Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

01 September 2021

together we will

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Meeting of the Board of Directors in Public
10.00 a.m. - 12 noon Wednesday 01 September 2021
Via Teams
AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
21/22-125	**Apologies for Absence**	Chair	Verbal	N/A
21/22-126	**Declaration of Interests**	Chair	Verbal	N/A
21/22-127	**Patient Story**	Deputy Chief Nurse	Video	N/A
21/22-128	**Minutes of Previous Meeting – 04 August 2021**	Chair	Paper	4
21/22-129	**Board Action Log**	Chair	Paper	17
21/22-130	**Chair's Business**	Chair	Verbal	N/A
21/22-131	**Key Strategic Issues**	Chair	Verbal	N/A
21/22-132	**Chief Executive's Report**	Chief Executive	Paper	19
Performance & Improvement				
21/22-133	**Quality and Performance Dashboards & Exception Reports**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Deputy Chief Nurse	Paper	25
21/22-134	**Finance Report for Month 4**	Chief Finance Officer	Paper	52
Governance				
21/22-135	**Guardian of Safe Working (Quarterly) Report**	Medical Director	Paper	70
21/22-136	**Monthly Safe Nurse Staffing Report**	Deputy Chief Nurse	Paper	83
21/22-137	**Legacy Board Assurance Framework**	Interim Director of Corporate Affairs	Paper	91
21/22-138	**2021/22 Board Assurance Framework**	Interim Director of Corporate Affairs	Paper	117
21/22-139	**Chair's Report – Finance, Business Performance & Assurance Committee**	Committee Chair	Verbal	N/A
21/22-140	**Chair's Report – Workforce Assurance Committee**	Committee Chair	Paper	125
21/22-141	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	128
21/22-142	**Any Other Business**	Chair	Verbal	N/A
21/22-143	**Date of Next Meeting – 06.10.2021**	Chair	Verbal	N/A

21/22-144	**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.	N/A

BOARD OF DIRECTORS

DRAFTMINUTES OF MEETING HELD IN PUBLIC

04 AUGUST 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 13.30 and Concluding at 16.00

Present

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
Matthew Swanborough	Director of Strategy and Partnerships
Mags Barnaby	Interim Chief Operating Officer
Debs Smith	Interim Director of Workforce

In attendance

Mags Barnaby	Interim Chief Operating Officer
Robbie Chapman	Deputy Chief Finance Officer
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

Apologies

Sir David Henshaw	Chair
Jayne Coulson	Non-Executive Director
Kathryn Brodbelt	Associate Medical Director
Chris Mason	Chief Information Officer
Simon Lea	Associate Medical Director
Claire Wilson	Chief Finance Officer

Reference	Minute	Action
21/22099	**Apologies for Absence**	
	Apologies for absence were noted as reported above. The Chair acknowledged the presence of governors in attendance. The Chair also informed the meeting that Allen Peters, Public Governor was unwell and attendees wished him a quick and complete recovery.	
21/22100	**Declarations of Interest**	
	No interests were declared at the meeting.	
21/22101	**Patient Story**	
	The Board viewed an elongated version of the Patient Story video, featuring Mr W a Retired School Teacher who spoke in relation to his recent 3 inpatient admissions for COVID-19 treatments. Mr W's general experience	

Reference	Minute	Action
	was positive but he highlighted a number of areas where improvements could be made. This included family support during COVID to patients at end of life, time spent in A&E, general facilities in bathrooms to support self-care and access to support for patients at mealtimes On the positive side, he observed a culture of hard work and support for one another among staff members, feeling listened to by staff and receiving personalised care from medics. Discussions took place on how to improve the areas for improvement expressed by Mr W and the Board expressed their wish to convey their appreciation to him for sharing his story. *Action : Deputy Chief Nurse* **The Board noted the patient story**	
21/22102	**Minutes**	
	The minutes of the meeting held on 07 July 2021 were approved as an accurate record.	
21/22103	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
21/22104	**Chair's Business**	
	The Chair reported that the Council of Governors had ratified an extension to the term of office of Sir David Henshaw as the Chairman by an additional three years, with effect from the end of February 2022. He also announced the re-appointment of Steve Igoe, Senior Independent Director for another three year term with effect from 1st October 2021. The Chair also drew attention to recent changes in the composition of the Executive Director team and to the ongoing effort to appoint permanently to vacant positions. There was acknowledgement that this presented a potential risk to business continuity and the capacity of the Executive Directors to deliver strategic objectives, thus requiring a pragmatic approach to how priorities were aligned and delivered. **RESOLVED:** **That the Board NOTED the Chair's Business**	
21/22105	**Key Strategic Issues**	
	There were no additional strategic issues to report.	
21/22106	**Chief Executive's Report**	
	The Chief Executive presented her report and highlighted that 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 had increased significantly to a total of 40 inpatients, with currently 10 of these patients in critical care.	

Reference	Minute	Action
	The Chief Executive noted that this level of activity appeared to have plateaued slightly behind rates within Greater Manchester, and this performance would continue to be tracked and monitored through the COVID situational reports, which were refreshed regularly. From a reset and recovery perspective, whilst the Trust performance is below the recovery trajectory (which had been revised from 85% to 95% by the national team in mid-July 2021), however it was worth clarifying to the Board that activity here is a proxy for the Elective Recovery Fund (ERF). The ERF was set up on a baseline value of all elective activity and the Trust performance was ahead from a value perspective therefore there were no current concerns to income. . The Chief Executive then referenced the ongoing support from the vaccination hub, citing the recent interim guidance pertaining to health care workers over the 50 booster along with flu. More detailed guidance was awaited in relation to the flu programme, and this would be rolled out staff once it was received by the NHS Trusts. The Board were informed that there had been nine series incidents in June and two (Reporting of injuries, Diseases and Dangerous Occurrences incidents (RIDDORs) which were being investigated and reported through the standard Trust assurance processes. The report also incorporated an update on the new quarterly staff survey, which would be undertaken in quarter two of the financial year. The Chief Executive stated that the quarter 3 survey would not be carried out due to the timing of the national staff survey taking place in the same period. The Board's received a briefing around the Millennium downtime incident which occurred in July 2021. This was following a planned maintenance of the Millennium system overnight, when error messages were generated. A decision was then made to take the system down while Cerner (the company hosting the hardware for the Millennium electronic patient record) continued to work on remedial actions. At that point the Trust declared a level two critical incident for the organisation, and set up an incident room. The Chief Executive assured the Board that the incident was managed accordingly with support from Cerner until the Millennium system came back online. An IT technical debrief had been undertaken, whilst a trustwide critical response debrief was scheduled to take place during the same week of the Board meeting. Once completed a review of lessons learnt would be carried out, with an update to the Board in due course. *Action : Chief Information Officer* The Chief Executive highlighted some leadership changes at the Cheshire and Merseyside ICS, with the recent appointment of David Flory (the Chair of Lancashire and South Cumbria ICS) as an acting chair. Sheena Cuminsky, Chief Executive at Cheshire and Wirral Partnership NHS Foundations Trust, had agreed to step into the post of Chief Officer on an interim basis for a period of three months.	

Reference	Minute	Action
	The Chief Executive reported that Dr Susan Hopkins, Chief Investigator for the SIREN study, had written to the Trust, expressing thanks and congratulations to the Trust SIREN study research team and the 215 study participants within the Trust. It was particularly encouraging that the Team had secured funding to continue the research for a further 12 months. In response to an enquiry from Steve Ryan, the Chief Executive confirmed that Cerner were closely involved in the management of the critical incident as it was their IT systems that they hosted that had resulted in the downtime **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
21/22-107	**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 June 2021 for their respective areas. The Chief Nurse highlighted the Board's attention to one MRSA Bacteraemia which had been deemed unavoidable with incidental findings, and minor lessons. A thorough review had been undertaken. There was also a grade 3 pressure ulcer relating to a complex patient that declined all appropriate treatment and equipment in relation to pressure relief. The Chief Nurse reported that there had been a significant reduction in grade 2 ulcers as a result of the safety work undertaken in the Trust, with an 80% reduction in Emergency Department, which was a positive trend, highlighted in their recent performance review. John Sullivan observed that there had been an improvement on the mandatory training uptake, such as CPR and PPE training. The Medical Director reported on the performance of the VTE assessment, which was at 97.4%. This had not translated into any patient safety risk, with the national standards being maintained. The Trust had seen an 20% increase in unscheduled visits to the Emergency Department, coupled with a 27% NWA with their category 1 patient calls, therefore this pressure extended to the C&M, and throughout the country. It was reported that patient flow had increased significantly, and the number of patients going through the right assessment areas was working well, with occasional delays to ambulance handover whilst COVID status screening was awaited. The Medical Director advised the Board that the narrative in the report stating that there were no patients waiting longer than 12 hours in ED was incorrect, as there had been a number of Mental health patients who had waited for long periods to access beds across the C&M patch. This particular concern had Chief Executive level focus and was also being monitored through the Mental Health Transformation Group. John Sullivan requested a review of the upper and control limits, citing the VTE graph as an example with variability being very low and control limits being wide. *Action : Chief Information Officer* Steve Ryan enquired whether the environment for the mental health patients	

Reference	Minute	Action
	was safe and appropriate. The Medical Director explained that the s136 was used as a place of safety; however this was currently located within the A&E department. There were three rooms available and a lot of work had been done to mitigate ligature and harm risk, which meant the room was less comfortable. It was a suboptimal environment for patients who were waiting for prolonged periods to access mental health inpatient beds, and this issue had been escalated to the Trust partners, and internally to assess how this could be improved. The Chief Executive added that this was a national and local issue which presented significant challenges. It was reported that as of Tuesday the 3rd of August, there had been four patients waiting in excess of 12 hours for access to mental health inpatient beds, with times ranging from 24 to 44 hours. This situation was also compounded by the fact that there were two mental health beds available nationally at that point in time. The interim Director of Workforce presented the highlights of the report, by drawing the Board's attention to two areas. Sickness absence performance had been maintained from May to June, at 5.68%, with the drivers typically being short term sickness as a result of stress, anxiety and depression. Mitigations included supporting managers and HR managers were currently undertaking departmental audits to ensure the sickness absence policy was being complied, with the results being reported through DPR. The staff survey actions also incorporated a significant focus on wellbeing. Appraisal compliance target was 88%. This had been maintained, with area the corporate divisions continued to experience challenges and support was being given as appropriate by the workforce team. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard and the Exception Reports for the period to 31 June 2021.**	
21/22-108	**Month 3 Finance Report**	
	The Deputy Chief Finance Officer reported on the finance about the ongoing pressure in Emergency Department, and the impact resulting on additional expenditure on temporary staffing. That pressure was anticipated to increase. The impact of the non-elective demand was a reduction on the elective programme in July the Trust anticipated a reduction in elective ERF funding at a later point in the financial year. ERF values for month one were now confirmed whilst an indicative figure had been given for month two, and they were both in excess of what the Trust had originally anticipated in the returns. The Trust had originally estimated to receive 1.4 million in respect of month one, and it had been confirmed that the Trust was on course to receive 2.6 million, an improvement of 1.2 million. The Board were informed that there were a number of reasons for this variance. Firstly, the rules and stipulations around ERF are not fully clarified therefore the Trust had to make some high level assumptions about case mix for example, which presented challenges in relation to track. Secondly, there was a degree of prudence in Trust projections due to some concerns about the recoverability of that income; however it was very positive news that the Trust was receiving this income.	

Reference	Minute	Action
	The Deputy CFO reported that the Wirral University Hospital Trust was one of the better performing district general hospitals in the region in this respect and added that the indicative figures for March were also positive; however these were yet to be confirmed in detail. Sue Lorimer requested an analysis of the medical and acute pay overspend of £2.5 million which was highlighting a potential £10m overspend, which seemed significant even in the context of the additional activity. *Action : Chief Finance Officer* The Deputy CFO agreed that this analysis would be featured in the Finance, Business, Performance and Assurance Committee papers for the August meeting. He explained that the expenditure was associated with the additional staffing costs and it would also be useful to assess the impact the substantive recruitments have on the run rate for that division. It was cited that there were some long term locum arrangements which had recently been substantively recruited for, such as gastro and haematology, therefore this would improve the position. The Medical Director added that this overspend issue was being reviewed and monitored jointly with the Chief Finance Officer and Director of Workforce in order to put in place mitigations. It was reported to the Board were informed that Esist had undertaken a review of the workforce in ED, with the report expected in September. A nursing review had also been undertaken. The Medical Director emphasised that there was a drive to address the issues caused by temporary staffing, however this was impacted by the 20% increase of activity (based on 2019 data, pre COVID). John Sullivan enquired whether there was an issue regarding a significant under-budgeting that needed to be addressed. The Deputy CFO explained that it was important to clarify the distinction between the financial plan and internal budget. The Trust plan for H1 had a degree of funding for non-core spend, this had been factored in, however when re-profiled budgets assumptions were made then all budgets would be made of substantive costs. The variance seen in relation are significant variances from the internal budgets because of agency spend as this was not planned. When factored against the original plan submitted to NHSI, the variance was still significant at over a million pounds, however not at the same scale as the £1.2m. Whilst the difference between non-core spending against core spend was significant, the difference was far lower in terms of the impact upon the financial plan submitted centrally. **RESOLVED:** **That the Board NOTED the report.**	
21/22-109	**Digital Strategy**	
	The Board received a presentation on the Trust's Digital Strategy which was highlighted as one of the enabling strategies, through which the 2021-2026 Strategy will be delivered. The Director of Strategy and Partnerships reported that the Digital Strategy had been reviewed by the Trust Management Board and was now being	

Reference	Minute	Action
	presented to the Board for approval. The digital strategy focussed on four areas, against the trust strategy, and the objective for Digital Futures, trying to align the core priorities back to each of those areas. From the onset there had been the aim to establish a core alignment around the use of technology, the empowerment of patients with data business intelligence driving decision making and enabling population health management. A series of meetings had been held with senior management and stakeholders such as the Chief Finance Officer. A number of clinical and corporate engagement sessions were held with staff, aided by the use of a questionnaire. This also extended to engaging through Healthwatch in order to bring forward the patient voice define those key priorities and objectives as well. Patient engagement was really essential in shaping the strategy. The Board was informed that the feedback indicated that people were very keen to move from telephone booking or manual booking towards a portal, accessing their own information, their own results, and also at being able to find health information more easily. In relation to digital foundations, the real focus was on moving away from servers, and data warehouse into cloud based solutions focused on cyber defences and ensuring that the Trust security and network access was in place, and segmentation for medical was up to standard. The Director of Strategy explained that this was one of the bigger areas of risk, as well as some of the important elements around telephone services, and also Microsoft Office 365 solution. In addition well around innovation as well as the transitioning to a single patient record to move away from paper to use patient portals in terms of a means of communication with patients, with a focus on integrated care record linking with the Community Trust and primary care. There was also a priority around developing a single training which would be aligned back to the workforce education programme and pushing back more to virtual learning environments, as evidenced through the COVID pandemic. The Director of Strategy advised that digital intelligence came out really strongly from staff keen to use it to help make decisions in terms of driving change within their unit or service as well as also using benchmarking activity The next phase of the strategy involved working with the divisions to identify their priorities for digital and informatics, as well as determining how they would be delivered and monitored. Steve Igoe stated that whilst the digital strategy was difficult to argue against it would be helpful to understand, particularly in terms of the hardware and infrastructure what the costings where. He cited an example of swapping out PCs with spinning disks into flash drive. It was important to determine the impact in terms of storage, data centres for instance. Steve Igoe stated that the strategy rollout potentially required a significant investment which would require some enhanced understanding. It was agreed that this particular issue would be addressed once an in-depth assessment of divisional requirements had taken place, with an update to the Board around the autumn period.	

Reference	Minute	Action
	Action: Chief Information Officer In response to a query from Steve Ryan it was confirmed that junior doctors had been incorporated within the engagement of the digital strategy. In addition, it was agreed that the digital strategy would be amended on page 83 (of the pack) to incorporate research. *Action: Chief Information Officer* **RESOLVED:** **That the Board approved the Digital Strategy**	
21/22-110	**Infection Prevention and Control (IPC) Strategy**	
	The Board received the report which provided assurance on compliance with the Health & Social Care Act: Code of Practice on the prevention and control of infections and related guidance. The Chief Nurse explained that it was a 3-year strategy which had been compiled based on the approved format by the IPC society. The Strategy had also ready been endorsed at IPC Committee, and approved at Patient Safety and Quality Board. The Chair asked for clarification on how vaccination and immunisation came through in the report. These were noted as detailed in the work plan at page 87 of the meeting's pack. The Board noted that the strategy was aligned to the Trust's strategy and would strongly build on the building blocks of the Trust's response to COVID-19 and success in reducing mandatory reportable infections. **RESOLVED:** • **The Board NOTED the IPC Strategy**	
21/22-111	**CQC Compliance and Action Plan**	
	The Board received the quarterly report on progress made against the actions arising from a past CQC Inspection. It was noted that deep dives had been undertaken in conjunction with divisions on some of the action plans and that there were plans to continue to monitor the implementation and embedding of the action plans. Attentions were drawn to the number of completed actions which had risen from 69% since the last report to 95%. 88% of the action plans were also reported as having been achieved. The Chair enquired how often the report should be submitted to the Board, and it was clarified that this was a quarterly report that should have been presented to the September Board, due to need to complete the deep dives first. **RESOLVED:** • **That the Board NOTED the update**	
21/22-112	**Monthly Safe Nurse Staffing Report**	
	The Chief Nurse presented the report which provided information regarding	

Reference	Minute	Action
	safe nurse staffing and the actions to improve the vacancy rates, which were around 11.5%. The Board were informed that the international nurses had arrived, and were integrating well within the workforce. The report also indicated that there had been three falls resulting in harm, which occurred on shifts where the staffing mix was below requirements, despite best efforts to mitigate these risks as much as possible. The Board were informed that the mitigations included allocating specialist nurses and non-ward based nurses on ward areas for examples, as well as redeploying some staff from outpatient areas as necessary. There was also an established regional call weekly to address maternity staffing and operational pressures. Steve Ryan reported that he had taken part in a Maternity Safety Champion call which had given him a great deal of assurance about the mitigations implemented to ensure safe staffing levels where in place. **RESOLVED:** **That the Board NOTED the report.**	
21/22-113	**Infection Prevention & Control Annual Report 2020/21**	
	The Board received the IPC annual report 2020/21 and noted the plan to continue with all the areas of strength in the previous year. Explanations were received on the quality improvement focus on further reductions in Clostridium difficile infection. The trajectories for the 2021/22 period were still under review by the Department of Health, and the Trust was currently working against the 2020/21 dashboard. At the back of the annual report was the audit report and the annual plan was still being worked through. The Chief Nurse recommended that the Board approve the report in her capacity as DIPC. John Sullivan enquired if the Trust was out of compliance with laboratory reporting since 2015. The Chief Nurse explained that this was a laboratory based reporting system. He further enquired whether there were any long term changes to practice identified, which would enable the implementation of enhanced infection control measures. The Medical Director explained that the CAG had already determined that the Trust would continue to implement infection measures and controls would continue to be in place nationally. John Sullivan requested that the IPC team should receive the thanks of the Board. It was noted that the report had been reviewed by the Quality Committee which had recommended it for Board approval. **RESOLVED:** • **That the Board APPROVED the IPC Annual Report 2020/21**	
21/22-114	**Workforce Disability Equality Standard (WDES)**	
	The Interim Director of Workforce explained that the WDES enabled a	

Reference	Minute	Action
	comparison of the experience of disabled staff, against non-disabled staff. There were 10 metrics that enabled the Trust to measure its performance. There was a requirement to publish the data by 31st of July, and an action plan by 31st October 2021. Overall experience of disabled staff continued to be less favourable than that of non-disabled staff. Improvements had been seen, as demonstrated by the staff survey, in terms of bullying and harassment. Recruitment data also showed an improvement in the numbers of disabled staff being shortlisted and appointed. The Board were informed that there were two areas where the Trust performed less favourably than the national average. Firstly, the number of disabled staff who felt their work was valued had declined. The interim Director of Workforce explained that this could have been caused by disabled staff being shielded as part of the pandemic, however this did not fully account for the difference as disabled staff in other Trust would have been in the same position. The second area of exception related to the number of disclosures of disabled staff, which was 2% against the national average of 3%, which was also seen as underreporting. The staff network would play a key role in identifying and progressing remedial action. The Board were informed that the attached action plan required a refresh in order to result in improvements for this year. The Interim Director of Workforce reported that she had requested a review of all the action plans pertaining to Equality, Diversity and Inclusion (EDI) to ensure consistency of delivery, and alignment to the Trust strategy. Steve Ryan suggested that the feedback pertaining to staff feeling less valued could be linked to appraisal rates, and if that could be part of the formal approach to explain how much staff were valued, then potentially the performance against this metric would improve. The Interim Director of Workforce emphasised that the rollout of the staff and wellbeing conversation as part of the appraisal would open a conversation of the health and wellbeing and disability status. The Chief Operating Officer stated that implementing remedial actions would enable the Trust to get further ahead than other Trusts within the national average. **The Board resolved to APPROVE the submission of the WDES submission.**	
	Workforce Race Equality Standard (WRES)	
	The interim Director of Workforce reported that there were 9 metrics: Appendix A illustrated the summary. The Board were informed that there were some areas where improvements had been made, such as number of staff of the view that the Trust provided equal opportunities. The likelihood of BAME applicant being shortlisted against white staff, as well as the number of staff who experienced discrimination at work from team leaders.	

Reference	Minute	Action
	Metric number 3 was also cited as increased, and a deep dive had been requested by the Interim Director of Workforce in light of this data. T**he Board resolved to APPROVE the submission of the WRES data.**	
21/22-015	**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 Board were informed that overall progress was good, with delivery across the three major programs, whilst taking into account ED pressures and staff availability to implement transformation at periods of heightened activity. The Board were informed of the NHS 111 project which was mandated. The Director of Strategy and Partnerships requested to amend the reporting arrangements, to be aligned to the project management infrastructure. Sue Lorimer requested a review of the volume of papers and number of agenda items that the Board was reviewing was very welcome **RESOLVED:** **That the Board NOTED the report.**	
21/22-116	**Chair's Report – Safety Management & Assurance Committee**	
	Steve Igoe reference the Trust performance in the report which provided positive assurance in relation to : • 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 **RESOLVED:** **That the Board NOTED the report.**	
21/22-117	**Chair's Report – Workforce Assurance Committee**	
	John Sullivan presented a verbal report, noting that the scheduled July meeting had been cancelled due to the Cerner Millennium incident, but had considered some items virtually, which included the • WRES • WDES • Disciplinary Policy **RESOLVED:** **That the Board NOTED the report.**	
21/22-118	**Chair's Report – Finance, Business Performance & Assurance Committee**	

Reference	Minute	Action
	Steve Ryan briefly summarised the discussions from CIP, QPR and business case which had been endorsed at the committee prior to its submission to the Board **RESOLVED:** **That the Board NOTED the report.**	
21/22-119	**Chair's Report – Quality Assurance Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held in July 2021 including: • There had been a national and Cheshire and Merseyside assessment of Harm reviews in order to enhance the process. An appropriate adaptation was being made, and the QAC had considered and approved the • The Committee had been assured by the MIIA review of the maternity NHSR standards • Assurance had been received in relation to the improvement in tissue ulcer care. • The final item was in relation to addressing a never event in radiology, with a particular focus on assessing whether the appropriate standards had been made, and some work included the provision of human factors and simulation training. An update would be given at the next PQSB and Quality Committee. **RESOLVED:** **That the Board NOTED the report.**	
21/22-120	**Report of Trust Management Board**	
	The Chief Executive highlighted that the items incorporated items that had already been covered in the agenda. **RESOLVED:** **That the Board NOTED the report.**	
21/22-121	**Communications and Engagement Monthly Report**	
	The Board received the report on the Trust's communications and engagement activities since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement. The Director of Communications and Engagement highlighted campaigns supported by her team including : • Band 5 nurses campaign • Pressures in A&E • NHS Procurement award nomination for the team • The approval of the £140,000 grant from NHS Charities which would support the wellbeing of Trust staff. **RESOLVED:** **That the Board NOTED the report.**	
21/22-122	**Any other business**	
	There was no other business conducted during the meeting.	

Reference	Minute	Action
21/22-123	**Date of Next Meeting** 01 September 2021 via MS Teams	
21/22-124	**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.	

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Chair

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Date

PUBLIC Board of Directors Action Log
1 September 2021
Action Log

No.	Minute Ref	Action	By Whom	Action status	Due Date
1	**21/22106** Chief Executives Report August 2021	To submit a lessons learnt report as a result of the Millennium critical incident	Chief Information Officer	Open	October 21
2	**21/22-107** Quality and Performance Dashboard August 2021	Information Team to undertake a review of the upper and control limits, on the graphs within the Quality and Performance dashboard	Chief Information Officer	Open	October 2021
3	**21/22-108** Finance Report August 2021	Chief Finance Officer to provide an analysis of the medical and acute pay overspend	Chief Finance Officer	Completed, the analysis was incorporated within the Finance report to the August meeting of the Finance Business, Performance Assurance Committee	August 2021
4	**21/22-109** Digital Strategy August 2021	To provide the Board with projected costings associated with the strategy after an assessment of divisional requirements has been undertaken	Chief Information Officer	Open	November 2021

5	**21/22-109** Digital Strategy August 2021	To amend the strategy to incorporate more narrative around research	Chief Information Officer	Open	October 2021

Agenda Item: 21/22-132

BOARD OF DIRECTORS
1st September 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 September 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)
This report incorporates narrative on an update on the governors' elections as well as the Annual Members Meeting

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
1 September 2021

Chief Executive's Report

Purpose

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

Introduction / Background

1. COVID-19 Update

The community prevalence of COVID-19 currently remains static with an incidence of 293 per 100,000 over 7 days at the time of writing this report. The number of COVID inpatients also remains static at 40. Of these, 27 have been admitted for treatment of COVID and another 13 who have COVID are being treated for other reasons. The Trust is not anticipating any drop in inpatient numbers as the national forecast is for a lower but prolonged peak compared to the January / February peak.

Staff members continue to be encouraged to participate in LAMP testing in addition to vaccination and infection, prevention and control practices. Hospital visiting and PPE guidance continues to be reviewed by the Trust Clinical Advisory Group on a weekly basis. 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, Planned Care

The National Standards for Outpatient activities in July were achieved; however Inpatient (IP) and Day Cases (DC) remain behind plan. Activity levels were challenged in July for IP/DC in the main due to, high levels of staff requiring to self-isolate, reduced uptake on Waiting List Initiative sessions and the Endoscopy washer replacement programme. This has continued into August; however activity levels are forecast to be higher in August than July.

All Cancer standards were achieved in July:

- 2 week wait
- 28 day
- 31 day
- 62 day
- Long waiting patients (maintaining pre-pandemic levels)
- Third wave recovery projection

The number of 52 week waits breaches remains below trajectory. The Trust is forecasting zero 52 week non-admitted breaches by the end of November

(excluding Priority 5/6 patients) 30

3. Vaccination Hub

The vaccination programme continues across the local health economy.
As at 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 five serious incidents (SI) in the month of July 2021; this is a decrease on the previous month. The Serious Incident Panel reports and investigates under the "Serious Incident Framework" so that learning can be identified.

There were no common themes or areas identified from the five reported incidents, which spanned areas of the trust, including the Women's and Children's (3), Diagnostics and Clinical Support (1) and Surgical Services (1). The Trust reported one Never Event in the month of July.

Duty of Candour has been commenced in line with legislation and national guidance.

5. RIDDOR Update

There were two incidents reported to the HSE in July 2021 in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Both events were slips, trips or falls which resulted in an over seven day period of absence for the members of staff involved.

One event involved a member of staff who slipped and fell on a small amount of water that was reported to have come from the patient shower, with the remaining event involving a member of staff who slipped and fell due to a spillage of soapy water.

6. 2021 Governor Elections and Annual Members Meeting

Following the update in July I am pleased to report that we have received nominations for 12 out of 13 constituencies where vacancies previously existed prior to this election. Voting will now commence in early September 2021, with the outcome announced at our Annual Members Meeting on the 30th of September 2021, where our staff, patients and the public can attend.
In the meantime I would like to congratulate the following governors who are elected unopposed:

Governors elected to public constituencies:

- Christine House , Liscard & Seacombe
- Sarah Evans, Birkenhead, Tranmere and Rock Ferry
- Peter Israel Peters, North West & North Wales
- Paul Dixon, Oxton & Prenton

In addition we now have two staff governors for the following constituencies:

- Gitana Diana Tyson, Nurses & Midwives CBH & other sites
- Ann Taylor, Nurses & Midwives (APH)

It is particularly encouraging that there is a higher level of interest in this round of elections, with 50% of the vacancies progressing to a voting stage due to more than one person submitting their nominations for the following constituencies:

- Public: Bebington & Clatterbridge
- Public: West Wirral
- Public: Bidston & Claughton
- Public: North West & North Wales
- Public: Greasby, Frankby, Irby & Upton
- Public: Leasowe, Moreton & Saughall Massie
- Staff: Medical & Dental

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 from the 3rd of September to the 28th September 2021.

7. Deloitte Well led review

Deloitte will shortly be commencing a well led review of the Trust Board, as well as the associated governance and operational infrastructure.
As part of this process we have committed to an extensive engagement process spanning across a wide range of stakeholders such as our governors, who will be contributing through focus groups.
A very short survey for staff will be issued over the next few days as part of the engagement process, and everyone is actively encouraged to participate.
Externally, Deloitte will engage with our partners and use the feedback to inform some developmental feedback that will enable the Trust Board to improve and enhance its effectiveness. The review is anticipated to be completed by November, and the Board will receive updates on progress, as appropriate.

8. Cheshire & Merseyside Acute & Specialist Trust Provider Collaborative updates

In early August CMAST announced the appointment of Linda Buckley as their Managing Director for the Cheshire & Merseyside Acute & Specialist Trust Provider Collaborative (CMAST). Linda was previously Director of Strategic Transformation / Locality Director with NHSE/I, and most recently has also been providing assistance to the Hospital Cell.

9. Interim guidance on the functions and governance of the integrated care board

NHS England and NHSI have issued further interim guidance which sets out the proposed core components of integrated care board (ICB) governance arrangements as outlined in the Health and Care Bill and the ICS Design Framework.
The guidance confirms the expected mandatory requirements (subject to legislation), as well as key considerations for system leaders as they design arrangements for April 2022.
The guidance will be considered further internally alongside the draft ICB Model Constitution and accompanying guidance, with a further update to the Board as appropriate.

Agenda Item: 21/22–133

Meeting of the Board of Directors
1st September 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 July 2021.

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

- 28 are currently off-target or failing to meet performance thresholds
- 18 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	

Quality Performance Dashboard

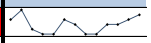
August 2021

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16	0.10	0.20	0.05	0.05	0.10	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.1%	95.3%	95.4%	95.1%	95.3%	94.7%	94.2%	94.9%	94.0%	94.4%	94.5%	94.7%	93.3%	94.23%	
	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	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	96.6%	96.2%	96.4%	96.6%	96.6%	96.2%	96.5%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	4	4	2	3	2	4	4	5	4	5	4	8	7	24	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	1	0	0	1	0	2	3	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
	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	1	4	1	5	10	8	4	7	6	5	7	5	1	18	
	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	8	5	3	7	3	1	3	6	6	3	5	7	3	18	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	1	0	0	0	0	0	0	0	0	0	0	1	0	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	99.2%	99.2%	99.0%	99.3%	99.2%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	4	0	0	1	0	1	0	0	0	0	1	1	2	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	95%	98%	96%	94%	91%	93%	Not avail	Not avail	96%	96%	96%	95%	96%	96%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	79.1%	79.9%	84.3%	85.9%	87.5%	89.1%	86.7%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	84.1%	82.3%	83.0%	83.6%	83.9%	86.1%	84.2%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	80.1%	67.0%	69.5%	70.8%	72.3%	74.3%	71.7%	
	Attendance % (12-month rolling average)	Safe, high quality care	DoW	≥95%	SOF	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.42%	93.48%	93.79%	93.90%	93.95%	93.88%	93.88%	
	Attendance % (in-month rate)	Safe, high quality care	DoW	≥95%	SOF	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	93.91%	94.71%	94.62%	94.32%	94.32%	93.52%	94.20%	
	Staff turnover % (in-month rate)	Safe, high quality care	DoW	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.67%	0.77%	0.95%	0.72%	0.79%	1.22%	0.92%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DoW	≤10%	WUTH	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.9%	13.0%	13.5%	13.2%	13.3%	13.0%	13.0%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	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	8.5	8.6	

Quality Performance Dashboard

August 2021

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%	98.4%	98.3%	98.3%	95.9%	97.7%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98%	98%	96%	96%	98%	97%	95%	97%	97%	99%	98%	98%	98%	98.3%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.9%	18.0%	18.0%	17.7%	18.4%	18.5%	18.2%	
	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	202	239	309	305	279	319	371	354	341	323	329	318	319	319	
	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	53	59	92	95	86	112	98	106	88	96	85	99	95	95	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	3.6	3.8	4.8	3.9	4.1	3.4	2.8	3.2	3.1	3.6	3.3	3.5	3.8	3.6	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	4.2	4.5	5.4	5.8	5.4	4.3	4.7	4.4	4.2	3.8	4.0	4.0	4.1	4.0	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	1016	1012	1014	1007	992	1020	1027	938	1097	1149	1131	1084	1115	1120	
	Delayed Transfers of Care	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	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	National reporting suspended	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	71.9%	81.3%	84.9%	84.5%	85.5%	82.5%	79.8%	83.1%	

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	2021/22	Trend
Caring	**Same sex accommodation breaches**	Outstanding Patient Experience	CN	0	SOF	3	5	1	0	0	3	2	0	0	2	2	3	4	11	
	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	87.0%	84.0%	87.0%	85.0%	84.0%	83.0%	82.0%	76.0%	81.3%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	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	National reporting suspended	10.8%	
	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	TBC	92.0%	91.0%	92.0%	94.0%	95.0%	95.0%	95.0%	94.8%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	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	National reporting suspended	29.3%	
	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	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	93.0%	94.3%	
	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	80.0%	100.0%	67.0%	94.0%	99.0%	95.0%	93.0%	97.0%	96.0%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	CN	≥25%	WUTH	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence	National reporting to recommence	National reporting to recommence	National reporting to recommence	National reporting to recommence	National reporting to recommence	National reporting to recommence	National reporting to recommence		

Quality Performance Dashboard

August 2021

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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 2020-21, and Q2 21-22	SOF	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	76.8%	77.8%	76.1%	73.5%	78.0%	67.8%	73.9%	
	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	1	1	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	78.0%	71.4%	64.8%	64.9%	71.4%	69.6%	65.3%	77.8%	78.8%	73.4%	68.1%	73.4%	57.7%	68.2%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	0.6%	0.7%	2.7%	4.3%	3.1%	4.3%	6.7%	2.3%	1.6%	1.7%	2.6%	2.3%	7.9%	3.6%	
	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	3.2%	4.2%	8.3%	13.8%	9.2%	13.2%	18.0%	8.7%	9.1%	11.0%	13.0%	9.3%	18.9%	13.0%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	67.89%	69.26%	69.61%	72.57%	75.64%	75.13%	75.13%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,980 for WUTH by March 2021	National	23034	24486	24212	22945	21633	21792	21880	21955	23444	24774	25873	26671	26979	26979	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	616	733	806	777	704	666	899	1108	1168	874	633	526	507	507	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	94.3%	97.4%	97.7%	98.5%	96.8%	87.5%	95.1%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	97.6%	98.8%	96.9%	97.6%	97.2%	95.4%	96.8%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	–	–	92.48%	-	-	94.20%	-	-	97.64%	-	-	97.21%	-	97.2%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	90.7%	94.8%	92.1%	98.0%	97.4%	97.2%	98.0%	93.0%	93.5%	94.7%	95.2%	99.2%	96.7%	96.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	–	–	92.44%	-	-	97.55%	-	-	94.73%	-	-	96.26%	-	96.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	80.7%	78.6%	82.6%	82.9%	85.3%	85.4%	80.9%	82.1%	84.1%	84.5%	84.1%	85.3%	87.1%	85.2%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	–	–	80.68%	–	–	84.60%	-	-	82.56%	-	-	84.66%	-	84.7%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	143	124	183	178	161	150	196	165	170	157	156	145	209	167	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	2.10	3.40	4.20	3.80	3.20	1.32	3.80	3.56	4.07	4.09	2.56	4.04	4.20	3.72	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	94%	100%	97%	100%	95%	100%	93%	95%	100%	97%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	1	0	2	1	4	2	2	4	4	0	2	1	2	1	

Quality Performance Dashboard

August 2021

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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	86	31	126	329	215	163	599	206	87	16	15	68	162	261	
	% Appraisal compliance	Safe, high quality care	DoW	≥88%	WUTH	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%	82.7%	

	Indicator	Objective	Director	Threshold	Set by	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	-0.2	0.0	0.0	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.4	0.0	0.1	
	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	3.02%	6.03%	6.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-40.5%	-37.7%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-10.4	-15.7	-15.7	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	52.8%	62.9%	12.0%	17.4%	17.4%	

Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse

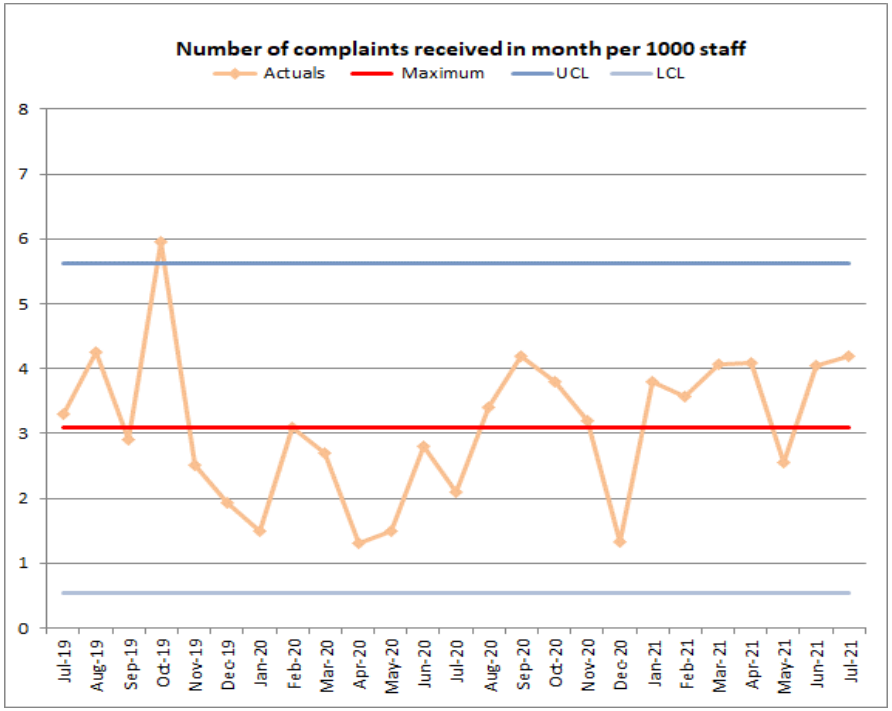
Performance Issue:
WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for July 2021 was 4.2.

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).

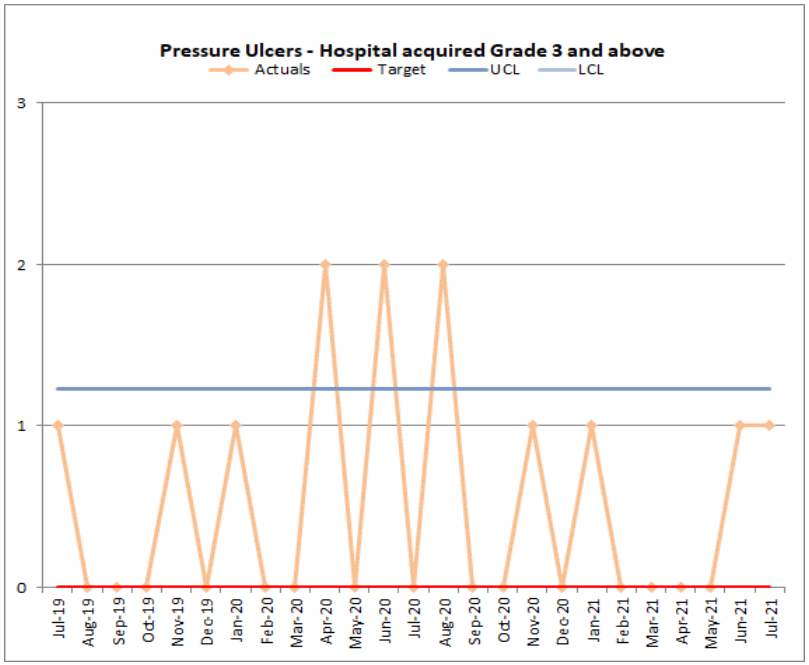
Following the first meeting of the Trust's Complaints and Claims Management Group in June, increased focus has been placed on the Divisions to try to resolve concerns in a timelier manner at a local level.

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).



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 July 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.



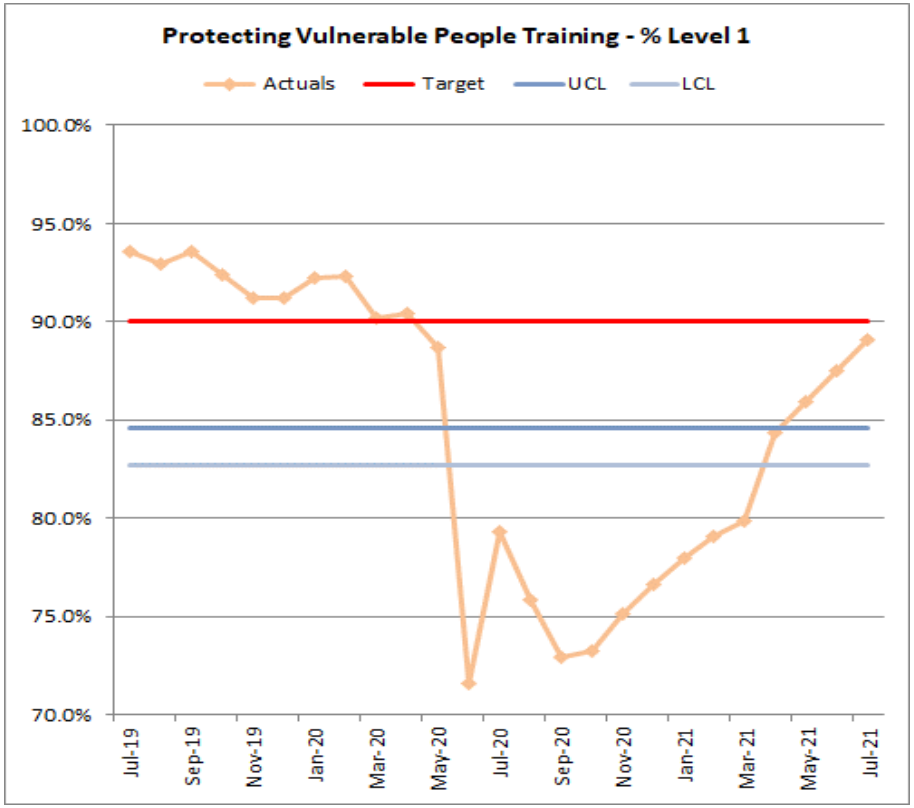
Protecting Vulnerable People Training - % Compliant Level 1

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 July at 89.1%.

Action:
Level 1 PVP is completed online and therefore can be accessed at anytime. 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:

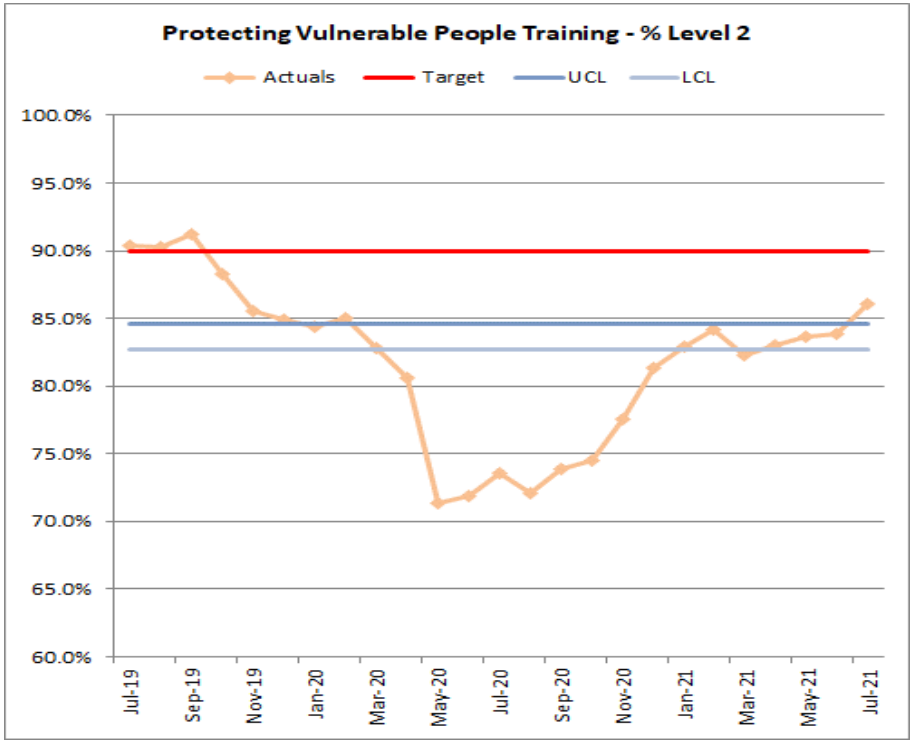
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been improving with a further increase in July 2021 to 86.1%.

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

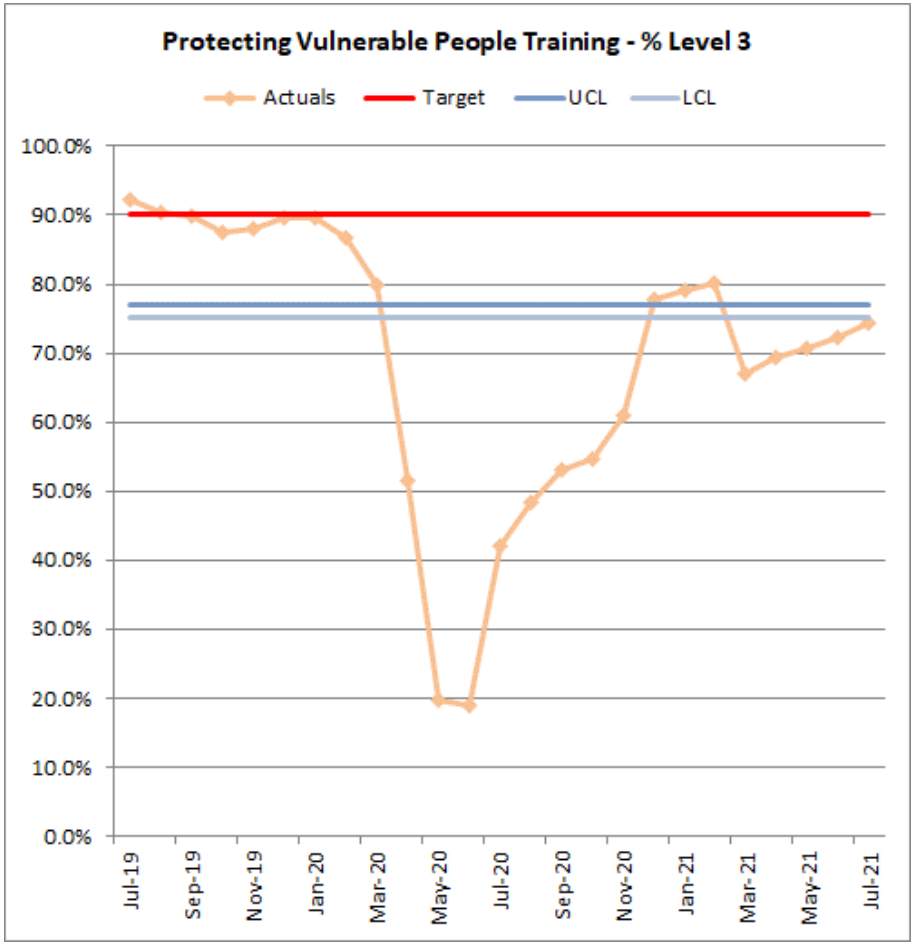
Performance Issue:
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been steadily improving, with July compliance increasing to 74.3%.

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.



Same sex accommodation breaches

Executive Lead: Chief Nurse

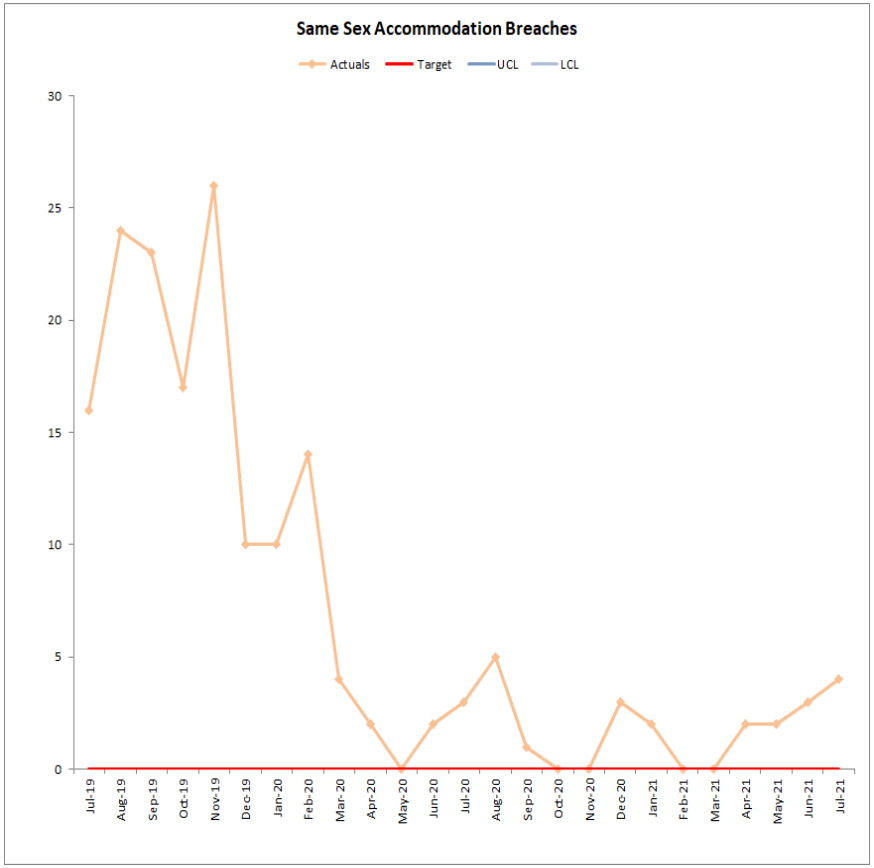
Performance Issue:
The national standard is set that providers should not have mixed-sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

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 4 such breaches in July 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.



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

Executive Lead: Chief Operating Officer

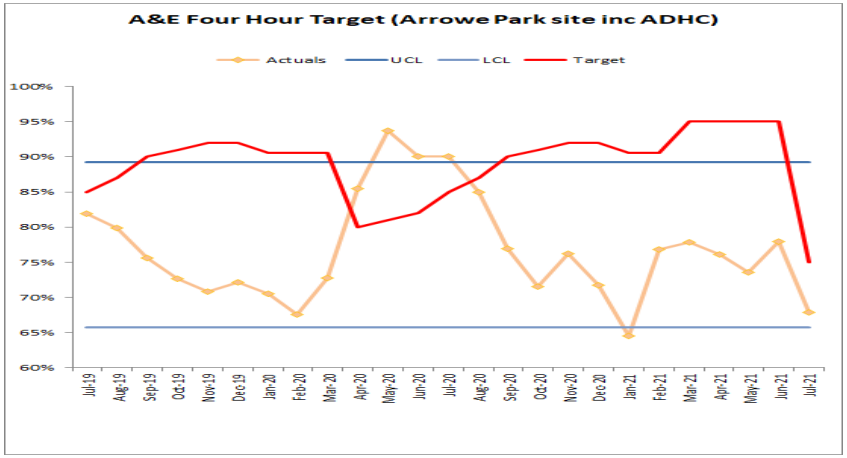
Performance Issue:
ED attendances have continued to exceed pre-covid levels since March 2021, hitting a peak during May-July of >300 attendances July has started to see a reduction but activity remains higher than 2019 level. Hospital occupancy has remained consistently over 90.

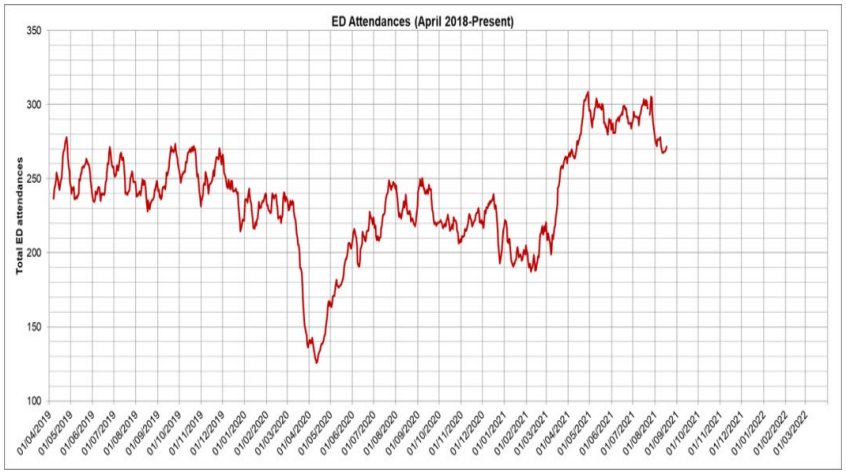
Bed capacity has been further compromised with the 3rd wave of covid with 2 designated covid wards. The impact has resulted on performance of around 61% against the 4 hour standard. The challenges across mental health services has resulted in a number of 12 hour breaches in the Trust

Action:
The improvements in bed breaches have been maintained and accounts for only 5% of breaches in ED this remains challenged due to occupancy. Triage times and the time taken for initial assessment is the focus of the improvement plan and is tracked through the transformation agenda, however the ability to implement this has been compromised with staffing sickness caused by isolating due to covid.

The division has been working closely with ECIST and a full emergency department workforce plan will be complete by September. A reset and recovery approach is planned in ED and the wider Trust from September. From a system perspective the Urgent Care Wirral Programme is now mobilized and aims to impact on delivery of the target.

In summery we are forecast to get back onto revised trajectory by September.





Expected Impact:
The workforce transformation plan for emergency service, parallel improvements across the Healthy Wirral Programme, which include ‘admissions avoidance’, ‘improved inpatient flow’ and ‘timely discharge’ will make the 95% target achievable.

Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

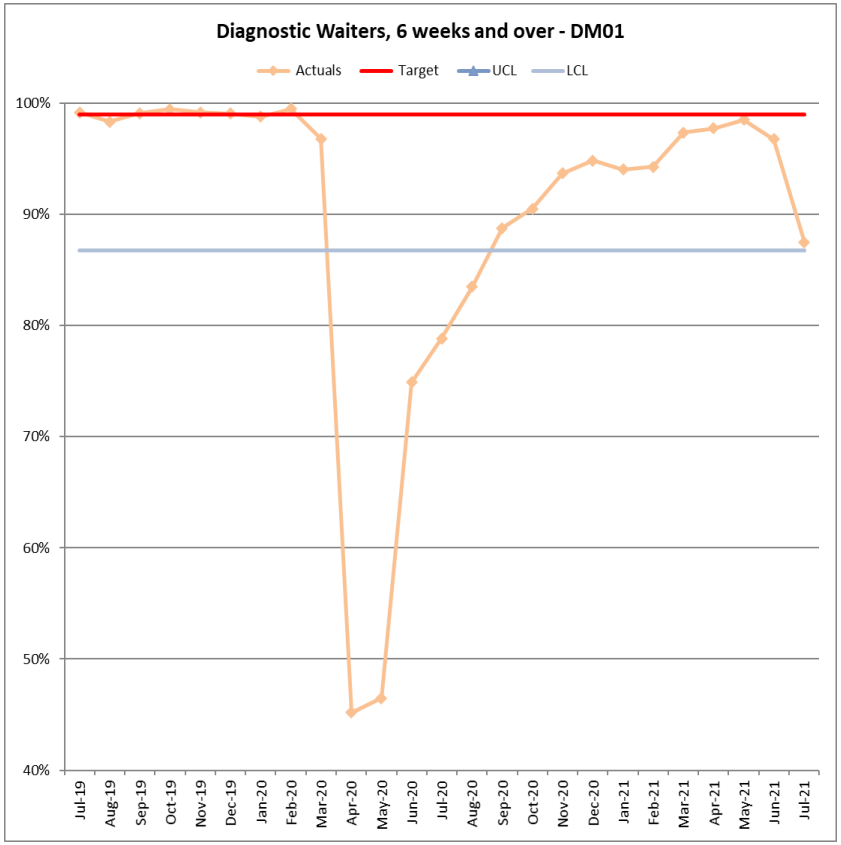
Performance Issue:
There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks. The position at the end of July 2021 was 87.5%.

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 being 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



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.

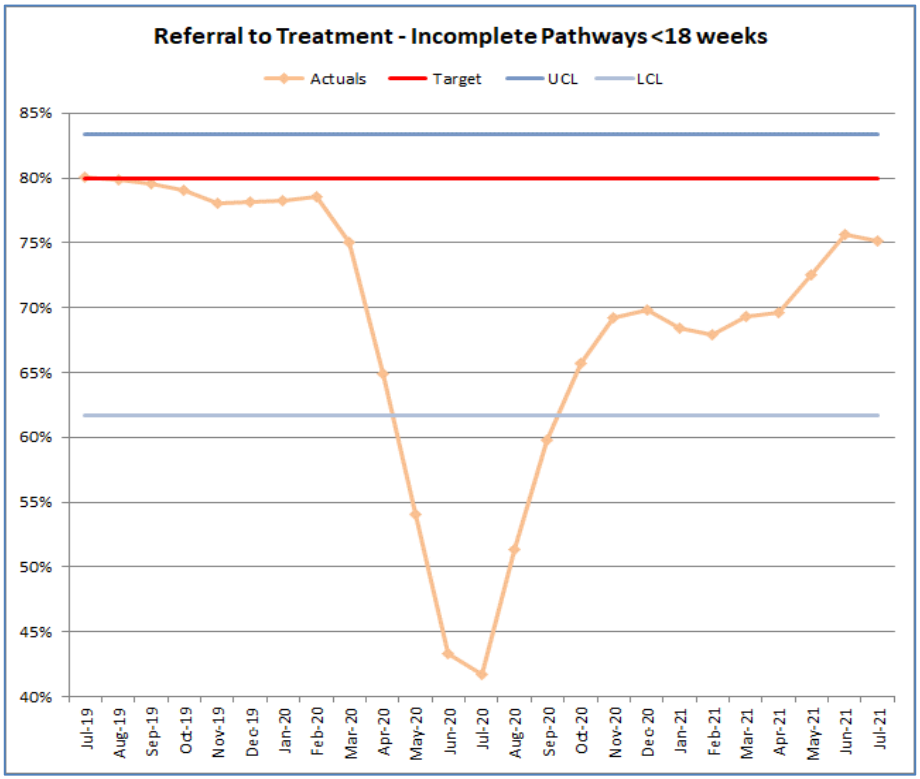
Following the directive to cease all non-urgent elective activities as part of the COVID response this metric sharply declined. The subsequent resumption of elective activity from July saw performance improve, until the onset of the Covid third wave from January 2021.

Referral to Treatment Performance for the Surgical Division for July 2021 was 66.89% against the agreed NHSI trajectory of 80%. August 2021 is currently at 67.03%.

Underperformance of Divisional activity in July 2021 has had an impact on Referral to Treatment Performance, increasing waiting times and list sizes. July's activity performance; New % (99), FUP % (86), DC % (70), IP % (71) against a target of 100% delivery across all four POD's.

Factor impacting activity delivery;

- CM downtime (25 cases)
- Inability to staff extra lists (WLI's)
- Anaesthesia – 18 consultants self-isolating in July 2021
- Oral surgery – 1 consultant down and 1.5 SAS doctors down
- Vascular – theatre staff pulled to backfill lists with higher P statuses
- Cancellation of patients testing positive at day 3 swab and too short notice to backfill list due to isolation requirements
- Higher A/L.



Activity delivery will continue to be an issue for August 2021 largely due to nursing staff shortages within ED/Critical Care for which theatre lists have been taken down to enable theatre staff to support in those areas.
Action: From March 8th the Trust has restarted non urgent activities and has developed activity and performance trajectories. To address Divisional activity underperformance the Division will; • Offer consultants WLI's where possible (however reliant on consultant uptake) • Use the independent sector where possible.
Expected Impact: It is expected that the performance will improve moderately month on month but scenario's around referral growth will be monitored closely. Activity levels in September are anticipated to increase as lower levels of A/L which will support improved Referral to Treatment performance.

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.

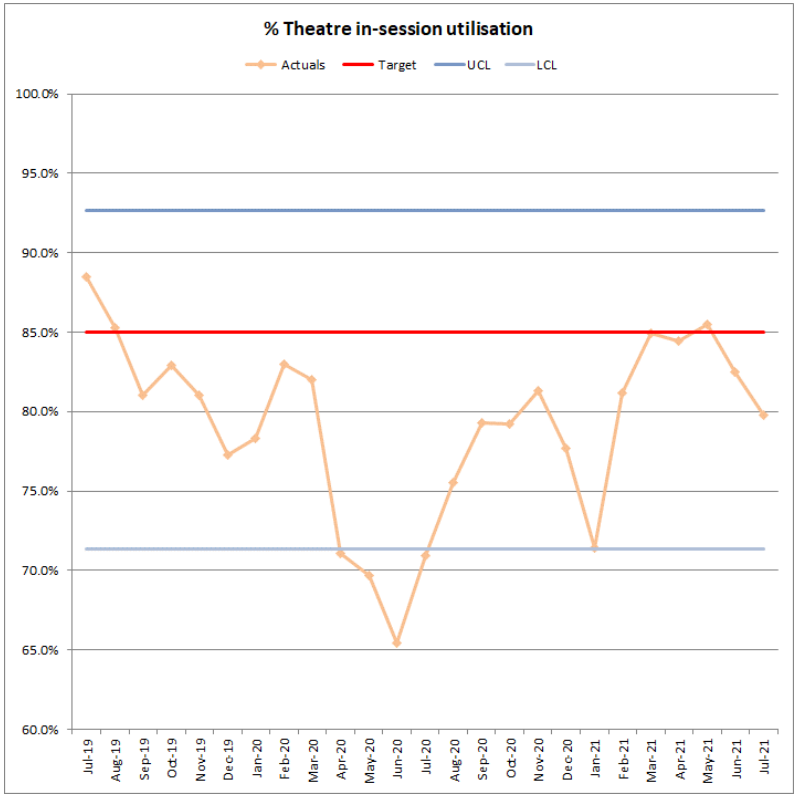
July saw a further reduction in theatre in session utilisation performance, 79.8%, largely due to lost sessions as a result of Cerner Millenium (CM) downtime (2 days in total) and increased on the day cancellations, patients not attending due to COVID positive results, inability to backfill these lists due to the requirement of patients to self-isolate ahead of surgery.

Staffing issues across the Trust in August may have a potential impact on theatre utilisation with theatre lists cancelled to move theatre staff into ED and Critical Care.

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.

CM issues have been resolved.



Expected Impact:

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

Operational issues in July impacted utilisation performance and staffing issues in August may further impact utilisation performance against the internal standard of 85%.

Appraisal compliance %

Executive Lead: Director of Workforce

Performance Issue:
The target for annual appraisal compliance is 88%. Compliance at the end July 2021 was 82.7%.

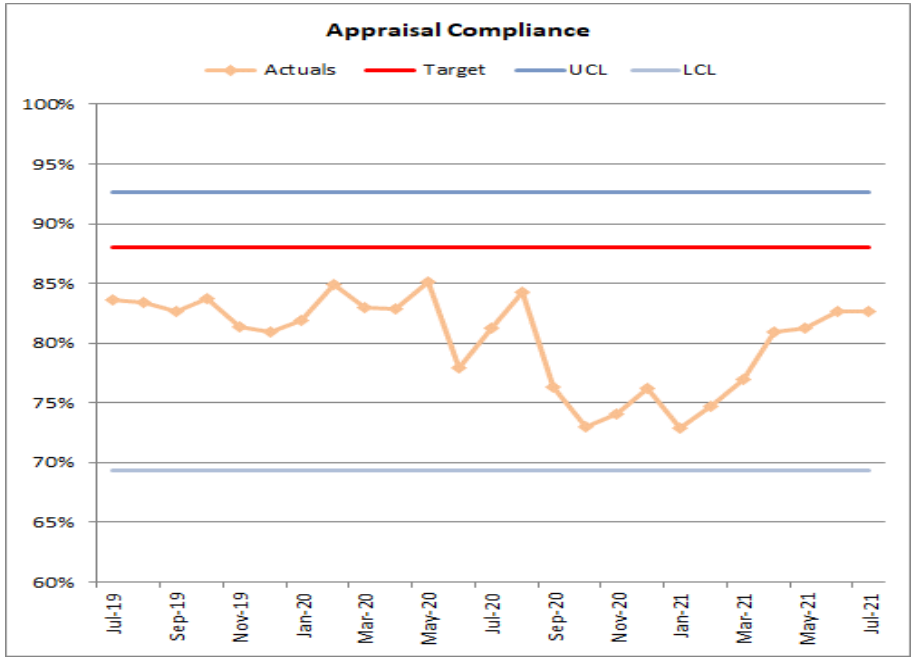
Although this target has not been achieved, the previous month's compliance has been sustained despite an increase in sickness absence in month. In addition, there has been sustained improvement since February 2021.

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.

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.



Staff attendance % (in-month rate)

Executive Lead: Director of Workforce

Performance Issue:
Sickness absence levels continue to be above the Trust's 5% target, both for in-month sickness and over a rolling 12 month period.

In-month sickness in July 2021 has increased to 6.48% which is a 0.8% increase from June 2021 and is the highest it has been since January 2021 (7.70%). The rolling 12-month figure in July 2021 was 6.12% which is a deterioration on last month from 6.05%.

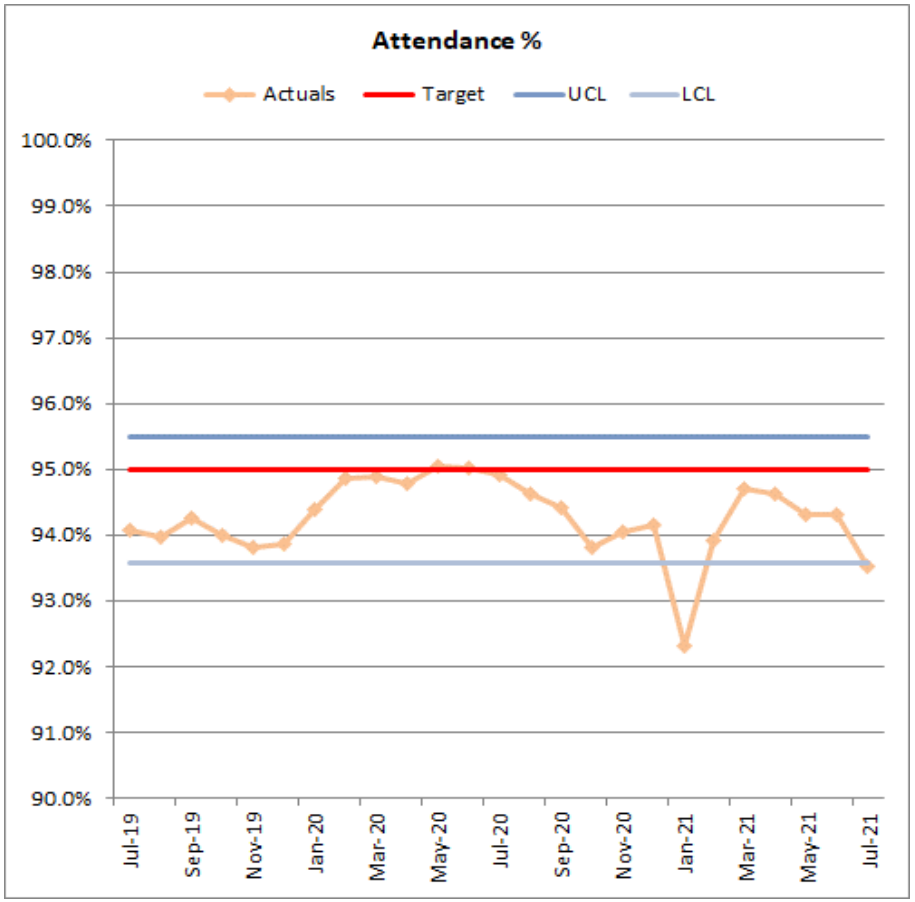
To provide some context the North-West region has sickness rate of 6.6%, compared to the national average of 5.4%.

5 Divisions have exceeded the 5% KPI in July 2021;

- Estates and Hotel Services (10.07%)
- Women and Children's (7.10%)
- Medicine and Acute (6.46%)
- Surgery (6.38%)
- Clinical Support (5.30%)

In July 2021 there were 301 episodes of long-term sickness (28 days+) across the Trust which accounted for 25.51% of total sickness. There were 879 episodes of short-term sickness which accounted for 74.49%.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence at 35.22% (106 episodes), followed by Musculoskeletal Health at 11.30% (34 episodes).



Gastro problems were the highest reported reason for short term sickness absence at 24.57% (216 episodes, an increase of 49 episodes this month) followed by Cough, Cold & Flu at 13.08% (115 episodes).

Action:
Work continues to be undertaken strategically, operationally and locally.

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, target specific areas requiring improvement and addressing short term absences.

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. Executive Team oversight is in place via Divisional Performance Reviews.

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. The plans have also been sent to the NHSE/I Regional Head of Staff Engagement and Experience for them to review and share any further good practice.

There continues to be a significant amount of wellbeing activity and promotions across the Trust including 'Building Personal Resilience sessions' and 'Team Time'.

Meetings have taken place with the NHSEi Team to shape the development of the new Attendance Management Development Programme to provide 'creating a positive culture' training for our

managers where sickness absence is high, specifically for managers in Nursing and Midwifery and Additional Clinical Services. This is now being designed and written by the consultants in conjunction North-West Employers. The team at NHSEI have also met with NW Leadership Academy who are leading the set up and evaluation of the Programme.

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 key areas of focus as set out below and have created an action plan to ensure delivery. The operational work of this group will be overseen by the Workforce Steering Board.:

- 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)

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.

Staff turnover % (in month rate)

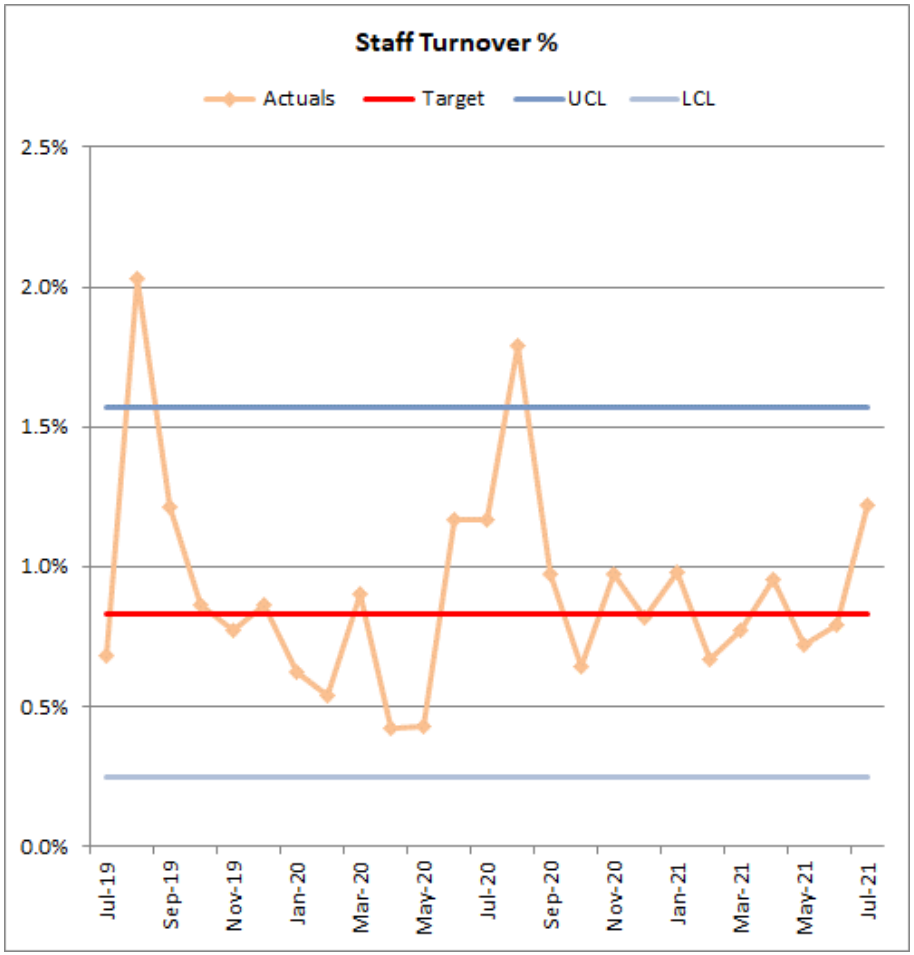
Executive Lead: Director of Workforce

Performance Issue:
The Trust target is set as a maximum rolling 12 month turnover threshold of 10%. Turnover in July 2021 was 12.99% cumulative and 1.22% in month. The highest staff groups were Admin & Clerical at 1.99% and Additional Clinical Services (which includes CSWs) at 1.58%

In terms of understanding the activity relating to starters v leavers, for the last 6 months more staff have started than have left the Trust. In the last quarter for nursing and midwifery there has been almost double the number of starters to leavers and for additional clinical services there has been over 2.5 times the number of starters. This is due to the positive increase in activity to appoint International Nurses and the focus on eliminating the HCA vacancy gap, with funding support from NHSi.

Actions:
Operational, clinical and HR staff continue to ensure that attention is focused on retention by reviewing the preceptorship programme, responding at pace to staff feedback via staff side colleagues, the freedom to speak up guardian, and guardian of safe working, and maximising access to wellbeing and staff support initiatives. An additional focus for 2021/22 is planned on development and support for line managers on key skills following feedback from the national NHS Staff Survey. Divisional level staff survey action plans have been produced.

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



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

Executive Lead: Medical Director

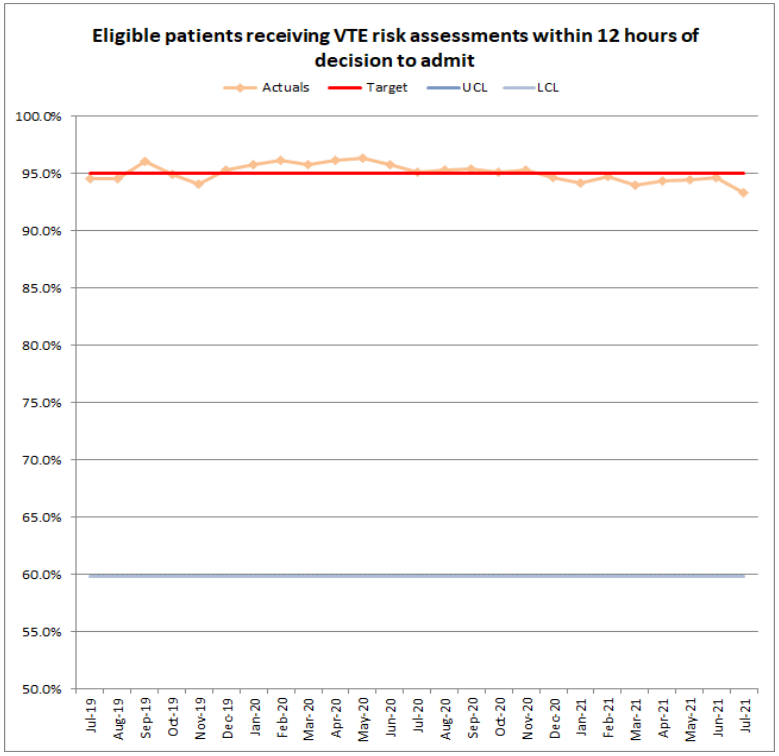
Performance Issue:
A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. July performance was below at 93.3%.

This will have been partially affected by the Wirral Millennium downtime experienced during the 22nd to 24th July. Analysis of the data has also shown that some patients in assessment who do not require a 12-hour assessment may not be appropriately excluded from the data.

The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital has been consistently met.

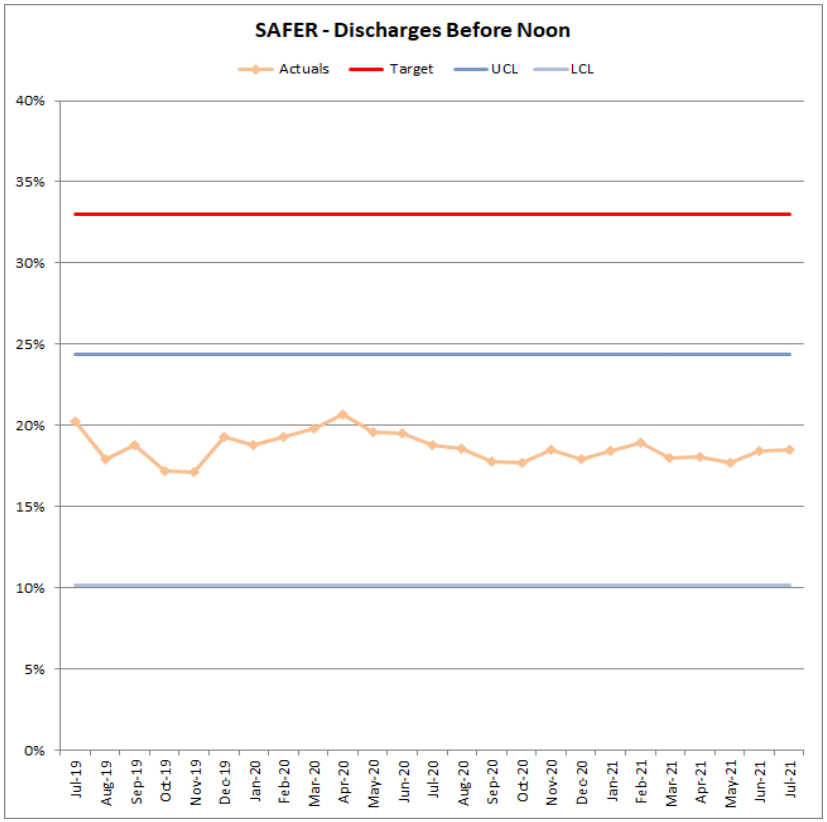
Action:
VTE compliance in each division is tracked through divisional governance reports to PSQB. A monthly report of all patients who did not receive as 12-hour assessment is now being shared with all AMD's to feedback to clinical teams.
Issues with data quality are being addressed to ensure all patients who do not clinically require a 12-hour assessment are not being inappropriately counted in the performance data.
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:
Improvement of performance to achieve minimum target value.



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 and surgical wards, full roll out continues Controls have been put into place to ensure ward rounds have commenced as planned and is comprehensively staffed by senior decision makers. SIE have a comprehensive programme of work with weekly Barriers to Discharge Meeting involving senior stakeholders/decision makers
Expected Impact: July data shows we are currently at 18% for patients discharged before midday “Golden patient” work-stream aims for a 5% improvement on current performance



Agenda Item: 21/22-134

Board of Directors

1st September 2021

Title:	M4 Finance Report
Responsible Director:	Claire Wilson, CFO
Author:	Robbie Chapman, Deputy CFO
Presented by:	Claire Wilson, CFO

Executive Summary

The Trust is reporting a surplus of £0.094m at M4, an adverse variance against plan of £0.005m.

In addition to £0.780m of income from the Elective Recovery Fund (ERF) in respect of M4, NHSEI confirmed that we would receive £2.589m for M1, £1.194m more than was originally reported.

Total employee expenses excluding COVID-19 were £ 94.171m at M4, this represents an overspend against our budget of £0.646m. However, this figure includes a significant overspend of £2.817m in respect of Medicine and Acute services, specifically relating to pressures in A&E, this is offset by underspends in other parts of the Trust.

The Trust is forecast to break-even for H1 in line with its plan.

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

The Board of Directors 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 M4 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	

Month 4 Finance Report 2021/22

Contents

1.1 **Table 1: Financial position – M4**

Month 4 Financial Position	Budget (Mth 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	30,694	31,978	1,285	123,294	124,755	1,461
Covid 19 income	1,914	1,796	(117)	7,622	7,356	(266)
Non NHS income - patient care	409	349	(60)	1,638	1,568	(70)
Other income	2,161	2,368	206	8,616	9,335	719
Total Income	**35,178**	**36,491**	**1,313**	**141,170**	**143,015**	**1,845**
Employee expenses	(23,170)	(23,637)	(467)	(93,525)	(94,171)	(646)
Operating expenses	(11,088)	(12,070)	(981)	(43,640)	(45,212)	(1,572)
Covid 19 costs	(612)	(447)	164	(2,498)	(2,175)	322
Total Expenditure	**(34,870)**	**(36,154)**	**(1,284)**	**(139,663)**	**(141,559)**	**(1,896)**
Non Operating Expenses	(382)	(367)	15	(1,525)	(1,463)	63
Actual Surplus / (deficit)	**(73)**	**(30)**	**44**	**(18)**	**(7)**	**11**
Control Total adjuestment	29	20	0	117	101	0
Surplus/(deficit) - Control Total	**(44)**	**(9)**	**35**	**99**	**94**	**(5)**

1.2 The Trust is reporting a surplus of £0.094m at M4, an adverse variance against plan of £0.005m. 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 £143.015m at M4. 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 £4.862m.

1.4 Our ERF income for M1 has now been confirmed as £2.589m, an improvement on what has been previously reported of £1.194m. The original figure represented a prudent estimate of our activity against national trajectories. We expect to receive this funding during M5.

1.5 The remaining figure accrued in respect of ERF has yet to confirmed and will not be received until M6 at the earliest. With national trajectories continuing at 95% of 19/20 levels we do not expect to receive significant ERF income in the remainder of the year.

1.6 We have received £9.335m in other income, a positive variance of £0.719m. 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.

1.7 Total employee expenses excluding COVID-19 were £94.171m at M4, this represents an overspend against our budget of £0.646m. This figure includes an overspend of 2.817m 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

Pay analysis (exc Covid)	Budget (Mth 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,360)	(20,882)	479	(85,984)	(83,897)	2,087
Bank	(706)	(902)	(196)	(2,911)	(4,108)	(1,197)
Medical Bank	(444)	(905)	(461)	(1,775)	(2,427)	(651)
Agency	(577)	(864)	(287)	(2,521)	(3,382)	(861)
Apprenticeship Levy	(83)	(85)	(2)	(333)	(357)	(24)
Total	(23,170)	(23,637)	(467)	(93,525)	(94,171)	(646)

1.8 Operating expenses were £45.212m at M4, an overspend of £1.572m. This reflects lower spend against clinical supplies and services than budget offset by increased expenditure on drugs, estates and premises.

1.9 Cash balances at the end of M4 were £18.7m.

1.10 The Trust has recorded capital spend of £2.533m at M4, which is £0.107m behind plan.

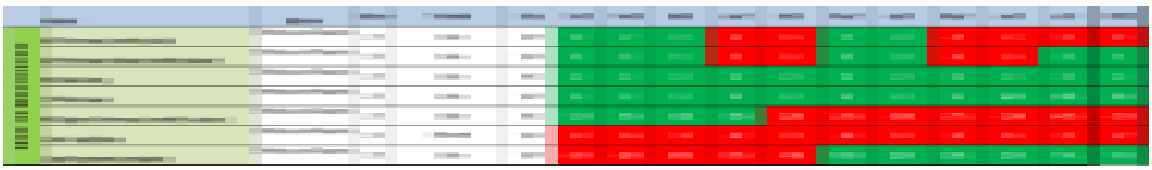
2. Background

2.1 The Trust resubmitted its financial plan to NHSE/I on the 22nd June 2021. 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 The funding arrangements for H2 have yet to be confirmed but it is likely 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: M4 Performance Dashboard**



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

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

3.1.3 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

- Our ability to operate within the H1 financial 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 M4, 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. M4 performance is in line with plan.

4. Financial Performance

4.1 **Income**

4.1.1 The Trust has received £143.015m at M4.

Table 4: Income analysis for M4

	Budget (Mth 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	4,722	3,461	(1,261)	16,142	15,181	(961)
Elective excess bed days	77	21	(56)	361	207	(154)
Non-elective	7,976	8,497	521	32,437	33,584	1,147
Non-elective Non Emergency	1,100	728	(372)	4,300	4,217	(82)
Non-elective excess bed days	450	150	(300)	1,412	664	(748)
A&E	1,353	1,395	42	5,294	5,656	363
Outpatients	3,404	3,307	(97)	12,550	13,290	740
Diagnostic imaging	285	278	(8)	1,064	1,045	(19)
Maternity	475	375	(99)	1,841	1,682	(159)
Non PbR	6,260	5,758	(501)	23,911	22,495	(1,416)
HCD	1,580	1,443	(138)	5,370	5,927	557
CQUINs	190	190	(0)	760	760	(0)
National Top up	1,220	3,505	2,285	10,925	11,623	698
Other	1,018	939	(79)	4,073	4,063	(10)
Sub-Total Board Clinical Income	30,110	30,048	(62)	120,440	120,396	(44)
Other patient care income	82	260	179	327	780	453
Elective Recovery Fund (ERF)	818	1,974	1,156	3,792	4,862	1,070
COVID-19 Income	1,914	1,796	(117)	7,622	7,356	(266)
Non-NHS: private patient & overseas	29	2	(27)	117	76	(41)
Injury cost recovery scheme	64	43	(21)	256	209	(47)
Total Patient Care Income	33,017	34,123	1,107	132,554	133,679	1,125
Other operating income	2,161	2,368	206	8,616	9,335	719
Other non operating income		0	0			0
Total income	35,178	36,491	1,313	141,170	143,015	1,845

4.1.2 Clinical income in M4 was in line with forecast. The lower elective & daycase and non-elective excess bed days income is offset by strong performance in respect of outpatients and non-elective care.

4.1.3 Patient care income exceeded budget by £1.170m, this was driven by £1.194m of additional ERF money in respect of M1 from what was previously reported. This increase is partly attributed to better performance across Cheshire and Merseyside, with income in excess of plans shared according to an agreed mechanism but can also be explained through a previously prudent expectation of income given the uncertainty in the allocation process earlier in the year.

4.1.4 Other Operating income was £9.335m at M3, a positive variance of £0.719m. 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.

4.1.5 A detailed breakdown of divisional performance in respect of income and activity is included at 6.2 of the appendices.

4. Financial Performance

4.2 **Expenditure: Pay**

4.2.1 The Trust has spent £94.171m on pay costs at M4. 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 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(3,837)	(3,845)	(9)	(15,500)	(15,151)	349
Other medical	(2,644)	(2,858)	(214)	(10,575)	(10,827)	(253)
Nursing and midwifery	(6,149)	(6,325)	(176)	(24,880)	(25,449)	(569)
Allied health professionals	(1,362)	(1,369)	(7)	(5,380)	(5,478)	(98)
Other scientific, therapeutic and technical	(570)	(489)	81	(2,281)	(1,990)	291
Health care scientists	(1,055)	(1,048)	7	(4,233)	(4,310)	(78)
Support to clinical staff	(4,365)	(4,326)	39	(17,680)	(17,440)	240
Non medical, non clinical staff	(3,105)	(3,293)	(188)	(12,664)	(13,168)	(505)
Apprenticeship Levy	(83)	(85)	(2)	(333)	(357)	(24)
Total	(23,170)	(23,637)	(467)	(93,525)	(94,171)	(646)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,360)	(20,882)	479	(85,984)	(83,897)	2,087
Bank	(706)	(902)	(196)	(2,911)	(4,108)	(1,197)
Medical Bank	(444)	(905)	(461)	(1,775)	(2,427)	(651)
Agency	(577)	(864)	(287)	(2,521)	(3,382)	(861)
Apprenticeship Levy	(83)	(85)	(2)	(333)	(357)	(24)
Total	(23,170)	(23,637)	(467)	(93,525)	(94,171)	(646)

4.2.2 Total pay costs in M4 were £94.171m, an overspend of £0.646m. This hides under-spends on staff across most of the Trust, with an overspend of £2.817m in Medicine & Acute.

4.2.3 The main driver of this is Medical staffing (£2.6m) both in Acute Care (£1.5m) & Medical Specialties (£1.0m). Medical bank and agency are being used to cover consultant vacancies within the Medical Specialties and support recovery in Haematology & Rheumatology. Vacancies, increased activity levels and sickness are driving the pressure within ED and Acute Medicine, with escalated rates being paid to increase uptake of shifts and ensure safe staffing levels. Nursing expenditure is (£0.2m) overspent due to the extension of the nurse incentive scheme through Q1.

4.2.4 A full analysis of the situation in respect of staffing within Medicine and Acute is included in the appendix from 6.1.12 onwards.

4. Financial Performance

4.3 **Expenditure: Non-Pay**

4.3.1 The Trust has spent £45.212m on non-pay operating expenditure at M4.

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

Non Pay Analysis (exc Covid)	Budget (Mth 4) £'000	Actual (Mth 4) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Supplies and services - clinical	(3,052)	(2,942)	109	(12,305)	(11,218)	1,087
Supplies and services - general	(425)	(405)	20	(1,683)	(1,524)	159
Drugs	(1,949)	(2,215)	(265)	(7,752)	(8,960)	(1,208)
Purchase of HealthCare - Non NHS Bodies	(1,239)	(1,196)	43	(3,788)	(3,306)	482
CNST	(1,152)	(1,153)	(2)	(4,606)	(4,606)	(0)
Consultancy	(11)	(72)	(61)	(44)	(191)	(147)
Other	(2,307)	(3,131)	(824)	(9,658)	(11,632)	(1,974)
Sub-Total	(10,135)	(11,115)	(980)	(39,835)	(41,437)	(1,602)
Depreciation	(953)	(954)	(1)	(3,805)	(3,777)	29
Impairment	0	(1)	(1)	0	1	1
Total	(11,088)	(12,070)	(981)	(43,640)	(45,212)	(1,572)

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, premises and non-capital estates works and expenditure on the Teledermatology initiative.

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 at 6.1.6 in 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 £2.175m on Covid-19 costs at M4, with £1.176m on pay and £0.999m on non-pay.

Table 9: YTD COVID-19 revenue costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Year to Date £'000
Medical Staff	(35)	(14)	(24)	(9)	(82)
Other Clinical Staff	(343)	(172)	(183)	(229)	(927)
Non Clinical Staff	(72)	(49)	(22)	(23)	(166)
Total Pay	(450)	(236)	(229)	(261)	(1,176)
Clinical Supplies	(101)	(207)	(230)	(162)	(701)
Other Non-Pay	(106)	(129)	(39)	(24)	(298)
Total Non-Pay	(208)	(337)	(269)	(187)	(999)
Total Covid Expenditure	**(658)**	**(572)**	**(498)**	**(447)**	**(2,175)**

4.4.2 The vaccination costs were £0.528m at M4 which was in line with plan and is funded centrally.

4.4.3 The testing costs were £0.717m at M4 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 £0.5m with £1m for the whole of H1. As at M4 the Trust has achieved £0.637m of CIP, of which £0.596m is recurring and £0.041m is non-recurring.

4.5.2 Plans are in place for to achieve a further £0.852m in CIP in H1 of which £0.541m is recurrent and £0.311m 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 9th August, 274 **opportunities** have been identified with a recurrent value of £5.751m IYE and £6.529m FYE. A breakdown by division can be seen in Table 10 below:

Table 10: IYE and FYE breakdown by Division

Division	IYE Opportunities Identified £m	FYE Opportunities Identified £m
DCS	1.708	1.736
M&A	1.602	2.120
Surgery	1.290	1.421
W&C	0.356	0.546
Corp	0.794	0.706
Total	**5.751**	**6.529**

4.5.4 **It should be noted that Table 10 above provides an estimate of the opportunities identified and is not adjusted for risk of delivery at this stage.**

4.5.5 73 projects with a value of £0.432m have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.5.6 187 projects with a value of £2.739m have progressed to design & plan (gateway 2), meaning documentation is now being completed on PM3 with indicative costings.

4.5.7 14 projects with a value of £2.580m have now moved into governance and assurance (gateway 3), meaning the QIA/EA has been completed and is awaiting panel review in September.

4.5.8 Since the last committee, the FYE has reduced by £1.026m. DCS have undertaken a review of all proposed CIP opportunities and have validate their projects for delivery in 2021/22. As a result, 10 projects with a value of £0.822m have been identified as 2022/23 delivery. Following this, DCS are now working on identifying further opportunities to mitigate this movement with the support of the Finance team and Productivity and Efficiency team. Benchmarking tools such as Model Hospital are being utilised to support this work.

4.5.9 The remaining £0.204m reduction is a combination of a variety of smaller schemes being identified as undeliverable in 2021/22.

4. Financial Performance

4.6 **Divisional performance**

4.6.1 The financial performance of each division is discussed in detail within the appendices but in terms of summary of performance:

Table 11: IYE and FYE breakdown by Division

Division	Budget Variance (£000)	WTE Variance with Bank (for M4)	Agency spend (£000)	CIP YTD (£000)	CIP Forecast H1 (£000)
M&A	-3,461	-13.16	2,008	86	166
Surgery	-381	-15.80	432	138	256
DCS	128	41.25	334	274	412
W&C	310	1.38	249	32	63
EHS	-207	39.33	86	0	0
Corporate	-188	51.95	273	66	241

4.6.2 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 (Noting that CIP forecast is not yet risk adjusted as explained in 4.5.4 above)

4.6.3 At M4 Medicine & Acute has an adverse variance against budget of £3.461m. It is important to highilight that the Division has required 13 more people in M4 than was allowed for within the budget and has incurred £2.008m of agency costs. These staffing pressures are a result of sickness, shielding and patient acuity in addition to a 15% increase on activity in A&E compared to 2019/20. CIP identification 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.

4.6.4 At M4 Surgery has an adverse variance against budget of £0.381m. CIP performance YTD centres around the reduced cost in respect of orthopaedic hip and knee implants following successful procurement process.

4.6.5 At M4 DCS has a positive variance against budget of £0.128m. The Division employed 41.25 fewer people than budget but has paid £0.334m 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.

4.6.6 At M4 Women's & Children's has a positive variance against budget of £0.310m, primarily as a result of vacancies. CIP performance YTD centres around reductions in budgeted establishment and changes in skills mix resulting in reduced costs.

4.6.7 At M4 Estates and Hotel Services has an adverse variance against budget of £0.207m. The Division 39.33 WTE fewer people than budget and has paid only £0.086m of agency costs YTD.

4.6.8 At M4 Corporate has an adverse variance against budget of £0.188m. CIP in respect of Corporate departments 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.

5. Financial Position

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

5.1.1 The movement in total assets employed at M4 is minimal.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 30.06.21 £'000	Actual as at 31.07.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	162,738	162,641	(97)	↓
12,864	Intangibles	12,620	12,558	(62)	↓
869	Trade and other non-current receivables	897	905	8	↑
177,293		**176,255**	**176,104**	**(151)**	↓
	Current assets				
4,788	Inventories	3,971	4,303	332	↑
16,848	Trade and other receivables	24,449	23,825	(624)	↓
0	Assets held for sale	0	0	0	→
21,294	Cash and cash equivalents	16,538	18,717	2,179	↑
42,930		**44,958**	**46,845**	**1,887**	↑
220,223	**Total assets**	**221,213**	**222,949**	**1,736**	↑
	Current liabilities				
(44,124)	Trade and other payables	(43,049)	(47,607)	(4,558)	↑
(4,622)	Other liabilities	(6,982)	(4,285)	2,697	↓
(1,090)	Borrowings	(1,125)	(1,137)	(12)	↑
(7,256)	Provisions	(7,235)	(7,235)	0	→
(57,092)		**(58,391)**	**(60,264)**	**(1,873)**	↑
(14,162)	**Net current assets/(liabilities)**	**(13,433)**	**(13,419)**	**14**	↓
163,131	**Total assets less current liabilities**	**162,822**	**162,685**	**(137)**	↓
	Non-current liabilities				
(2,479)	Other liabilities	(2,452)	(2,443)	9	↓
(5,193)	Borrowings	(5,193)	(5,193)	0	→
(7,318)	Provisions	(7,044)	(6,946)	98	↓
(14,990)		**(14,689)**	**(14,582)**	**107**	↓
148,141	**Total assets employed**	**148,133**	**148,103**	**(30)**	↓
	Financed by				
	Taxpayers' equity				
171,121	Public dividend capital	171,121	171,121	0	→
(64,220)	Income and expenditure reserve	(64,227)	(64,257)	(30)	↓
41,240	Revaluation reserve	41,240	41,240	0	→
148,141	**Total taxpayers' equity**	**148,134**	**148,104**	**(30)**	↓

5. Financial Position

5.2 **Capital Expenditure – July 2021**

Capital Programme - 31 July 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	560	560	560	0	560
Total funding	**14,038**	**560**	**14,598**	**14,598**	**0**	**14,598**
Expenditure						
Pre-commitments 20/21	5,007	388	5,395	5,395	0	1,505
Estates	2,671	0	2,671	2,671	0	112
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	118
Surgery	688	66	754	754	0	203
Women and Children's	236	0	236	236	0	99
Other	90	0	90	90	0	0
Contingency[2]	633	(370)	263	263	0	0
Donated assets	0	560	560	560	0	15
UEC	1,300	0	1,300	1,300	0	9
Total expenditure (accruals basis)	**14,038**	**560**	**14,598**	**14,598**	**0**	**2,533**
Capital programme funding less expenditure	**0**	**0**	**0**	**0**	**0**	**12,065**
Capital expenditure	14,038	0	14,038	14,038		2,526
NBV asset disposals	0	0	0	0		0
Donated assets	552	0	552	560		7
CDEL impact	**14,590**	**0**	**14,590**	**14,598**		**2,533**

[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 M4 is slightly plan but we expect to recover this before year end. 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	**16,538**	**21,294**
Operating activities		
Surplus / (deficit)	(30)	(7)
Net interest accrued	18	68
PDC dividend expense	352	1,406
Unwinding of discount	(3)	(11)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	337	1,456
Depreciation and amortisation	935	3,758
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(8)	(15)
Changes in working capital	1,675	(1,792)
Investing activities		
Interest received	0	2
Purchase of non-current (capital) assets [1]	(755)	(5,965)
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	(0)
PDC dividend paid	0	0
Finance lease rental payments	(5)	(21)
Total net cash inflow / (outflow)	**2,179**	**(2,578)**
Closing cash	**18,717**	**18,716**

[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 £2.179m increase in cash balances in month.

5. Financial Position

5.4 Treasury

Borrowings summary July 2021

Borrowings summary

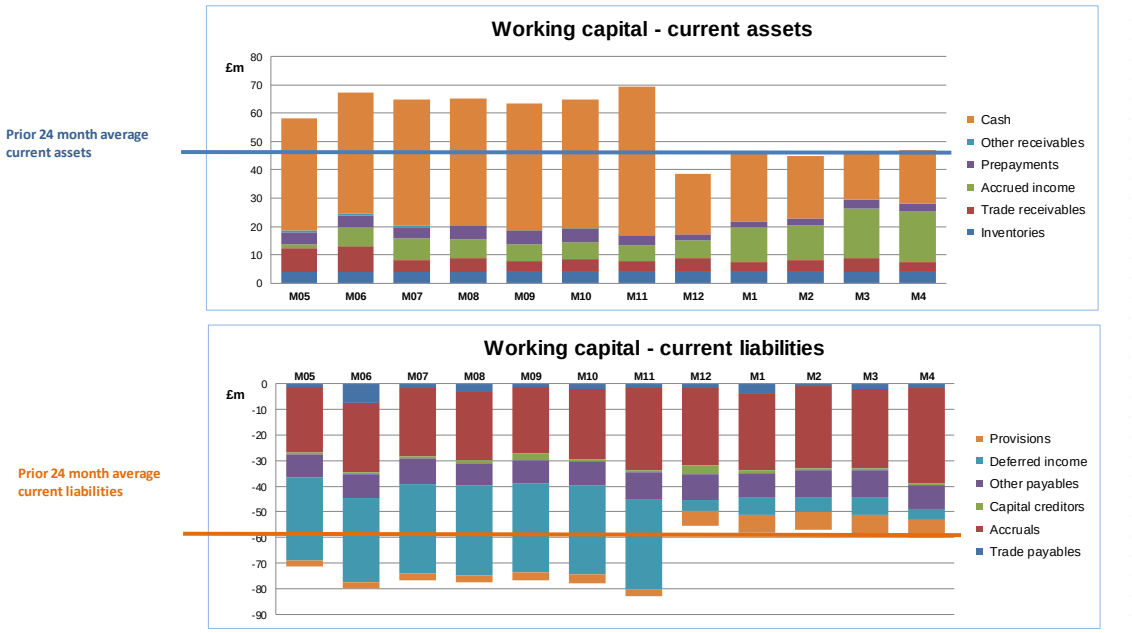
	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar21	Conversion to PDC Sept20	Forecast Repayment 20/21	Forecast Closing Balance Mar21
	£'000	Years	%	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	0	(750)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	0	(265)	3,583
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 M4 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%	-15.7	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	2.6	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	1.1%	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%	3
	Overall NHSI UoR rating				**2**

5.6.1 The liquidity rating of 4 is a deterioration in month due to the large number of accruals made but we anticipate this to be a temporary situation and plans are in place to improve our liquidity. The capital service capacity metric has improved to 1. The I&E margin reflects the YTD surplus. Agency spend is higher than threshold but an improvement in month and we expect this to improve given the plans in place around exit strategies. The overall UoR rating of 2 is expected to continue for the remainder of the year.

Agenda Item: 21/22-135

Meeting of the Board of Directors

1 September 2021

Title:	Q1 Report on Safe Working Hours: Doctors and Dentists In Training April-June 2021
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director
Presented by:	Dr Helen Kerrs, Guardian of Safeworking

Executive Summary

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

This paper describes the concerns raised by doctors and dentists in training to the Guardian of Safeworking, locum shift cover and fines incurred by the trust

Key points:

- 42 exceptions raised in Q1 in relation to working hours. All exceptions are now closed.
- There were 9 exception reports in relation to training. All are now closed.
- Most exceptions raised related to working hours on F1 rotas in both medicine and surgery (66.6%).
- There were 2 fines issued to surgery in relation to a breach in contract due to length of shift. The shifts are now compliant as a result of moving the handover on Friday AMs ahead of departmental teaching.
- Medical registrars have raised an issue about potential disparity between the two medical registrar rotas. Medical staffing are reviewing the master rota with the Director of Medical Education.
- Surgical F1s are moving to a team based system following feedback from the last cohort. It will be reviewed for assurance of benefit in October prior to rotational changes in December.

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

Which strategic objectives this report provides information about:	
Outstanding Care	**Yes**
Compassionate Workforce	**Yes**
Continuous Improvement	**Yes**
Our Partners	**no**
Infrastructure	**no**

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
None	
Specific communications and stakeholder /staff engagement implications	
Media Interest	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
None	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
None	
Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING April to June 2021

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total):	292 (283.2WTE)
Number of doctors / dentists in training on 2016 TCS (total):	292 (283.2WTE)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.6 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reports by specialty				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	24	24	0
General Practice	0	1	1	0
General Surgery	0	12	12	0
Paediatrics	0	3	3	0
T&O	0	2	2	0
Total	0	42	42	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	28	28	0
F2	0	1	1	0
SHO	0	10	10	0
SPR	0	3	3	0
Total	0	42	42	0

Exception reports by rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Paediatrics T1 2021 1 in 11	0	3	3	0
GP F2 2020	0	1	1	0
Med GPSTs Card WE 2020	0	2	2	0
Medicine F1 Rota 2020	0	18	18	0
Medicine IMT3 2020 LTFT 80% MTWT	0	3	3	0
Stroke T1	0	1	1	0
Surgical F1 Rota 2020	0	10	10	0
Surgical T1 1:10 2020	0	2	2	0
T&O SHO 2020	0	2	2	0
Total	0	42	42	0

Exception reports (response time)				
Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	7	11	10	0
F2	1	0	0	0
SHO	7	3	0	0
SPR	0	3	0	0
Total	15	17	10	0

Exception reports (with regard to training/academic issues)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	5	5	0
General Surgery	0	4	4	0
Total	0	9	9	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	8	8	0
SHO	0	1	1	0
Total	0	9	9	0

Exception reports by rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine F1 Rota 2020	0	5	5	0
Surgical F1 Rota 2020	0	3	3	0
Surgical T1 1:10 2020	0	1	1	0
Total	0	9	9	0

Exception reports (response time)				
Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	4	1	3	0
SHO	1	0	0	0
Total	5	1	3	0

b) Work schedule reviews

(None – Medicine Registrars rotas to be reviewed in July.)

c) Locum bookings

i) Bank

Locum bookings (bank) by department					
Department	Number of shifts requested	Number of shifts worked via bank	Number of shifts given to agency	Number of hours requested	Number of hours worked via bank
A&E	1677	511	354	12,033.86	4627.65
Acute Medicine	122	118	0	1069.75	1036.42
Clatterbridge	9	9	0	118	118.42
Colorectal	1	1	0	10	10
Critical Care	12	12	0	103	103
ENT	2	2	0	13	13
General Medicine	311	44	267	428.5	428.5
General Paediatrics	25	23	2	225.25	200.5
General Surgery	212	26	186	263.5	264.42
Geriatric Medicine	12	11	0	100	87.5
Haematology	1	1	0	8	8
Neonates	2	2	0	26	26
Obs & Gynae	60	17	26	498.25	11.25
OMFS	5	5	0	19	19
Ophthalmology	19	19	0	308	308
Renal	3	3	0	25	25
T&O	42	34	7	332.5	335.76
Urology	14	11	3	174.25	165.25
Total	2529	849	845	15,755.86	7787.67
Cost		£603,903.53	£560,514.90		
Total locum cost		£1,164,418.43			

Locum bookings (bank) by grade					
Grade	Number of shifts requested	Number of shifts worked via bank	Number of shifts given to agency	Number of hours requested	Number of hours worked via bank
F1	27	26	0	225	212.5
F2	59	58	0	500.37	491.96
SHO	1722	437	551	10,677.33	4031.24
REG	721	328	294	4353.16	3151.97
Total	2529	849	845	15,755.86	7887.67

Locum bookings (bank) by reason					
Reason	Number of shifts requested	Number of shifts worked via bank	Number of shifts given to agency	Number of hours requested	Number of hours worked via bank
Covid	12	4	0	102	23.5
Extra Activity	9	9	0	55.5	55.5
Sickness Cover	50	45	0	445.5	401.5
Vacancy	2302	638	845	13,647.12	5933.76
Other Absence Cover	43	40	0	382.75	350.42
No Reason Recorded	113	113	0	1122.99	1122.99
Total	2529	849	845	15,755.86	7887.67

ii) Agency

Locum bookings (agency) by department				
Department	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
A&E	354	354	3495.25	3495.25
General Medicine	267	267	2089.75	2089.75
General Surgery	186	186	1761.5	1761.5
Obs & Gynae	26	26	318.25	318.25
Paediatrics	2	2	25	25
T&O	7	7	76.5	76.5
Urology	3	3	25.5	25.5
Total	845	845	7791.75	7791.75

Locum bookings (agency) by grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
SHO	551	551	4921.75	4921.75
REG	294	294	2870	2870
Total	845	845	7791.75	7791.75

Locum bookings (agency) by reason**				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	845	845	7791.75	7791.75
Total	845	845	7791.75	7791.75

d) Locum work carried out by trainees

Locum work by trainee								
Specialty	Grade	No of shifts worked	No of hours worked	Exception Report Hours	Average hours rostered per week*	Average Hours Non-resident on Call Per Week	Average actual hours worked per week**	Opted out of WTR?
Medicine	SPR	20	191	0	43.29	0	59.21	Y
Medicine	IMT	12	112.5	0	47.54	0	56.92	Y
Medicine	F1	1	172.5	0	42	0	56.38	Y
Medicine	F2	20	152	0	42.31	0	54.98	Y
Medicine	F2	12	91.16	0	45.67	0	53.27	Y
Medicine	SPR	8	84.5	0	45.13	0	52.17	Y
Paediatric	F2	6	68.45	0	45.18	0	50.88	Y
Medicine	IMT	8	75.25	0	44.42	0	50.69	Y
Surgery	F2	8	77.5	0	43.92	0	50.38	Y
Paediatric	SHO	6	45.25	0	46.6	0	50.37	Y
A&E	F2	10	114.5	0	40.83	0	50.37	Y
Medicine	F2	5	52	0	45.98	0	50.31	Y
Surgery	SPR	4	43.5	0	46.38	0	50.01	Y
Medicine	F2	6	70	0	44	0	49.83	Y
Medicine	F2	6	59	0	44.5	0	49.42	Y
A&E	SPR	7	68.5	0	43.67	0	49.38	Y
T&O	F2	5	50	0	45.13	0	49.3	Y
Medicine	SPR	6	56.5	0	44.46	0	49.17	Y
Medicine	ACCS	5	41	0	45.67	0	49.09	Y
Total		341	3115.95					

Note: Full data set as an appendix – see Appendix 1
*calculated as an average over a 12 week period
**calculated using expected hours for non-resident on call and all hours for resident on call

e) Vacancies

Vacancies by month						
Division	Grade	April	May	June	Total gaps (average)	Number of shifts uncovered
Medical and Acute	F1	7	7	7	7	0*
Medical and Acute	ST1/2	6	0	2	2.67	0*
Surgery	ST3-5	0	0	1	0.33	0*
Total		13	7	10	10	0*

*vacancy shifts filled by agency/bank

f) **Fines**

Fines by department		
Division	Number of fines levied	Value of fines levied
Surgery	2	£146.42
Total	2	£146.42

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£ 0	£146.42	£ 0	£146.12

Qualitative information

The trust is continuing to work hard to make sure junior doctors enjoy their time at Arrowe park hospital and feel supported. Through the junior doctors forum, juniors have continued to present their new ideas. The IT clinical fellow has created a WUTH junior doctors and ANP section on Microsoft teams and sharepoint. The vision is to create a one stop shop for all non-clinical communications, meetings and documentations.

There has been a breach of contract due to shift length in general surgery – It related to Friday AM shift handover occurring after weekly teaching. The rota is now compliant with the move of handover to before teaching. Teaching is to be recorded for doctors in handover or on leave and will be available via sharepoint.

Medical registrar rota review – Medical registrars have raised an issue that they feel there is a disparity between the 2 medical registrar rotas and have asked why. It may be due to a training requirement. Medical staffing are reviewing the master rota to understand the difference in the 2 rota frequencies.

The surgical F1's had concerns about being ward based versus team based; they presented their finding at the junior doctor's forum. The directorate supported a move back to team base with a review at 3 months. The medical outliers will still be covered by the surgical F1's.

Appendices

Appendix 1:

Locum work by trainee								
Specialty	Grade	Number of shifts worked	Number of hours worked	Exception Report Hours	Average hours rostered per week*	Average Hours non-resident on call per week	Average actual hours worked per week**	Opted out of WTR?
Medicine	SPR	20	191	0	43.29	0	59.21	Y
Medicine	IMT	12	112.5	0	47.54	0	56.92	Y
Medicine	F1	1	172.5	0	42	0	56.38	Y
Medicine	F2	20	152	0	42.31	0	54.98	Y
Medicine	F2	12	91.16	0	45.67	0	53.27	Y
Medicine	SPR	8	84.5	0	45.13	0	52.17	Y
Paediatrics	F2	6	68.45	0	45.18	0	50.88	Y
Medicine	IMT	8	75.25	0	44.42	0	50.69	Y
Surgery	F2	8	77.5	0	43.92	0	50.38	Y
Paediatrics	SHO	6	45.25	0	46.6	0	50.37	Y
A&E	F2	10	114.5	0	40.83	0	50.37	Y
Medicine	F2	5	52	0	45.98	0	50.31	Y
Surgery	SPR	4	43.5	0	46.38	0	50.01	Y
Medicine	F2	6	70	0	44	0	49.83	Y
Medicine	F2	6	59	0	44.5	0	49.42	Y
A&E	SPR	7	68.5	0	43.67	0	49.38	Y
T&O	F2	5	50	0	45.13	0	49.3	Y
Medicine	SPR	6	56.5	0	44.46	0	49.17	Y
Medicine	ACCS	5	41	0	45.67	0	49.09	Y
Surgery	F1	6	48.5	4.25	44.37	0	48.77	Y
O&G	SHO	2	16.5	0	47.29	0	48.67	Y
O&G	SPR	3	9.25	0	47.83	0	48.6	Y
Surgery	SHO	4	48.5	0	44.54	0	48.58	Y
Surgery	F1	2	9	0	47.75	0	48.5	Y

Medicine	F1	1	12.5	0	47.38	0	48.42	Y
Medicine	IMT	4	24	0	46.13	0	48.13	Y
O&G	SHO	1	12	0	47.13	0	48.13	Y
Medicine	SHO	1	12.5	0	47.06	0	48.1	Y
Medicine	IMT	3	35	0	45.04	0	47.96	Y
Medicine	F2	3	23.5	0	45.83	0	47.79	Y
Medicine	ACCS	2	23.5	0	45.81	0	47.77	Y
Medicine	SHO	1	12.5	0	46.63	0	47.67	Y
O&G	SHO	2	7	0	47.04	0	47.62	Y
Urology	SHO	1	3.5	0	47.29	0	47.58	Y
Paediatrics	F2	1	10	0	46.67	0	47.5	Y
Surgery	F2	4	36.42	0	44.38	0	47.42	Y
Medicine	IMT	3	29.5	0	44.94	0	47.4	Y
Medicine	F1	3	29.5	0	44.87	0	47.33	Y
Ophthalmy	SPR	3	48	0	36.21	22	47.21	Y
Medicine	F2	3	9.5	0	46.38	0	47.17	Y
Medicine	SPR	2	20.5	0	45.46	0	47.17	Y
Paediatrics	SPR	4	38.5	0	43.9	0	47.11	Y
Medicine	SPR	1	6	0	46.54	0	47.04	Y
Medicine	IMT	1	12.5	0	46	0	47.04	Y
O&G	SPR	1	4	0	46.63	0	46.96	Y
Medicine	IMT	1	12.5	0	45.81	0	46.85	Y
O&G	SHO	4	24	0	44.83	0	46.83	Y
O&G	SHO	3	29.25	0	44.17	0	46.61	Y
Surgery	F1	1	4.5	0	46.21	0	46.59	Y
Medicine	F2	2	16	0	45.21	0	46.54	Y
Medicine	F2	1	12	0	45.5	0	46.5	Y
O&G	SHO	5	37	0	43.42	0	46.5	Y
Paediatrics	F2	1	3	3.5	45.92	0	46.46	Y
A&E	F2	6	31	0	43.83	0	46.41	Y
Paediatrics	SHO	2	12	0	45.4	0	46.4	Y
Surgery	F1	1	8	0	45.63	0	46.3	Y
Paediatrics	SHO	2	9	0	45.54	0	46.29	Y

Medicine	F1	2	20.5	0	44.58	0	46.29	Y
Medicine	F2	1	7.67	0	45.4	0	46.04	Y
Paediatrics	SHO	1	3	0	45.67	0	45.92	Y
T&O	F2	1	11	0	44.92	0	45.84	Y
O&G	SPR	3	18	0	44.21	0	45.71	Y
Surgery	SPR	1	10	0	44.88	0	45.71	Y
Medicine	SHO	2	15	0	44.25	0	45.5	Y
Medicine	F1	1	8	5	44.13	0	45.21	Y
A&E	F2	4	34	0	42.33	0	45.16	Y
Medicine	F1	2	20	0	43.46	0	45.13	Y
Medicine	F1	5	34.5	0	42	0	44.88	Y
T&O	SHO	1	12.5	0	43.46	0	44.5	Y
Medicine	IMT	2	18	0	42.83	0	44.33	Y
T&O	McH	1	12	0	43.25	0	44.25	Y
Paediatrics	SPR	1	12.5	0	42.9	0	43.94	Y
T&O	MTI	5	35	0	41	0	43.92	Y
A&E	F2	4	38.5	0	40.58	0	43.79	Y
A&E	F2	8	42	0	40.25	0	43.75	Y
Paediatrics	SPR	1	12.5	0	42.56	0	43.6	Y
A&E	SHO	3	27	0	41.33	0	43.58	Y
A&E	F2	2	17.5	0	42.08	0	43.54	Y
Medicine	IMT	1	12.5	0	41.96	0	43	Y
Paediatrics	SPR	2	8.75	0	40.96	0	41.69	Y
A&E	F2	1	12	0	40.67	0	41.67	Y
O&G	SPR	2	7	0	41.06	0	41.64	Y
A&E	F2	1	4	0	40.67	0	41	Y
Anaesthetic	SHO	1	9	0	40.13	0	40.88	Y
Surgery	SPR	1	12.5	0	39.79	0	40.83	Y
A&E	SPR	10	87	0	31.92	0	39.17	Y
A&E	F2	2	2	0	38	0	38.17	Y
A&E	SPR	9	60	0	32.83	0	37.83	Y
A&E	F2	2	22	0	35.25	0	37.08	Y
A&E	F2	3	25.5	0	33.83	0	35.96	Y
A&E	SPR	2	20	0	33.25	0	34.92	Y

T&O	F2	6	54.5	0	27.58	0	32.12	Y
Medicine	SPR	1	4.5	0	31.38	0	31.76	Y
Total		341	3115.95					

*calculated as an average over a 12 week period

**calculated using expected hours for non-resident on call and all hours for resident on call

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-136

Board of Directors
1st September 2021

Title:	Monthly Safe Nurse Staffing Report
Author :	Tracy Fennell - Deputy Chief Nurse Johanna Ashworth Jones – Programme developer, Corporate Nursing Team
Responsible Director:	Tracy Fennell – Deputy Chief Nurse
Presented by:	Tracy Fennell - Deputy Chief Nurse

Executive Summary

Month 4 was a challenging month for safe staffing; no serious harm has been reported as a result.

During this period 11 wards reported shifts with a professional judgement of red (risk of care standards falling below expected levels) despite additional mitigations being put in place.

In Month 4 there was as increase in the number of incidents reported that related to nursing and midwifery staff shortages. All incidents have been reviewed and actions are place to address the issues raised.

The Trust launched the local Registered Nurse (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 vacancies have reduced significantly to 0.49%

Recommendation: (e.g. to note, approve, endorse)
The Board is asked to note and receive the Safe Staffing 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	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: • CSW vacancies have reduced to 0.49% • No known serious harm occurred as an impact of reduced staffing • Establishment reviews have commenced in line with Developing Workforce Safeguards (2018) NHSE guidance Gaps: • 11 shifts had a professional judgement of red in M4 • There has been an increase in the number episodes where care standards fell below expected levels reported on the Safe Staffing Oversight Tracker (SSOT) in M4 • Staff isolating due to COVID community prevalence continues to impact staffing during M4	
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
1 September 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 increased by 0.84% to 12.31% (M4) from 11.47% (M3). Due to the flight restrictions imposed due to COVID, there has been a delay in the expected arrival of international nurses in M4. The Trust reported a small number of nurses leaving the Trust creating a slight increase in RN vacancies. The 16 delayed international nurses from M4 are planned to arrive in M5.

Cohesive partnership working between Human Resources, Corporate Nursing Department and Divisions has streamlined recruitment processes thus reducing delays in CSW recruitment times. As a result CSW vacancies have reduced to 0.49% (M4) from 3.08% (M3).

Weekly corporate RN and CSW recruitment continues along with commencement of CSW apprenticeships and on-going recruitment into the Care Support Worker Development (CSWD) Programme.

The Trust launched the local RN recruitment utilising the “We are WUTH” branding across a number of channels to further reduce RN vacancies. The International Recruitment Programme also remains on track with 105 of the planned 160 international nurses arrived at the Trust to date, the 55 remaining nurses are planned to arrive in Q2/3.

1.2 Sickness

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

RN sickness has increased by 1.28% to 6.79% (M4) from 5.51% (M3).

CSW sickness has reduced for the 2nd consecutive month to 9.16% (M4) from 9.89% (M3). Despite high levels of CSW sickness the Trust has been able to maintain fill rates for CSW at 97% days and 96% for nights due to the improvements in CSW vacancies and improved NHSP CSW fill rates.

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M4 the SSOT reported the number of shifts that fell below minimum RN staffing levels as 614 which is an increase from 446 (M3).

To reduce the risks in areas with reduced staffing levels 407 staff were relocated from other areas.

In M4, 11 shifts were assessed by the Senior Nursing Team as a professional judgement of red (high risk of care standards falling below expected levels). This is the highest number of red professional judgement shifts recorded over the last 12 months with the next highest being 2 (M3). 9 of the 11 shifts were within the Medical Division and 2 in the Women's and Children's Division. Details are listed below:

Ward 32 (1 shift)

This shift was reported during the Cerner downtime internal incident that was declared by the Trust. Registered Nurse staffing was 2 RN's and 1 supernumery international nurse for 29 patients (against a planned roster of 5 RNs). The shortfall was as a result of NHSP cancellations. At this time there was extensive senior nurse presence across the Trust overseeing safety in all areas due to the Cerner downtime incident.

Ward 26 (8 red shifts reported in M4)

Staffing for this area has been reduced due to a number of vacancies and increased sickness levels. RN vacancies have now all been filled however staff are just concluding recruitment checks so have not yet commenced in post. Sickness is being managed proactively in line with the provisions of the associated policy.

Vacant NHSP gaps were covered clinically by the Matron where possible and additional hours were also supported by the Pharmacist to support drug rounds to mitigate risks.

Despite additional support the reduction in RN staffing has impacted on delayed observations and completion of mNews however this has not resulted in any MET calls or known patient harm.

During the recent establishment reviews Ward 26 was highlighted as having an increased acuity. As with other areas during the COVID pandemic, Ward 26 staffing has been flexed in line with the increased acuity to ensure the ward remains safe.

A full report on the outcome of the ward establishment reviews will be presented to Board of Directors in October 2021.

Gynaecology Assessment Unit (2 shifts)

There were two shifts rated as red for professional judgment for Gynaecology Assessment Unit (GAU) this did result in some patients being redirected to the Emergency Department and Ward 54.

1.4 Impact on Care

29 falls occurred in M4 where staffing levels were less than expected however following a review of these falls there is no evidence to suggest that reduced staffing was a contributing factor.

There was a significant increase in the number of staff reporting missed breaks, 100 (M4) compared with 57 (M3).

The increased number of red RN shifts also impacted on the quality of care undertaken in a timely manner with delays reported in the following:

- Delayed / Missed Observations, 198 (M4) compared with 74 (M3)
- Delayed / Missed Pressure Care , 82 (M4) compared with 44 (M3)
- Delayed / Missed MNews, 367 (M4) compared with 120 (M3)
- Delayed Medications, 263 (M4) compared with 79 (M3)

2 Actions to mitigate risks

The number of hours covered by nursing agencies increased during (M4) to 6% compared with 4.8% (M3). WUTH requested 27501 registered nursing hours to be covered during M4 with 59% being filled by NHSP.

Establishment reviews commenced in M4 and will be finalised in M5, these establishment reviews include a full acuity and dependency audit review of each area.

The Trust remains on track with the International Recruitment Programme in line with agreed plans. The remaining 55 nurses are expected to arrive in the Trust in Q3/Q4. 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 commenced 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 Children's and maternity staffing.

3.1 Maternity

M4 is the fourth consecutive month that the delivery suite has been noted as an area submitting higher numbers of staffing incidents. These are linked to the regional pressures in maternity services that has resulted in several providers across Cheshire & Merseyside needing to divert cases to other Trusts.

A regional Gold Command structure has been set up with a daily sit rep being submitted to NHSE, this supplements the weekly sit rep already submitted. WUTH has not required to divert cases in M4 however the Maternity Unit has remained in a state of escalation on a daily basis. This has required additional support from the Community Midwifery Service. WUTH has accepted diverted cases where possible from other Trusts during this period following daily local risk assessment.

A number of in-utero transfers (IUT) have been declined in M4 due to midwifery staffing but each IUT declined has been subject to senior clinical review by the Consultant Obstetrician.

3.2 Children's services

Plans are in place for the anticipated surge in Respiratory Syncytial Virus (RSV) that will impact on the Children's Ward, Paediatric Assessment Unit (PAU) and Children's Emergency Department. No increase in cases was evident in M4 however this continues to be monitored and reported daily.

There are currently no vacant children's nurse posts where additional staffing is required this has been sourced through NHSP and Agency.

The Trust Escalation and Divert Policy for Children's Services is currently under review and expected to be ratified next month with a potential of regional adoption to follow. There have been no reported incidents where children have been required to be diverted out of the organisation, and the Trust continues to support transfers into the organisation.

3.3 Neonates

There are currently 5 WTE staff allocated to the remaining vacancies for the Neonatal Unit that are currently going through the recruitment process. These gaps have been covered in the short term with NHSP cover and staff working additional hours. The Neonatal Unit has been extremely busy with babies being transferred in from as far as Bradford due to the lack of capacity regionally.

There have been 12 reported incidents regarding staffing submitted across Women's and Children's Division all being reported as low harm. The majority are linked to the regional pressures being seen across maternity services. Acuity in the unit continues to be monitored closely through each shift and senior support in and out of hours has been rostered for additional support.

4. Conclusions

M4 was noted to be a significantly challenging month for staffing in both in 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.

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 M5 is expected to continue provide increased staffing challenges due to the rising community COVID prevalence. There is expected to be a further increase in staff absence and an increase in acuity due to increased births, increased positive COVID cases and a rise in RSV cases. 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- July 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	Jul	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	8.5	
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	4.1	
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	3.6	
Corporate Nursing	Number of ward below 6.1 CHPPD		0	2	0	0	0	1	1	0	1	4	1	3	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	79%	81%	83%	84%	83%	84%	82%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	86%	91%	91%	92%	93%	100%	97%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	77%	84%	78%	84%	80%	82%	78%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	95%	71%	101%	98%	99%	98%	96%	
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%	81.50%	
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%	84.80%	
Informatics	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	50%	50%	52%	55%	55%	53%	51%	
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%	13.44%	
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%	12.31%	
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%	6.97%	
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%	0.49%	
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%	6.79%	
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%	9.16%	
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%	1.12%	
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%	1.88%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	0	0	0	0	0	2	11	
Corporate Nursing	Number of RN Red Shifts *		359	445	454	243	499	689	330	383	323	427	446	614	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	26	36	16	16	21	19	29	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	0	1	1	0	0	3	1	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	2	1	27	2	2	1	2	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	1	2	0	0	1	2	2	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	33	6	14	14	9	4	7	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	38	2	3	1	10	2	12	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	119	34	41	42	71	57	100	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	278	31	126	75	248	74	198	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	237	72	286	90	226	120	367	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	46	23	58	15	43	44	82	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	299	88	193	55	199	79	263	
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	105	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	0	1	0	0	1	0	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	1	0	1	0	0	1	0	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	0	0	0	1	1	1	
Corporate Nursing	Staff Moves		232	329	140	164	172	606	337	337	288	341	302	407	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	43952	35299	34182	24465	24192	24382	27501	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	42759	33056	30218	24122	24171	23421	25435	
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%	59.00%	
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%	84.00%	
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%	6.00%	
NHS Professionals	% of Agency staff used CSW	0%	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:21/22-137

Board of Directors
Legacy Board Assurance Framework review
1st September 2021

Title:	Legacy Board Assurance Framework review
Responsible Director:	Chief Executive Officer
Author:	Molly Marcu, Interim Director of Corporate Affairs
Presented by:	Molly Marcu, Interim Director of Corporate Affairs

Executive Summary
Following the completion of the review of the legacy Board Assurance Framework (BAF), this report is presented to the Board for approval as part of the process of transitioning to the new BAF, which is presented to this Board meeting as a separate item on the agenda.

Recommendation:
The Board is asked to: • Note and approve the revisions to the BAF where deletions are proposed • Note and endorse the incorporation of revised legacy risks onto the 2021/22 BAF

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)
Weak arrangements for monitoring the delivery of strategy and associated risks expose the organisation to gaps in internal control, which may adversely impact on quality of care and reputation
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
The Foundation Trust Code of Governance places specific responsibilities on NHS Board to monitor delivery of strategy ,associated risks and corresponding mitigations
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Not applicable at this current stage
Specific communications and stakeholder /staff engagement implications

Not applicable		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Not applicable		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
not applicable		
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	This document has been previously shared with Divisional Directors, Executive Directors and Non- Executive Directors	
Background papers / supporting information	Not applicable	

1. Background

In November 2020, the Trust Board collectively agreed that a complete refresh of the Board Assurance Framework was required in order to ensure an alignment to the newly approved Trust Strategy.

A series of steps were then agreed at the June 2021 meeting of the Board, including a review of the relevance of risks on the legacy BAF.

As part of this review, it was agreed that risks that are either considered complete or deemed no longer relevant/ applicable (based on the new objectives/priorities) will be closed.

2. Legacy BAF review process

The legacy BAF risks were considered between late June and July 2021 by the Executive and Non-executive directors ahead of the August Board seminar session, where the new Board Assurance Framework risks were reviewed.

Any actions arising from these meetings (as well as the seminar) were incorporated into the version of the BAF that is submitted to the September Board meeting.

This process enabled a collective decision making process amongst Board members ahead of the submission of the legacy BAF to the September Board meeting.

The outcome of the detailed assessment of each risk previously incorporated within the legacy Board Assurance Framework (BAF) report is summarised in this report outlines the status and actions taken in relation to the risk, which are incorporated within this report in section 3 of this report .

The legacy BAF itself is incorporated as ***Appendix A.***

3. Outcome of BAF risks review

Table 1 below outlines the status of the risks previously incorporated on the legacy BAF. In summary, the majority of the legacy risks have been deleted or merged onto the new BAF as part of a new risk.

Legacy BAF risk ID	Risk title	Proposed action	Rationale	Actions taken
PR1 Demand that overwhelms capacity to deliver care effectively				
1.1	Exponential **growth in demand for care** caused by an ageing population (forecast annual increase in emergency demand of 4-5% per annum); -2% reduced social care funding and increased acuity leading to more admissions & longer length of stay	Merge risks 1.1, 1.2 and 1.3 into 2 onto the new BAF: One pertaining to scheduled care, and the other unscheduled care on the new BAF.	There are only 2 aspects of risks pertaining to excessive demand, and it is proposed that these should relate to scheduled and unscheduled care. The previous risks on GPs ageing population or neighbours are in effect gaps in controls that would increase or decrease the rating, and consequently the level of assurance available	New BAF updated accordingly, controls, action plans and assurances being populated and also shared with divisional directors and agreed with the Chief Executive Officer
1.2	Operational f**ailure of General Practice** to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort' Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH			
1.3	Operational **failure of neighbouring providers** that creates a large-scale shift in the flow of patients and referrals to WUTH			
PR2 Critical shortage of workforce capacity & capability				
2.1	There is a national shortage of registered nurses and in some specialities for other health care professionals including medical staffing. This is affected by the demographic factors, uncertain impact after Brexit and increased competition. The threat has been further exacerbated as a result of the current Covid-19 pandemic with increased demand on clinical	Risk 2.1 &2.2 should be replaced by the following: *Gaps in staffing resulting in an adverse impact on quality of care and a failure to meet regulatory standards* *Adverse Impact on quality and continuity of delivery of patient care due to a high level of sickness absence and reliance on temporary staffing.*	Both risks 2.1 and 2.2 are linked to staff shortages. This revised risk is more focussed on the source of the risk exposure; therefore the controls and action plans will also be directly related to the area.	Risks incorporated within the new BAF
2.2	Decrease in workforce productivity arising from reduced attendance and staff morale	Discussions with the Director of Workforce and other Board members confirmed that this risk can be blended with the gaps in staffing risk	This risk can be incorporated as a gap in control. KPIs associated with this gap would therefore provide positive or negative assurance	Incorporate within gaps in staffing risk as a gap in control

Legacy BAF risk ID	Risk title	Proposed action	Rationale	Actions taken
			depending on what the level of assurance is	
2.3	Workforce becomes deskilled due to increasing dependence on technology/ diminishing training budget and or inability to complete mandatory or role specific training	It is recommended that this risk as it's not a significant BAF risk	Mandatory training/compliance with training is not deemed an area of significant risk to be incorporated on the Board Assurance Framework	Risk has been deleted, and therefore not carried forward to the new BAF.
PR3: Failure to achieve and maintain financial sustainability				
3.1	Increased cost & income volatility as a result of tariff changes; deteriorating condition of clinical estate; dependency on temporary staffing; growth in competition from the private health sector; contract penalties/ fines leading to uneconomic services.	Risk deleted	The recommendation is made on the basis that the context and scope was too wide and vague	New BAF updated accordingly
3.2	Insufficient CIP delivered due to lack of internal capacity to identify and deliver recurrent savings; competing performance priorities; reliance on system-wide change; competing regulatory priorities or unexpected spend to address quality/ compliance issues.	Risk reviewed with Chief Financial Officer and consequently Board members, and proposed to be reworded to: *Failure to deliver sustainable cost improvements*	The focus of the risk has been refined to make it clearer on what the constraints are	
3.3	Growth in the burden of backlog maintenance and medical equipment replacement costs to unaffordable levels	Revise this risk to : *Adverse impact on delivery of clinical care and application of infection control measures due to the quality of the Trust's estate, and maintenance backlog*		
3.4	Increasing cost of clinical and civil liability insurance due to non-compliance with Health & Safety legislation; levels of harmful and indefensible care and increasingly litigious society	Transfer risk to corporate risk register from BAF	This is not a BAF level risk	Risk removed from the BAF
PR4 : Catastrophic failure in standards of safety and care				
4.1	An outbreak of infectious disease (such as pandemic Covid-19, influenza; norovirus; infections resistant to antibiotics, high legionella counts) that forces closure to one or more areas of	delete risk, amalgamate with business continuity risk	not applicable	Risk deleted

Legacy BAF risk ID	Risk title	Proposed action	Rationale	Actions taken
	the hospital and/or causes avoidable serious harm or death to service users			
4.2	A widespread **loss of organisational focus on patient safety and quality of care** leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction.	delete risk	This risk was created at a time when there was uncertainty due to Covid. This risk is no longer relevant to the Trust	Risk deleted
4.3	Adoption of **new technologies as a clinical or diagnostic aid** (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine; genomic medicine)	delete risk	This is not actually a risk in itself. The risk around technology should be : Risk of failure to implement transformational improvements as a result of digital enhancements	Risk deleted
PR5: A major disruptive event leading to rapid operational instability				
5.1	A large-scale **cyber-attack** that shuts down the IT network and severely limits the availability of essential information for a prolonged period	Amalgamate risks 5.1, 5.2 and 5.3. Revise risk to the following: *Risk of business continuity and the provision of clinical services due to a large scale cyber- attack, critical infrastructure supply chain failure therefore impacting on the quality of care*	the scope of the risks individually were previously too narrow, and therefore not a significant BAF risk	Incorporate within the BAF under the digital heading
5.2	A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period			
5.3	A critical supply chain failure (including the potential impact of Brexit on suppliers) that severely restricts the availability of essential goods, medicines or services for a prolonged period			
5.4	A pandemic disease outbreak that results in a temporary or prolonged disruption to the continuity	Revise this to :	Whilst the likelihood of a pandemic is high the focus of	Incorporated onto new BAF

Legacy BAF risk ID	Risk title	Proposed action	Rationale	Actions taken
	of core services across the Trust, which also impacts significantly on the local health service community	Prolonged disruption to the continuity of core services due to ineffective emergency preparedness arrangements in the event of a major disease outbreak	the risk should be on the impact	
Fundamental loss of stakeholder confidence				
6.1	Changing regulatory demands (including Covid-19) or reduced effectiveness of internal controls resulting in failure to make sufficient progress on agreed quality improvement actions; Or widespread instances of non-compliance with regulations and standards.	The recommended action was to delete this risk and merge it with the gap in staffing risk in PR2, linking it to regulatory compliance	This risk has a lot of legacy content which doesn't apply to the circumstances of the Trust any more. This risk has changed significantly over the past 12-18 months, with improved assurance from CQC reviews. Key regulators such as NHSI/E and the CQC sit on the System improvement Board where a decision was made to remove the Trust's Challenged Provider Status	Not applicable Risk deleted and merged with the gap in staffing risk on the new BAF
6.2	Failure to take account of shifts in **public & stakeholder expectations** resulting in unpopular decisions and widespread dissatisfaction with services with potential for sustained **publicity in local, national or social media** that has a long-term influence on public opinion of the Trust	Delete risk	This risk is based on legacy content which does not apply to the circumstances of the Trust at this point in time, particularly following the removal of 'challenged provider' status	Risk deleted

4. Recommendations

The Board is asked to:

- Note and approve the revisions to the BAF where deletions are proposed
- Note and endorse the incorporation of revised legacy risks onto the 2021/22 BAF

Board Assurance Framework (BAF): 2020/21

Appendix A

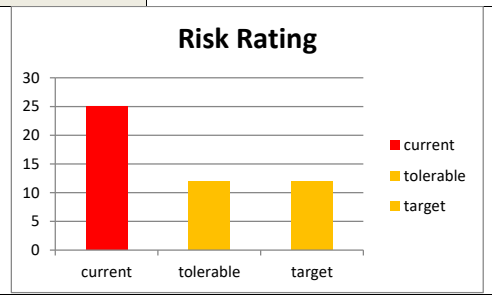
Board Assurance Framework – Quarter 3 2020/21

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

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

Board Assurance Framework (BAF): 2020/21

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



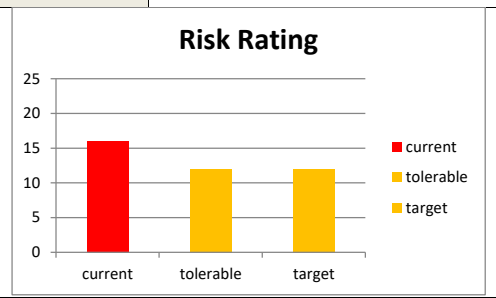
Strategic threat (what might cause this to happen)	Controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk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

Board Assurance Framework (BAF): 2020/21

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

Board Assurance Framework (BAF): 2020/21

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



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

Board Assurance Framework (BAF): 2020/21

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

Board Assurance Framework (BAF): 2020/21

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

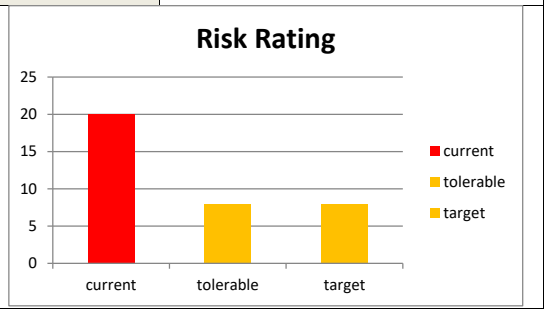
Board Assurance Framework (BAF): 2020/21

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

Board Assurance Framework (BAF): 2020/21

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

Strategic priority	**Continuous Improvement:** Maximise our potential to improve and deliver best value **Infrastructure:** improve our infrastructure and how we use it.

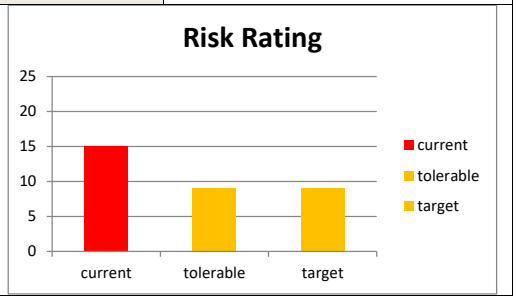


Risk course (what might cause this to happen)	Controls (controls/ systems/ processes **already** in place to assist in managing the risk & reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Plans to improve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

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

Board Assurance Framework (BAF): 2020/21

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



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

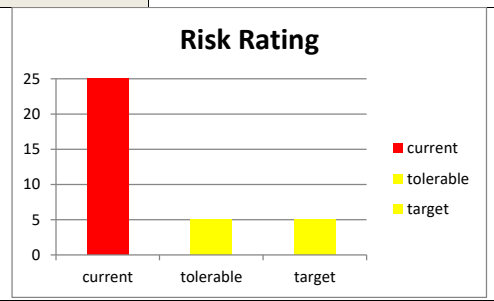
Board Assurance Framework (BAF): 2020/21

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

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

Board Assurance Framework (BAF): 2020/21

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



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

Board Assurance Framework (BAF): 2020/21

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

Board Assurance Framework (BAF): 2020/21

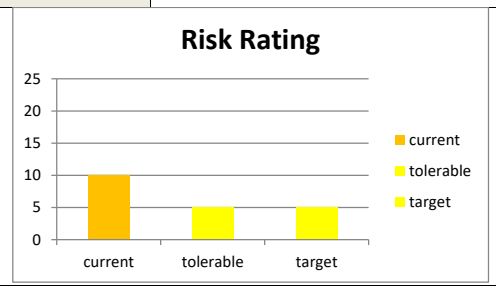
Risk cause (what might cause this to happen)	**Controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control**	**Plans to improve control** (are further controls possible in order to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

Board Assurance Framework (BAF): 2020/21

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

Board Assurance Framework (BAF): 2020/21

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



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

Board Assurance Framework (BAF): 2020/21

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

Agenda Item 21/22 - 138

Board of Directors' Meeting
2021/22 Board Assurance Framework
1st September 2021

Title:	2021/22 Board Assurance Framework
Responsible Director:	Chief Executive Officer
Author:	Molly Marcu, Interim Director of Corporate Affairs
Presented by:	Molly Marcu, Interim Director of Corporate Affairs

Executive Summary
The purpose of this report is to enable the Board to review, approve and adopt the attached 2021/22 Board Assurance Framework (BAF), which is also aligned with the 2021/26 Trust Strategy objectives. This report also incorporates recommendations for monitoring BAF risks at Board and Committee level, in line with the discussions held at the Board seminar in August 2021. This approach will then be set out in the draft Risk Management Strategy which will be submitted to the Board in October 2021.

Recommendation:
The Board is asked to: 1. Note, approve and adopt the revised BAF with effect from September 2021 2. Note and approve the process and frequency for monitoring the BAF at Board and Committee level 3. Note, approve and adopt the annual process aligned to refreshing the BAF

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)
Weak arrangements for monitoring the delivery of strategy and associated risks expose the organisation to gaps in internal control, which may adversely impact on quality of care and reputation

Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
The Foundation Trust Code of Governance places specific responsibilities on NHS Board to monitor delivery of strategy and associated risks		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
Not applicable at this current stage		
Specific communications and stakeholder /staff engagement implications		
Not applicable		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Not applicable		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
not applicable		
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	Not applicable	
Background papers / supporting information	Not applicable	

1. Background and Purpose

An effective Board Assurance Framework (BAF) will give the Board with a simple comprehensive tool for effective and focused management of principal risks to meeting its objectives.

It provides a structure for the evidence to support the Annual Governance Statement disclosure. This simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

The main aim of the BAF refresh is to provide the Board with a mechanism of identifying and assessing risks significant to the delivery of Trust strategy, whilst evaluating the effectiveness of controls, and monitoring the action plans.

The structure of the revised BAF (and associated report) is based on six key elements:

- Clearly defined principal objectives aligned to clear lines of responsibility and accountability.
- Clearly defined principal risks with an assessment of potential impact and likelihood.
- Key controls by which these risks can be managed.
- Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.
- BAF reports identifying that risks are being reasonably managed and objectives being met, together with gaps in assurances and gaps in risk control.
- Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

The purpose of this report is to enable the Board to review the refreshed BAF and if deemed appropriate, adopt its use with effect from September 2021.

2. Board Assurance Framework Refresh Process

The Board held a seminar workshop in August to consider the draft risks proposed by Executive Directors in their capacity as risk owners. A key focus of the workshop was to adopt the unitary board approach, with two non- executive directors leading the discussions of each group.

This enabled collective agreement amongst non- executive and executive board members about the risks deemed significant to the delivery of the Trust's strategic objectives.

In undertaking this review the Board also considered the output of the Risk appetite workshop in July which was facilitated by Merseyside Internal Audit.

Following the completion of the session, the BAF has been refined further to reflect the output of the Board seminar, and is attached as appendix A.

It is worth noting that this is the first version of the newly adopted BAF, and therefore the risks and controls will be updated over the next few months.

The format of the 2021/21 BAF report is based on best practice arising from publications such as the Audit Committee's Taking it On Trust Study and the Integrated Governance Handbook, most recently updated in 2016.

MIIA have reviewed the draft BAF and confirmed that it meets their assurance criteria.
BAF assurance reports to the Board will reflect:

- New risks added since the last meeting
- Changes in risk ratings
- Updates on delivery of action plans, at points in which they fall due
- Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.
- Triangulation with any other items on the agenda, such as performance reports
- Recommendations for remedial actions that require detailed board review

Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.

As part of the delivery of the risk management strategy, it is recommended that the Board will:

- Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda
- Assess and evaluate the appropriateness of risk tolerance levels and formally agree any amendments.
- Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions
- Review the BAF on a bi-monthly basis with effect from November 2021
- Delegate responsibility to each Committee to review the BAF at alternate times to the Board meeting, with effect from October 2021
- Receive assurance updates through the written Committee Chair reports, which will be modified accordingly to enable this level of reporting consistently

The format of the Committee Chair reports will be presented to the Board at the October meeting, alongside the draft Risk management strategy and risk appetite statement.
It is proposed that following the feedback from the Board's discussion, the BAF will be reviewed through the Committees meetings in October.
This will include a review of the controls, and action plans will inform the BAF update submitted to the Trust Board.

3. Annual BAF refresh process

In line with best practice, it is recommended that the BAF document should be refreshed annually in line with the Trust Strategy refresh process in a seminar, at the end of the financial year, prior to being formally adopted at the beginning of the next financial year.

4. Next Steps

The BAF is an evolving document that must also remain dynamic, whilst capturing risk of a strategic nature.

Next steps include a further review of risks and controls aligned against each strategic objective for completeness, ahead of the next presentation of the BAF in November. This will include an in-depth review of the Continuous improvement strategic objective.

5. Recommendations

The Board is asked to:

1. Note, approve and adopt the revised BAF with effect from September 2021
2. Note and approve the process and frequency for monitoring the BAF at Board and Committee level
3. Note and approve the recommended process for further refining the BAF, in advance of the next BAF update to the Board in November 2021
4. Note, approve and adopt the annual process aligned to refreshing the BAF

Board Assurance Framework

August 2021.

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score	Current Risk Score (CxL)	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
1. Strategic Objective: OUTSTANDING CARE - Provide the best care and support													
1.1	Chief Operating Officer	Quality Committee	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience	Implementation of emergency demand & patient flow management arrangements Winter capacity plan ED Streaming Defined escalation areas (act as flood plain) during periods of exceptional pressure Discharge procedures Use of admission avoidance schemes Use of SHOP model medical review Ambulatory & Day case care. Daily board rounds, recording of Criteria to Reside and discharge pathway	TMB and Operational Performance Committee oversight	None Identified	Diagnostics - delays in getting results leading to poor patient care and treatment. The Trust continues to not delivering the national 4 hour standard for ED performance.		20 (4x5)	16 (4x4)	12		
1.2	Chief Operating Officer	Operations &Performance Group and FHPA Committee	Failure to meet constitutional targets, resulting in an adverse impact on patient experience and quality of care	Clinical harm reviews, management of overdue follow-up appointments, implementation of clinical prioritisation process. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 post P2 Breach. Harm review process. Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually	Operational Delivery Group (Monthly) 'Operations and Performance Group oversight (Weekly) Divisional Access & performance Meetings (weekly) Theatre Resource Group & Theatre scheduling (weekly) Cancellation Avoidance Decision Group (Daily) Monthly Divisional Quality Board Divisional Performance Reviews	NHSI/E oversight of Trust improvement plan	Substantial challenges remain in delivering elective outpatient activity. There is a gap between capacity and demand in a number of specialties , which has widened since the pandemic	to be confirmed	16 (4x4)	16 (4x4)	12	to be confirmed	TBC
1.3	Chief Operating Officer	Operations &Performance Group and FHPA Committee	Failure to effectively manage volume of scheduled care demand, adversely impacting on quality of care and patient experience	Clinical harm reviews, management of overdue follow-up appointments, implementation of clinical prioritisation process. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 post P2 Breach. Harm review process. Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually	Operational Delivery Group (Monthly) 'Operations and Performance Group oversight (Weekly) Divisional Access & performance Meetings (weekly) Theatre Resource Group & Theatre scheduling (weekly) Cancellation Avoidance Decision Group (Daily) Monthly Divisional Quality Board Divisional Performance Reviews	NHSI/E oversight of Trust improvement plan	Substantial challenges remain in delivering elective outpatient activity. There is a gap between capacity and demand in a number of specialties , which has widened since the pandemic	None identified	16 (4x4)	16 (4x4)	12	to be confirmed	TBC

Board Assurance Framework

August 2021.

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance i.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score	Current Risk Score (CxL)	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
2. Strategic Objective:	**COMPASSIONATE WORKFORCE- Be a great place to work**												
2.1	Interim Director of Workforce	Workforce Assurance Committee	Failure to fill vacancies, resulting in an adverse impact on quality of care and a failure to meet regulatory standards, and a detrimental impact on staff wellbeing	Vacancy management and recruitment systems and processes workforce planning processes TRAC system for recruitment e-Rostering systems and procedures used to plan staff utilisation E-rostering and job planning to support staff deployment	Workforce Assurance Committee oversight	None Identified	National shortages in certain roles Full rollout of clinical job planning is pending	TBC	20 (4x5)	16 (4x4)	12	Monitor impact of retention and recruitment initiatives	Sep-21
2.2	Interim Director of Workforce	Workforce Assurance Committee	Failure to retain sufficient numbers of staff, adversely impacting on the Trust's ability to provide high quality patient care.	implementation of staff survey action plans training and development activity exit interview process	Workforce Steering Board Workforce Assurance Committee oversight	TBC	Availability of required capabilities and national shortage of staff in key Trust roles. Talent management and succession planning framework is yet to be implemented	Staff turnover rates	16 (4x4)	16 (4x4)	12	Agreement of workforce strategy and sign-off of associated action plan	Quarter 4 2021/22 period
2.3	Interim Director of Workforce	Workforce Assurance Committee	High level of sickness absence and long term detrimental impact on staff well-being, adversely impacting on the Trust's ability to provide high quality patient care.	Health and safety and wellbeing policies Staff Survey Action Plans which are heavily focused on Health, Wellbeing and Attendance. Delivery against the plans is monitored via the Divisional Performance Reviews	Workforce Steering Board Workforce Assurance Committee oversight	TBC	Availability of required capabilities and national shortage of staff in key Trust roles. Staff vacancies a significant risk.	Staff turnover rates	16 (4x4)	16 (4x4)	12	Implementation of People Plan elements pertaining t	on-going
2.4	Chief Executive Officer	Trust Board	Constraints in Board capacity and capability due to turnover, lack of succession planning and talent management	Implementation of Executive Director recruitment plan Executive Director and Board development plan Implementation of Board succession planning	Board approval of Board development plan	2021/22 Deloitte Well led review report and action plan	The Trust has licence condition undertakings pertaining to Board capability and capacity The Deloitte well led review action plan will be in place following the completion of the review in early November 2021	The Board leadership and turnover challenges are cross referenced in the Head of Internal Audit Opinion of 2020/21	16 (4x4)	16 (4x4)	12	Implementation of Deloitte well led review and Board	Sep-21
3. Strategic Objective: CONTINUOUS IMPROVEMENT - Maximise our potential to improve and deliver best value													
3.1	Chief Finance Officer	Finance and Performance Committee	Failure to deliver sustainable cost improvements	Implementation of Cost Improvement Programme	FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Board receive update on CIP as part of monthly finance reports.	CIP arrangements subject to periodic review by Internal Audit. Monthly CIP return subject to significant scrutiny by NHSEI	Limited capacity to identify savings within operational teams given ongoing pressures of service delivery.	Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change	16 (4x4)	16 (4x4)	8	Finalise estates strategy and agree priority programmes	Sep-21
3.2	Chief Finance Officer	Finance and Performance Committee	Failure to deliver the financial plan due to uncertainty around the future financial regime	Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime.	Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance.	External auditors undertake annual review of controls as part of audit of financial statements Annual internal audit plan includes regular review of budget monitoring arrangements.	Forecasting has proven inaccurate, historically, and further work needed to strengthen arrangements.	N/A	16 (4x4)	16 (4x4)	8	Finalise estates strategy and agree priority programmes	Sep-21
3.3	Chief Finance Officer and Director of Strategic Partnerships	Finance and Performance Committee	Limitations in accessing capital resources to support the delivery of the Trust's strategies, e.g. digital and estates	Implementation of capital programme Ongoing programme of external reviews of the estate the appointment of authorised engineers development and implementation of masterplans for Hospital plans Operational plan for the Digital Strategy Capital Management Group meets on monthly basis with representation from Operational teams, Estates and Finance.	Capital Committee oversight Authorised Engineers annual report	NHS England Premises assurance Model, ERIC database and benchmarking model for trend analysis	funding restrictions, 30% increase in costs for capital on capital schemes, restricted availability of materials	Diagnostic work is ongoing due to new management and lack of visibility of compliance	20 (4x5)	20 (4x5)	16 (4x4)	Finalise estates strategy and agree priority programmes	Sep-21

Board Assurance Framework

August 2021.

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score	Current Risk Score (CxL)	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
3.4	Director of Strategy and Partnerships	Transformation Board	Failure to deliver sustainable productivity gains due to an inability to embed service transformation	Programme Board oversight Service improvement team and Quality Improvement team resource and oversight Implementation of a programme management process and software to track delivery Quality impact assessment undertaken prior to projects being undertaken	Quarterly Board assurance reports Monthly Programme Board chaired by CEO to track progress	MIIA internal audit review of Cost Improvement Programmes, which highlighted an audit opinion of moderate assurance	Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff Historic estate infrastructure system working	TBC			8	Finalise estates strategy and agree priority programmes	Sep-21
4. Strategic Objective: OUR PARTNERS - Provide seamless care working with our partners													
4.1	Director of Strategy and Partnerships	Trust Board	Risk that ongoing uncertainty regarding the infrastructure of the Cheshire and Merseyside ICS causes material variability in strategic resourcing and planning, resulting in a change in strategic direction	WUTH senior leadership engagement in ICS through Director of Strategy and CEO. Wuth Strategic intentions are aligned with the ICS, for example ensure master plans and decisions are taken as a system to optimise the way we use public estate across Wirral to	CEO and Director of Strategy updates to Board and Executive Director meetings	ICS Chair updates, ICS meetings	Lack of clarity on ICS accountability and governance infrastructure	Significant change in leadership at ICS may require time	16 (4x4)	16 (4x4)	12 (3x4)	TBC	Sep-21
4.2	Director of Strategy and Partnerships	Trust Board	Uncertainty regarding risk sharing and accountability arrangements within Cheshire and Merseyside ICS, resulting in significant risk exposure for the Trust, outside of tolerance levels	ICS design framework ICS Body governance Input of Trust CEO and Director of Strategy into Outline of the ICP Structure	Monitoring of timeline to development of Target Operating Mo	TBC	Lack of clarity on ICS accountability and governance infrastructure	Formal Accountability infrastructure will not be in place till April 2022	20 (4x5)	16 (4x4)	12 (3x4)	TBC	Sep-21
5. Strategic Objective: DIGITAL FUTURE - Be a digital pioneer and centre for excellence													

Agenda Item: 21/22-140

BOARD OF DIRECTORS
1st September 2021

Title:	Workforce Assurance Committee Chair's Report
Author:	John Sullivan
Responsible Director:	Debs Smith
Presented by:	John Sullivan

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

This was the first full Workforce Assurance Committee meeting since March 2021. Throughout the interval Workforce priorities have remained largely constant. Namely, staffing in all its forms, organisation development, culture, communications and staff engagement. Workforce Directorate morale has been adversely impacted by the emergent issues of 2021 and there is now a need for consolidation, re energising and refocusing of the reorganised Workforce Directorate. The committee were reminded that the Workforce Directorate staff play a critical part in the delivery of the Trust's strategy and the care and treatment of patients. The committee reassured the Workforce Directorate that they have the continued support of the Trust Board in their development and delivery of the Workforce and Education Strategy.

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

See Purpose section below

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

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

Risks 2.1, 2.2, 2.3 and 2.4 from July 2021 BAF

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

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

Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Compliance with Disability Equality Standards and Race Equality Standards
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

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

BOARD OF DIRECTORS
1st September 2021

Workforce Assurance Committee Meeting held 12 August 2021 -- Chair's report

Purpose

To provide the Trust Board with assurance on Workforce matters including:

- Updated Disciplinary Policy that now includes recommendations from Improving People Practice
- Workforce performance KPIs and Organisation Development progress
- Workforce Planning
- Volunteer strategy implementation
- Freedom to Speak Up Annual Report -- to be received at Trust Board
- Guardian of Safe Working Quarterly Report -- to be received at Trust Board
- Communications and Engagement
- Trade Union Facilities Time reporting

Introduction / Background

The first Workforce Assurance Committee full meeting since March 2021.

Conclusions

- The Workforce and Education Strategy update will provide the direction of travel for the Trust's Workforce and the Workforce Directorate.
- Workforce Assurance terms of reference and cycle of business are to be reviewed and reissued.
- The Trust will seek to integrate the NHS National, Regional and local (Cheshire & Mersey) People Plans into one coherent Workforce and Education Strategy.
- The NHSE North West Attendance Deep Dive initiative continues to be a priority within the Workforce Directorate
- The NHSE North West Managing Attendance Pilot continues and will be complete by 31 October 2021.
- Workforce planning is a key component of the Workforce Directorate reorganisation.
- Workforce risks in the Board Assurance Framework are in the process of being updated.

Recommendations to the Board

Continue to support the implementation of the reorganisation of the Workforce Directorate.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-141

Board of Directors
01 September 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 and August to 2021, 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.

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.

Trust Public Board
1 SEPTMBER 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 and media

- We produced a press release when the new upgraded High Dependency Unit (HDU) at our Arrowe Park Hospital opened on 9th August. The HDU cares for patients who have been stepped down from intensive care, but who require more extensive care than in a ward area. Following a 12-week refurbishment, the new HDU will provide enhanced care for patients. The facility includes six specialist side rooms, enhanced infection prevention and control measures as well as a new ventilation system allowing even better care, especially catering for the needs of patients with COVID-19. We highlighted the innovation in design and staff engagement as the project was designed utilising 3d design software and engagement with the HDU staff was delivered via virtual reality. This enabled the HDU team to submerge themselves into their new facility, in advance of completion; and provide key feedback to the design team. The press release was covered in the Echo and The Globe.

- There was further coverage and communications from the CCG (Stop the abuse/assault of NHS staff - Wirral CCG) as 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. At WUTH, we've also highlighted the actions we've taken (including successful prosecutions and custodial sentences) in a zero tolerance approach to violence against our staff, especially in the Emergency Department.

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- A localised version of the national RSV press release was drafted to include a comment from our Medical Director and Respiratory Consultant, Dr Nikki Stevenson and this was picked up by Liverpool Echo, Birkenhead News and The Wirral Globe. Dr Stevenson was also interviewed for Radio City and Capital Radio, and featured in their news bulletins on Wednesday 11 August. She was also interviewed by BBC Radio Merseyside for the live Breakfast show on 13th August. The RSV campaign seeks to inform parents about the symptoms and treatments for this common virus in children.

- As a Trust we have been supporting NHS England in encouraging pregnant women to have the COVID-19 vaccination. Consultant Midwife, Angela Kerrigan, who is based at Wirral Women and Children's Hospital was interviewed by BBC North West Tonight and Granada offering advice to pregnant women who may be reluctant to have the vaccine. This was also covered in The Wirral Globe Angela has also been doing regular live questions and answer sessions on Facebook to offer advice and information to pregnant women.

- The Trust along with others in England has seen an increase in pregnant women with COVID-19, who had not been vaccinated, being admitted to hospital. Angela Kerrigan has also been filmed for NHS regional materials on vaccination for pregnant women, which will launch w/c 23rd August.

- World Patient Safety Day takes place on 17th September World Patient Safety Day 2021 (who.int) with a theme of safe maternal and new born care. We are working with Women and Children's to develop campaign materials for this event featuring our Maternity Safety Champion and Non Exec Director Dr Steve Ryan, further encouragement for women to have the vaccine and promoting a range of other maternity and neonatal safety initiatives.

- We supported our Procurement Team with a video for their entry, which 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. Please see more information about the awards **here**.

- The work of the Communications Team and IPC with our 'Keep it SIMPLE' campaign has been shortlisted for a Forward Communications award by the publication 'Leading Healthcare'. The 'Keep it SIMPLE' infection prevention control campaign from WUTH has also received further national praise when the publication **National Health Executive July / August 2021** featured interviews with Chief Nurse and Director of Infection Prevention and Control, Hazel Richards and Jay Turner Gardener - Associate Director of Nursing for Infection Prevention & Control outlining the success of the messaging and behaviour changes. The 'Keep it SIMPLE' approach was singled out by the CQC as an example of outstanding practice at WUTH

when they did an IPC focussed inspection earlier this year.

- The return of BBC's BAFTA award winning 'Ambulance' has also resulted in some broadcast coverage for Arrowe Park Hospital as the series was filmed during winter 2021 when the hospital saw significant numbers of COVID-19 patients and pressures in the Emergency Department.

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 the Government's new guidance on August 16th on self-isolation changes generally and how healthcare professionals could return to work if double-vaccinated and taking regular tests.
- We are preparing to communicate the annual NHS Staff Survey, which will start in late September.
- We produced adverts to recruit Band 5 nurses locally and also in support of our drive to recruit new governors for the Trust.

WUTH Charity

The team continues to plan future events and deliver some activity safely and in line with restrictions.

- The first event for the Mayor's Charity, where WUTH charity is a beneficiary, 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 have been released.

- 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

- Charity Golf Day – 15th September 2021- 10 teams have confirmed there attendance with more 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 supported WUTH Charity again with a charity car wash. The Mayor brought his car to be washed, but the event was 'washed out' by torrential rain, so a further date has been scheduled for September. All proceeds will be shared between the Fire fighters Foundation and the Tiny Stars Neonatal Appeal.

Stakeholders

- 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 met with system partners in a workshop facilitated by the CCG to look at how, as a system, we can signpost the right pathways for patients to access services, although all parts of the system are reporting higher demand, greater acuity and delayed patient presentations. We are working with the CCG to produce a letter to households in the Borough, along with our other campaign materials, explaining treatment options for patients.

Conclusions:

The Board of Directors is asked to note the report

Recommendations to the Board

None