan by approved deadline	Completed 1 week post deadline	Completed up to 1 week post deadline	Completed to deadline
Financial Benefits Forecasted benefits compared with the agreed budgeted benefits	<95% of the financial benefits will be realised	95-99% of the financial benefits will be realised	100% of the financial benefits will be realised
Decisions Resolution of key decisions that affect project progression	Outstanding decision 2 week after identification	Outstanding decision 1 week after identification	Decision made at time of identification / No outstanding decision

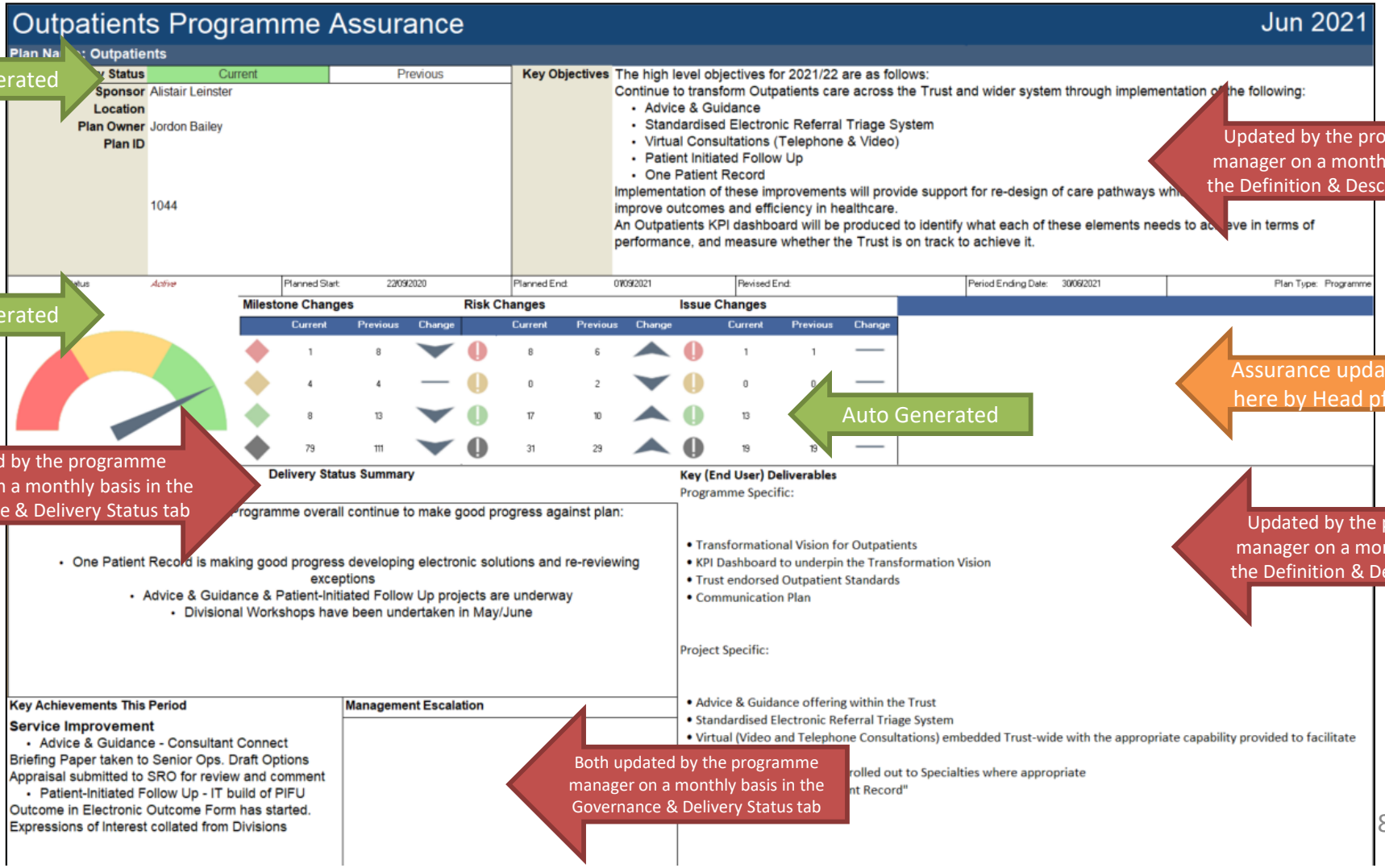
How the new RAG rating works

1. Project managers provide a RAG rating for each of the 5 areas detailed in the criteria
2. PM3 automatically generates an average RAG rating for the project
   The system encourages a focus on project delivery by providing an averaged out RAG Rating. E.G if financial delivery is changed to Red, the project RAG rating will automatically be adjusted to reflect. All RAGs have interdependencies with each other.
3. When all projects have been updated, PM3 automatically generates a programme RAG rating based on the average RAG Ratings of the projects

Reporting Process

- Each Transformation programme will be assured on a monthly basis.
- The assurance narrative will be featured on the programme level report.
- The delivery RAG rating will be automatically produced by PM3. The assurer will review the generated RAG against the criteria specified in the framework and the information in PM3.
- The projects within the programme will be reviewed to ensure the project managers continue to provide up to date information.
- The corresponding workflow status on PM3 will be cross checked against the delivery framework to ensure clear oversight over progression.
- Programme Managers will update information in PM3 by COP Tuesday Week 2.
- The Head of Productivity, Efficiency & PMO will run assurance reports on Wednesday Week 2.
- Assurance reports will be presented at Programme Board, with an overview shared with Trust Board.

This page of the report is ran at PROGRAMME level and is updated by the Programme Manager



This page of the report is ran at PROJECT level and is updated by the Project Manager

Auto-Generated				Updated on a monthly basis by the Project Manager in the 'Governance' & 'Delivery Status' tab for each individual project	Inputted by Project Manager in the definition tab		Updated on a monthly basis by the Project Manager in the 'Governance' & 'Delivery Status' tab for each individual project						Inputted by Head of Productivity, Efficiency & PMO
ID	Programme	Plan Name	Plan Owner	Delivery Status Summary	Planned Start	Planned End	Overall	Progress	Risk = / >10	Issues = / >10	Financial Benefits	Decisions	Key Activities Planned Next Reporting Period	Assurance Comments
1686	Outpatients	Advice & Guidance	Jordon Bailey	• Briefing on Consultant Connect taken to Senior Ops • Draft Options Appraisal submitted to SRO for review and comment	01/03/2021	10/05/2021	G	G	G	G	W	G	• Decision to be made on Options Appraisal • Implementation Plan for Phase 2 to be scoped out	
1103	Outpatients	DE - Attend Anywhere	Michelle Murray	Project Closure report approved by OTSG on 04/03/2021, awaiting approval from programme board. Awaiting feedback as to who will take forward the production/maintenance of the newly agreed Survey Monkey for Video Consultations.	01/04/2020		B	G	G	G	W	G	• Identify the department to update the Video Consultation Survey and take forward the future maintenance - issue raised at OTSG, awaiting feedback. • Awaiting approval from programme board for the sign off of the project closure report.	
1124	Outpatients	DE - Outpatients One Patient Record	Nickee Smyth	All paper documentation has been received and signed off by the divisions as a complete list. Work has begun on the creation of the electronic solutions, however, escalated to all divisional workshops the importance of signing off documents prompted as to ensure IT resource is available. BI are unable to take over the management of scanning figures as the data fields are unavailable and they are not able to differentiate between a clinical note that has been scanned and a clinical note that has been enetered directly into the patients record.	16/12/2019	09/04/2021	A	A	G	A	W	G	Continue to scope documents that can be made electronic. Provide steering group with clear guidance on those that cannot be made electronic documenting the reasons why and potential exit plan. BI to take over report of casenotes	
1119	Outpatients	Electronic Referral Triage	Jordon Bailey	• Specialties have indicated their preferred options and the Options Appraisal has been signed off at Outpatients Transformation Steering Group 30/11/20, Programme Steering Group 09/12/20 and Programme Board 16/12/20	14/09/2020	04/12/2020	B	G	G	G	W	G	• Project closure	
1417	Outpatients	Electronic Referral Triage - Phase 2	Jordon Bailey	• Project closed with Closure Report circulated	04/01/2021	01/03/2021	B	G	G	G	W	G	• Hand over remaining Implementation work to Patient Access Team • Present Closure Report to May Outpatient Transformation Steering Group & Programme Steering Group	
1107	Outpatients	Outpatients Programme Project	Jordon Bailey	• Covered within the "Outpatients" Programme on PM3	29/09/2020	01/08/2021	G	G	G	G	W	G	• Covered within the "Outpatients" Programme on PM3	
1415	Outpatients	Outpatients Vision & KPIs	Jordon Bailey	• Outpatients Vision & KPIs signed off at Programme Steering Group in March. Project closed with draft dashboard to be presented at Outpatient Transformation Steering Group in May. Added as milestone within Outpatients Programme on PM3 for visibility.	04/01/2021	01/02/2021	B	G	G	G	W	G	• N/A - Project closure.	
1940	Outpatients	Patient-Initiated Follow Up	Jordon Bailey	Project Phase 1 commenced week beginning 12/04 and finished on Friday 28/05 (overran by 4 days)	14/04/2021	24/05/2021	B	G	G	G	W	G	• Set up Phase 2 which includes: • Final sign off of all required documentation • Work with BI to confirm Trust is set up to record and report correctly in line with national framework • Work with Patient Access Team to ensure they are all set up to administrate PIFU processes accordingly • Contact Divisions to assess pilot Specialties • Formalise Project Group as PIFU moves into Implementation phase • Small scale launch	
1331	Outpatients	Room Booking	Jordon Bailey	• Summary paper and recommendation submitted to SRO	13/11/2020	18/12/2020	B	G	G	G	W	G	• Project closure	

Benefits of the adapted assurance

- The proposed adaptation on the current assurance will produce no further work for the project and programme managers and has been designed with a focus on delivery whilst ensuring key project governance is adhered to
- The areas covered in the current assurance will continue to be assured through the framework and documented in PM3
- The proposed adaptation will facilitate Trust wide programme reporting and allow clear visibility on programme progress e.g the number of programmes across the Trust with their correlating RAG status
- The new reporting will also support conversations re resource management and project teams availability
- Following the role out of the new assurance within SIT, the framework and process will be implemented across all project teams across the Trust e.g IT & HR
- The assurance process will be centrally managed within the PMO and lead by the Head of Productivity, Efficiency & PMO
- Ad Hoc and in-depth assurance reporting outside of the transformation programmes can be provided at request

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NHS Foundation Trust

Programme Assurance Ratings

Hope Lightfoot
Head of Productivity, Efficiency & PMO

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Patient Flow Assurance

Patient Flow Assurance Report — Jun 2021

Plan Name: Patient Flow

Delivery Status	Current	Previous
Sponsor	Matthew Swanborough	
Location	Wirral University Teaching Hospital	
Plan Owner	Sarah Towey	
Plan ID	1048	

Key Objectives

High Level
- Bed Occupancy: 93%
- Time spent in ED: 240 mins
- Average Inpatient Length of Stay: 7.1 days
- Number of long stay patients 21 day+: 90

ED
- No corridor waits
- Patients receive ED triage within 15 mins
- Diagnostic orders completed within 60 mins (Bloods, CT, X-ray, MRI)
- Patients Seen by an ED Doctor in 60 mins
- Specialty Dr advice within 2 hours
- ED bed requests made within 180 mins
- Patients leaving ED within 4hrs (National Standard)

Assessment
- Patients assessed by Senior Doctor in Assessment Unit within 3 hours
- 80% of same day discharges in an Ambulatory Setting (trolleys and chairs only)
- Patient LoS within Assessment Unit target (AMU, SEU, GAU = 48hrs, OPAU = 72hrs, CDU= 12hrs)

Ward
- Each base ward pulls one patient from an Assessment Unit by 10am
- 33% Discharges by 12 noon
- Pathway 0; time between RFD to Discharge: 60 mins
- Pathway 1,2,3; Time between RFD to Discharge: 24 hours

Enablers
- CAPMAN: Patients leaving ED (admitted) within 30 mins of ED bed request
- CAPMAN: Bed base reservations occupied within 25 minutes of becoming available (from Assessment wards only)
- CAPMAN: Patients receiving speciality triage on M page in Assessment Unit transferred to Base Ward within 60 minutes
- CAPMAN: Number of beds turned around from Dirty to Clean within 30 minutes

Status	Active	Planned Start:	22/09/2020	Planned End:	Revised End:	Period Ending Date:	30/09/2021	Plan Type:	Programme

Delivery Status Summary

Continuing to make progress against the plan for the live Flow projects in the programme.

Barriers to Discharge Phase 2: Exception report written to request extension to end of August, accepted by PSG. Milestones to be amended following project meeting (14/07/21). Focus going forward to be on Pharmacy and Phlebotomy PDSA's and data analysis to be carried out on varying data samples.

111 First Phase 2 Implementation: Project proposal approved. Project initiated. Focus on creation of pre-arrival form and streaming tool, staffing requirements, Communications and Readiness assessment for Assessment Units.

Optimal Discharge Pathway in ED: The Optimal Pathway for triage and diagnostics has been mapped and agreed. This will be issued to ED staff. The impact of the model is impacted by staffing resources and periods of high demand in ED. Next steps around communication of pathway.

ED RAT: First PDSA completed. PDSA report has been shared with the project team. Proposal for project is to be paused due to staffing resource with timescales reset to the end of August.s>ﺑﻲﻲBarriers to Discharge: Phase 2
- Project extension signed off.
- Pharmacy PDSA planned for week commencing 19th July.

Phase 2 111 First: Development
- Project approved and initiated

Optimal Discharge Pathway in ED
- The Optimal Model has been mapped and documented. The model has been reviewed and agreed the project team.
- Work has been undertaken with WCT staff on initial streaming and development of a patient slip process.

ED RAT
- PDSA findings report shared with project team. Identification of areas that need to be refined before re-running the PDSA.

Assurance Update: 15/07/21

The patient flow programme has been assured against the SIT Assurance Framework.
Project Proposal has been signed off with clearly identified benefits - attached in PM3.
Plan confirmed to be in PM3 with identified communication and engagement milestones. The communication plan is due for review at the end of July and the team will reviewing and updating the plan during Augusts flow steering group.
QIA approved (as applicable) & EA approved (as applicable) have been signed off by the Medical Director and Director of Nursing.
Milestone Plan in PM3 is defined and on track, however the programme is experiencing delivery issues. The programme has a new programme manager alligned who will undertake a review of the KPI delivery issues to identify a suitable approach to support delivery.
The barriers to discharge project has been granted an extension to support delivery.
Performance of the individual projects within Patient Flow have been reviewed and assured. Project Managers have updated the narrative inline with decisions throughout July's meetings and are on track to continue with delivery. Focus to be give on Barriers to Discharge following the extension approval.
The patient flow set of programme meetings have taken place during the month of July and have had adequete attendance with valid and productive discussion points. The team continue to escalate any concerns through Programme Steering Group and are addressed accordingly. The programme has been RAG rated as Amber in line with the delivery assurance and the comments above. The team have been asked to focus on improving the KPI delivery to support the programme and ensure measurable outputs are recored in the system. The programme is now in Gateway 4, 'Implementation'.

Over-all Rag Rating: Amber
Gateway: Active

Key Achievements This Period	Management Escalation
Barriers to Discharge: Phase 2	Escalation made to PSG regarding staffing resources which

Assured by Head of Productivity, Efficiency & PMO, Hope Lightfoot, 15.07.21

Patient Flow Assurance cont.

Key Achievements This Period	Management Escalation
Barriers to Discharge: Phase 2 • Project extension signed off. • Pharmacy PDSA planned for week commencing 19th July. **Phase 2 111 First: Development** • Project approved and initiated **Optimal Discharge Pathway in ED** • The Optimal Model has been mapped and documented. The model has been reviewed and agreed the project team. • Work has been undertaken with WCT staff on initial streaming and development of a patient slip process. **ED RAT** • PDSA findings report shared with project team. Identification of areas that need to be refined before re-running the PDSA.	Escalation made to PSG regarding staffing resources which impacts on the results of all flow projects.

Assured by Head of Productivity, Efficiency & PMO, Hope Lightfoot, 15.07.21

Key (End User) Deliverables
Patient Flow Programme: • Flow Programme Plan • Flow Project Plans • Flow Communication Plan • Clear governance, reporting structure & benefit profile for each standard • Monthly Flow performance dashboard • Live Command Centre Flow reports **Project Specific Outputs:** • **Barriers to Discharge Phase 2**- Delivery of PDSA's around Pharmacy and Phlebotomy. Embed and Sustain Plan for each Ward in scope of both phases. Data analysis on discharges post midday across varying Wards. Overall impact of both projects so far. • **ED RAT** - Delivery of PDSA's and output report from PDSA's. Preferred RAT Model and evidence to support benefit. • **Optimal Triage Pathway -** Model defined and communicated to staff. • **111 First Phase 2 Implementation** -

Patient Flow Assurance cont.

Plan Status													
ID	Programme	Plan Name	Plan Owner	Delivery Status Summary	Planned Start	Planned End	Overall	Progress	Risk = / >10	Issues = / >10	Financial Benefits	Decisions	Key Activities Planned Next Reporting Period
1394	Patient Flow	111 First Phase 2	Jane Hayes-Green	Project Closed. Acceptance of 111 First Phase 2 Implementation Proposal at Patient Flow Steering Group (06/07/21) and accepted at PSG (12/07/21). Closure Report has been approved by SRO offline (13/07/21).	15/12/2020	18/06/2021	B	G	G	G	W	W	N/A - Project Closed and 111 First Phase 2 Implementation initiated.
2839	Patient Flow	111 First Phase 2: Implementation	Rob Jewsbury	Project proposal approved at Flow Steering Group.	07/07/2021	22/10/2021	G	W	W	W	W	W	Set up project team meetings. Agree team members.. Hold first team meeting to review milestones, actions, risks, issues.
1520	Patient Flow	Barriers to Discharge: Phase 1	Jane Hayes-Green	Project Closed. Closure Report accepted at Flow Steering Group and Programme Steering Group in May 2021.	04/02/2021	28/05/2021	B	G	G	W	W	G	N/A - Project Closed and Closure Report accepted at Flow Steering Group and PSG. Phase 2 of the project currently active.
2022	Patient Flow	Barriers to Discharge: Phase 2	Sarah Towey	• An exception report has been written to request an extension of the project to the end of August. This is due to a limited amount of support being offered to Phase 2 Wards (with milestones being missed), identification of issues that could be resolved by the project and a change in project manager. • The extension will add further tasks and processes in scope of this project, therefore the scope has been extended to reflect this. • Some Milestones were missed due to staffing pressures, however with extension granted these have been revised and further development work added.	14/06/2021	27/08/2021	A	A	G	W	W	G	• Plan to be in place for PDSA's around Phlebotomy and Pharmacy, following sign off of extension by PSG. • Review of PDSA's and investigate how findings can be rolled out to all Wards in scope of Phase 1 and Phase 2 of the project. • Plan deep dive into data sets for discharges post midday, data samples identified. • Start to build up lessons learnt and key findings from Performance Reviews (on both phase 1 and phase 2 Wards)
1308	Patient Flow	Bed Bureau Recommendations	Jeanette Roberts	Project Closed. Deep Dive into Recommendations went to Programme Board in May 2021.	11/11/2020	19/05/2021	B	G	W	W	W	G	N/A - Project Closed.
1707	Patient Flow	Bloods & ECG within 30 Mins	Jane Hayes-Green	Project Closed. This project has been converted into the 'Optimal Pathway: Triage and Diagnostics', the proposal for this was accepted by Patient Flow Programme Lead. The project started 14/06/21.	05/04/2021	04/06/2021	B	G	W	W	W	G	N/A - Project Closed. This project has been converted into the 'Optimal Pathway: Triage and Diagnostics' which is currently active.

Patient Flow Assurance cont.

2821	Patient Flow	ED Optimal Pathway Triage and Diagnostics	Ian Lightfoot	The Optimal Pathway for triage and diagnostics has been mapped and agreed. The impact of the model is impacted by staffing resources and periods of high demand in ED	14/06/2021	06/08/2021	G	G	G	G	W	W	To document how the patient slip process would work and to seek agreement from the project team To produce a recommendations report To review the staffing model required to support the process and feed into the ECIST workforce review. There are meetings with ECIST on the 15th and 16th of July. The optimal model diagram is to be issued to staff and put on walls in cubicles and staff rooms. A confirmation form will be signed by staff to confirm that they have read and understood the process.
2818	Patient Flow	ED RAT	Ian Lightfoot	Delivery of project milestones on track. First PDSA completed (week commencing 28th June), staffing issues experienced during this . PDSA report prepared and presented. A decision has been made by the project lead to extend the timescales of the project until the end of August due to staffing pressures in ED. The project will be paused until the PDSA can be refined and repeated with greater staffing resource.	18/06/2021	06/08/2021	G	G	G	G	W	W	• Project to be paused - decision required on this. • Plan to rerun the PDSA in a revised form when staffing allows.
1721	Patient Flow	EM Dr Response within 1 Hour	Ian Lightfoot	Proposal in development. Medical Staffing Workforce Group has been established to undertake a workforce review.	28/06/2021		B	W	W	W	W	W	
1109	Patient Flow	Patient Flow Programme Project	Jane Hayes-Green	Covered within the Patient Flow Programme on PM3.	29/09/2020		A	G	G	A	W	G	Covered within the Patient Flow Programme on PM3.
1694	Patient Flow	Triage within 15 mins	Jane Hayes-Green	Project Closed. This project has formed part of the 'Optimal Pathway: Triage and Diagnostics' project, this project is now active.	05/04/2021	04/06/2021	B	G	G	W	W	G	N/A - Project Closed.
1111	Patient Flow	Updated Discharge Operating Model	Jane Hayes-Green	Project Closed.	29/09/2020	31/10/2020	B	W	W	W	W	W	N/A - Project Closed.

Perioperative Assurance

NHS
Wirral University

Perioperative Assurance Report

Jun 2021

Plan Name: Perioperative

Delivery Status	Current	Previous	
Sponsor	Matthew Swanborough		
Location	Wirral University Teaching Hospital		
Plan Owner	Nickee Smyth		
Plan ID	1046		
Status	Active	Planned Start:	22092020
Planned End:		Revised End:	
Period Ending Date:	30092021	Plan Type:	Programme

Key Objectives

The perioperative improvement programme will achieve the following high level objectives:
1. Enhancing patient safety and experience
2. Achieving operational excellence

Delivery Status Summary

EBF - The project exception report was reviewed at PSG & all date have been pushed back by 6 weeks, awaiting review at programme board - RAG status to remain as RED until approval completed.
Engagement has been good over the past 2 weeks and there have been a number of meetings held with clinical leads. However, from the meetings, a number of additional build requirements have been identified, namely additional order forms, procedures and folders to be built out for each speciality. This build work was not accounted for and could impact analyst time.
Plan is to capitalise on the good engagement and progress and push forward with further meetings with a view to go lives by middle August.
Pre Op Assessment - Exception report was submitted and agreed by PSG last month but overall delivery status remains amber due to further expected delays.
Initial Training / Design Reviews have taken place with the pre-op nurses with good feedback and questions raised. A further clinical meeting is to be held to resolve these queries.
Analyst resource in place for patient portal questionnaire, build started 29th June. Some work has started on the MPages, however, work is still on-going with PACs and therefore delivery is likely to be delayed. This will continue to be monitored but a possible further 6 week delay to the MPages is expected. Following discussions at PPSEO meeting 13th July, it was agreed that go-live of the pre-op triage workflow should be deferred until after junior doctor handover and possibly moved to end Aug / Beginning Sept to avoid clashes with annual leave. This will be reviewed and any new exception report required will be submitted to next month's programme board once the full impact is reviewed.The risks and issues have been updated to Amber to show concerns regarding patient portal workflow and registration processes. Patient portal registration issues have been escalated via steering group and DPSOC. A meeting has been held with clinical leads and a report drafted for submission to DPSOC
Electronic Consent - Multiphase approach agreed by the Project Team.
Phase 1 - Interim Scanned consent to be adopted by all services for elective procedures. Phase 2 - Electronically documented consent forms for all procedures. Phase 3 - Utilise Patient Portal where possible.
Phase 1 – All outpatient elective consent forms to be scanned into Millennium went live on 1st July – There is an issue associated with back scanning of consent forms that have already been filed into the case notes.
Preparation for phase 2 is underway with the collation of all consent forms – once they have been received the team will be able to quantify the clinical time required to review the consent forms.

Assurance Update: 15/07/21

The Perioperative programme has been assured against the SIT Assurance Framework.
Project Proposal has been signed off with clearly identified benefits - attached in PM3.
Plan confirmed to be in PM3 with identified communication and engagement milestones.
QIA approved (as applicable) & EA approved (as applicable) have been signed off by the Medical Director and Director of Nursing.Milestone Plan in PM3 is defined and on track -plan owner to detail in Delivery Status Summary with reference made to any milestones revised in that period.
Delivery against key performance metrics and benefits-tracking through the use of the benefits tool in PM3.
Performance of the individual projects within Periop have been reviewed and assured. Project Managers have updated the narrative inline with decisions throughout July's meetings and are on track to continue with delivery.
An exception report has been delveoped for the Electronic Booking Form project and is due to be presented at July's Programme Board for approval. The report requests a 6 week extension to accomodate the additional changes that have been requested within the project that are not achievable within the current time scale.
The Periop set of programme meetings have taken place during the month of July and have had adequete attendance with valid and productive discussion points. The team continue to escalate any concerns through Programme Steering Group and are addressed accordingly. The programme has been RAG rated as Amber in line with the delivery assurance and the knowledge that all projects have asked for extensions over the past few months, impacting on overall programme delivery. The project team continue to progress with delivery and identify solutions to presenting issues within a timely manner.The programme is now in Gateway 4, 'Implementation'.

Over-all Rag Rating: Amber
Gateway: Active

Assured by Head of Productivity, Efficiency & PMO, Hope Lightfoot, 15.07.21

Key Achievements This Period

EBF
- Exception report reviewed at Programme Steering Group - dates pushed out by 6 weeks initially.
- Engagement has improved and clinical leads have been identified in most areas
- Analysts have had initial meetings with T&O, Colorectal, Upper GI and Ophthalmology
- A significant amount of additional build work has been identified following the initial meetings
- Overall positive feedback and engagement from teams

Pre Op Assessment
Training / Comms with pre-op nurses completed with almost all staff having attended
Build for pre-op forms completed
Build started on patient portal questionnaire.

Electronic Consent
Multiphase approach agreed by the Project Team
- Multi phase approach has been approved by the project team
  - Phase 1 - Interim Scanned consent to be adopted by all services for elective procedures.
  - Phase 2 - Electronically documented consent forms for all procedures
  - Phase 3 - Utilise Patient Portal where possible.

Phase 1 – All outpatient elective consent forms to be scanned into Millennium from 1st July – There is an issue associated with back scanning of consent forms that have already been filed into the case notes.
Preparation for phase 2 is underway with the collation of all consent forms – once they have been received the team will be able to quantify the clinical time required to review the consent forms.

Management Escalation

EBF

Exception report approved at Programme Steering Group - to be escalated to Programme Board.

Electronic Consent

Medical Records have raised they do not have the resource required to back scan consent forms for those specialities that have been completing and filing consent forms in the case notes.

Key (End User) Deliverables

PROGRAMME REFRESH:
- Refreshed PIDs and plans

PRE-OP TRIAGE:
- To-be process and design of the new pre-op triage service
- Implementation of a new triage service
- Service review report

THREE PHASE RECOVERY:
- New building
- New process and procedure for Three Phase Recovery

REDUCE ON THE DAY CANCELLATIONS:
- Standard process for cancelling procedures
- Sustain and review plans

ELECTRONIC CHECK-IN:
- Design and implementation plans

THEATRE SCHEDULING SYSTEM:
- Technical build plans
- Training and communication plans
- Implementation of a live theatre scheduling system

TRAY STANDARDISATION:
- Cost-efficient trays with standardised equipment across the trays for surgical procedures

ELECTRONIC BOOKING FORM:
- Standardised procedure list for all surgical specialties
- Bespoke booking forms for all surgical specialties

Perioperative Assurance cont.

Wirral University Teaching Hospital

Plan Status

ID	Programme	Plan Name	Plan Owner	Delivery Status Summary	Planned Start	Planned End	Overall	Progress	Risk = / >10	Issues = / >10	Financial Benefits	Decisions	Key Activities Planned Next Reporting Period
1091	Perioperative	DE - Electronic Booking Form	Katherine Hanlon	The project exception report was reviewed at programme steering group and all date have been pushed back by 6 weeks, awaiting review at programme board - RAG status to remain as RED until approval completed. Engagement has been good over the past 2 weeks and there have been a number of meetings held with clinical leads. However, from the meetings, a number of additional build requirements have been identified, namely additional order forms, procedures and folders to be built out for each speciality. This build work was not accounted for and could impact analyst time. Plan is to capitalise on the good engagement and progress and push forward with further meetings with a view to go lives by middle August.	28/09/2020		R	R	R	A	W	W	• Build work as identified to be completed • Engagement with Clinicians to continue and be built upon • Periop Group to review and sign off Order forms to ensure clinical safety maintained
1087	Perioperative	DE - Theatre Scheduling	Lynn Tarpey	Steering Group have agreed that this project is delivered and there only a small number of outstanding items. As such, GH has drafted a closure report for presentation at programme board. Pippa Ankers to feed back on draft specifically what works outstanding relating to printing.	01/10/2019	31/12/2020	B	G	G	G	W	W	Project Closure
1514	Perioperative	DE- Pre Op Assessment	Katherine Hanlon	An exception report was submitted and agreed by Steering Group and Programme Board last month but overall delivery status remains amber due to further delays that are expected. Initial Training / Design Reviews have taken place with the pre-op nurses with some good feedback and questions raised. A further clinical meeting is to be held to resolve these queries. Plan and analyst resource is in place for completing the patient portal questionnaire build, this build started 29th June. Some work has started on the MPages, however, work is still on-going with PACs and therefore delivery is likely to be delayed. This will continue to be monitored but a possible further 6 week delay to the MPages is expected. Following discussions at PPSEO meeting 13th July, it was agreed that go-live of the pre-op triage workflow should be deferred until after junior doctor handover and possibly moved to end August / Beginning September to avoid clashes with annual leave. This will be reviewed and any new exception report required will be submitted to next month's programme board once the full impact is reviewed.	01/02/2021	31/08/2021	A	A	A	A	W	G	- Complete build of patient portal questionnaire - Build work continuing on MPages - Go Live plan confirmed
1180	Perioperative	Digital Operating List & Safety Board	Sarah Towey	Project is on to deliver against the project plan.	02/10/2020		B	G	G	G	G	W	Capital business case completed and will be taken to the surgical Capital Management group on 14th January 2021 for approval.
1326	Perioperative	Electronic Consent	Nickee Smyth	Issues identified within the Interim Scanned consent process are being investigated by the Clinical Director of Perioperative Medicine with the aim of having all elective consent forms scanned into the patients record before the arrive in theatre. Cerner solutions for eSignature and forms has been reviewed but will not be available within the UK until the middle of 2022 - decision made to discount this as an option at this point.	16/11/2020		G	G	G	G	W	W	• Go Live of Phase 1 - Scanned Consent for all Elective procedures. • Quantify clinical time required for reviewing all consent forms per speciality. • Draft implementation approach and plan for phase 2

Perioperative Assurance cont.

Wirral University Teaching Hospital NHS Foundation Trust

1089	Perioperative	Perioperative Programme Project	Nickee Smyth		28/09/2020		G	W	W	W	W	W	
1094	Perioperative	Pre-op Triage Service - Phase 1	Sarah Towey	The project milestones are currently on track - the project will be split into 2 phases; Phase 1 - Creation of the Pre-op questionnaire and build into Cerner. Phase 2 - Functionality of the pre-op questionnaire in Cerner and go live. Creation of the surgical mpage is pivotal for the pre-op triage service to be able to go live.	17/02/2020	31/12/2020	B	A	G	G	W	W	Determine the requirements for this project to be able to progress with phase 2 - to make the Cerner pre-op questionnaire functional. Awaiting process mapping session to identify the current workflow and envisaged workflow to identify the work involved to progress.
1174	Perioperative	Review of on the day cancellations RI	Sarah Towey	Project progress is on track against the milestones.	02/10/2020		B	G	G	G	W	W	Sign off processes and supporting documentation and go live with the new process.
1126	Perioperative	Three Phased Recovery	Sarah Towey	This project is on track against the milestones.	02/12/2019	04/12/2020	B	G	G	G	W	W	Sign off closure report and handover benefits realisation to the Division.
1186	Perioperative	Tray Standardisation	Sarah Towey	This project is ahead of schedule.	02/10/2020	16/12/2020	B	G	G	G	W	W	Sign off exception report to hand this project over to the Divisions to remove the project from periop scope and continue to run the project within the Division.

Outpatients Assurance

Outpatients Assurance Report — Jun 2021

Plan Name: Outpatients

Delivery Status	Current	Previous
Sponsor	Matthew Swanborough	
Location	Wirral University Teaching Hospital	
Plan Owner	Jordon Bailey	
Plan ID	1044	

Key Objectives

The high level objectives for 2021/22 are as follows:

Continue to transform Outpatients care across the Trust and wider system through implementation of the following:

- Advice & Guidance
- Standardised Electronic Referral Triage System
- Virtual Consultations (Telephone & Video)
- Patient Initiated Follow Up
- One Patient Record

Implementation of these improvements will provide support for re-design of care pathways which are both innovative and improve outcomes and efficiency in healthcare.
An Outpatients KPI dashboard will be produced to identify what each of these elements needs to achieve in terms of performance, and measure whether the Trust is on track to achieve it.

Status	Planned Start	Planned End	Revised End	Period Ending Date	Plan Type
Active	22/09/2020	07/09/2021		30/06/2021	Programme

Delivery Status Summary

The projects within and the Programme overall continue to make good progress against plan:

- One Patient Record is making good progress developing electronic solutions and re-reviewing exceptions
- Advice & Guidance Phase 1 is nearing conclusion
- Patient-Initiated Follow Up Phase 2 is underway
- Work continues to refine Outpatients KPI Dashboard

Key Achievements This Period

Service Improvement

- Advice & Guidance - . Draft Options Appraisal circulated to OTSG & then PSG for review and comment
- Patient-Initiated Follow Up - IT build of PIFU Outcome in Electronic Outcome Form has been delivered including testing. Scoping exercise of Admin workflow has also taken place. Expressions of Interest collated from the Divisions and Pilot Specialities identified. PIFU SOP & Clinical Protocol signed off by Programme Clinical Lead
- Outpatient Standards: Journey to Date presentation well received at Programme Board

Digital Enablers

- One Patient Record - IT analysts continue to develop electronic solutions. Targeted actions delivered to Divisions at workshops

Management Escalation

- N/A

Assurance Update: 15/07/21

The Outpatients programme has been assured against the SIT Assurance Framework.
Project Proposal has been signed off with clearly identified benefits - attached in PM3.
Plan confirmed to be in PM3 with identified communication and engagement milestones.
QIA approved (as applicable) & EA approved (as applicable) have been signed off by the Medical Director and Director of Nursing.Milestone Plan in PM3 is defined and on track -plan owner to detail in Delivery Status Summary with reference made to any milestones revised in that period.
Delivery against key performance metrics and benefits-tracking through the use of the benefits tool in PM3.
Performance of the individual projects within Outpatients have been reviewed and assured. Project Managers have updated the narrative inline with decisions throughout July's meetings and are on track to continue with delivery. Discussion has taken place re the delivery of the 'One Patient Record' project and a paper has been requested to be presented to the Medical Director to address issues around specific specialities.
An options apprisal for the 'Advice and Guidance' project has been written and presented to the Divisional Directors for feedback to support the progression of the project. Updates will be provided at Programme Board.
The Outpatients set of programme meetings have taken place during the month of July and have had adequete attendance with valid and productive discussion points.
The team continue to escalate any concerns through Programme Steering Group and are addressed accordingly. The programme has been RAG rated as Green in line with the delivery assurance and the comments above. The issues referenced above have been met with mitigation solutions that will support the delivery of the individual projects. The team will focus on implementing solutions over the coming month to progress the projects further. This will not impact on the over-all delivery of the Outpatients programme. The programme is now in Gateway 4, 'Implementation'.

Over-all Rag Rating: Green
Gateway: Active

Assured by Head of Productivity, Efficiency & PMO, Hope Lightfoot, 15.07.21

Key (End User) Deliverables

Programme Specific:

- Transformational Vision for Outpatients
- KPI Dashboard to underpin the Transformation Vision
- Trust endorsed Outpatient Standards
- Communication Plan

Project Specific:

- Advice & Guidance offering within the Trust
- Standardised Electronic Referral Triage System
- Virtual (Video and Telephone Consultations) embedded Trust-wide with the appropriate capability provided to facilitate them
- Patient-Initiated Follow Up rolled out to Specialties where appropriate
- Single Electronic "One Patient Record"

Outpatients Assurance cont.

Plan Status

ID	Programme	Plan Name	Plan Owner	Delivery Status Summary	Planned Start	Planned End	Overall	Progress	Risk =/ >10	Issues =/ >10	Financial Benefits	Decisions	Key Activities Planned Next Reporting Period
1686	Outpatients	Advice & Guidance	Jordon Bailey	• Options Appraisal submitted to Programme Steering Group following provisional approval at Outpatient Transformation Steering Group - additional time requested from PSG to review and comment. Decision to proceed to Programme Board will depend on whether any comments are received.	01/03/2021	10/05/2021	A	A	G	G	W	A	• Decision to be made on Options Appraisal by Programme Steering Group • If no comments suggesting otherwise Options Appraisal to move on to Programme Board
1103	Outpatients	DE - Attend Anywhere	Michelle Murray	Project Closure report approved by OTSG on 04/03/2021, awaiting approval from programme board. Awaiting feedback as to who will take forward the production/maintenance of the newly agreed Survey Monkey for Video Consultations.	01/04/2020		B	G	G	G	W	G	• Identify the department to update the Video Consultation Survey and take forward the future maintenance - issue raised at OTSG, awaiting feedback. • Awaiting approval from programme board for the sign off of the project closure report.
1124	Outpatients	DE - Outpatients One Patient Record	Nickee Smyth	It has been brought to the attention of the project team that T&O have not been following processes in line with the Outpatient Standards set, as a result they have been recording outpatient consultations on paper and have been filing the history sheets into the case notes rather than sending them to be scanned. As a result there is a need to continue to supply casenotes to the speciality. This has been escalated to the programme lead and PSG. A paper is being produced for the Medical Director. Progress has been made with integrated height and weight devices and we are in final testing stages.	16/12/2019	09/04/2021	R	A	G	R	W	G	Continue to implement documents that can be made electronic. Provide steering group with clear guidance on those that cannot be made electronic documenting the reasons why and potential exit plan. Project closure report to be presented to OTSG
1119	Outpatients	Electronic Referral Triage	Jordon Bailey	• Specialties have indicated their preferred options and the Options Appraisal has been signed off at Outpatients Transformation Steering Group 30/11/20, Programme Steering Group 09/12/20 and Programme Board 16/12/20	14/09/2020	04/12/2020	B	G	G	G	W	G	• Project closure
1417	Outpatients	Electronic Referral Triage - Phase 2	Jordon Bailey	• Project closed with Closure Report circulated	04/01/2021	01/03/2021	B	G	G	G	W	G	• Hand over remaining Implementation work to Patient Access Team • Present Closure Report to May Outpatient Transformation Steering Group & Programme Steering Group
1415	Outpatients	Outpatients Vision & KPIs	Jordon Bailey	• Outpatients Vision & KPIs signed off at Programme Steering Group in March. Project closed with draft dashboard to be presented at Outpatient Transformation Steering Group in May. Added as milestone within Outpatients Programme on PM3 for visibility.	04/01/2021	01/02/2021	B	G	G	G	W	G	• N/A - Project closure.
1940	Outpatients	Patient-Initiated Follow Up	Jordon Bailey	Project Phase 1 commenced week beginning 12/04 and finished on Friday 28/05 (overran by 4 days)	14/04/2021	24/05/2021	B	G	G	G	W	G	• Set up Phase 2 which includes: • Final sign off of all required documentation • Work with BI to confirm Trust is set up to record and report correctly in line with national framework • Work with Patient Access Team to ensure they are all set up to administrate PIFU processes accordingly • Contact Divisions to assess pilot Specialties • Formalise Project Group as PIFU moves into Implementation phase • Small scale launch
1331	Outpatients	Room Booking	Jordon Bailey	• Summary paper and recommendation submitted to SRO	13/11/2020	18/12/2020	B	G	G	G	W	G	• Project closure

Agenda Item: BM21/22-116

BOARD OF DIRECTORS
04 August 2021

Title:	Chair's Report – Safety Management Assurance Committee (SMAC)
Responsible Director:	Hazel Richards, Chief Nurse
Author:	Steve Igoe, Non-Executive Director
Presented by:	Steve Igoe, Non-Executive Director

Executive Summary
A summary of the issues discussed at the Safety Management Assurance Committee held on report 21 July 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	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)
Across all BAF areas
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)

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees	NA	
Background papers / supporting information	NA	

BOARD OF DIRECTORS
04 August 2021

Report of Safety Management and Assurance Committee

Purpose

This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee on 21st July 2021.

Introduction / Background

1. Update on Health and Safety performance activity and dashboard

The Committee were provided with a detailed update on H&S data and progress against actions previously identified along with additional assurance and performance. The Trust Dashboard was discussed along with detailed information on RIDDOR events, Duty of Care notices and EUPL claims and the outcome of those claims as a learning episode.

Between 1st April 2021 and 27th June 2021 there were 5 RIDDOR incidents .3 related to slip, trip or fall .1 related to manual handling and 1 related to a physical assault. The monthly average of RIDDOR reportable events across this reporting period is 1.6 compared to 2.7 the previous year.

There were a total of 394 non clinical incidents reported in the same period .Of these, 229 resulted in no harm and 161 resulted in low harm. It is thought that there is an increasingly enhanced reporting environment which may well be leading to an increase in reporting. The biggest issue continues to be incidents of violence and aggression and a detailed paper on the Trust's response to such issues was discussed later in the meeting.

Several H&S policies were reviewed and updated.
Duty of care notices and EUPI claims continue to be at a low rate.
There are currently 45 H&S risks on the risk register, risk 214 (legionella) is the only risk scored as significant and this continues to be actively monitored and mitigated where possible.

The trust was notified that it had been successful in its ROSPA application and was awarded gold status by letter of 14th June 2021.

2. Health and Safety Annual Report

A copy of the Trust's annual Health and Safety performance report for 2020-2021 is provided for the Board's information as an appendix to this brief update.

Key issues covered in the report are:

- Health and Safety Activity
- A summary of key H&S improvement work undertaken in 2020/21
- Progress against actions identified through the Arcadis inspections in 2019/20

- Performance of the Health and Safety Management committee
- Annual Health and safety Work plan 2021/22 Performance and progress against identified priorities
- Trust wide performance Dashboard highlights ROSPA preparation
- Regulator notifications and activity Further improvements in work streams H&S Audit Activity

3. Divisional Exception Report

Divisional exception reports were received for:

- Diagnostics and clinical support
- Medicine and Acute
- Surgery
- Women's and children's Estates and facilities

Good progress is being made in all of the above areas other than estates and facilities. With an enhanced management structure and qualified staff having been appointed to key roles, the Trust is now in the discovery phase in relation to a substantial number of compliance issues that will need to be resolved over coming months. This will undoubtedly require investment in compliance and CAFM software as well as a detailed understanding and prioritization of LTM and PPM works along with statutory compliance requirements.

4. Review of Committee effectiveness

A detailed report on the effectiveness of the Committee was received. A detailed action plan was agreed to enhance the effectiveness of the Committee over the next year.

5. An update on Disclosure and Barring Service

An update was received in relation to the Trust's position in relation to DBS clearance for contractors when on site .An action plan was produced in terms of mitigating existing risks to children and vulnerable adults however it was accepted that the best way to manage this was to ensure that in any contracting arrangements the contractor attending the site would be required to confirm their adherence to DBS requirements .IT was noted that this might take some time given the amount of contracts to be reviewed however the current plan did provide substantial mitigation in the meantime.

6. Self-assessment of the Trust's arrangements for managing violence and aggression against the NHSE/1 VAP reduction standards

This is the single biggest non-clinical incident (see earlier) and one which is subject to continued management and development of controls. The self-assessment against the reduction standards was broadly positive however it was recognized that there remains work to do to try to reduce the number of such incidents and a detailed action plan was presented to and discussed by the committee. The trust has a violence and aggression prevention group who will continue to report regularly to the SMAC.

7. **General updates** were provided to the Committee on:

- The Needlestick injuries and trends of sharps improvement plan
- Health & Safety Committee Chair's report
- Legal services report on non-clinical claims

Conclusions

The above and attached serve to update the Board of Directors on the work and discussions of the Safety management assurance committee.

Recommendations to the Board

The Board of Directors is asked to note the report.

SJ Igoe

Chair of Safety Management Assurance Committee
27th July 2021

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: SMAC 20/21-087

Safety Management Assurance Committee Meeting
21st July 2021

Title:	Health and Safety Annual Performance Report
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
This paper provides the Safety Management Assurance Committee with an update of data and progress for the year 20-21 along with additional assurance and performance. This paper also includes a summary of activity undertaken by the Health & Safety Team in 2020-21. The Trust dashboard is included for further information as **Appendix 1** to this report

Recommendation:	
The committee is requested to review the report for discussion	
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 center 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-PR 5 – Major Disruptive Incident (Leading to rapid operational instability) Associated Risks: 214, 196, 197, 258, 460, 474, 475.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
The Health & Safety at Work Etc. Act 1974 and supporting Health & Safety regulations The Health & Safety Executive and Public Health England and NHS England Guidance
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
Risk of losing stakeholder confidence, with this report providing assurance
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Trusts Visions and Values
Council of Governors implications / impact (e.g. links to Governors statutory role, significant

transactions)		
None		
FOI status	Document may be disclosed in full	
	Document includes FOI exempt information	Yes
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	None	
Background papers / supporting information	None	

Wirral University Teaching Hospital
NHS Foundation Trust

Annual Health and Safety Performance Report

2020- 2021

1. Executive Summary

This report provides the Board of Directors with an overview of Health and Safety performance and assurance activities undertaken for the year 2020/21, together with an update on progress against the Annual Health and Safety Work Plan developed utilising recommendations from the independent Health and Safety Audit and other sources of intelligence.

As a result of COVID19, progress with the actions identified following the Arcadis Inspections were suspended in March 2020; this was due to the requirement to focus on the challenges the pandemic posed to activity within the organisation. The Divisions were subsequently requested at the H&SMC in April 2021 to progress all outstanding actions within their respective improvement plans and report on progress at the H&SMC meeting in July 2021.

There have been continued improvements in relation to the number of Employer Liability and /Public Liability claims with 11 fewer claims in 2020/21 compared to the previous year. Whilst there has been a slight increase in the number of RIDDOR reportable incidents, which rose by 3, when compared with 2019/20, this increase was anticipated and was as a result of the changes to RIDDOR and the requirement to report certain COVID19 events, which accounted for 16 of the total 27 reported in 2020/21. There has been a significant reduction in the overall number of non-clinical incidents reported in 2020/21 with 632 fewer incidents reported than the previous year. Some benchmarking has been undertaken with similar sized Trusts, with several Trusts reporting a similar reduction in the number of events reported in 2020/21. This is likely as a result of reduced activity and increased home working for some staff, during the COVID19 pandemic.

The H&S performance dashboard continues to be utilised at each H&S Management Committee and Safety Management Assurance Committee, where each Division is represented and presents the data for their services.

The ROSPA application submitted in January 2021 has been assessed by the ROSPA panel and the Trust was awarded ROSPA gold accreditation for a second consecutive year, which is an outstanding achievement and reflects continued progress and improvements in Health & Safety management over the last year. However there remains significant work to be undertaken in order to further improve H&S management, with continued engagement and commitment required from Trust and Divisional leadership and the wider workforce.

The Health and Safety Annual Work Plan has under gone a full review and includes actions contained within the H&S Improvement plan for 2019/20 and the Health & Safety COVID19 recovery plan with of 43 of the total 77 actions within the H&S Annul plan completed.

2. Health & Safety Activity

2020/21 proved a challenging year with the COVID19 pandemic impacting both work activity and personal life. The global pandemic prompted working practices within all organisations to be reviewed with a range of changes to policies and practices required in order to manage and reduce the risks associated with COVID19. Whilst developing processes to address and manage the risks of COVID19 was the focus of H&S Activity in 2020/21, these reports highlights some of the key Health & Safety activities undertaken in 2020/21 in order to further strengthen and improve on existing H&S arrangements.

2.1 Summary of Key H&S improvement work undertaken in 2020/21

- The H&S Annual Work plan has been reviewed and incorporates actions from the H&S COVID19 recovery plan and the H&S Improvement plan with 43 of the total 77 actions completed.
- A Gap analysis was undertaken as a result of the HSE Inspections of 17 Trusts in relation to their arrangements for managing COVID19. The findings of the GAP analysis were presented to the H&SMC and the associated improvement plan approved at the Environmental Group
- The following 4 H&S related polices have been subject to trust wide consultation and review
    - ❖ The Personal Protective equipment Policy
    - ❖ The Fire Safety Policy

- ❖ The Liquid Nitrogen Policy
- ❖ The Search Policy

- A total of 156 non clinical investigations were undertaken, including 27 RIDDOR rapid review or local review investigations which included investigations into COVID19 Occupational Diseases and COVID19 Dangerous Occurrences

- Re-Establishing the non-executive led Safety Management Assurance Committee which was suspended as a result of COVID19 to monitor Health & Safety performance for assurance

- The Health and Safety Responsibilities matrix has been reviewed and is now included as an Appendix to the Health & Safety Policy

- Violence and Aggression and Sharps Safety Improvement plans were developed and are being monitored by the respective specialist group

- VAP and NITS group were both re-established in August 2020 to monitor violence and aggression and sharps safety management arrangements and compliance

- The ROSPA application was completed and a range of evidence collated to support the application was submitted in January 2021

- The Estates Department were assisted with the development of an Electrical Safety SOP including PAT Testing

- Developed a risk assessment for the safe use of Oxygen Cylinders for use within the Trust

- Developed a risk assessment for Door Stoppers which addressed actions required within the associated CAS Alert

- Developed a range of H&S processes to support the organization during the COVID-19 pandemic including:

  - ❖ Developed a range of risk assessments specific to the Respiratory Protective Equipment which include the HSE hierarchy of controls
  - ❖ Developed risk assessments for the safe use of FFP3's and FFP2's which also include the HSE hierarchy of controls
  - ❖ Developed Individual and Environmental COVID19 risk assessments with involvement of key stakeholders
  - ❖ Developed a RIDDOR reporting process for COVID19 events
  - ❖ Established a Personal Protective Equipment Group, Environmental Group and Outbreak Group with agreed Terms of Reference and attendance of key stakeholders

2.2 Progress against actions identified through the Arcadis Inspections in 2019/20

The Divisions have previously progressed a range of actions identified following the inspections undertaken by Arcadis in 2019/20 however completion of all actions identified was delayed as a result of COVID19. Divisions were requested at the H&SMC in April 2021 to revisit their respective improvement plans and progress any outstanding actions and report on progress at the H&SMC meeting in July 2021.

2.3 Performance of the Health & Safety Management Committee (H&SMC)

A self-assessment of the performance of the H&SMC was undertaken with the involvement of key stakeholders and presented at the HSMC in August 2020. A self-assessment questionnaire was developed utilising the H&SMC ToR with a total of 26 questions included within the self-assessment questionnaire. The results of the self-assessment identified the H&SMC were fulfilling their duties and responsibilities in accordance with the agreed ToR .

- The Health and Safety Management Committee meet on 10 occasions with consistent high attendance from members and staff side representatives with 2 H&SMC meetings (April and May) suspended as a result of COVID19.
- A H&SMC cycle of business for 2020/21 was developed with a H&S topic for each month, a range of subcommittee chairs reports and specialist reports developed and presented and divisional H&S reports , Dashboards and exception reports developed and communicated to appropriate forums through the H&S Governance structure
- Non Clinical RIDDOR investigations and EL/PL claims are included within the H&SMC agenda for shared learning
- Other H&SMC agenda items include H&S Improvement plans, the Annual H&S Work Plan , H&S Related CAS alerts

2.4 Annual Health & Safety Work Plan 2021/22

An annual H&S work plan has been developed for 2021/22 which incorporates actions within the H&S COVID 19 Recovery Plan and the H&S Improvement plan following the Arcadis external audit. Following the review and the removal of duplicate actions, there are 77 actions required to be undertaken directly by the Health and Safety Team and 5 actions, were the team are required to support other areas in taking an action (82 in total). To date, of the 77 actions required, 43 have been completed, 16 are underway and 18 are yet to be started. An updated version of the annual H&S work plan will be brought to the SMAC meeting in August 2021.

3. Performance and progress against identified priorities

The Trust dashboard for Health and Safety performance measurement is now embedded and forms part of the monthly H&SMC report. Each Division has a Divisional specific dashboard which they are using to communicate H&S performance through their Divisional governance arrangements. They also present their performance at each H&S management Committee and Safety Management Assurance Committee – **See Appendix 1 for further information. A review of the dashboards and exceptions report is underway following request by the Divisions.**

3.1 **Trust Wide Performance dashboard highlights**:-

RIDDOR:

There have been a total of 27 RIDDOR reportable incidents across the reporting period: 12 were reported as Occupational Diseases relating to COVID 19, 10 resulting in over seven day absences from work, a further 4 were reported as COVID 19 Dangerous Occurrence's , the remaining RIDDOR event was reported as a specified injury (fractured wrist).

4 related to a Slip Trip Fall
2 related to Manual Handling a patient
2 related to manual handling objects
2 related to a physical assault
1 related to a burn involving an Entonox cylinder
4 were reported a COVID 19 Dangerous Occurrence's
12 were reported as COVID 19 Occupational Diseases

- There were 3 more RIDDOR reportable events compared with the previous year which was anticipated as a result of changes to the reporting criteria for covid 19 dangerous occurrences, diseases and deaths
- COVID19 Occupational Diseases was the highest incident type reported with a total of 12 and accounting for 44% of all RIDDOR reportable events
- COVID 19 Dangerous Occurrences were joint second highest with Slips Trips and Falls with 4 respectively
- COVID19 events reported under RIDDOR accounted for 59.25% of the total RIDDOR reportable events

- There has been a decrease in RIDDOR reportable incidents being reported within the statutory timescale. This was understandable and as a result of rigor and assurance required from the Executives that the COVID19 events meet the revised RIDDOR criteria prior to these being reported to the HSE

H&S Incident reported in 2020/21:

The number of H&S incidents/ near misses recorded through Ulysses Safeguard decreased from 1970 reported in 2019/20 to 1338 reported in 20/21, a decrease of 632. It is worth noting that 716 of the total reported in 2020/21 were recorded as near misses. A benchmarking exercise was undertaken with other similar size Trusts with several reporting similar reductions in the number of incidents being reported during the COVID19 pandemic

Top 6 highest non-clinical incidents:-

- Violence and Aggression – 469 (previously 535)
- Unsafe Environment – 200 (previously 213)
- Collision with an Object 101 (previously 108)
- Slips Trips Falls –108 (previously 134)
- Sharps -86 (previously 133)
- Manual Handling –71 (previously 118)

Lessons learnt are shared with Divisions through Health and Safety Management Committee. Specific actions requested are detailed within Divisional H&S reports and sent to all Divisions.

The timely management of incidents reported and managed within the Ulysses system in 2020/21 stands at 55% and slightly lower than the 59% achieved in 2019/20. However we have seen improvement during quarter one of the current year.

The timely reporting and managing of H&S incidents is important as it allows for earlier investigation and retention of any evidence required to assess the risk and/ or respond to potential claims.

Mandatory H&S Training compliance

Overall compliance with Health and Safety training and MH theory are both just below the target of 95% and whilst Moving & Handling people is below 90% with all Divisions working hard to ensure the target of 95% compliance is met.

- H&S Level 1 94.47%
- Moving & Handling 94.10%
- M&H Practical 88.73%

Attendance at H&S meetings

There have been a total of 10 H&SMC meetings during the reporting period with good attendance and engagement with approximately 20 people attending each meeting. 2 H&SMC meetings (April and May) were suspended as a result of COVID19.

3.2 ROSPA Preparation and Submission for 2020-21:-

A second ROSPA application was submitted in January 2021 with results of the ROSPA assessments and awards delayed until June 2021 as a result of COVID19. The second submission was submitted with strong supporting evidence and ROSPA confirmed on the 14/06/2021 that the Trust had been awarded the ROSPA Gold award for a second consecutive year .Whilst achieving the ROSPA Gold award for two consecutive years is an outstanding achievement, there still remains significant work to be undertaken in order to further improve H&S management and continued engagement and commitment will be required from Trust and Divisional leadership and the wider workforce.

3.3 Regulator Notifications/ Activity

There were no HSE Inspectors notifications or activity within the reporting period within the Trust. The HSE did however undertake unannounced spot inspections of 17 other Trusts to assess compliance with COVID19 management arrangements. The HSE made seven key recommendations with a request for all Trusts to review their report and recommendations to ensure compliance with COVID119 arrangements were appropriately robust. It is important to note that the Trust was subject to an inspection of our Infection Prevention and Control measures by the CQC in February 2021, which included management of COVID19. The CQC inspection identified many examples of good practice with the Trust rated as outstanding following this inspection. As a result of the HSE inspections the H&S Team within the support of key stakeholders undertook a Gap analysis of our Trusts arrangements for managing COVID19. The Gap analysis considered several factors including the internal audits undertaken by the Environmental Matron, the findings of the CQC findings following their assessment of the Trusts IPC arrangements and responses of Key Stakeholders in relation to their specific areas of responsibility. In order to obtain a higher level of assurance and further strengthen existing COVID19 arrangements across all areas of the Trust 9 recommendations were made.

A paper which included the findings of the Gap analysis was presented at the H&SMC meeting in May 2021 and an improvement plan has been developed which was presented to the Environmental Group for approval.

4 Further Improvements in work streams

A number of priority work streams have been identified, in addition to the work being undertaken to further develop and embed the Health and Safety framework across the Trust.

- **Health & safety Champions**
  To support and further improve local H&S management arrangements and aid with personal development of staff all wards and departments will be requested to nominate a H&S Champion for their respective area. The H&S Champion will support the manager with developing the contents of their H&S and COSHH folders support the quarterly inspection process, support with hazard identification and risk assessments. A total of 40 H&S Champions have already been appointed from wards following an initial request and further requests will be made so all wards and departments have a nominated H&S Champion in place.

- **Health & Safety Training**
  To support the H&S Champions full fill their roles and to further support local managers two new Health & Safety Training modules are being developed. The proposed contents of the H&S Training module for managers has been circulated to key stakeholders with a request to include anything else they consider would be beneficial . The same approach will be used to develop the H&S Training module for the H&S Champions.

- **Health & Safety Awareness Week**
  To raise the profile of Health & Safety and to increase awareness of key H&S hazards and risks and how these should be managed a Health & Safety Awareness week with involvement of key stakeholders is being planned for September/ October this year. Members of the H&SMC will be requested to agree five key topics of focus that will be covered during this awareness week.

- **Divisional Dashboards**
  A review of the information contained within the Divisional Dashboards' will be undertaken to ensure these capture data required for more meaningful trends identification enabling improved assurance and easier interpretation and presentation of the date contained within these.

❖ **Process for Managing RIDDOR and Non Clinical Local Review Investigations**
A standard operating procedure for managing RIDDOR and non-clinical investigations will be developed with the involvement of key stakeholders which will support the existing process for undertaking and managing clinical rapid reviews and local reviews.

5 H&S Audit activity

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

- All areas are required to complete quarterly Health and Safety inspections which are undertaken and managed locally.
- The Perfect ward has been utilized to integrate 17 key questions into audits already being conducted within clinical areas, one of the questions specifically asks for confirmation that the quarterly inspection has been completed. There is also assurance in other areas that are accredited such as labs and Endoscopy who must show completion of inspections as part of their accreditation.
- In addition there were further audits relevant to Health and safety undertaken during 2020-21 which are described below:-
    - Inoculations and Exposure to Bodily Fluids-Auditing the Role of the Occupational health Department within the Policy – February 2021
    - The Environmental Matron carried out weekly audits across the Trust relating to COVID19 compliance

6 Next Steps

Significant work has been undertaken to establish a framework by which Health and Safety can be effectively managed. Progress continues to be made on progressing work streams included within the Health & Safety Annual Work Plan and the recommendations made as a result of the Arcadis External inspections undertaken within our Trust ; embedding new processes across the Trust to further strengthen existing H&S arrangements ; identifying other areas of improvement through key performance indicators.

7 Recommendations

The Board is asked to note the continued improvements made, the performance measures being used and the next steps identified.

Appendix 2 **Trust Wide (Data correct as of 30/03/2021)**

Total no. non-clinical safety incidents			
	2019/20	2020/21 (ytd)	Increase/ Decrease
No reported (monthly average)	1970 (164.16)	1338 (121.87)	↓
% incidents managed in Ulysses within Trust Timescale	59%	55.37%	↓
Incident Rate	37 117.63	25 209.84	↓
RIDDOR incident			
	2019/20	2020/21	Increase/ Decrease
No reported 2019/20	24 (2)	27 (2.25)	↑
% reported within timescale	75%	25.9%	↓

EL & PL Claims			
	2019/20	2020/21 (average per month)	Increase/ Decrease
No. new claims received	37 (3.08)	26 (2.26)	↓

RIDDOR Injury Type		
	2019/20	2020/21
Death	0	0
Specified injury	3	1
Light Duties	1	0
Over 7 day absence	19	10
No injury(DOcc)	1	4
Occ Diseases	0	12

Near Miss/ Non-compliance	
No. of near miss incidents reported	716 (53.51% of Total number of incidents reported)
No. of near miss incidents investigated	

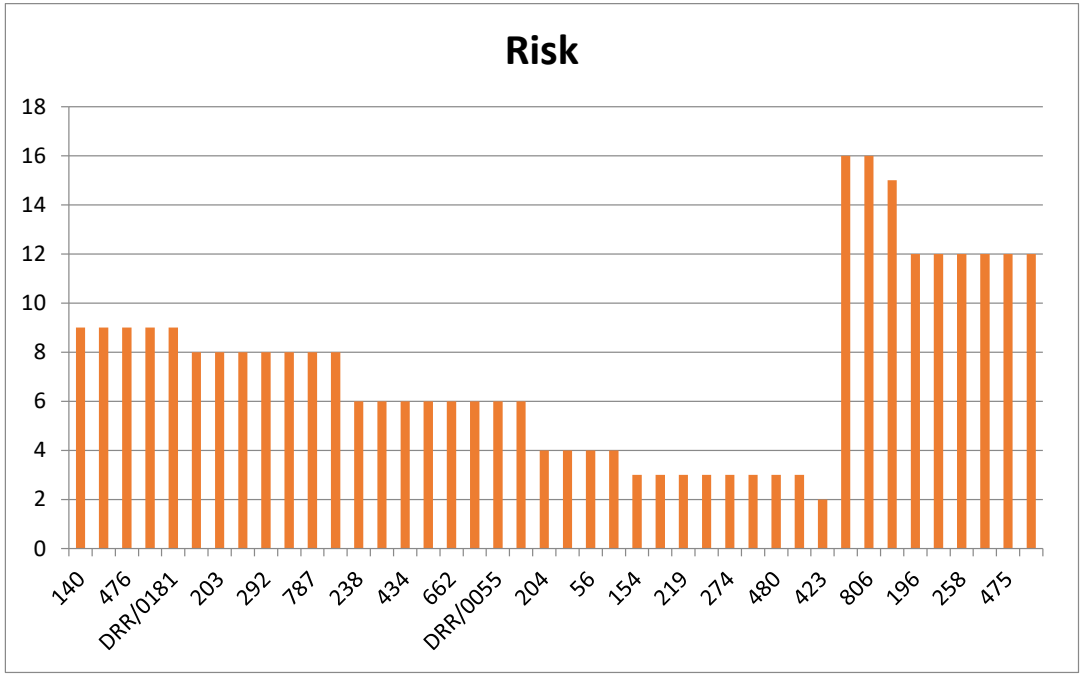
H&S Interventions	
No. of informal advice *(corrective actions)*	**0**
No.of letters of recognition	**0**
No. notice of urgent action	**0**
No. of suspension notices	**0**
No. of duty of care notices	18

H&S Assurance activity	
No. of inspections	**14**
No.of audits	**0**
No. of investigations	156
No. of process reviews	0
No. of Senior team H&S Tours –	0

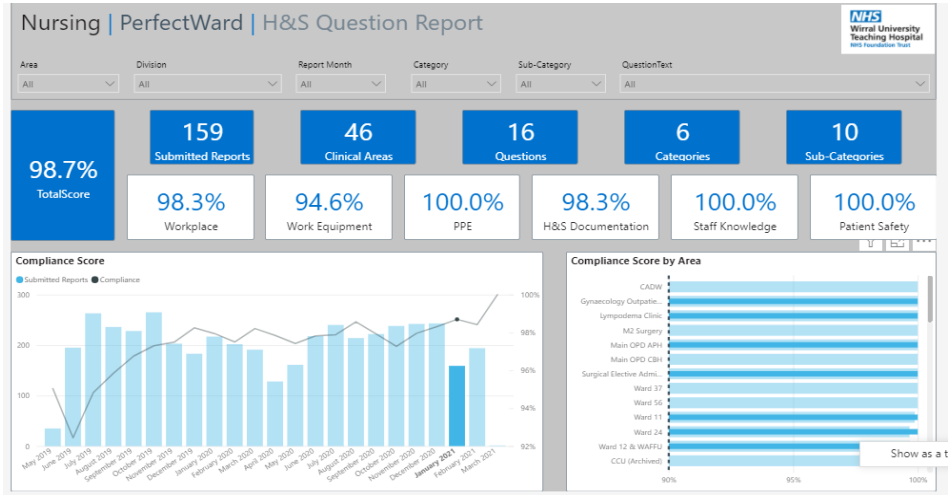
H&S Communication & Consultation (Trust wide)	
No. of HSM Committees	10
No.of SMA Committees	6
No. of H&S Comms	197
No. of Policies reviewed	5

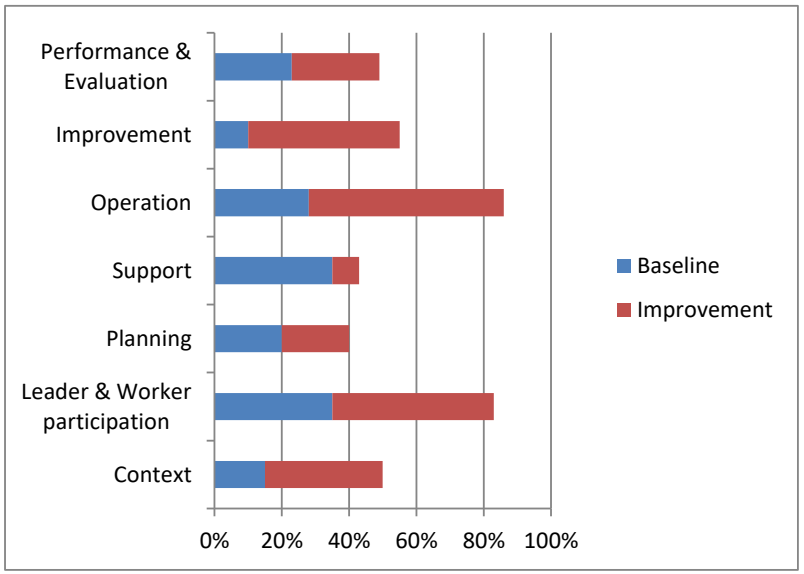
Training and attendance at Trust H&S meetings	
% Divisional attendance	80%
% attendance	100%
% Compliance Mandatory Training	
• H&S Level 1	94.47%
• Moving & Handling	94.10
• M&H Practical	88.73%

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


Risk
18
16
14
12
10
8
6
4
2
0
140
476
DRR/0181
203
292
787
238
434
662
DRR/0055
204
56
154
219
274
480
423
806
196
258
475


469
Violence & Aggression
200
Unsafe Environment
101
Collision/Contact
108
Slips/Trips/Falls
86
Sharps
71
Manual Handling


Nursing | PerfectWard | H&S Question Report
NHS
Wirral University Teaching Hospital
Area
Division
Report Month
Category
Sub-Category
QuestionText
98.7%
TotalScore
159
Submitted Reports
46
Clinical Areas
16
Questions
6
Categories
10
Sub-Categories
98.3%
Workplace
94.6%
Work Equipment
100.0%
PPE
98.3%
H&S Documentation
100.0%
Staff Knowledge
100.0%
Patient Safety
Compliance Score
Compliance Score by Area
Show as a t


Performance & Evaluation
Improvement
Operation
Support
Planning
Leader & Worker participation
Context
0%
20%
40%
60%
80%
100%
Baseline
Improvement

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22-118

BOARD OF DIRECTORS
4th August 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:	Steve Ryan, Non-Executive Director

Executive Summary
This report provides a summary of the work of the FBPAC which met on the 22nd July 2021. The Committee recommends that the Board of Directors ratify the submission of the financial and operational plans.

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)
No new risks identified.
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		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees	Paper reports on the activities of Board sub-committee.	
Background papers / supporting information	NA	

BOARD OF DIRECTORS
4th August 2021

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 22nd July 2021.

1. Finance Report for the period ending June 2021

The Committee received the Month 3 finance report and noted the overall position of a surplus of £0.023m at M3, a negative variance of £0.032m against the plan of £0.055m.

The Committee was pleased with the new sections of the report in respect of CIP performance, divisional performance and income and activity analysis. The report also provided members with an overview of the key risks and associated mitigations, thus providing the Committee with a trackable mechanism of monitoring progress.

The Committee asked for clarification regarding Elective Recovery Funding (ERF) and our dependence on the performance of other Trusts and the Cheshire & Merseyside system in respect of the 5 Gateways. Committee discussed these issues and how they might affect the ERF in the second half of H1 and beyond.

The Committee noted the significance of high cost drugs and sought assurance that this was being incorporated into plans going forward. Committee discussed the inclusion of high cost drugs within block contract values and the potential impact of increased costs due to COVID treatments.

2. CIP Planning 2021/22

The Committee welcomed the report and were encouraged by the progress made in respect of design and organisation of the programme and engagement with the divisions.

Members received assurance from the proposed Quality Impact Assessment (QIA) process that will be applied going forward. QIA Panels for all CIP schemes are due be arranged for September to ensure all projects have been approved prior to transaction from October onwards.

3. Quality and Performance Dashboard

The Committee received a report with the latest measures in respect of quality and performance.

The Committee discussed the continued pressure in respect of the Emergency Department at Arrowe Park and the increased pressure in respect of maternity and paediatric services across Cheshire and Merseyside. Beyond these immediate risks the Committee noted the potential knock on effect in respect of elective activity.

The pressure this could cause on Finance was also discussed but the Committee observed the key limiting factors in respect of increased cost, most notably the availability of staff. The Committee acknowledged the increased pressure this would put on existing staff and the need to provide effective support.

4. Workforce Directorate Business Case

The Committee received a report from the Interim Director of Workforce on the proposal for investment in the service and restructure of the team to support the objectives of the Trust more effectively.

The Committee discussed how the Trust compares with other organisations in respect of key workforce metrics and how this investment will support better performance in these areas.

There was broad support for the proposal. The Committee did, however, request a clear implementation plan for the changes and for that to be brought back to Committee for review along with an assessment of the benefits realised.

Agenda Item: BM21/22 – 119

BOARD OF DIRECTORS
04 AUGUST 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 *Contextual and background information pertinent to the situation / purpose of the report.*
This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 28TH July 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
Background papers / supporting information	

BOARD OF DIRECTORS
4th August 2021

Report of the Quality Assurance Committee
Held on 28th July 2021

Purpose

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 28th July 2021.

Introduction / Background

1. Adapting the surveillance programme for harm reviews from extended waiting times

The Committee supported the recommendations of a detailed report into the background of this issue and the rationale for the proposed adaptation. The recommendation to bring focus onto identified higher risk clinical pathways was congruent with regional and national advice and is supported by the Clinical Commissioning Group. Building on strong clinical engagement, the surveillance approach can be adapted if new evidence emerges.

2. Infection Prevention and Control (IPC)

The Committee received the IPC Strategy and Annual Report, which are both on the agenda for this Board of Director's meeting. The Committee noted that the strategy was very well aligned to the Trust's strategy and would strongly and clearly build on the building blocks of the Trust's response to Covid-19 and success in reducing mandatory reportable infections.

There will be a specific quality improvement focus on further reductions in Clostridium difficile infection. Despite these successes the Committee noted the importance of maintaining effective measures as the pandemic subsides, such as requiring visitors to maintain social distancing and face mask-wearing when circumstances require (as they do currently).

A report on nosocomial Covid-19 infection demonstrated that it was important to adopt (and if possible pre-empt and exceed) national guidance on controls to minimise cross-infection. The Clinical Advisory Group & the Infection and Prevention Control team continue to play a key role guiding our response.

3. Assurance on Maternity Services

Through the Patient Safety and Quality Board (PQSB), the Committee noted that assurance had been received by a MIAA internal audit which demonstrated full compliance with the ten standards of the NHS Resolution Maternity Incentive Scheme

4. Emergency Department

Through PQSB, the Committee received and update on executive oversight of the care quality in the Emergency Department. An executive-led thematic review is to be brought to the September Committee. The Committee was please to note a 94.1% reduction in hospital acquired pressure ulcers in the department during a quality improvement initiative.

5. Focus on National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive procedures (LocSSIPs)

The Medical Director and Chief Nurse outlined their approach to seeking further assurance in relation to these two standards across the organisation. As care pathways are adapted and modernised, procedures, which once were undertaken in operating theatres, may increasingly take place in a range of clinical areas.

It is important that the care processes in those areas are as robustly governed as they are in operating theatres. The WHO safety checklist would be an example of such a process. The Medical Director and Chief Nurse will be supported by a clinical lead for the work who will work with the Divisions to develop an approach to ensure comprehensive assurance.

Conclusions

The Committee received appropriate and detailed documentation in relation to the items it considered on 28th July 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: 21/22-120

BOARD OF DIRECTORS
04 August 2021

Title:	Report of the Trust Management Board
Responsible Director:	Hazel Richard, Chief Nurse / DIPC
Author:	Oyetona Raheem, Board Secretary
Presented by:	Hazel Richard, Chief Nurse / DIPC

Executive Summary
To provide a summary of the Trust Management Board held on 27 July 2021 via Microsoft Teams.

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)
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	NA	
Background papers / supporting information	NA	

BOARD OF DIRECTORS MEETING IN PUBLIC
04 August 2021

REPORT OF THE TRUST MANAGEMENT BOARD

Purpose

To provide a summary of the businesses and risks presented and discussed at the Trust Management Board held on 27 July 2021 via Microsoft Teams.

Introduction / Background

A summary of the topics covered is provided below:

1. Patient Experience Strategy

TMB received a presentation on the Patient Experience Strategy which comprised staff, patient and board engagement workshops. The next steps were noted as collation of the draft patient experience visions for review by the Executive Team, to narrow them down to the top 3 or 4. Staff members and patients would then be able to vote for their favourite patient experience vision.

TMB noted the six steps and brand promises by each of the divisions as well as the timeline for delivery of the Patient Experience Strategy

2. Month 3 Finance Report

TMB received the Month 3 finance report and noted a surplus of £0.023m which represented an adverse variance against plan of £0.032m.

TMB received explanations on the anticipated income from the Elective Recovery Fund (ERF) which was not expected until Month 4 as well as on the estimates of activity against national trajectories. NHSI have confirmed that the trajectories in respect of ERF will increase to 95% for the remainder of H1, which would significantly reduce the amount of income available to the Trust for Months 4-6.

The Deputy CFO gave explanations on how the changes in ERF had led to expectation of much more challenging CIP targets. CIP was previously set at 2% but now expected to be above 3%.

3. Digital Strategy

TMB received a presentation on the Trust's Digital Strategy which was one of the enabling strategies, through which the 2021-2026 Strategy will be delivered. TMB noted the breakdown of the Digital Strategy into 4 domains of Digital Future strategic objective: Digital Foundations, Digital Innovations, Digital Education and Digital Intelligence; as well as delivery plans including Digital Strategy development workshops, engagement sessions and patient questionnaire.

TMB noted the current position, key priorities and areas for improvements over the next five years as well as details of how progress in delivery will be monitored.

TMB discussed the significance of involving all divisions in the development of the Digital Strategy. PM acknowledged the support that had been received from divisions in this regard.

The Digital Strategy proposal was endorsed by TMB.

5. Clatterbridge Master Planning

TMB received a progress update on the Clatterbridge Master Planning.

TMB noted that the Trust had not developed a master plan for the campus since 2014. TMB also noted the plan to undertake, in partnership with Clatterbridge Cancer Centre (CCC) and Cheshire and Wirral Partnership (CWP), a campus master planning exercise using specialist architectural consultancy.

6. Workforce Steering Board – Key issues Report

TMB reviewed the report from the Workforce Steering Board held on 16 June 21 and noted that discussions had been held on the following issues:

- Workforce Performance Report
- Workforce Planning Update
- Covid-19 Staff Asymptomatic Self-Testing (LAMP)
- Respect at Work
- NHS Staff Survey 2020 - OD Response to Staff Survey / Trust-wide Improvement Plan
- Safe Employment / Corporate and Local Induction Update
- Occupational Health and Wellbeing Update
- Volunteer Strategy Update

7. Digital Programme & Services Oversight Committee (DPSOC) Key Issues Report

TMB reviewed the report of the DPSOC held on 15 July 2021 and noted some of the issues discussed including:

- IT Project Portfolio report
- IT Departmental high scoring risk report (>10)
- Programme Headlines & Challenges
- Optimisation Priorities
- Departmental Risks

Discussions took place on:

- Operational planning – 18 month IT plans which was due at TMB in September 21.
- Cyber security – operational plan being drawn up.
- Completion of Wi-fi provision survey within the Trust and installation of additional access points to start in August 21.
- Medical records storage locations – actions being progressed following a health and safety review of areas.

8. Risk Management Committee Key Issues Report

TMB reviewed the report of the Risk Management Committee held on 06 July 2021

summarising the key quality initiatives and noted that there were currently 481 live risks on the Risk Register which represented an increase of 1 since the previous meeting.

TMB also noted the reduction in the number of overdue actions from 81 to 39 following the meeting in June 2021 and that Corporate Nursing had reviewed and closed all but one of their actions.

9. PSQB Report

TMB reviewed the report of the Patient Safety and Quality Board (PSQB) held on 8 July 2021 and noted the key issues discussed including:

- WISE Accreditation Inspections Update
- Transfusion/HTC Compliance
- Divisional Governance Reports for:
- Diagnostics & Clinical Support
- Medicine & Acute
- Women's & Children's
- Divisional Responses to NatSSIPs Gap Analysis for
- Surgery Division
- Medicine & Acute Division
- Diagnostics & Clinical Support Division
- Assurance processes for the delivery of reliable safe care within the Emergency Department at WUTH
- IPC Annual report 2020-21 and IPC Strategy 2021-2023
- Legal Services Report 2020-21
- Discharge process – summary of improvements in progress
- Special Educational Needs and Disabilities Report
- CQC Action Plan Quarterly Update
- Action Plan for Issues from Nosocomial COVID Mortality Review
- Maternity Services Quarterly Update Including an Overview of Compliance with CNST Actions
- Patient Experience Strategy Progress Update
- Emergency Department Thematic Review
- Quality Strategy Year 3 Measures
- Gap Analysis: CQC Assessment of Mental Health Services within Acute Hospitals

TMB noted the progress with the ward assessment and accreditation (WISE) including the six areas that have retained their accreditation level and one which had moved from level 2 to level 3.

TMB noted the report on "Gap Analysis: CQC Assessment of Mental Health Services within Acute Hospitals" including the identified gaps which would form the basis of an improvement plan.

TMB noted that PSQB had reviewed the IPC annual report and three year strategy which was approved for presentation to the Trust Board on 4th August.

10. Operational Performance Committee

TMB reviewed the minutes of the Operational and Performance Committees held on 15 July 2021 and noted the key issues discussed including:

- Severe Asthma Service
- Pipeline Planning
- Update on Business Case Process Development
- Trust and Divisional Quality Performance Dashboard
- Redesign and Relaunch of Virtual Fracture Clinic
- Medical Day Unit Review Update
- Endoscopy DM01 Recovery
- Reset and Recovery Update
- Clinical Harm Reviews
- Management of Overdue Follow Ups Senior Manager
- Pending Investigation Queue Senior Manager
- P Status Update
- Implementation of National Standards for D Status - Diagnostic Tests
- Paper Works: the Critical Role of Administration in Quality Care

11. Divisional Updates

The TMB reviewed and noted the key issues in the previously circulated updates from each operational division.

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:
BM2122- 121

PUBLIC BOARD OF DIRECTORS
04 AUGUST 2021

Title:	Communications and Engagement Report
Responsible Director:	Debs Smith Interim Director of Workforce
Presented by:	Sally Sykes, Director of Communications and Engagement

Executive Summary
The report covers the Trust's communications and engagement activities in July 2021 since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and engagement, WUTH Charity 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 with staff and stakeholders.

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. Staff engagement supports providing the best patient care.
Council of Governors' implications / impact (e.g. links to Governors' statutory role, significant transactions)
None, unless reputation risks manifest in an unforeseen way

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

Previous considerations by the Board / Board sub-committees	Monthly reports to Board, Workforce Steering Group and WAC
Background papers / supporting information	Report attached with appropriate links embedded.

PUBLIC BOARD OF DIRECTORS
4 AUGUST 2021

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 and WUTH charity supported significant staff engagement on the NHS' 73rd birthday, celebrated this year as 'The Big Tea'. Arrowe Park Hospital entrance was lit in blue light and a series of staff events and local fundraising took place to support the NHS.

- WUTH Medical Director, Deputy CEO and Respiratory Physician Dr Nikki Stevenson has expressed support for a new hard hitting campaign to 'Stop the abuse' directed at General Practice staff. As many as three-quarters (75%) of practice staff receive abusive comments from patients daily, a survey has shown ahead of the launch of the new campaign to highlight the abuse. The survey findings coincide with the launch of a campaign from the Institute of General Practice Managers (IGPM) to end all abuse towards general practice staff, marked with the release of a video featuring staff reading out **examples of abuse they have received**
.
- The Vaccination Hubs continued to require campaign and communications support whether for changes to advice and guidance or to communicate to staff and the public the availability of booking slots and the opening up of vaccine for new eligible cohorts – including younger age groups and the ability to book into Clatterbridge directly from the national booking system. We provided media support to making local people aware of the Wirral Vaccination Bus touring the community and also to the availability of walk-in clinics at our Clatterbridge site.
- We worked with system partners to promote a new tool for the public to

reduce their alcohol intake. During the COVID-19 pandemic harmful drinking has risen significantly, consequently impacting on people, communities, and services. Champs Public Health Collaborative have launched a free Lower My Drinking app funded by Cheshire and Merseyside Health and Care Partnership. The Lower My Drinking app helps individuals set a drinking goal, and then helps them to achieve it a number of behavioural tools and techniques. The Lower My Drinking App is free to download from the **App store** or **Play store**.

- As our Emergency Department, along with others in the region, continued to experience significantly increased demand, we sustained our messaging to 'Keep A&E free for emergencies'. While the key message is to contact NHS 111 in the first instance, face-to-face appointments with GPs have resumed and Walk-in Centres on the Wirral are now fully open, including the Urgent Treatment Centre at Arrowe Park, if it is not an emergency. There's an example of the campaign **here**

Media

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

- Increased community prevalence of COVID-19 cases and new variants of concern meant that we had to keep visiting restrictions, which was communicated to the public and via the media.
- We also joined with other health and social care providers in maintaining restrictions such as mark wearing and social distancing, using materials provided by Public Health England and the NHS Confederation campaign #NotTooMuchToMask | NHS Confederation
- We issued a news release following our joint nomination with Wirral Council for a Municipal Journal national public service award for the work done at the start of the pandemic to provide a safe quarantine for UK nationals returning from Wuhan- Municipal Journal Awards | Wirral University Teaching Hospital The award nomination was covered in The Wirral Globe and the Liverpool Echo, which also conducted an interview with Dr Nikki Stevenson about the Wuhan guests' repatriation.
- In further awards nominations, our Procurement Team has been shortlisted for the North Excellence in Supply Awards 2021. This is for the NHS Procurement Transformation Award and they have been shortlisted for all their work in Managing PPE stock during the pandemic. The transfer of the recording of deliveries of PPE from spreadsheet to a virtual store meant managers were able to view more easily how stocks were being managed. The ability to create a 'real time' information flow to the trust Command Centre meant shortages could be more easily identified. Please see more information about the awards **here**.
- The extreme hot weather meant we had to support staff and patients to help them keep cool in exceptional circumstances. There was coverage in the Liverpool Echo of the heatwave following a complaint from a mother about the heat on a ward where her baby was being cared for.
- We provided information for the Department of Health and Social Care's launch of the 'Our NHS Buildings' website. This is the official home of the

government's major NHS infrastructure projects, including new hospital builds, upgrades and investment in equipment and technology. The website will provide regular updates for patients and staff on the progress of local schemes, showcasing developments and milestones at each hospital build or upgrade location, with an interactive map- **here**. The Arrowe Park Urgent and Emergency Care Upgrade Project (UECUP) is featured and more information will be added as the project progresses.

- **A WUTH Consultant has warned about multi-faceted pandemic health impact. -** Dr Scott Murray, a former President of the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) and a Consultant Cardiologist at WUTH has written about the challenges in this article - Leading heart doctor warns about multi-faceted pandemic health impact | InYourArea Community

- The Healthcare Technology specialist online publication published and over view of our forthcoming Digital Strategy. Health Tech Trends Series 2021: Digital aims in Wirral University Teaching 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; thank yous to staff and charity updates.

- There was an increased need to communicate self-isolation rules following increases in staff absences arising from contact tracing in the community and in schools. The Government's new guidance on how healthcare professionals could return to work if double-vaccinated and taking regular tests required communications support to help explain the guidance to staff and managers.

- We continued to promote the Quarterly People Pulse Staff Survey, which now replaces the Staff Friends and Family test and going forward will be the main measure of ongoing staff feedback (with the exception of Q3 when the main Staff Survey takes place).

- We produced adverts to recruit Band 5 nurses locally and also in support of our drive to recruit new governors for the Trust.

- In internal communications we supported the Trust in ensuring that staff are fully aware of the legal obligations to preserve documents following the Government's announcement of a Public Inquiry into the pandemic.

- We provided business continuity communications support to the Trust, CCG and other partners during the IT outage, which started on 22 July, following routine maintenance to the Cerner Millennium system. The incident was reported in the Wirral Globe - IT system suffers outage

- The Board is asked to note continuing progress with the WUTH research agenda. Dr Susan Hopkins, Chief Investigator for the SIREN study, wrote to

Janelle Holmes, Chief Executive, expressing thanks and congratulations to our SIREN study research team and the 215 study participants here at WUTH. The purpose of this study is to understand whether prior infection with SARS-CoV2 (the virus that causes COVID-19) protects against future infection with the same virus. Funding for a further phase of the study has been approved to March 2022.

WUTH Charity

The team continues to plan future events and deliver some activity safely and in line with restrictions.

- NHS Charities Together (NHSCT) grant - The application for £143,000 for the Bowman's refurbishment was presented to NHS CT Board week commencing 22nd July. The decision will be announced week commencing 26th July. Further funding is expected to be released by NHS CT, the themes and timeframes for these grants have yet to be confirmed.

- Wirral Mayor's Charity of the Year – The Head of Fundraising has had an extremely positive first meeting with the Mayor and the Civic Office. The Mayor is very keen to support WUTH Charity and the discussion focussed on introductions to the Mayor's supporter contacts. The Civic Office will share all charity activity with the Wirral Council communications team for global emails to council staff. The first event for the Mayor's Charity is the Mayor's Ball, which will take place on 15th October 2021 at Thornton Hall Hotel; details for the evening including how to purchase tickets are expected in mid-August.

- Corporate support - Innospec, based in Ellesmere Port are currently attempting a challenge to complete a 1000 miles in July. Funds raised will be shared between our Tiny Stars Neonatal appeal and Diabetes UK. The current total is £3412.38 and will be matched funded, up to an additional £4000.
- NHS Big Tea 5th July – A pared back version of the original plans took place on the 5th July. The charity team distributed over 4000 cakes to staff. To mark the day staff could also claim a free cup of tea. The Charity team also visited a number of local businesses including local branches of Santander.

- Arrowe Park Abseil 10th/11th September. Uptake for the event is going well with over 40 people signed up to date. (88 people took part in 2019). Please contact wuth.charity@nhs.net if you would like to take part.

- Charity Golf Day – 15th September 2021- 5 teams have confirmed there attendance with another 10 registering their interest. A press release was sent out promoting PGA Golfer John Singleton's support Carden Park to host Wirral neonatal unit charity golf day | Wirral Globe

- Charity Car Wash 9th August – Heswall Community Fire Station has confirmed they will support WUTH Charity again with a charity car wash. All proceeds will be shared between the Fire fighters foundation and the Tiny Stars Neonatal Appeal. The Mayor has confirmed he will attend and have the Mayor's car washed to assist with Charity awareness.

More information about all the events planned can be requested via

WUTH.Charity@nhs.net

Stakeholders

- We were very pleased to report that Wirral University Teaching Hospital has moved out of being categorised as a 'challenged provider' by NHSE/I and is no longer subject to oversight from a System Improvement Board (SIB) at regional level, which had been in place for around 3 years.

- NHSE/I remarked that significant progress has been demonstrated across each domain and, whilst it is acknowledged that in some areas, further improvement will be required, the leadership, relationships and governance processes now in place within the Wirral system mean that the improvement journey can now revert back to business as usual monitoring and scrutiny processes with NHSE/I as regulator. We communicated this to system stakeholders and thanked our staff for their significant contribution to this development.

- We continued to work with system partners to promote different ways to access healthcare in the light of substantially increased pressures on A&E.

- We held the first meeting of the system communicators who are going to be supporting the communications work stream for the Urgent and Emergency Care Upgrade (UECUP) project.

- Maternity Voices are providing their expertise to help us refresh the Wirral Women and Children's website in line with the recommendations of the OCKENDEN REPORT

Conclusions:

The Trust Board of Directors is asked to note the report

Recommendations to the Board

To note the changes to the Staff Friends and Family Test being replaced with the Quarterly Staff People Pulse survey (with the exception of Q3 when the main staff survey takes place.)