Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

25 July 2018

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25 JULY 2018

COMMENCING AT 9AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

Foundation Y1 Doctors – Meet with Execs/Non-Exec Directors
****Board to meet with Foundation Doctors at 12 Noon****

AGENDA

1	**Apologies for Absence** Chair	v
2	**Declarations of Interest** Chair	v
3	**Chair's Business** Chair	v
4	**Key Strategic Issues** Chair	v
5	**Board of Directors**	
	5.1 Minutes of the Previous Meeting – 27 June 2018	d
	5.1.2 Board Action Log Chair	d
6	**Chief Executive's Report** Chief Executive	d

7. Quality and Safety

7.1	**Patient Story** Head of Patient Experience	v
7.2	**Mortality Dashboard & Report** Interim Medical Director	d
7.3	**Infection Prevention & Control Progress Report** Director of Nursing & Midwifery	d

8. Performance & Improvement

8.1	**Integrated Performance Report**	
	8.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	8.1.2 Wirral A&E Delivery Board Exception Report Chief Operating Officer	v
	8.1.3 Month 3 Finance Report Director of Finance	d

8.2	**Wirral Acting as One** Director of Finance	p

9. Workforce

9.1	**Bi-Monthly Nurse Staffing Report** Director of Nursing & Midwifery	d
9.2	**Nursing Midwifery & AHP Workforce Strategy Update** Interim Director of Workforce	d

10. Governance

10.1	**Report of Workforce Assurance Committee** Chair of Workforce Assurance Committee	d
10.2	**Report of Quality & Safety Committee** Chair of Quality & Safety Committee	v
10.3	**Safeguarding Annual Report** Director of Nursing & Midwifery	d
10.4	**CQC Inspection Report** Director of Governance & Quality	d
10.5	**Board Assurance Framework** Director of Governance & Quality	d
10.6	**Business Case to replace Magnetic Resonance Imaging Scanner** Director of Finance	d

11. Standing Items

11.1	**Items for BAF/Risk Register** Chair	v
11.2	**Items to be considered by Assurance Committees** Chair	v
11.3	**Any Other Business** Chair	v
11.4	**Date and Time of Next Meeting** Wednesday 26 September 2018	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

27 JUNE 2018

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
David Jago	Director of Finance
Gaynor Westray	Director of Nursing and Midwifery
Dr Mark Lipton	Interim Medical Director
Graham Hollick	Non-Executive Director
Sue Lorimer	Non-Executive Director
John Coakley	Non-Executive Director
John Sullivan	Non-Executive Director
Chris Clarkson	Non-Executive Director

In attendance

Helen Marks	Interim Director of Workforce
Anthony Middleton	Director of Operations and Performance
Paul Charnley	Director of IT and Information
Karen Johnstone	Senior Corporate Assistant (Minutes)

Apologies

Jayne Coulson	Non-Executive Director

Reference	Minute	Action
BM 18-19/049	**Apologies for Absence** Noted as above.	
BM 18-19/050	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/051	**Chair's Business** The Chair welcomed all to the meeting in particular, Janelle Holmes, in her new role as Chief Executive and Christopher Clarkson as newly appointed Non-Executive Director. The Chair also thanked David Jago for his contribution as Acting Chief Executive for the past six months. The Chair advised that he had recently met with the Chair of Wirral Community NHS Foundation Trust to discuss health and social care system in Wirral. The Chair reported that he had recently attended a meeting with all the Chairs across the Healthy Wirral Economy to discuss an integrated approach to services. The Chair advised that Wirral has a number of health and social care workstreams and it is planned to prioritise the workstreams.	

Reference	Minute	Action
	CQC Report The Chair advised the Board that the Trust had received the draft CQC report. The Executive Directors were in the process of reviewing the report for factual accuracy and the amended report would be submitted by the 4 July 2018 deadline. While the CQC rating of 'Requires Improvement' was in line with our expectations, it was particularly pleasing that the good care given by staff had been recognised and also significant improvements in End of Life Care and Maternity services. It was reported that NHSi had also been advised of the draft CQC report. The Chair advised that a letter had been received from the CQC which highlighted a number of issues in relation to Fit and Proper Person Declaration. This has now been rectified and the Director of Workforce has written to the CQC addressing each of the issues detailed within the letter. In order to support the ongoing collaboration the Chair reported that he had recently met with representatives from Primary Care Wirral. The Board agreed that the Divisions should be invited to attend Board of Directors meetings on a rotational basis to open the lines of communication and engagement to discuss issues within the Division. In order to ensure that the Governors are more engaged with the Board a joint Governor and Board Workshop was arranged for 11 July 2018. The purpose of this workshop was to promote more effective working relationships between Executives, Non-Executives and Governors.	**HM**
BM 18-19/052	**Key Strategic Issues** Those members present apprised the Board of key strategic issues and objectives being undertaken and concurrently progressed. **Director of Finance** The Director of Finance felt there is a risk around the financial plan and highlighted that it essential that the Trust ensures that it delivers against the NHSi Plan. It was also highlighted that the Trust may be scrutinised by NHSi in relation to loans. A discussion took place in relation to a Financial Strategy and it was agreed that the Director of Finance would develop a Financial objectives for 2018/19 including use of SLR for discussion at the Board Strategy away day in July 2018. **Interim Medical Director** It was reported that the younger medics within the organisation have expressed an interest to be involved and contribute towards the recovery and transformation work.	**DJ**

Reference	Minute	Action
	The Chief Executive advised that discussions had taken place with Associate Medical Directors who are also keen to be involved and progress the transformation work. A discussion took place regarding the format of the Medical Board and the need to engage with the senior consultant body within the Trust was highlighted. A discussion took place in relation to engagement and communication with local MPs and the Chair reported that he would be meeting with a number of local MPs. The Chief Executive advised that she would be attending the Local Authority Overview and Scrutiny Committee on 27 June 2017. The Director of Operations highlighted the recent and successful Acute Medical Unit (AMU) week. It was reported that there seems to be an appetite for change from an operational point of view. The Chair reported that a strategic Board Away Day is to be arranged and the Governors are to be invited to attend. Following the Board Away Day a half day away day to be arranged with the Board and Consultants to socialise the Vision and Strategy outside of the Medical Board. The Medical Director shared his own patient story after a recent operation and reported that patients' biggest fear is of having their operation cancelled on the day of the operation. The Medical Director attended a positive meeting recently in which research collaboration across Wirral and West Cheshire was discussed. The University of Chester has expressed an interest to be involved in research collaboration. The Chair highlighted that Life Sciences at Liverpool University were investing in research and have also expressed an interest to collaborate with the Trust. The Director of Workforce and Interim Medical Director to progress in order to maximise potential. The Medical Director fed back from a recent Healthy Wirral Partners Lock In session regarding progress of projects and re-admissions audit with the Wirral Clinical Commissioning Group. **Director of Nursing** The Director of Nursing and Midwifery advised that she had recently met with the Director of Governance and Quality to discuss planned engagement sessions with the Clinical Divisions. An End of Life Care meeting held recently with the Director of Quality and Patient Safety at Wirral Community Trust to discuss a hospital team working in partnership with the community based team. This has been agreed in	**ML**

Reference	Minute	Action
	principle, capacity and demand at WUTH is being reviewed to ensure correct levels of staff being TUPEd across. A meeting is also planned with the Director of Nursing and Quality at Wirral Clinical Commissioning Group to present the proposal. Following on from the successful visit which took place in 2016 with Mr Rebello, Her Majesty's Senior Coroner for the Liverpool and Wirral Area, and the Q & A session that he delivered, the Director of Nursing and Midwifery has invited both Mr Rebello and Mrs Bhardwaj, Area Coroner, to visit the Trust. The visit has been arranged for 6 November 2018 and Mr Rebello will be visiting the Bereavement Services Office and Mortuary. Mr Rebello has also agreed to deliver a further Q & A session with clinical staff in the Lecture Theatre. The Seacombe Birth Centre – Highfield Team Midwives were awarded an Achievement Award on 26 June 2018 at Northern Maternity and Midwifery Festival. Example of staff going the extra mile: To tackle the recent heatwave Ward 37/38 bought ice creams and ice lollies or patients, visitors and staff. **Director of Workforce** The Director of Workforce gave an update on the twelve month "Top Leaders" programme consisting of Leadership Masterclass lectures delivered by external speakers to further develop the Trust's talent pipeline. The Director of Workforce advised that an expression of interest has been submitted to the Northwest Leadership Academy for the "Shadow the Board" programme to support the shaping of future Board members and leaders. **Director of IT and Information** The Director of IT and Information reported that a working group representing each Division had been established and is meeting on a weekly basis to address and prioritise issues related to Cerner Millennium. It is intended that further governance arrangements will be created for a wider user group in conjunction with any future governance plans to be agreed with the newly appointed Director of Quality and Governance. It was reported that work is progressing with the Countess of Chester in relation to a joint partnership agreement, the COCH Electronic Patient Record Programme Board has had two meetings with representatives from WUTH and further COCH members will be joining our Programme Board. Engagement, demonstration and training events are taking place and a detailed plan is being drawn up. **Chief Operating Officer** The Chief Operating Officer advised that a meeting had been arranged to scope the requirements of engaging an independent provider to manage a Discharge Unit on the Clatterbridge site.	

Reference	Minute	Action
	Discussions have also taken place regarding modifications to the hospital bed base to include an emphasis on more frailty beds particularly during the winter period. Following a review of the Fix it Office it was reported that the majority of the calls were Estates related in nature. The review highlighted a number of issues in relation to processes and timescales which are to be addressed by the Associate Director of Estates.	
BM 18-19/053	**Board of Directors** **5.1 Minutes of the Previous Meeting – 25 May 2018** The minutes of the previous Board of Directors meeting held on 25 May 2018 were approved as an accurate record. **5.1 Minutes of the Previous Meeting – 30 May 2018** The minutes of the previous Board of Directors meeting held on 30 May 2018 were approved as an accurate record. **5.1.2 Board Action Log** The Board agreed the Action Log. The Chair provided an update in relation to action point 9. It was reported that NHSi have advised that given the challenges there is no intent to revise the financial control total for 2018/19 of a surplus of £11 million; the Trust will be unable to access the Provider Sustainability Fund of £12.5 million. The importance of ensuring that the Regulators understand that the Trust would be unable to turnaround the financial deficit in the timescale required was highlighted. The Board queried whether there was a risk of non-delivery. It was reported that the Trust would need to deliver the plan given the level of deficit etc and past non delivery. Penalties levied as part of a MoU agreed in April will be reinvested back into WUTH.	
BM 18-19/054	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following key areas: **National Pay Award** The three year pay award deal covering 2018 – 2021 has been confirmed. The pay award will be actioned in July 2018 and backdated from 1 April 2018. It was confirmed that there would be funding linked to this, but there are no further details at present. **NHSi and NHSe** The Trust has received a joint letter from Ian Dalton (NHSi) and Simon Stevens (NHSe) highlighting the intention to establish integrated working arrangements with effect from September 2018.	

Reference	Minute	Action
	National Funding Settlement The Prime Minister has set out proposals for a long-term NHS funding settlement of an extra £20.5 billion – an average annual rise of 3.4% above inflation which would equate to approximately £12 million for the Trust. Awaiting further details. **Musculo Skeletal (MSK) Integrated Service** The MSK contract has been award to the Trust on a five year prime(3+2) provider basis. This is a new service for the health economy and the model will need to be shaped based on demand and patient flows. Redesign work will be undertaken with GPs and the Community Trust. **Wirral System Acting as One** At a recent "Lock In" Session in June 2018 a number of key areas were discussed such as a system sustainability plan with six primary schemes being planned. The Trust agreed that it would be involved with the Urgent Care, Frailty and Women and Children workstreams. It was agreed that the Director of IT and Information would be included from a GDE perspective. **CEA Awards** NHS Employers and the British Medical Association have agreed changes to the clinical excellence awards (LCEA) scheme. Local variations to the LCEA scheme or new performance pay schemes have been introduced by the employer in consultation with staff. Further performance payments will continue to be non-pensionable and time-limited for between one and three years. They will continue to be paid annually by lump sum and will not include uplift for those undertaking Additional Programme Activities. **Leadership Masterclasses** Initial feedback has been positive, a formal review will be undertaken and feedback provided. **Treat Me Well** Working in partnership with Cheshire and Wirral Partnership Trust, Wirral Community Trust and Mencap the Trust hosted the launch of "Treat Me Well" campaign on 19 June 2018. It was well attended by staff, partners and service users with a commitment to ensure patients with learning disabilities have the required reasonable adjustments in place when they attend the hospital. **AMU Awareness Event** Nursing and Medical staff from AMU promoted the service as part of National Acute Medicine Awareness Week on 21 June 2018 with displays at the main entrance and a bake off / cake sale with proceeds being split between WUTH Charity and Sepsis Awareness Charity. It is planned to refurbish the relative's room on the unit. **NHS 70th Birthday Celebrations – 5 July 2018** A number of staff will be taking part in a special breakfast show feature on BBC Radio Merseyside to mark NHS 70th Birthday celebrations.	

Reference	Minute	Action
	The Trust also recently welcomed a major TV production crew at Clatterbridge Hospital. This production will be screened on BBC later this year. It was reported that plans are in place to support the Board in improving the quality of the Board agenda and the Board Assurance Framework.	
BM 18-19/055	**Patient Story** John Molyneux, Deputy Head of Patient Experience, and Dr Catherine Hayle, Consultant in Palliative Care, joined the meeting with the daughters of a patient who sadly passed away from secondary breast cancer which had spread to her lungs and bones to highlight to the Board how important news was communicated regarding their mother and the effect that it had on their mother and their family. The daughters explained that their mother was advised by a doctor that there was a tumour in her lung. Their mother never wanted to know about her prognosis and left the room when the doctor tried to explain advising that her daughters could hear the news. Their mother wrote a letter to the hospital advising that she did not wish to know the prognosis and the doctors at Clatterbridge respected and adhered to their mother's wishes. Their mother was admitted to Arrowe Park Hospital by ambulance and the doctors in the Emergency Department were amazing. The daughters stayed for eleven days and nights, sleeping on the floor and did their best to ensure that the new doctors and nurses did not convey their mother's diagnosis to her. However, one doctor approached their mother's bedside during a brief period when she was on her own and told their mother of her diagnosis despite their mother asking the doctor to stop and wait for her daughters. The daughters felt that as a consequence of the doctor's actions their mother became mentally unstable and was afraid of being left on her own. Their mother died three weeks later. The daughters reported that the doctor had written a letter of apology advising that she was unaware although there were references in their mother's notes. The Chair conveyed his sincere apologies and thanked the daughters for relaying the story the Board with such dignity and advised that it is powerful to hear from patients or relatives direct. The Palliative Care consultant advised that in reach work is ongoing and doctors are supported by individualised communication training. The Board queried the reason why the doctor concerned was no longer employed by the Trust. The Director of IT and Information highlighted that there is a lack of integration with Cerner Millennium and the system in place at Clatterbridge Cancer Centre and that the original letter would have been stored within the Clatterbridge Cancer Centre notes.	

Reference	Minute	Action
BM 18-19/056	**Integrated Performance Report** **8.1.1 Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the Integrated Dashboard and Exception Reports and highlighted the following key areas: **A & E 4 Hour Standard** The A & E 4 hour standard for May 2018 was 83.51% on the Arrowe Park site including the All Day Health Centre. This is an improvement from the April 2018 position and better than the planned trajectory. Due to the planning submissions to NHS Improvement for 2018-19, the Trust has received revised guidance requesting a re-profiling of the A & E trajectory for the Arrowe Park site element to reflect a better than expected performance in the early part of the year and the likelihood of a deteriorating position in the winter months. It was confirmed that the Trust had over performed in April and May 2018 which could increase the target already achieved and allow for a dip in trajectory in Quarter 4. It was confirmed that this would still be a challenge, NHSE would be monitoring the Economy and discuss performance with A&E Delivery Board. It was reported that there is a focus on ambulance handovers and it is expected that figures will improve this month. Additional nursing had been deployed to support to A & E outside of the A & E footprint. It was highlighted that the Team has recently visited Whiston hospital which has the best improvement in ambulance turnaround over the last twelve months. There are also plans to revise the assessment criteria for care homes so that the care homes are contractually bound by the Trust's assessment and system agreement re "Trusted Assessor" as presently the Trust undertakes an assessment and also the care homes who may have a different view to that of the hospital. It was reported that there are plans to increase the assessment bed base for frailty patients. **RTT Trajectory** There is a national focus for elective care with an objective that the patient waiting list should not increase in March 2019 from that level reported in March 2018. The RTT measurement improved for May 2018 at 74.58% although this remains below the target of 92%. The Trust has agreed on a local basis to aim for 80% RTT compliance by March 2019 and no 52 week waiters **Cancer Waiting Times** The management of individual patient pathways and validation of waiting times is continuing, though there are difficulties across the country in reporting performance from the new national cancer times system, it is expected that the standard will be achieved for Quarter 1. There had been concerns in relation to Cancer Two Week Wait which have now been resolved.	

Reference	Minute	Action
	It was reported that the graphical dashboard now incorporates tumour analysis for the 62 day standard as there were a number of areas where the Trust failed to achieve in respect of colorectal cancer. This was shared with the National Cancer Team in May 2018. A meeting has been arranged with the Cancer Network to discuss further. A discussion took place in respect of robot usage in Gynaecology and Urology specialties. The Chief Operating Officer advised that he is liaising with Divisions on an appropriate split in usage. A discussion took place regarding theatre utilisation and it was advised that there are a number of issues in theatre which will be addressed. It had been agreed to source additional resources to support surgery. The Chief Operating Officer highlighted that there will be focus this year on surgery. It was agreed to consider asking Divisional leadership teams to attend Board throughout the year ideally to discuss current projects and clinical strategy. **Infection Prevention and Control** The Director of Nursing and Midwifery provided a verbal Infection Prevention and Control report. C *difficile* threshold for the 2018/19 is 28 cases. At the end of May 2018 there were four confirmed avoidable C *difficile* cases, with one case awaiting post infection reviews. The post infection reviews showed an improvement with medical engagement, resulting in a more timely process. One MRSA reported in April 2018 has been assigned to the Wirral Clinical Commissioning Group following a post infection review. E.coli threshold for the 2018/19 is 42 cases, this being a 10% reduction on the previous year. At the end of May 2018 there were six E Coli cases. The Trust is working in collaboration with Wirral Clinical Commissioning Group, Public Health England and Wirral Community Foundation Trust to support this improvement plan. It was reported that E.coli is to be a new element within the Integrated Quality Dashboard. The Board queried the lessons learnt in relation to C *difficile* and were advised of the plan to review the Infection Prevention and Control service including the use of HPV and UV light technology. Themes from post infection reviews have been identified as being environmental concerns specifically in relation to effective cleaning from both nursing and facilities staff. It was agreed that a monthly Infection Prevention and Control Progress report under the Quality and Safety section would be provided to future Board meetings. The Board queried that despite the Trust's existing plans and improvement the Trust will only achieve c85% of the A & E Four Hour Standard. It was reported that WUTH in isolation is unlikely to achieve 95% by March 2019 unless radical steps are put in place such as a Step Down Ward. It was highlighted that leadership teams are committed to recovery plans. **8.1.2 Wirral A & E Delivery Board Exception Report** The Chief Operating Officer presented the Wirral A & E Delivery Board Exception verbal report and highlighted the following key areas:	

Reference	Minute	Action
	It was reported that there is both a Regulatory and National focus on early planning for winter 2018/19. The Acting Chief Executive attended a meeting with Regulators to review the learning from last year. There is a focus on bed occupancy rates and historically the Trust has run with high occupancy rates and it is planned to reduce the bed occupancy rates to 92% to allow for flexibility in capacity. It was highlighted that the Economy should be planning for 92% as one of the short comings has been that there is not enough acute capacity. It was highlighted that there had been a number of minor patients that had breached and it was explained that the Trust had classified minors as walk-ins. There is now a daily 10.00 am report advising of minors numbers in the Emergency Department. An explanation was provided in relation to stranded patients who are in-patients over 7 days and super stranded patients who are in-patients over 21 days. It was reported that based on expectations and demand and to mitigate the impact on existing resources the Trust would need an additional 48 beds. It was highlighted that the Divisions would be engaged in the design and development of the Wirral Plan. In conjunction with this the Transformation Team is undertaking a piece of work. It was reported that there has been a national focus to bring winter plans forward this year and a meeting has been arranged with partners from the Economy to discuss the Winter Plan as the deadline for submission of the final Winter Plan is 28 June 2018. It was highlighted that the Economy wide model would be taken on board regionally. The Board queried whether the Trust would be paid at marginal rate. The Chief Operating Officer advised that the Trust would expect full renumeration of costs. It was agreed that the Winter Plan Update would be agenda item at the July 2018 Board of Directors meeting. **8.1.3 RTT Update** The Chief Operating Officer presented the RTT Update report and highlighted the following: The Trust had been routinely reporting compliance with the 92% RTT target for a number of years. Team was instructed to undertake a deep dive and the results indicated that the data quality was inadequate. The Team engaged with the National Intensive Support Team to provide support and guidance. A governance structure has been put in place with programme groups reporting through to a RTT Strategic Group chaired by the Chief Operating Officer. Prior to the identification of issues the Trust was reporting RTT performance in excess of the 92% standard, but once the data cleansing was complete it was clear the position was closer to 80%. A robust patient harm review process has been put in place for any patient	**AM**

Reference	Minute	Action
	whose pathway exceeds 52 weeks at time of treatment. The results indicate that patients are falling into two categories of either no harm or low harm. Following discussions with Commissioners, it has been agreed that one of the contractual objectives for this year would be an RTT position of 80% by March 2019. The Intensive Support Team have recognised the excellent progress in the embedded systems and the data quality validation and have advised that future monitoring will no longer be necessary from August 2018. A discussion took place in relation to plans for delivery of the 92% RTT standard going forwards. It is anticipated that there will be discussions taking place between NHSi and NHSe with the regulators coming together early September which will inform future planning guidance. **8.1.4 Month 2 Finance Report** The Director of Finance presented the M2 Finance Report and the following key areas were highlighted: The Board were apprised that at the end of May 2018 the Trust was reporting an actual deficit of £6.6 million against a plan of £6.2 million an adverse to plan performance of £0.40 million. This is after the utilisation of £0.9m non recurrent resource. The Trust's financial position is attributed to a clear correlation of income and performance which is related to Division of Surgery with elective income £1.6 million below plan. Substantive workforce costs are £2.6 million under plan offset by £1.6 million bank costs and £0.6 million agency spend. There needs to be a focus on long standing agency usage around consultants, out patients and theatres. Cash balances at the end of May 2018 exceeded plan by £3.8 million at £7.5 million reflecting above plan brought forward balances. Capital expenditure at £0.6 million is in line with plan. The Trust has submitted a plan to NHS Improvement which delivers a deficit of £25 million which includes a Cost Improvement Programme of £11 million. The Board expressed concern in respect of elective surgery being off plan and the non-achievement of Quarter 1. The Board also expressed concern in relation to the above plan deficit and the adverse performance to plan. The Board discussed the challenges affecting the financial position in particular the Surgical Division. The Transformation Team are currently undertaking a Rapid Improvement Event in Theatres. The Team spent a week at Clatterbridge Hospital and a week at Arrowe Park Hospital reviewing the processes in Theatres in order to understand delays in the system.	

Reference	Minute	Action
	It was agreed that the Division of Surgery and their leads would be invited to attend a meeting with Executive Directors and Non-Executive Directors to discuss issues in relation to elective surgery.	**AM**
BM 18-19/058	**Report of Finance Business Performance Assurance Committee** The Chair of the Finance Business Performance Assurance Committee presented the report and highlighted the following key areas: • Disappointing start to the year with a £6.6 million deficit against a plan of £6.2 million • The Committee received a presentation on the income and expenditure position of each service for 2017/18. The Committee were assured of service line reporting and that there is an agreement across the organisation to develop and engage • The Associate Director of Estates presented an action plan to the Trust's findings against the Naylor report. The Committee were advised that a draft Wirral Estates Strategy had been submitted to the Cheshire and Merseyside Estates Programme Management Board without prior review or agreement of the Finance Business Performance Assurance Committee or Board of Directors. The Committee felt that the strategy was fragmented and out of the line of vision and requested regular actions plans in order to monitor progress.	
BM 18-19/059	**Service Transformation Team Programme Update** The External Programme Assurance Manager presented the Service Transformation Team Programme Update and highlighted the following key areas: The External Programme Assurance Manager confirmed that he has been working with the Transformation Team one day a week supporting the Team with their vision, framework and change management process to become more patient focussed. The draft Transformation plans are to be submitted to the Transformation Steering Group on 18 July 2018 for agreement. The Service Transformation Team have identified domains that would be required for assurance purposes and Team plan to develop a dashboard to include leading indicators, situation reporting, plans and milestones, lagging indicators and benefits realised. The Board queried how issues, problems and blockers in the system would be resolved. It was explained that there would be an Executive Lead and Sponsor for each workstream with support provided from the Transformation Team. If issues were unable to be resolved the Executive Lead would escalate to the Programme Board. It was reported that the Team are developing documentation and a communications plan to convey key messages to promote engagement.	

Reference	Minute	Action
	It was also reported that the Team plan to offer training for staff and to develop the service and an assurance framework. It was highlighted that it would take six to nine months to fully embed the new process. The Board queried how this work would link in with the work being undertaken by the Director of Governance and Quality Improvement. It was confirmed that the Director of Governance and Quality Improvement would be responsible for implementing governance arrangements which would be a separate piece of work.	
BM 18-19/060	**Items for BAF/Risk Register** The Board raised the risk of: • Surgery • Estates • RTT It was agreed to discuss further outside of the meeting. The Board were advised that the BAF / Risk Register would be reviewed by the Director of Governance and Quality.	**PM**
BM 18-19/061	**Items to be considered by Assurance Committees** The Board requested that Infection Prevention and Control be considered by Assurance Committees.	
BM 18-19/062	**Any Other Business** There was no other business.	
BM 18-19/063	**Date and Time of Next Meeting** The next Board of Directors meeting will be held on Wednesday 25 July 2018 at 9.00 am in the Boardroom, Education Centre.	

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Chair

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Date

Board of Directors Action Log
Updated – June 2018

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.6.18						
1	BM 18-19/051	Divisions to be invited to attend Board, on a rotational basis, pertaining to divisional engagement.	**HM**		Ongoing	
2	BM 18-19/052	Director of Finance to develop financial objectives for discussion at Board Away Day	**DJ**		31 July 2018	
3	BM 18-19/052	Post Board Away Day – engagement session with Board & Consultant Body re Vision and Strategy.	**ML**		Ongoing	
4	BM 18-19/056	Trust Board to be apprised of key components of the Winter Plan.	**AM**	To be incorporated into July Board of Directors CEO Report.	July 2018	
5	BM 18-19/056	Exec/Non-Exec Directors to be invited to attend a joint session with the Surgical Division	**AM**	Session scheduled for 23 July 2018.		**Completed**
6	BM 18-19/060	Board Assurance Framework to be reviewed by Director of Governance and Quality	**PM**	Board Paper scheduled for July 2018 Trust Board meeting.	July 2018	
Date of Meeting 30.5.18						
2	BM 18-19/034	Workforce Assurance Committee to consider merits of a day conference to encourage further and collaborative Consultant engagement.	**HM JS**		Ongoing	
5	BM 18-19/041	Medically Optimised / Intermediate Care Scheme. Brd update to be provided once final proposition had been agreed.	**AM**		Ongoing	
Date of Meeting 25.04.18						
1	BM18-19/003	Progress the process for appointing into the roles of Senior Independent Director and Deputy Chair, in conjunction with Board colleagues and the Council of Governors	**DH**	Concurrent appointment of Non-Executive Directors ongoing. To be reviewed upon confirmation of appointments.	Ongoing	

2	BM18-19/004	The Board agreed that a full proposition by Executives should be developed in relation to overcoming key strategic issues which harnesses involvement from GPs and included scrutiny from Dr Coakley. The Board then requested that a summit with the CCG be established to progress the proposition.	**JH** **JH**	JH has met with GPs. Director of Operations to undertake a presentation at the May Trust Board. Dr Coakley to be engaged upon return from annual leave.	June 2018	
4	BM18-19/006	The Board agreed that the Quality and Safety Committee review progress with the health and safety agenda in future. Also review the concerns associated with the lack of availability of the software system Ulysses for reporting non-clinical incidents and the increase in the number of RIDDOR incidents	**KE**	Outlined with Associate Director of Estates and to be discussed further.	Ongoing	
6	BM18-19/007	The Board requested that an update on the "deep dives" and the position with regards to establishment and the acuity and dependency audit work be provided to the Quality and Safety Committee in July.	**TF**	All deep dives and the establishment reviews will be presented in July to Quality & Safety Committee.	July 2018	
7	BM18-19/009	Ensure future Ward to Board reporting focussed on interventions and outcomes and not an articulation of the issues or problems	**DJ**		Ongoing	
8	BM18-19/010	The Board did agree that further discussion on the capital plans was required at the next Finance Business Performance and Assurance Committee in June.	**DJ**		June 2018	
11	BM18-19/012	The Chairman requested that the Executives produce a "strawman" of the new vision and strategy ahead of the Board Away Day to be planned. The Board agreed that the Away Day would not be facilitated on this occasion.	**JH**	In progress – Update to be provided at June Board of Directors	June 2018	
12	BM18-19/017	The Chairman noted that there were booths not working and requested that these either be removed or replaced. The Chief Operating Officer agreed to pick up this action.	**JH**	Ongoing - has been escalated and under review by Director of IT and Informatics.	Ongoing	
13	BM18-19/017	The Chairman also asked that the number of posters around the Trust that indicate what we must not do be reviewed and reduced wherever possible.	**HM**	Ongoing – concurrent audit being undertaken and posters being removed & replaced.	Ongoing	
Date of Meeting 28.3.18						

2	BM 17-18/265	Formal proposal for the wrap around services, utilising the Clatterbridge bed stock as a step down facility, to be developed and presented for approval.	**AM**	Working Group assessing scope and feasibility. Initial stakeholder communications enacted via economy. Presentation to be undertaken at May Board of Directors; 'Medically Optimised / Intermediate Care Scheme'.	May 2018	
3	BM 17-18/265	An overarching Board statement would be beneficial that clearly articulates the Board priorities and strategy, to be used internally and with external stakeholders, for sustainable services across the Wirral.	**DJ**	Strategy Refresh proposed, to be discussed at future Board Meetings.	Ongoing	
4	BM 17-18/265	Dr Gilby to continue the work being undertaken pertaining to Clinical Sustainability.	**SG**	W&WC Alliance meeting held, programme support to be agreed.	Ongoing	
8	BM 17-18/269	Having agreed produce a joint Wirral and West Cheshire Clinical Strategy [WUTH/Countess of Chester], the Medical Directors from WUTH and the Countess of Chester had agreed to determine the most beneficial approach to the commission.	**SG**	See above	Ongoing	
16	BM 17 – 18/277	A Trust wide Estates Strategy, including a review/assessment of a works backlog (circa £7M), to be implemented once the findings from a recently tendered '6 Facet Survey' have been received.	**GL**	6 Facet survey tenders received and preferred supplier selected. Report and findings will be available September 2018	September 2018	
Date of meeting 7.2.18						
1	BM 17-18/210	1st review of 2018/19 Objectives to be developed for discussion at future Board meeting.	**TW**	~~Paper submitted to April Board Meeting.~~ Strategy Refresh proposed, to be discussed at future Board Meetings.	Ongoing	
Date of Meeting 29.11.17						
1	BM17-18/172	CEO Report – Strategy. The Board also agreed to include the recommendation from the Non-Executives that the aims needed to be more explicit about meeting the future changing needs of the population.	**DA TW**	Will form part of operational plan narrative submission to NHSI. Update at April Board.	April 2018	

7	BM17-18/178	Approval of Risk Management Strategy - The Board agreed to defer this item to the December meeting at the request of the Interim Quality Governance Consultant.	**SG**	To be agreed as part of 2018/19 Planning.	Ongoing	
8	BM17-18/182	Items for the BAF/Risk Register - The Board recommended that the recruitment of a high calibre HR replacement be included on the BAF	**CS**	Experienced interim recruited to role.	Ongoing	
9	BM17/18/183	Items to be considered by the Assurance Committees – Q & S Committee – focus on the new methodology for patient stories and the evaluation of learning from these together with the further work required in relation to exit interview analysis to inform future talent management policies. FBPAC - focus on monitoring the actions taken by the Trust to reduce the monthly pay overspend together with the developing the narrative ahead of any future financial re-forecast.	**JH/GW** **DJ/GL**	Actioned and ongoing Actioned and ongoing	Ongoing Ongoing	
Date of Meeting 25.10.17						
3	BM17-18/149	Articulate in the aims and objectives how the Trust would maximise value from developing an ACO or from horizontal integration as it was not clear where the savings or where the benefits might arise	**TW**	Long list of Healthy Wirral Initiatives being reviewed in terms of quantifiable benefits	Q1 2018/19	
8	BM17-18/154	Finance Business Performance and Assurance Committee to review the potential savings/benefits from developing an ACO	**TW**	To focus on function and pathways as opposed to form.	Q1 2018/19	
Date of Meeting 25.05.16						
20	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**	Director of IT and Information currently evaluating this work	Ongoing	

BOARD OF DIRECTORS	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	25 July 2018
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

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

National

New Secretary of State
On the 9th July 2018 a new Secretary of State for Health and Social Care was appointed, the Rt. Hon Matt Hancock MP. He was Secretary of State for Digital, Culture, Media and Sport from 8 January 2018 to 9 July 2018. He replaces Jeremy Hunt MP who held the position of Secretary of State for Health from September 2012 to July 2018 making him the longest serving Secretary of State for Health in British history.

NHS 70

The NHS marked its 70th Birthday on 5th July 2018. This created a perfect opportunity to celebrate the achievements of one of the nation's cherished institutions, to appreciate the vital role the service plays in our lives, and to recognise and thank the extraordinary NHS workforce who provide support and care for us all, day in, day out.

The Trust joined in the celebrations such as the 'Big 7 Tea Parties' and sensational bake-off entries for WUTH Charity as well as special 70th birthday cupcakes delivered to our inpatients. Staff and patients got involved with a huge sing-along in the foyer of Arrowe Park Hospital and Radio Clatterbridge presented a special outdoor broadcast with WUTH Charity 'Big 7 Tea Party' on the hospital site.

There were some wonderful exhibitions and displays, celebrations of the first NHS70 baby being born in our Women and Children's Hospital and some high profile recognition from the stars of a new drama being filmed at Clatterbridge Hospital.

I would like to thank all our staff who made the day so special and for creating a huge sense of pride for our hospital.

Agenda For Change 2018/19 Pay Award

The Department of Health and Social Care (DHSC) has issued a communication outlining its plans to provide additional funding to organisations for Agenda for Change (AfC). Following the agreement of the Government to the AfC multi-year pay deal the DHSC has confirmed that it will be making payments or allocations as appropriate to the NHS bodies.

These payments and allocations will be for the calculated additional cost of the pay reform in 2018/19 over and above the funding already received for directly employed staff on AfC contracts.

NHS Improvement has been advising the DHSC on the amount to fund each provider for directly employed staff. This has been calculated using a combination of Electronic Staff Record (ESR) data (to determine the relative impact based on the distribution of AfC staff across individual bands and points of scale) and planned levels of AfC expenditure for substantive and bank staff derived from organisations' latest plan submissions as at 2 July 2018.

The Trust will receive an additional allocation of £3.95m with 1/12 to be received in July, 4/12 in August to reflect back date to April, then ongoing 1/12.The allocation will be reviewed once additional cost has worked through to July payroll.

Learning from Deaths

'Learning from deaths working with families' document was developed by NHS England on behalf of the National Quality Board (NQB). The document includes information for families and carers that will help them understand the processes involved, what to expect and where they can go for support. The guidance is being developed following a recommendation set out in the Care Quality Commission's review 'Learning, candour and accountability' which was published in December 2016.

The review was carried out in response to the very low numbers of investigations or reviews of deaths at Southern Health NHS Foundation Trust. NQB's guidance sets the principles that families can expect trusts to follow after the death of someone in NHS. Families who helped develop this guidance asked that these principles be expanded; and for more detail to be included, to reflect their feedback and experiences. The Trust is about to review its Serious Incident process as part of the wider Quality Governance review this will include incorporation of the 8 key recommendations identified within the document.

Pressure Ulcers

In June 2018 NHS Improvement released 'Pressure ulcers: revised definition and measurement Summary and recommendations document'. The recommendations in the document are designed to support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts. It is expected all recommendations will be delivered

by all Trusts by April 2019. This key document will be reviewed and reported though Quality & Safety to ensure all recommendations are embedded into clinical practice.

Regional & Local

CQC

The CQC inspected the Trust between 13th March and 3rd May 2018 including a Use of Resources review. A full update on the report is on the agenda. The Trust received a rating of 'Requires Improvement' in both areas. Whilst caring across the services reviewed was rated as good with significant improvements recognized in End of life Care & Maternity services, the rating for Well Led was inadequate. The rating of requires improvement was largely anticipated following the recent highly publicised issues the Trust faced and the changes to the Board and leadership arrangements. NHSi have offered support to the Trust to deliver the improvements and the team are in the process of assessing what support would be most helpful to deliver the improvements at pace.

Economy Winter Plans

Each health and social care system has developed a winter plan, and this has received initial challenge and scrutiny from both regulators. The feedback has been relatively uniform for each economy with a strong emphasis on acute bed occupancy, elimination of minor A&E breaches, reduction in stranded patients and delayed transfers of care. Economies whose plans were not comprehensive enough are now subject to fortnightly teleconferences with regulators to track progress. However, Wirral is not one of those.

Wirral will however receive a full day supportive visit to see how these plans are being implemented, which will involve teams from NHSE and an acute peer representative. The visit is planned for the 6th August.

Each economy is subject to this supportive visit, and of note Anthony Middleton, Chief Operating Officer will be the Acute representative on the Warrington & Halton system visit on the 26th July.

Winter Planning Approach

The Wirral Winter plan contains a number of out of hospital interventions to reduce demand and improve discharge flow, but ultimately asks for an additional 48 beds in the hospital and 20 community beds to be provided.

This information has been shared with Divisions and an action group has been set up from the end of July with a high degree of clinical involvement to safely mobilise the provision of beds. The CCG at present has strongly refuted the notion that this additional bed capacity should be funded over and above the agreed 18/19 contract, and is subject to discussion at contractual meetings and A&E Delivery Board.

NHSI Oversight and Support Meeting (OSM) – Access Standards

At the last NHSI OSM the senior delivery manager for NHSI has confirmed that a more focussed review and support will be exercised on the delivery of elective standards. To date the primary focus, matching the national priority, has been the urgent care system but it was agreed that the subject is covered in many other arenas. This approach is very much welcomed given the national shift on to total waiting list size, as opposed to waiting times and reflects WUTH's outlier position.

MSK Service

The new MSK Integrated Service successfully went live on 1st July 2018. All referrals are received electronically via the national E-Referral system and triaged by advanced clinicians. Referrals are passed on to the most appropriate service to meet the patient's needs and patients are offered choice of provider for consultant appointments and choice of location for therapy appointments.

Anticipated minor problems associated with a major change have been resolved quickly. However, some governance issues have been highlighted to Wirral CCG with respect to GPs monitoring rejected referrals.

Initial figures are extremely positive and indicate that around 70 patients have been deflected from consultant clinics to physiotherapy since go live. Further analysis will take place over the coming weeks and months to confirm the impact on consultant waiting times. Wirral CCG has removed direct access to MRI scans for GPs with the intention of reducing inappropriate MRIs. The MSK triage service is now responsible for ordering MRIs and in the first two weeks, orders have reduced significantly.

Patients from existing providers will start to transfer on 1st August 2018. Discussions with the Trust's legal team are ongoing on whether TUPE applies to staff in those providers. A Transformation and Engagement Plan will be completed by the end of August 2018. This will contribute to CQUIN payments for 2018/19, and outline the planned realisation of benefits across the duration of the contract.

Janelle Holmes
Chief Executive
July 2018

Board of Directors	
Agenda Item	7.2
Title of Report	Mortality Review & Dashboard
Date of Meeting	25 July 2018
Author	Dr M Lipton: Interim MD
Accountable Executive	Dr M Lipton
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	4
Level of Assurance **Positive** **Gap(s)**	N/A
Purpose of the Paper **Discussion** **Approval** **To Note**	To Note and Support
Reviewed by Executive Committee	N/A
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. Executive Summary

In 2016, the CQC published 'Learning, candour and accountability – a review of the way NHS trusts review and investigate the deaths of patients in England', It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognize their insights as a vital source of learning.

In March 2017, the National Quality Board, NQB, published 'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care'; this report is in response to the CQC document.

2. Background

- The Mortality Review Policy was agreed at Trust Board in September 2017.
- The Trust's third mortality dashboard is included being for the period of Q18/19 as well as an update to previous dashboards.
- 26 deaths in Q1 at present need to have a second line review by SJR, RCA or Women's and Children's review. These have been raised from primary mortality review, elective deaths and serious incident meetings. No secondary review has been raised from the bereavement Service or junior doctors at death certification.
- 20 deaths in Q3 and 46 deaths in Q4 needed to have second line review either by SJR, RCA or Women's and Children's review, 31 of these are still outstanding, including 1 for tertiary review.
- 6 deaths from Q3 – Q1 have been judged as avoidable being <=3 on the avoidable death score.
- Mersey Internal Audit Agency reviewed the service and gave "significant assurance" with 2 advice for improvement – a medium and a low risk to service.
- An internal mortality outlier report is under way into Myocardial Deaths Jan 17 – Dec 17, a review of 43 patients. This was due to significant outlier for only this calendar period on SHMI, but not HSMR; nor has this been triggered again. The Myocardial Ischaemia National Audit Process, (MINAP) for previous years has shown no outlier tendencies.
- The 2016 Mothers and Babies Reducing Risk Through Audit report has been published, (MBBRACE). A report will be submitted to CGG with any necessary actions and follow-up on the previous year's action plan.

3. Key Issues/Gaps in Assurance

- A secure tracking system for the primary mortality reviews is now in place.
- SJR faculty still requires governance arrangements and assessment of demand.
- There is a significant lag through our system to identify lessons learnt.
- To review bereavement office pack to encourage earlier reporting of care problems.
- To participate in CCG and wider mortality reviews

4. Next Steps

- To progress above actions

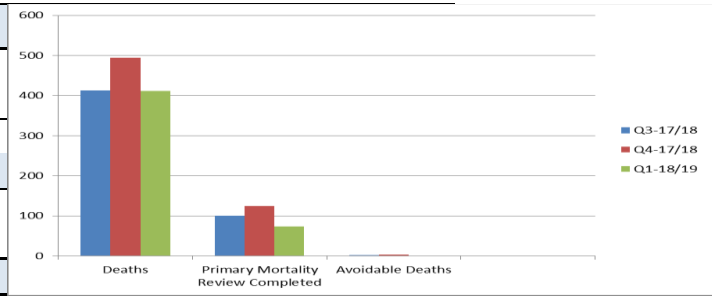
5. Recommendations

- To note and support report

Wirral University Teaching Hospital: Learning from Deaths Dashboard

Total Number of deaths		Primary Mortality reviews		SJRs, RCAs & formal Reviews		Total deaths considered potentially avoidable	
Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18
413	494	100, (24%)	120, (24%)**	20, (5)*	34 (19)*	2	3
Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19
412		74, (399)*		26,(16)		1	

()*-in process, **-tracking process failure



Avoidable Death Assessment Score	Score 1 Definitely avoidable		Score 2 Strong evidence avoidable		Score 3 Possibly avoidable >50:50		score 4 Probably avoidable but not very likely		Score 5 Slight evidence of avoidability		Score 6 Definitely not avoidable	
	Q3	0	Q3	0	Q3	2	Q3	0	Q3	1	Q3	12
	Q4	0	Q4	2	Q4	1	Q4	3	Q4	4	Q4	8
	18/19 Q1	0	18/19 Q1	0	18/19 Q1	1	18/19 Q1	0	18/19 Q1	2	18/19 Q1	5
	17-18 Q3-Q1	0	17-18 Q3-Q1	2	17-18 Q3-Q1	4	17-18 Q3-Q1	3	17-18 Q3-Q1	7	17-18 Q3-Q1	25

Summary	Total actvity Q1 2018/19	Deaths Q1 2018/19
elective surgical patients:	17,158	2
patients with severe learning disabilities	not available	2
patients with severe mental health needs	not available	0
Women's and Children's Hospital		11
Neonatal patients:	863	5
Births:	750	6
Mothers:	744	0

	17/18 Q3	17/18 Q4	18/19 Q1
Avoidable deaths	2	3	1
Still under investigation	1***	19	16

***3rd level review

Narrative for "Learning from Deaths dashboard"

Q1 18/19 Dashboard

- At WUTH there have been 412 deaths in quarter 1, (1st of Apr – 30th of June 2018). This compares to 365 deaths in the same period of 2017
- There are two national mortality indexes for the hospital: Firstly HSMR-hospital standardised mortality ratio - this measures 85% of in-patient deaths adjusted for palliative care, social deprivation and admission history. It is a more timely mortality index.
- HSMR for WUTH Apr 17 to Jan 18 is 90, (expected is 100, 2SD-85.4 to 94.7) which means we are significantly better than what is expected by statistical analysis.
- Secondly SHMI – Standardised Hospital Mortality Index – this measures all deaths in the hospital and those occurring within 30 days of discharge.
- SHMI for WUTH Jul 16 to Jun 17 is 97, (expected is 100, 2SD-92.0 to 100.7) which means we are within the expected range by statistical analysis.
- Of the Q4 2017/18 deaths 74 have had a completed primary mortality review,(PMR), 320 are in process. If all PMRs were completed 97% of all deaths would be reviewed by the end of July.
- There have been, so far, 26 deaths which now require a more detailed review. These reviews will take place using 1) Strategic Judgmental Review, – a specifically trained process to assess the death for any lapses in care, with an assessment as to whether the death was avoidable; 2) Root Cause Analysis for those deaths where a serious incident has been raised – eg: in-patient fall; 3) Deaths in Women's and Children's hospital – specific national processes are followed for these deaths.
- At the present notification there have been 2 elective surgical death 6 deaths undergoing RCAs, 9 deaths undergoing SJRs and 11 deaths in Women's and Children's hospital.
- From the second line review of Q1 deaths an important learning point is the need for patient fall's assessment to provide the optimum resources available for patients at risk from falls. There has been a large push on falls assessment completions within the Trust with ownership by the new nursing ward leadership teams.
- The dashboard for Q1 will be updated at the time of the Q2 dashboard.

Q4 17/18 Dashboard

- At WUTH there have been 496 deaths in quarter 4, (1st of Jan – 31st of Mar 2018). This compares to 438 deaths in the same period of 2017.
- Of the Q4 deaths 120 have had a completed primary mortality review, 24% of all deaths. Unfortunately the tracker system failed but has now been secured for Q1.
- There have been 43 deaths which required a more detailed review. 19 are still in progress. 2 RCAs, 2 in W&C services and 15 SJRs.
- From the second line review of Q4 deaths important learning points have been 1) Red flag for AAA and 2) failure of documented communication with patient and relatives, in deteriorating patients
- The Q4 17/18 dashboard will be updated at the time of the Q1 18/19 dashboard.

Q3 17/18 Dashboard

- Of the Q3 2017/18 deaths 100 had a completed primary mortality review. This was 24% of total deaths in the quarter
- There have been identified 20 deaths for more detailed review of which 1 is outstanding requiring a tertiary review.
- From the second line review of Q3 deaths, important learning points are: 1) to treat in-patient falls as if they present from outside the hospital to ED, thus national protocols are followed regarding CT head scans and the reversal of anti-coagulation. 2) for all patients admitted to the hospital; they are assessed as to the likelihood of having a fall. 3) for deteriorating patients without the prospect of recovery a discussion regarding not performing cardio-pulmonary resuscitation is undertaken with the patient and relatives, furthermore this decision is documented within the patient's electronic patient health record. 4) The nMEWS escalation policy must be followed, further junior doctor resource has been found to respond promptly to nMEWS alerts.
- The Q3 dashboard will be updated at the time of the Q2.

BOARD OF DIRECTORS	
Agenda Item	7.3
Title of Report	Infection Prevention & Control Report July 2018
Date of Meeting	25th July 2018
Author	Mr Joe Allan, Associate Director of Nursing for Infection Prevention & Control
Accountable Executive	Mrs Gaynor Westray, Director of Nursing & Midwifery and Director of Infection Prevention & Control
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 2 and 12
Level of Assurance **Positive** **Gap(s)**	Positive - Plans to further reduce health care associated infections and to sustain improvements with infection prevention & control practices within the Trust. Current Gaps - Further scoping exercises into screening for CPE and MRSA - Financial pressures associated with the implementation of Aseptic Non Touch Technique
Purpose of the Paper **Discussion** **Approval** **To Note**	For discussion and Approval
Reviewed by Assurance Committee	No
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1. Executive Summary

The purpose of this report is to inform the Trust Board of the plans to further reduce health care associated infections (HCAI) and to sustain improvements with infection prevention & control (IPC) practices within the Trust.

The Health and Social Care Act (2008), updated 2015 (Code of practice on the prevention and control of infections) clearly identifies criteria to ensure that patients are cared for in a clean environment, which minimises the risk of acquiring a HCAI.

The Infection Prevention & Control Team's (IPCT) aim is to support the organisation proactively to reduce avoidable HCAI. Also the IPCT is focusing on a number of identified areas for further improvement to reduce HCAI and to firmly embed infection prevention into everyday practice to keep patients, visitors and staff safe.

This report outlines the overall role of the IPCT and will provide a further overview of areas identified requiring review to further reduce and sustain HCAI:

- Role of the IPCT
- *C. diff* management
- Hand hygiene adherence
- ANTT for identified clinical invasive procedures
- CPE screening
- MRSA screening
- Review of Ward 25 – Isolation ward

It is recognised that some of the changes to practice will have potential cost implications and these costs will be fully understood as part of the review process. The IPCT will consider alternative cost savings as part of the process to support any potential cost pressures to the Trust.

Any proposed changes to policy and / or practice will be clearly outlined and discussed at the Trust's IPC Group and will form part of the Trust's governance processes.

The Board is asked to

- The Board is asked to note the content of this report and request further assurance if indicated

2. Background

The purpose of this report is to inform the Trust Board of the plans to reduce health care associated infections (HCAI) and to sustain improvements with infection prevention & control (IPC) practices within the Trust. This work is monitored through the Trust's Infection Prevention & Control Group which reports to the Quality and Safety Group. Infection prevention & control indicators are managed daily and reported monthly through an integrated performance report.

The Health and Social Care Act (2008), updated 2015 (Code of practice on the prevention and control of infections) clearly identifies criteria to ensure that patients are cared for in a clean environment, which minimises the risk of acquiring a HCAI.

HCAI remains a major cause of avoidable patient harm and nationally there have been significant reductions in the number of patients developing an HCAI. Across the wider health system other HCAI's have risen due to the emergence of a number of resistant organisms.

The Infection Prevention & Control Nurses currently work Monday to Friday and provide an out of hours on-call service each evening and every weekend, including bank

holidays. The infection Control Doctor is also a Consultant Medical Microbiologist and the Director of infection Prevention & Control is the Director of Nursing & Midwifery.

The IPCT aim is to focus on areas for further improvement to reduce HCAI and to firmly embed infection prevention into everyday practice to keep patients, visitors and staff safe.

This report will provide an overview of IPC practices and polices identified as requiring review to further reduce and sustain HCAI Role of the IPCT:

- Infection Prevention & Control Team (IPCT) review
- *C. diff* management
- Hand hygiene & Bare Below the Elbows
- ANTT for identified clinical invasive procedures
- CPE screening
- MRSA screening
- Review of Ward 25 – Isolation ward

3. Key Issues/Gaps in Assurance

3.1 Infection Prevention & Control team (IPCT) Review

The IPCT currently work Monday to Friday and the nurses provide out of hours support (evenings and weekends) through an on-call system. The team consists of the following members:

Clinical staff

- One WTE Associate Director of Nursing (joined 26th June 2018) – Band 8C
- One WTE Interim Team Leader/Matron (April 2017) – Band 8A
- Two WTE Senior Infection Prevention & Control Nurses – Band 7 (One Vacancy)
- Two WTE Infection Prevention & Control Nurses – Band 6

Non-clinical staff

- One WTE IT Analyst – Band 5
- One WTE Infection Prevention & Control assistant – Band 3
- One WTE administrator – Band 3

Executive/Medical Support

- Director of Infection Prevention & Control (DIPC) is the Director of Nursing and Midwifery
- Infection Control Doctor is a Consultant Medical Microbiologist

The Assistant Director of Nursing for IPC is currently reviewing the IPCT working arrangements and part of this review is to explore the possibility of seven day working. It is anticipated that a seven day service will increase IPC support to the clinical teams and with the management of patient flow although the weekend working should not be a cost pressure to the Trust. Therefore, on-call arrangements will be reviewed and the current cost of on-call payments will be utilised to support weekend enhancement payments.

In order to deliver a seven day clinical IPCT service with one nurse covering weekends the IPCT nurse establishment will need to be 5.6 WTE as a minimum. A paper proposing changes to the working pattern will be completed in consultation with staff side colleagues.

The current advice and support provided to the Trust by the IPCT is also being reviewed with a focus on increased visibility within the clinical areas. In addition, the IPCT will re-establish links and working relationships with each division within the Trust.

3.2 C. diff

Reporting for *C. diff* in patients aged over 65 years was mandatory from 2004 and in 2007 this was extended to all patients aged over 2 years. The Trust trajectory for 2018 / 2019 for avoidable cases is 28 (avoidable cases are determined if lapses in care).

In Q1 2018 / 2019 the Trust reported 16 cases of which 7 were deemed avoidable and post infection reviews (PIR) for June 2018 are still in progress (Table 1). In 2017 / 2018 the Trust reported 27 avoidable cases in total against a trajectory of 29.

Table 1

Month	Number of Cases	Avoidable Cases
April	5	4
May	6	1
June	5	2
Total	**16**	**7**

The PIR identified the following themes from the lapses in care:

- Delays in isolation
- Delays in sending stool samples
- Documentation
- Communication
- Environmental & equipment cleanliness
- Divisional engagement

It is recognised that inappropriate antimicrobial prescribing has not been identified as a theme and the IPCT work closely with the Trust's Antimicrobial Pharmacist.

All cases confirmed after 72 hours of hospital admission are apportioned to the Trust and a post infection review (PIR) is completed to determine if the infection is avoidable and to share any learning. Currently the PIR is facilitated by the IPCT with engagement from the patient's clinical team (consultant and senior nurses), Antimicrobial Pharmacist and the Consultants in Medical Microbiology.

The findings from the PIR is discussed within the division and themes escalated to the Trust's infection prevention group that is chaired by the DIPC. Any common or recurring themes are escalated to the Trust Quality & Safety group if appropriate.

The results and findings from the PIR investigations are reported nationally to Public Health England through the IPC Data Capture System (DCS). The IPC DCS captures all mandatory HCAI organisms and this information is used to benchmark NHS organisations.

The IPCT is currently reviewing the Trust's response to preventing and managing *C. diff* with the following range of measures:

- Updating the hand hygiene policy and availability of hand hygiene products
- Increased divisional ownership and introducing rapid patient reviews to determine immediate concerns and learning
- Introducing senior *C. diff* overview panels to determine avoidable / unavoidable and to identify themes
- Reviewing the role and function of the isolation ward (currently Ward 25)
- Diarrhoea management guidance on the Trust electronic patient record system
- Antimicrobial Pharmacy staff reviewing patient prescriptions
- Reviewing the post infection review (PIR) process and proposing a 72 hour rapid review PIR
- Review of environmental decontamination (cleaning) products
- Enhanced training to domestic staff in the new Hotel Services training room

During 2018 / 2019 the Trust has identified one inpatient area as having a period of increased incidence (PII) for *C. diff*. The IPCT is currently supporting the staff within this area with a wide range of measures; this includes high level cleaning in all clinical areas using Hydrogen Peroxide Vapor (HPV).

3.3 Hand Hygiene

Hand hygiene is the single most effective method to reduce the incidence of cross infection with healthcare. In 2004 following the national 'Clean Your Hands' campaign the Trust launched and promoted the use of alcohol hand rub in all clinical areas and within specific non-clinical areas such as catering. The World health Organisation's 'Five Moments' for hand hygiene is the process promoted within the Trust and this defines opportunities for hand hygiene.

The IPCT is currently reviewing the location of alcohol gel dispensers throughout the Trust to ensure visibility and availability within appropriate areas. This includes adding alcohol gel dispensers to the main foyer and other entrances / exits of the hospital as currently there are no facilities available for visitors entering or leaving. Also the signage at the entrance to clinical areas will be renewed and any associated costs of the changes to be discussed with the suppliers. Discussions started in July 2018 with suppliers to have the dispensers and signage in place by October 2018.

A hand hygiene awareness campaign will also be launched following the product review to include clear messages on infection prevention measures to be undertaken whilst in the Trust. The hand hygiene campaign will include patients with a particular focus on hand hygiene during meal times and after using the toilet.

All clinical hand wash basins will be audited during 2018 / 2019 to ensure appropriate hand hygiene facilities are available with posters demonstrating the appropriate technique to use when washing hands with soap and water.

The 'Bare Below the Elbow' message to all staff in clinical areas will form part of the hand hygiene campaign and the Trust is currently reviewing the uniform policy.

3.4 Aseptic Non Touch Technique (ANTT)

ANTT is a safe and effective technique that should be used for cannulation and blood culture collection within the Trust and this should be undertaken by all clinical staff that undertake these procedures. ANTT is an essential procedure for reducing the risk of infection to patients during invasive procedures and this is achieved by reducing the presence of micro-organisms as is practically possible. ANTT is a clinical skill that must be in place in order to achieve full compliance and effectiveness. The process of undertaking ANTT is being rolled out as a joint exercise by the Trust's Clinical Skills Laboratory and the IPCT.

In order to effective reduce any potential skin contamination during ANTT, the patient's skin must be decontaminated and the most effective method is to apply a solution containing both 2% Chlorhexidine with 70% Alcohol. It has been recognised that there is a significant cost to the Trust to introduce the 2% Chlorhexidine with 70% Alcohol as it is a licensed product and the estimated cost to the Trust is £70,000.00 per annum (based on the number of cannulations inserted and blood cultures taken). IPCT is working with the procurement team to explore options for cost savings in other areas to support the cost pressures of introducing ANTT.

Trust roll out is the preferred option although IPCT would support a three month trial within both Critical Care and the Emergency Department (ED). ED currently inserts approximately 10,000 cannulas to patients in a three month period and Critical Care insert approximately 700 cannulas and the estimated cost of this trial will be £4150.00 for the 2% Chlorhexidine with 70% Alcohol skin preparation. Care Quality Commission

(CQC) during their inspection in March 2018 highlighted poor compliance with ANTT practices within Critical Care.

ANTT training has been delivered to approximately 20 staff who will themselves become trainers for ANTT and there are further training sessions planned throughout July, August and September 2018. ANTT in the form of E-learning has been launched successfully throughout NHS Wirral Community Trust and whilst the Trust is exploring this option to support the education component there will still need to be a practical competency assessment completed.

3.5 Carbapenemase Producing *Enterobacteriaceae* (CPE)

Enterobacteriaceae are a group of bacteria found in the gut of humans, Carbapenems are a group of antibiotics used for serious infections and Carbapenemase are enzymes created by some of the bacteria. Nationally there has been an increase in CPE cases and in 2014 the Department of Health produced a toolkit for acute trusts for early detection and management.

In February 2014 the Medical Directors for both NHS England and Public Health England took the unusual step to write to all Chief Executives to advocate the use of the toolkit to minimise the spread of CPE across England.

The Department of Health toolkit for CPE recommends assessing all patients on admission and screening those identified as high-risk for CPE. High-risk patients are defined as those who have been an inpatient in a hospital abroad or those who have been an inpatient in a UK hospital with a known CPE problem in the last 12 months.

The current policy in the Trust is to screen all CPE contacts that have been alerted electronically (IPCT place the CPE alert on patients following exposure as an inpatient) and any inter-hospital transfers are screened for CPE on admission to the Trust. In order to fully implement the Department of Health CPE toolkit the Trust will need to:

- Introduce clinical assessment criteria for CPE upon admission to the Trust for all patient groups
- Introduce admission screening for CPE for patients who have been an inpatient within another hospital with a CPE problem within the last 12 months

The IPCT is currently working with the clinical laboratory to establish processes for CPE admission screening and the associated costings. Further scoping is required to determine processes and associated laboratory costs and it is anticipated that this will be completed by September 2018. Also the IPCT will undertake a benchmarking exercise with a number of neighbouring acute Trusts to ensure a consistent approach to managing CPE across the wider health economy and this will be completed by September 2018.

3.6 MRSA Screening

MRSA screening was introduced to all acute Trusts in 2002 for high-risk areas and identified patient groups and in 2004 this was extended to all patients being admitted, both elective and non-elective. The current MRSA screening programme for the Trust is a nose and groin specimen along with any wound or line present. Patients identified as carrying MRSA (colonized) are treated with a skin cleansing and nasal ointment (known as eradication therapy) with the aim of removing the MRSA and reduced the risk of the patient developing an MRSA blood stream infection. The Trust has not reported any attributed MRSA Bacteraemia for Q1 of 2018 / 2019 and in 2017 / 2018 we reported two MRSA Bacteraemias that were attributed to the Trust.

MRSA screening and eradication therapy have seen a significant reduction nationally on blood stream infections (MRSA Bacteraemias) and all NHS organisations must introduce a zero tolerance for avoidable cases. In 2014 the Department of Health revised the MRSA screening advice and recommended that acute Trusts reviewed their MRSA

policy. The Trust reviewed their MRSA policy following the 2014 recommendations and in view of the MRSA Bacteraemia improvements seen within the Trust a decision was made to continue with the existing policy. Q1 of 2018 / 2019 MRSA has been isolated on 21 patients that have been deemed hospital acquired (HA) cases and appropriate precautions have been put in place to reduce further cross infection (Table 2).

Table 2

Month	Number of HA Cases	Clinical Site	HA Running Total
April	11	3	11
May	4	2	15
June	6	0	21
Total	**21**	**5**	**21**

The IPCT will again review the Trust's MRSA policy and will benchmark with similar acute Trusts before making recommendations to the Infection Prevention and Control Group for a final decision in September 2018.

3.7 Ward 25 – Isolation Ward

Ward 25 is managed by the Medical Division and opened as an infection control ward in November 2015 with 8 en-suite side rooms to manage patients with CPE. The ward was extended to accommodate 22 patients to include patients with *C. diff* and is a combination of single side rooms and 2 step down bays. The design, layout and function of the ward has identified a number of risks associated with patient safety and the Associate Director of Nursing for IPC is supporting the Medical Division to reduce these risks and to review the function of Ward 25.

The review of ward 25 will include all patient safety incidents, nursing indicators and patient experience. The review will be presented at the Trust's IPCG for further discussion and action in August 2018.

4 Next Steps

The key issues above have outlined the IPC areas for further review and there are a number of measures that will need to be explored before any further changes to policy and / or practice are introduced within the Trust.

It is recognised that some of the changes to practice have potential cost implications and these costs will be fully understood as part of the review process. Furthermore, the IPCT will consider potential cost savings as part of the process to support any possible cost pressures to the Trust.

Any proposed changes to IPC policy and / or practice will be clearly outlined and discussed at the Trust's IPC Group and will be subject to the appropriate governance processes.

5 Conclusion

HCAI remains a major cause of avoidable patient harm and nationally there have been significant reductions in the number of patients developing an HCAI. The Trust has reported significant reductions in a number of HCAI, in particular with MRSA Bacteraemias.

The Trust's IPCT is currently working proactively to reduce the incidence of avoidable HCAI. It is recognised that a number of IPC procedures/policies need to be reviewed in order to further sustain or reduce HCAI.

The reviews will ensure that any relevant IPC guidance will be considered and the IPCT will benchmark with neighbouring acute Trusts to ensure a consistent approach across the wider health economy.

It is anticipated that there will be some financial implications to the proposed changes and the IPCT will understand the costs associated if recommending changes. In addition, the IPCT will work with procurement colleagues to review existing expenditure with a focus on cost savings that could be offset against expenditure.

6 Recommendations

- The Board is asked to note the content of this report and request further assurance if indicated

Board of Directors	
Agenda Item	**8.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**25th July 2018**
Author	**John Halliday, Assistant Director of Information**
Accountable Executive	**Anthony Middleton** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

The report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of June 2018.

2. Background

The key national priorities are the A&E four hour target and the financial position. Other key targets by exception are covered in the opening section of the dashboard. An overview of performance against the access standards is provided below.

3. Key Issues

Access Standards

A&E 4 Hours

Key Access Standards : A&E 4 Hours	Target	April	May	June	Trend
A&E 4 Hour Standard *(Wirral wide including all WICs/MIUs)*	>=95%	87.74%	89.89%	89.85%	
A&E 4 Hour Standard *(APH site inc ADHC)*	STF >=90% by Sept 18	80.27%	83.51%	83.43%	
A&E 4 Hour Standard *(APH site : ED only)*	>=95%	71.86%	76.86%	76.80%	
Ambulance Handovers > 60 minutes	Zero	178	107	142	

A&E 4 Hours

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of June was 89.85% as measured across the combined Wirral WUTH ED, WCT Walk-in Centres and MIUs. This is the external view of Wirral performance by NHS England. Performance for ED with the All Day Health Centre on the Arrowe Park site was 83.43%, with ED alone at 76.80%.

At 83.43%, the APH site performance was better than the recovery trajectory submitted to NHS Improvement (NHSI). At the request of NHSI this trajectory has been amended to reflect expected further improvement from October to December, an expected slight deterioration in the winter months of January and February, and the final return to the 95% standard compliance in March 2019.

Across this quarter, ED attendances have seen a reduction of 1.7%. The largest reduction has been in ambulance attendances with 242 lower than the same period in 2017 - a 9.3% variance. Despite this reduction, resus attendances remains the same (<1%), suggesting patients with higher acuity are not reducing. The overall 4-hour recovery trajectory for July is 85%, with the position up to the 11th July at 84.03%.

WUTH remains one of the worst performing hospitals in the region for ambulance turnaround times, which should be achieved within 15 minutes. There was no improvement between May and June, with the average for both months at 17 minutes. However the first two weeks of July is showing a turnaround average of 14 minutes and breaches of the 60 minute standard has improved significantly. This is based on a much more rigorous escalation and deployment solution of nursing staff from both within ED and the wider matron complement as well as improved flow as demonstrated by the 4 hour performance standard.

Referral to Treatment

Key Access Standards : RTT	Target	April	May	June	Trend
RTT Incompletes : 18 Weeks Position	>=92%	74.29%	74.58%	75.74%	
RTT Incompletes : 52 weeks waiters	0 per month	66	67	78	
RTT Incompletes : Total waiters	n/a	25454	26648	26957	
RTT Incompletes : 39 weeks waiters	n/a	818	1009	882	
Diagnostics 6 Weeks Standard *	>99%	99.03%	98.24%	97.90%	

Key Access Standards : RTT (latest month)	Target	Acute & Med	Surgery	W&C	Clin Support
RTT Incompletes : 18 Weeks Position	>=92%	85.02%	69.53%	85.18%	30.84%
RTT Incompletes : 52 weeks waiters	0 per month	6	71	0	1
RTT Incompletes : Total waiters	n/a	7341	15448	3954	214
RTT Incompletes : 39 weeks waiters	n/a	56	781	12	33
Diagnostics 6 Weeks Standard *	>99%	92.86%	96.80%	-	98.97%

The national measurements for elective care in 2018/19 is the measurement of total waiting list size, with an objective that the list should not increase by March 2019 compared with March 2018 and the elimination of over 52 week waiters by March 2019. The Trust has also agreed on a local basis to aim for 80% RTT compliance on the same timescale.

The agreed incomplete RTT performance trajectory was achieved at the end of June at 75.74%. However the number of 52 week waiters and total RTT waiting list both increased and were above trajectory.

The Clinical Divisions have provided a specialty based trajectory to inform the overarching improvement plan. Formal weekly monitoring arrangements are in place to manage and where appropriate and possible to expedite clock stop events.

Performance against the 6-week diagnostic standard at the end of June was 97.90%, and so below the minimum 99% standard. The department with the largest number of breaches is echocardiography, and in particular a backlog of patients awaiting Dobutamine Stress Echocardiograms (DSE). Of the 68 Echo breaches in June 59 were for DSE. This has arisen due to consultant workforce pressures and the prioritisation of inpatient workload. Additional sessions continue to be run by the department to reduce the wait and an NHS locum consultant has with DSE experience has also now commenced. Workload has also been reallocated to release DSE trained consultants to undertake additional lists and reduce the numbers waiting by the end of July.

Additional capacity in radiology is also being commissioned, in the form of a mobile scanner to help reduce waiters in MRI from the last week in July.

Cancer Waiting Times

The Trust achieved all Cancer standards for Quarter 1 overall.

Cancer Waiting Times *	Target	April	May	June	Trend
Cancer : Two Week Wait	>=93%	94.24%	93.37%	95.21%	
Cancer : Two Week Wait Breast Symptoms	>=93%	100.00%	93.75%	100.00%	
Cancer : 31 days to First Treatment	>=96%	96.45%	96.36%	96.03%	
Cancer : 31 days to Subsequent Treatment (Surgery)	>=94%	100.00%	100.00%	100.00%	
Cancer : 31 days to Subsequent Treatment (Drugs)	>=98%	100.00%	100.00%	100.00%	
Cancer : 62 days Urgent Referral to Treatment	>=85%	86.98%	86.05%	93.57%	
Cancer : 62 days NHS Screening to First Treatment	>=90%	93.75%	100.00%	100.00%	
Cancer : 62 days Consultant Upgrade to First Treatment	>=85%	88.79%	91.76%	96.97%	
*Note : Performance figures not yet finalised					

Cancer Waiting Times * (latest month)	Target	Acute & Med	Surgery	W&C	Clin Support
Cancer : Two Week Wait	>=93%	96.21%	92.34%	97.68%	-
Cancer : Two Week Wait Breast Symptoms	>=93%	-	-	100.00%	-
Cancer : 31 days to First Treatment	>=96%	100.00%	91.53%	100.00%	-
Cancer : 31 days to Subsequent Treatment (Surgery)	>=94%	-	100.00%	100.00%	-
Cancer : 31 days to Subsequent Treatment (Drugs)	>=98%	100.00%	-	100.00%	-
Cancer : 62 days Urgent Referral to Treatment	>=85%	100.00%	85.94%	100.00%	-
Cancer : 62 days NHS Screening to First Treatment	>=90%	-	-	100.00%	-
Cancer : 62 days Consultant Upgrade to First Treatment	>=85%	100.00%	94.74%	-	-
*Note : Performance figures not yet finalised					

There were individual tumour groups where standards were not achieved for the quarter:

Two week waits - Colorectal; Urology
31 days from decision to treat - Urology; Gynaecology
62 Day from urgent referral to treatment – Upper GI; Head & Neck; Urology; Gynaecology; Other
62 Day consultant upgrade – Colorectal

Infection Prevention and Control

In June 2018 the Trust reported a further two incidents of avoidable C Difficile toxins, bringing the total now to 7 (tolerance 28 for 2018/19)

Pressure Ulcers grade 2 and above

During June 2018 an elderly lady was admitted with multiple co-morbidities including a deep tissue injury on sacrum, which developed into a grade 4 pressure ulcer. Duty of candour was completed and a full investigation is in progress with the findings to be reported to Board in September.

Complaints

In June the Trust experienced an increase in complaints received, resulting in a total of 110 live complaints with 60 being overdue. A Head of Patient Experience has been appointed and started in post with remit to prioritise complaints management, including triage to ensure consideration as a potential serious incident and to review the process and sign off with divisions including letter structure.

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

The key operational challenges in quarter one have been the achievement of the improvement trajectories for both A&E 4-hours and the RTT waiting position. As those improvement trajectories become more challenging through quarters two and three, the balancing of pressures on urgent care against the need to continue to improve elective waiting times will become more acute.

6. Recommendation

The Board of Directors are asked to note the Trust's current performance to the end of June 2018.

Access (Operations)

A Middleton

✓	!	×	Not rated
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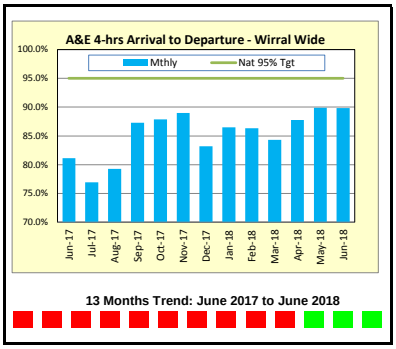
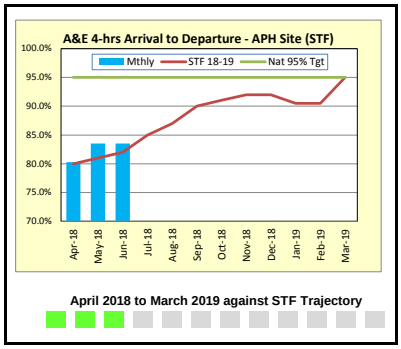
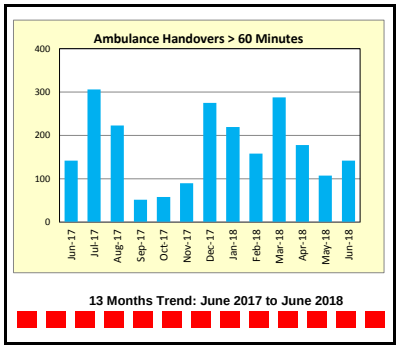
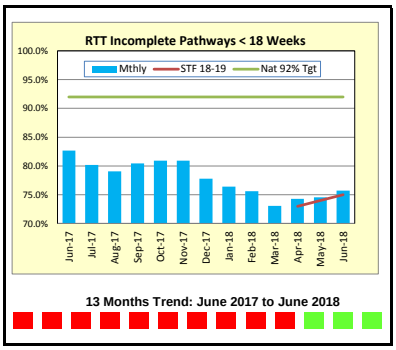
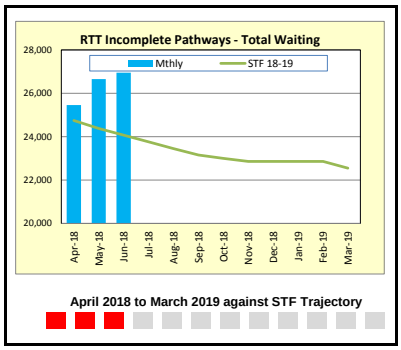
Access (Operations)

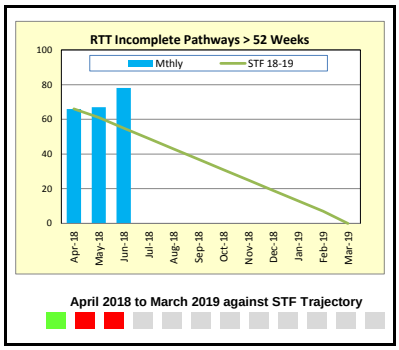


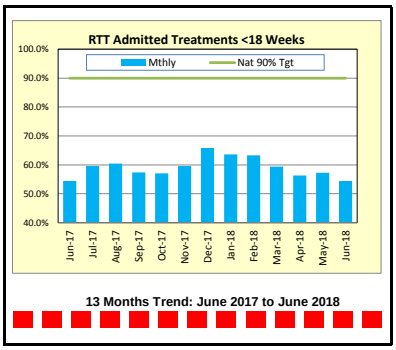


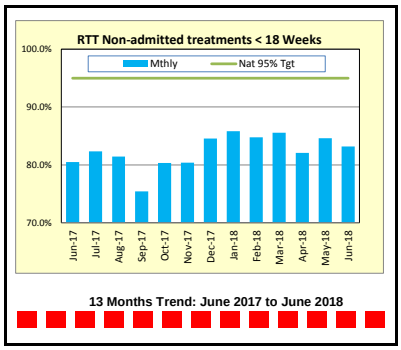


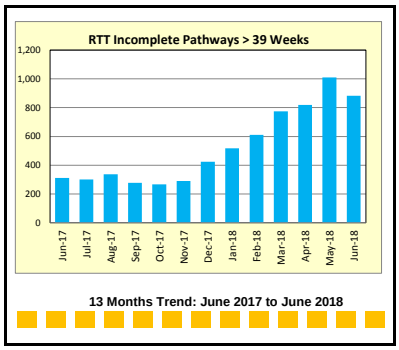


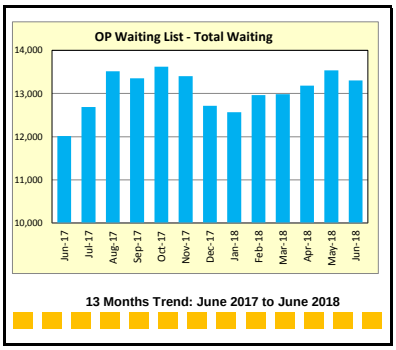


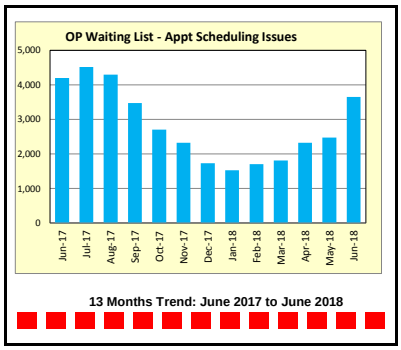


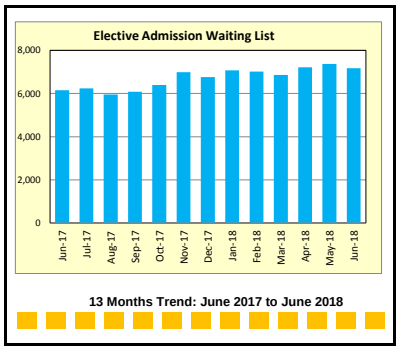


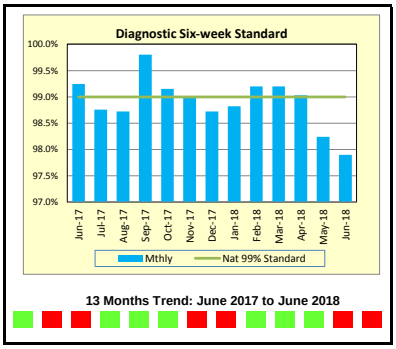


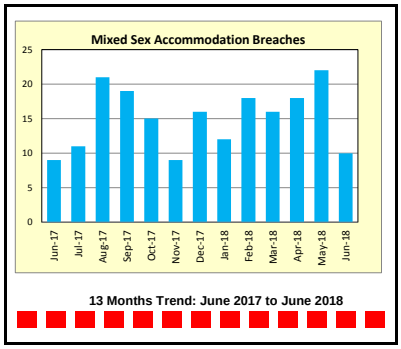


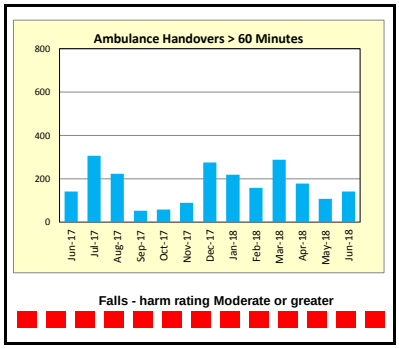












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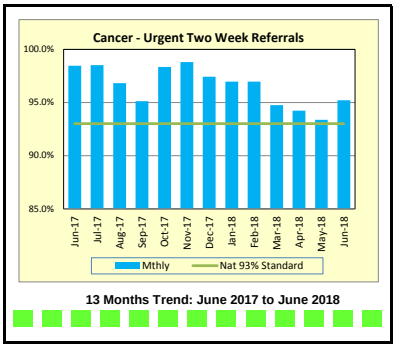

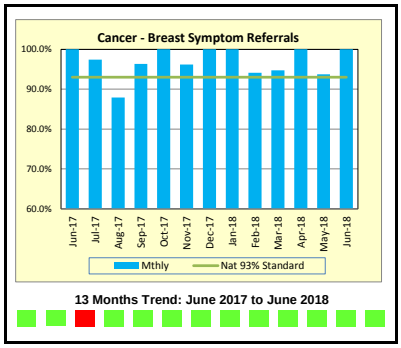

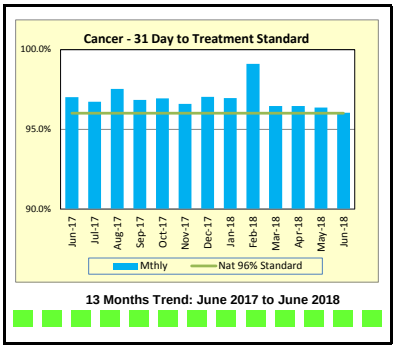

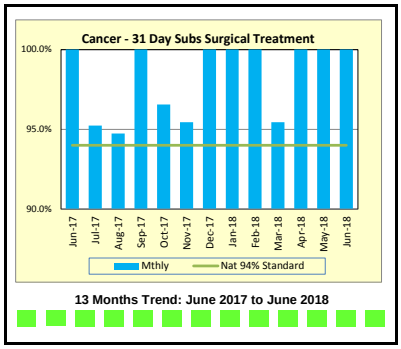

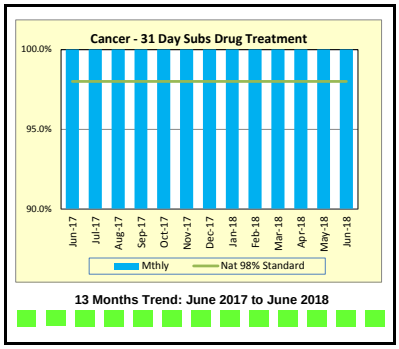

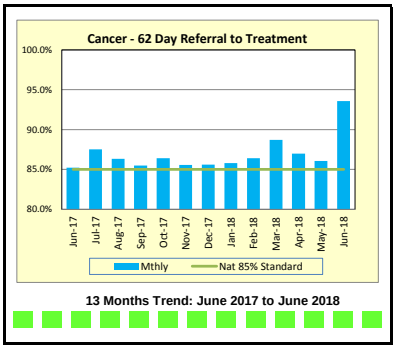

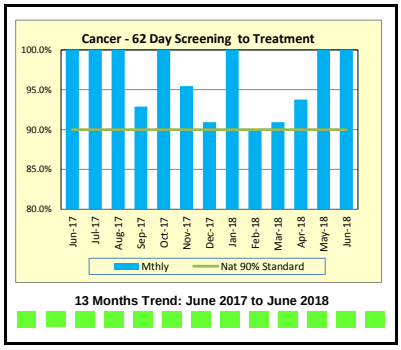

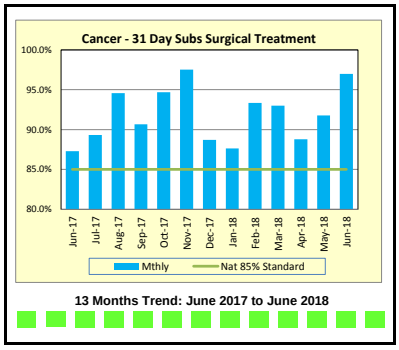

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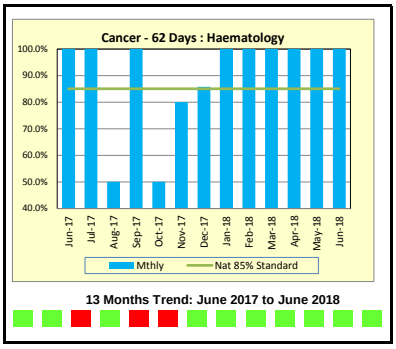

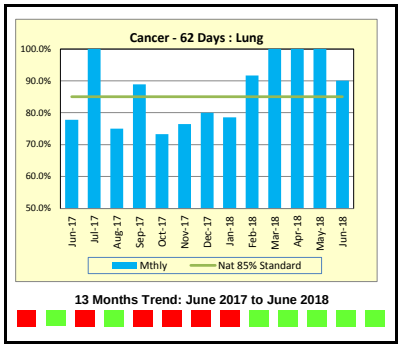

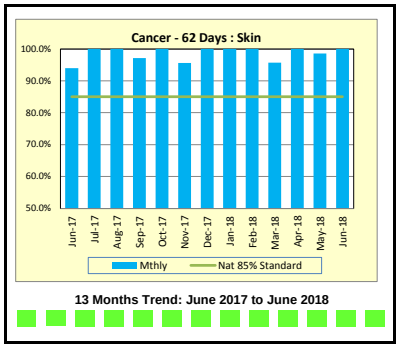

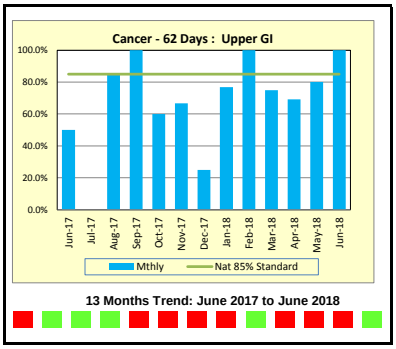

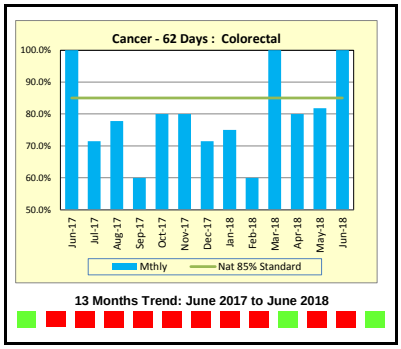

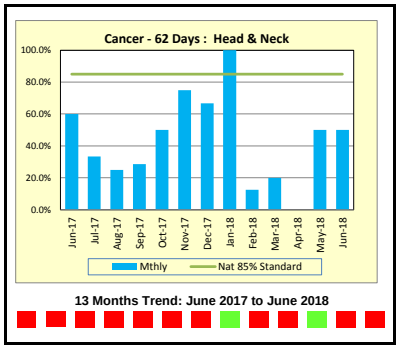

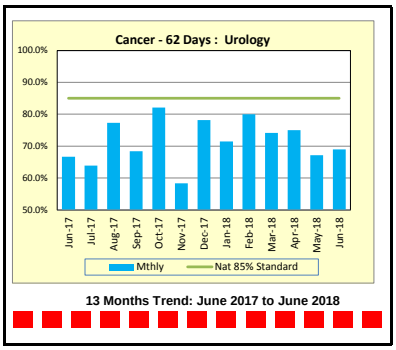

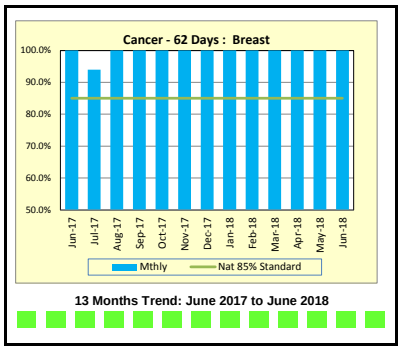

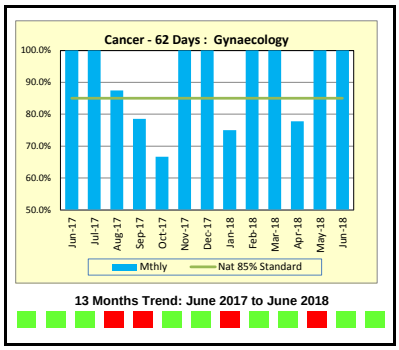

Patient Experience

G Westray

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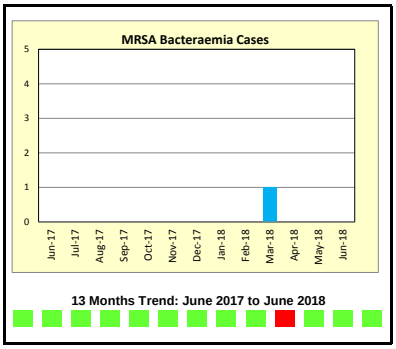
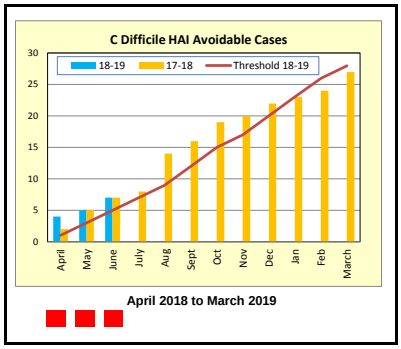
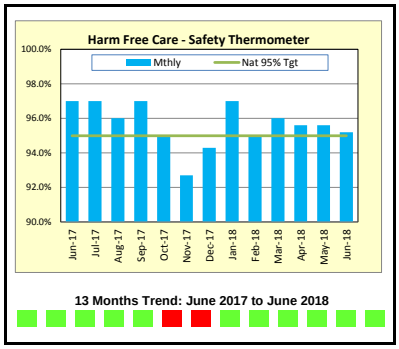
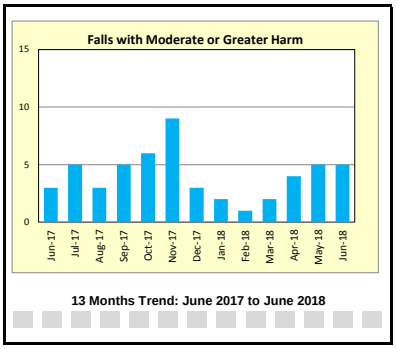
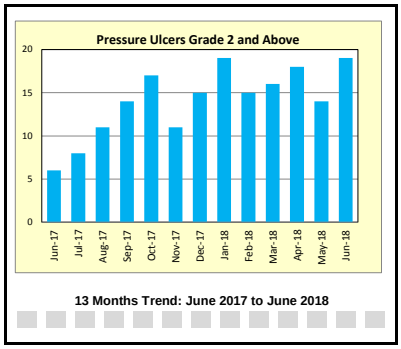
Patient Experience

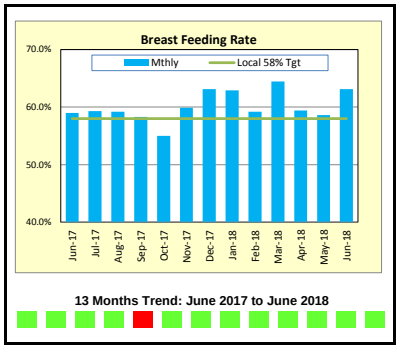


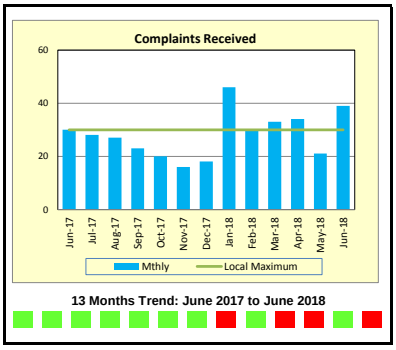


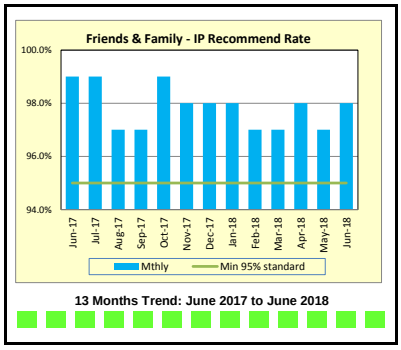


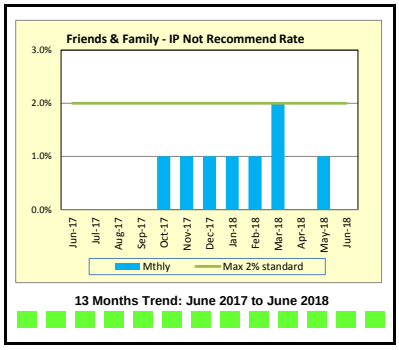










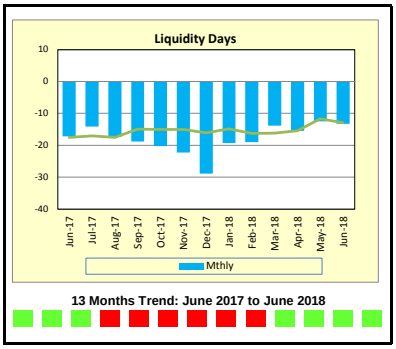


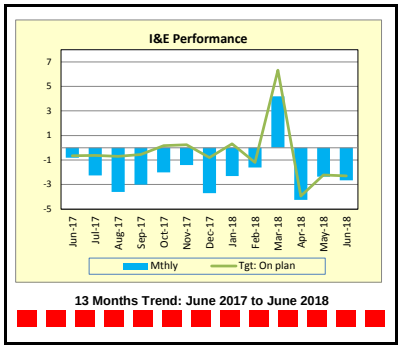
Use of Resources

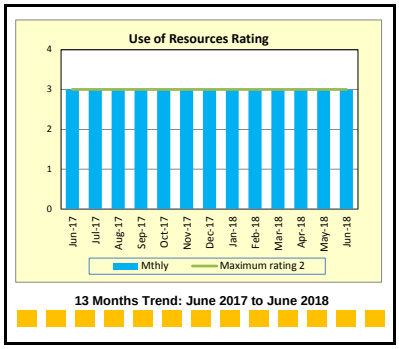
D Jago

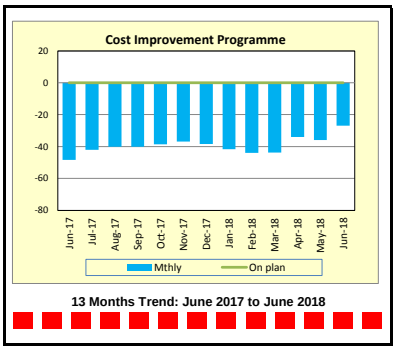
✓	!	×	Not rated
3	1	3	1

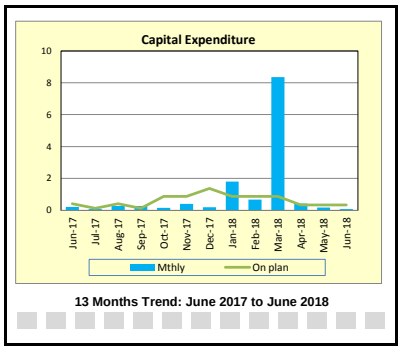
Use of Resources

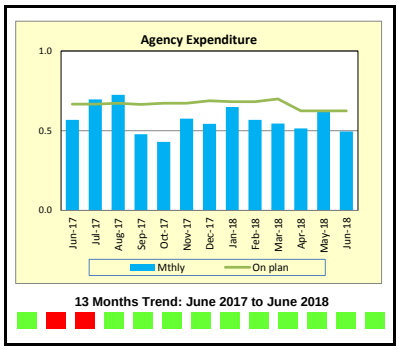


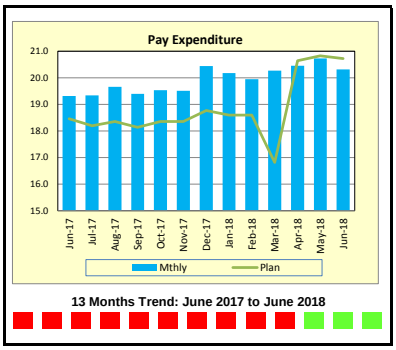


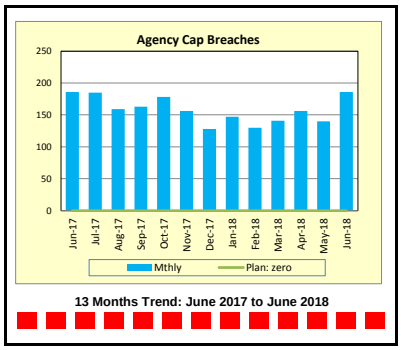












Workforce

H Marks

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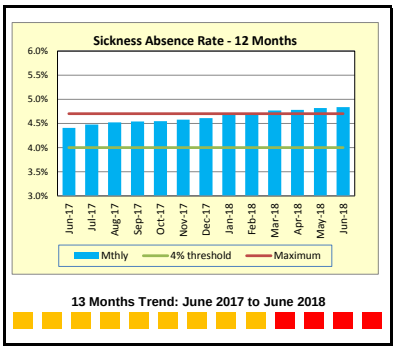
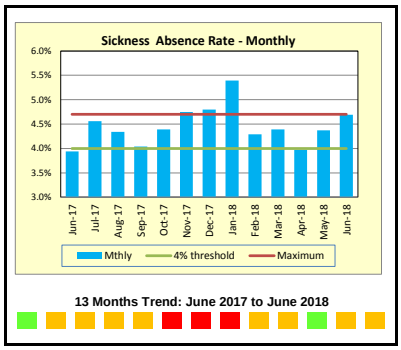
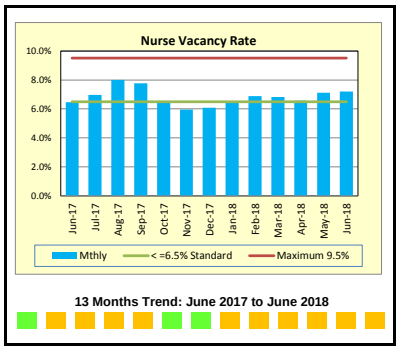
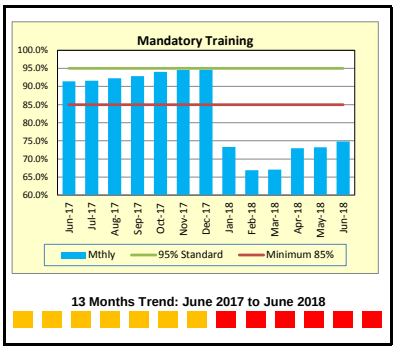
1	6	3	

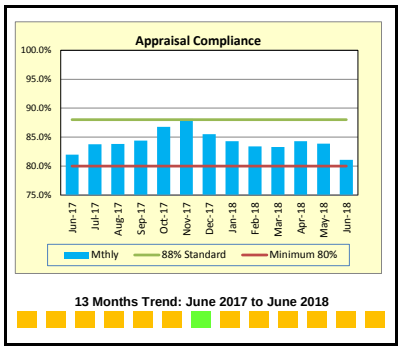
Workforce (HR)

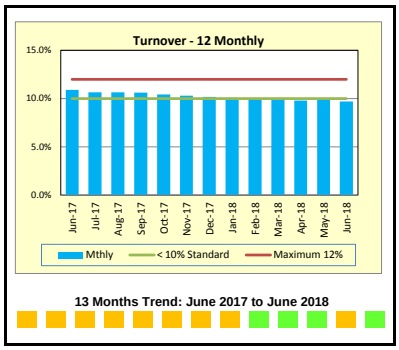


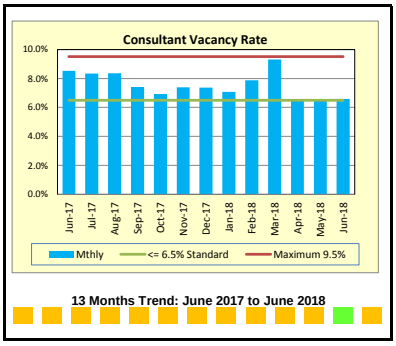


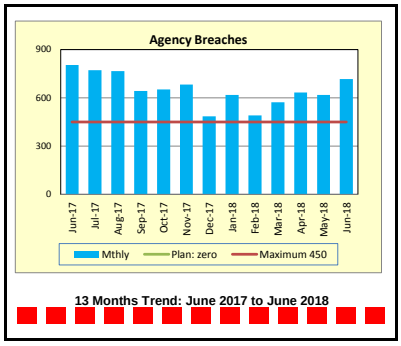


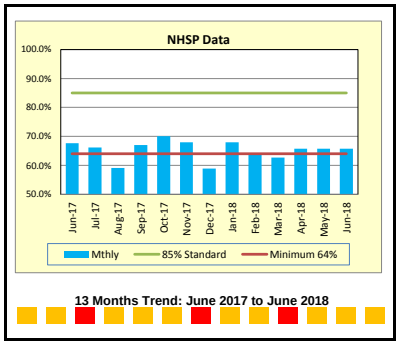


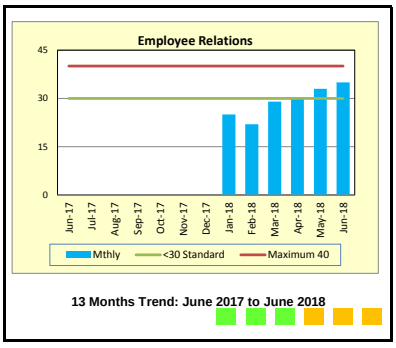












Board of Directors	
Agenda Item	8.1.3
Title of Report	**Month 3 Finance Report**
Date of Meeting	25th July 2018
Authors	Shahida Mohammed – Assistant Director of Finance
Accountable Executive	David Jago Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 3 Finance Report 2018/19

Contents

2. Financial performance

The Trust did not accept the Control Total issued by NHSI for 2018/19 of a surplus of £11.0m; it is therefore unable to access the Provider Sustainability Fund (PSF) resource of £12.5m.
The Trust submitted a plan to NHSi which delivers a deficit of (£25.0m); this includes a Cost Improvement Programme (CIP) of £11.0m

The following summary details the Trust's financial performance during June (Month 3) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£9.3m) against a plan of (£8.5m). The Trust continues to experience a sustained increase in demand for its non- elective services. This in turn has led to continued operational costs in delivering the increase in demand. This reflects gaps in medical staffing posts, resulting in premium costs incurred. The position is compounded further as there has been an increased acuity of patients seen in the Medicine Division.

The main areas driving the adverse position is the under performance in elective and daycase activity, which is 1,060 spells behind plan (8.3%), with a financial impact of (£1.8m), and Outpatients first attendances which are showing an adverse variance of 1,204 (5.3%), and a financial consequence of (£0.2m). This is partially mitigated by the continued over performance in non-elective activity excluding births which is 198 spells ahead of plan (1.8%), delivering a financial benefit of £0.2m (net of MRET).

Other activity areas from a financial perspective are broadly in-line with plan.

The overall expenditure position is £0.9m below plan as at the end of Q1 and is largely supported by £0.6m of non-recurrent balance sheet release. The Trust plan was recently resubmitted to NHSI in June and following feedback to the Board now reflects the anticipated use of bank and agency. The agency spend of £1.6m is £0.3m under the NHSI cap but includes the release of c£0.3m of old agency accruals.

The delivery of cost improvements is on plan as at the end of Q1 and the forecast for the year is £8m with materially £3m still unidentified but work is on-going to crystallise further opportunities to close this gap. The plan for the delivery of cost efficiencies has been largely profiled to be achieved during Quarter 3 and 4 of the year c74%.

The overall position includes £1.1m of non recurrent balance sheet support in Q1, of this £0.9m was released in Mths 1 and 2.

The Trust still has significantly high numbers of "medically optimised" patients within the bed base, reflecting a lack of alternative support within the health and social care system and consequent adverse to plan financial performance.

Cash balances at the end of June were £6.2m, exceeding plan by £4.1m. This is primarily due to positive working capital movements and capital outflows below plan.

2. Financial performance

The year to date capital spend is £0.67m, which is slightly behind plan. Capital expenditure will continue to be monitored at a detailed level at Finance and Performance Group (FPG) and reported to Finance, Business Planning and Assurance Committee (FBPAC) to ensure that outturn is in line with budget.**2.1 Income and expenditure**

Month 3 Financial performance	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
NHS income from patient care activity	305,787	25,702	25,267	(434)	75,658	73,735	(1,923)
Non NHS income from patient care	1,377	115	118	3	344	318	(27)
Income - PSF	0	0	0	0	0	0	0
Other income	29,428	2,438	2,484	45	7,297	7,483	187
Total operating income before donated asset income	336,593	28,255	27,869	(386)	83,299	81,536	(1,763)
Employee expenses	(247,732)	(20,720)	(20,316)	404	(62,181)	(61,484)	697
Operating expenses	(101,879)	(8,859)	(9,258)	(399)	(26,667)	(26,475)	192
Total operating expenditure before depreciation and impairments	(349,611)	(29,579)	(29,575)	5	(88,847)	(87,959)	888
EBITDA	(13,018)	(1,325)	(1,706)	(381)	(5,548)	(6,423)	(874)
Depreciation and net impairment	(8,160)	(669)	(669)	(0)	(2,006)	(2,006)	(0)
Capital donations / grants income	0	0	20	20	0	76	76
Operating surplus / (deficit)	(21,178)	(1,993)	(2,354)	(361)	(7,555)	(8,353)	(799)
Net finance costs	(4,104)	(318)	(304)	13	(936)	(903)	34
Gains / (losses) on disposal	0	0	0	0	0	0	0
Actual surplus / (deficit)	(25,282)	(2,311)	(2,658)	(348)	(8,491)	(9,256)	(765)
Reverse capital donations / grants I&E impact	243	20	(0)	(20)	61	(15)	(76)
Reverse net impairments other than DEL impairments	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	(25,039)	(2,291)	(2,658)	(368)	(8,430)	(9,271)	(841)
Less provider sustainability fund (PSF)	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) [AFPD] excluding PSF	(25,039)	(2,291)	(2,658)	(368)	(8,430)	(9,271)	(841)

- The year to date performance position shows an actual AFPD of (£9.3m), which is (£0.8m) worse than the planned deficit. This main driver of the position is the under performance in elective clinical income (£1.9m).
- Although pay costs are below plan, this reflects the net impact of vacancies in qualified nursing posts, managed through skill mix reviews. Unfilled posts in Corporate areas, and additional costs associated with bank and agency costs in order to cover “gaps” in clinical areas.

2. Financial performance

- The non pay underspend is largely related to clinical supplies due to the reduced number of elective activity undertaken during quarter 1.
- It should be noted the overall position also includes £1.1m non-recurrent balance sheet support, of this £0.9m was released in Mths 1 and 2.

2.2 Income

Activity

	Current month				Year to date			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%
Income from patient care activity								
Elective	718	629	(89)	(12.35%)	2,126	1,639	(487)	(22.90%)
Daycase	3,685	3,447	(238)	(6.46%)	10,710	10,137	(573)	(5.35%)
Elective excess bed days	385	159	(226)	(58.71%)	1,026	514	(512)	(49.92%)
Non-elective	4,242	4,082	(160)	(3.78%)	12,409	12,553	145	1.17%
Non-elective excess bed days	835	832	(4)	(0.42%)	2,407	2,625	218	9.05%
A&E	7,616	7,848	232	3.05%	23,102	23,297	195	0.84%
Outpatients	26,747	24,502	(2,244)	(8.39%)	75,083	72,442	(2,640)	(3.52%)
Diagnostic imaging	2,603	2,131	(471)	(18.11%)	7,439	6,697	(741)	(9.96%)
Maternity	521	475	(46)	(8.76%)	1,579	1,456	(123)	(7.80%)
Total NHS patient care income	47,350	44,105	(3,245)		135,881	131,361	(4,520)	

- The main specialities driving the under performances in elective and daycase activity are Colorectal, Ophthalmology, ENT and Orthopaedic surgery. The re-commencement of the elective programme of activity was initially delayed during April, this has now resumed, although productivity and delivery challenges remain.
- The “booked” activity is being monitored on a weekly basis by Divisions, the focus is to enact remedial action plans to ensure the position does not deteriorate further.
- The demand for emergency care has broadly continued in-line with growth assumptions.

2. Financial performance

- Outpatient activity is under performing significantly particularly in relation to outpatient first attendances and procedures, the main area is Cardiology, due to gaps in the medical workforce, and Trauma and Orthopaedics.

Income

	Current month				Year to date			
	Plan £'000	Actual £'000	Variance £'000	%	Plan £'000	Actual £'000	Variance £'000	%
Income from patient care activity								
Elective	2,243	2,186	(57)	(2.52%)	6,753	5,452	(1,301)	(19.27%)
Daycase	2,394	2,288	(106)	(4.42%)	6,975	6,466	(509)	(7.30%)
Elective excess bed days	93	38	(55)	(59.09%)	248	126	(122)	(49.17%)
Non-elective	8,403	8,431	28	0.33%	24,745	24,788	43	0.17%
Non-elective excess bed days	205	202	(3)	(1.55%)	592	648	56	9.55%
A&E	1,064	1,100	36	3.40%	3,227	3,270	43	1.32%
Outpatients	3,021	2,741	(280)	(9.28%)	8,517	8,099	(418)	(4.91%)
Diagnostic imaging	208	167	(41)	(19.61%)	591	517	(73)	(12.42%)
Maternity	443	375	(68)	(15.35%)	1,345	1,238	(107)	(7.92%)
Non PbR	5,729	5,769	40	0.69%	16,967	17,076	109	0.64%
HCD	1,284	1,359	75	5.83%	3,853	3,724	(130)	(3.36%)
CQUINs	563	563	(0)	(0.03%)	1,688	1,688	(0)	(0.03%)
Other	0	(12)	(12)	0.00%	0	468	468	0.00%
Total income from patient care (SLAM)	25,649	25,206	(443)	(101.59%)	75,500	73,558	(1,942)	(2.57%)
Other patient care income	53	62	9	16.92%	158	177	19	11.99%
Non-NHS: private patients & overseas	36	39	3	8.42%	109	89	(20)	(18.38%)
Injury cost recovery scheme	76	76	0	0.00%	228	223	(6)	(2.41%)
Non NHS: Other	2	2	(0)	(12.52%)	7	6	(1)	(16.60%)
Total income from patient care activities	25,817	25,385	(432)	(88.78%)	76,003	74,053	(1,950)	(2.57%)

- Of the year to date under recovery in NHS income (£1.9m), the main driver is the elective and daycases, which is showing a deficit of (£1.8m), reflecting both activity and casemix variances.

2. Financial performance

- Other PbR areas are broadly balanced with the exception of outpatients, this under recovery is predominantly in outpatient first attendances and procedures.

- Although High Cost Drugs (HCD) are showing an under recovery this is offset with a corresponding reduction in expenditure.

2. Financial performance

2.3 Expenditure

The overall expenditure position as at the end of Q1 is showing an under-spend of c£0.9m against the NHSI submitted plan. The main driver of this underspend is the release of non-recurrent prior year accruals of c£0.6m and lower spend on clinical supplies due to the non-delivery of the elective plan.

Pay and other operating expenses for the Trust are detailed below.

2.3.1 Pay

Pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(225,638)	(18,881)	(18,556)	325	(56,610)	(56,125)	485
Bank	(6,667)	(553)	(628)	(75)	(1,695)	(1,769)	(73)
Medical bank (locums)	(7,057)	(588)	(564)	24	(1,764)	(1,740)	24
Agency	(7,470)	(623)	(494)	129	(1,886)	(1,625)	261
Other - Apprenticeship levy	(900)	(75)	(75)	0	(225)	(225)	(0)
Total	(247,732)	(20,720)	(20,316)	404	(62,181)	(61,484)	697

- The plan has been revised in June in line with NHSI requirements and has been restated with regards to pay to reflect the anticipated use of bank staff and agency. This has resulted in an annual plan of c£13.7m for bank staff and c£7.5m for agency staff.

- Against this revised plan the substantive workforce costs are below plan by c£0.5m at Q1 and are marginally above plan for bank use which is mitigating vacancies in substantive posts in both nursing and medical staffing. Included in substantive costs is further non-core spend in overtime of £0.8m ytd and £0.4m on WLIs. Non-core spend is c11% of the pay bill. Vacancies continue in Clinical Support and some of the Corporate areas.

- The agency spend is £1.6m against the NHSI ceiling of £1.9m showing a £0.3m underspend year to date. However it must be noted that underspend is largely due to the release of a non-recurrent prior year accruals.

2. Financial performance

2.3.3 Non pay

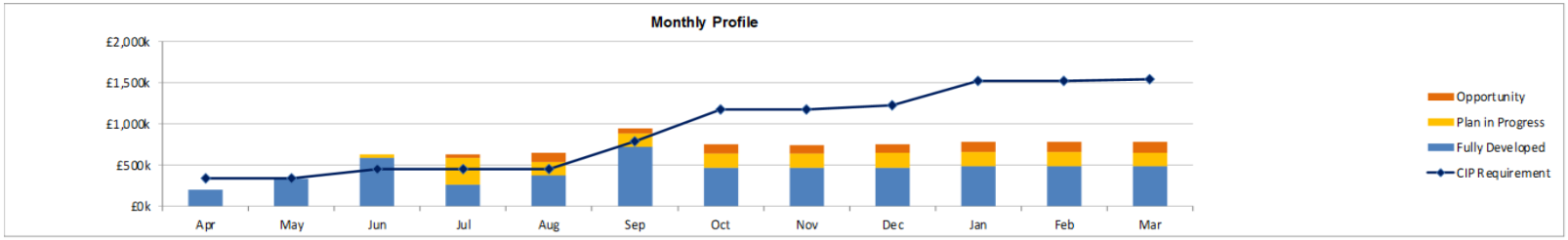
Non pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Supplies and services - clinical	(35,475)	(3,038)	(2,952)	85	(9,127)	(8,255)	873
Drugs	(25,396)	(2,139)	(2,209)	(70)	(6,416)	(6,202)	214
Other	(49,168)	(4,351)	(4,766)	(414)	(13,129)	(14,024)	(895)
Total	(110,039)	(9,528)	(9,927)	(399)	(28,673)	(28,481)	192

- Non pay expenditure is £0.2m underspent as at the end of June.
- The clinical supplies position reflects the reduced levels of elective activity, trauma and orthopaedic below plan activity levels and theatre clinical supplies spend in Surgery accounting for the majority of this underspend.
- Drug costs are below plan cumulatively and £75k above plan in-mth and £130k below plan ytd is in relation to high cost drugs that is offset as a variance in clinical income.
- Other expenditure includes pressures in outsourcing of (c£0.5m) as we continue to use Spire for RTT delivery and to manage radiology reporting pressures in Clinical support.

2. Financial performance

2.4 CIP

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	In Year Forecast Fully Developed £k	In Year Forecast Variance £k	In Year Forecast Pipeline £k	In Year Forecast Total £k	In Year Forecast Variance £k	Recurrent Savings NHSI Plan £k	Recurrent Savings Fully Developed £k	Recurrent Savings Variance £k	Recurrent Savings Pipeline £k	Recurrent Savings Total £k	Recurrent Savings Variance £k
Transformation																
Improving Patient Flow	Anthony Middleton	0	366	**366**	1,000	1,200	**200**	0	1,200	**200**	1,000	0	(1,000)	0	0	(1,000)
Improving Productivity	Anthony Middleton	94	62	(32)	478	393	(85)	169	562	**84**	478	22	(456)	280	302	(176)
Collaboration	Janelle Holmes	35	35	**0**	952	500	(452)	150	650	(302)	952	1,044	**92**	300	1,344	**392**
Digital Wirral	Paul Charnley	250	250	(0)	1,000	1,000	**0**	0	1,000	**0**	1,000	0	(1,000)	0	0	(1,000)
Sub total - transformation		**379**	**713**	**334**	**3,430**	**3,092**	(337)	**319**	**3,411**	(18)	**3,430**	**1,066**	(2,364)	**580**	**1,646**	(1,784)
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	34	28	(6)	134	117	(17)	0	117	(17)	134	19	(115)	0	19	(115)
Estates & Site Strategy	Dave Sanderson	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Pharmacy and Meds Management	Pippa Roberts	59	50	(8)	500	226	(274)	274	500	**0**	500	226	(274)	274	500	**0**
Procurement and Non Pay	Jane Christopher	82	113	**32**	1,150	481	(669)	669	1,150	(0)	1,150	447	(703)	669	1,116	(34)
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	140	264	**124**	1,936	1,445	(491)	1,380	2,824	**889**	1,936	1,496	(440)	1,428	2,925	**989**
Unidentified		446	0	(446)	3,850	0	(3,850)	0	0	(3,850)	3,850	0	(3,850)	0	0	(3,850)
Total		**1,139**	**1,169**	**30**	**11,000**	**5,361**	(5,639)	**2,642**	**8,003**	(2,997)	**11,000**	**3,254**	(7,746)	**2,951**	**6,206**	(4,794)



YTD CIP performance is broadly on plan as at the end of Q1. The current in-year forecasting shows £5.4m of fully developed schemes with a further £2.6m identified as "plans in progress and opportunities", and of concern c£3.0m still unidentified. This excludes the potential benefits from the Outpatient productivity programme for Surgery and Medicine as the review is still underway. This position is a £1.0m improvement on the M2 reported position, all within clinical areas. Further work is required in some of the Corporate areas. However, despite the inclusion of the additional opportunities this month all divisions, with the exception of Women & Children, are currently forecasting a position significantly behind the plan requirement.

The profile of CIP plan and delivery is reflected in the table above and the concern is the unidentified gap post September.

Work is on-going to identify further opportunities in both clinical and corporate areas to close the gap.

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 30.06.18 £'000	Actual as at 30.06.18 £'000	Variance (to plan) £'000	Plan 31.03.19 £'000
	Non-current assets					
159,754	Property, plant and equipment	⇩	159,428	159,130	(298)	160,148
12,763	Intangibles	⇩	12,081	12,052	(29)	12,369
903	Trade and other non-current receivables	⇩	903	805	(98)	903
173,420		⇩	**172,412**	**171,987**	**(425)**	**173,420**
	Current assets					
4,171	Inventories	⇧	4,171	4,117	(54)	4,171
18,423	Trade and other receivables	⇩	19,151	15,563	(3,588)	18,424
0	Assets held for sale	⇨	0	0	0	0
7,950	Cash and cash equivalents	⇩	2,090	6,181	4,091	1,773
30,544		⇩	**25,412**	**25,861**	**449**	**24,368**
203,964	**Total assets**	⇩	**197,824**	**197,848**	**24**	**197,788**
	Current liabilities					
(32,538)	Trade and other payables	⇧	(29,027)	(29,423)	(396)	(27,752)
(3,224)	Other liabilities	⇩	(3,224)	(3,590)	(366)	(3,224)
(1,074)	Borrowings	⇨	(1,074)	(1,075)	(1)	(1,076)
(548)	Provisions	⇨	(548)	(548)	0	(548)
(37,384)		⇧	**(33,873)**	**(34,636)**	**(763)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	⇩	**(8,461)**	**(8,775)**	**(314)**	**(8,240)**
166,580	**Total assets less current liabilities**	⇩	**163,951**	**163,212**	**(739)**	**165,180**
	Non-current liabilities					
(8,812)	Other liabilities	⇧	(8,727)	(8,727)	0	(8,470)
(49,258)	Borrowings	⇩	(55,278)	(55,279)	(1)	(73,221)
(2,318)	Provisions	⇧	(2,271)	(2,270)	1	(2,131)
(60,388)		⇩	**(66,276)**	**(66,276)**	**0**	**(83,826)**
106,192	**Total assets employed**	⇩	**97,675**	**96,936**	**(739)**	**81,366**
	Financed by Taxpayers' equity					
77,575	Public dividend capital	⇨	77,575	77,575	0	78,031
(12,259)	Income and expenditure reserve	⇩	(20,776)	(21,515)	(739)	(37,541)
40,876	Revaluation reserve	⇨	40,876	40,876	0	40,876
106,192	**Total taxpayers' equity**	⇩	**97,675**	**96,936**	**(739)**	**81,366**

Capital asset variances	£m
Capex underspend	-0.4
Donations above plan	0.1
Total variance of capital assets to plan	**-0.3**

Cash variances	£m
EBITDA and donations below plan	-0.9
Working capital movements	3.9
Capital expenditure (cash basis) below plan	1.1
Total variance of cash to plan	**4.1**

3. Financial position

Wirral University Teaching Hospital NHS Foundation Trust

3.2 Capital expenditure

	2018/19 NHSI capital plan £'000	Full year Budget [1] £'000	Full year Forecast [2] £'000	Variance £'000	Full year Forecast [2] £'000	Green light schemes [4] £'000	Variance £'000	YTD Actual £'000
Funding								
Depreciation	8,160	8,160	8,160	0				2,006
Loan repayment	(1,015)	(1,015)	(1,015)	0				0
Finance lease	(60)	(60)	(60)	0				(15)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	79	79	0				76
Public Dividend Capital	456	456	456	0				0
Total funding	**10,791**	**10,870**	**10,870**	**0**				**5,317**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		0	0	0	0	0	0	0
Divisional priorities - *Surgery*		76	109	(33)	109	34	75	21
Divisional priorities - *Women and Children's*		18	18	0	18	18	0	0
Divisional priorities - *Clinical Support and Diagnostics*		20	37	(17)	37	17	20	17
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,500	1,500	0	1,500	0	1,500	0
Divisional priorities - contingency [3]	500	1,712	1,662	50	1,662	0	1,662	-
Informatics - *Digital Wirral / Global Digital Exemplar*	2,811	2,811	2,811	0	2,811	2,811	0	99
Informatics	500	500	500	0	500	106	394	106
Estates - backlog maintenance	1,500	2,525	2,525	0	2,525	628	1,897	345
All other expenditures		529	529	0	529	359	170	7
Contingency [3]	1,180	1,101	1,101	0	1,101	0	1,101	-
Contingency	3,250	n/a	-	-	n/a	-	-	-
NHSI plan subtotal	**10,791**							
Donated assets	0	79	79	0	79	79	0	76
Total expenditure (accruals basis)	**10,791**	**10,871**	**10,871**	**0**	**10,871**	**4,052**	**6,819**	**671**

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

[2] Current forecast includes slippage from 2017/18.

[3] Funding is transferred as business cases are approved.

[4] Green light schemes are those for which a feasible capital bid form has been approved, the scheme is expected to deliver in year and order(s) have been raised.

3.3 Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening cash	**7,477**	**3,762**	**3,715**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(2,658)	(2,320)	(338)	(9,256)	(8,516)	(740)	(25,282)	(25,282)
Net interest accrued	113	124	(11)	329	356	(27)	1,806	1,806
PDC dividend expense	191	191	0	573	573	0	2,292	2,292
Unwinding of discount	0	3	(3)	1	9	(8)	6	6
(Gain) / loss on disposal	0	0	0	0	0	0	0	0
Operating surplus / (deficit)	(2,354)	(2,002)	(352)	(8,353)	(7,578)	(775)	(21,178)	(21,178)
Depreciation and amortisation	669	669	(0)	2,006	2,007	(1)	8,160	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(20)	0	(20)	(76)	0	(76)	0	0
Changes in working capital	537	(287)	824	3,068	(860)	3,928	(996)	(996)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	9	3	6	24	9	15	48	48
Purchase of non-current (capital) assets [1]	(1,274)	(1,250)	(24)	(4,401)	(5,457)	1,056	(12,444)	(12,444)
Sales of non-current (capital) assets	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0
Financing activities								
Public dividend capital received	0	0	0	0	0	0	456	456
Loan funding [2]	1,200	1,200	0	6,036	6,036	0	24,027	24,027
Interest paid	(55)	0	(55)	(56)	0	(56)	(1,845)	(1,845)
PDC dividend paid	0	0	0	0	0	0	(2,335)	(2,335)
Finance lease rental payments	(6)	(6)	0	(18)	(18)	0	(70)	(70)
Total net cash inflow / (outflow)	**(1,296)**	**(1,673)**	**377**	**(1,769)**	**(5,861)**	**4,092**	**(6,177)**	**(6,177)**
Closing cash	**6,181**	**2,090**	**4,091**	**6,181**	**2,090**	**4,091**	**1,773**	**1,773**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.
[2] Support funding currently comprises a working capital facility, and 'uncommitted loans', issued by DHSC and administered by NHSI.

Wirral University Teaching Hospital NHS Foundation Trust

4.1 Single oversight framework

UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-12.9	3	-13.3	3	-12.9	3
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-5.8	4	-6.8	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-10.2%	4	-11.4%	4	-7.4%	4
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-1.2%	3	0.0%	1
	Agency spend (%)	Distance of agency spend against cap	20%	0.9%	2	-13.2%	1	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust is continuing to underspend against the agency cap, achieving an *Agency spend* rating of 1. This metric prevents the UoR rating from dropping to 4 — which would place the Trust in the highest risk category with NHSI.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 3 UoR rating is 3 overall, which is in line with the 2018/19 plan UoR rating of 3.
- Forecast UoR rating is 3.

Board of Directors	
Agenda Item	9.1
Title of Report	Bi-Monthly Safer Staffing April / May 2018
Date of Meeting	25 July 2018
Author	Tracy Fennel Deputy Director of Nursing and Midwifery Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head of Clinical Excellence & Organisational Development,
Accountable Executive	Gaynor Westray Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 3
Level of Assurance **Positive** **Gap(s)**	**Positive** • A robust process has been agreed to ensure acuity and dependency/establishment reviews are undertaken and reported bi-annually. • Improved governance has noted a reduction in overtime payments and an increase in NHSP recruitment. • A Nursing, Midwifery and AHP strategy has been developed • A Safer Staffing policy has been drafted. **Current Gaps** • Sickness remains above the Trust target for nursing and midwifery groups • Skill mix has become diluted in some areas due to the high vacancy factor. • Some areas have noted a reduction in skill mix that potentially can compromise the quality of care; mechanisms are in place to monitor quality care indicators.
Purpose of the Paper **Discussion** **Approval** **To Note**	For information and discussion.
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	No

1. Executive Summary

This report provides the Board of Directors the bi-monthly comprehensive report on nursing staffing based on the Trust position against the requirement of the National Quality Board (NQB) Safer Staffing Guidance and the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 for adult in patient wards. The report includes information on registered nurse / midwives and clinical support workers, drawn from a range of staffing data and information including vacancy rates and staffing related incidents for April & May 2018.

2. Background

The Board of Directors has previously received reports on nurse staffing outlining nurse staffing numbers, establishments and the Trust plans to achieve the NICE requirements for adult wards against a background of a national shortage of registered nurses. The purpose of this paper is to provide the Board with the reported position for April and May 2108, the actions taken to mitigate the impact on patient experience and patient care and the forward plans.

3. Recruitment

A key priority for the Trust is to ensure appropriate nurse staffing levels are established and maintained. The previous investments in nurse staffing, as well as a robust recruitment plan, has ensured that the Trust has had a stable nursing and midwifery workforce. In view of the national issues surrounding nurse recruitment, the organisation has endeavoured to be more creative around supporting nurse's personal development at ward level through the facilitation of planned rotational posts.

Other strategies are also being explored such as Hybrid roles that offer within 1.0 WTE 30 hours ward based duties and one day within a specialist nursing function. These posts are desirable and offer the added benefit of ensuring specialist skills such as Tissue Viability, Infection Control, Safeguarding, and Falls Management are infiltrated into the ward areas. The Trust has been involved in a number of recruitment events that has led to the recruitment registered nurses as highlighted in table below. Further recruitment events are scheduled at Chester Pride August 2018, Dublin recruitment fair in July 2018 and Nursing Times Manchester recruitment fair in September 2018. Local recruitment is ongoing with targeted recruitment events covering ED, theatres, Medicine & Acute and Surgery.

Table 1 Total Recruitment by Division (July 2017 – June 2018)

	RN	CSW
Emergency Department	13	
Medicine & Acute	61	26
Critical Care	7	
Women & Childrens	15	
Surgery	29	
Theatres & Anaesthetics	12	
Total	137	26

4. Vacancies

The current vacancy rate for all registered nursing and midwifery posts is 7.11%, however the priority is band 5 Nursing posts. Vacancies for inpatient and ED areas Band 5 nurses

has increased Trust wide from 7.03% March 2017 (42.70wte) to 13.94% in May 2018 (95.37wte) due to establishment changes within the agreed bed base.
The current divisional position is as follows:

- Medicine & acute 17.20%
- Surgery 16.39%
- W&C 10.22%

The Trust vacancy rate for Band 5 Registered Nurses has remained broadly static against a deepening national shortage of registered nurses. Benchmarking identifies a quarter of NHS Trusts reported a registered nurse vacancy rate of over 15%,with the highest vacancy rate at 37%. This equates to approximately a national 28,000 Band 5 nurse vacancies, with an average vacancy rate of 16%. The development of the Nursing, Midwifery and AHP workforce strategy and Organisational Development with a strong recruitment and retention plan is essential to retain the current workforce and bring about positive and swift impact on the vacancy rate. A 'retaining clinical staff' task and finish group is being established to develop evidence based retention actions with the first meeting scheduled for August 2018.

The Trust is currently targeting newly qualified registered nurses with 17 being offered posts upon qualification September 20 18. The 47 'sign off students' placed at WUTH to complete their training are aware of recruitment opportunities. The Trust continues to support return to practice and are also supporting eight CSWs through Foundations of UK Nursing Programme to gain NMC registration

The Trust overall does not currently hold significant vacancies for the care support worker (CSW) role due to ongoing rolling recruitment and over recruiting in Medicine and Acute Division. The Trust position being -1.96%

The current divisional position is as follows:

- Medicine & acute -7.59%
- Surgery 11.59%
- W&C 10.94%

However work has commenced to identify a clear plan relating to Band 1-4 CSW roles ensuring this is fully understood in relation to the wider workforce plan. A mapping exercise is ongoing to identify where band 4 roles will supplement nursing teams verses where they will be utilised as a career pathway to a registered nurse qualification. This will be reported to Board as part of the six monthly establishment reviews. WUTH currently has six trainee nursing associates (January 2017 cohort) that are progressing through their second year of the programme and an additional cohort of six trainee associates commenced March 2018.

5. Retention

Concerns were raised in the previous Hard Truths Commitments reports in relation to staff moves and the potential impact on leaver figures. A review has concluded that currently there is a lack of compliance with the exit policy and completion of exit Interviews. Although it is understood some exit interviews are undertaken recording of this is inconsistent. This metric will be measured and outcomes be addressed via the Workforce Assurance Committee (WAC). A review of the current evidence however does not suggest staff moves are contributing to the number of staff leaving the Trust. Factors such as acuity, promotional offers, and travelling are known contributors to staff making the decision to leave. It is understood staff moves do have a detrimental effect on staff well-being hence advanced rota planning, block bookings and rotational contracts are being studied to reduce the necessity to move staff, however some on the day moves will always be inevitable due to sickness.

There is a clear link between staff wellbeing feeling valued and retention plans. Organisational Development plans are underway to ensure this is addressed timely. In addition the Back to the Floor programme has utilised the “Quality Bus” to engage staff on the “What matters to you” campaign to inform the content of the Nursing, Midwifery and AHP workforce strategy. In addition senior Nursing team have committed to increase visibility not only on the wards but supported with a restructure of nursing meetings to include a professional Nurse Forum, ward managers meeting, specialist nursing meeting and matrons meetings. These have noted good engagement and attendance since their introduction in April 2018.

6. Use of Existing Staff

Rostering

A project plan has been developed and is ongoing to ensure the Trust maximises the benefits of E Roster. KPI reports are now being produced and monitored monthly to ensure maximum benefits of effective rostering are achieved. KPIs had identified a significant amount of double time overtime shifts were being booked and paid due to significant staffing challenges. However limited governance around double time overtime bookings had led to ineffective rostering and increased costs. This has been addressed with strict sign off for bookings by the Divisional Directors of Nursing. This has accrued a saving of £65,000 across the Medical and Acute Division in May 2018. This has also led to an increase in substantive post holders applying to join NHSP in May 2018, with 50 recruited against an average of 20-30 staff per month

Temporary Staffing - NHS Professionals (NHSP)

Overall demand for RNs in May 2018 was responded to by a fill rate of 61.2% by NHS Professionals (NHSP) against a target of 85%. Actions being taken to increase fill rate include;

- Vacant shifts requests to be sent to NHSP six weeks in advance in line with roster timetable being monitored through roster KPI reports and escalated to Divisional DoN where non-compliant.

- Review of top 5 areas with lowest fill rate to be undertaken to include staff feedback

- Student nurses to be recruited as CSW’s via bank exclusive programme

It has also been identified many staff are reluctant to apply to NHSP as current rates of pay for nursing band 5 and clinical support worker band 2 bank staff at WUTH are set at the bottom of scale for staff joining NHS Professionals. 59% of band 5 nurses and 40% of band 2 CSWs are already at top of pay scale. A business case has been developed providing an options appraisal to address this issue.

Reasons for requests in May 2018 remain consistent; with vacancy being the highest accounting for 52% of the top 10 requested shifts followed by sickness. Highest requests currently are Ward 19, Emergency Department, Ward 38, and Ward 23.

Agency use remains consistently low at 3.2 % of overall use, and remains lower than the national average. Performance of NHSP contracts is monitored monthly in the NHSP performance meeting

Safe Staffing Fill Rates

It is a requirement of the Trust to provide to NHS England monthly nurse and midwifery staffing fill rates broken done by clinical area for day and night shifts. These rates include

registered and unregistered staff and are used to calculate Care Hours per Patient Day (CHPPD). Please see appendix one for fill rates by clinical area for April and May 2018.
The Trust has developed a locally agreed RAG rating for staffing fill rates, each month all shifts which are classified accordingly with RED (under 79% fill rate) or BLUE (over 100%) reported in a Divisional Director of Nursing Assurance report to ascertain mitigating actions, escalation, assurance and to monitor trends to ensure safe staffing is in place, identify any learning outcomes and provide insight for establishment reviews.

Exception report - April 2018

Ward 10 had three of the four shift categories rated as RED this was due to a requirement to change the establishment as the ward had a reduction in beds to accommodate for the new unit Wirral Acute Femoral Fracture Unit (WAFFU). The establishment has now formally changed to reduce the number of planned staff to meet the reduced number of beds.

Ward 27 Registered Nurse shifts for both day and night were rated as RED however both the CSW's shifts were rated as BLUE as this was due to grade changes to support vacancies – the ward sister also worked clinically ensuring that there was safe staffing at all times.

Ward 32 demonstrated vacancies and short notice sickness during April, resulting in three of the four shift categories being rated as RED. In order to ensure safe staffing the ward sister worked clinically, Twilight shifts were filled where full nights were not possible. Ward 32 has flexible staffing as the ward also covers CCU, CDS and HAC so staffing during these times remained fluid to cover where required.

Ward 38, a newly appointed ward sister required support in ensuring that staffing met the full establishment requirements, Advance practitioners and band 3 CSW were allocated to registered nurse shifts. Safe staffing remained in place.

ITU supports the level of patients needed to be admitted with the contingency to use the nurse educators and critical care outreach to supplement numbers when the unit is having a peak in patient demand. Safe staffing was in place at all times.

Dermatology - whilst three of the four shift categories was rated RED this is due to a need to change the establishment to allow for the ward being closed on a Friday.
Both ward 25 and WAFFU had grade changes in place to support safe staffing as correlated with BLUE fill rates for non-registered staff.

Exception report - May 2018

Ward 12 day shifts were rated as RED, safe staffing remained in place as Patient acuity was low and therefore RNs were moved to support other areas as demand required. Ward sister worked clinically to support.

MSSW have fluid staffing with ACU – safe staffing was in place to meet the acuity of patients.

As in April both ward 25 and WAFFU had grade changes in place to support safe staffing as correlated with BLUE fill rates for non-registered staff.

Dermatology had reduced number of patient requiring inpatient care during May and therefore the staffing was a reflection of patient activity.

Ward M2 Ortho had reduced patient activity requiring less staff to support patient needs – staff were reutilised to support other areas.

ITU was not required at full capacity during May for 1:1 nursing and therefore the unit was safe at all times.

The consistent measure of nursing provision within the model hospital portal is Care Hours per patient day CHPPD. The table below is the latest data available from within the portal which is for January 2018.

Table 2: CHPPD

	WUTH	National Average	Peers based on Trust size and spend
Total CHPPD	7.1	7.5	7.6
Registered Nurse	3.9	4.6	4.6
CSW	3.2	3	3

Work continues nationally and regionally to ensure that the data contained within the Hospital Portal is accurate and in line with Lord Carters recommendations. This will be taken forward through the nursing and midwifery strategy work.

Sickness

Sickness absence rates have demonstrated a month on month rise in the registered nursing/ midwifery cohort of staff. The rolling 12 month absence data shows that performance is significantly above the Trust target of 4% (5.36% for May 2018). Understandably this level of absence places further pressure on the workforce. A monthly sickness report is monitored by the Divisions to increase understanding and visibility of the areas that are experiencing absence rates consistently above the Trust target. This is demonstrating a reduction in the number of long term absences following increased compliance with the sickness and absence policy.

WUTH are currently an outlier within the Model Hospital portal for sickness levels for sickness rates within registered nursing and midwifery as shown in the table 3 below.. This is based on January 2018 data which is the latest data available within the portal. The table below indicates the sickness levels per staff group in comparison to the national average and other peer Trusts based on size and spend.

Table 3: WUTH sickness benchmarked against National / peer organisations (source Model hospital portal, NHS Improvement)

	WUTH	National Average	Peers based on Trust size and spend
Registered Nurse	6.3%	4.9%	5.3%
CSW	7.5%	7.8%	7.3%
Midwives	6%	5.6%	5.6%

Staffing in times of Escalation

Ensuring safe staffing during periods of escalation can be a challenge, during periods of high activity additional areas were utilised to meet operational demand. Non ward based nursing staff are released to assist inpatient escalation areas however this approach is inconsistent with limited understanding of the service impact this creates. The nurse staffing escalation guide has been circulated to all ward sisters / charge nurses and hospital clinical coordinators. This provides guidance and supports decision making if concerns are raised with regard to staffing. This is incorporated into the Safer staffing policy currently in draft for consultation that supports effective management and deployment of staff to ensure safe staffing.

Dependency and Acuity

A full acuity and dependency review of inpatient wards will be undertaken in July 2018. The Emergency department will also complete the BEST staffing review tool. These results will form part of the next Bi annual establishment paper for presentation to Board of Directors in November 2018.

Therapeutic Supervision (1:1 Nursing)

The Trust does not currently have a live system in order to monitor the use, requests and provision of 1:1 nursing. The current temporary staffing (NHSP) request system does not interface with E roster, therefore there may be times when unfilled demand remains in the NHSP request system but is filled by other routes, such as substantive staff overtime. There is also no clinical documentation specifically related to provision / non-provision of 1:1 nursing within the electronic patient record, providing no auditable trail as to how the risk for the patient has been assessed and what level of care has been provided.

The need for 1:1 supervision of patients is often paramount to the patient's safety and therefore the use of staff for this purpose is being monitored via the daily staffing sheets at a corporate level. The table below shows the number of requests compared with the number supplied. It should be acknowledged that this is high-level data and does not currently provide an understanding into the use of 1:1 supervision.
Whilst the Trust awaits an addition into Wirral Millennium the Corporate team will develop the daily staffing sheets to provide greater insight.

Table 4: Therapeutic Supervision (1:1 Nursing)

Data taken from Daily staffing sheets								
Overall trust total	Day				Night			
	1:1 requested	1:1 supplied	Variance	% fill rate	1:1 requested	1:1 supplied	Variance	% fill rate
April	212	71	141	33%	282	178	104	63%
May	180	75	105	42%	227	173	54	76%

Ward sisters / charge nurses

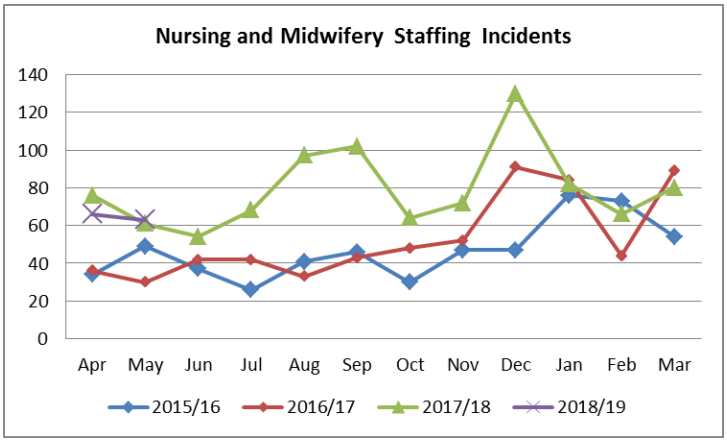
Within WUTH Ward sisters and Charge Nurses should be 100% supernumerary. This provides capacity for clinical supervision and delivery of the Trust safety and quality key performance indicators. Evidence has shown that ward sisters are being required to provide clinical cover within the areas to maximise safe staffing. In light of this a data capture exercise was implemented to monitor the number of clinical shifts that Ward Sisters and Charge nurses are working (see table 5). The Trust has 6 months of data now and is using this as part of the wider establishment review and in support of developmental band 6 roles.

Table 5: Supernumerary Time for Ward Managers

Ward sister / Charge nurse			
Month	0% to 20% Clinical shifts worked	21%to 50% Clinical shifts worked	51% to 100% Clinical shifts worked
April 2018	21 wards	5 wards	15 wards
May 2018	20 wards	10 wards	11 wards

7. Reported Staffing Incident data

During April 2018 (66) there was a significant reduction in the number of staffing incidents recorded in comparison to April 2017 (76) and was also a significant reduction on March 2018 (80). Risk scores remain low with no actual recorded patient harms.



Staffing incidents are reviewed each month by the senior nursing team and a monthly summary report is shard to monitor trends and themes.

Exception report - April 2018

The areas with the most frequent number of reported incidents were Ward 17 with 9 incidents, Ward 18 with 8 incidents and ITU with 6 incidents.

Ward 17 – On review there was no single theme for the recoding of incidents. Some incidents related to high acuity patients and a perception of insufficient staff to provide the care required. All incidents were reviewed by the Division and assurance regarding safe staffing provided.

Ward 18 – Incidents related to increased acuity of patients. One incident was used to record a flag of staff being unable to take breaks. All incidents were reviewed by the Division and assurance regarding safe staffing provided.

ITU – Incidents reported bed closures to maintain patient safety. On review of the incident it appears that some incident forms were a duplicate of the same incident. All incidents were reviewed by the Division and assurance regarding safe staffing provided.

Exception report - May 2018

M1 Rehab and ward 54 featured as areas with the most frequently recorded incidents with a total of 5 each.

M1 Rehabilitation incidents all related to 2 RN's on duty instead of the rostered 3. Ward M1 rehab has recently been supported as an area of concern and has had a full establishment review resulting in an establishment change. This is being monitored closely and will be reviewed again formally as part of the full acuity and dependency audit.

Ward 54's incidents all related to the opening of escalation beds. The Division has encouraged staff to complete incident forms during escalation if there are any concerns regarding inappropriate outliers for staff skill mix or staffing concerns. The appropriate use of escalation beds has been escalated to the Deputy Director of Nursing.

8. Next Steps

The Nursing, Midwifery and AHP workforce strategy with the associated work plan will be presented for Board of Directors in July 2018. It will support recruitment, retention and promoting career pathway development for nursing and midwifery roles.

The second cycle of establishment reviews will commence 16 July 2018, starting with the initial data collection around acuity and dependency scores. In areas of specialism e.g. acute surgery / stroke units with high levels of time consuming tasks such as Total Parenteral Nutrition (TPN), high volumes of Intravenous antibiotics or PEG feeds an additional metric (Activity Follow) will be undertaken to support effective judgements to be made in relation to staffing models against patient needs. The outcomes of the forthcoming establishment reviews will be presented in November 2018 to the Board of Directors.

9. Conclusion

Whilst the Trust's nurse vacancy rates are better than organisations that we are benchmarked against, sickness absence rates and CHPPD are deteriorating. We recognise that the model hospital data suggests that the spend for nursing is an outlier when reviewed against similar organisations, however this is due in part to the length of service of a high proportion of our nursing workforce.

There are emerging early indicators such as reduced fill rates, static elevated vacancy levels at ward level, reduction in supervisory status of our ward managers, increasing sickness absence and some wards experiencing a reduction in CHPPD that suggests significant focus is required in this area moving forward.

The Trust continues to look at innovative ways to review the ward establishments and implement a variety of support roles across Band 3 and 4 however this needs to be implemented with caution as reducing the skill mix can have a detrimental effect on quality and safety. These areas will be monitored by triangulating a range of validated metrics within the Ward Accreditation and Monthly Ward Dashboards to ensure Quality and safety of care is not compromised.

10. Recommendations

The Board of directors is asked to receive this report for information and discussion.

Appendix 1

April 2018

	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
10	60.8%	73.2%	65.6%	82.2%
11	85.9%	94.5%	100.0%	131.6%
12	71.4%	94.3%	81.7%	156.7%
OPAU	78.4%	92.5%	100.0%	100.0%
17	85.2%	106.2%	83.7%	108.9%
18	88.0%	102.9%	86.7%	108.9%
20	91.6%	102.7%	77.8%	145.9%
21	83.0%	105.6%	79.9%	118.9%
22	90.5%	97.4%	87.8%	100.0%
23	83.8%	103.9%	84.4%	109.1%
27	77.1%	114.6%	75.6%	123.3%
26	91.1%	97.0%	88.9%	112.2%
30	84.1%	89.4%	76.7%	96.7%
32	78.7%	95.0%	71.7%	74.2%
33	94.5%	99.2%	66.7%	107.8%
36	89.6%	97.8%	80.8%	113.8%
38	86.6%	92.1%	75.0%	75.0%
53	98.6%	84.4%	100.0%	73.7%
54	96.5%	100.0%	100.0%	100.0%
AMU	90.6%	99.6%	97.1%	95.4%
MSSW	57.4%	84.3%	100.0%	94.4%
EDRU	92.6%	108.5%	90.6%	138.4%
ESAU	113.0%	76.6%	96.2%	101.7%
ITU	76.6%	86.7%	77.3%	76.7%
HDU	95.0%	76.7%	96.7%	100.0%
Delivery suite	99.5%	100.0%	100.0%	100.0%
Neonatal	98.3%	93.3%	95.8%	73.3%
Children's	91.2%	122.3%	114.3%	171.7%
M2 Ortho	71.6%	88.6%	93.3%	73.3%
M2 Surg	100.0%	100.0%	100.0%	100.0%
CRC	92.6%	98.7%	100.0%	100.0%
M1 rehab M1 MO	80.9%	78.2%	79.3%	96.0%
Dermataology	97.7%	43.9%	76.2%	76.2%
25	65.8%	103.0%	66.7%	98.7%
CCU	100.0%	92.0%	87.3%	100.0%
37	50.0%	100.0%	50.0%	96.8%
24 IPC	76.1%	65.8%	90.0%	97.5%
WAFFU	74.6%	119.3%	51.7%	196.7%

May 2018

	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	RN CHPPD	CSW CHPPD	Total CHPPD
10	91.0%	89.0%	100.0%	135.5%	3.5	3.9	7.4
11	82.4%	93.1%	97.8%	153.8%	4.0	4.9	8.9
12	66.2%	68.9%	90.3%	80.6%	2.9	2.2	5.1
OPAU	80.1%	94.3%	100.0%	100.0%	3.4	4.0	7.4
17	86.7%	109.4%	81.2%	107.5%	2.9	2.9	5.8
18	86.7%	98.8%	90.0%	108.6%	3.0	3.0	6.0
20	87.4%	98.0%	90.9%	111.3%	3.1	2.5	5.6
21	78.1%	109.9%	87.9%	125.8%	2.5	3.3	5.9
22	87.5%	100.0%	88.2%	102.2%	2.7	2.7	5.4
23	81.3%	98.5%	95.7%	130.4%	3.2	3.2	6.5
27	70.6%	122.6%	67.4%	123.7%	2.2	3.5	5.7
26	82.3%	94.8%	82.8%	104.3%	2.6	2.7	5.3
30	82.8%	79.3%	80.7%	90.3%	3.5	2.4	5.8
32	77.5%	95.5%	87.6%	97.8%	2.9	2.9	5.8
33	82.9%	96.9%	70.4%	112.9%	2.4	3.5	5.9
36	88.6%	102.8%	77.4%	102.1%	2.7	2.8	5.5
38	84.3%	93.4%	79.8%	84.7%	2.8	2.6	5.3
53	100.0%	79.6%	100.4%	68.5%	4.1	3.5	7.6
54	98.3%	93.8%	100.0%	106.5%	3.7	2.5	6.2
AMU	92.5%	100.0%	96.4%	98.4%	5.0	4.5	9.6
MSSW	73.7%	77.7%	100.0%	82.8%	3.2	3.1	6.4
EDRU	104.1%	103.2%	71.2%	176.2%	5.4	4.4	9.8
ESAU	98.9%	74.0%	96.7%	101.5%	5.1	4.3	9.4
ITU	72.0%	67.7%	75.4%	77.4%	25.3	2.2	27.5
HDU	100.0%	87.1%	98.4%	100.0%	18.0	4.1	22.1
Delivery suite	100.0%	100.0%	100.0%	100.0%	35.9	5.1	41.0
Neonatal	102.4%	103.2%	99.2%	83.9%	11.8	1.4	13.2
Children's	97.7%	126.6%	115.0%	154.8%	8.9	2.7	11.7
M2 Ortho	67.3%	76.3%	100.0%	58.1%	7.4	3.9	11.3
M2 Surg	100.0%	100.0%	100.0%	100.0%	6.3	6.3	12.6
CRC	95.9%	94.7%	100.0%	100.0%	2.3	3.2	5.5
M1 rehab M1 MO	86.8%	98.4%	89.8%	101.2%	1.9	2.8	4.7
Dermataology	100.0%	76.1%	56.3%	78.3%	7.1	5.9	12.9
25	67.2%	101.1%	66.7%	102.4%	2.8	6.0	8.8
CCU	100.0%	91.1%	90.4%	100.0%	8.2	4.1	12.3
37	100.0%	100.0%	100.0%	96.9%	2.8	2.8	5.6
24 IPC	70.4%	101.2%	98.4%	124.7%	2.5	4.0	6.4
WAFFU	90.3%	124.6%	59.7%	171.0%	5.5	6.6	12.1

Board of Directors	
Agenda Item	9.2
Title of Report	Nursing, Midwifery & AHP Workforce Strategy
Date of Meeting	25th July 2018
Author	Helen Marks, Director of Workforce
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Principle risk 3 **Workforce:** failure to attract and retain safe staffing levels will impact on our ability to deliver high quality safe care in a sustainable manner
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	
FOI status	yes
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The following nursing, midwifery and allied health professional (AHP) strategy that has been produced in order to address recruitment and retention challenges facing the Trust.

2. Background

The draft nursing and midwifery strategy was presented at the March 2018 board meeting. The draft strategy was agreed with the view that the document would be consulted on and that the final strategy would be presented at Trust board for approval.

Following the Trust board meeting the Executive Director of Nursing and Midwifery led a consultation exercise 'What Matters to You' to engage in discussions with the workforce to ensure that the strategy reflected what is important to our staff and used this information to continually shape the strategy. As a result of the exercise the strategy has been extended to include AHPs.

3. Nursing, Midwifery and AHP Workforce Strategy

The strategy has been shaped around the following key headings:

- What our patients can expect from our nursing and midwifery workforce
- What our nursing, midwifery and AHP workforce can expect from us
- What our communities can expect from the trust
- What our approach is to research

Under each of these headings are a number of initiatives to enhance and raise the Trust's profile in relation to the recruitment of nurses and a number of interventions that will assist with retention as well as address sickness absence.

Included within the strategy is the Executive Director of Nursing & Midwifery commitments, which are aligned with both the document and the feedback from the workforce.

The actions that are required to implement this strategy will be included in the overarching OD work plan. This is to ensure that it is encompassed under the seven corporate themes that have been agreed by Trust board in March 2018 as well as avoiding numerous separate action plans being developed. The implementation and progress of the actions in relation to this strategy will be overseen by the Workforce Assurance Committee.

4. Recommendation

It is recommended to Trust Board:

- To approve the attached nursing, midwifery and AHP strategy
- To agree to that the implementation and progress of this strategy will be through the Workforce Assurance Committee

Helen Marks
Interim Director of Workforce
July 2018

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Nursing, Midwifery and Allied Health Professionals

Workforce Strategy 2018-2020

Background

This Nursing, Midwifery and Allied Health Professional Workforce Strategy has been shaped in partnership with the clinical staff across the Trust. The strategy is designed to describe the steps the Trust will put in place to assist in recruiting and retaining its Nursing, Midwifery and Allied Health Professional workforce.

As part of the process in shaping this document the Executive Director of Nursing and Midwifery led the campaign 'What Matters to You' to engage in discussions with the wider workforce and ensure the strategy reflected what is important to our staff and used this information to develop the strategy.

The Executive Director of Nursing and Midwifery, who is also the professional lead for Allied Health Professionals has outlined her commitments, which are embedded within the Strategy and the commitments are detailed at the end of the Strategy

Below is a summary of the feedback we received

What matters to you?

You have told us that your patients matter most to you and that to deliver the standard of care that you want to give; we need to support you by ensuring that we have the right number of staff available in the right place at the right time. You would like staff to work effectively in strong teams showing respect for each other whilst working in an environment that supports the highest standard of care delivery. You want clear lines of communication across all levels of the organisation that will demonstrate safe effective leadership. You want support for all staff members to work to their highest level by committing to individual learning and development plans for all staff members.

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Our Patients

Our patients deserve the best care and therefore they can expect the following:

1. Patients will receive compassionate individualised care. In addition the promotion of our patient's health and wellbeing will be in every discussion ensuring that they are treated as an individual instead of a diagnosis.

2. The recruitment of high quality staff, which means that we will attend a programme of recruitment events where we will be in attendance as well as running our own.

3. That all our Nursing, Midwifery and Allied Health Professionals regardless of whether qualified or non-qualified will have completed their entire mandatory, essential and clinical skills training as a core kite mark of patient safety and clinical effectiveness.

4. That all our Nursing, Midwifery and Allied Health Professionals will be actively involved in continuous professional development in order to enhance their skills.

5. That our patients will be cared for in a harm-free environment. We will work towards reducing avoidable harm such as pressure ulcers, hospital acquired infections, medication errors and reducing falls.

6. We will continue to improve the discharge experience.

7. That our patients receive excellent care at the end of life.

8. The outcomes from the Friends and Family Test will be feedback into the multi-professional leadership teams in order to engage the wider workforce to make any necessary changes.

Our Workforce

Our Nursing, Midwifery and Allied Health Professional workforce can expect the following:

1. To increase the capacity and capability of our workforce, ensuring all staff embrace the values and behaviours of Wirral University Teaching Hospital.

1. Building on our existing preceptorship and development programme. To have practice educators in every clinical area to support newly qualified staff to make the transition from training to practice.

2. To continually review our clinical skills programmes meet the needs of modern Nursing, Midwifery and Allied Health Professionals practice.

3. Develop an annual Allied Health Professionals good practice day celebrating the roles and developments.

4. That all senior clinical staff will have access to compassionate leadership and coaching programmes that will assist in creating a pipeline for future roles such as; Matrons, Advanced Practitioners, Nurse Consultants.

5. Clinical Support Workers will have a development programme in place that will support them into different roles such as nursing associates, therapy assistants, and maternity support workers.

6. Develop clear career pathways that facilitate the journey from apprenticeships to professional roles within the Trust and continue to make better use of workforce modernisation roles.

7. That employer supported bursaries or apprenticeships will be offered to assist in non-registered employees becoming qualified as a way of 'growing our own' talent.

8. Create working environments that support health and wellbeing of Nursing, Midwifery and Allied Health Professionals and build resilience, to support engagement in positively shaping the services we provide.

9. Develop the skills of our Nursing, Midwifery and Allied Health Professionals to support our patients who have mental health difficulties and learning disabilities more effectively

10. The trust will align training with all patient safety and quality indicators to ensure learning from incidents and complaints to improve the quality of care and the patient experience. To actively facilitate and support concerns being raised, with the assurance that they will be addressed effectively and promptly.

11. An increase the effectiveness of e-roster for Nursing, Midwifery and allied Health Professionals.

12. To adopt approaches that recognise and value our nursing, midwifery and AHP workforce

Our Communities

As a major health care provider on the Wirral our communities can expect:

1. A workforce that reflects the diversity of the community we serve.

2. No barriers for people from any background (and from any of the protected characteristics) from joining or progressing in the Trust.

3. The Trust to provide work experience in non-registered roles or registered roles for the appropriately qualified either on a part-time or flexible basis.

4. Increase the scope of volunteering programme across the Trust through working with third sector partners.

5. To create links with schools and colleges in order to raise the awareness of Nursing, Midwifery and Allied Health Professional roles, which will include work experience / taster days.

6. To develop an approach to traineeships, apprenticeships and work experience linked to increasing employment opportunities as a first step into a health care career.

7. The Trust to play a key role to work with our stakeholder, partners and other agencies in working towards the creation of a healthy Wirral.

Our Research

We want to ensure that our Nursing, Midwifery and Allied Health Professionals are facilitated to take part and contribute to research through:

1. The encouragement of our clinical staff to publish papers with a view to write for publications and achieving Trust publications in peer reviewed professional, research and management journals

2. To work in collaboration with Universities to develop clinical research career for Nursing, Midwifery and Allied Health Professionals and supporting secondment and/or sabbaticals to facilitate clinical staff to participate in research which will feedback into the Trust.

3. To optimise the use of technology and informatics to address clinical variance and to ensure that we deliver safe evidence based Nursing, Midwifery and Allied Health Professional care.

Wirral University Teaching Hospital
NHS Foundation Trust

Recruit, Retain & Respect...

Staffing / Respect

We will recruit, retain and respect compassionate, competent and caring staff

We will strengthen our preceptorship programme to ensure new staff are supported in their introduction to their chosen career

Our retirees will be invited to create retire and return plans to retain the experience that we value

Our relationship with temporary workforce providers will be strengthened to ensure we are responsive to safe staffing

E-Roster will be reviewed and relaunched to ensure it is fit for purpose and contributing towards safer staffing

Leadership / Teamwork

Multidisciplinary education and development will become our normal approach

We will work closely with our external partners to review skills and knowledge to develop new roles

We will promote and celebrate diversity

We will say 'Thank You' more often

We will recognise the contribution and hard work of our teams through the clinical accreditation process

We will work with our Patients, Staff, Governors, Members and other stakeholders helping us to respond and improve services for patients families and carers

Learning and Development

All our staff will have a meaningful appraisal and personal development plan

Practice educators will be introduced across all specialities

We will develop 'Careers on a page' clearly showing staff how to progress within their professional group

Career clinics will be introduced to raise awareness of opportunities

Care support staff will all be supported to complete the care certificate

'Grow Our Own' will be a key strategy to a sustainable, educated, competent workforce

We will support our staff to engage in research to improve patient care

Communication

We will commit to 'back to floor' to hear 'what matters to you' and deliver key messages to all staff

There will be a regular Divisional Director of Nursing and Midwifery bulletin for our staff

Open forums will be held, allowing the workforce to set the agenda

We will improve perceptions of Nursing , Midwifery and AHP workforce by celebrating professional qualifications

Safety summits and Safety bites will allow for prompt dissemination of safety messages

Environment

Will we ensure our clinical voice contributes to the Trust's estate strategy

PLACE inspections will provide a platform for quality improvement

Our Health and Safety colleagues will help us to ensure our environment is safe, and fit for purpose

Communal spaces will be provided for our staff to rest, relax and rehydrate

We will maximise the benefits of being a digital organisation

BOARD OF DIRECTORS	
Agenda Item	10.1
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	25 July 2018
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance	Positive
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The second meeting took place on Thursday 19 July 2018. Unfortunately apologies were received from all invited NEDs, with the exception of the Chair. However, the Trust Chair did attend part of the meeting. The Freedom to Speak Up Guardian also attended the meeting. Participation in the meeting was strong and the agenda covered twelve items in the two hours available.

Actions from the first meeting had all been progressed to completion.

2. Key Issues

Workforce Assurance Governance Structure

A proposed change in the governance structures was accepted, with 'workforce decision making' delegated to a new Workforce Performance Group (WPG) supported by specialist sub groups for Diversity & Inclusion, Education, Communication & Engagement and Health & Wellbeing.

Equality & Diversity Update

The new Diversity & Inclusion Strategy, the underpinning 2018-2022 Action Plan and the Workforce Race Equality Standards (WRES) report were all received and approved by the committee. The committee noted the considerable progress made in the area of Diversity & Inclusion at the Trust in 2018 under Sharon Landrum's, Equality and Diversity lead, leadership.

Freedom to Speak Up

The Freedom to Speak Up Guardian attended her first Workforce Assurance Committee [WAC] meeting and gave a verbal update report. Q1 2018-19 showed an increase in concerns raised from 15 to 33. (She explained that an increase in reporting should be viewed as a positive). However, it was noted that 11 of the 33 concerns raised were anonymous (neither attributed to an individual or department). Unfortunately the latter cannot be followed up as rigorously as they could be if more information was provided by those raising the concerns.

Mandatory Training

A critical review of Mandatory Training (MT) provision was presented by the Assistant Director of Organisational Development. A number of recommended changes to MT were accepted. These included a significant reduction in Mandatory Training elements (some transferred to Essential Training), a future review of Essential Training and Trust Induction, the reintroduction of training blocks and the further development of e-learning packages.

Nursing, Midwifery and Allied Health Professionals Workforce Strategy 2018-2020

The updated strategy was presented. The strategy has had significant staff consultation and now includes the commitments by the Executive Director of Nursing & Midwifery. The overarching themes of those commitments are Recruit, Retain and Respect. The required actions, falling out of that strategy, will be included in the overall organisational development work plan and progress will be overseen by the committee.

Recruitment 'Deep Dive'

The Assistant Director of Workforce Effectiveness provided a verbal report on her recent review of recruitment. A number of recommendations for change were discussed and she will bring a final version to the next WAC meeting. Dissatisfaction with recruitment and the limited services of the shared service were discussed. The committee observed that

recruitment and retention are critical success factors for the Trust going forward. With this in mind the committee supported the bringing forward of a proposal to install a resource planning and forecasting capability at WUTH.

OD work plan

The updated OD work programme was presented by the Assistant Director of OD with the addition of SMART objectives as requested at the last WAC meeting. The original 2 year programme will be extended to 3 years in order to sustainably embed changes in the organisation's values and behaviours leading to an improved Trust culture going forward.

Emergency Department (ED) Cultural Review and Improvement Plan

An update on the above was presented by the Assistant Director of Organisational Development. The progress was noted and the ongoing need to maintain improvement momentum was supported.

Medical Engagement

The Director of Workforce updated the committee on the recent discussion with the Chair of Medical Board and her attendance at Medical Board. Unfortunately the Chair of Medical Board Chair is unable to attend the WAC meetings going forward but thanked the committee for the invitation. The Committee will continue to reach out to the Consultant body and seek to involve and engage medical consultants where possible.

2018 NHS Pay Deal

The deputy director of workforce provided a briefing on the new Agenda for Change pay deal. The national 3 year pay deal implementation will be supported by Payroll, HR and Finance departments. A joint communication is planned with staff side to explain the changes that will be taking place in relation to the deal. It was also noted that the union GMB had not agreed to the pay deal.

HR&OD Dashboard

The new HR & OD metrics were presented. 'Red' KPIs were noted for Sickness Absence, Agency Breaches, Staff Engagement and counselling waiting times in Occupational Health.

3. Next Meeting

25th October 2018 1pm to 3pm

4. Recommendations

- To note the contents of the report

Board of Directors	
Agenda Item	10.3
Title of Report	Safeguarding Annual Report 2017-2018
Date of Meeting	25 July 2018
Author	Susan Fogarty – Associate Director Nursing for Safeguarding
Accountable Executive	Gaynor Westray – Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 2
Level of Assurance **Positive** **Gap(s)**	**Positive** • The Trust is compliant with Child Protection Information Sharing (CP-IS) • Strengthening of governance and staffing arrangements has been approved to ensure safe and effective care for vulnerable people. • Safeguarding Assurance Group now aligned to Quality and Safety Committee. • Learning disability service and Dementia for Matron now sit within safeguarding portfolio • MCA trigger question for DoLs in Wirral Millennium designed, prompting the front line staff to consider and complete MCA at admission point **Gaps** • Current compliance at 31 March 2018 for Protecting Vulnerable People training; Level 1– 84.47%, Level 2- 82.5% and Level 3- 85.16% against target of 95% • Currently there is a delay in DoLs applications being completed to supervisory body. A development project within Wirral Millennium of a Deprivation of Liberty Application form via Ulysses Safeguard System will enable frontline staff to grant the 7 day Urgent within timescale required.
Purpose of the Paper	Discussion and approval
Data Quality Rating	Silver
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	No

1. Executive Summary

This annual report provides a summary of key issues and safeguarding activity in relation to the Wirral University Teaching Hospital (WUTH) safeguarding team during 2017/18. It provides assurance to the Board of Directors and external agencies with evidence of how WUTH discharges its statutory duties in relation to safeguarding children and young people, Children Looked After and Adults at risk of compliance with statutory and contractual requirements, national and local safeguarding guidance.

The Trust recognises that safeguarding is integral part of its core business. The Safeguarding Annual Report sets out how the Trust remains committed to provision of the highest standards to ensure effective patient care which in relation to safeguarding requires the Trust provide a safe environment to protect patients from harm and the knowledge that its workforce are aware of their roles and responsibilities in respect of safeguarding.

The Annual Report provides an update following the launch of the Protecting Vulnerable People Strategy in September 2016. This followed a fundamental review of safeguarding training which was undertaken in May 2016 to ensure that the workforce was equipped with the correct level of knowledge, skills and competencies to protect service users from harm and abuse.

The Annual report provides evidence which demonstrates that safeguarding is firmly embedded as a priority across all service areas. The report also includes an update in respect of Trust compliance with the application of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) as well as assurance in relation to risk management, activity, compliance with standards and safeguarding governance.

2. Background

The Annual Report provides a summary of the key issues, activity and performance of the Safeguarding Team, and the wider Trust, during 2017/18 in order to evidence to the Board of Directors and external agencies how WUTH discharges its statutory duties in respect of the below legislation:

- Statutory requirement under Section 11 of the Children Act (1984, 2004) to safeguard and protect children and families who access care.
- Safeguarding Vulnerable Adults in line with Care Act 2014.
- Mental Capacity Act 2005 and Deprivation of Liberty Safeguards amended in 2007.
- Working Together to Safeguard Children (2015).
- Policies and Procedures of Local Safeguarding Children Board.
- CQC Regulation 13: Safeguarding service users from abuse and improper treatment.
- CQC Regulation 12: Safe care and treatment.
- Looked After Children: Knowledge, skills and competences of health care staff (Intercollegiate Role Framework March 2015).

3. Key Issues/Gaps in Assurance

3.1 Protecting Vulnerable People Training

The Trust remains non-compliant with Protecting Vulnerable People training compliance, divisional action plans are in place and assurance is monitored via Safeguarding Assurance Group and Safeguarding Assurance Framework at Wirral Contracts Performance Meeting

3.2 The Trust must ensure that all applications for Deprivation of Liberty are completed in line with legislation

There has been a significant increase in the number of Deprivation of Liberty Safeguarding applications made to the supervisory body within 2017 /18. A gap was identified in the ability to grant applications. The development of a Deprivation of Liberty application form via the Ulysses Safeguard system was completed enabling clinical staff to grant a seven day applications in line with legislation. The project was successful and operational from April 2018.This now ensures the Trust is compliant with legislation.

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3.3 Child Protecting-Information Sharing (CP-IS)

The Trust launched the CP-IS to enable staff to securely share information across partner agencies when a child presents in an unscheduled care setting in March 2018**.**

3.4 Strengthening of governance and staffing arrangements within the Trust have been approved to ensure safe and effective care for vulnerable people.

A review of the overall governance and staffing arrangements completed. Safeguarding Assurance Group is now aligned to Quality and Safety Committee Learning Disability service and Matron for Dementia are now within the safeguarding portfolio.

4. Next Steps

The key next steps for 2018/19 are:

- Ensure that PVP training reaches 95% compliance
- Further embed MCA/DoLs awareness and processes throughout the Trust.
- Continue to promote safeguarding as a responsibility of all Trust staff to safeguard all patients and staff.

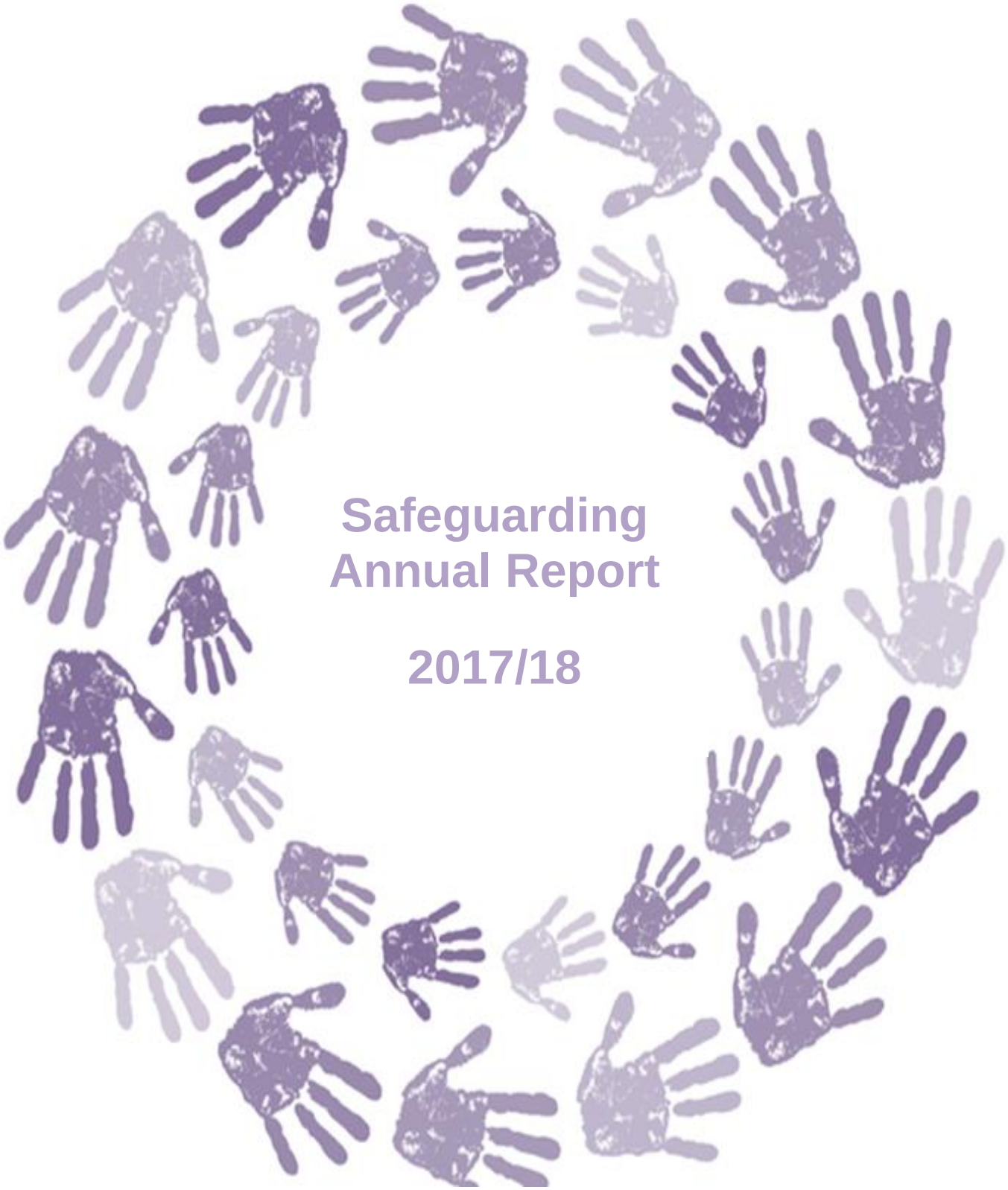
5. Conclusion

Safeguarding children and adults at risk continues to have a high profile within the Trust. Although robust safeguarding structures and processes are embedded in everyday practice across the Trust, it remains key that the Trust meets its statutory requirements and continue to safeguard its most vulnerable patients.

6. Recommendations

The Board of Directors is asked to receive and approve the Safeguarding Annual Report for 2017/18.

Wirral University Teaching Hospital NHS
NHS Foundation Trust



Safeguarding Annual Report

2017/18

Foreword

As the Associate Director Nursing for Safeguarding within the Trust, I am pleased to introduce Wirral University Teaching Hospital Safeguarding Annual Report for the period of 2017-1018.

The purpose of the report is to provide a declaration of assurance that the Trust is fulfilling its duties and responsivities in relation to promoting the welfare of children, adults and families who come into contact of our services.

The term “safeguarding” covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect and which enables them to retain independence, wellbeing, dignity and choice. Safeguarding also encompasses prevention of harm, exploitation and abuse through provision of high quality care, effective responses to allegations of harm and abuse, responses that are in line with multi-agency procedures and lastly, using learning to improve services to our patients.

The Trust safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change and respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

Due to the nature of safeguarding we work collaboratively in partnership with a number of external agencies. The report reflects the high level of activity across all work streams in order to improve processes and build on existing systems and procedures. We continue to strive to further improve and achieve good compliance against all our safeguarding standards internally and externally in order to safeguard the most vulnerable in our society.

Safeguarding is everyone’s business, but this cannot be achieved without the dedication and professionalism of all staff and partners and thank them for their continued contribution.

Sue Fogarty Associate Director Nursing Safeguarding

KEY ACHIEVEMENTS

Strengthening of Governance and staffing arrangements within the Trust has been approved to ensure the provision of safe and effective care for vulnerable people.

Hospital Independent Domestic Abuse Advisor (IDVA) to be recruited to ensure that victims of Domestic Abuse receive the correct support at the "Golden hour"
Continue to embed the Pre Birth Liaison Group to ensure practice improvement for the unborn child to be. Highlighted as an area of good practice within the OFSTED feedback to the local authority

Launch of Child Protection-Information Sharing (CP-IS) to enable staff to securely share information across partner agencies when a child presents to an unscheduled care setting in March 2018 to ensure Mental Capacity Assessment tool is now embedded within Wirral Millennium

Both adult and children "Referrals into the Social Care" have been developed and embedded into Cerner Millennium Stand-alone PREVENT Policy
Stand-alone Managing Allegations People in a Position of Trust (PiPoT)

Contents:

4. **Partnership working**
5. **Children and Young People Safeguarding Liaison /Child Death Overview Panel (CEDOP)**
6. **Safeguarding Supervision and Support**
7. **Safe Recruitment and Vetting Procedures**
8. **Information sharing**
9. **Risk Register**
10. **Women's and Children's Services**
    - 10.1 New Developments in Maternity
    - 10.2 Safeguarding Children
11. **Safeguarding Adults**
12. **Mental Capacity Act/Deprivation of Liberty Safeguards**
13. **Domestic Abuse/Harmful Practices/FGM**
14. **Protecting Vulnerable People Training**
    - 14.1 Protecting Vulnerable People Training Evaluation Data
    - 14.2 Protecting Vulnerable People Training Compliance
15. **Children Looked After**
16. **PREVENT**
17. **Child Sexual Exploitation**
18. **Key Objectives for 2018/2019 – Next Steps**
19. **Conclusion**

Appendices:

1. **Safeguarding Structure**
2. **Adult Safeguarding Statistics Dashboard**
3. **Domestic Violence Statistics Dashboard**
4. **Women's and Children's Statistics Dashboard**
5. **Pre-Birth Liaison Statistics**
6. **Safeguarding Children and Young People Statistics Dashboard**

1. Introduction

Safeguarding is a shared responsibility with the need for effective joint working between partner agencies and professionals that have different roles. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- The commitment of senior managers and board members to safeguarding children and adults at risk
- Clear lines of accountability within the organisation for work on safeguarding
- Service developments that take account of the need to safeguard all service users, and is informed, where appropriate, by the views of service users
- Safeguarding training and continuing professional development so that staff have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to children, adults and looked after children
- Safe working practices including recruitment and vetting procedures
- Effective interagency working, including effective information sharing.

The report provides evidence that safeguarding is firmly embedded as a priority across all service areas.

The Trust is committed to safeguarding and this is evident from “Ward to Board” with strong culture of safeguarding vulnerable patients of any age that come into contact of our services, either as patients, carers, staff or members of the public.

As outlined in the Safeguarding Strategy 2015-2017 “Safeguarding is everyone’s responsibility” and reflects the “One chance Rule is embedded in all divisions across the Trust. Discharging safeguarding duties effectively is based upon five key priority outcomes within the strategy. The priorities defined by the local children and adult safeguarding boards.

The key priorities and objectives are:

- Domestic Abuse, Neglect, Child Sexual Exploitation, Early Help and Mental Capacity Assessment and Deprivation of Liberty
- Effective safeguarding, leadership, structure and processes
- Learning and improvement through experience, audit and partnership working
- Continuing the development of a caring, safe and effective workforce including compliance with Protecting Vulnerable People Training Strategy
- Engaging with service users and external agencies

A copy of the strategy is uploaded onto the Safeguarding web page for all Trust staff.

The Safeguarding Strategy is currently being updated to reflect the key priorities in partnership with Wirral Safeguarding Children and Adults Boards.

2. Governance Arrangements for Safeguarding

A review of the overall safeguarding governance and staffing arrangements has been undertaken. The outcome and agreed changes in service provision within the Safeguarding portfolio within the Trust will strengthen the governance and staffing arrangements to ensure the provision of continued safe and effective care for vulnerable people.

The Safeguarding Assurance Group is now aligned to the Quality and Safety Committee. The purpose of the review was to strengthen the current arrangements and clearly define roles and lines of accountability within the team. The new structure will strengthen visibility of safeguarding within the Trust and the terms of reference have been reviewed. Having expanded the membership to the Safeguarding Assurance Group, this will provide robust assurance and accountability from the divisional workforce.

This requires a commitment from Board members to ensure the team is equipped with appropriate skills and knowledge to develop and maintain quality standards that will provide assurance to ensure appropriate systems and processes are in place and ensure safeguarding culture is embedded within the organisation.
The new structure increases the Trusts ability to provide assurance in relation to:

- Health and Social Care Act 2008 (Regulated activities)
- Regulation 13: Safeguarding Service Users from abuse and proper treatment.
- Regulation 12: Safe Care and Treatment

As part of the restructure it was agreed that the Learning Disability Service and Matron for Dementia with clear lines of managerial and accountability will now sit within the safeguarding portfolio. Reporting arrangements via Safeguarding Assurance Group.

Key recommendation of the review concludes that swift agreement to the proposed restructure of the Safeguarding team to ensure the team is able to respond to statutory and contractual obligations providing a concerning performance and board assurance.

The Trust Board has an identified Executive Director who leads on Safeguarding for the Trust. This is the Director of Nursing and Midwifery who champions safeguarding throughout the organisation and represents the organisation on both the Local Safeguarding Children Board

Mrs. Gaynor Westray, Director of Nursing and Midwifery has Executive Responsibility for Safeguarding in her portfolio and are supported by highly dedicated and motivated safeguarding team.

A Safeguarding team structure chart is given in Appendix 1

By removing the Named Nurse for Safeguarding Children and the Named Midwife role out of the Associate Director Nursing for Safeguarding role will provide further assurance within safeguarding children and unborn arena.

The Associate Director Nursing for Safeguarding who takes strategic oversight and operational management of WUTH safeguarding service and oversees all WUTH safeguarding arrangements to assure both statutory and contractual requirements are met.

The Named professionals and Lead Specialists are proactive on the local Safeguarding sub groups ensuring the Trust are liked in at all levels to multi-agency developments and assurance.

The Named professionals have a key role in promoting good professional practice within the Trust, providing advice and expertise for fellow professionals and undertake duties to safeguard children and adults in line with the guidance and legislation (Working Together 2015 and the Care Act 2014).

Safeguarding activity across the Trust continues to increase in volume and complexity. Causes for concern are recognised more frequently across clinical areas causing additional pressures within the team.

The Named professionals have a key role in ensuring a safeguarding training strategy is in place and delivered across the organsiation. They lead on safeguarding audits, carrying out regular audits focusing on process and outcomes.

3. Safeguarding Assurance

The Safeguarding service is required to evidence assurance and compliance through various domains, nationally and locally. The Trust aims to ensure there is an organizational approach to safeguarding patients and service users, their families and carers.

3.1 Safeguarding Assurance Group (SAG)

Previously the Safeguarding Strategic Team is chaired by the Director of Nursing and Midwifery and held bi- monthly and process strategic leadership and oversight and accountability. This group is accountable to the Quality and Safety Committee to investigate any activity within its terms of reference.
This group enables Named Professionals from the Safeguarding Team, alongside the Named Doctor for Safeguarding to meet with Designated Health Professionals from the Clinical Commissioning Group who provide scrutiny and oversight of the Trust's compliance with safeguarding standards, including the Safeguarding Assurance Framework.

The Pre Birth Liaison Group from Women's Services and the Emergency Department Safeguarding Meeting provide assurance into the Safeguarding Assurance Group of the effectiveness of safeguarding, within those key areas, identifying gaps in assurance and monitored via the SAG.

Terms of reference outlined below have been reviewed and key areas are outlined below

- Ensure the Trust is compliant with Section 11 audit tool and monitor progress of action. Section 11 of the Children Act 2004, the Care Act 2014 and the Mental Capacity Act 2005 places a duty on NHS organisations to ensure their function and any services they contract out to are discharged having regard to the need to safeguarding and promote the welfare of children and adults at risk
- Ensure the Trust is compliant with Safeguarding Assurance Framework. Assurance is provided via Quality and Contract monitoring quarterly within the Clinical Commissioning Group
- Ensure that safeguarding is at the forefront of service planning
- Provide assurance to the Trust and relevant external Boards in respect to safeguarding vulnerable people
- Advise the trust on any implications of key government documents, national enquiries and external inspecting bodies. (e.g. Care Quality Commission (CQC)) or external reviews.
- Ensure there are agreed systems, standards and protocols in place to protect those most vulnerable and that all staff work together effectively, within a clear framework of managerial supervision and multi-agency procedures
- Ensure concerns are escalated appropriately when not acted upon in accordance with approved multi agency procedures
- Discuss outcomes of serious case/critical incident reviews, national enquiries, external inspections and monitor implementation of any recommendations for the Trust
- Ensure there is an effective culture in information sharing across partner agencies and address any barriers to information sharing
- Ensure that safeguarding arrangements within the Trust are regularly reviewed through quality scrutiny processes
- Monitor compliance against key performance indicators relevant to safeguarding vulnerable people
- Monitor compliance with the multi-agency safeguarding training strategy and take appropriate action
- Monitor high level risks entered on the Trust's risk register and approve the appropriate controls to manage or mitigate risk
- Identify and approve all policies relating to safeguarding vulnerable persons cared for within the Trust
- Agree and monitor progress of the annual work plan and ensure its link to the wider business of the children's and adults safeguarding boards. e been identified:

A Chairs Report is a standing item on Quality Safety Committee receiving highlighted areas of positivity and gaps in assurance with associated work stream which members are assured of the measures in place for safeguarding children and adults at risk.

3.2 Monthly Safeguarding Dashboard Report presented at Clinical Governance Group

Safeguarding assurance regarding training compliance and MCA/DoLS is Included with the Integrated Quality Dashboard that is presented to Clinical Governance Group monthly.
Gaps in assurance as part of the Safeguarding Assurance Framework and Section 11 audit is presented quarterly.

3.3 Quarterly Safeguarding Assurance Frameworks for Children, Adults and Children Looked presented at Quality Dashboard for Wirral Contracts Performance Meeting

The safeguarding team submits quarterly data regarding Protecting Vulnerable People Training, DoLS update and assurance regarding the Trust position with the Safeguarding Assurance Framework, Section 11 Audit. Key performance indicators are monitored by the Designated staff within the CCG. The Safeguarding Assurance Framework is embedded within the WUTH Quality Schedule and is submitted as part of the Trusts Quarterly contractual assurance.

3.4 Section 11 Audits - Self Assessment against Commissioned Service Standards for Safeguarding and Children and Adults at Risk presented at Wirral Contracts Performance Meeting

The Safeguarding Board Section 11 of the Children Act 2004 outlines to all agencies who deliver services to children, young people under the age of 18 are required to assure the Safeguarding Board that they have effective arrangements in place to safeguard and promote the welfare of children and young people.

The annual self- assessment audit in now embedded within the Section 11 audit which provides a self-assessment of arrangements provided to safeguard all vulnerable people within their organisation and the effectiveness of safeguarding arrangements across the partnership. The assessment tool is Rag rated - Red, Amber Green against all standards which is monitored by the Designated Nurse in the CCG who establishes a baseline against the standards and the action plan is then monitored via the Safeguarding Assurance Group. Areas of concern are escalated to Quality and Safety Committee.

The Trust completed the Section 11 audit tool within expected timescale. The following actions were generated and monitored via an action plan with timescales and is monitored via the Safeguarding Assurance Group. Any exemptions are highlighted to Quality and Safety Committee.

3.5 Safeguarding Incident Reporting

Safeguarding incident referrals are now integrated into the Trust Safeguard database to record all safeguarding incidents. The system automatically raises the issue of an incident. Following receipt of the incident documentation received by the Safeguarding Team, it is recorded in Cerner Millennium system to ensure all staff has access to all safeguarding information.

The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS).
Any escalations are alerted to Clinical Commissioning Group and Care Quality Commission as required.

The Associate Director Nursing for Safeguarding or deputy attends the weekly Trust Quality Safety Summit and Trust SI panel which reviews themes and incidents and near misses which is well attended by staff.

3.6 Safeguarding Team Activity and Performance

During April 2017 to March 2018, the Safeguarding Team has seen a significant increase in referrals for Deprivation of Liberty Safeguards. There has been an increase in activity and complexity of referrals received. Data and performance is outlined within the specialty assurance within the report.

Changes within the children arena with the Trust adopting the “Right Service Right Time” Threshold guidance has impacted on the amount of referrals progressing at higher level to

the local authority. The strategy is designed to improve staffs understanding of threshold of needs to ensure that one a child's needs are identified the partnership response is swift, effective and leads to positive outcomes for children.

3.7 Serious Case Reviews/Domestic Homicide Reviews/Learning Reviews for Children and Adults

During the timeframe, there has been one Serious Case Review (SCR) Subsequent action plan will be developed by the Safeguarding Board and monitored externally by the Safeguarding Board and any WUTH actions will be monitored by the Safeguarding Assurance Group.

Action plan from previous SCR with 23 recommendations across the partnership is monitored via the Safeguarding Board. WUTH had one recommendation which is now completed. An audit of the effectiveness will be completed in January 2019.

Two further cases did not meet the threshold for SCR and a Multi-Agency Review has been completed with practitioners and their managers which identified key lines of enquiry. The reviewer is currently compiling her report and the Trust will monitor any subsequent recommendations via the Trust Safeguarding Assurance Group (SAG)

There have been no Serious Case Reviews for adults in this period; however three cases were discussed for consideration at Serious Case Review sub group: two of these have subsequently been escalated to Merseyside Safeguarding Adult Board. One Safeguarding Adult Review has been completed and awaiting independent reviewer for the outstanding cases.

There have been no Domestic Homicide Reviews or OFSTED inspections during 2017-2018.

3.8 Inspections/Reviews

The Trust has had CQC inspection during March 2018. At the time of writing the Trust is awaiting the findings of the inspection.

4. Partnership Working

Wirral University Teaching Hospital is a key partner agency in the safeguarding arena on Wirral. This is achieved through:

- Membership of Safeguarding Children and Adult Boards
- Active contribution to:
    - Serious Case Reviews (adults and children)
    - Multi agency and single agency reviews
    - Domestic Abuse – Fast task Meetings
    - Domestic Homicide reviews
- Bi monthly attendance at Multi Agency Risk Assessment Conferences (MARAC) – sharing appropriate information and ensuring actions are subsequently completed and relevant flag is uploaded onto Cerner Millennium

- Bi monthly attendance at Multi Agency Child Sexual Exploitation (MASCE) meetings - sharing appropriate information and ensuring actions are subsequently completed and relevant flag is uploaded onto Cerner Millennium

- Submit quarterly mandatory reporting into the Home Office supporting the PREVENT agenda

- Submit quarterly mandatory reporting to NHS Digital quarterly for the FGM agenda

- Participates in multi-agency audit with Safeguarding Children Board

- Providing data to Board via Safeguarding Dataset.

- Quarterly attendance at Wirral Safeguarding Children Forum. The meeting is chaired by Designated Doctor and Nurse for Wirral Clinical Commissioning Group and is attended by partner agencies within the health economy of Wirral.

In supporting partnership working the Trust Safeguarding Team members participate in various multi-agency forums and delegates from the Trust attend.

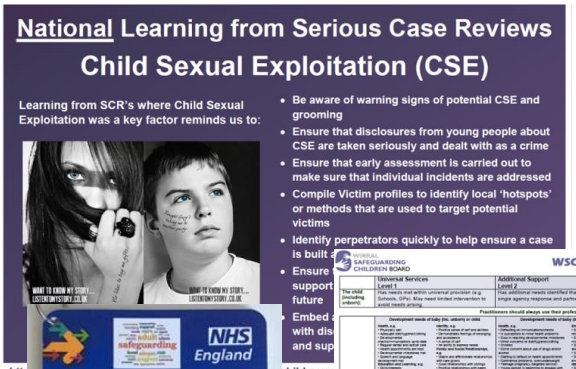
Forum	Responsibility
WSCB	Director of Nursing & Midwifery/Associate Director Safeguarding
Safeguarding Adult Review	Named Nurse Adults at Risk
Improving Outcomes Meeting	Named Nurse for Safeguarding Children & Young People
Communication & Engagement	Named Nurse Adults
Performance	Named Nurse/Midwife Safeguarding
Child Sexual Exploitation Committee	Named Nurse Safeguarding Children
Quality Assurance	Named Nurse Adults at Risk
Domestic Abuse Committee	Lead Specialist for Domestic Abuse
Wirral MARAC Steering Group	Associate Director Safeguarding
Wirral Adult Safeguarding Forum	Named Nurse Adults at Risk
Wirral Health Safeguarding Children Forum	Named Midwife and Specialist in Domestic Abuse/Named Nurse Safeguarding Children

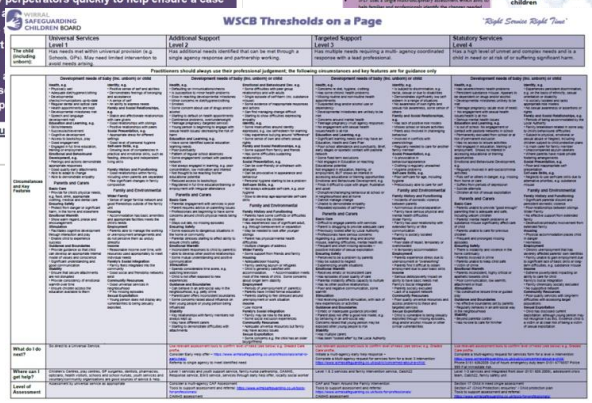
4.1 Learning and improvement through experience and partnership

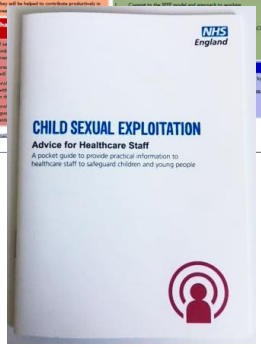
To improve engagement and communications to the workforce relating to key messages and learning from Serious Case reviews, Multi-agency reviews the team continuously updates training to reflect responses to issues identified nationally and locally.

The team produces a monthly Safeguarding Little Gem which outlines key facts and updates which provide in line with training requirements of both children and adult intercollegiate guidance.

Further guidance is uploaded onto the Trust intranet page with added links to Safeguarding Boards.







5. Child Death Overview Panel (CEDOP)

A total of 21 child deaths in Wirral from 1st April 2017-31st March 2018 have been recorded. Out of the 21 cases, **15** were expected, 6 were Sudden Unexpected Death of Child (SUDiC's).

All child deaths are reviewed by the Child Death Overview Panels (CDOP) which has a statutory function as defined within the Children's Act 2004 and Working Together (2015). Through a comprehensive multi-disciplinary review of child deaths, the CDOP aims to improve the understanding of how and why child has died.

One case remains a police investigation and one has progressed to a Multi-agency Learning Review to consider what learning there might be from the case to improve practice and procedures for the future.

6. Safeguarding Supervision and Support

The Trust is required to provide safeguarding supervision to all health practitioners who case load safeguarding cases. The Safeguarding Supervision, states that safeguarding supervision is offered to all professionals who hold a caseload with safeguarding children concerns, and staff/departments that have direct involvement with safeguarding children and young people cases.

Following recommendations from the Care Act 2014, the policy has been amended to include practitioners who support adults. Safeguarding Supervision is provided by staffs who have undertaken the accredited NSPCC Safeguarding Supervisors course.

The Trust has **20** Safeguarding Supervisors who ensure that all staff who case load receive quarterly safeguarding supervision apart from midwifery colleagues. The Trust has made decision that midwifery colleagues receive safeguarding supervision six weekly, due to the potential escalation of safeguarding concerns which may occur within the pregnancy.

As part of the Safeguarding Assurance Framework, a KPI is that staffs who require safeguarding supervision are receiving supervision in accordance with policy and national guidance. The Trust has been **100%** during 2017-18

The Named Nurse for Safeguarding Children has previously provided group supervision for all Emergency Department (ED) staff and this will now be undertaken by the Children and Young People Safeguarding Liaison Manager.

Moving forward he Trust will ensure that group supervision for acute services and paediatric wards will be completed on an informal basis due to the fact that staffs do not carry caseload.

The Named Nurse, Named Midwife, Named Nurse for Adults at Risk, and Named Doctors all access safeguarding supervision from Designated Nurses and Doctor and are **100%** with the KPI.

The Safeguarding Supervision Policy has been updated during the period of reporting.

The quality and effectiveness of safeguarding supervision is to be audited quarterly and findings will be presented at the SAG.

7. Safe Recruitment and Vetting Procedures

Following the publication of the Lampard report 2015 into lessons learnt in the aftermath of Jimmy Saville, the Trust has considered changing the DBS frequency to three years.

The Trust reviewed these arrangements through the Senior Management Team and concluded that this Trust would remain consistent with other Trust's in the region which means that we will not introduce the undertaking of 3 yearly DBS checks. The Trust will however amend our HR policies to ensure that all staff are clear as to the need to self-declare should they have any criminal convictions, we will also commit to undertaking annual communications to ensure staff are clear of this requirement.

8. Child Protection Information Sharing

Child Protection - Information Sharing (CP-IS) project is an NHS Digital sponsored work programme dedication to developing an information sharing solution that will deliver a higher level of protection to children who attend NHS unscheduled care settings.

The Trust went live with CP-IS on 26th March 2018 within three key unscheduled areas within the Trust: Emergency Department, children's Emergency Department and Maternity triage for capturing any unborn child that is subject to a child protection plan.

The information sharing focuses on three specific categories of child:

- Children on Child Protection Plan
- Children with Looked after status (children with full care orders and voluntary care agreements)
- Pregnant women whose unborn child has a pre-birth protection plan

WUTH have worked proactively to ensure all children on Child Protection Plans and Children Looked After are flagged on the Trust IT systems. The CP-IS project will complement and enhance current processes in place.

9. Risk Register

Regulation 13 –Safeguarding service users from abuse and improper treatment
Currently the Trust has 4 identified risks on the Trust risk register March 2018

9.1 Safeguarding training did not meet the requirements of Royal Children's Paediatric Child Health Guidance. (RPCG 2014)

The Trust must ensure that its staff is fully equipped with the skills and competencies to protect all users from harm and abuse, and to ensure it is meeting the required legislation standards across all levels of training.

Protecting Vulnerable People Training compliance is below the agreed 95% Divisional actions plans are in place and monitored via the SAG and CGG internally and scrutinised by the CCG externally.

9.2 The Trust may be at risk of illegally depriving patients of their liberty when urgent/extended urgent authorisations expire. This is due to failure/delay of the local authority (supervisory body) completing granted or not granted authorisations following the application by WUTH within timescales.

The Trust continually escalates to the supervisory body when an urgent authorisation is due to expire. This data is reported on the monthly Quality Integrated dashboard at CCG and monitored at the safeguarding assurance group.

9.3 The Trust may be unlawfully detaining patients due to mental capacity assessments not being completed in a timely fashion.

Safeguarding team undertake visibility walkabouts to support and guide staff to enhance their knowledge in relation to MCA. All staff have been provided the NHS England Safeguarding booklet which included MCA guidance. Safeguarding newsletter – Little Gem dedicated for MCA and DoLs and a "Safely Does It" articles cascaded to clinical areas. MCA is included within all levels of Protecting Vulnerable People training. This data is reported on the monthly Quality Integrated dashboard at CCG and monitored at the safeguarding assurance group. MCA flag now included within the admission clerking to prompt MCA completion at admission. Data now shows an improvement for the time MCAs are being completed.

9.4 The Trust not routinely screening for Female Genital Mutilation (FGM) apart from maternity services

Acute Trusts have a mandatory duty to report known cases of FGM, as routine screening is not undertaken throughout key areas within the Trust there may be gaps in reporting this data to NHS Digital.

Ongoing progress with Wirral Millennium to introduce key screening questions with identified areas.

10. Women's and Children's services

Maternity services within the Trust have provided care for **3259** women delivering at between April 2017 and March 2018.

223 cases that have supplementary safeguarding cause for concern provided has provided further operational challenges for the Directorate. Causes for concern arise from working with a wide variety of services and agencies including Children's Social Care, social workers, health visitors and others. As such, multi-agency safeguarding for maternity services remains a key priority to promote the health and wellbeing of women, their babies and their families.

Midwives are now being empowered to take responsibility for managing safeguarding cases in line with national and local policies and procedures. The number and complexity of referrals is increasing particularly for families with previous involvement with the local authority, domestic abuse, drug and alcohol use and mental health issues and as such safeguarding is becoming increasingly challenging.

The Trust had a Named Midwife who brought extensive knowledge and skills to strengthen the strategic aspect of the role within the Trust and took the lead in the safeguarding of vulnerable women and babies and is working closely with partner agencies to ensure a co-ordinated approach which meets local and national targets. The Named Midwife and safeguarding practitioner work closely with Substance Misuse Midwife, Teenage Pregnancy Midwife and Perinatal Mental Health Midwife team due to the high level of safeguarding issues with these cases.

10.1 New developments in maternity:

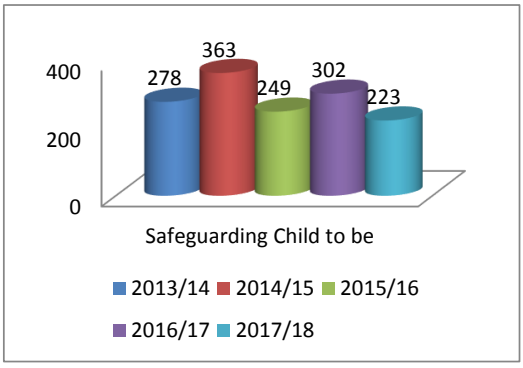
Wirral Pre-Birth Liaison Group
Following on from the launch of the Wirral Safeguarding Children Board Threshold Document in 2016, which outlines that all vulnerable unborn and children receive the Right level of support at the Right time, discussions were held with the local authority and Wirral University Teaching Hospital to scope the feasibility of launching a Wirral Pre-Birth Group Liaison Meeting. The Head of Safeguarding and Named Midwife for the Trust benchmarked other organisations in the North West and the formation of the Wirral Pre Birth Liaison Group (WPBLG) was formed. Multi-agency meetings were held and Terms of Reference agreed by partner agencies including Multi-Agency Safeguarding Hub (MASH), Wirral Community Trust, Early Help Services, WUTH midwives.

WPBG is a pathway to share information with consent and knowledge of the client in order to develop a coordinated plan to safeguard children and unborn babies.

The aim of the meeting, held monthly within the Trust is chaired by Named Midwife for Safeguarding Unborn is to ensure that babies are adequately safeguarded, both pre-birth and immediately after birth, by either;

- Level 2 – Additional support when additional needs identified can be met through a single agency response.
- Level 3 – Targeted Support when multiple needs require a multi-agency co-ordinated response with a lead professional or
- Level 4 – Statutory Services when a high level of unmet and complex needs and the unborn is identified as a child in need or risk of suffering significant harm

Safeguarding the Child to Be (Pre-Birth) activity



This year the safeguarding team received a total of 223 referrals that related to child to be. There is a reduction by adopting the safeguarding threshold of need to ensure the right service at the right time. A joint audit between the Trust and the Local Authority is due to commence in May 2018, findings will be shared at the safeguarding board. This data can be seen in the graph in appendix 5.

What difference has the Wirral Pre-Birth Liaison Group made to the protection of vulnerable women and babies?

Midwives alongside multi-agency partner agencies on Wirral ensure that vulnerable women and unborn are discussed monthly to ensure that they receive the "Right Service at the Right Time"
Due to the number and complexity of referrals is increasing, particularly for families with previous social care involvement, domestic abuse, substance misuse, mental health issues, safeguarding is becoming increasingly challenging.

Key Achievements

- The development of Wirral Pre-Birth Liaison Group, multi-agency approach
- in line with WSCB "Right Service Right Time"
- Regular monthly meetings with Named Midwife with Head of Midwifery to identify key themes and ensure all safeguarding processes are embedded to safeguard mothers and babies
- Improved communication between the midwifery services and Safeguarding, including information sharing with Local Authority.
- WUTH have **36** CAF Champions who have completed multi agency training from the WSCB– **12** from the maternity arena. This in turn will enable them to support their peers when completing CAF/TAF documentation and supporting them as Lead Professionals
- Reduction in delay of providing early help to families and the unborn through more streamlined process of referral through the WPBLG Planning Meeting
- Appropriate feedback from referral due to WPBLG

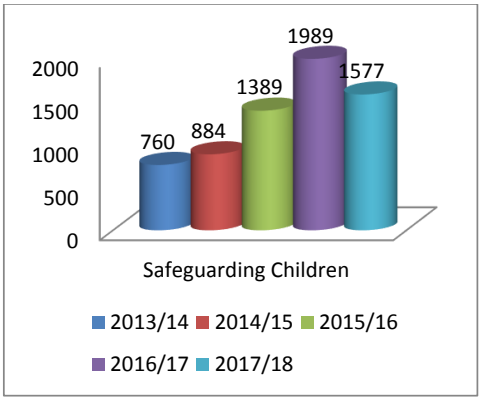
Improvement of midwives liaising with Local Authority in relation to Discharge Planning Meetings.

Challenges/Priorities

- Further develop a comprehensive safeguarding Resource file for all areas within the Trust. This will contain all up to date relevant safeguarding information which will support and enable midwives with correct toolkit to support midwives in discharging their safeguarding responsibility
- Quality assure multi-agency birth plans
- To ensure that Key staff are aware of training sessions for 'Safer Families and Enhancing Futures' which will be implemented in October 2017
- Stand-alone Midwifery Safeguarding Policy

The Named Nurse for Safeguarding Children continues to deliver a quality service that strives to ensure that every child and young person is provided with safe, high quality car. Flagging system within the health records assists the identification of children and young people who may be vulnerable and need of support, or they are at risk and need to be kept safe.

Safeguarding Children Activity



This year the safeguarding team received a total of 577 referrals that related to safeguarding children. There is a reduction by adopting the safeguarding threshold of need to ensure the right service at the right time. This data can be seen in the graph in appendix 6.

10.2 Safeguarding Children

Key Achievements

- The team actively promotes the voice of the child, act as their advocate and when issues arise with parents or carers that present to the Trust with substance misuse, mental health concerns, the child is also of paramount importance and appropriate referrals are made to MASH for Early Help and Support to be offered**.**
- The system for flagging electronic records for all children who are subject to Child Protection Plan and Looked After Children
- The system for flagging electronic records children and young people at risk of Child Sexual Exploitation to enable staff decision making
- Electronic flagging system for children and young people who are discussed at the Multi Agency Child Sexual Exploitation Meeting (MACSE)
- Bi-Monthly attendance at MACSE meetings (monthly) to remain updated with progress of Vulnerable Children and Young people.
- WUTH have **36** CAF Champions who have completed multi agency training from the WSCB
- Development of Threshold document in ED department to ensure right service at right time in regards to referrals to social care. Including the needs of the adults with children who attend ED.
- Improved training to workforce around challenge/ escalation procedures to Local Authority.

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- Improved partnership with Local authority and partner agencies, such as Early Help Team, CAMHS, and Response.

- Continue to participate in SCR around CSE and to disseminate learning to WUTH staff through PVP training, Little Gems and multiagency posters.

- The Safeguarding Children's Policy reviewed and updated.

- Developed excellent relationships with wider areas of women and children's Division including NNU, Gynae Ward, Children's ward, Children' outpatients, CED/PAU.This has led to the uptake of Safeguarding link/ambassadors on each unit to help support staff with ongoing safeguarding issues/processes.

- Improved attendance by medical staff to attend Paediatric Peer review - KPI> 90%. Peer review has also involved staff from ED, wards and clinics to improve learning and reflection.

- Little gems – monthly production to include Safeguarding information in relation to Children and Young people, and to also signpost staff to multiagency teaching to enhance Safeguarding knowledge and development

- Quality assurance "Request for services form" to reduce the number of inappropriate referrals into the Local Authority.

- Visibility walks to all areas by the team to support staff in relation to their safeguarding responsibilities

- Regular Meetings and discussions with Children's ED Liaison manager and attendance at ED meetings to continue to enhance patient experience from admission to discharge.

- Improved communications and relationships with Cheshire Wirral Partnership concerning mental health of parents

Challenges and Priorities

- **To further embed the service of CAF/TAF champions and Safeguarding Ambassadors**
- **Improve quality and accuracy of data management with the introduction of Databases for Children and young people who attend WUTH with safeguarding concerns, those who are discussed at MACSE, 16-19 years and the Unborn**
- **Continue to embed the threshold document in ED to improve appropriate referrals to the Local Authority**
- **Increase awareness of MCA and consent for those young people 16 and 17 years old**
- **Deliver bespoke training with Safeguarding links/Ambassadors in relation to safeguarding Children and Young people**
- **Capture the voice of the child at every opportunity**
- **Continue to disseminate key messages to raise awareness of CSE**

WUTH Safeguarding Team is:

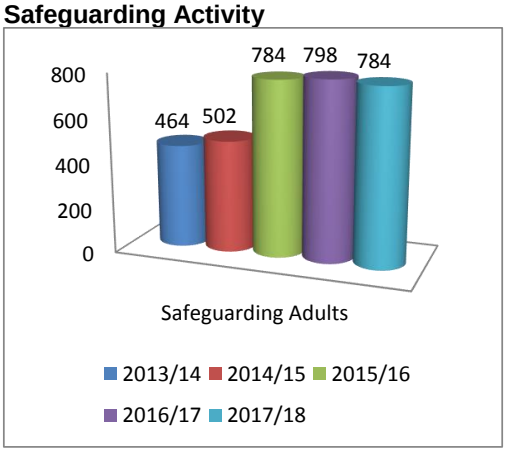
PROUD THAT……

WITH THE NEW THRESHOLD DOCUMENT AND THE PRE-BIRTH LIAISON GROUP STAFF CAN ENSURE THAT APPROPRIATE REFERRAL TO SOCIAL CARE ARE COMPLETED!

11 Safeguarding Adults

The Care Act established a clear framework for how agencies should protect adults at risk of abuse and neglect by embracing the principle "Person knows best". There is an emphasis on working with adults at risk to have greater control in their lives to both prevent it from happening, and to give meaningful options of dealing with it should it occur. The 6 safeguarding principles identified in the Care Act being empowerment, protection, prevention, proportionality, partnership working, and accountability. This work includes considering not only the individual affected but also the concept of 'Think Family' and to identify others who may be at risk promoting the making safeguarding personal agenda.

Safeguarding Activity



This year the safeguarding team received a total of 784 referrals that related to adults at risk. This has remained consistently in line with the previous 2 years activity. The collection of safeguarding adults data is broken down into categories to identify between concerns raised outside the Trust and also within the Trust itself, this can be seen in the graph in appendix 2.

Key Achievements

- The requirement for an Adults Local Authority Designated Officer function was removed from the Care Act legislation. WUTH now has a standalone policy People in positions of Trust – PiPOT in line with the North West overarching policy. The policy clearly sets out the processes following an allegation against a member of staff and the requirements for cases to be discussed at the Rapid Response meeting to identify an appropriate route to investigate within 24hrs. Each partner agency, in their annual assurance statement to the SAB, will be required to provide assurance that arrangements to deal with allegations against a person in a position of trust within their organisation are adequate and are functioning effectively

- 46 cases regarding PiPOT were discussed within the Rapid Response forum meeting regarding allegations concerning both adults and children

- 100% compliance in Named Professionals receiving safeguarding supervision

- Front line staff are referring safeguarding concerns directly to the Local Authority (right service right time) since the launch of an Adult Multi -Agency referral form for WUTH staff in October 2016

- WUTH remain a leading pioneer with the devolvement of the Adult Multi - Agency referral form

- Weekly reports produced from Wirral Millennium to capture referral data

- Staff engagement continues through the through the use of monthly safeguarding edition little GEMS, presenting incidents at the safety summit for wider learning, visibility walks and bespoke sessions

- The safeguarding team support the Trusts Local Security Manager Specialist (LSMS) in the delivery of the positive handling training to ensure that the role of the Mental Capacity Act is considered and applied when the use of restraint is required in best interests

Challenges / Priorities

- Monitor compliance of the Multi Agency Adult referral form when staff are raising concerns directly with the local authority and provide support to staff to further embed in identified areas
- Continue to support the ward accreditation programme to include the safeguarding agenda
- Work alongside Chief Nursing Information Officer to further streamline safeguarding functions within Wirral Millennium
- Complete a cycle of Audit to ensure best practice is being achieved in relation to the protection of our most vulnerable patients in line with our statutory requirements
- Further embedment of the Principles of the Care Act and the promoting of 'Making Safeguarding Personal'

12. Mental Capacity Act/Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) protects and empowers individuals who are unable to make decisions for themselves. The MCA applies to everyone working in health and social care providing support, care and treatment to people aged 16 and over who live in England and Wales.
The Deprivation of Liberty Safeguards was an amendment of the MCA 2005, it is the procedure prescribed in law when it is necessary to deprive individuals of their liberty whom lack capacity to consent to their current care and treatment in hospital to keep them safe.

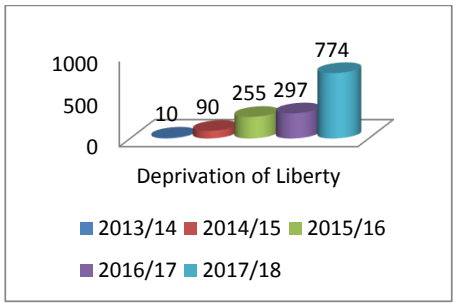
Mental Capacity Act 2005

In March 2017, the Law Commission produced its final proposal on a replacement for the Deprivation of Liberty Safeguards (DoLS), and suggested amendments to the Mental Capacity Act

itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people's rights in areas such as best interest decisions. The government has made an interim response and they will provide a final one in spring 2018.

From April 2017 coroners no longer have a duty to undertake an inquest into the death of every person who was subject to an authorisation under DoLS

MCA and DoLS Activity



Referrals for Deprivation of Liberty this year have resulted in an all- time high of 774 and of those referrals 495 Deprivation of Liberty applications were made by the Trust; this data can be found in the graph in appendix 3.

Key Achievements

- There has been a staggering 217% increase in the number of Deprivation of Liberty Safeguarding applications made by the Trust
- Overall the team had a 161% increase in Deprivation of Liberty referrals for patients to the team identified by the front line staff
- Development of a Deprivation of Liberty application form via Ulysses Safeguard for front line staff to grant applications deprivation of liberty at the time required to avoid delays. Plan to go live in April 2018
- MCA trigger question for DoLs in Wirral Millennium designed, prompting the front line staff to consider and complete MCA at admission point began in Q4. Daily reports is audited by the team and escalations made for areas of non-compliance
- Q3 saw MCA & DoLS in the inclusion of the monthly Quality Integrated dashboard, allowing for sharing of MCA and DoLS data throughout the Trust within the divisions
- Overall the team had a 16% increase in Deprivation of Liberty referrals to the team
- Weekly reports produced from Wirral Millennium to monitor the number of MCA and Best interests completed enabling the safeguarding team to quality assure and audit
- DoLS flag addition to the visibility white boards

Challenges and Priorities

- Monitor and audit the application of the Mental Capacity Act and best interest's completion through clinical audit.
- To continue to increase staff awareness and knowledge and support staff in the completion of Mental Capacity Assessments, with a view of removing the risk from the Trust risk register in relation Deprivation of Liberty safeguards admission consent
- Further develop front line staff in their awareness and responsibilities of Mental Capacity Act and Deprivation of Liberty Safeguards
- Await the Law commissions review of Deprivation of Liberty Safeguards approval and ensure that the Trust is complaint with all statutory requirements set out under the proposed Liberty Protection Safeguards (LiPS)
- Work with the Chief Nurse Information Officer to refine and expand the current MCA and BI tools currently embedded within Wirral Millennium with a shared aim of quality improvement supporting the making safeguarding personal agenda

13 Domestic Abuse/ Harmful Practices/FGM

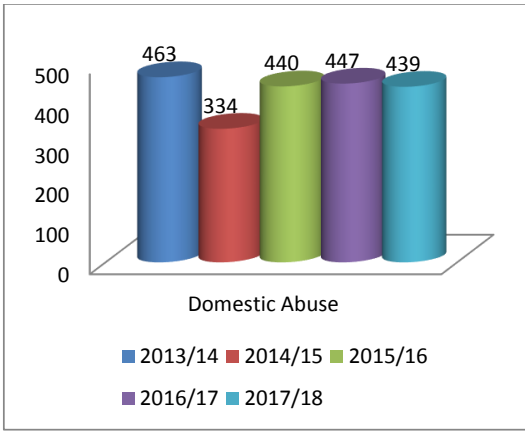
Each year an estimated 1.9m people in the UK suffer some form of domestic abuse and with more than 100,000 people in the UK being at high and imminent risk of being murdered or seriously injured as a result of domestic abuse.

On Wirral it is estimated that the level of domestic abuse is higher than the national average for England. In 2016-17 the incident rates of high risk cases for Wirral were 27% while in England it is estimated that the incident rate is 20.4%.

To support the victims of domestic abuse who attend WUTH and disclose domestic abuse the Trust have a Lead Specialist for Domestic Abuse and Harmful Practice in post within the Safeguarding Team.
The aim of this service is to works across all areas of the Trust in both hospital and community and provides support, education and advice to all WUTH staff to ensure that victims who attend WUTH receive the appropriate support, advice and safety planning prior to discharge.

The Domestic Abuse Specialist also provides support to patients over the age of 16 and their families.

In 2017-2018 WUTH Safeguarding Team received a total of **439** referrals regarding domestic abuse.
267 of these referrals have been from patients attending WUTH and making a disclosure of domestic abuse to staff, with the highest proportion of referrals being received from A&E. A total of **172** referrals were received from the police by the Safeguarding Team for any pregnant victim on Wirral.



Key Achievements

- The inclusion within the new structure of the team to include the recommendations from Safe Lives regarding a hospital based Independent Domestic Abuse Advisor (IDVA) is a key achievement to ensure that the victims of domestic abuse who present to the Trust receive the appropriate support. The news has been welcomed by the local Safeguarding Board

- All staff are empowered to take responsibility to aid and support patients when a disclosure of domestic abuse is made. Staff are expected to offer all patients a domestic abuse risk assessment following a disclosure of domestic abuse. This change of practice has been incorporated through the development of Domestic Abuse, FGM and Harmful Practice training in the PVP training.

- Key areas such as Maternity and the Emergency Department have also received additional bespoke training as these areas have been identified as the key areas for referrals.

- Developments within maternity department Cerner Millennium function ensures that all patients who attend midwifery appointments are asked the routine screening questions in relation to domestic abuse and FGM

- A new Domestic Abuse policy has been developed and launched in May 2017 which includes harmful practice.

- The team has facilitated **26** referrals for victims at high risk of harm to MARAC within Wirral.

- The domestic abuse risk assessment is accessible on Cerner for all staff to complete.

- Additionally the safeguarding team have continued to support patients through partnership working with an attendance at MARAC every fortnight.

- All victims discussed at Wirral MARAC are flagged on Cerner to ensure that staff are aware of the safeguarding concerns and can liaise with the safeguarding team to discuss further actions/safety plans for the patient when the attend WUTH.

- The system for flagging electronic records for all pregnant women who have had FGM undertake

Challenges and Priorities

- Further support to ED staff in completing the Domestic Abuse Risk Assessment as not all the staff is currently completing this. Audit is being completed to share with management regarding staff completion of the domestic abuse risk assessments. It is believed that once all staff are completing the domestic abuse risk assessments upon a disclosure that the referral to MARAC of high risk cases that have been identified through WUTH will be higher.
- Further development within Cerner to ensure that routine screening questions are implemented into all departments but specifically ED

  • Continue to audit quality of referrals received to ensure that all appropriate safeguarding procedures completed as stipulated in the Domestic Abuse Policy

  • Continue to develop the routine screening questions in relation to FGM throughout the Trust as per Multi-agency Policy

14. Protecting Vulnerable People Training

In September 2016, the Trust adopted Protecting Vulnerable People to encompass all aspects of safeguarding adult and children training.

The training matrix was reviewed in line with both children and adult intercollegiate guidance to ensure the workforce would be compliant with skills, knowledge and competencies required at each level.

Compliance against the matrix is recorded centrally by Learning and Development and compliance reports are cascaded within the workforce monthly.

Divisional compliance is monitored with trajectories at the Safeguarding Assurance Group.

Compliance until 31st March 2018 is outlined in the graphs in 14.2.

Level 1 – 84.47% - a total of 2067 workforce compliant
Level 2 – 82.50% - a total of 2174 of workforce compliant
Level 3 – 85.16% - a total of 599 staff of workforce compliant

A further group of staff who require additional specialist level competencies at Level 3 as outlined within the Royal College Paediatrics and Child Health 2014 should receive 12-16 hours. Currently this data is not centrally collected but within the divisions. Further work with divisions and Learning and Development to capture this data to provide assurance to our commissioners and external regulators is required.

14.1 Protecting Vulnerable People Training Evaluation data

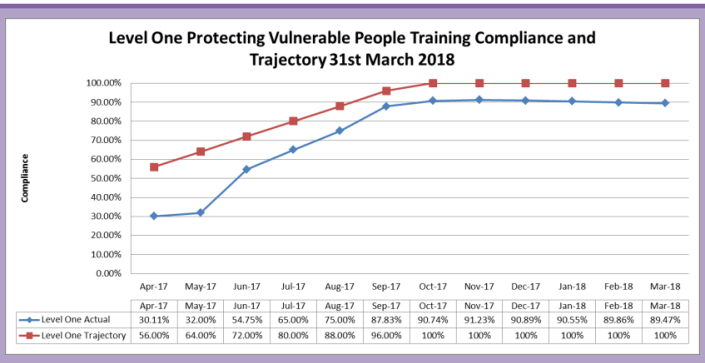
Following the launch of the PVP training programme, data collections from evaluation sheets are currently being processed. These include both Level 2 and Level 3 data from the face to face sessions held in the Lecture Theatre within the Education Department.
Initial data identifies:

- Over 95% of staff has stated that the training has improved knowledge within the safeguarding arena.
- Over 95% of staff felt the teaching sessions were clearly structured
- 90% of staff rated training as excellent or very good
- 95% strongly agreed that the training was well organised.
- 90% of trainees felt able to interact and ask questions.

Ongoing discussion with Learning & Development to further progress with E –Learning

Below is compliance from 1st April 17-31st March 2018

14.2 Protecting Vulnerable People Training Compliance data until 31/3/18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level One Actual	30.11%	32.00%	54.75%	65.00%	75.00%	87.83%	90.74%	91.23%	90.89%	90.55%	89.86%	89.47%
Level One Trajectory	56.00%	64.00%	72.00%	80.00%	88.00%	96.00%	100%	100%	100%	100%	100%	100%

Overall Trust compliance has increased from **30.11% to 84.47%** within the timescale for the annual report.
This equates to a total of **2067** staff who have received Protecting Vulnerable People training.
Divisions receive a monthly Compliance report to enable them to track which staff remain non-compliant

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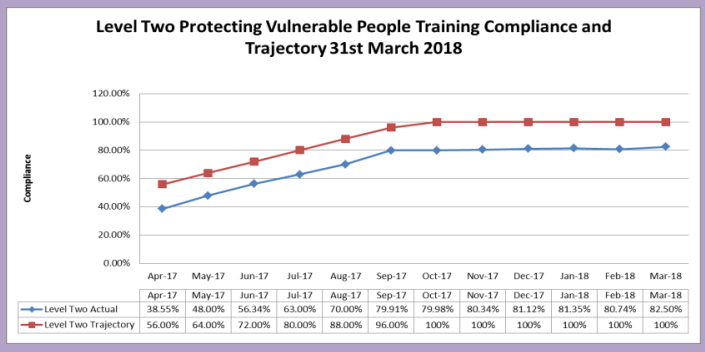
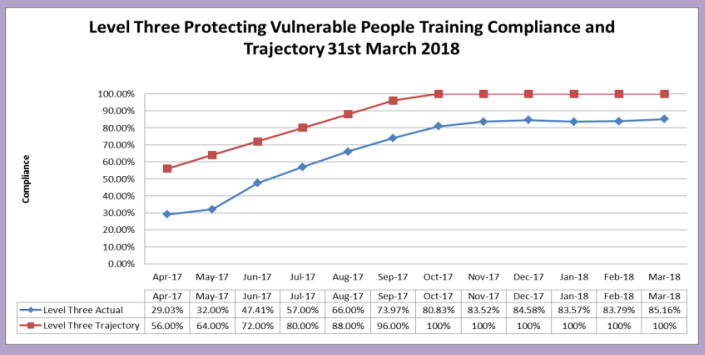


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level Two Actual	38.55%	48.00%	56.34%	63.00%	70.00%	79.91%	79.98%	80.34%	81.12%	81.35%	80.74%	82.50%
Level Two Trajectory	56.00%	64.00%	72.00%	80.00%	88.00%	96.00%	100%	100%	100%	100%	100%	100%

Overall the Trust compliance has increased from **38.55% to 82.50%**
This equates to **2174** staff who have received Protecting Vulnerable People training



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level Three Actual	29.03%	32.00%	47.41%	57.00%	66.00%	73.97%	80.83%	83.52%	84.58%	83.57%	83.79%	85.16%
Level Three Trajectory	56.00%	64.00%	72.00%	80.00%	88.00%	96.00%	100%	100%	100%	100%	100%	100%

Overall the Trust compliance has increased from **29.03% to 85.16%.** This equates to **599** staff who have received Protecting Vulnerable People training

15. Children Looked After

Wuth is commissioned to deliver initial health assessments for Children Looked after. Ongoing discussions taking place between WUTH and Wirral commissioners to discuss Service Level Agreement (SLG) for Initial Health Assessments.

The SLG was developed in partnership with Wirral CCG and WUTH. The Trust is awaiting the draft service specification.

In the interim, the CLA service agreement is monitored by the standards and compliance indicators in the Safeguarding Assurance Framework.

The service is supported by the Designated Doctor for Children Looked After and the Trust has appointed a Named Doctor in July 17 for CLA.

Assurance is provided via the Safeguarding Assurance Framework to our commissioners and Section 11 Audit.

16. PREVENT

Prevent is included within all levels of the Protecting Vulnerable People (PVP) Training.

Following on from the launch of PVP Training Strategy in September 2016, PVP training is now included within the compliance reporting specific to required skills and knowledge required. The Trust is compliant with Prevent training requirements.

The Trust remains a non- priority site, however the reporting mechanism is required via NHS Digital and also via the Safeguarding Assurance Framework to the Clinical Commissioning Group.

The Trust has two PREVENT leads – Associate Director of Nursing and Named Nurse for Safeguarding Adults

The Trust has two PREVENT leads – Associate Director of Nursing and Named Nurse for Safeguarding Adults.

17. Child Sexual Exploitation (CSE)

Tackling Child Sexual Exploitation is a priority for Wirral University Teaching Hospital with the partnership. A high profile case on Wirral has highlighted the need for vigilance when the child or young person accesses our services which has resulted in Serious Case Review (SCR)

The Trust has completed and is compliant with the Trust action plan following the SCR. Audit to be completed in six months to provide assurance and effectiveness.

The Director of Nursing and Associate Director Nursing Safeguarding has fully engaged with NHS England's managing of Wirral' s local investigation and has participated in tele conferences to provide updates when required. The Trust has identified a lead for CSE within the new safeguarding structure who co-ordinate information gathered from national and local reviews.

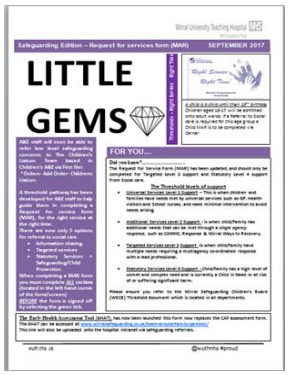
CSE is a mandatory reporting incident to the safeguarding to ensure that CSE toolkit is completed.

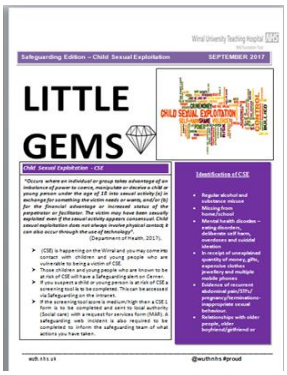
The Trust Lead for CSE attends the bi-monthly Multi-Agency Child Sexual Exploitation Meeting (MACSE) meetings to ensure a multi-agency response.

Cascading of information to raise awareness of CSE, spotting the signs and reporting mechanisms within the Trust and further guidance on the Trust website for staff. Staff can also access the Safeguarding Boards website to raise and enhance knowledge. Further awareness material including an online e-learning package. Themed updates from the Safeguarding Board are disseminated within the Trust and displayed in key areas within the emergency department, Women's and Children's division.

CSE training has been incorporated with the Protecting Vulnerable People training which is mandatory for all levels of staff. Multi-agency CSE training aims to provide practitioners across all agencies with best practice principles for working with children and young people who have been or are at risk of being sexually exploited.

The Trust participated in the Safeguarding Boards CSE day including displaying of posters, engagement via twitter every day for a week before and after CSE including promotion of CSE pledges.





18. Key Objectives for 2018-19

Next Steps

Safeguarding work plan highlighting priorities and objectives

Further development of Wirral Millennium to improve data collection and recording

Achieve and maintain Protecting Vulnerable People training compliance

Utilise the E-Learning platform for safeguarding training once live within the Trust

Development of safeguarding databases to provide more detailed breakdown of safeguarding data to provide assurance internally and externally

Inclusion of Safeguarding within the Trust Ward Accreditation Programme

Launch safeguarding excellence ward's on each floor with a view to share and roll out good practice throughout the Trust.

Identification of Safeguarding Ambassadors and provide bespoke multi agency training to support all staff within the divisions.

Embed the new statutory proposals from the Law commission once agreed by government for Deprivation of Liberty recommendations

Develop a robust mechanism of sharing good practice, clinical audit and serious case reviews within the Trust

Further develop a comprehensive safeguarding Resource file for all areas within the Trust. This will contain all up to date relevant safeguarding information which will support and enable midwives with correct toolkit to support midwives in discharging their safeguarding responsibility

Quality assure multi-agency birth plans

Stand-alone Midwifery Safeguarding Policy

To further embed the service of CAF/TAF champions and Safeguarding Ambassadors

Improve quality and accuracy of data management with the introduction of Databases for Children and young people who attend WUTH with safeguarding concerns, those who are discussed at MACSE, 16-19 years and the Unborn

Continue to embed the threshold document in ED to improve appropriate referrals to the Local Authority

Increase awareness of MCA and consent for those young people 16 and 17 years old

Deliver bespoke training with Safeguarding links/Ambassadors

Capture the voice of the child at every opportunity

Continue to disseminate key messages to raise awareness of CSE

Monitor compliance of the Multi Agency Adult referral form when staff are raising concerns directly with the local authority and provide support to staff to further embed in identified areas

Continue to support the ward accreditation programme to include the safeguarding agenda

Work alongside Chief Nursing Information Officer to further streamline safeguarding functions within Wirral Millennium

Complete a cycle of Audit to ensure best practice is being achieved in relation to the protection of our most vulnerable patients in line with our statutory requirements

Further embedment of the Principles of the Care Act and the promoting of 'Making Safeguarding Personal'

Monitor and audit the application of the Mental Capacity Act and best interest's completion through clinical audit.

To continue to increase staff awareness and knowledge and support staff in the completion of Mental Capacity Assessments, with a view of removing the risk from the Trust risk register in relation Deprivation of Liberty safeguards admission consent

Further develop front line staff in their awareness and responsibilities of Mental Capacity Act and Deprivation of Liberty Safeguards

Await the Law commission's review of Deprivation of Liberty Safeguards approval and ensure that the Trust is complaint with all statutory requirements set out under the proposed Liberty Protection Safeguards (LiPS)

Work with the Chief Nurse Information Officer to refine and expand the current MCA and BI tools currently embedded within Wirral Millennium with a shared aim of quality improvement supporting the making safeguarding personal agenda

Further support to ED staff in completing the Domestic Abuse Risk Assessment as not all the staff is currently completing this. Audit is being completed to share with management regarding staff completion of the domestic abuse risk assessments. It is believed that once all staff are completing the domestic abuse risk assessments upon a disclosure that the referral to MARAC of high risk cases that have been identified through WUTH will be higher.

Further development within Cerner to ensure that routine screening questions are implemented into all departments but specifically ED

Continue to audit quality of referrals received to ensure that all appropriate safeguarding procedures completed as stipulated in the Domestic Abuse Policy

Continue to develop the routine screening questions in relation to FGM throughout the Trust as per Multi-agency Policy

The next steps will form the basis to the safeguarding work plan and Safeguarding Strategy for this coming year.

19. Conclusion

This year, we mark and celebrate the 70th anniversary of the National Health Service (NHS).

Since its start in 1948, the NHS has had one simple premise at its heart that care should be based on need, and free from the point of delivery.

What about Safeguarding? For me and my colleagues, Safeguarding means protecting people's health, wellbeing and human rights, enabling them to live free from harm, abuse and neglect.

As we celebrate the anniversary of the NHS it is only right we also celebrate the achievements of safeguarding. This report sets out our achievements for the year but we must always look at what we can be improved. We must strive to enhance ways to protect, support and improves the lives of the most vulnerable people in our society. We must always be thinking about the challenges that lie ahead.

2018-19 will be a significant year for all in safeguarding, particularly those involved in child protection. The multi-agency reforms in response to the Children and Social Work Act 2017 will see some of the biggest changes to child safeguarding in the last 40 years. Throughout the reforms, it is imperative that the voice of the child is heard.

We as a Trust are awaiting the findings of the collaboration with the Law Commission and Department of Health on the review of the Mental Capacity and Deprivation of Liberty Safeguards and the impact of the review upon the Trust.

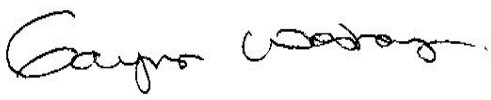
During April 2017, the existing Safeguarding Adults Boards in Knowsley, Liverpool, Sefton and Wirral formed the new Merseyside Safeguarding Adults Board to work together to achieve more effective and personalized safeguarding.

Whilst this annual report provides many examples of the positive and inspiring progress we have made, we are constantly seeking ways in which to improve how we work together internally and with our partner agencies for the best outcomes for all those who come into contact of our service. As a service we are looking forward to the year ahead in ensuring safeguarding is maintained as a high priority for the Trust and is:

Everyone's Business.

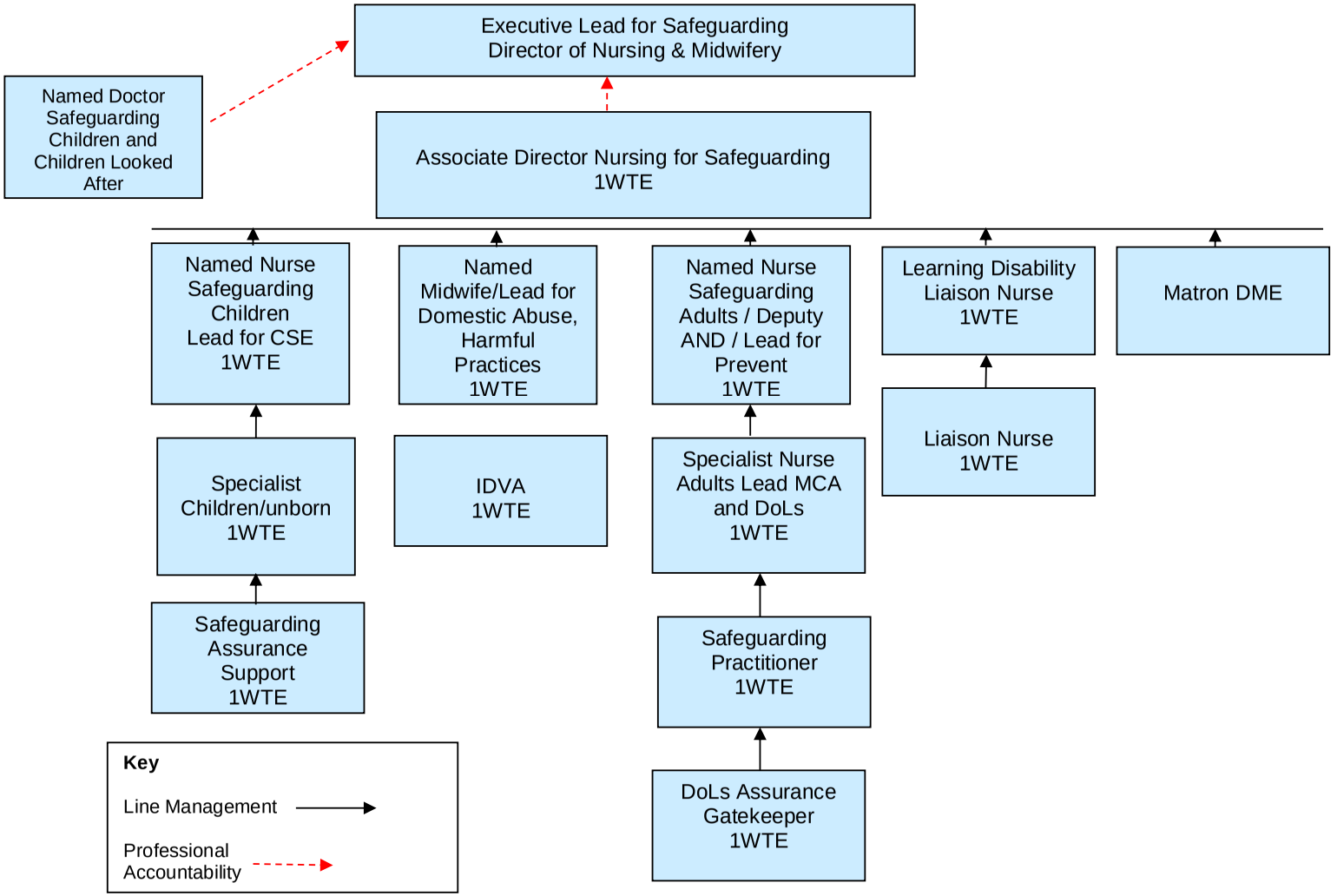
Finally, I would like to take this opportunity to thank all of our staff who continue to work hard to keep children, young people and adults safe. Without you the successes reported here would not happen.

Gaynor Westray Director of Nursing & Midwifery



Wirral University Teaching Hospital NHS
NHS Foundation Trust

Safeguarding Structure



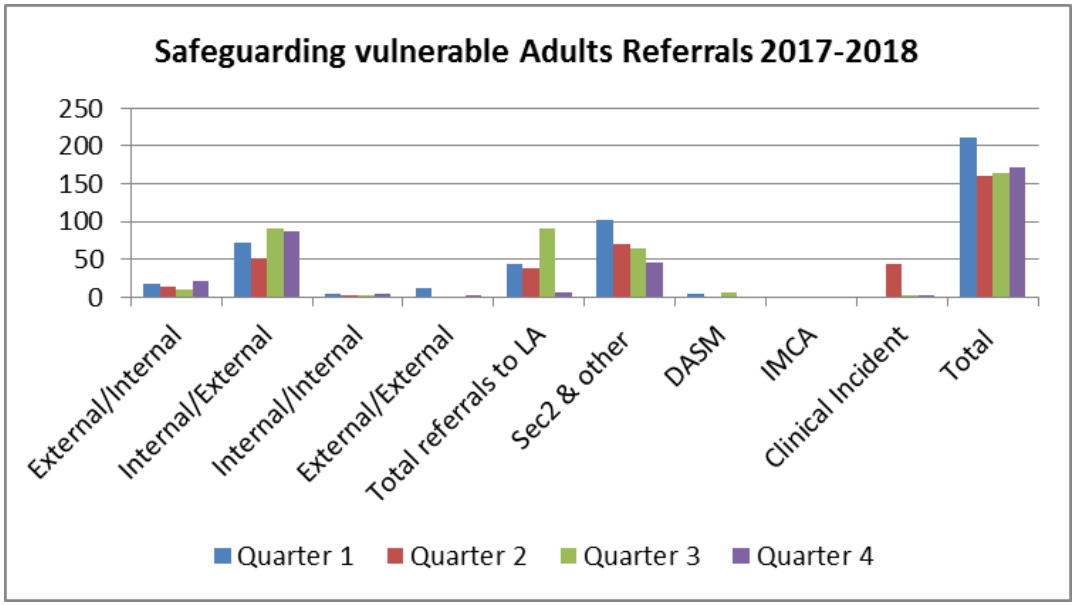
Wirral University Teaching Hospital NHS
NHS Foundation Trust

Adult Safeguarding Statistics Dashboard

The collection of safeguarding adult's data has been broken down into categories to identify where the concern has been escalated from and who the alleged perpetrator is. They are classified as follows and can be seen in the graph in appendix 2

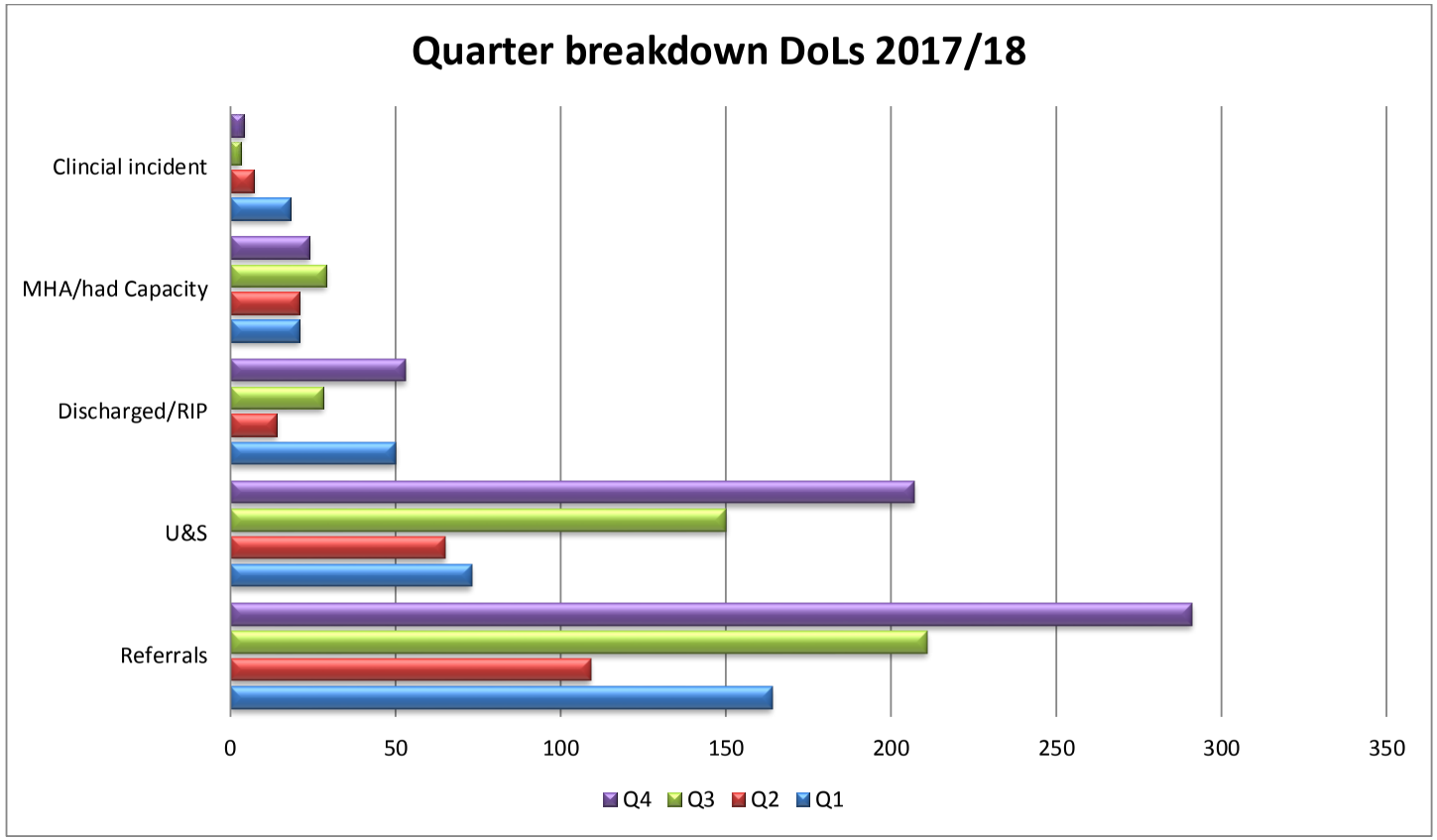
- IE - Internally raised concerns in the hospital by WUTH staff about an external safeguarding concern
- EI - Externally raised concerns against WUTH to the local authority resulting as safeguarding section 42 enquiry
- II - Internally raised concerns regarding an internal safeguarding concern within WUTH
- EE - External concern however support is required from an external agency such as the police or social care as the victim has attended hospital as a result of the suspected abuse

Section 2 and other - These are the concerns raised internally by WUTH staff to the safeguarding team that are not true safeguarding cases, they may include patients that are self-neglecting and require care needs assessments or input form the mental health team. The team does however provide advice and support to direct the staff to the appropriate professionals and agencies. This category also records when advice only has been provided or any mental health referrals that the team has been made aware of due to self-harm and neglect. The safeguarding team will when appropriate share with the local authority for information sharing purposes only.



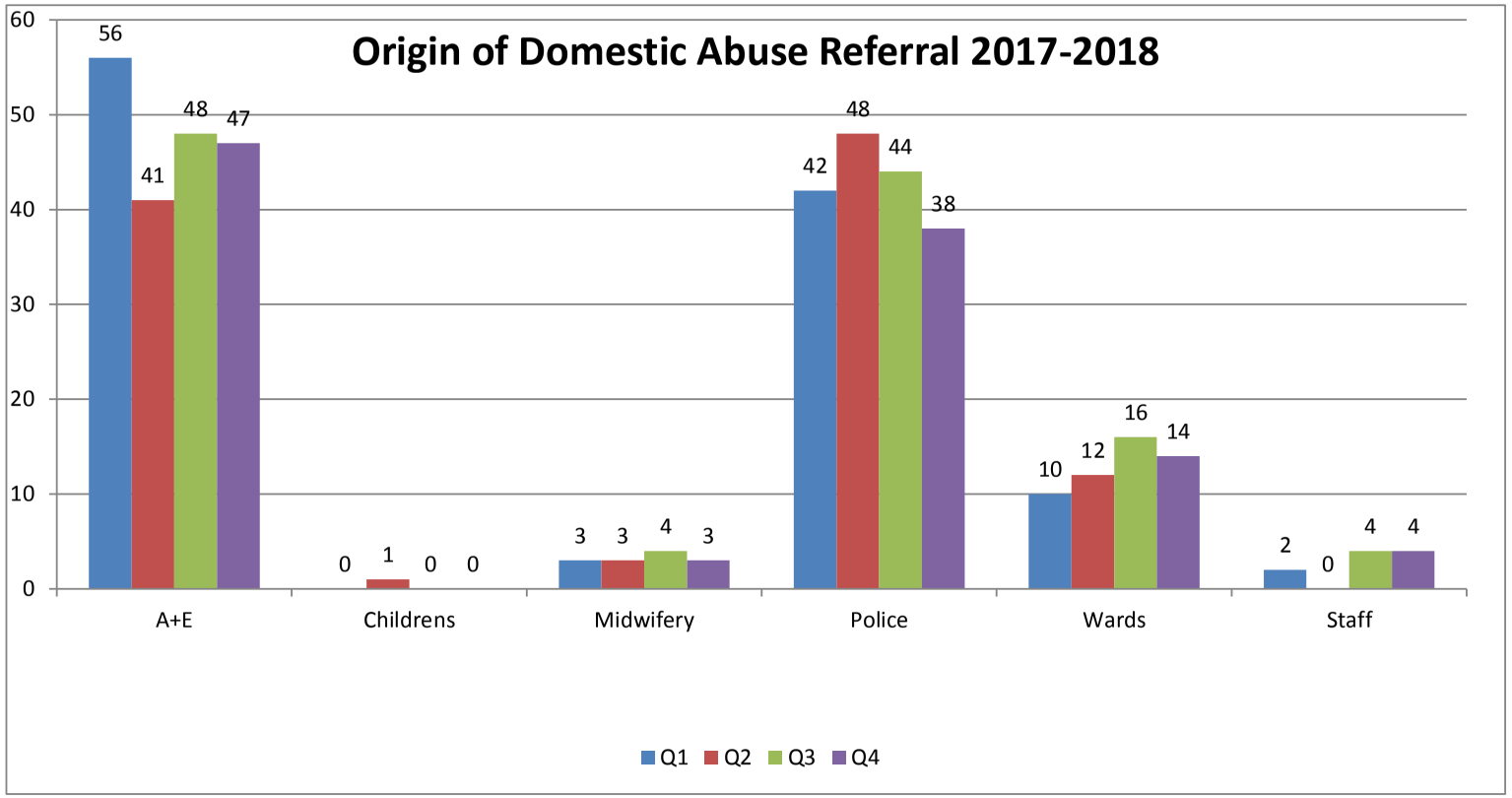
Appendix 3

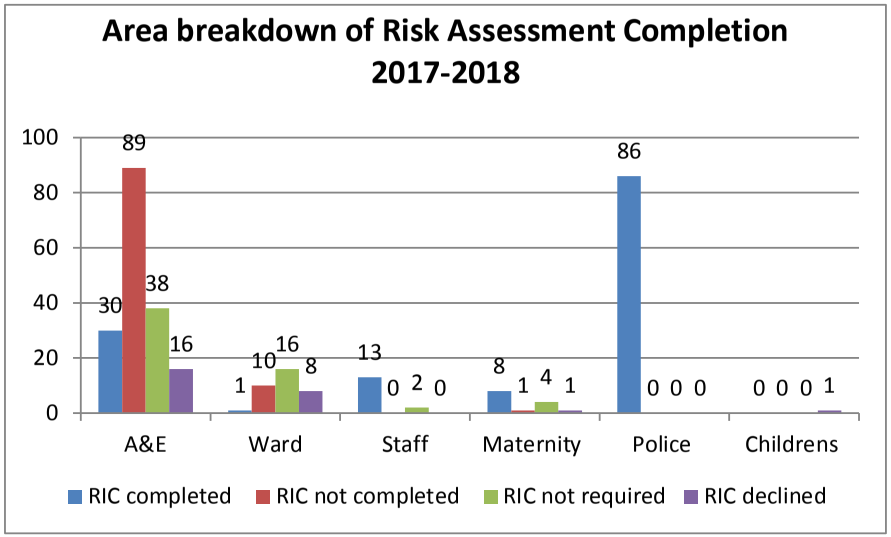
Deprivation of Liberty Statistics Dashboard

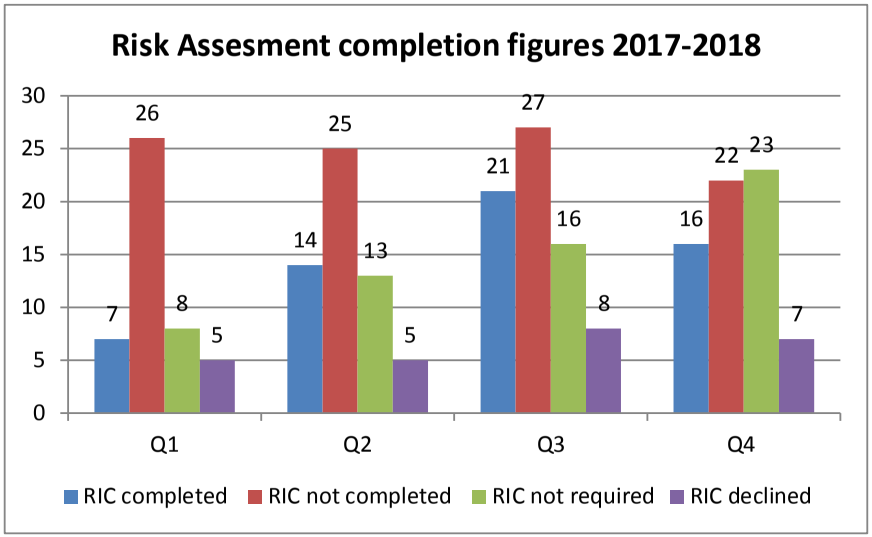


Domestic Violence Statistics Dashboard

Appendix 4


Origin of Domestic Abuse Referral 2017-2018
60
50
40
30
20
10
0
56
41
48
47
0
1
0
0
3
3
4
3
42
48
44
38
10
12
16
14
2
0
4
4
A+E
Childrens
Midwifery
Police
Wards
Staff
Q1
Q2
Q3
Q4

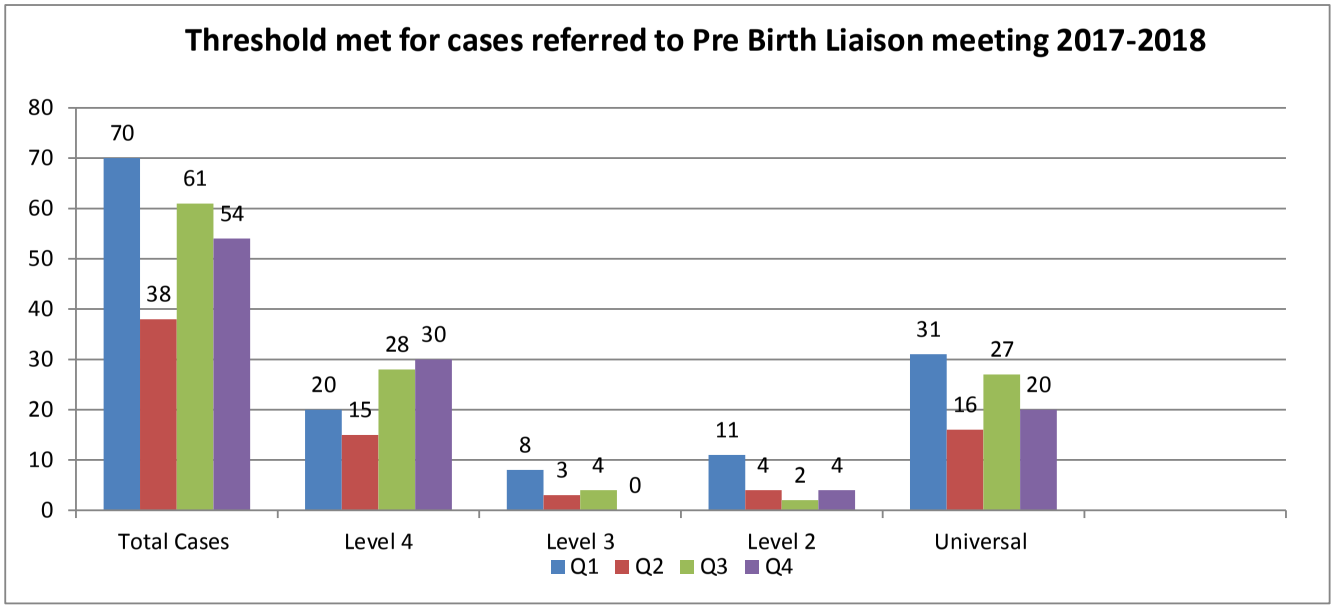




A total of 192 referrals received during timeframe from Emergency Department. Gap identified regarding non completion of Risk Assessment (RIC) completed by frontline staff. The recruitment of the Independent Domestic Abuse Advisor (IDVA) will support and continue to educate staff to complete. Improvement will be monitored by the Safeguarding Assurance Group.
Increase to 52 referrals from the ward areas which are an increase of 10 from last year.

Appendix 5

Pre Birth Liaison meeting statistics



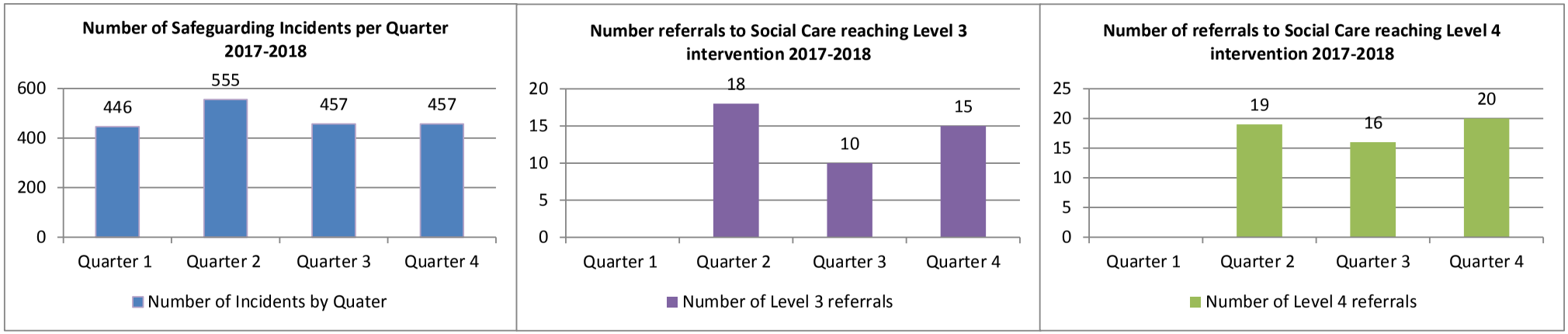
A total of 223 referrals have been discussed at Pre-Birth Liaison meeting which is a reduction from last year's reporting. This can be attributed to the staff making appropriate referrals in line with social care "Right Service Right Time" threshold document which is embedded across the Trust.

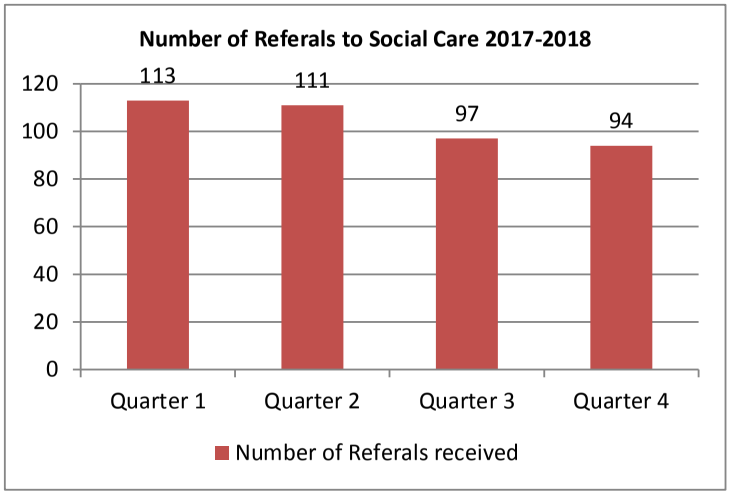
123 met the criteria for Statutory Level 4 child protection, **15** Level 3 Targeted Support from multi-agency support
21 93 cases discussed via the multi-agency meeting required no additional multi-agency support and are supported by midwifery service alone.

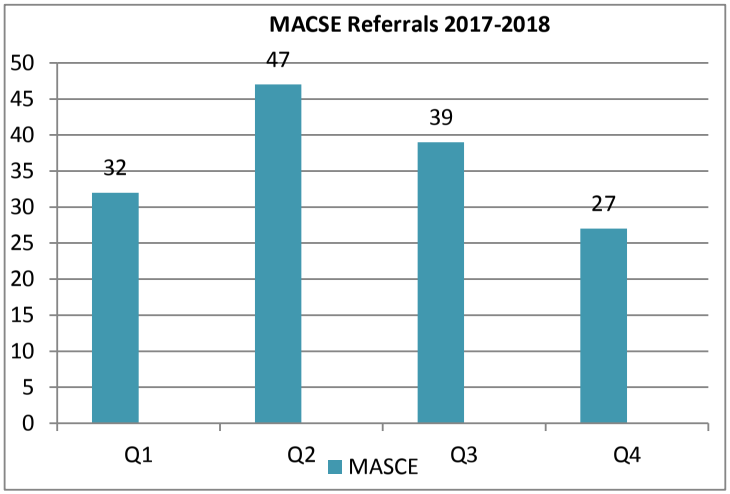
Wirral University Teaching Hospital NHS
NHS Foundation Trust

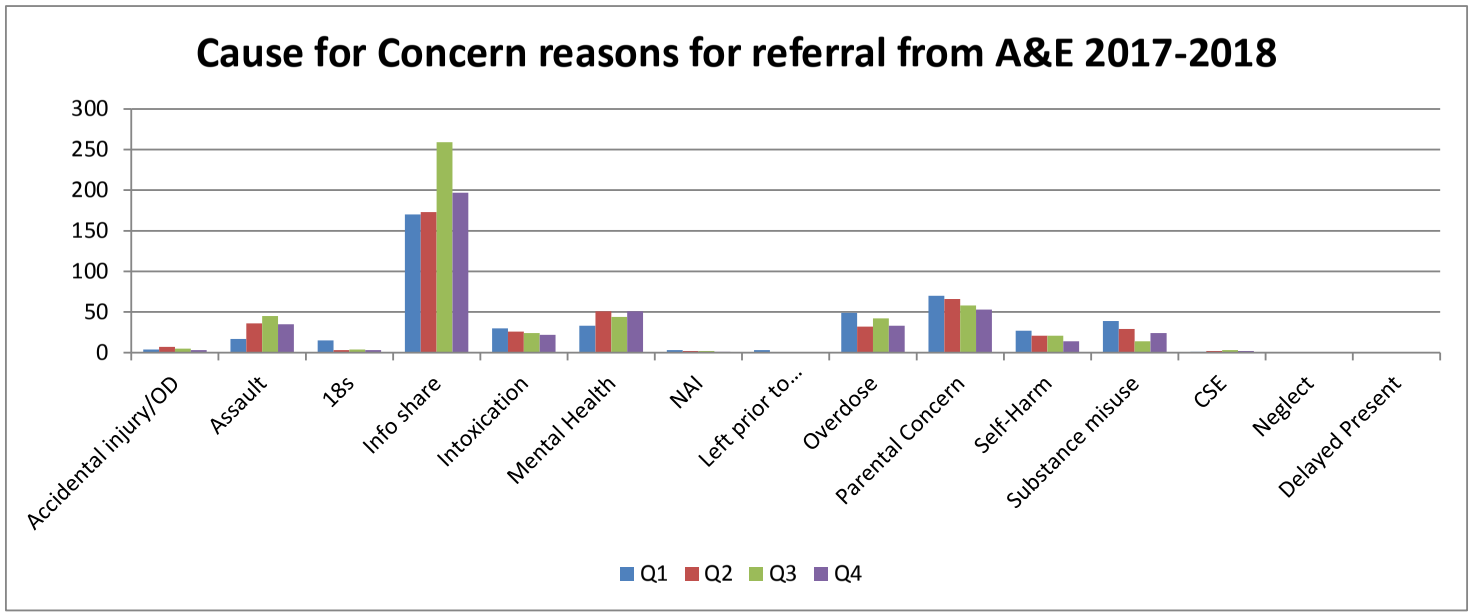
Appendix 6

Safeguarding Young Children and Young people statistics Dashboard









A total of **1577 referrals received which is a reduction from last years data. This can be attributed to the launch of the "Right Service Right Time" Threshold document from social care and staff making more appropriate referrals to ensure that the child received the correct support.**

A rise in referrals received regarding parental concern when the parent attends with concerns regarding mental health, substance misuse and domestic abuse.

BOARD OF DIRECTORS	
Agenda Item	10.4
Title of Report	Care Quality Commission Inspection Report
Date of Meeting	25th July 2018
Author	Paul Moore, Executive Director of Quality & Governance
Accountable Executive	Paul Moore, Executive Director of Quality & Governance
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	The report has implications for all BAF risks.
Level of Assurance **Positive** **Gap(s)**	Limited assurance. The Trust is rated as requires improvement overall, no change in overall rating since last inspection (September 2015). The Trust is rated as inadequate overall under the well-led domain.
Purpose of the Paper **Discussion** **Approval** **To Note**	To consider the report and the immediate steps being taken to respond to the matters highlighted.
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	External report.
FOI status	Document published by CQC.
Equality Impact Assessment Undertaken **Yes** **No**	Not adverse equality impact identified.

1. Executive Summary

The CQC inspected the Trust between 13th March and 3rd May 2018. The Trust is rated 'Requires Improvement' overall as a combination of a range of observations, including: instability in the Executive Team and turnover of senior leaders; compliance with Fit & Proper Persons Requirement; ineffective governance (including risk management, quality monitoring, quality of information, concerns around culture, assessment of competence and skills, incident handling arrangements); environmental cleanliness; assessment of falls and pressure ulcer risk; access to Children's Emergency Department 24 hours per day; transfer of patients out of hours; and use of Deprivation of Liberty Safeguards.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ May 2018	Requires improvement ➔ Mar 2018	Good ➔➔ May 2017	Requires improvement ➔➔ May 2017	Inadequate ➔ May 2018	Requires improvement ➔➔ May 2018

The report is attached to enable the Board to consider and discuss the findings in full. By way of a summary to assist the Board:

Are services safe?

The CQC rating of safe stayed the same. CQC rated 'Safe' as requires improvement because:

- *Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.*
- *There were periods of understaffing or inappropriate skills mix which were not always addressed quickly enough.*
- *There was a high number of bank and agency staff used.*
- *Information on patient safety was not always timely. Risk assessments were not always being completed in some service areas.*
- *Incidents were not always being recorded or investigated in a timely way and in line with national guidance and trust policy. People did not always receive a timely apology when something went wrong.*
- *Major incident equipment had not always been checked regularly and was not always easily accessible should it be required in an emergency situation and unanticipated event.*
- *There were times when areas were being used to care for patients which were not always fit for purpose and the appropriate equipment and facilities always available.*
- *There was insufficient attention to keep patient records safe.*

However, good practice points were identified as follows:

- *There were systems and processes in place to keep people safe from abuse and safeguarding policies were in line with best practice guidance;*
- *Staff could access patient information when they needed it to plan and deliver care, treatment and support; and*
- *People received their medicines when required.*

Are services effective?

CQC rating of effective deteriorated since last inspection. CQC rated 'effective' as requires improvement because:

- *Staff did not always adhere to the Mental Capacity Act 2005 principals and guidance was not always effective. There were times when deprivation of liberty safeguards applications had not been made in a timely way which meant there was a risk that patients were being detained unlawfully.*
- *In some services outcomes for patients who used services were sometimes below expectations when compared with similar services.*
- *There was limited evidence of monitoring adherence to national guidelines to ensure care pathways were up to date and appropriate.*
- *Not all staff had the right skills and experience to fulfil their roles. There was limited leadership development in services and some services were not able to evidence staff*

competencies to fulfil additional roles. There were gaps in support arrangements for staff for professional development.

However, good practice points were identified as follows:

- *People's care and treatment was planned and delivered based on national guidance and standards.*
- *Pain relief was effectively managed.*
- *There was participation in relevant local and national clinical audits together with external reviews where appropriate to help improve standards of care.*

Are services caring?

CQC rating of caring stayed the same. CQC rated 'caring' as good because:

- *Feedback from people who used the services and those close to them were positive about the way staff treated people.*
- *People were treated with respect and kindness during all interactions we observed. People felt supported and said staff cared for them.*
- *Staff supported people and those close to them to manage their emotional responses to care and treatment. Personal, cultural, social and religious needs were understood.*
- *People said staff spent time with them and provided information in a way they could understand. Staff responded compassionately when people needed help and supports.*
- *People's privacy and confidentiality was respected the majority of times.*

However, improvement opportunities were identified as follows:

- *CQC did observe that people's dignity was not always maintained and there were occasions when the facilities provided in certain areas did not always promote privacy and dignity.*

Are services responsive?

CQC rating of responsive stayed the same. CQC rated 'responsive' as requires improvement because:

- *There were shortfalls in how the needs of different people were taken into account on the grounds of protected characteristics under the Equality Act. There were no network groups for patients.*
- *Information was not always accessible for people and not readily available in different languages.*
- Complaints were not always being responded to in a timely way and there was little evidence of the learning applied to practice within services
- Not all services had been planned and provided that met the needs of the local people, for example the children's department was not open 24 hours a day.
- People did not always receive treatment in a timely way. This was because the urgent and emergency service had continually failed to meet the target to transfer, admit or discharge patients.
- Access and flow continued to be a challenge for the trust and there were significant patient moves out of hours, a high number of delayed discharges and patients being cared for on a ward that did not meet their speciality.
- Medical certification of death continued to be a long standing issue and there were not always available in the required timeframe.

However, good practice points were identified as follows:

- *Services had responded to individual needs. For example, areas designed to help people living with dementia and a bereavement room for families and loved ones of patients who had passed away.*
- *There was a translation service in place and there was access to a psychiatric liaison service when required.*
- *There was a rapid discharge team in place to help facilitate patients who were end of life to die in their preferred place of care where appropriate.*

Are Services well-led?

CQC rating of well-led deteriorated since the last inspection. CQC rated 'well-led' as inadequate because:

- *The leadership, governance and culture did not always support the delivery of high quality person-centred care.*
- *Not all leaders had the necessary experience, knowledge and capacity to lead effectively. There were unstable leadership teams throughout the trust. The need to develop leaders had not always been identified and action was only just beginning to be taken. There was little attention to succession planning and board development.*
- *In some services there was limited evidence of a strategy and workable plans to make improvements. There was no effective approach to monitoring or providing evidence of progress against delivery of the strategy or plans on a regular basis.*
- *Managers across the trust had not always promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff informed us that they had witnessed or experienced bullying or harassment and we found that when concerns had been raised, they had not always been dealt with in a timely manner.*
- *People did not always receive a timely apology when something went wrong in line with national guidance and regulation.*
- *The trust did not always ensure that all recruitment checks had been completed for senior leaders in line with national guidance and regulation.*
- *Equality and diversity were not consistently promoted and there were no specific network groups available for staff with particular protected characteristics under the Equality Act.*
- *The governance arrangements and their purpose were unclear and did not always operate effectively. There had been a recent governance review but staff were not always clear about their role and what they were accountable for.*
- *Risks were not always dealt with appropriately and the risk management approach was not applied consistently. Risk registers and actions were not always regularly reviewed and there was no evidence that the corporate risk register had been regularly reviewed and updated before the inspection.*
- *Information that was used to monitor performance or make a decision could not be relied on to be accurate or reliable. For example, workforce information. Required data to be submitted to external organisations was not always reliable.*
- *There was little recent innovation or service development and there were a number of policies and standard operating procedures that were overdue for review.*

However, good practice points were identified as follows:

- *Senior leaders had recognised that improvement had to be made and had begun to involve staff in the review of the strategy and review of the trust values.*
- *The executive team had begun to visit service areas to help improve the accessibility and visibility of the team.*
- *The risk registers across the trust did show that most risks had controls in place to reduce the level of risk.*

- *There was evidence of collaborative working with other NHS organisations and stakeholders and there was recognition that there was a need to work in a more integrated way for the benefit of patients.*

The Executive Summary must clearly state the purpose of the paper in terms of what the Board / Committee is being asked to do (e.g. make a decision, approve, or note)

2. Next Steps

The findings of the report, and the recommendations contained in the list of 'must do' and 'should do' actions are accepted in full. The Trust has until 10th August to develop and formally submit its action plan to CQC in response to the inspection report. At the time of report the action plan continues to be developed and subject to agreement. The discussion at the Board meeting can helpfully inform and shape how the action plan is subsequently developed. The immediate steps taken or in progress include:

- Action to stabilise and transition rapidly towards a substantive leadership team and Board of Directors;
- Executive Director of Governance & Quality Improvement appointed and joined the Board on 9th July 2018. He will provide the leadership to transform quality governance, and drive on behalf of the CEO and Board the Quality Improvement Plan in concert with the Executive Medical Director and Executive Director of Nursing;
- The Quality Improvement Plan, currently being developed, is being mapped to the 102 recommendations made and will address all CQC issues, alongside other improvement opportunities identified in parallel;
- Dedicated PMO support to accelerate quality improvement has agreed and action underway to appoint a project manager;
- The Board have set aside time to finalise and clarify more directly the Trust's strategy, vision and priorities;
- The Trust has initiated an OD programme – and we intend to continue to drive the programme to develop organisational culture;
- The Executive Director of Governance & Quality Improvement is currently taking stock of quality governance capacity and capability, and will initiate a rapid governance development and improvement programme once conclusions are reached. This is expected to focus on addressing better internal control, assurance and accountability for quality; risk management, exemplary corporate governance;
- In partnership with our staff and stakeholders, we will consult and develop both a Quality Improvement Strategy and model for improvement for the Trust to solidify the quality priorities and move beyond compliance actions to transformation and outcome-based quality goals.

3. Conclusion

The CQC inspection identified no material improvement in ratings since 2015. The ratings overall stayed the same, but there was deterioration in both the effective and well-led domains. The findings of the report, and the recommendations contained therein are accepted in full. 102 recommendations have been made by the CQC to comply with the requirements of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Planning to address those requirements, and other quality priorities, is currently underway.

4. Action Required by the Board

The Board are invited to:

- consider and discuss the CQC inspection findings;
- note that the recommendations are accepted in full and planning is underway to address them; and
- advise on any other immediate actions required by the Board as the plans are developed.

Enclosure: Wirral University Teaching Hospital NHS Foundation Trust **Inspection report.**

Wirral University Teaching Hospital NHS Foundation Trust

Inspection report

Arrowe Park Hospital
Arrowe Park Road
Wirral
Merseyside
CH49 5PE
Tel: 01516785111
www.wuth.nhs.uk

Date of inspection visit: 13 March to 3 May 2018
Date of publication: 13/07/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Wirral University Teaching Hospital NHS Trust provides services at Arrowe Park Hospital and Clatterbridge Hospital.

The hospitals are located on the Wirral peninsula in the North West of England and serves the people of Wirral and neighbouring areas.

Wirral University Teaching Hospitals NHS Foundation Trust became a Foundation Trust on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with 855 beds trust-wide, including 749 at Arrowe Park Hospital.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

The other site is Clatterbridge Hospital in Bebington and provides surgical and medical rehabilitation services together with some outpatient services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Wirral University Teaching Hospital NHS Foundation Trust was last inspected in September 2015 and rated requires improvement overall. We inspected the trust on 13 March to 15 March, 20 March to 23 March and 1 to 3 May 2018. We looked at medical care, surgery, end of life care, urgent and emergency services, maternity and the critical care unit. We also assessed the well led aspect of the trust.

We inspected certain services at Arrowe Park Hospital based on the level of risk and also inspected the well-led aspect as this had not been inspected before. We did not visit services at Clatterbridge Hospital as part of this inspection.

Summary of findings

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- There was an unstable executive leadership team with a significant turnover of senior leaders. This had affected the capability and capacity within the senior leadership team together with the pace to progress improvements in care provided.
- The trust was not fully compliant with the fit and proper person requirements as not all appropriate checks had been completed on directors and non-executive directors.
- Although there was a trust governance structure in place the arrangements did not always operate effectively. Some new systems had been put in place to monitor quality and safety across the trust but the improvement was difficult to assess.
- The risk management system was applied inconsistently throughout services and risk registers and action plans to mitigate the risks were not always reviewed in a timely way.
- Information used in reporting, performance management and delivering quality care was not always accurate or reliable. Leaders and staff did not always receive accurate information to enable them to challenge and improve performance.
- Not all services had a clear vision for what it wanted to achieve and did not always have workable plans to make improvements.
- There was not always a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff informed us that they had witnessed or experienced bullying or harassment and we found that when concerns had been raised, they had not always been dealt with in a timely manner.
- Not all services provided enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. We found that there were still staffing shortages which had not improved since the last inspection. We also found times when staff did not have all the competencies required to care for patients in the maternity unit following emergency surgical procedures.
- The trust had not always managed patient safety incidents well. This was because serious incidents had not always been reported and investigated in line with the NHS England Serious Incident Framework 2015 or trust policy so that improvements were made to reduce the risk of similar incidents happening again. There were occasions when an apology was not given in a timely way when things went wrong.
- Some areas of the hospital were not as clean as they should have been and not all equipment had been serviced or maintained adequately.
- Not all services had suitable premises for patients and in critical care they did not always comply with best practice guidance for the design of the environment. There were times when some areas were being used that were not always appropriate due to the lack of facilities when the hospital was busy.
- In the emergency department patient risk assessments for falls and pressure ulcers had not been completed in line with trust policy and best practice guidance. This was particularly important as patients had spent more than 12 hours in the department on a regular basis.
- The children's emergency department was not open 24 hours a day, seven days a week. This meant that children were sometimes assessed and treated in inappropriate areas of the department.

Summary of findings

- There were a large number of patient moves, especially at night. Services did not monitor the reason for placing patients into these areas and therefore could not clarify if the placements were made for clinical reasons. There were also a large number of patients ready for discharge across the trust. This had not improved since the last inspection.
- There were safeguarding processes in place to protect people from abuse, however these were not always effective. We had concerns that some patients who required restrictions in place to keep them safe were potentially being deprived of their liberty without lawful authority.

However

- Staff understood how to protect patients from abuse. Safeguarding policies for adults and children were readily available and staff received appropriate levels of safeguarding training.
- The service provided care and treatment based on national guidance. Staff had access to information to support them in providing the most appropriate care and treatment.
- Staff cared for patients with compassion. Patients were treated with dignity and had their privacy maintained the majority of occasions.
- Leaders had recognised that culture within the trust required improvement and had recently undertaken external reviews and put actions in place. We also found improvements in the culture in maternity services following our last inspection.
- There had been improvements in how end of life services was led since the last inspection. There had been an increase in consultant cover for palliative medicine and performance dashboards were not in place to monitor and improve the service.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.
- There were periods of understaffing or inappropriate skills mix which were not always addressed quickly enough. There was a high number of bank and agency staff used.
- Information on patient safety was not always timely. Risk assessments were not always being completed in some service areas.
- Incidents were not always being recorded or investigated in a timely way and in line with national guidance and trust policy. People did not always receive a timely apology when something went wrong.
- Major incident equipment had not always been checked regularly and was not always easily accessible should it be required in an emergency situation and unanticipated event.
- There were times when areas were being used to care for patients which were not always fit for purpose and the appropriate equipment and facilities always available.
- There was insufficient attention to keep patient records safe.

However

- There were systems and processes in place to keep people safe from abuse and safeguarding policies were in line with best practice guidance.
- Staff could access patient information when they needed it to plan and deliver care, treatment and support
- People received their medicines when required.

Summary of findings

Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always adhere to the Mental Capacity Act 2005 principals and guidance was not always effective. There were times when deprivation of liberty safeguards applications had not been made in a timely way which meant there was a risk that patients were being detained unlawfully.
- In some services outcomes for patients who used services were sometimes below expectations when compared with similar services.
- There was limited evidence of monitoring adherence to national guidelines to ensure care pathways were up to date and appropriate.
- Not all staff had the right skills and experience to fulfil their roles. There was limited leadership development in services and some services were not able to evidence staff competencies to fulfil additional roles. There were gaps in support arrangements for staff for professional development.

However

- People's care and treatment was planned and delivered based on national guidance and standards.
- Pain relief was effectively managed.
- There was participation in relevant local and national clinical audits together with external reviews where appropriate to help improve standards of care.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Feedback from people who used the services and those close to them were positive about the way staff treated people.
- People were treated with respect and kindness during all interactions we observed. People felt supported and said staff cared for them.
- Staff supported people and those close to them to manage their emotional responses to care and treatment. Personal, cultural, social and religious needs were understood.
- People said staff spent time with them and provided information in a way they could understand. Staff responded compassionately when people needed help and supports.
- People's privacy and confidentiality was respected the majority of times.

However

- We did observe that people's dignity was not always maintained and there were occasions when the facilities provided in certain areas did not always promote privacy and dignity.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- There were shortfalls in how the needs of different people were taken into account on the grounds of protected characteristics under the Equality Act. There were no network groups for patients.
- Information was not always accessible for people and not readily available in different languages.

Summary of findings

- Complaints were not always being responded to in a timely way and there was little evidence of the learning applied to practice within services
- Not all services had been planned and provided that met the needs of the local people, for example the children's department was not open 24 hours a day.
- People did not always receive treatment in a timely way. This was because the urgent and emergency service had continually failed to meet the target to transfer, admit or discharge patients.
- Access and flow continued to be a challenge for the trust and there were significant patient moves out of hours, a high number of delayed discharges and patients being cared for on a ward that did not meet their speciality.
- Medical certification of death continued to be a long standing issue and there were not always available in the required timeframe.

However

- Services had responded to individual needs. For example, areas designed to help people living with dementia and a bereavement room for families and loved ones of patients who had passed away.
- There was a translation service in place and there was access to a psychiatric liaison service when required.
- There was a rapid discharge team in place to help facilitate patients who were end of life to die in their preferred place of care where appropriate.

Are services well-led?

Our rating of well-led went down. We rated it as inadequate because:

- The leadership, governance and culture did not always support the delivery of high quality person-centred care.
- Not all leaders had the necessary experience, knowledge and capacity to lead effectively. There were unstable leadership teams throughout the trust. The need to develop leaders had not always been identified and action was only just beginning to be taken. There was little attention to succession planning and board development.
- In some services there was limited evidence of a strategy and workable plans to make improvements. There was no effective approach to monitoring or providing evidence of progress against delivery of the strategy or plans on a regular basis.
- Managers across the trust had not always promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff informed us that they had witnessed or experienced bullying or harassment and we found that when concerns had been raised, they had not always been dealt with in a timely manner.
- People did not always receive a timely apology when something went wrong in line with national guidance and regulation.
- The trust did not always ensure that all recruitment checks had been completed for senior leaders in line with national guidance and regulation.
- Equality and diversity were not consistently promoted and there were no specific network groups available for staff with particular protected characteristics under the Equality Act.
- The governance arrangements and their purpose were unclear and did not always operate effectively. There had been a recent governance review but staff were not always clear about their role and what they were accountable for.

Summary of findings

- Risks were not always dealt with appropriately and the risk management approach was not applied consistently. Risk registers and actions were not always regularly reviewed and there was no evidence that the corporate risk register had been regularly reviewed and updated before the inspection.
- Information that was used to monitor performance or make a decision could not be relied on to be accurate or reliable. For example, workforce information. Required data to be submitted to external organisations was not always reliable.
- There was little recent innovation or service development and there were a number of policies and standard operating procedures that were overdue for review.

However

- Senior leaders had recognised that improvement had to be made and had begun to involve staff in the review of the strategy and review of the trust values.
- The executive team had begun to visit service areas to help improve the accessibility and visibility of the team.
- The risk registers across the trust did show that most risks had controls in place to reduce the level of risk.
- There was evidence of collaborative working with other NHS organisations and stakeholders and there was recognition that there was a need to work in a more integrated way for the benefit of patients.

Ratings tables

The ratings tables in the report show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time.

Outstanding practice

We found examples of outstanding practice in medical care services, maternity services and surgical services.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 34 breaches of legal requirements that the trust must put right. We found 78 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

Due to the nature of some concerns we had following this inspection, we issued actions required by the trust. This meant the trust had to be compliant with the relevant regulation.

We issued requirement notices. Our action related to breaches of five legal requirements at a trust-wide level and seven in core services at Arrowe Park Hospital.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust continues to take the necessary action to improve its services following this inspection and the previous inspection in October 2017. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

- In medical care services there were areas specifically designed for patients with dementia which included reminiscence rooms designed to resemble a pub and a beauty salon from the 1950's and contained equipment from that era.
- In maternity services they carried out community PROMPT training (a package that trains the attendees how to deal with obstetric and neonatal emergencies in the home setting) for the local ambulance trust staff and community midwives to train together. The maternity department were runners up this year in the Royal College of Midwives "Excellence in Midwifery Education, Learning and Research award for the delivery of the course.
- Maternity services had a "Mums and Midwives" drop in so women could receive their free Pertussis and flu vaccinations.
- Theatre staff took part in multi-disciplinary clinical simulations as part of continued learning. Staff described a change in practice as a result of one simulation.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations.

Action the trust **MUST** take to improve:

Trust-wide

- The trust must ensure that all governance, incident and risk systems and processes are effective and fully implemented.
- The trust must ensure that all policies are reviewed and up to date with national guidance.
- The trust must ensure that complaints are managed effectively in line with trust policy.
- The trust must ensure that people receive an apology when things go wrong in a timely way and that duty of candour is applied in line with national guidance and trust policy.
- The trust must ensure that all fit and proper person's checks are completed in line with guidance for all directors and non-executive directors at board level and they are compliant with the fit and proper person's regulation at all times.
- The trust must ensure that all information that is used for managing performance is accurate an up to date.
- The trust must ensure that all application for deprivation of liberty safeguards are made in line with legislation.
- The trust must ensure that all information is monitored to improve the flow of patients through the hospital and all areas being used for additional beds are fit for purpose.
- The trust must ensure that safeguarding children training is in line with national guidance.
- The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning.

Urgent and Emergency Care

- The service must ensure that the environment and equipment are maintained and cleaned in line with trust policy and best practice guidance.

Summary of findings

- The service must ensure that appropriate numbers of nursing and medical staff are available at all times.
- The service must ensure that there is a member of staff trained in paediatric advanced life support available at all times.
- The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.
- The service must ensure that patient safety checklists and patient risk assessments, including falls and pressure ulcers are completed in line with trust policy and best practice guidance.
- The service must ensure that all medicines, including controlled drugs and patient group directions are managed in line with trust policy and legislation.
- The service must ensure that all incidents, including serious incidents are reported and investigated in line with trust policy and the NHS Serious Incident Framework 2015.
- The service must ensure that all staff complete full competency assessments to undertake their roles and that this is recorded in line with trust policy.
- The service must ensure that there are effective systems in place to monitor the service provided and that when areas for improvement are identified, actions to make improvements are completed in a timely manner.

Medical Care Services

- The service must deploy sufficient staff with the appropriate skills on wards and on the acute medical unit, medical short stay ward and ambulatory care unit.
- The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.
- The service must ensure premises are suitable for the purpose for which they are used, especially in the discharge hospitality centre and day case unit.
- The service must ensure patients' nutrition and hydration needs are met including supporting patients to eat and drink.
- The service must ensure that safeguarding systems and processes are operated effectively and capacity assessments completed in a timely manner to ensure that patients are not deprived of their liberty without lawful authority.
- The service must ensure they assess the risk to health and safety of patients when accommodating patients in escalation areas and do all that is practicable to mitigate any risks. Care and treatment of patients with higher acuity must take place in appropriate areas that are safe for such use.
- The service must decrease the number of patients transferred between wards at night. The transfer of dementia patients at night must only take place in exceptional circumstances to ensure that care and treatment is appropriate, meets individual needs and reflects preferences.

Surgery

- The trust must ensure all premises are maintained and fit for purpose.
- The trust must ensure there are enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The trust must ensure systems and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Summary of findings

Critical Care

- The service must ensure that the unit provides a suitable environment for patients, staff and visitors. The trust must ensure plans are developed to indicate when facilities will comply with national standards
- The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service.

Maternity Services

- The service must ensure that there are adequately skilled and competent recovery staff available at all times to recover women who have been in theatre.
- The service must ensure there are adequate security arrangements to keep babies safe at all times.
- The service must ensure that women's care records are kept securely in locked cabinets at all times.

Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **SHOULD** take:

Trust-wide

- The trust should ensure that culture within the trust is improved.
- The trust should ensure that engagement with staff, patients and the public is improved.
- The trust should consider how innovation is promoted within the trust.
- The trust should ensure that the quality strategy is reviewed and monitored effectively.
- The trust should ensure that divisional review of performance is undertaken effectively.
- The trust should consider how there is a trust oversight of all staffing issues.
- The trust should consider ways in engaging effectively with the council of governors and the public.
- The trust should ensure that compliance with national guidance is monitored.

Urgent and Emergency Care

- The service should ensure that mandatory training is completed by all staff in a timely way.
- The service should ensure that records for children are completed consistently, including using the mandatory safeguarding questions for children at all times and correctly using the paediatric early warning score.
- The service should ensure that all staff are compliant with hand hygiene in between providing direct care and treatment to patients.
- The service should ensure that the paediatric area is secured at all times, reducing the risk of unauthorised access to the department.
- The service should ensure that patients who have an increased modified early warning score are monitored and escalated for further review, in line with trust policy.
- The service should ensure that staff are able to access major incident equipment in a timely manner and that major incident equipment is checked and maintained in line with trust policy.
- The service should ensure that the transfer of care for all patients is completed appropriately, in line with trust policy.

Summary of findings

- The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.
- The service should ensure that best interest decisions and mental capacity assessments are recorded in line with trust policy and legislation.
- The service should ensure that staff are able to raise concerns when needed and that they are acted on in a timely manner.
- The service should ensure that health and safety risk assessments are kept up to date.
- The service should consider ways to make sure that patient pathways for different conditions are included in all patient records and completed fully when appropriate.
- The service should consider ways in which to make sure that all staff have an understanding of female genital mutilation and aware of the legal requirement to report incidences of this.
- The service should consider ways to make sure that all equipment in the department is stored appropriately.
- The department should consider ways to ensure that all breaches of mixed sex accommodation in the emergency department review unit are recorded appropriately.
- The service should consider ways to make sure that complaints are dealt with in both a timely manner and in line with trust policy.
- The service should consider ways to improve the response rate of both staff, patients and relatives in order make further improvements to the service.

Medical Care Services

- The service should improve mandatory and safeguarding training compliance across all staff groups.
- The service should ensure the safe and proper storage of medicines on wards.
- The service should ensure that equipment and premises are kept clean and daily checks take place.
- The service should ensure all equipment is secure, properly maintained and appropriately located. Particularly, sluice rooms which store substances hazardous to health and urine samples should be locked.
- The service should ensure that all resuscitation trolleys across the service are regularly checked and emergency equipment has the appropriate portable appliance tests carried out.
- The service should improve performance across all metrics in the national falls audit.
- The service should ensure all staff have an up to date appraisal.
- The service should ensure that venous thromboembolism (VTE) assessments are carried out within 24 hours of admission in line with national institute of clinical excellence guidance.
- The service should ensure that patients accommodated on escalation wards have access to a dedicated multi-disciplinary team.
- The service should ensure they provide health promotion services to support national priorities to improve the population's health.
- The service should ensure the privacy and dignity of patients is maintained at all times
- The service should ensure all patients who are not on the correct speciality ward, have regular senior medical reviews.

Summary of findings

- The service should ensure that patients are discharged at an appropriate time to ensure this meets the needs and safety of the patient.
- The service should ensure that a standard operating policy is in place for the practice of 'boarding' patients and there is an effective governance process.
- The service should ensure that they provide information to patients and relatives so that they are aware of how to raise a concern or complaint.
- The service should ensure there are sufficient managers at senior nurse and clinical lead level to run a service providing high quality sustainable care.
- The service should improve the visibility of leaders and improve communication between staff at ward level and leaders.
- The service should ensure that staff feel valued and supported and they are able to speak up and are listened to when they do so.
- The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way.

Surgery

- The service should ensure any emergency equipment in areas accessible to the public without a constant staff presence should be secure.
- The service should audit the implementation of the World Health Organisation Surgical Safety Checklist Five Steps to Safer Surgery.
- The service should ensure all medical records are stored securely.
- The service should ensure medicine refrigerator temperature readings are consistently recorded across the surgical division.
- The service should ensure consistent reporting of incidents by all staff.
- The service should ensure a record is maintained when role specific competencies are achieved.
- The service should ensure the paediatric theatre recovery area is suitably decorated for children.
- The service should ensure that bed moves for patients with dementia are reduced particularly at night.
- The service should consider patient engagement in future service developments.

Critical Care

- The service should ensure that staff monitor the drugs room temperature and take action to address the temperature if it is outside of an appropriate range.
- The service should ensure that it has a vision and strategy which is communicated to its staff.
- The service should review the reception and entry system arrangements for visitors to the unit.
- The service should ensure that patient leaflets are up to date, relevant and accessible for patients and visitors to the unit.
- The service must ensure that staff employed to cover duties are aware of ongoing audits and adhere to processes and guidance in the same way.

Summary of findings

- The service should ensure that storage of gas cylinders is in line with the policy and best practice.
- The service should ensure that the unit meets the trust target of 95% for completion of mandatory training and for protecting vulnerable people training.
- The service should consider ensuring there are adequate signs on entry to the unit instructing visitors to wash their hands.
- The service should monitor and audit nursing staff carrying out aseptic non touch technique when administering medication.
- The service should ensure all sluice areas and medication rooms in the unit are secure and that refrigerators in the medical room and packed appropriately.

Maternity Services

- The service should ensure that all equipment is recorded, serviced and calibrated in line with the manufacturer's instructions.
- The service should ensure response to all complaints are in line with trust policy.
- The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations.
- The service should ensure that birth partners and staff attending theatre wear appropriate theatre attire at all times.
- The service should ensure that mandatory training, safeguarding training and appraisal compliance is increased.
- The service should ensure up to date cleaning schedules are in place in all areas and that all areas are clean.
- The service should ensure that all guidance for staff has the latest version numbers documented to ensure up to date best practice is being followed by all staff.
- The service should consider either purchasing lone worker devices for community staff or implementing a robust system for checking on the welfare of their staff.
- The service should ensure that all relevant documentation is completed in the personal child health record.
- The service should review the staffing arrangements of the transitional care unit to prevent access and flow issues in the unit such as delayed inductions of labour.
- The service should review obstetric cover for the triage area to prevent access and flow and delays in treatment issues.
- The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles.

End of Life Services

- The service should consider reviewing the way documents are stored on the electronic patient record to ensure that important information such as capacity or pain assessments can be easily located by staff when needed.
- The service should ensure that the issue with the timely completion of medical cause of death certificates is recorded and monitored via the relevant risk register.
- The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust Inadequate because:

- There was an unstable leadership team with a number of key posts vacant and currently being undertaken by interim roles. There had been a significant turnover of leaders including the chief executive and chairman. This had affected the capability and capacity within the senior leadership team together with the pace to progress improvements in care provided. There was no succession planning and development of the leadership team.
- The trust was not fully compliant with the fit and proper person requirements as not all appropriate checks had been completed on directors and non-executive directors. This was a beach of regulation.
- The quality strategy had not been reviewed for some time and the trust was just commencing a review of the strategy but this was not going to be completed until the new chief executive and chairperson were in place. The operational plan did not include an effective approach to monitoring as there were no key milestones identified for measuring the key priorities at all levels of the service. The trust values had been in place for some years and not all staff understood the meaning of the values.
- Staff satisfaction was mixed and staff did not always feel actively engaged, empowered or supported. There were teams working in silos and there was evidence that management and clinicians did not always work cohesively. There was evidence that when concerns had been raised these had not always been acted upon in a timely way, though this was improving. There was evidence that the culture was top-down and directive. There was evidence that staff had experienced bullying and harassment and that the culture was at times defensive. People did not always receive a timely apology when something went wrong in line with national guidance and trust policy.
- Equality and diversity were not always promoted and there were no specific network groups for those with particular protected characteristics under the Equality Act. Board members recognised that there was work to be done to improve the equality and diversity across the trust.
- Although there was a governance structure in place the arrangements did not always operate effectively. There had been a recent review of the governance arrangements but how these were being operationalised and monitored was unclear and parts had been put on hold whilst a further review was going to be undertaken. There had not been any recent external review. Whilst there had been some new systems put in place to monitor quality and safety across the trust, systems were still relatively new. This meant the improvement was difficult to assess. Staff were not always clear about their roles within the governance structure and this had caused uncertainty.
- There were safeguarding processes in place to protect people from abuse, however these were not always effective. We found a number of occasions when the deprivation of liberty safeguards processes had not been put in place as soon as they were required. This meant that there was a risk that patients were being detained unlawfully.
- The risk management system was applied inconsistently throughout services and risk registers and action plans were not always reviewed in a timely way. The approach to service delivery and improvement had been reactive. The sustainable delivery of quality care was put at risk by the financial challenge.

Summary of findings

- Information used in reporting, performance management and delivering quality care was not always accurate or reliable. Leaders and staff did not always receive accurate information to enable them to challenge and improve performance.
- Although leaders had recognised that engaging with staff needed to improve, there was limited evidence obtaining the views of the council of governors and the public and who used services. There was insufficient attention to appropriately engaging with particular equality characteristics.
- There was little innovation or service development. There was evidence that incidents were not always being reported and investigated in a timely way and the incident management systems were applied inconsistently. This meant there was a risk of missed opportunities to learn and improve services.

However

- To improve board members awareness of patient experience patient stories were being heard at board meetings.
- Leaders had recognised that culture within the trust required improvement and had recently undertaken external reviews and put actions in place. They had also put on a number of events which had proved relatively popular with staff.
- There was a weekly quality safety summit meeting which looked at themes from incidents and near misses. This was well attended by staff.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔🡐 May 2018	Requires improvement 🡇 Mar 2018	Good ➔🡐 May 2017	Requires improvement ➔🡐 May 2017	Inadequate 🡇 May 2018	Requires improvement ➔🡐 May 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Arrowe Park Hospital	Requires improvement → ← May 2018	Requires improvement ↓ May 2018	Good → ← May 2018	Requires improvement → ← May 2018	Inadequate ↓ May 2018	Requires improvement → ← May 2018
Clatterbridge Hospital	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Overall trust	Requires improvement → ← May 2018	Requires improvement → ← May 2018	Good → ← May 2018	Requires improvement → ← May 2018	Inadequate ↓ May 2018	Requires improvement → ← May 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Arrowe Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← May 2018	Requires improvement ↓ May 2018	Good → ← May 2018	Requires improvement → ← May 2018	Inadequate ↓ May 2018	Requires improvement → ← May 2018
Medical care (including older people's care)	Inadequate ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement → ← May 2018	Inadequate ↓ May 2018	Inadequate ↓ May 2018
Surgery	Requires improvement → ← May 2018	Requires improvement ↓ May 2018	Good → ← May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018
Critical care	Requires improvement → ← May 2018	Good → ← May 2018	Good → ← May 2018	Good ↑ May 2018	Requires improvement → ← May 2018	Requires improvement → ← May 2018
Maternity	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
End of life care	Good ↑ May 2018	Good ↑ May 2018	Good → ← May 2018	Good ↑ May 2018	Good ↑↑ May 2018	Good ↑ May 2018
Outpatients	Requires improvement Sept 2015	Not rated	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Overall*	Requires improvement → ← May 2018	Requires improvement → ← May 2018	Good → ← May 2018	Requires improvement → ← May 2018	Inadequate ↓ May 2018	Requires improvement → ← May 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Clatterbridge Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Surgery	Requires improvement Sept 2015	Good Sept 2015	Outstanding Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Outpatients	Requires improvement Sept 2015	Not rated	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Overall*	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Arrowe Park Hospital

Arrowe Park Road
Wirral
Merseyside
CH49 5PE
Tel: 01516785111
www.whnt.nhs.uk

Key facts and figures

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust.

The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

We last inspected the hospital in September 2015 and we rated it as requires improvement.

During this inspection we visited surgical wards, medical wards, theatres, critical care unit and the emergency department. We also visited maternity services and looked at end of life services We spoke with patients and their relatives. We also spoke with various members of staff including senior managers, the specialist palliative care team, doctors, nurses, healthcare support workers, therapy staff and pharmacy staff. We also spoke with patients and relatives.

We observed care and treatment and looked at care records of patients. We received comments from focus groups and we reviewed the hospital's performance data.

Summary of services at Arrowe Park Hospital

Requires improvement 

Our rating of services stayed the same. We rated it as requires improvement.

A summary of services at this hospital appears in the overall summary above.

Urgent and emergency services

Requires improvement ➔➔

Key facts and figures

The emergency department provides care and treatment to approximately 250 adults and children a day. Services are provided to both adults and children for medical and surgical emergencies and trauma.

Some areas of the department had been modernised. This included the reception area and waiting room, the triage and minor injuries area as well as the resuscitation and high dependency area. The majors area, children's area and the emergency department review unit are based in the old hospital.

The department has three rooms to manage mental health patients, including a 136 room for patients who were brought to the department by the police. Mental health liaison services are provided by a local mental health trust.

We visited all areas of the emergency department including the reception and waiting area, the triage area, majors and resuscitation areas, the children's area as well as the emergency department review unit.

We spoke to staff of different grades, including nurses, doctors as well as members of the management team from both the department and the division of medicine. We also spoke to staff from other areas of the hospital that had regular contact with the emergency department.

We reviewed 20 sets of patient records for adults and children, including five prescription charts. We also reviewed information that was provided by the trust before and after the inspection. We spoke to patients and relatives about their experience and observed care and treatment being delivered.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- When things had gone wrong, the approach to reviewing and investigating causes was sometimes insufficient. This was because serious incidents had not always been fully investigated in line with the NHS England Serious Incident Framework 2015 so that improvements were made to reduce the risk of similar incidents happening again.
- Serious incidents had not always been identified in a timely manner. This was because we found that between January and December 2017, only two had been reported within 48 hours, which was not in line with the NHS England Serious Incident Framework 2015.
- The department had continually struggled to meet the Royal College of Emergency Medicine standard for all patients to be triaged within 15 minutes of arrival between March 2017 and February 2018. Records indicated that compliance for patients who had self presented had varied between 32% and 46%.

Urgent and emergency services

- The service did not always provide enough staff with the right skills and training to keep people safe from avoidable harm and to provide the right care and treatment. This was because a member of staff who was up to date with advanced paediatric life support was not always available in the department. There were also a high number of occasions when the planned number of nursing and medical staff had not been achieved.
- Staff kept appropriate records of patients' care and treatment. However, staff had not always followed trust policy and local procedures when transferring records to inpatient areas of the hospital.
- Patient risk assessments for falls and pressure ulcers had not been completed in line with trust policy and best practice guidance. This was particularly important as patients had spent more than 12 hours in the department on a regular basis.
- The service had not always controlled infection risk well. We found the environment and equipment to be visibly dirty in some areas of the department.
- The service had not always recorded and stored medicines in line with trust policy and legislation. We found examples of when controlled drugs had not been checked regularly as well as when the amount of controlled drugs administered had not been recorded or countersigned by another member of staff.
- Although the service had appropriate policies and procedures in place for staff to follow in the event of an emergency, staff did not understand what their roles would be if an emergency happened. Major incident training had not been provided to staff in the department.
- The service had not used safety monitoring results well. This was because the service was unable to provide monitoring information about the total number of patient harms in the department between April 2017 and March 2018.

However,

- Some areas of the department had been recently modernised. A trust register was kept to monitor whether equipment in the department had been tested for safety, however, on reviewing records it was unclear whether equipment was still located in the department and if it had been tested for safety.
- Staff understood how to protect patients from abuse. Safeguarding policies for adults and children were readily available and staff received appropriate levels of safeguarding training.
- The service provided mandatory training in key skills to all staff and made sure all staff completed it.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service provided data to the Royal College of Emergency Medicine so that patient outcomes were measured against similar services nationally. However, records indicated that results for some areas were worse than the national average.
- The service was not always able to evidence that staff were competent to undertake their roles. This was because training records had not been completed fully and a record of these had not been kept in line with trust policy.
- Records indicated that pain management had not always been recorded appropriately and pain relief had not always been given in a timely manner.

- Staff did not always work together as a team to benefit patients. We observed that there were not always good working relationships between staff from the department and from other areas of the hospital.

However,

- The service provided care and treatment based on national guidance. Staff had access to information to support them in providing the most appropriate care and treatment.
- Staff gave patients enough food and drink to meet their needs.
- Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Patients were treated with dignity and had their privacy maintained on most occasions.
- Staff involved patients and those close to them in decisions about their care and treatment on most occasions.
- Staff provided emotional support to patients and relatives to minimise their distress. We observed staff spending time to comfort patients and relatives as well as taking time to provide information about their care and treatment.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- People had not always received treatment in a timely way. This was because the service had continually failed to meet the four target to transfer, admit or discharge patients.
- On some occasions, the trust planned and provided services in a way that met the needs of local people. However, the children's department was not open 24 hours a day, seven days a week. This meant that children were sometimes assessed and treated in inappropriate areas of the department.
- The service had not investigated complaints in a timely manner and learned lessons from the results were not shared with all staff. We found examples of when complaint investigations had taken longer than expected and although complaints were discussed in different meetings, we did not see any evidence of learning from these.
- The department did not have any link nurses for areas such as end of life. This was important because link nurses share best practice with the wider hospital.

However,

- The service had taken account of patients' individual needs on most occasions. For example, a bereavement room had been developed for families and loved ones of patients who had passed away.

Urgent and emergency services

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate because:

- The service did not have a clear vision for what it wanted to achieve and did not always have workable plans to make improvements. The division of medicine did not have a clear plan to make improvements despite poor performance over the 12 months and an improvement plan had only recently been developed for the emergency department.
- Managers across the service had not always promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some staff informed us that they had witnessed or experienced bullying or harassment and we found that when concerns had been raised, they had not been dealt with in a timely manner.
- The service did not have managers at all levels with the capacity to run a service providing high quality sustainable care. At the time of the inspection, the department had a matron but did not have a department manager or a practice educator. In addition, the service was not always able to ensure that the shift leader remained supernumerary due to frequent staffing shortages.
- The service had not used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. We found a number of occasions when poor performance had been identified, but actions to make improvements had not always been taken in a timely manner. There were a number of basic safety concerns and a lack of embedded culture of safety.
- The service had not collected, analysed, managed and used information well to support all its activities. We had concerns that data provided by the trust for the service was not always accurate. This meant that we were not assured that managers had the correct information available.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Inadequate ↓

Key facts and figures

The medical care service at Arrowe Park Hospital has 394 inpatient beds.

The trust had 51,148 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 26,231 (51.3%), 2,727 (5.3%) were elective, and the remaining 22,190 (43.4%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 10,285
- General medicine: 9,467
- Geriatric medicine: 9,327

(Source: Hospital Episode Statistics)

The 'acute and medical' division manages medical services. There are various wards including general medical and specialist services within the division including stroke services, cardiology, respiratory, haematology, nephrology, cardiac care unit, endoscopy, dialysis unit and care of the elderly. Wards 27 and 21 are specialist dementia care wards.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected medical care services including care of the elderly between 20 and 23 March 2018.

During the inspection we visited ward 14 (escalation area), ward 12 (surgical/medical ward), ward 19 (escalation), ward 21 (male dementia), ward 22 (geriatric medicine), ward 23 (stroke unit), ward 24 (geriatric medicine), ward 25 (isolation unit), ward 27 (female dementia) ward 32 (cardiology), ward 36 (gastroenterology), ward 37 (respiratory care) and ward 38 (respiratory care). We also visited the cardiac care unit, endoscopy department, day case unit, ambulatory care unit, acute medical unit, medical short stay ward and discharge hospitality centre.

We spoke with members of staff including senior managers, members of the patient experience team, ward sisters as well as registered nurses and doctors and clinical support workers. We also spoke to 18 patients and relatives.

We observed care and treatment and looked at 40 patient care records and seven prescription cards as well as service performance data.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate because:

Medical care (including older people's care)

- The service did not maintain levels and skill mix of staffing to keep patients safe. We found that planned and actual staffing levels demonstrated gaps in registered nursing staff and clinical support workers. We had similar concerns in relation to staffing shortages in some areas at the last inspection. The service used bank and agency staff to provide care and treatment but many shifts were not filled by this. We reviewed incident reports which indicated that patient care had been affected due to the lack of appropriate and qualified staff, especially on the acute medical unit.
- The service had a high number of vacancies for medical and dental staff. There was a high turnover of both nursing and medical staff, over three times higher than the trust target. The shortage of medical staff meant that patients placed on wards which were not best suited to their needs (outliers) did not receive a timely review by a consultant.
- Though the service provided mandatory training in key skills to all staff, compliance rates were below the trust target. The mandatory training compliance rates provided by the service before and during inspection differed significantly.
- We found some areas were cluttered with equipment, equipment was dusty and some areas did not complete daily cleaning checklists. We found unlocked store cupboards that contained syringes and needles.
- In some areas we found unsecured sluice rooms which contained substances that are hazardous to health as well as sharp items such as scissors, and urine samples. Patients were not constantly supervised in these areas, meaning that patients with dementia or who were confused could access harmful substances or items.
- The day case unit lacked appropriate facilities and equipment to provide safe care and treatment to medical inpatients.
- Additional beds were opened in areas which were not routinely used for medical patients. These escalation areas did not fully comply with the standard operating procedure defined by the service and we did not find evidence that all escalation areas had been risk assessed prior to opening. This meant that patient safety was put at risk as patients who had higher acuity care needs were not cared for in areas which were not suitable to their needs.
- Although information was available that was accurate and up to date and was shared with those involved in the care of the patient, we found records trolleys were not stored securely to prevent unauthorised access, and computer terminals were not always locked and displayed confidential information.
- The storage of medication did not always meet national guidelines. We found medication that had not been placed in secure cupboards and nutritional supplements that were out of date.
- There were issues that persistent since the last inspection, for example unsecure medical notes and unlocked areas that contained hazardous liquids. This was inconsistent across the service.

However,

- Staff received training in sepsis and compliance rates were high.
- Staff observed hand washing and 'bare below the elbow' guidelines. They used personal protective equipment when delivering care and treatment to patients.
- The service had introduced measures to prevent falls. Although the service performed worse than the national average on two of the four agreed measures in the national audit of inpatient falls there had been a decrease in falls in the areas the prevention work was focussed.

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005 and the service used a safeguarding pathway which resulted in a delay from admission to a capacity assessment being completed. Staff should submit a deprivation of liberty safeguards application as soon as the lack of capacity is identified. However, we found records where this did not happen and saw that staff were able to bypass this mandatory field within the electronic patient record. Some patients did not have current deprivation of liberty safeguards in place as they had lapsed and there was no evidence of best interest decisions being made for them.
- The trust provided audit data which told us that they were not yet compliant with the National Institute for Health and Care Excellence guidance for undertaking the venous thromboembolism risk assessment within 24hours of admission.
- Staff did not consistently undertake nutritional assessments for patients and we saw mixed adherence to the policy to escalate malnutrition universal screening tool scores. There was low compliance with the requirement for weekly assessment using the malnutrition universal scoring tool. During our observations of meal times we identified a number of patients who required assistance to eat their meal who did not receive support.
- The service did not always make sure that all staff received an annual appraisal. Appraisal rates were significantly below the trust target.
- We did not see evidence of health promotion activities provided for patients within the hospital and linking with the wider community.

However,

- Service provided care and treatment based on national guidance and had policies and procedures in place which reflected this.
- The service monitored the effectiveness of care and treatment and performed as expected against the national average in most audits.
- The trust had a positive result in the Stroke SSNAP audit and achieved a grade A overall which is the highest grade achievable. Staff monitored patients' pain through regular 'intentional rounding'. Pain relief was available to patients.
- Service monitored the effectiveness of care and treatment and patient outcomes were reviewed.
- We observed a multidisciplinary team approach to patient care across the service which included staff from therapy service such as speech and language therapy, physiotherapy and occupational therapy as well as specialist nurses and consultants.

Is the service caring?

Requires improvement  

Our rating of caring went down. We rated it as requires improvement because:

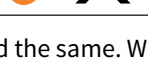
- The service did not always protect the privacy and dignity of patients. We observed in the discharge hospitality centre male and female patients dressed in nightwear sitting together with no other covering or blanket to preserve dignity. Medical patients on the surgical day case unit did not have access to a shower and there was only one toilet designated for single sex use meaning the opposite sex patients had to use a commode.
- The Family and Friends response rate for the service was lower than the national average.
- Some relatives told us that they did not feel that all staff had communicated with them about their loved one's care and treatment in a timely manner.

- We observed patients who required assistance to eat were not always offered support, the service scored lower than the national average in the food domain of the 2017 Patient Led Assessment of the Care Environment.

However,

- Patients and relatives gave positive feedback about the way staff treat people. Overall, patients and relatives told us that staff cared for them with compassion, dignity and respect.
- We observed positive and respectful interactions between staff and patients and saw a large number of thank you cards and letters displayed.
- Staff offered appropriate emotional support to patients and their relatives. The service supported relatives of patients who had died in hospital through the 'tie for treasure' bag initiative, which gave the relatives of patients who had passed away in hospital a personal keepsake of their loved one.
- The service encouraged relatives and carers involvement in care and treatment and was signed up to 'John's Campaign'. This recognises that carers of dementia patients should be welcomed in hospital as they provide crucial support. The service supported carers involvement through open visiting hours and providing facilities for relatives and carers to stay in hospital if they wished.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it, referral to treatment times were consistently below the national average.
- Information provided by the service showed that there was a shortage of medical beds and a number of patients placed on wards that were not best suited to meet their needs (also known as outliers).
- Issues with patient flow resulted in additional beds being opened in areas which were not routinely used for medical patients. Escalation areas did not fully comply with the standard operating procedure defined by the service.
- Ward 25 was the outlier ward for infection prevention and control and did not have a dedicated consultant. We reviewed electronic patient records and found that some patients had not had regular consultant reviews.
- There were a large number of patients moved after 10pm which included patients who were living with dementia.
- We saw that patients were being discharged patients later in the day due to delays in setting up packages of care. The service discharged 183 people after 10pm in February 2018. There were also a large number of delayed discharges across the service which impacted on the availability of beds on the wards.
- The service had introduced a practice of 'boarding' patients who were deemed fit for discharge in seated areas. At the time of our inspection the service had not ratified a standard operating procedure or risk assessment for this practice.
- We did not see promotion of the concerns and complaints process displayed in the wards or departments we visited. The service did not always investigate complaints in a timely manner as per their policy. However, staff told us an improvement plan was being developed to address this.

However,

- The service took account of patients' individual needs for those patients with complex needs such as dementia or learning disability. Notice boards on wards identified dementia champions for those areas and wards had access to a specialist learning disability nurse five days a week.
- There was a matron with a lead on dementia who had oversight of the implementation of initiatives to improve care for dementia patients.
- The service worked with Healthy Wirral to understand and meet the needs of the local community.

Is the service well-led?

Inadequate  

Our rating of well-led went down. We rated it as inadequate because:

- The service did not have sufficient managers at all levels to run a service providing high-quality sustainable care. There were gaps in leadership posts especially at senior nurse and clinical lead level.
- Staff reported that executive level leaders were not visible and accessible to staff at ward level.
- Although divisional leaders demonstrated an understanding of the challenges the medical division faced and could identify actions to address them, they struggled to implement change due to the lack of devolved governance structures to divisional level and financial pressures.
- Not all staff understood and or could communicate the vision and strategy for the service.
- There was not always a positive culture that supported and valued staff. We saw that morale was low in medical and nursing staff and some staff were afraid to speak up. Other staff felt that when they did speak out they were not listened to and changes were not made.
- The service had defined lines of accountability but these did not always support the delivery of good quality and sustainable services. We saw that this led to inconsistent performance across the service in areas such as cleanliness, environment and equipment and records.
- The service did not have effective systems for identifying risks and planning to reduce them. We did not see that all identified risks were escalated to the risk register and the service did not have robust and safe oversight of risk to patient safety in escalation areas
- The service had failed to make improvements in key areas highlighted in the previous inspection, for example ensuring sufficient staffing levels and secure storage of patient records.
- Bank and agency staff did not always have access to patients' records and compliance with mandatory data security training was low.
- The service did not engage staff, patients and the public in planning and managing services.

However,

- The divisional management team held monthly clinical governance and quality improvement meetings.
- Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible via the trusts intranet facility. Important information was shared with staff in daily ward 'huddles' to keep staff up to date and aware of issues.

Medical care (including older people's care)

Outstanding practice

There were areas of outstanding practice in this service. See Outstanding Practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Requires improvement ↓

Key facts and figures

Arrowe Park Hospital provides a range of surgical services including general surgery, urology, ear, nose and throat, ophthalmology, orthopaedic trauma and elective surgical services in a mixture of longer stay and short-stay wards.

There is also a day surgery unit, a surgical assessment unit (SAU) a surgical elective admissions lounge (SEAL) and the Wirral Acute Femoral Fracture Unit (WAFFU).

The trust had 34,088 surgical admissions from October 2016 to September 2017. Emergency admissions accounted 9,872 (29%), 18,890 (55%) were day case, and the remaining 5,326 (16%) were elective.

We inspected the hospital as part of an unannounced inspection between 20 March and 23 March 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. At the last inspection, we rated one of the key questions for the service as requires improvement so we re-inspected all five key questions. During our inspection we visited the general theatre and recovery area, the preoperative surgical service, the surgical assessment unit, the surgical elective admissions lounge, the Wirral Acute Femoral Fracture Unit and five inpatient wards, wards 10,11,17,18 and 20.

During the inspection we reviewed staffing and checked equipment and storage of medicines. We reviewed 20 patient records, 14 prescription charts and spoke with 25 patients and three relatives. We spoke with 80 staff of different grades including nurses, doctors, consultants, ward managers, allied health professionals and senior managers. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Requires improvement →←

Our rating of safe stayed the same. We rated it as requires improvement because:

- At the time of our inspection the theatre recovery area was being used to care for day surgery patients until they were ready for discharge. This was inappropriate due to the lack of facilities for patients who had recovered from a surgical procedure within the recovery area.
- Ward 17 was showing signs of wear and tear and the facilities available were not suitable for the acuity of patients on the ward. Piped oxygen and wall mounted suction was not available at every bed space and portable heaters and electrical extension cables were in use due to the limitations of the environment. A planned refurbishment of the ward had been postponed. There were also hazardous chemicals that were not locked away which posed a risk to patients and the public.
- Resuscitation trolleys were not sealed or tagged in any area we visited. We saw one trolley which was kept in a waiting room which meant there was a risk that emergency equipment could be tampered with and not available when required.

- Incident reporting was variable and not all staff we spoke with were aware of the never events that had occurred within the division.
- Records were not always kept secure. We saw record trolleys that were unlocked and unattended which meant there was a risk that patient information could be accessed by unauthorised people.
- The World Health Organisation (WHO) Surgical Safety Checklist Five Steps to Safer Surgery was in use and recorded electronically, however the process had not been not audited since the introduction of the electronic system the previous year to ensure it was being implemented correctly.
- Current standards from the Association for Perioperative Practice (AfPP) state that at least one member of staff on duty in the theatre recovery area should have completed advanced life support training however none of the 68 recovery staff had received this training.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There were times when the number of nursing shifts on wards, filled as planned, fell below 70%.
- The number of pressure ulcers and catheter acquired infections had increased between October 2017 and December 2017.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service prescribed, gave and recorded medicines well. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- Whilst the service monitored care and treatment there were some outcomes for people who used services which were below expectations compared with similar services.
- Patients had a higher than expected risk of readmission for elective admissions when compared to the England average. There was a higher mortality rate than expected for hip fractures and there had been an increase in the post operative length of stay for patients undergoing bowel cancer procedures.
- The service did not participate in all the national audits for which it was eligible, for example the national vascular registry 2017.

Surgery

- Although staff told us they undertook competency training for additional roles, we were not assured these had been completed for certain competencies as there was not always documented evidence.
- Patients were not always being deprived of their liberty in line with national guidance and legislation. There was a lack of consistency in how people's mental capacity was assessed. Of the four records reviewed relating to patients subject to a Deprivation of Liberty Safeguards (DOLS) order, not all had a mental capacity assessment completed and submissions to the Local Authority were not completed as soon as a restriction had been put in place.

However,

- Staff could describe the use of evidence based guidance that underpinned care within their clinical area.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Arrangements were in place to maintain patient privacy and dignity.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We also observed positive interactions between staff and patients.
- Patients we spoke with stated they were consulted regarding their treatment and had been kept informed of their plan of care. Parents were invited into the theatre recovery area to support their children.
- Spiritual care was available from the chaplaincy for patients of all faiths and included the opportunity to discuss any worries or concerns prior to surgery.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- Some people were not able to access services when they needed to. There had been a marked increase of cancelled operations which had not been rescheduled within 28 days between August 2017 and September 2017 and was above the England average.
- From January 2017 to December 2017 the trust's referral to treatment time for admitted pathways for surgery was consistently worse than the England average and all elective orthopaedic surgery had been suspended at the time of our inspection due to pressures within in the hospital on beds required for medical patients.
- There were a high number of patients who moved between wards during their stay. Some of these moves were during the night and included vulnerable patients.

- Although the service treated concerns and complaints seriously and investigated them, the time to investigate and respond to complaints was slow and not in line with the trust complaints policy. Complaint information was not always available for patients and the public.

However,

- Arrangements were in place to accommodate people in vulnerable circumstances in the surgical elective admissions lounge and theatre.
- A range of information leaflets and literature was available for patients to read about a variety of conditions and support services available.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Although the service had a strategy in place there was no workable implementation plans to put this into action or how It would be monitored.
- Staff knowledge about the role of the Freedom to Speak Up Guardian was variable and some staff told us that staff satisfaction was variable across the service.
- Risks and issues were not always dealt with in a timely way. We found occasions when risk assessments had not been completed. A risk assessment relating to issues on a ward was not completed until concerns were raised during our inspection.
- We were not assured that all risks on the risk register were being managed in a timely way. There were risks that had been on the register for over two years and it was not always clear if actions had been implemented to mitigate the risk.
- Following an external review of the pain service completed in February 2017 it identified that the service required additional staff. This had been on the risk register since 2015 and this had still not been fully resolved.
- There was a limited approach to obtaining the views of people who used services for service developments and improvements.
- Although managers discussed divisional performance in a number of meetings there was limited evidence of scrutiny and challenge across all areas of performance.

However,

- Staff reported that senior managers of the service were visible and approachable.
- Safety huddles were conducted at the beginning of each shift which allowed information to be shared with staff which promoted a learning culture.
- The service collected, analysed, managed and used information to support improvements in standards of care.

Outstanding practice

There were areas of outstanding practice in this service. See Outstanding Practice section above.

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Requires improvement

Key facts and figures

The critical care unit at Arrowe Park Hospital is a 18 bedded unit commissioned to provide care and treatment for eight level three and ten level two adult patients. This configuration can be changed according to demand and the unit was equipped to be able to take 18 level three patients if required.

The critical care unit is divided into two clinical areas, a 12 bedded unit where the level three intensive care unit patients are cared for and a separate six bedded level 2 high dependency unit. Both areas have two side rooms each for the purpose of isolating patients that present with an increased infection control risk. A critical care outreach service is also provided. The outreach team are based within the critical care department and managed by the divisional matron.

According to the Intensive Care National Audit and Research Centre data from 1 April 2017 to 31 December 2017, the units had 617 admissions. The service is a member of the Cheshire and Merseyside Critical Care Network. For the purposes of governance, critical care sits in the trust's medical and acute division.

We visited the unit on 13, 14 and 15 March 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

As part of the inspection we spoke with consultants, junior medical staff, a pharmacist, two pharmacist technicians, 27 members of the nursing team, one allied health professional, two members of support staff, one member of the housekeeping team, five patients and the families of eight patients. We also reviewed patient records, policies, guidance and audit documentation to support our decision on ratings.

As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- Not all staff understood how to protect patients from abuse, or how to recognise and report abuse. The trust set a target of 95% for completion of safeguarding training but only 56% of eligible nursing staff had completed level 2 training.
- The service did not always control infection risks well. While clinical areas appeared clean staff did not always follow infection control procedures. We observed staff failing to carry out the aseptic non touch technique when administering medication.

Critical care

- The service did not have suitable premises and equipment and the premises were not always looked after well. The unit did not comply with best practice guidance for the design of the environment, did not have side rooms with appropriate airflow or single sex toilets.
- Staff areas, waiting rooms and corridors appeared unkempt, cluttered and on occasions dirty. Sluice areas with cleaning products were not secure and oxygen cylinders were not stored in line with best practice guidance.
- There was a mixed sex toilet attached to the waiting room which was out of order. The toilet had no seat; we were told this had been reported. The floor was dirty and the flooring needed improving.
- Staff attended mandatory training courses but compliance rates were below the trust target. The overall compliance rate was 30%.

However:

- The risks to patients were assessed and their safety monitored and managed so they were supported to stay safe. All patients admitted acutely to the unit were continually assessed and monitored using early warning scores and other recognised tools.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was adequate nursing staff and consultant cover to meet patient needs and in line with national requirements.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. The unit used an electronic patient records adapted for critical care which was comprehensive and easily assessable.
- The service prescribed, gave, recorded and stored most medicines well. Patients received the right medication at the right dose at the right time. Prescriptions were signed and dated accordingly and drugs were documented as required. While most drugs were stored properly, the service did not always act when the temperate of the fridges used to store medicines were higher or lower than it should be.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately and were encouraged to do so. Managers investigated incidents and shared lessons learned with the whole team in meetings and huddles. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them, for example by creating action plans to address changes in results. They also took part in national audits, including the intensive care national audit and research centre.
- Staff gave patients enough nutrition and hydration to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Patient records showed that patients had had their fluid state/ fluid balance checked.

Critical care

- The service made sure staff were competent for their roles. The unit met the national requirement for nursing staff with a post registration award in critical care nursing and had practice nurse educators to support staff with courses and equipment training.
- There was good multidisciplinary working and we saw that staff from the unit worked well together and across services to deliver care and treatment. The unit could access specialist nurses when required. The outreach team reviewed all patients on wards who had been discharged from critical care.

However:

- Not all staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. There was currently no support within the unit for patients who were suspected to be experiencing depression or required psychology or psychiatric support.
- Not all nursing staff on the unit had not completed the Immediate Life Support training.
- There was only one physiotherapist available on the unit during the week. This fell short of the guidelines for the provision of intensive care services 2015 which suggests a ratio of one whole time equivalent physiotherapist to four intensive care unit Level 3 beds.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion and treated patients with kindness, dignity and respect. Feedback from patients confirmed that staff treated them well and gave them emotional support.
- Staff provided emotional support to patients to minimise their distress**.** The unit has recently introduced patient dairies for the unit, a valuable tool in helping patients come to terms with their critical illness experience.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff communicated well with patients in a manner that they could understand their care, treatment and condition.

However:

- The bed areas were separated by curtains which could be easily movable and were disposable, however the density of the curtains did not reduce the level of general noise and did not improve the level of auditory privacy in the bed space.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

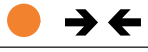
- The service took account of patients' individual needs**.** The critical care follow up team offered physical and psychological support to patients and their families following critical illness and the unit used patient passports to support communication.

- The unit were making improvements to improve access and flow to the unit and discharge from the service. Although there were delayed discharges they had made improvements to rectify this and the unit had raised the issue on the risk register. Critical care bed management issues were discussed at the trust bed management meeting, where previously they hadn't.
- There were no recent complaints received about critical care services.
- Patients had access to computers to help with activities such as reading and playing computer games.

However;

- The trust did not always plan and provided services in a way that met the needs of local people**.**
- There was no reception desk within unit and nursing staff were called away from their duties to answer the phones and greet visitors entering the unit.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The unit had not always had consistent nursing leadership and while the ward matron had been off sick for a period of time, we could see that many changes had reverted back, or failed to continue.
- The existing critical care unit footprint and bed layout did not meet the latest guidance published by the Department of Health in 2013. We were aware that management knew the impact the environment was having on patient safety, however we were not assured that the risk was being acted upon in a timely way as the service had only begun to develop a feasibility plan which had not yet been completed.
- Although senior managers told us what the unit's vision was the unit did not have a formal vision and strategy for what it wanted to achieve and workable plans to turn it into action.
- The unit had put in place a risk register after the last inspection, however we were not assured that all risks had been managed in a timely way as a number of the risks were over 12 months old.

However,

- All senior managers spoke highly of the matron. Changes had been made to systems and processes prior to a period away from the unit, to improve patient safety and the efficiency of staff; however, some nursing staff told us they were uneasy about the changes.
- Managers across the unit promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. We spoke to said there was a good team spirit within the unit. Unit managers had identified ways to support staff when having to move areas to work.
- Although staff had expressed their dislike to being moved from the unit to cover other areas in the hospital, managers were aware that this had affected moral and were trying to improve this.
- The service learnt when thing did not go well. **We saw copies of a 'Learning lessons safety bulletin', produced for the nursing staff by the critical care lead. The bulletin was informative, easy to read and well thought out. Providing information on incidents, new guidelines and changes in policies.**

Critical care

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

We previously inspected maternity jointly with gynaecology so we cannot compare our ratings directly with the previous ratings.

The service provides 24 hour maternity services for women that reside in an around the Wirral area. Between October 2016 and September 2017, there were 3,115 births at the trust.

The service has 47 maternity beds at Arrowe Park Hospital. These consist of ward 53, the combined antenatal and postnatal ward (32 beds), labour ward (10 beds) and the midwife-led unit, Eden Suite (five beds). The unit also facilitates a home birth service and is due to open a standalone "pop up" birth centre.

Outpatient services include the hospital antenatal clinic, an antenatal day unit, a triage assessment area and an obstetric sonography (pregnancy scanning) service.

Community antenatal clinics take place in locations throughout the Wirral catchment area including GP surgeries, Children's Centres and in a shopping centre.

We inspected the maternity department as part of an unannounced between 13 and 15 March 2018. We visited all maternity areas within the hospital maternity department including obstetric theatres. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection we spoke to over 40 members of staff including administrative support staff, clinical support workers, breastfeeding support workers, student midwives, midwives, senior midwifery matrons, the head of midwifery, obstetricians of varying grades, anaesthetists and operating department practitioners and three women and three family members.

Before the inspection we held a focus group with 10 midwives and health care assistants and one pharmacist.

We reviewed 11 prescription charts and 10 sets of maternity records

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff and set a target of 95% compliance. However, only hospital midwives and hospital support workers had achieved this.

- There were not always cleaning schedules in all areas meaning we were not assured that clinical areas were checked and cleaned regularly. Staff and relatives entered obstetric theatres with outside footwear presenting an infection control risk. Drug fridges were not checked consistently and were not always secure or clean meaning we were not reassured about the safe storage of the medicines within and whether they were safe for use. Staff rooms were not clean, had broken equipment in them and appeared generally unkempt.
- The service had suitable premises and equipment and, on the whole, looked after them well. However, we observed baby weighing scales and oxygen saturation monitors being used which did not appear to have been serviced recently.
- The maternity unit did not have a baby security tagging system that provided an automated alert if unauthorised removal of a baby was attempted. We observed during our inspection that a door to the labour ward was broken and did not always lock that was only fixed after the end of day two of our inspection. There was not always a member of staff monitoring who was entering or leaving this area.
- The service had, on most occasions, enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, for two of the three days of our inspection the transitional care unit was not open to admissions due to inadequate skill mix of staffing and the neonatal unit was closed to admissions.
- Although staff mostly kept appropriate records of patients' care and treatment women's maternity records were not kept securely on the wards and there was an ongoing connectivity issue inhibiting community midwives from updating the maternity information technology system or taking booking bloods in a timely way.
- The service mostly prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. However, we were not assured that all women were offered self-medication or that the system for monitoring the medicines in the cupboard was robust enough.
- There was not always the correct staff with the competencies available to provide post-operative emergency care out of hours.

However

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- We observed that the World Health Organisations surgical safety checklist was completed correctly in maternity theatres.
- Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Is the service effective?

Good

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidenced its effectiveness. The service carried out audits to ensure both compliance and effectiveness of care provided and to benchmark their performance and highlight areas for improvement.

Maternity

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and individual preferences.
- Staff managed pain well. Women had access to a variety of analgesia in labour including relaxation and hypnosis.
- The service achieved good outcomes for women and babies. The trust was achieving above the target set for initiation of breastfeeding at birth, had reduced its still birth rate, had low tear rates and high rates of vaginal birth after previous caesarean section.
- The service made sure staff were competent for their roles. Managers completed staff appraisals and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients. Midwives, obstetricians and other healthcare professionals supported each other to provide good care.
- Maternity services were available seven days a week. Midwifery, obstetric and anaesthetic cover was provided outside of normal working hours and the midwifery staff we spoke to told us that they felt supported during these periods.
- The service promoted the health and wellbeing of mother and baby at various opportunities and worked well with the wider trust colleagues to ensure it was compliant with the mental capacity act.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for women and their families with compassion. Feedback and observations confirmed that staff treated them well, with kindness and compassion. Women described care from midwifery and obstetric staff as good or excellent.
- Staff provided emotional support to women and their partners to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. We observed staff interacting positively with women and those close to them.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good because:

- The service planned and provided services to meet the needs and wishes of people who used the services. Services were provided to reflect the needs of the local population such as specialist clinics and an antenatal clinic in a local shopping centre.
- Women could access the service mostly when they needed and wanted to.
- The service took account of people's individual needs. The service provided additional support and services to women such as pregnant teenagers, women with mental health needs and women who did not speak English as a first language

- The service treated complaints and concerns seriously, investigated them and shared the lessons learnt in a variety of formats such as patient stories.

However,

- Complaints were not always responded to within accepted time frames.
- Due to lack of adequate specialist staffing the transitional care unit was not always available for women and babies to be cared for. However, we were told by the head of midwifery of plans to work with the neonatal unit staff to provide maternity assistant practitioner staffing at all times.

Is the service well-led?

Good ➔➔

Our rating of well-led improved. We rated it as good because:

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff were positive about the improvements to the culture since the last inspection.
- The service had leaders at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff were positive about the leaders and the changes they had made.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning when things went well and when they went wrong, promoting training, research and innovation.
- The service supported some leadership training and development and had been recognised in a national award for its training.

However,

- While the service had systems for identifying risks, planning to eliminate or reduce them some identified risks such as women undergoing induction of labour in side rooms on the ward or unqualified midwives recovering women following emergency caesarean sections were not on the risk register.
- The maternity service did not have a current robust data collection system, such as a maternity dashboard. While the service collected information, it was not presented so it could be easily used to benchmark outcomes, review clinical and quality performance and implement clinical changes.
- Some staff felt that the senior midwifery leaders and executive board members could be more visible.
- We were told by the head of midwifery and several of the staff that governance was improving but there is no specified lead in the department and senior midwives had no designated time to carry out this role.

Outstanding practice

There were areas of outstanding practice in this service. See Outstanding Practice section above.

Maternity

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Good ↑

Key facts and figures

The trust provides end of life care at their Arrowe Park Hospital site. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, palliative and end of life care, and bereavement support and mortuary services.

The trust had 1,565 deaths from October 2016 to September 2017.

The trust is part of the North West Coast Palliative and End of Life Strategic Clinical Network. Their team of consultants in palliative medicine collaborate with integrated specialist palliative care nurses to help patients on the end of life pathway and their families cope with their condition and treatment of it.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited 20 wards in different specialty areas. We also visited the bereavement office, the mortuary and the chapel.

We spoke with 50 members of staff at different levels including doctors, nurses, managers, volunteers, porters and administrative support staff. We spoke with 16 patients receiving palliative or end of life care, and nine relatives. We reviewed ten patient records and 10 prescription charts. We observed care and treatment and attended a multidisciplinary daily board round.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff, including 'protecting vulnerable people'. The protecting vulnerable people courses contained modules relating to safeguarding adults, safeguarding children, PREVENT , Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Risks to people who were receiving palliative or end of life care were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or challenging behaviour. Risk assessments were person-centred, proportionate and reviewed regularly. There were daily handovers at board round to ensure that staff could manage any identified risks to people receiving end of life care.

End of life care

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. There had been in increase in medical cover by consultants in palliative medicine since our last inspection in September 2015.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave and recorded medicines well, including appropriate anticipatory medication. Patients had daily medication reviews documented and those on syringe drivers were appropriately managed.
- The service had good oversight of patient safety incidents related to end of life care and managed them well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and appropriate support.

However,

- Some documents were hard to find on the electronic patient records system, which was only stored chronologically and was not searchable.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance for people receiving end of life care. This was monitored to ensure consistency of practice.
- People receiving palliative and end of life care had comprehensive assessments of their needs, which included consideration of clinical needs, including pain relief, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated. Appropriate referral pathways were in place to make sure that needs were addressed.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- The service gave appropriate pain relief to patients in a timely way. Symptom control relief guidelines including pain management were available for staff to access on the trust intranet.
- Staff participated in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer reviews. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. It was used to improve care and treatment and people's outcomes and this improvement is checked and monitored.
- All staff, including volunteers, were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was available to meet these needs.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

End of life care

- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. This included a 24 hour rota to provide on site nursing cover for end of life care, and a 24 hour helpline providing medical advice.
- The end of life care team provided a seven day service with a minimum of three clinical nurse specialists in the hospital Monday to Friday, and two at weekends. The palliative medicine consultant resource across Wirral and all of these doctors collaborated to provide a 24 hour advice line to both hospital and community settings.
- There was an end of life care folder on every ward with information leaflets for families including practical advice such as how to access the parking concession passes.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However,

- Hospital staff were not always able to maintain and further develop their professional skills in palliative and end of life care. Capacity on the wards meant that staff could not always be released to attend training offered by the end of life care facilitators.
- It was not easy to find completed mental capacity assessment on the electronic patient record system.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients receiving end of life care, and their families, confirmed that staff treated them well and with kindness.
- We saw evidence that people were treated with dignity, respect and kindness during interactions with staff and relationships with staff were positive. People felt supported and say staff cared about them.
- Staff supported people and those close to them to manage their emotional response to their care and treatment. People's personal, cultural, social and religious needs were understood. People were supported to maintain and develop their relationships with those close to them, their social networks and the community.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients said they had been consulted about their wishes for future care and plans were being put in place to accommodate these.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- Facilities and premises were appropriate for the services being delivered. There was a clean and newly furnished family room in the bereavement office where relatives could meet with the bereavement team and some environmental improvements had been made to the visiting area in the mortuary.

End of life care

- The service took account of patients' individual needs. Staff we spoke with were aware of different religious and cultural practices following the death of a family member or close friend. Translator facilities were available to the service and there was access to a psychiatric liaison team. There was a 'reasonable adjustment' care plan for patients with cognitive impairment or learning disabilities and a similar 'this is me' document for patients living with dementia, that noted their personal preferences.
- People could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs. A consultant in palliative medicine attended a daily clinical session in the acute medical unit which meant there was contact with patients who may be coming towards the end of life, from the start of their inpatient admission.
- There was a rapid discharge process in place, with involvement from an integrated discharge team and the district nurses where appropriate.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. All complaints relating to end of life care, and subsequent responses, were reviewed by the clinical service lead for palliative medicine and discussed at the weekly business meeting when relevant.

However,

- Medical certificates of death were not always available in the required timeframe. This had been identified as an issue at the last inspection.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was a consultant in palliative medicine in the role as clinical lead for palliative and end of life care, a band 7 lead nurse managing the end of life care facilitators and volunteers, and a service manager for the community based palliative care team.
- We spoke with all of the managers and leads for the teams and found them all to be enthusiastic, experienced, and knowledgeable about their service. They were visible and approachable, and were working together to move the service forward.
- The director of nursing was the executive lead for end of life care and the clinical lead for palliative and end of life care said they had good access to them. A new non-executive director for end of life care had recently been appointed.
- There was a palliative and end of life care steering group which met monthly and had oversight of the strategy and action plan. The trust wide clinical governance group received six-monthly updates on the progress made by the palliative and end of life care steering group to deliver the strategy. This had been put in place since our last inspection in September 2015.
- There was a comprehensive Adult Palliative and End of Life Care Strategy 2016-19 in place detailing what the service wanted to achieve, with defined plans to turn it into action. Good progress was being made with this, despite some delays due to changes in the trust executive team. This was a much-improved situation from the time of our last inspection in September 2015.

End of life care

- The service had an ambition to make palliative and end of life care as good as it could possibly be each and every time. There was a hospital palliative and end of life care redesign plan developed in January 2018 which set out an operational plan for meeting their vision to provide care that was proactive, well-coordinated and patient focused.
- Managers promoted a positive culture that supported and valued staff and all the staff we spoke with passionate about their roles in palliative and end of life care.
- The service used a systematic approach to continually improve the quality of its palliative and end of life care. The arrangements for governance and performance management were clear and operated effectively. There was a weekly business meeting for end of life care, where they reviewed all incidents and complaints, as well as the six monthly patient experience report. This was not in place at the time of our last inspection in September 2015.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. They were reviewed at the monthly clinical governance group and locally, at the monthly steering group and the weekly business meetings. There was a performance dashboard which was updated and reviewed regularly.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Questionnaires were handed to all bereaved families and information received was analysed, recorded and acted on by the service.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. It was evident that a lot of time had been spent on developing plans to improve services for end of life care, and that these were continuing.

However,

- Although we saw evidence that the teams were trying to work together and support each other. Staff told us that there were times when they did not feel fully engaged with each other due to reporting to different managers and different priorities.
- The risks associated with palliative and end of care were known to the service but were recorded on different divisional risk registers which did not always match those recorded on the trust risk register. Not all of them were updated and one had incorrect controls recorded next to it.
- Some of the information collected by the different elements of the end of life care service had to be entered onto two different electronic information systems. This meant time was lost duplicating patient information in two places.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Our inspection team

Nicholas Smith, head of hospital inspection and a lead inspection manager led this inspection. An executive reviewer supported our inspection of well-led for the trust overall.

the team included a further inspection manager, ten inspectors, one assistant inspector, fifteen specialist advisers, and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Board of Directors	
Agenda Item	10.5
Title of Report	Board Assurance Framework
Date of Meeting	25th July 2018
Author	Julie Adley-Sweeney, Membership Manager
Accountable Executive	Paul Moore, Director of Governance and Quality Improvement
BAF References	All
Level of Assurance	Gaps with mitigating action
Purpose of the Paper	Discussion
Review by Executive Committee	Not applicable
Data Quality Rating	Bronze – qualitative data
FOI status	Full Disclosure
Equality Impact Assessment Undertaken	N/A

1. Executive Summary

The attached report includes the following:

- An summary of the risks and their associated risk scores in the Board Assurance Framework (BAF)
- A detailed analysis of each risk and the associated actions to mitigate these

2. Next Steps

The Board of Directors is asked to fully consider key risks, assurances and mitigating actions detailed within the BAF.

Board Assurance Framework – Summary July 2018

Risk Ref	SMT Lead	Theme	Potential Risk	Current Score L x C	Tolerable Score L X C	Exec Comm	Assurance Committee
1	MD	Quality of Care	Quality and Safety – The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	4 x 5 = 20 ↑	1 x 5 = 5 ↑	CGG	Board, QSC
2	DoNM	Quality of Care	Patient Experience – The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	3 x 3 = 9 ↔	2 x 2 = 4 ↔	PFEG	QSC
3	DoW	Quality of Care	Workforce – failure to attract and retain safe staffing levels will impact on our ability to deliver high quality safe care in a sustainable manner	4 x 4 = 16 ↑	1 x 4 = 4 ↓	WCG	Board, QSC
4	MD	Quality of Care	**MERGED WITH RISK** 1	2 x 4 =8	2 x 4 = 8	CGG	QSC
5	DoF	Finance & Use of Resources	**Sustainability:** The Trust is unable to deliver financial performance in line with £25.0m deficit plan submitted with consequent adverse impact on ability to manage capital and cash with further risks centring on inability to cover financial obligations	4 x 5 = 20 ↔	3 x 5 = 15 ↔	F & P	FBPAC
6	DoF	Finance & Use of Resources	Efficiency – The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	4 x 4 = 16 ↔	3 x 5 = 15 ↔	F & P	FBPAC
7	DoF	Finance &Use of Resources	**Controls:** The Trust is unable to manage its agency spend and meet its agreed agency control total resulting in Use of Resources deterioration to level 4	3 x 5 = 15 ↔	2 x 5 = 10 ↔	F & P	FBPAC
8	DoF	Finance &Use of Resources	Value for Money – Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	4 x 4 = 16 ↔	3 x 3= 9 ↔	F & P	FBPAC
9	COO	Operational Performance	4-Hour A&E Standard – Failure to achieve the trajectory targets agreed with NHSI for 2018/19 resulting in poor patient experience, regulatory action & loss of STF funding	4 x 5 = 20 ↔	2 x 4 = 8 ↔	F & P	Board, FBPAC
10	COO	Operational Performance	RTT – Failure to achieve the trajectory targets agreed with NHSI for 2018/19 resulting in poor patient experience and regulatory action	4 x 5 = 20 ↔	2 x 5 = 10 ↔	F & P	Board QSC FBPAC
11	COO	Operational Performance	Cancer – Failure to deliver the National Cancer Standards for 2018/19 resulting in poor patient outcomes, regulatory action & loss of STF funding	2 x 5 = 10 ↔	2 x 5 = 10 ↔	F & P	QSC
12	DoNM	Operational Performance	C.diff: There is a risk that the Trust fails to effectively manage infection, prevention & control resulting in harm to patients, poor patient experience and potential financial penalty associated with exceeding the permitted cumulative number of C.diff cases for 2018/19 (28 avoidable Cdiff) The standard penalty is £10K for every case over the avoidable with a maximum of £200K (2018 / 2019 NHS standard contract).	4 x 4 = 16 ↔	2 x 3 = 6 ↔	CGG	QSC
13	DoS&S	Strategic Change	NHS C & M – there is a risk that we are unable to work effectively in collaboration with organisations within our C & M footprint to implement agreed plans in a timely way that inhibits our ability to provide clinically & financially sustainable, locally accessible high quality services	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
14	DoS&S	Strategic Change	Healthy Wirral – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
15	DoS&S	Strategic Change	Operational Step Change & Internal Transformation – Failure to prioritise strategic change and implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
16	DoI&I	Strategic Change	IT – Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment.	3 x 4 = 12 ↔	2 x 4 = 8 ↔	IIT&MDG	FBPAC
17	COO	Strategic Change	Estates – failure to develop & implement a strategic estates strategy impacts on patient & staff experience and financial sustainability	4 x 5 = 20 ↔	3 x 5 = 15 ↔	F & P	FBPAC
18	CEO	Leadership &Improvement	Enforcement Action – Insufficient progress against agreed financial and access targets results in further regulatory action and enforcement of Section 111	4 x 5 = 20 ↔	2 x 5 = 10 ↔	Board	Board
19	MD	Leadership & Improvement	Clinical Engagement – failure to improve clinical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity & increased costs	4 x 4 = 16 ↔	3 x 4 = 12 ↔	CGG	Board QSC
20	DoI&I	Leadership & Improvement	Data Quality – failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	4 x 4 = 16 ↔	2 x 4 = 8 ↔	II&CG	FBPAC

Quality of Care

Strategic Objective:			**We are** the best NHS Trust in the region, because our staff, and the patients who use our services, say we are **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	2a – Continue to deliver our quality strategy and build on the recommendations of our September 2018 CQC inspection	
				Linked Risks/ collaboration opportunities	Risks 2, 3, 9, 10, 12	
Risk ID:	1	**Risk:**	**Quality and Safety:** The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	**Board Lead:**	Medical Director	**Date last reviewed:** July 2018
				Audit Committee Position	MIAA Safe Staffing (nursing) – limited assurance – Feb 17 MIAA Mandatory Training audit – significant assurance – July 17	

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **13 Risks in total**
Current Risk Score:	4 x 5 = 20	• Quality and Safety Committee commissions "deep dive" reports • Weekly safety summits followed by a review of serious incidents (real time learning) • Weekly Safety Bites bulletin • Review of Integrated quality dashboard & identification of key action required • Using CQC Insight to prioritise intervention • Harm care reviews in place for long waiters • Availability of 7 day consultant – agreed respiratory business case at SMT and since appointed • Safeguarding committee • Nutrition steering group • Incident reporting and learning feedback • Development of Care bundles • Development of Quality Improvement strategy	• Failure to receive 'Good' or better in next CQC Inspection (16) • MCA/DOLs not always being completed on admission (16) • Best Interests Assessments by partner agency not always been carried out meaning Trust is in breach of DOL Law (16) • AMU Overcrowding (16) • Replacement of the MARS system (16) • Ability to remove CPE from the Environment (15) • Medicine Storage (15) • Storage and Security of medicines – Staff behaviour (15) • Inadequate Medicines procurement – not being able to supply other legal entities (15) • Discharge Summaries inadequately completed (15) • Prescribing and administration of infusion and fluids & other continuous infusions (15) • Certain Defibrillators will become unsupported during 2018 (15) • Blood Traceability (15)
Tolerable Risk Score:	1 x 5 = 5		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Audits and Patient Feedback indicate improvements in End of Life Care • Maternity cultural review – positive patient and staff feedback through FFT • Safety thermometer targets compliant • HSMR and SHMI data better than national expectations • Increased awareness of MCA/Dols – although still more work to do • A and E cultural review – positive outcome from A and E action plan • Improved assurance to board relating to safe staffing from Workforce assurance committee meeting • Bi annual Director of Nursing and Midwifery Safer staffing report • Ward accreditation • Accurate timely articulation of validated harms in Integrated dashboard / supporting narrative • CQC report – Good End of life care / improvement in Maternity services • Monthly Deep dive updates to CGG • CQC review meetings, NHSI resources meetings	Cross reference to integrated quality dashboard Ward accreditation KPIs Safer staffing data
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could be taken?)
1. Trust wide safety culture – concerns with Never Events 2. Safe staffing – Nursing in Medicine & Acute and Junior Medical Staff Trust wide	1. Introduction of safety summits and OD interventions - ongoing 2. Nurse recruitment campaigns & development of hybrid roles and development of workforce plan

3. Medicines storage audit (clinical areas) – 59% compliant in Sept deterioration from Aug 4. Clinical handover flagged as a risk by CQC following serious incident review/audit of electronic handover indicates non-compliance – July 17 5. Protecting Vulnerable People training behind trajectory although increasing 6. Access to good quality data that aids decision making 7. Current compliance against all CQC fundamental standards 8. 2 out of 5 standards for 7 day working not met 9. Compliance with Nutrition and hydration standards and the MUST tool 10. Mortality reviews figure requires improvement, 11. A&E culture review- raises concerns, action plan commenced February 18. 12. High numbers of patients moved at night	3. Meds Storage – Non- compliant areas to provide update to next CGG 4. Closer monitoring of audit compliance with electronic handover 5. Trajectory of improvement in place for MCA/Dols training 6. Improving Integrated Quality Dashboard , developing improved supportive narrative to aid triangulation 7. CQC action plan in place monitored weekly 8. Future changes to assessment units and medical ward based consultant teams will address this. 9. Trust-wide Nutrition & Hydration Meeting established to monitor and support management. 10. Deputy Medical Director to ensure electronic solution implemented w/c 27/11/17 11. Harm free care assurance meeting 12. Introduction of fit for purpose RCA for harms / weekly validation panels supported by SMEs to enable timely validation of risks (March 18) 13. Review of operational model of wards , move of OPAU to increase frailty bed base , change of model for M1 / Ward 24 14. Development of care bundles 15. Development of Falls strategy and Pressure Ulcer strategy 16. Development of Quality Improvement strategy 17. MIAA review ACU , A and E , Respiratory wards October 2018

Quality of Care

Strategic Objective:			**We are** the best NHS Trust in the region, because our staff, and the patients who use our services, say we are **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver an FFT recommend score of above 95% and a non-recommend score of below 2% 1b – Deliver a year on year reduction in the number of complaints and a year on year improvement in response times 2b – Deliver the Harm Free Care programme and ensure that the Trust Harm Free Care score is no lower than 95% 2c – Deliver a Hospital Mortality Rate that is better than expected 7c – Look to improve our Research and Development Metrics	
				Linked Risks/ collaboration opportunities	Risk 9 - 4 hour A & E Standard Risk 10 - RTT	
Risk ID:	2	**Risk:**	**Patient Experience:** The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	**Board Lead:**	Director of Nursing and Midwifery	**Date last reviewed:** July 2018
				Audit Committee Position	MIAA previous Limited Assurance report on water safety – High risk recommendations completed Mar 17.	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 3 = 9
Tolerable Risk Score:	2 x 2 = 4
Direction of Travel:	⟷

Controls: (What are we currently doing about the risk?)

- Monthly Integrated Quality Dashboard
- Revised QIA process for all CIP schemes with post implementation review
- Harm free care meeting
- PEFEG to be recommenced August 2018

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)

- Positive QIA process review undertaken by CCG – August 17
- Safety thermometer targets compliant – October 17
- HSMR and SHMI data better than national expectations
- Bereavement survey – 100% recommend rate Sep 17 from 57% in 2014

Key Performance Indicators

Cross reference to integrated quality dashboard

Gaps/rationale for current risk score/emerging risks

1. Complaints response times show levels outside of acceptable timescales
2. Out of time complaints reducing, weekly complaints tracker meeting in place
3. FFT scores in ED and outpatients deteriorating
4. PLACE survey – food scores lower than expected following CIP initiative although Trust responded by making further changes
5. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year

Mitigating actions: (What more should we do?)

1. Short term resource identified to respond to longstanding complaints
2. Find workable solutions to gathering data for FFT- look for good practice examples and review approach.
3. Further action being considered by the Trust as escalated as concern from QSC
4. Learning from Inquests to be linked to safety summits
5. Trust to continue to raise awareness of the need to undertake on a timely basis
6. Introduction of fit for purpose RCA for harms / weekly validation panels supported by SMEs to enable timely validation of risks (March 18)
7. Trust introducing kiosks to increase available feedback from patients
8. what matters to you campaign to inform development of Patient experience strategy
9. promotion of matrons hotline / increase visibility of matrons to resolve complaints locally

Quality of Care

Strategic Objective:			**We** put our people first so they can put our patients first, and we create the workforce of tomorrow by investing in the workforce of today **To ensure:** our people are aligned with our vision	**Key Measures:**	1c - Deliver a year on year improvement in our staff satisfaction survey score 5a – Deliver the OD work programme to achieve the seven corporate themes, Values & Behaviours, Leadership, Engagement, Healthy Workplace, Valuing our workforce, Learning Organisation and Inclusivity 5b – Continue to work towards reducing our sickness absence and ensuring that our workforce have quality appraisals		
				Linked Risks/ collaboration opportunities	Linked risks 1, 2, 9, 10, 12		
Risk ID:	3	**Risk:**	**Workforce:**. failure to attract and retain safe staffing levels will impact on our ability to deliver high quality safe care in a sustainable manner	**Board Lead:**	Director of Workforce	**Date last reviewed:**	July 2018
				Audit Committee Position	MIAA – reviewing the HR metrics		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **2 Risk in total**
Current Risk Score:	4 x 4 = 16	• Workforce Assurance Committee • Workforce & Organisational Development Dashboard • NHS Staff Survey	• High Numbers of Registered Nurse Vacancies within Medicine and Acute Specialities (16) • Levels of therapy staff on Ward 33 (15) • Increase in sickness absence • National shortage of trained doctors and nurses
Tolerable Risk Score:	1 x 4 = 4		
Direction of Travel:	↑		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Delivery against Workforce metrics targets (e.g. vacancy rate, attendance, appraisal, staff satisfaction, mandatory training) • NHS Staff Satisfaction Survey • Regular temperature testing across the organisation • Medical engagement survey • Impact evaluation of leadership programmes undertaken by MIAA	See dashboard presented to Workforce Assurance Committee

Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could be taken?)
1. Workforce metrics benchmark well but below Trust target 2. Staff FFT Recommend the Trust as a place to work – 52% Q2 17/18 deteriorating 3. Staff FFT Overall staff engagement score per NHS staff survey – 3.76 4. High nursing vacancy rate, particularly within Medicine and Acute 5. A and E culture review – Action plan commenced February 18	1. OD work programme 2. New HR metrics reviewed at the Workforce Assurance Committee 3. Improved Workforce Planning approach with dedicated lead nominated from within HR&OD to work with the Divisions. 4. Nursing, Midwifery and AHP workforce strategy to improve recruitment and retention 5. Top leaders programme and the shaping of a talent pipeline 6. Developing leadership at every level of the organisation

Quality of Care -MERGED WITH RISK 1 (THIS WILL BE REMOVED FROM THE FRAMEWORK)

Strategic Objective:			**To be:** the top NHS Trust in the north west for patient and staff satisfaction **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver a FFT recommendation score of above 95% and a non-recommendation score of below 2% 2b – Deliver the Harm Free Care programme to ensure that our harm free care score is no lower than 95%	
				Linked Risks/ collaboration opportunities	Risk 1 Quality and Safety Countess of Chester – Vascular/Urology/Renal/haematology/Womens and Childrens/diagnostics	
Risk ID:	4	**Risk:**	**Improving Clinical Outcomes:** The Trust is unable to ensure consistent delivery of evidenced based practice 7 days per week as a result of failure to provide consultant review of all emergency admissions in 14 hours	**Board Lead:**	Medical Director	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we mitigating this risk?) • Monthly Integrated Quality Dashboard • Weekly safety summit • Weekly serious incident review • Weekly Safety Bites Bulletin – Trust-wide • Embedded clinical pathways and protocols • Embedded clinical escalation policy	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **O Risks in total**
Current Risk Score:	2 x 4 = 8		
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• HSMR and SHMI data better than national expectations • Safety Thermometer targets are compliant – July 17 • 3 out of the 5 standards for 7 day working are being met	See integrated quality governance dashboard

Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What are we doing to mitigate this risk further?)
1. Number of RCAs with action plans overdue 2. 2 out of 5 standards for 7 day working not met 3. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year 4. Never Events – see risk 1	1. Action as part of quality governance review process 2. What action has been agreed for 7 day working? 3. Learning from Inquests to be included as part of safety summit work 4. The wider learning from the RCA review of Ophthalmology to be used Trust-wide 5. Implementation of learning from deaths Policy – Q3 2017/18

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating of level 3	
				Linked Risks/ collaboration opportunities	CoCH – collaboration on finance function and strategic estates work	
Risk ID:	5	**Risk:**	**Sustainability:** The Trust is unable to deliver financial performance in line with £25.0m deficit plan submitted with consequent adverse impact on ability to manage capital and cash with further risks centring on inability to cover financial obligations	**Board Lead:**	Director of Finance	**Date last reviewed:** July 2018
				Audit Committee Position	The Committee requested that FBPAC review the Trust's responsibilities in relation to the Better Care Fund	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Divisional financial review meetings in place to monitor and where required identify potential risk mitigations to delivery of financial plan and CIP.
- TSG/Divisional governance structure & process re identification & delivery of CIP/transformation work programme.
- Business as usual process initiated in areas where substantive recruitment has taken place thereby releasing interim support
- Contract negotiations concluded with main commissioners and control re cash payments of contractual performance
- Rolling 13 week cash flow forecasting
- Reviewing trade creditor payment terms and conditions

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risk in total

- Failure to Meet CIP Targets (16)

Assurances (How do we know if the things we are doing are having an impact?)

- Cash support agreed & drawn down with capital cash team presently in line with plan.
- Cash preservation initiatives deployed to protect cash balances.
- The Trust achieved an overall Use of Resources Rating of 3 in line with plan.
- The cash position at end of M2 was £7.5M above plan by £3.8M with the variance primarily due to receipt of the cash in respect of CGH land transaction .

Key Performance Indicators

Liquidity

Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
4	3	3	3	3

Gaps/rationale for current risk score/emerging risks

1. Overall deficit of £6.6m at end of M2. £0.4m above planned deficit.
2. CIP delivery below plan with £0.55m delivered against a plan of £0.69m.
3. Concerns with the BCF and efficacy of investment.
4. Board approved uncommitted loan of £21.7M in October 17 and delegated arrangements for drawdown with additional net borrowing required in 18/19 of £24.0m
5. Underlying deficit position at month 2 standing at c£7.5M.Plan submitted details underlying at £35.0m
6. Go forwards risk re interest payable on borrowings plan caters for £1.8m
7. Uncertainty around full funding of nationally agree pay award

Mitigating actions: (What further mitigating action could we take?)

1. Divisional monthly scrutiny meetings taking place to identify corrective action required with a deep dive into Surgery as agreed with Board of Directors
2. Non delivery of CIP partially mitigated (at month 2) by deployment of non-recurrent initiatives but not available going forwards.
3. Working capital management to support cash balances and forecasting and cash preservation initiatives being progressed (ongoing)
4. Cash drawdown facilities to manage cash and liquidity challenges.
5. Plan incorporates interest rates payable on borrowings

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8c – Implement relevant recommendations of Lord Carter's review of hospital performance and productivity to deliver an Adjusted Treatment Cost figure putting WUTH in top 10% of NHS Trusts in England	
				Linked Risks/ collaboration opportunities	CoCH as per risk 4	
Risk ID:	6	**Risk:**	**Efficiency:** The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	**Board Lead:**	Director of Finance	**Date last reviewed:** July 2018
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Transformation workforce and non-pay work streams governed through TSG
- Monitoring of implementation of Carter recommendations
- Robust Pharmacy Hospital Transformation plan
- Adherence to NHSI Model Hospital procurement best practice

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)

- ATC currently at 0.91
- Performing well against pharmacy model hospital metrics
- Procurement efficiency work stream aligned to Carter report recommendations
- Strong PPIB usage and adherence
- Reporting performance through to FBPAC

Key Performance Indicators

Headline Metrics	As reported in dashboard
Cost per Weighted Activity Unit (WAU)	£3,365
Potential savings opportunity	4.89%
Surplus/ deficit as % of expenditure	7.00%
Total pay cost per WAU	£2,269
Total non-pay cost per WAU	£1,096

Gaps/rationale for current risk score/emerging risks

1. Carter figures based on annual reference costs
2. Pay cost per WAU identified as outlier and opportunity for productivity improvement
3. Absence of plan to implement GS1
4. Minor varaiances to peer median on best price
5. Outlier in medical productivity and nursing costs per WAU

Mitigating actions: (What further mitigating action could we take?)

1. Workforce plan/strategy being developed with Divisions
2. STT to differentiate from data quality issues to absolute opportunity
3. Refreshed IT strategy to include GS1 implementation

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating at level 3	
				Linked Risks/ collaboration opportunities		
Risk ID:	7	**Risk:**	**Controls:** The Trust is unable to manage its agency spend and meet its agreed agency control total resulting in Use of Resources deterioration to level 4	**Board Lead:**	Director of Finance	**Date last reviewed:** July 2018
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 5 = 15
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Agency compliance report received and reviewed by EMT weekly
- Divisional authorisation controls in place
- Workforce Assurance Cttee with agency spend as "hot topic"

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Trust is currently below its month 2 agency trajectory expenditure plan by £0.1m •	As at month 2 agreed expenditure plan agency control total stood at £1.2m with actual expenditure at £1.1m.
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Minimal retrospective authorisation 2. Breaches in respect of wage, price cap and framework 3. CIP behind plan 4. Increasing run rate on agency and rate breaches 5. Key speciality/posts challenge notably senior medical workforce	1. Ensure minimal retrospective authorisation (ongoing) 2. Review case of need for non-clinical agency and innovative recruitment and retention initiatives –

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources rating of level 3	
				Linked Risks/ collaboration opportunities		
Risk ID:	8	**Risk:**	**Value for Money:** Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	**Board Lead:**	Director of Finance	**Date last reviewed:** July 2018
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Tolerable Risk Score:	3 x 3 = 9
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Transformational Team governance working with Divisions adhering to NHSI guidance delivering safe, sustainable cost improvement plans
- Budgetary Control
- Core Financial controls
- Service Line Reporting relaunch
- Divisional Performance review process
- Annual Plan

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• MIAA Core financial systems High Assurance 2017/18 • ATC index • External audit opinion noting key exceptions • Reference Cost Index	Overall UoR detailed within Risk 5 New use of resources guidance
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Improve adoption of SLR through new clinical leadership structure 2.Regulatory rating re Use of resouces	1. Action plan re-launched SLR with focus on three service lines

Operational Performance

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the A & E 4 hour standard in year and delivery of national cancer standards		
				Linked Risks/ collaboration opportunities			
Risk ID:	9	**Risk:**	**4 Hour A&E Standard:** Failure to achieve the trajectory targets agreed with NHSI for 2018/19 resulting in poor patient experience, reduced clinical quality, regulatory action and loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:**	July 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risks in total**
Current Risk Score:	4 x 5 = 20	• Continuous senior management overview • Full improvement plan in place to deliver sustainable improvements signed off by ED delivery Board and regulators • Internal monitoring arrangements in place with mitigation plans	• Failure to meet ED Standards and subsequent overcrowding (20)
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)

- Improvement in performance continues with delivery against
- Comparable position with other economy's significantly improved

Key Performance Indicators

Feb 17	July	Mar 17	Jun 18	May 17	Jun 17
	80.27%	83.51%	83.43%		

Gaps/rationale for current risk score/emerging risks

- Health Economy improvement plan agreed

Mitigating actions: (What further mitigating action could we take?)

- Agreed health economy action plan to deliver sustainable improvement is being tracked via ED Board to ensure delivery to agreed timescales
- Winter plan for 18/19 submitted

Operational Performance

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour A & E standard in year and delivery of national cancer standards	
				Linked Risks/ collaboration opportunities		
Risk ID:	10	**Risk:**	**RTT** – Failure to achieve the trajectory targets agreed with NHSI for 2018/19 resulting in poor patients experience and regulatory action	**Board Lead:**	Chief Operating Officer	**Date last reviewed:** July 2018
				Audit Committee Position	Audit committee requested that FBPAC review the impact on the Trust's provider licence as a result of the failure of RTT. The specific licence requirement is as follows "are clear systems in place for notifying individual patients about choice re "18 week" breaching when arranging alternative care	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- RTT Improvement Board in place
- Full Recovery Action Plan in place
- Weekly Access and Performance meeting established
- Development of data quality and patient tracking reports
- Compliance with Access Policy
- Reporting via Finance and Operational Group
- Full patient tracking in place with live PTL
- CCG Contract Monitoring meeting
- Data Quality monitoring in place
- Elective Intensive Support Team (IST) review of Trust action plan complete.

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risks in total

- Failure to meet ED Standards and subsequent overcrowding (20)
- Failure to achieve 62 Day Cancer Target – Urology (16)

Assurances (How do we know if the things we are doing are having an impact?)

1. RTT Strategic Group provides oversight of improvement work

Key Performance Indicators

Apr 18	May 18	Jun 18
74.29%	74.58%	75.74%

Gaps/rationale for current risk score/emerging risks

1. Data quality – gaps in assurance (Actions 1 and 2)
2. Long waits in some specialties for first out-patient appointment (Actions 3 & 4)
3. Additional capacity to clear backload no robustly available
4. Mismatch between NHS constitutional standard/Single Oversight Framework and STF trajectories agreed with regulators and commissioners

Mitigating actions: (What further mitigating action could we take?)

1. Clean up of PTL
2. Full roll out of 18 week training
3. Intensive Support Team supporting the improvement work
4. Full recovery action plan in place

Operational Performance

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour A & E standard in year and delivery of national cancer standards	
				Linked Risks/ collaboration opportunities		
Risk ID:	11	**Risk:**	**Cancer:** Failure to deliver the National Cancer Standards for 2018/19 resulting in poor patient outcomes, regulatory action & loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:** July 2018
				Audit Committee Position	MIAA – Activity Data Capture report – 31 day cancer – significant assurance/62 day cancer – limited assurance	

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risks in total**
Current Risk Score:	2 x 5 = 10	• Cancer tracking and monitoring weekly • Escalation policies in place • Full divisional overview • Review via Finance & Performance Group and FBPAC • CCG Contract Monitoring meeting	• Failure to achieve 62 Day Cancer Target – Urology (16)
Tolerable Risk Score:	2 x 5 = 10		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Compliance with cancer standards regularly achieved with adherence to agreed pathways • Capacity in line with current demand	**Apr 18**: Delivered; **May 18**: Delivered; **Jun 18**: Delivered
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
• National awareness campaigns drive demand and not always pre-warned which can increase demand & mismatch capacity (no mitigating actions applicable) • Overall compliance reliant on good performance in dermatology	

Operational Performance

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8b – Deliver national infection and prevention control targets for C.diff for 2018/19	
				Linked Risks/ collaboration opportunities		
Risk ID:	12	**Risk:**	**C.diff:** There is a risk that the Trust fails to effectively manage infection, prevention & control resulting in harm to patients, poor patient experience and potential financial penalty associated with exceeding the permitted cumulative number of C.diff cases for 2018/19 (28 avoidable Cdiff) The standard penalty is £10K for every case over the avoidable with a maximum of £200K (2018 / 2019 NHS standard contract).	**Board Lead:**	Director of Nursing and Midwifery	**Date last reviewed:** July 2018
				Audit Committee Position	Internal Audit – Water Safety – Significant assurance report received August 17	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Tolerable Risk Score:	2 x 3 = 6
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Rapid detection, effective isolation & doing the basics brilliantly
- HPV Programme and use of Ultra Violet Light Machines (UVLM) to be operationally delivered without interruption, together with effective environmental cleaning
- Isolate effectively; use Ward 25 and side rooms in the best way possible based on agreed protocols
- Doing the basics brilliantly; Daily & weekly MDT of patients with IPC concerns, Antimicrobial stewardship and prescribing audits
- Reconfiguration of beds within medicine and acute
- Review use of isolation ward 25

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risks in total

- Ability of Trust to remove CPE from the environment (15)

Assurances (How do we know if the things we are doing are having an impact?)

- Full HPV and UVLM Programme in place
- Agreed protocols for isolation and step down
- Robust assurance on hand hygiene
- PIRs completed and lessons learned / actioned effectively
- Divisional reports presented to IPORT
- Divisional IPC meetings in place and effective
- IPC annual report
- Partnership working at providers forum and at Hospital IPCG

Key Performance Indicators - Year to Date Cumulative

2018 (tolerance 28 cases)	**Number of Cdiff Cases**	**Avoidable Cases**
April	5	4
May	6	1
June	5	2
Total	**16**	**7**

Gaps/rationale for current risk score/emerging risks

- Challenges associated with cohort nursing on Ward 25 (isolation unit)
- Absence of effective MDT / daily specialist nurse reviews and prompt action
- No follow up on discharged patients to reduce reoccurrence / readmissions

Mitigating actions: (What further mitigating action could we take?)

- Review the operational management of 25 to ensure high risk cohorts are maintained (positive CDiff and CPE) with appropriate staffing levels are in place
- Formalise the weekly MDT to include all patients with CDiff infection
- Delivery of the IPC improvement plan on time, mitigating actions as required, in particular

• Insufficient assurance on doing the basics brilliantly; hand hygiene, environmental cleaning, admin/data, monitoring alerts, step up/down from isolation • Failure to follow up Post Infection Reviews to learn lessons • Gaps in team and lack of ownership engagement across the trust beyond IPC. • Recent external peer reviews highlighted a range of recommendations	to CPE management and high risk patients, cleaning provision and approach to screening. Review of all estates priorities/work that directly impacts onto patient areas • Robust improvement plan monitored via NHSI resource meeting and IPCG • ADN for IPC recruited and in post June 2018 • Review of IPC service and screening policy commenced July 2018 • C difficile post infection reviews (PIR) are still in progress for June 2018 although to date we have reported a total of 7 avoidable cases for 2018 / 2019. • The ADN for IPC is currently scoping with the Director of Infection Prevention & Control and the Infection Control Doctor to introduce a C difficile PIR rapid review process (within 72 hours of laboratory confirmation).

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	3b – Work with acute/secondary, primary, community and social care partners on 'end to end' redesign of the unscheduled care system and services for older people 3c – Work with CoCH to deliver an agreed model for future development of services 4a – Progress the integration of back office & clinical support functions with CoCH 6a – Contribute proactively to the development of the NHS for C&M (STP) Cheshire and Mersey footprint ensuring that the needs of Wirral citizens and the Wirral pound are fully considered	
				Linked Risks / collaboration opportunities	C&M Health & Care Partnership solutions may negatively impact provision of services in Wirral. The pace of delivery of Wirral solutions may be impacted by complexity of working with multiple organisations. Lack of intellectual and/or financial headroom may reduce delivery pace	
Risk ID:	13	**Risk:**	**Cheshire &Merseyside Health & Care Partnership (STP):** There is a risk that we are unable to work effectively in collaboration with organisations within our C&M footprint to implement agreed plans in a timely way that inhibits our ability to provide clinically & financially sustainable, locally accessible high quality services.	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:** May 2018
				Audit Committee Position		
Risk Rating: (Likelihood x Consequence)			**Controls:** (How are we currently managing this risk) • Engagement in C&M Health & Care Partnership emerging governance arrangements (Q1 2018) • Avoid distraction of LDS, which is now largely superseded by refreshed C&M Health & Care Partnership and 'Place Based Collaboration System' care by accelerating progress on WWC Alliance, defining a handful of clinical and corporate services we can rapidly take forward (Q1 2018) and planning to develop a Wirral & West Cheshire Clinical Strategy (Q3 2018). • Proactively design future configuration of Women & Children's services for Wirral and West Cheshire as an exemplar solution for C&M Health & Care Partnership (Q1 2018) • Work fully with 'North 4' Pathology footprint in line with NHSI direction to move toward 29 consolidated pathology networks across England without impeding further value from building further on extant WWC collaboration (Q1-4 2018) • Provide effective Leadership of elements of C&M Health & Care Partnership macro plans, e.g. reducing variation and high quality hospital care	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**		
Current Risk Score:	4 x 5 = 20					
Tolerable Risk Score:	3 x 5 = 15					
Direction of Travel:	⟷					
Assurances (How do we know if the things we are doing are having an impact?)				**Key Performance Indicators**		
Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme. Tangible, SMART key performance measures and indicators agreed to enable effective assurance of progress / escalation of impediments / exceptions.				1. Fully defined C&M Health & Care Partnership governance available and endorsed by WUTH Board 2. WWC Alliance governance & change delivery framework & 2018 programme of work available / endorsed by WUTH Board. 3. WWC solution for Women & Children's services available/endorsed by WUTH/CoCH and embedded in C&M Health & Care Partnership macro plans 4. WWC pathology proposals form core of North 4 pathology planning & delivery timeline reflects pace required by WWC Alliance 5. C&M Health & Care Partnership plans agreed for reducing variation & enabling high		

	quality hospital care
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. C&M Health & Care Partnership governance arrangements lack clarity and/or direct grip 2. Acceptance of proposed solution for Women & Children's Services is uncertain 3. Absence of capacity & capability to prioritise strategic change over short term delivery of standards (4 hour, access, financial balance)	1. Focus further on Wirral & West Cheshire Alliance ahead of C&M Health & Care Partnership provider network 2. Create additional capacity / capability to drive strategic priorities that directly improve short term delivery of standards (4 hour, access, financial balance) 3. Work more closely with colleagues, patients, citizens, volunteers, third & private sector

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	3a – Continue to support the roll out of the Healthy Wirral Programme 4b – Develop and implement a strategy to support a closer working relationship with primary care services 6a – Contribute to the development of the STP for the period 2021 across the Wirral, South Mersey and Cheshire and Mersey footprints and achieve all 2016/17 milestones		
				Linked Risks/ collaboration opportunities	CCG / LA Integrated Commissioning Strategy and/or Healthy Wirral solutions may negatively impact provision of sustainable services by WUTH through unintended consequences. The pace of delivery of Healthy Wirral solutions may be impacted by absence of intent and / or consensus on route to Place Based Collaboration System care and / or lack of intellectual and / or financial headroom to move quickly. Timeframe for CCG strategy delivery (3 year) is incongruent with regulator's drive for 12 month turnaround.		
Risk ID:	14	**Risk:**	**Healthy Wirral:** Failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:**	May 2018
				Audit Committee Position			
Risk Rating: (Likelihood x Consequence)			**Controls:** (How are we currently managing this risk?) - Definition of governance arrangements supporting Healthy Wirral (HWPB, HWEDG, HW50+, GDE Board) - Agreed roadmap / programme of work to deliver better heath, better care & better value in line with published commissioning strategy - Effective Wirral Integrated Provider Partnership established to provide cohesion and grip on provider collaboration - Clarity on resolving contradiction between delivery of financial balance via Commissioner Strategy delivery (3 year) and Regulator drive for surplus in 18/19.	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**			
Current Risk Score:	4 x 5 = 20						
Tolerable Risk Score:	3 x 5 = 15						
Direction of Travel:	↔						
Assurances (How do we know if the things we are doing are having an impact?)				**Key Performance Indicators**			
Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme. Tangible, SMART key performance measures and indicators agreed to enable effective assurance of progress / escalation of impediments / exceptions.				• reduction in the level of unplanned hospitalisation for chronic ambulatory care sensitive conditions bringing Wirral nearer to the NHSE average • Reduction in the level of emergency admission for acute conditions not usually requiring hospital admission bringing Wirral nearer to the NHSE average • A year on year reduction in ED attendances/non-elective admissions/avoidable readmissions (as a % of all admissions) admissions from nursing homes • A reduction in ALOS bringing WUTH in line with best quarter performance			
Gaps/rationale for current risk score/emerging risks				**Mitigating actions:** (What further mitigating action could we take?)			
1. Governance arrangements for Healthy Wirral lack definition and grip 2. There is no clearly defined roadmap to enabling place based accountable care				1. New Model of care (52-9-4-1)to be piloted within HW50+ programme, with a MOU 2. Delivery MSK Prime Provider contract let by CCG & secured by WUTH in partnership with WCT & PC 3. Further Wirral Leaders Lock-In session in March 2018 to reach agreement on roadmap and timetable 4. Wirral Integrated Provider Partnership established 5. Primary & Acute Care collaboration being piloted with Primary Care Wirral 6. Acceleration of recent urgent care solutions to continue to improve system delivery of 4 hour standard 7. HWPB TOR redeveloped, MOU to be established, independent Chair and Programme Director to be appointed			

Strategic Change

<table>
<tr><td colspan="3">Strategic Objective:</td><td rowspan="2">We provide safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future</td><td>Key Measures:</td><td colspan="3">All impacted if trust is not sustainable</td></tr>
<tr><td>Linked Risks/ collaboration opportunities</td><td colspan="3">• Focus on the short term / urgent may impact delivery of future state
• Lack of resource may constrain our ability to take forward all we wish / need to
• Inability to effectively prioritise may lead to missed opportunity to maximise value</td></tr>
<tr><td>Risk ID:</td><td>15</td><td>Risk:</td><td rowspan="2">Operational Step Change & Internal Transformation: Failure to prioritise strategic change & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients</td><td>Board Lead:</td><td>Director of Strategy and Sustainability</td><td>Date last reviewed:</td><td>May 2018</td></tr>
<tr><td colspan="3"></td><td>Audit Committee Position</td><td colspan="3"></td></tr>
<tr><td colspan="3">Risk Rating: (Likelihood x Consequence)
Current Risk Score: 4 x 5 = 20
Tolerable Risk Score: 3 x 5 = 15
Direction of Travel: ⟷</td><td>• Controls: (How are we currently managing this risk?)
Establish Strategy & Sustainability Planning Group (SSPG) to complement and link effectively with F&PG, FBPAC, TSG, WWC Alliance, Healthy Wirral and C&M HCP
• Establish 18/19 operational planning timetable to connect divisional planning to the SSPG
• Establish Governor Strategy and Sustainability Advisory Committee
• Establish a diagonal change agent network
• Develop a robust approach to enable priorities to be set, and to linked to to trust vision</td><td colspan="4"><u>Aligned Risks on Trust Corporate Risk Register (15 or above)</u>
<u>0 Risks in total</u>
•</td></tr>
<tr><td colspan="4">Assurances (How do we know if the things we are doing are having an impact?)
• Comprehensive operational plan for 18/19 that links and prioritises strategic system change with operational step change with low level ‘bau’ cash releasing efficiencies / tactical savingss.
• Clear strategic roadmap for 2018 initially and then beyond to 2020
• Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme.</td><td colspan="4">Key Performance Indicators
• Improved performance against CSFs, KPMs and KPIs (will form part of updated performance reports to the Trust board)</td></tr>
<tr><td colspan="4">Gaps/rationale for current risk score/emerging risks
• Bandwidth to effectively manage all of the priorities</td><td colspan="4">Mitigating actions: (What further mitigating action could we take?)
• Encourage, recognise & reward broader engagement in making real our strategic ambitions. Provide a more accessible vision for our future to enable more colleagues to connect fully and understand their role in enabling.
• Prioritisation process underway as part of sustainability challenge</td></tr>
</table>

Strategic Change

Strategic Objective:			**We are** a national exemplar for transforming care through innovation and technology	**Key Measures:**	7a – Work towards full digitization of the Electronic Patient Record 7b – Work towards the achievement of HIMMS level 7 7d – Look to improve our digital maturity index score		
				Linked Risks/ collaboration opportunities			
Risk ID:	16	**Risk:**	**IT:** Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment	**Board Lead:**	Director of IT and Information	**Date last reviewed:**	February 2018
				Audit Committee Position	Issues raised by MIAA resolved or accepted		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risk in total**
Current Risk Score:	3 x 4 = 12	• The Trust uses a standardised implementation methodology to engage and involve users in the system design and testing. • All staff receive classroom based training prior to receiving a user name & password. • Progress with the programme is managed through the Informatics governance structure and reported to the Digital Wirral Programme Board. • All major go lives are signed off by the CEO and Medical Director.	• No Access to Child Health System – Women & Children's (20) –this is now being transferred to Wirral Community Trust
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Post implementation reviews completed at major milestones • External review of GDE programme by representative of NHS Digital	A new benefits programme is being developed under Digital Wirral programme which will develop a set of metrics for the benefits of the programme published in September 2017
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Training required for clinical staff (inc locum and bank staff) to ensure appropriate use of Cerner system following successful implementation of phase 3 (Action 1) 2. Limited Assurance received following the MIAA IT Service Continuity Review (Actions 2 and 3) 3. Delays in receiving GDE funding (Action 4) although funding now received 4. Additional work require to prepare for implementation of renewed General Data Protection Regulations (GDPR) (Action 5) 5. Lack of tracking system to determine "real time" bed state and patient flow (Action 6)	1. Undertaking review of training e.g. drugs administration refresher and will produce proposal for on-call training service for locums and bank staff (to include associated costs) (Date TBC) 2. Work underway to complete IT Service Continuity action plan to address limited assurance assigned by Internal Audit. A report was taken to Trust Board in January and progress will be reported on a quarterly basis 3. 'Snapshot' audit to confirm achievement of improved assurance in combination with cyber security and system resilience work – outcomes reported to Audit Committee in March 2017 and further audit in Q2 4. GDE benefits realisation plan for GDE (Statement of Planned Benefits) has been signed off by NHS Digital and Divisions are working through it through TSG This will contribute to a refreshed business case. To be previewed by Trust Board once the financial details are settled planned for March 18 5. Information, IG & CG to oversee implementation of GDPR action plan through active engagement with the Clinical Divisions and Corporate Services – March 2018 6. Continue with the Capacity Management Solution but develop business case for "real time" tracking system for future investment

Strategic Change

<table>
<tr><td colspan="3">Strategic Objective:</td><td>We provide safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future</td><td>Key Measures:</td><td colspan="3">4a – Progress (i) the development of a VAT efficient Special Purpose Vehicle for service delivery (ii) A SEP with a third party</td></tr>
<tr><td colspan="3"></td><td></td><td>Linked Risks/ collaboration opportunities</td><td colspan="3"></td></tr>
<tr><td>Risk ID:</td><td>17</td><td>Risk:</td><td rowspan="2">Estates: Failure to develop & implement a strategic estates strategy impacts on patient & staff experience; collaborative working and clinical service strategies and financial sustainability</td><td>Board Lead:</td><td>Chief Operating Officer</td><td>Date last reviewed:</td><td>May 2018</td></tr>
<tr><td colspan="3"></td><td>Audit Committee Position</td><td colspan="3">• limited assurance report on water safety – reviewed before March 17 confirming high level recommendations completed
• Full compliance review requested and undertaken in Estates against all the critical areas. This work should be aligned to the Health and Safety compliance and audit programme.
• Internal Audit – Estates Maintenance Review – Significant assurance report received</td></tr>
<tr><td colspan="3">Risk Rating: (Likelihood x Consequence)</td><td rowspan="4">Controls: (How are we currently managing this risk?)
• Experienced legal and financial partners have been contracted to ensure that the Trust follows the correct procurement process and avoid unnecessary legal challenges
• Ongoing monitoring of compliance with Water Safety measures undertaken by IPORT
• Glen Adams has been appointed chief engineer with specific duties concerning compliance.</td><td colspan="4"><u>Aligned Risks on Trust Corporate Risk Register (15 or above)</u>
<u>0 Risks in total</u></td></tr>
<tr><td>Current Risk Score:</td><td colspan="2">4 x 5 = 20</td><td colspan="4" rowspan="3"></td></tr>
<tr><td>Tolerable Risk Score:</td><td colspan="2">3 x 5 = 15</td></tr>
<tr><td>Direction of Travel:</td><td colspan="2">⟷</td></tr>
<tr><td colspan="4">Assurances (How do we know if the things we are doing are having an impact?)</td><td colspan="4">Key Performance Indicators</td></tr>
<tr><td colspan="4">• To be developed as the programme progresses
• Estates maintenance review – significant assurance report received
• High risk areas in limited assurance report satisfactorily dealt with and acknowledged by MIAA
• Initial Compliance assessment undertaken on all estates compliance and associated action plans produced.</td><td colspan="4">See integrated quality dashboard</td></tr>
<tr><td colspan="4">Gaps/rationale for current risk score/emerging risks</td><td colspan="4">Mitigating actions: (What further mitigating action could we take?)</td></tr>
<tr><td colspan="4">1. Inability to fully address backlog maintenance challenge
2. General capital investment demands vs capital resource and prioritisation requirement and residual risk
3. Authorised Person and Competent Person training needs to be undertaken
4. Procurement process for strategic estates partner as agreed at Board of Directors abandoned with adverse impact on a strategic estates plan for 2018/19</td><td colspan="4">1. Prioritisation of maintenance issues in place. Further review undertaken by Executives to prioritise key items of work that would improve patient and staff experience
2. Strategic estates plans to be developed on a transitional basis using proposed six facet survey results. Six facet survey out to tender.
3. Authorised person and competent persons are undertaking the role, despite not having the written qualifications. Training in place for 2018/19.
4. Contingency planning proposals to be determined</td></tr>
</table>

Leadership and Improvement

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – Deliver a Use of Resources (UoR) rating of level 3 8e – Work to improve our NHSI governance rating	
				Linked Risks/ collaboration opportunities	Risks 5,6,7,8,9,10	
Risk ID:	18	**Risk:**	**Enforcement Action** - Insufficient progress against agreed financial and access targets results in further regulatory action and enforcement of Section 111	**Board Lead:**	Chief Executive	**Date last reviewed:** July 2018
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • Quality review meetings with NHSI action points agreed • Monthly OSM meetings with NHSI • Monthly Board performance and financial reporting • Operational Task and Finish Groups for RTT and A & E • Full licence compliance review at each Audit Committee	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total** •
Current Risk Score:	4 x 5 = 20		
Tolerable Risk Score:	2 x 5 = 10		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Removal of enforcement actions in relation to requirement for interim support • Positive Well led Governance Review 2016/17	• Overall UoR (see Risk 5) • Liquidity (see Risk 5) • 4Hour A&E Standard (see Risk 9) • RTT (see Risk 10) • Cancer (see Risk 11) • C.diff (see Risk 12)
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
• Non-achievement of financial control total • Non-compliance with A & E and RTT standards • Trust signed up to revised enforcement undertakings in March 2018 • NHSI invoked their powers under section 111 in relation to the Chairs appointment • Qualified VFM opinion 2017/18 • CQC well led	The actions being undertaken to mitigate the risks relating to RTT; A & E 4 hour standard and financial performance are outlined separately in the BAF as described under linked risks

Leadership and Improvement

Strategic Objective:			**We put** our people first so they can put our patients first, and we create the workforce of tomorrow by investing in the workforce of today **We excel** in a quality improvement/learning culture that allows us all to reduce unwarranted variation and constantly improve our services	**Key Measures:**	5a – Continue the on-going delivery of the Workforce and OD Strategy in order to deliver (i) a healthy organisational culture (ii) a sustainable and capable workforce (iii) effective leaders and managers		
				Linked Risks/ collaboration opportunities	1,2,3 & 4		
Risk ID:	19	**Risk:**	**Medical Engagement:** failure to improve medical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity and increased costs	**Board Lead:**	Medical Director	**Date last reviewed:**	July 2018
				Audit Committee Position			
Risk Rating: (Likelihood x Consequence)			• **Controls:** (What are we currently doing about the risk?) Medical Engagement Strategy agreed • Medical Engagement Road Map – 3 Year Plan commenced April 17 • Consultant Recruitment Process focussed on values for re-structure. • 2 week bespoke induction programme for new consultants • 2nd year consultant foundation programme (new multi-disciplinary top leaders programme September 2018) • Clinical leaders' development programme • 'Later Years' Clinical Excellence Programme • Informal drop-in sessions run by Medical Director and Chief Operating Officer • Response to the medical engagement results • Structural change to enable clinically led services	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**			
Current Risk Score:	4 x 4 = 16						
Tolerable Risk Score:	3 x 4 = 12						
Direction of Travel:	⟷						

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Staff survey • Medical Director 1:1 with Senior medical leaders • Chief Operating Officer 1:1 with Divisional Medical Directors • Senior Medical Leaders Meetings (Monthly)	• Monthly Integrated Quality Dashboard • Attendance at weekly safety summit
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What more should we do?)
• High level focus on quality and safety from senior clinical leaders to junior and trainee medical staff. • Medical Engagement Survey results – Jun 17	• Developing new organisational structure to ensure services are clinically led. • Re-design medical leadership Job Descriptions and Personal Specifications to support the new structure, and to focus on values, professional leadership and patient safety. • Change programme Terms of Reference to be agreed ahead of undertaking Board development to ensure that there is an understanding on the effectiveness of the Board's role of setting and maintaining healthy organisational culture.

Leadership and Improvement

Strategic Objective:			**We are** a national exemplar for transforming care through innovation and technology	**Key Measures:**	7a – Work towards the role of the Trust as a teaching institution 7b – Work towards the achievement of HIMMS level 6	
				Linked Risks/ collaboration opportunities		
Risk ID:	20	**Risk:**	**Data Quality:** failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	**Board Lead:**	Director of IT and Information	**Date last reviewed:** February 2018
				Audit Committee Position	• May 2017 - Trust received qualified limited assurance on the Quality Account due to RTT data issues • Oct 17- MIAA activity data capture review – A & E significant assurance. 31 day cancer - significant assurance/ 62 day cancer – Limited assurance • IG Toolkit audited with significant assurance	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Tolerable Risk Score:	2 x 4 = 8
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- All staff receive training on their use of the IT system prior to receiving their usernames and passwords
- There is significant validation built into the Trusts millennium system to ensure that only valid data can be collected
- The Data Quality Group reporting to the Finance and Performance Committee
- Where individual members of staff are found to be causing errors, this is escalated to line managers

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Generally speaking there is a series of local and national audits which cover these areas and show that WUTH performs strongly compared with their peers. Individual issues raised by the reports will be dealt with by the Data Quality Group or Audit committee • MIAA significant assurance reports for 31 day cancer and A & E	A dashboard of issues such as completion and timeliness of coding is reviewed on a monthly basis at the Information, Information Governance and Clinical Coding Group
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Lack of awareness of the clinical coding agenda (Action 1) 2. It is not always clear the provenance of data used in performance reports (Action 2) 3. Quality Account external audit review highlighted concerns with data quality in relation to RTT and A & E (Action 3) 4. MIAA report on ESR and E rostering highlighting 5 areas that require further investigation	1. Raise the profile of the clinical coding agenda by ensuring a senior clinical coding presence at key governance meetings, may be suffering as a result of staff shortages – a package of measures is being adopted to retain trained coders. 2. Introduce data quality kite-marks for all reported KPIs and incorporate in dashboards. 3. Dedicated project led by operational team has improved the position on RTT and A&E 4 and 12 hour waiting data is now subject to routine audit for breaches and near misses 4. HR undertaking investigation, Audit Committee reviewing outcomes.

Board of Directors	
Agenda Item	10.6
Title of Report	BUSINESS CASE TO REPLACE MR SCANNER (MR1) Radiology Department – Arrowe Park Hospital
Date of Meeting	25th July 2018
Authors	Pam Black Head of Radiology
Accountable Executive	David Jago Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	2a, 8a
Level of Assurance • **Positive** • **Gap(s)**	Gaps – Trust feasibility reviews still to be finalised as part of the CBF process, including IT, Estates and Infection Prevention & Control
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion and approval
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Summary

This paper outlines the case for replacement of the oldest of WUTH's two static Magnetic Resonance Imaging Scanners (MR1). MR1 is currently 17 years old and more than twice the recommended lifespan for an MR scanner as set out by the Royal College of Radiologists (RCR)[(1)].

The Radiology department has 2 static MR scanners that provide an MR service for all inpatients, outpatients, emergency department patients and 100% of the DA referrals from GP's across Wirral.

The MR service is crucial to the delivery of a number of national targets including but not limited to; A&E 4 hour target, all Cancer targets, length of stay, RTT 18 week target and the 6 week diagnostic access standard. The current national focus on the optimisation of all cancer pathways has significant reliance on early access to MR scanning[(4)].

MR1 has been subject to a number of breakdowns in 2018. The manufacturer will no longer guarantee the availability of spare parts. Unplanned replacement of the MRI scanner would cause significant operational disruption, impacting waiting times and patient flow.

2. Background

A Radiology department is reliant on its imaging equipment and highly skilled staff to be able to provide an imaging service for the healthcare community. As noted in the RCR 'Good Practice Guide for Clinical Radiologists', all patients have the right to expect the highest standards of service that is appropriately resourced in terms of staffing and radiology equipment[(1)].

Access to timely MR investigations is an integral part of the drive to "Achieving World Class Cancer Outcomes: Taking the Strategy Forward" published by NHS England in May 2016[(4)].

The Phillips 1.5 Tesla MR Scanner (MR1) was installed at APH in 2001. It presents an increasing risk to service continuity due to its age, availability of parts and system reliability. The trust holds one other static 1.5 Tesla MR scanner (installed September 2009) with the service being further supported by a mobile MR scanner situated at Clatterbridge General Hospital. The Radiology department has recently agreed a contract with Spire Murrayfield to provide further capacity for bariatric patients which none of the other MR scanners currently provide.

The MR service undertook almost 20,000 examinations in 2017-18, an increase of 3,000 (+18%) on the previous year, and forms an essential component of every patient care pathway.

The replacement, upgrading and expansion of particularly high value radiology equipment has been and continues to be very challenging for trusts, especially in light of the wider financial climate.

2.1 Rationale for the replacement of MR1

The RCR 'Good Practice Guide for Clinical Radiologists' provides guidance on the standards for the lifetime of radiological equipment, and states that "the performance of investigations in radiology departments is dependent on the use of high quality equipment which is appropriate to the task" [(1)].

It also provides guidance for the expected useful lifetime of such equipment, quoting a time period of 7 years for Magnetic Resonance Imaging Equipment.

Other factors to be taken in consideration are:

- Intensity of use - MR1 is used 12 hours per day, 7 days per week and only shuts on Christmas day.
- Image quality - the quality of images reduces over time increasing the risk of misdiagnosis.
- Equipment maintenance - the cost of maintaining older equipment increase with age as the equipment breaks down more frequently. MR1 has broken down on 5 occasions since the beginning of 2018 - not only does this lead to a higher than average costing maintenance contract but also to a loss of core capacity which inevitably impacts on our in-year financial position (whether that be through direct loss of income or additional expenditure from having to outsource to DHC).
- Availability of spare parts - Phillips has already stated that they have very limited spare parts due to the age of the scanner and it is inevitable that sooner rather than later they will not be able to maintain and/or fix the scanner.

Radiology equipment has a finite lifetime based on the above factors.

3. Key Issues

3.1 Less reliability and increased downtime leading to loss of income and breaching diagnostic standards[(3)]. Older equipment breaks down more frequently and becomes increasingly difficult to find parts for repairs. Equipment is out of action for some time, significantly reducing trust capacity to meet demand (which is ever increasing) and effectively causing key targets to be missed and a corresponding loss of income. The impact is also felt across the wider trust in relation to RTT and Cancer targets.

3.2 Lower diagnostic capability and reduced image quality. Newer technology provides higher resolution imaging and not having access to this will inevitably lead to requests for repeat scanning and imaging, increasing radiation dose, reduced efficiency and limited capacity. This new technology allows for shorter scan times which in turn, reduces respiratory artefacts and improves the

experience for the patient as they do not have to hold their breath for long periods.

3.3 Slower throughput. Newer technology - such as shorter scanning techniques - speeds up the process and provides a greater throughput of patients, increasing the department's productivity and efficiency.

3.4 Inability to scan the full range of patients (service limitation). Newer technology provides higher resolution imaging, which allows for innovative techniques to be employed and a full range of examinations to be provided.

4. Finance

In principal, it has been agreed to fund the replacement of the MR scanner via the 2018/19 capital programme. However, this is subject to senior approval of the business case and accompanying capital bid form.

The capital and associated revenue costs are as follows:

- Indicative cost of MR 1.5 Teslar (obtained via NHS Supply chain) = **£1,018,156** including VAT.

- Indicative costs of enabling works (obtained via the two shortlisted suppliers, Siemens Healthineers and Phillips is approximately £500,000 including VAT.

- There will be maintenance costs after the one year warranty, with the best deal usually being obtained by paying up front. Having a good quality maintenance contract reduces the downtime, ensures excellent response to call outs allowing the scanner to have an uptime of 98-99%. It is estimated that the new maintenance contract (again, obtained from the two shortlisted suppliers, Siemens Healthineers and Phillips) will cost between £64k and £73k per year, depending on the level of service required and desired payment schedule.

  To note – the current MR1 maintenance contract costs £120k per year but despite this high value, the supplier is still unable to guarantee the sourcing of parts that could be needed during a breakdown (due to the age of the equipment). A notice period of 6 months (TBC – potentially 3 months) would be required against the existing maintenance contract, after which a small CIP saving could be recognised for the trust.

- There will be a need to continue to provide the current level of service while the scanner is being replaced. Costs for a relocatable MR scanner are approximately £7,500 + VAT per week, equating to £108,000 including VAT over a 12 week period. Formal more accurate quotations are currently being sought via NHS Supply Chain.

Not to use a mobile scanner during the enabling and installation works would incur costs due to breaches of access times, loss of income and put severe pressure on the A&E target, cancer services and length of stay.

- Assuming an estimated volume profile of 7,500 – 8,000 scans per year and an average tariff, the MR scanner generates revenues of £1m for the trust as part of the Direct Access Diagnostics contract. We have also seen activity growth of 9.9% between Q1 last year and Q1 this year (across our MR activity as a whole), which though expected to fall as a result of the MSK contract still means that we are very much dependent on the running of 2 static scanner to maintain demand.

  If the decision was made not to replace MR1 (markedly reducing service capacity) then there would be a significant loss of DA/OP income to the trust as resource is diverted to manage inpatient and A&E patient flows. DHC capacity is already at its maximum which means there would be no further potential to divert patients here. These are both risks that must be considered alongside the do nothing option.

- Staffing costs to operate the current MR service (excluding management and medical staffing) are £625k per year – if the decision was made not to replace MR1 then there would be significantly staffing implications and associated cost in the short to medium term. This is an additional risk that must be considered alongside the do nothing option.

Summary table:

Costs (incl. VAT	**Year 0**	**Year 1**	**Year 2-7**
Capital:	£k	£k	£k
Scanner Replacement	-1,018	0	0
Enabling works	-500	0	0
Sub-total; Capital	**-1,518**	**0**	**0**
Revenue (cash):	£k	£k	£k
Mobile hire (TBC)	-108	0	0
Balance of MRI Scanner Fund[1]	20	0	0
12 month warranty[2]	0	0	0
Maintenance - new contract[3]	0	-43	-73
Maintenance - old contract[3]	10	120	120
Sub-total; Revenue (cash)	**-78**	**77**	**47**
Revenue (non-cash)	£k	£k	£k
Depreciation[4]	-38	-152	-152
Sub-total; Revenue (non-cash)	**-38**	**-152**	**-152**
Total cost	**-1,634**	**-74**	**-105**
CIP opportunity (revenue cash)	**0**	**77**	**47**

[1] Balance of MRI Scanner Fund (currently held as revenue grant monies) to be contributed toward in year cost of replacing the scanner.

[2] 12 month warranty included within initial cost and assumed to run from Sep-18 to Aug-19. New contract assumed at cost of £73k per year, pro-rated for 7 months in year 1.

[3] Current contract assumed to require 6 month notice period (from end Aug-18) so no CIP opportunity in year 0 (offset by non-recurrent mobile hire cost). Higher CIP value in year 1 due to part-year effect of new maintenance contract, lower recurrent value from year 2 onwards.

[4] Assuming straight line depreciation of full capital value over 10 year period, with one quarter being charged in year 0 (assuming implementation before 31st December 2018, as per trust depreciation policy). Potential to reduce the annual cost by extending over 15 years.

Further detail is available in the capital bid form.

5. Option Appraisal

Option	Benefit	Risk
Do Nothing	No capital outlay No costs for enabling works No revenue implications for maintenance No costs for mobile van	Further increase in downtime Loss of income Reduction in image quality Increased risk of misdiagnosis Increased radiation dose Poor patient experience Loss of service due to inability to fix scanner
Replace Scanner (capital purchase)	Better image quality Reduction in downtime Reduction of risk of loss of income Improved patient care Improved patient flow and efficiency	High capital outlay in times of financial difficulty Increased depreciation charges going forward Temporary cost implications for mobile scanner
Managed Equipment Service	No capital outlay New scanner (and all associated benefits listed under replacement option above) Replacement of equipment against agreed lifecycles Cost of contract includes installation, training, maintenance, upgrades and disposal of equipment	Significant recurrent revenue costs (quotes from 2-3 years ago when this option was last scoped suggest a charge of £2-3m per year depending on equipment specification and maintenance schedule)

6. Recommendation & Next Steps

It is recommended that the Trust Board approves the business case to replace MR1 as part of the 2018/19 capital programme, aswell as the associated enabling works and temporary mobile hire.

The capital bid form relating to this spend has also been completed and circulated for all necessary approvals, including the Director of Finance and Chief Operating Officer.

The Radiology Department is ready to move forward with the procurement process and place an order as soon as all approvals have been granted. The MR scanner will be replaced within the current financial year.

References

1. Royal College of Radiologists: “Good Practice for Clinical Radiologists”. 2nd edition.
2. “Evaluation of Diagnostics Capacity across the NHS in England”, 2020 Delivery on behalf of Cancer Research U.K. 2015
3. “Qualitative Evidence on the Clinical Benefits of the Latest Magnetic Resonance Imaging, Computerised Tomography and Linear Accelerator Equipment. 2015
4. “Achieving World class Cancer Outcomes:Taking the Strategy forward” May 2016