Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

1st November 2018

MEETING OF THE BOARD OF DIRECTORS ON THURSDAY 1 NOVEMBER 2018

COMMENCING AT 10AM IN THE BOARD ROOM

EDUCATION CENTRE, ARROWE PARK HOSPITAL

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 September 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	**Infection Prevention & Control Update Report** Director of Nursing & Midwifery	d

8. Performance & Improvement

8.1	**Integrated Performance Report**	
	8.1.1 Quality & Performance Dashboard and Exception Reports Chief Operating Officer, Medical Director, Director of Nursing & Midwifery, Director of Workforce, Director of Governance & Quality	d
	8.1.2 Wirral A&E Delivery Board Exception Report Chief Operating Officer	v
	8.1.3 Month 6 Finance Report Director of Finance	d
	8.1.4 2019/20 Planning Guidance and Payment Reform Director of Finance	d

9. Workforce

9.1	**Freedom to Speak Up (FTSU) Six Monthly Update** Gary Price, Freedom to Speak Up Guardian	d

10. Governance

10.1	**Report of Workforce Assurance Committee** Chair of Workforce Assurance Committee	d
10.2	**Report of Finance Business Performance & Assurance Committee** Chair of Finance Business Performance & Assurance Committee	d
10.3	**Report of Trust Management Board** Director of Governance & Quality	d
10.4	**CQC Action Plan Progress Update** Director of Governance & Quality	d
10.5	**Report of Programme Management Board** Director of Transformation & Partnerships	d
10.6	**Report of Charitable Funds Committee** Chair of Charitable Funds Committee	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 28th November 2018	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

27 SEPTEMBER 2018

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
Chris Clarkson	Non-Executive Director
Jayne Coulson	Non-Executive Director
Graham Hollick	Non-Executive Director
David Jago	Director of Finance
Dr Mark Lipton	Interim Medical Director
Sue Lorimer	Non-Executive Director
Helen Marks	Director of Workforce
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

In attendance

Joe Allan *	Associate Director of Nursing, IP&C
Natalia Armes	Director of Transformation & Partnerships
Mike Baker	Head of Communications
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Steve Evans *	Governor
Graham Morrison *	Member of the Public / Patient Story
Tom Houghton	Member of the Public
Steve Igoe	Associate Non-Executive Director
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Paul Moore	Director of Quality and Governance
Dr Nicola Stevenson	Associate Medical Director, Medical & Acute
Nigel MacLeod	PA [Minutes]

Apologies

Paul Charnley	Director of IT and Information
John Coakley	Non-Executive Director
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

* Denotes attendance for part of the meeting.

Reference	Minute	Action
BM 18-19/090	**Apologies for Absence** Noted as above.	
BM 18-19/091	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/092	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting, including the Divisional Medical Directors and Mr Tom Houghton, Local Democracy Reporter, BBC & the Echo.	

Reference	Minute	Action
	In opening the meeting, the Chair outlined the evident improvements and achievements already undertaken, pertaining to the Trust's long term sustainability, mirrored by improved and progressive interaction with the regulators. Having attended the NHSI 'Learning from Improvement' national event, the Chief Executive confirmed that the plans, priorities and direction currently, being undertaken by the Trust, where in line with those taken by Trusts' highlighted as being successful and demonstrating a significantly improved and sustained performance.	
BM 18-19/093	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Workforce** – the Board noted the Trust's decision to participate in a Home Office led pilot for WUTH employees, who are non UK EU citizens. The pilot scheme will allow these employees to apply in person for UK immigration status prior to Brexit. The Board was apprised that the Trust's 'Top Leaders Programme' is currently being reviewed and refreshed for the future. **Mr John Sullivan, Non-Executive Director** – having reviewed recent data, Mr Sullivan highlighted a deteriorating trend in both sickness levels and appraisal completion. Assurance was sought and received that concurrent activity, from an engagement perspective, would seek to address the situation. **Director of Quality and Governance** – having commenced the implementation phase of the Trust CQC Action Plan, Mr Moore was encouraged by the evident desire from colleagues to address concerns and implement improvements. The level of commitment and deputed ownership by colleagues to move forward at pace, supported by a sense of drive, passion and determination, was clearly demonstrable. It was confirmed that the Serious Incident Review Group now meets weekly, to ensure processes and learnings are reviewed and implemented as required. **Director of Nursing & Midwifery** – the Board learned that the Trust had formally launched the refreshed Nursing, Midwifery and Allied Health Professionals Strategy, as previously outlined and approved by the Board of Directors. The SEPSIS awareness week had been well received by both patients and staff. The Director of Nursing & Midwifery thanked those patients who had supported the event, by sharing their personal experiences and reflections. On behalf of the Board, Mrs Westray attended recent meetings of both Clatterbridge and Arrowe Park League of Friends and was able to convey the thanks and appreciation from the Trust Board for the League's ongoing support.	

Reference	Minute	Action
	Arrowe Park League of Friends continues to support facilities with recent donations to the Neonatal Ward having been extremely well received. As Clatterbridge League of Friends will in 2019 celebrate their 65th anniversary, the Trust is currently discussing with the League a pledged donation of £65K, to be spent on the Clatterbridge Health Park. Sir David Henshaw, on behalf of the Trust, reiterated his thanks to Arrowe Park and Clatterbridge League of Friends for their ongoing association, help and support. **Mrs Sue Lorimer – Non-Executive Director** – the Board was apprised that the recent Charitable Funds meeting had been well received, with a clear and demonstrable desire by the Charitable Partners to work collaboratively with the Trust to secure additional funding. Mrs Lorimer had thanked all those involved for their ongoing support, as the additional funding raised was extremely well received and appreciated. It was agreed that the Charitable Funds Committee would establish a prioritisation list and then engage with patients, public and alternative Partners/Organisnations to seek further support. **Director of Transformation and Partnerships** – Mrs Armes thanked colleagues for their support upon her recent appointment and outlined that over the coming weeks and months a proposed scope of work would be shared with colleagues. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that a review and implementation of revised processes is gaining traction, and being well received across the division. Mr Ellard also confirmed that having undertaken significant work in delivering high quality outcomes, WUTH had received a 10% reduction pertaining to the insurance premium for litigation costs. A saving of circa £700K PA. **Director of Finance** – Mr David Jago confirmed that having attended a number of system wide Director of Finance meetings, a sense of drive and commitment to work in collaboration was evident, with a specific focus in regards to procurement. **Mr Graham Hollick, Non-Executive Director** – having heard from the Chief Pharmacist, at the recent Audit Committee, the need for a less generic training in the use of Cerner; the Committee welcomed the progression in this regard via the inclusion of both service users and analysts as trainers. **Interim Medical Director** – Dr Lipton apprised the Board with key updates: 1. Three Consultants in Emergency Surgery had recently been appointed. 2. The recent Peer Review had been identified as 'good' and circulated for review. 3. Dr Lipton was now chairing a paperless Steering Group to support transition across the Trust. **Chief Operating Officer** – in collaboration with Estates, and having identified key projects for the Trust, it had been agreed to provide additional Project	

Reference	Minute	Action
	Management support to escalate a programme of work to reduce the current back log. The Board was apprised that a tender process re the provision of additional staff car parking would commence week commencing 1st October, with completion anticipated by the end of the Financial year. **Associate Medical Director, Medical & Acute -** Dr Stevenson apprised the Board that Patient demand had remained at consistent levels across the summer. There had been no evidential abatement of patient demand, having transitioned from Winter 2017/2018 into the summer of 2018. This paradigm had also been cognisant within other areas of the hospital, but also to a degree across the wider Health Economy. Dr Stevenson welcomed the decision to invite the Associate Medical Directors to attend the Trust Board meetings, and felt the more inclusive feel and nature had been welcomed across the divisions, instilling a greater degree of Board support and collaboration. **Mr Chris Clarkson, Non-Executive Director** – the Board was apprised that positive progress is being made pertaining to theatre improvements, with further details to follow. **Mrs Jayne Coulson, Non-Executive Director** – having met with the Head of Patient Experience and the Director of Nursing & Midwifery, nine specific areas of attention & review had been agreed to support the overall refresh of the Patient Complaints process. The Board was apprised that initial meetings had now been undertaken, pertaining to the concurrent Outpatients review, with a series of further meetings and actions agreed and implemented. Having attended a recent ward 'walk around' with the Director of Nursing & Midwifery, Mrs Coulson apprised the Board that it was evident colleagues had a real desire for patient care and demonstrated a 'can do' attitude to support progression and improvement, as the Trust continues its current journey. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board of improved traction, having implemented the theatre improvement programme.	
BM 18-19/094	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 25 July 2018 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 18-19/095	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained	

Reference	Minute	Action
	within the written report, and welcomed Dr Nicola Stevenson and Mrs Natalia Armes, having recently been appointed as Medical Director and Director of Transformation & Partnerships respectively. **Capital Award** – the Trust had been notified that its £2M bid against the national urgent care capital fund, to support a 30 bed ward refurbishment, along with a redesign of assessment function, had been approved. This was one of only three successful bids across Cheshire & Merseyside. **Flu** - NHSI / NHSE had released a press statement outlining an expectation that all front line staff would be expected to receive a flu vaccination. Colleagues who elect not to receive the vaccination will be asked to outline the reason in order to support greater compliance. An expectation is that there will be 100% compliance. WUTH achieved a vaccination rate of 81.3% in 2017, compared to the national statistic of 68.7%. **CQC Ionising Radiation (Medical Exposure) Regulation** – CQC Inspectors conducted a short notice announced inspection of compliance on 21 August 2018. A comprehensive improvement plan has subsequently been submitted and implementation will be tracked via the Quality & Safety Committee. **Adult Health & Care Overview & Scrutiny Committee** – the Chief Executive had presented the CQC Inspection report on the 12 September 2018. It was agreed that Healthwatch will coordinate a Trust visit by Councillors, to observe the improvement work being undertaken. **Major Trauma Unit** – following a visit from the Cheshire and Merseyside Major Trauma Network, WUTH had again achieved the required standard for reaccreditation. **Accreditation for Anaesthesia** – the Department of Anaesthesia has been recognised by the Royal College of Anaesthesia, one of 17 Trusts nationally, as an ACSA accredited department. **Urgent Care Services Consultation** – the public consultation into future plans for Urgent Care on the Wirral commenced 20 September 2018, to conclude 12 December 2018. **Serious Incidents and Learning Lessons** – during July and August 2018 the Trust declared six serious incidents for investigation. One of the incidents was also declared a 'Never Event'. Having investigated the reported incidents, common themes and learnings have been addressed; including: • Failure to escalate mNews and failing to escalate to Critical Care Outreach for Sepsis screening. • Delays with escalating to appropriate pathways. • Documentation and transferring patients during the night. The Board was apprised that the number of serious incidents had reduced during the last two months, due to the criteria for Serious Incidents within the national Framework being applied. Previously, the Trust had used a locally agreed Wirral Health and Care Commissioning criteria.	

Reference	Minute	Action
	Mr Paul Moore, Director of Quality & Governance, provided Board assurance that the Trust is adhering to the NHSE Serious Incident Framework and applying the correct level of required challenge. It was agreed that the Director of Quality & Governance would provide Board colleagues with regular updates from the weekly Serious Incident Panel meetings.	PM
BM 18-19/096	**Patient Story** The Board was joined by Mr Morrison, who apprised the Board of his experience following his admittance to the Intensive Care Unit. [ICU] Having been in work and experiencing initially flu like symptoms, Mr Morrison outlined how during the day his situation deteriorated and he had experienced distressed breathing and worsening symptoms. By 4.30pm that same day, Mr Morrison had been admitted to Intensive Care and remained in a coma for the next 20 days. Mr Morrison spoke highly of the care and professionalism extended to him whilst a patient of Intensive Care, and being an employee of the NHS, and previously a trainer within the medical profession, could not speak more highly of the dedication of those working within the unit. As a patient, Mr Morrison outlined to the Board a number of aspects that he felt would be of benefit for patients in similar circumstances. Having lost a period of 20 days, Mr Morrison explained that to assist with patient orientation, the provision of clocks that indicated day, date and time, including the ability to determine AM or PM, would be beneficial. This was especially prevalent as ICU is located internally within the hospital complex and had no windows. Board members appreciated the observation and felt this should be incorporated within an overall dementia strategy. Furthermore, whilst appreciating the concept of a quiet hour between 4pm and 5pm to aid patient's recovery, having woken up during this time and experiencing the dimmed lights and quietness, this had been disorientating and impeded the ability to ascertain the time of day. Having then transferred to a ward environment, to continue recovery, Mr Morrison apprised the Board with a number of observations that could be improved and reviewed. These had included aspects of medication provision, dispense and collaboration between ITU and the ward, as well as general care standards, handover processes between departments/wards and physical bed provision. From a cultural perspective, Mr Morrison also apprised the Board of his observations aligned to staff interactions with each other. On behalf of the Board, the Chair expressed his thanks and appreciation to Mr Morrison for sharing his experience and would welcome further insight and suggestions as the Trust evolved and developed from a leadership, cultural and environmental perspective. The Board agreed that the Director of Quality and Governance would incorporate this within the ongoing governance review being undertaken.	

Reference	Minute	Action
BM 18-19/097	**Infection Prevention & Control progress Report** Mr Joe Allen, Associate Director of Nursing for Infection Prevention and Control [IPC], provided the Board with an update pertaining to the current health care associated infection position and the proposed improvements with IP&C practices within the Trust. The processes within the Trust to reduce the incidence of avoidable infections are concurrently being reviewed by the infection Prevention Control Team. Furthermore, the number of cases identified is being reviewed, with a programme of work embedded to mitigate and reduce Alert Organisms; CPE, E.Coli, MRSA and Clostridium difficile [C.diff]. The programme of work incorporates a number of aspects: • C.diff rapid reviews and weekly c.diff exec review meetings. • Divisional IPC monthly meetings. • Daily IPC Quality Visits. • Review of environment / equipment cleaning – introducing Chlor-Clean (hypochlorite solution). • Refresher training for hydrogen peroxide vapour cleaning. • Introducing thermal disinfection for water jugs & beakers. • Site survey of hand hygiene products, with the introduction of foam based products, to enhance and highlight the importance of hand hygiene. Having apprised the Board with an overview of the work being undertaken, and collaboration with facilities management and procurement, Mr Allen agreed to provide the Board with an update of the overall IPC strategy in January 2019.	**GW**
BM 18-19/098	**Integrated Performance Dashboard** The Chief Operating Officer presented the latest Integrated Performance Dashboard and Exception Report. As previously outlined, the A&E 4 Hour trajectory had been amended to reflect a progression towards achieving 95% compliance by March 2019. August 2018 recorded a standard of 90.00%, as measured across the combined WUTH, Walk In Centre and Minor Injury Unit. Specific performance of the Emergency Department and All Day Health Centre had been recorded at 83.60%, a positon below the agreed recovery trajectory of 87%. The Board had been apprised that whilst there had been a reduction in the overall attendances, when comparing April to August 2017 versus 2018, resus attendances remained approximately the same, suggesting the overall demand and pressure of patients with higher acuity had not abated. Whilst clarification is awaited from both regulators, as to whether they are focusing on site or economy level performance, Health Economy Partners are working collaboratively to address the position and improve performance. The Chief Operating Officer confirmed that the agreed incomplete Referral to Treatment [RTT] performance trajectory achieved at the end of August was 77.15%, in line with the improvement trajectory submitted to NHSI. However, the number of 52 week waiters and total RTT waiting list both increased and	

Reference	Minute	Action
	were above trajectory, culminating in the Trust now undertaking weekly reporting. As previously documented, a key RTT target for 2018-19 is to ensure the total waiting list at March 2019 is no higher than the position reported at March 2018, a position of 24,736 Patients. Total waiting at the end of August was 27,308, an increase of 2,572. It is anticipated that the reported position will continue to deteriorate in the short term, a reflection of both the reduced elective programme and circa 1,700 patients being transferred to the Trust's waiting list, having introduced the Musculoskeletal contract 1 July 2018. Regulators had been fully engaged, with an appreciation that the long term objectives, and benefits, will realise an overall reduction in waiting list numbers and times. Stakeholder Comms will also be developed to reflecting the strategic aims and overall benefits, whilst appreciating an increase in the short term. Having identified an escalation pertaining to ambulance handovers and arrival to departure times, Mr Sullivan sought and received assurance that the Trust continues to refine and implement plans, to provide additional support at times of increased demand and surge. Jayne Coulson had not received assurance that the number of complaints recorded, reflected receipt via any means and not just those received in paper form. Having implemented a weekly Pressure Ulcer review meeting, it is anticipated that the three month decreasing trend will transition and will positively reflect across the rolling 12 month average. Mr Sullivan sought and received assurance that the increase in pay expenditure, along with associated agency spend, had been noted with Divisions, who remain engaged in concurrent discussions.	
BM 18-19/099	**Wirral A&E Delivery Board Exception Report** The Chief Operating Officer apprised the Board that a key priority of the Wirral A&E Delivery Board is the ongoing scrutiny and review of the Winter Plan. Having been subject to an Economy Wide Review visit on the 6 August, a number of positives and good practices had been identified that the system are now progressing.	
BM 18-19/100	**Winter Plan 2018/2019** Having provided Trust Board members with a copy of the Wirral Winter and Unplanned Care System Sustainability Plan 2018-19, the Chief Operating Officer apprised the Board of the key aspects: • The Patient flow bundle, SAFER, had been recognised as now embedded across the Trust. • Timely ambulance handovers.	

Reference	Minute	Action
	• Improved utilisation of a 'one front door' approach to maximise patient flow to the most appropriate treatment area. • Agreed actions to meet and exceed 'transfer to assess' [T2A] targets. Cognisant of the exceptional circumstances experienced during the winter of 2017/18, a pivotal component and key demand for the Trust, is the mobilisation of 48 additional beds. The comparable 2017/18 figure had been additional capacity of 27 beds. Each Division had developed a plan and collaboratively worked to achieve the goal by relocation of service, new models of provision or estate development. The location of additional beds is currently planned for: • 30 beds at Clatterbridge, utilising the Old Wirral Neuro Ward (Medically Optimised Model) • 18 beds at Arrowe Park, a combination of Surgical and Medical Wards. The options presented negated any additional staffing challenges, the exception being the Medically Optimised Ward, subject to Trust Board approval of contract award. It was confirmed that any estate reconfiguration costs will be made available from the current capital programme. Final sign off is anticipated by the end of September 2018 with the programme to commence November 2018. Board members agreed that an additional component was to ensure Patient discharges remain on track, to meet or exceed required standards. The Chief Operating Officer updated the Board that whilst an improved trajectory was evident, now achieving 33% of planned discharges by 2pm, as opposed to 4pm, delays continued to be experienced by the provision of timely community care packages. Furthermore, whilst there is recognition by the regulators that the Trust had been able to achieve the additional required capacity, there is an expectation that the related cost, circa £1.1M, would be absorbed by the Trust. To negate a repetition of the 2017/18 decline in elective procedures and productivity, having now identified the additional bed capacity, along with a further 20 community beds, the Trust are implementing plans to address this. This will also alleviate the associated financial impact of reduced elective activity. Cognisant of the agreed activity, the Chair reiterated the importance of ensuring the engagement and support of divisions through the process. It was confirmed that additional Ward reviews had been undertaken along with increased theatre and planned care sessions. The Board agreed the activity undertaken in meeting regulators requirements should be encompassed within the Stakeholder Comms being developed.	**HM**
BM 18-19/101	**Month 5 Finance Report** The Director of Finance apprised the Board of the summary financial	

Reference	Minute	Action
	position. At the end of month 5, the Trust reported an actual deficit of £15.8M versus planned deficit of £14.3M, an adverse to plan of £1.5m. The Board was apprised that the underlying deficit is closer to £17M given release of £1.1M of non-recurrent support during Quarter 1. The Board was reminded that having not accepted the Control Total issued by NHSI for 2018/19 of a surplus of £11M, the Trust was unable to access the Provider Sustainability Funds resource. The Trust had submitted a plan of £25M deficit to NHSI in April 2018. The areas driving the adverse position, whilst not exclusive, included underperformance in elective and day case activity; £2.7M below plan. Those specialities highlighted included Colorectal, Ophthalmology and Orthopaedics. It was reported that Outpatients is reporting below plan at £0.5M with an adverse performance in month at £69K. A further update would be provided upon completion of the concurrent Outpatients performance review. The Trust had achieved a Use of Resource Rating of 3, which had been in line with plan and had been supported by the deliverance of agency expenditure of £3.08M versus a cap of £3.08M. It was confirmed that there was some headroom on this metric and a breach of cap would not automatically result in a Use of Resources Rating of 4. The Board was apprised that at month 5, pay was below plan by £0.8M, driven by substantive below plan costs mainly driven by nursing being £1.5M below plan. Additional key aspects apprised to the Board included: • Non pay expenditure was above plan at £1.3M, noting MSK outsourcing costs of £1M. • CIP had delivered £2.7M versus plan of £2.0M. • Cash balances at the end of August were £6.2M, exceeding plan by £4.2M. The Director of Finance outlined to the Board that the forecast outturn deficit at the end of month 5, remained at circa £30M with a best case deficit and actions required to deliver this at £25.0m. When considering the organisational recovery plan, key actions included: • Divisional reviews to focus on CQUINS and forecast outturn; the key areas being Health and Wellbeing, Mental Health Education and antibiotic prescribing. • Review of Cost Improvement Programme to improve upon £10.0M and delivery of CIP in full at £11.0M. • Review of GDE revenue funding. Having sought clarification, pertaining to the in month deficit positon, Mrs Lorimer was advised that key aspects of the adverse positon included: • Increased spend associated with clinical and theatre supplies. • Reduced elective programme. • Increased pay costs associated to the national pay award.	

Reference	Minute	Action
BM 18-19/102	**Volunteer Strategy** The Director of Workforce apprised the Board that WUTH currently had 146 active volunteers, compared to an average comparable figure across the North West of 362. The Board learned that by 2020, the objective is to increase the number of volunteers by 50%, and will seek through volunteering to: • Strengthen links and engagement with the local community. • Be known as an organisation that values, encourages and supports volunteering and recognises and appreciates the important contribution volunteers can make. • Provide rewarding experiences that may provide steps into work. • Support adults and school age leavers to make career choices by providing experience in this environment. A summary of the activities that will assist in facilitating the growth objective was outlined as: • Creating a culture that nurtures volunteers • Extending volunteering roles • Volunteering for young people • Work experience • Retire and volunteer • Rewarding our volunteers • Strong governance and influencing • Third sector • Evaluation Having debated and agreed the objectives and strategic approach, it was agreed that activities would be expanded to also include and incorporate environmental aspects and a conjoined approach to support the overall Estates plan. Jayne Coulson also recommended links are established with the Private Sector, as a number of Companies encouraged employees to become actively involved in supporting local charities and organisations. BT, as an example, supported employees by allowing each employee to undertake 9 hours of volunteering as part of a wider team building and engagement programme. Having reviewed the proposed next steps, and in conjunction with the additional points outlined, the Board approved the paper and strategic approach to increase the volunteer workforce by 50% over the next two years. The Board also agreed that the Workforce Assurance Committee would monitor implementation and progress. It was also agreed that engagement and the strategic approach would be incorporated within the Trust's planned stakeholder communication.	**HM AM** **HM** **HM**
BM 18-	**Report of Workforce Assurance Committee**	

Reference	Minute	Action
19/103	Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee [WAC]. **EU Settlement Scheme (pilot) –** the Board was apprised of the Trust's decision to participate in a Home Office led pilot for WUTH employees who are none UK EU citizens. The pilot scheme will allow these employees to apply in person for UK immigration status prior to Brexit. The Trust's participation is a proactive step in staff retention post Brexit. **Workforce Planning –** WAC accepted the need for a new, effective and robust workforce planning process within WUTH. Workforce planning awareness sessions are being planned and a workforce planning tool (WRAPT, developed and funded by NHS England) is being explored. **Organisational Development Work Programme 2018-2020 review –** WAC received an update on the themed OD Work Programme for 2018-2020, along with the underpinning Divisional OD Work Programmes. Whilst it had initially been intended that the work programme would be delivered over the next 2 years, given the scale of work involved, it was agreed that this will be extended to a 3 year period to maximise cultural change opportunities. Mr Sullivan reiterated the sentiment expressed earlier pertaining to sickness absence levels. The Board was apprised by the Director of Workforce that the newly appointed Health & Wellbeing Manager will be reviewing this and implementing a process to help and support colleagues in returning to work. The Board learned that there are currently 180 members of staff off long term sick, the two highest contributing reasons noted as stress & anxiety and MSK.	
BM 18-19/104	**Report of Finance Business Performance & Assurance Committee** Mrs Sue Lorimer, Non-Executive Director, apprised the Board of the key aspects from the Finance Business Performance & Assurance Committee [FBPAC], having last met 21 August 2018. **M4 Finance Report** – the Director of Finance reported that the Trust had delivered a deficit of £12.4M against a plan of £11.4M. As had been previously reported to the Committee, the main factors attributing to the adverse position related to underperformance in elective day case activity and Outpatients attendances. As outlined within the Board paper, the Committee had also received updates pertaining to CQuIN performance. **One-to-One Midwifery** – FBPAC had noted the outstanding balances from this provider and agreed to pursue recovery whilst gaining and understanding other Trust's appetite for action. **Service Line Reporting [SLR]** - FBPAC had approved the strategy for the development of SLR noting the intention to relaunch the use of SLR and to engage further with clinical staff in the development and use of the information. The Committee had noted that in the absence of the Digital Wirral plan, to measure performance against, it had been difficult to gain the relevant	

Reference	Minute	Action
	assurance from the Digital Wirral Programme Board report. Furthermore, with no mitigating actions outlined, pertaining to gaps in assurance, FBPAC had been unable to gain assurance from the Information Coding Report. The Director of Finance agreed to review this further with Director of IT and Information.	**DJ PC**
BM 18-19/105	**Report of Audit Committee** Mr Graham Hollick apprised the Board of the key aspects from the recent Audit Committee. **Board Assurance Framework [BAF]** – whilst noting the in-depth concurrent review being undertaken by the Director of Governance & Quality, the Committee sought and received assurance that the refreshed BAF will be submitted to future meetings for review. **Single Tender Waivers** – having expressed concern at the number of single tender waivers, the Committee had received assurance that a majority of these had pertained to catering, with the required sign off processes having been adhered to and due to national problems with the award of this category to a supplier. **Consultant Job Planning** – the Committees attention had been drawn to two high level risks driving limited assurance; these had been outlined as: • The Trusts need to strengthen and reinvigorate the job planning process for 2018/2019. Assurance had been received that the appropriate Divisions had been engaged with the required action being taken. • The requirement to ensure all Consultants received a formal annual review of performance against their respective job plan. **Take Home Medicines Discharge** – having received an update pertaining to discharge medication, assurance was sought and received that findings from tested discharge summaries would be fed back to staff groups, and the Discharge Task and Finish Group, to drive improved performance and learning and improve upon the limited assurance given. **Anti-Fraud Progress Report** – the Committee received the progress report noting key awareness and communications within the Trust. Mr Hollick concluded by reiterating to the Board the timing of the risk management audit being moved to quarter 4, the current position pertaining to job planning and the need to re-audit take home medicines prior to the year end.	
BM 18-19/106	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the pre circulated paper provided progress pertaining to the CQC Action Plan. As the paper summarised the first round of 'confirm and challenge 'meetings, the Board accepted the paper as submitted.	
BM 18-19/107	**Receipt of Governor Election Report**	

Reference	Minute	Action
	Having provided full details at the Annual Members Meeting, the Chair apprised the Board with a key synopsis. Three existing Governors had been successfully re-elected: • Angela Tindall • Eileen Hume • Rohit Warikoo There had been two newly elected Staff Governors and three newly elected Public Governors. Two constituencies were not elected to; • Bebington and Clatterbridge. • Heswall, Pensby and Thingwall.	
BM 18-19/108	**Items for BAF/Risk Register** <u>Board Assurance Framework</u> The Director of Quality and Governance, having had the opportunity to consider the principal risks and the associated actions being undertaken to mitigate overall risk, summarised for the Board's benefit a range of plausible risk scenarios which might better illustrate the Board's strategic risk horizon. The scenarios covered: 1. Failure to achieve and maintain financial sustainability. 2. Demand for care that overwhelms capacity 3. Critical shortage of workforce capacity and capability 4. Catastrophic failures in standards of safety and care 5. Fundamental loss of stakeholder confidence 6. Major disruptive event 7. Breakdown of Strategic Partnerships For the next meeting, the Director of Quality and Governance agreed to expand upon the risk scenarios to give the Board greater visibility of the most likely risk vectors and, if the Board feel there is sufficient currency to develop further, use as the basis for developing of the Board Assurance Framework going forward.	**PM**
BM 18-19/109	**Items to be considered by Assurance Committees** None	
BM 18-19/110	**Any Other Business** There was no additional business raised for discussion.	
BM 18-19/111	**Date of next Meeting** Thursday 1st November 2018.	

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Chair

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Date

Board of Directors Action Log
Updated – September 2018

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.9.18						
1	BM 18-19/095	Board to be provided with regular updates from the Serious Incident panel	**PM**		Ongoing.	
2	BM 18-19/097	Associate Director of Nursing for Infection Prevention & Control to provide an update of the Trust's overall IPC strategy	**GW**		January 2019	
3	BM 18-19/100	Winter Plan – key components of Winter Plan to be incorporated within Stakeholder Comms	**HM**		Ongoing	
4	BM 18-19/102	Volunteer Strategy Strategy to be updated to also include activities to support the Trust's estates plan. Consider engagement with Private Sector Organisations. Key components to be incorporated within Stakeholder Comms.	**HM AM** **HM** **HM**		Ongoing	
5	BM 18-19/104	Review of Information and Coding Assurance Report to FBPAC	**PC DJ**	Discussed at Oct FBPAC the need for clarity on risks raised and mitigating action	Ongoing	Revised report to Dec FBPAC
6	BM 18-19/108	Draft Board Assurance Proposals to be presented.	**PM**		Ongoing	
Date of Meeting 25.7.18						
9	BM 18-19/077	To support and provide further context & clarity pertaining to the Healthy Wirral Programme, Simon banks and Dr Sue Wells to be invited to a future Board meeting.	**JH**		.	To attend Board 1.11.18

12	BM 18-19/080	To support Trust wide collaboration and engagement, a representative from Medical Board to be asked to attend the Workforce Assurance Committee.	**HM**		Ongoing	
14	BM 18-19/084	Identified 7 key Board Assurance Framework themes to be incorporated within overall Strategic Plan.	**PM**		Ongoing	
15	BM 18-19/088	Review of Board Papers to be incorporated within overall governance review.	**PM**		Ongoing	
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**		October 2018	
3	BM 18-19/052	Post Board Away Day – engagement session with Board & Consultant Body re Vision and Strategy.	**ML**		September 2018	
Date of Meeting 25.04.18						
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	**AM**	Outlined with Associate Director of Estates and to be discussed further.	September 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 Away Day scheduled for 31 July for sign off of Strategy.	September 2018	
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 as part of environmental work.	
Date of Meeting 28.3.18						
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.	**AM**	6 Facet survey tenders received and preferred supplier selected. Report and findings will be available September 2018.	Delayed until completion of '6 Facet Survey'.	
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~~. Healthy Wirral Plan coming to Board September 2018.	September 2018	
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. Healthy Wirral Plan coming to Board September 2018.	September 2018	

BOARD OF DIRECTORS	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	1st November 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 October 2018.

1. Regulation 28: Prevention of Future Death

I am making the Board aware of correspondence received from the Coroner on 9th October 2018 following a recent Inquest. It concerned a Patient with significant medical problems including chronic obstructive pulmonary disease admitted to Arrowe Park Hospital in February 2018. During the Patient's stay her condition fluctuated but stabilised following

medical treatment. There was an acute and rapid onset of respiratory failure 17 days after admission from which the Patient did not recover.

Although the Coroner concluded that death was a consequence of natural causes, reflecting the action identified by the Trust following its own investigation into the matter, the Coroner was concerned with: (i) the lack of compliance with the oxygen policy, in particular the failure to ensure an arterial blood gas sample was taken for analysis from a patient known to be sensitive to oxygen; and (ii) the adequacy of the response to the signs of clinical deterioration (compliance with the National Early Warning Scoring policy and procedures).

I have asked the Director of Quality & Governance to develop and lead the Trust's response to the actions identified in the Coroner's letter. This response will be reviewed by me, as Chief Executive, before replying to the Coroner Office.

2. Serious Incidents

In September 2018 the Trust declared one incident that crossed the threshold for reporting as a serious incident. This matter concerned a Patient requiring insertion of a chest drain to deal with an accumulation of pus in the pleural cavity. Initial chest drain was not effective and after senior review a second drain was required. During insertion of the second chest drain the drain was inserted into the liver in error. The problem was recognised shortly after insertion. Immediate action was taken to stabilise the Patient which was successful. The Patient was subsequently transferred to a specialist unit for ongoing treatment. Duty of Candour was completed and staff have been supported as an investigation progresses.

3. Neonatal

A meeting was recently held with the Chief Executive's and Medical Director's of Wirral University Teaching, Alder Hey Children's NHS FT and Liverpool Women's NHS FT to discuss the issues pertaining to neonatal services (and wider women's and children's services).

In the first instance the next steps is for the 3 clinical teams to meet through a series of workshops to discuss the full implications for tertiary services in more detail and provide recommendation as to how to progress this in a way that engages all colleagues in the service. The Board will be kept informed of the outcomes of those discussions.

4. Cheshire & Merseyside Provider Group Meeting held on 16th October 2018

a) Age Related Macular Degeneration (AMD)

Colleagues will doubtless be aware of the recent ruling against Pharmaceutical companies Bayer and Novartis in relation to the use of Lucentis /Eylea and Avastin for the treatment of Age Related Macular Degeneration (AMD), with a switch from one (Lucentis) to the other (Avastin) having the potential to save £500m nationally.

Initial review of data across Cheshire & Merseyside suggested that we spend £17.7m per annum and there is the potential to save anything between 50% - 95% of that by switching to alternatives.

Individual organisations are or may be planning to engage in discussion with legal advisors with a view to changing current practice. It is proposed that Cheshire & Merseyside engage a single legal opinion if indeed this is required at all given some areas in the country have already sought that and have implemented the change at scale. I would request the Board support this approach which would ensure change was made across the system.

b) Presentation from Andrew Bibby (NHS Assistant Regional Director of Specialised Commissioning)

An assessment of all 210 commissioned services has been undertaken to determine the future commissioning models appropriate and at what system/regional level this would be based on.

This has identified:

- 76 services sustainable within current form
- 3 to be introduced to the health economy (delivered but not commission includes A12b - Cancer: Skin (Adult), B07c - Tropical Medicine (All Ages) and D09a - Ear Surgery: Cochlear Implants (All Ages)
- 6 that require a North West approach B08a - Specialised Services for Haemoglobinopathy Care (All Ages), D01d - Complex Disability: Prosthetics, D06a - Specialised Burn Care (All Ages), D07a - Cleft Lip and/or Palate Services including Non-cleft Velopharyngeal Dysfunction (VPD) (All Ages), D16a - Critical Care E07b - Paediatric High Dependency Care
- 32 services for potential change of delivery/consolidation. In terms of method this will be via Single provider, lead/prime provider models, or and Accountable Care network. This includes items such as Neonatal.

5. System Improvement Board

Following a number of internal and external investigations and a Care Quality Commission rating of 'requires improvement', NHS Improvement has made the decision to place the Trust on its 'Challenged' Provider Programme. The purpose of the programme is to give support to the Trust to successfully implement its improvement plan. The governance for this includes a System Improvement Board chaired by NHS Improvement. The System Improvement Board is made up of partner organisations, regulators, and patient representatives.

The purpose of the board is to provide support and challenge to ensure that improvement is delivered in the best interests of patient care. The System Improvement Board will meet quarterly with the first meeting on the 8th November 2018.

Janelle Holmes
Chief Executive
October 2018

BOARD OF DIRECTORS	
Agenda Item	7.2
Title of Report	Infection Prevention & Control Performance Report
Date of Meeting	1 November 2018
Author	Mr Joe Allan, Associate Director of Nursing for Infection Prevention & Control
Accountable Executive	Mrs Gaynor Westray, Director of Nursing & Midwifery / Director of Infection Prevention & Control
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 2 and 12
Level of Assurance **Positive** **Gap(s)**	Positive - Zero cases of MRSA Bacteraemia - Progress within IPC high level improvement plan Current Gaps - Estates issues - Environment / equipment cleaning processes
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 update and inform the Board of Directors of the current healthcare associated infection (HCAI) performance and the proposed improvements with infection prevention & control (IPC) practices across 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. This report outlines the Trust's current position of HCAI from 1 April 2018 – 30 September 2018.

This paper will also provide a summary of the IPC high level improvement plan that was developed following a peer review in November 2017 including an overview of completed and outstanding actions.

2. Background

Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives. Avoidable infections are not only distressing and potentially life threatening for patients, but also consume valuable healthcare resources.

The Trust IPC systems and processes and the clinical environment was peer reviewed by Manchester Royal Infirmary in November 2017 and following feedback a full IPC high level improvement plan was developed identifying key areas for improvement. The IPC improvement plan is presented for discussion and review at both the Trust Infection Prevention & Control Group (IPCG) and Patient Safety and Quality Board (PSQB).

3. Healthcare Associated Infection Summary Report

The Trust IPC Team is currently reviewing a number of processes across the Trust to reduce the incidence of avoidable healthcare associated infections. The processes being reviewed include 'back to basics' specifically around cleaning standards, hand hygiene competency and compliance, skin disinfection and education/training.

The below table outlines the Trust's current position of all 'alert' organisms from 1 April 2018 to 30 September 2018

Division	CPE	C. diff Toxin	MRSA	MRSA Bacteraemia	E.coli	Klebsiella	Pseudomonas	MSSA
Medicine & Acute	54	19	27	0	17	9	6	8
Clinical Support	1	1	0	0	0	2	0	0
Surgery	14	5	4	0	4	1	0	1
Women's & Children's	0	0	0	0	2	1	0	1
Total	**69**	**25*** **12 avoidable**	**31**	**0**	**23**	**13**	**6**	**10**

*detailed PIR undertaken within the weekly C.diff executive reviews

Summary to date:

- *Clostridium difficile* avoidable cases – 12 against a threshold of 12 cases (2018/19 threshold - 28 cases)
- MRSA Bacteraemia – Zero cases
- MRSA (colonisation) – 31 cases (screening specimens on admission and transfer)
- *E.Coli* – 23 cases against a threshold of 23 cases (2018/19 threshold – 42 cases)
- CPE all confirmed cases - 69 cases (screening specimens, currently no threshold)

In addition The Director of Infection Prevention & Control, supported by the IPC Team is undertaking weekly *C.diff* executive reviews. The review meeting was introduced in August 2018 and the themes identified from the reviews are outlined below. Education and training is being co-delivered with IPC team and divisional matrons regarding clinical pathways and isolation of patients. A daily report is produced for the divisions and bed management team identifying patients that require isolation. The concerns around estates and environment have been shared with colleagues in estates and hotel services with a review meeting scheduled to prioritise and confirm actions.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	1	3	5	7	9	12	15	17	20	23	26	28
Cases	4	1	3	1	3	0						
Total	**4**	**5**	**8**	**9**	**12**	**12**						

Themes identified from *C.diff* executive review meetings:

- One period of increased incidence on ward M1 in June 2018
- Delays in obtaining stool samples / delays in specimens received in laboratory
- Delays in isolation of patients with diarrhoea (limited side room availability)
- Environmental cleaning
- Estates issues (broken hand wash facilities, broken macerators, insufficient isolation etc.)
- Thermal disinfection (dishwashing) patient water jugs and beakers

4. IPC High Level Improvement Plan

The IPC high level improvement plan was developed following a peer review from Manchester Royal Infirmary in November 2017, identifying key areas for improvement. The improvement plan is presented for discussion and review at both the Trust Infection Prevention & Control Group and Patient Safety and Quality Board. The improvement plan has been updated to reflect the concerns from both the *C.diff e*xecutive reviews and IPC audit and surveillance. Progress against actions is summarised below

Action Required	Lead	Progress	RAG
Development of IPC dashboard	IPC	Completed (please refer to quality performance dashboard)	Green
Re-energise Divisional IPC meetings with TOR and standardised report template for escalation to IPORT	Divisions	Completed June 2018 with monthly report to IPCG	Green
Leadership and review of team structure	Corporate	ADN IPC appointed and commenced in post July 2018 Team review completed including on call commitment Divisional IPC ambassadors identified to support ongoing training and compliance	Green
Review process and develop SOP for post infection review for alert organisms	IPC/Divisions	Completed November 2017 SBAR completed and presented at divisional IPC Improvement plans to IPORT escalated to IPCG	Green
Review process and develop SOP for *Cdiff* post infection review	IPC/Divisions	Completed with weekly Exec review *Cdiff* meeting introduced in August 2018	Green

Antimicrobial stewardship: Aim to change prescribing practice to help slow the emergence of antimicrobial resistance (AMR) and ensure that antimicrobials remain an effective treatment for infection.	Pharmacy/IPC	AMR lead identified Role of AM pharmacist embedded in Trust Review of prescriptions to ensure appropriate prescribing with feedback mechanism to primary care	Green
IPC policies up to date	IPC	Completed June 2018 IPC policy tracker monitored via IPCG	Green
Review protocols for IPC screening	IPC	Completed Shared Trust wide and integrated into Wirral Millennium	Green
Develop plan for Trust wide roll out of Aseptic Non Touch Technique (ANTT), target high risk areas	IPC / Clinical Skills	Plan developed and introduced in high risk areas CCU, Ward 17, Ward 30 All areas to be compliant by February 2019	Amber
Alcohol gel location and review of products	IPC	Review completed Rated amber until new products to be introduced and evaluated with roll out December 2018 Improving visibility at key public locations (main entrances, lift lobby etc.) February 2019	Amber
Review IPC education regarding decontamination / cleaning	IPC	Review completed. Updated IPC training packages (e-learning, induction) Rated amber due to actions re: Introduce role of housekeeper as part of establishment review. Assurance required from divisions re compliance with decontamination of equipment	Amber
Review of Hydrogen Peroxide Vapour for IPC cleans	IPC / Hotel Services	Review completed. Training and education completed for domestic staff September 2018 Prioritisation for HPV for areas following PIR and periods of increased incidence (PII) rated amber until practice embedded	Amber
Wirral Wide IPC approach to reduce gram negative blood stream infections (GNBSI) by 50% by 2021	IPC / CCG	IPC team part of the NHSI collaborative for GNBSI and Wirral wide IPC network Catheter care audit across health economy June 2018 resulting in the introduction of white lid for jugs for patients on fluid balance August 2018	Amber

IT solutions for automated reports on compliance with screening	IT/IPC	IT testing the system with a 'go live' planned for November 2018	Amber
Isolation facilities across Trust Ensure effective use of side rooms to ensure early isolation	Divisions/estates	Five additional side-rooms as part of winter plan Works approved with timeline completion date January 2019	Amber
Competency and compliance with effective hand decontamination Trust wide	All	Hand hygiene competencies launched Trust wide September 2018 Hand hygiene policy updated September 2018 IPC week 15 October Perfect Ward app in use for IPC hand hygiene audits October 2018 (130 users registered to date) Weekly for Ward managers Monthly for Matrons Ward accreditation with IPC components for roll out November 2018 Rated amber until embedded and results available from end December 2018 Monitored via IPCG with report to PSQB	Amber
Review of cleaning schedules / processes / cleaning standards and metrics (C4C) / cleaning products / thermos-disinfection of patients water jugs and beakers	IPC / Hotel Services	Cleaning schedules, credits for cleaning (C4C) scores, thermos-disinfection discussed with hotel services (Pilot completed re use of dishwasher) further actions required. Meeting scheduled 5 November 2018	Red
Safe clean ward environment, including De-clutter, adequate storage, minor works, availability of hand wash basins (ward 30 and domestic room)	IPC / Estates / divisions	Work schemes to be identified and supported by Estates	Red
Water safety – to reduce risk of Legionella and Pseudomonas: Flushing of water outlets Weekly for legionella Daily in augmented care facilities for pseudomonas	Divisions/estates	Compliance at ward level needs to improve with effective escalation in division and accountability PSQB agreed expectation of 100% flushing compliance end November 2018	Red

5. Summary

Although the number of alert organisms identified within the Trust is within the thresholds developed by NHSi, further work is required across the Trust to ensure patient safety remains the priority and that patients are not exposed to unnecessary and avoidable risk. The updated IPC screening protocol allows the Trust to be aware of individual patient infection status or a potential infection risk ensuring that appropriate management is put in place to isolate and prevent transmission to a bacteraemia.

The priority to ensure a safe clean clinical environment is essential to support further reduction in the incidence of infection. The areas highlighted in the above summary table that require immediate attention and support from colleagues in Estates and Hotel services include; the review of cleaning schedules and standards, including the metrics currently used to provide assurance, credits for cleaning (C4C). The provision of thermo-disinfection for patients water jugs and beakers once a day (as a minimum). Work is required to address estates / environment issues e.g. flooring, storage, and provision of hand wash basins in identified areas.

At ward and department level there is an urgent requirement for wards / dept. managers to take ownership for water safety. This is a daily or weekly flushing of water outlets (depending on clinical area) to reduce risk of Legionella and Pseudomonas. This issue was discussed in detail at PSQB and divisions agreed to a 100% compliance across all areas by the end of November 2018.

6. Recommendation

The Board of Directors is asked to note the progress made to date and the further work required both within the Divisions and within Estates and Hotel Services to ensure patient safety remains the Trust priority and patients are not being exposed to unnecessary and avoidable risk.

BOARD OF DIRECTORS	
Agenda Item	Item 8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	1st November 2018
Author	WUTH Information Team and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This revised 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 September 2018.

2. Background

This Quality and Performance Dashboard replaces the previous integrated quality report and is designed to provide the Board of Directors with an accessible oversight of the Trust's performance against key indicators. The additional exception report provides a summary of the remedial action being undertaken where indicators are not meeting the established targets or thresholds for the standards.

The Quality & Performance Dashboard is work-in-progress and will develop further iterations over time. This will include development of targets and thresholds where these are not currently established and the sourcing of data where new indicators are under development.

3. Key Issues

Of the 52 indicators with established targets or thresholds:

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

Appendix 2 details the indicators that are not meeting the required standards in an exception report. The report includes a brief description of the **I**ssue, the **D**ecision and remedial **A**ction (IDA).

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

Performance against many of the indicators is not where the Trust needs to be. The actions to improve are noted in the exceptions and this report in future will provide monitoring and assurance on progress

6. Recommendation

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

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2018

	Indicator	Director	Threshold	Set by	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD	13 month Trend	In-year 2018/19 Trajectory
Safe	Falls per 1000 occupied bed days reported on Ulysses (excluding lowered to floor incident)	DON	≤4.8 per 1000 Bed Days	WUTH		1.00	1.40	1.40	1.30	1.50	1.30	1.90	2.20	1.50	2.00	2.30	1.20	1.85		
	Eligible patients having VTE risk assessment within 6 hours of decision to admit	MD	≥95%	SOF	75.5%	74.3%	78.6%	64.3%	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	73.0%		
	Harm Free Care Score (Safety Thermometer)	DON	≥95%	National	97.0%	95.0%	92.7%	94.3%	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	95.5%		
	Serious Incidents declared	DQ&G	≤48 pa (= 4 per month)	WUTH	6	12	16	11	6	10	6	7	16	15	10	2	1	51		
	Never Events	DQ&G	0	SOF	1	1	0	0	0	1	0	0	0	0	1	0	0	1		
	CAS Alerts not completed by deadline	DQ&G	0	SOF	0	1	0	1	1	3	0	0	1	5	1	0	0	7		
	Clostridium Difficile (avoidable)	DON	≤28 for FY18-19, 2.42 per month	SOF	2	3	1	2	1	1	3	4	1	3	1	3	0	12		A M J J A S
	E.Coli infections	DON	≤42 pa (No more than 3 per month)	WUTH	6	6	7	2	4	1	2	4	2	6	7	2	3	24		
	CPE Colonisations/Infections	DON	TBC	WUTH	12	16	21	20	16	13	10	11	14	17	18	18	15	93		
	MRSA bacteraemia	DON	0	National	0	0	0	0	0	0	1	0	0	0	0	0	0	0		
	IPC Environmental Cleanliness Score (Radom area)	DON	≥85% (gold)	WUTH	76.0%	87.0%	–	69.0%	78.5%	71.3%	81.0%	73.0%	75.3%	–	–	–	78%	74.1%		
	Hand Hygiene Compliance	DON	100%	WUTH	89%	94%	93%	94%	89%	94%	99%	95%	97%	88%	89%	90%	81%	90.0%		
	Medicines Storage audits - % of areas fully compliant	MD	100%	WUTH	60%	78%	74%	–	52%	51%	52%	57%	70%	69%	71%	74%	–	68.2%		
	Surgical Site Infections (data once per year over 3 months)	DON	TBC	WUTH	Indicator Under development															
	Surgical Safety Checklist Compliance	MD	100%	WUTH	Indicator Under development															
	Protecting Vulnerable People Training - % compliant (Level 1)	DON	100%	WUTH	87.7%	89.2%	91.2%	90.9%	90.6%	89.9%	89.5%	89.2%	–	–	87.4%	–	85.6%	87.4%		
	Protecting Vulnerable People Training - % compliant (Level 2)	DON	100%	WUTH	79.9%	80.0%	80.3%	81.1%	81.3%	80.7%	82.5%	84.8%	–	–	82.7%	–	82.2%	83.2%		
	Protecting Vulnerable People Training - % compliant (Level 3)	DON	100%	WUTH	74.0%	80.8%	83.5%	84.6%	83.6%	83.8%	85.2%	85.6%	–	–	85.6%	–	86.5%	85.9%		
	Nursing Vacancy Rate	DHR	≤6.5%	WUTH	7.76%	6.48%	5.96%	6.09%	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	9.25%		
	Consultant Vacancy Rate %	DHR	≤6.5%	WUTH	5.63%	5.30%	7.71%	7.75%	7.47%	8.26%	9.31%	6.52%	6.50%	6.15%	7.19%	6.44%	–	6.4%		
	Sickness absence % (12-month rolling average)	DHR	≤4%	SOF	4.54%	4.55%	4.58%	4.61%	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.91%		
	Short-term sickness (in month rate)	DHR	TBC	WUTH	1.98%	2.21%	2.43%	1.92%	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.08%		
	Long-term sickness (in-month rate)	DHR	TBC	WUTH	2.06%	2.18%	2.32%	2.88%	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.58%		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

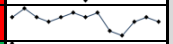
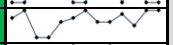
September 2018

	Indicator	Director	Threshold	Set by	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Effective	SHMI	MD	≤100	SOF	93.22	–	–	94.04	–	–	99.49	–	–	–	–	–	–	99		
	HSMR	MD	≤100	SOF	91.2	91.0	73.0	89.0	88.0	88.0	88.0	88.7	93.0	93.0	–	–	–	91		
	Mortality Reviews Completed				Indicator Under Development															
	Nutrition and Hydration - MUST completed at 7 days	DON	≥95%	WUTH	60%	–	–	–	–	–	–	44%	59%	71%	78%	67%	74%	65.5%		
	SAFER BUNDLE: % of discharges taking place before noon	COO/ DON	≥33%	National	15.9%	16.3%	16.7%	18.1%	18.0%	18.4%	17.3%	17.9%	17.6%	18.8%	18.4%	17.4%	18.1%	18.0%		
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	COO/ DON	≤156	WUTH	361	370	369	369	412	417	422	418	405	341	386	387	411	391		
	SAFER BUNDLE: Expected date of discharge achieved	COO/ DON	TBC	WUTH	Indicator Under Development															
	Length of stay - elective (actual in month)	COO	TBC	WUTH	3.7	4.0	4.4	5.0	3.9	10.2	4.0	3.8	4.3	3.8	4.1	4.1	4.2	4.1		
	Length of stay - non elective (actual in month)	COO	TBC	WUTH	4.8	4.8	5.0	5.2	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.1		
	Emergency readmissions within 30 days	COO	TBC	WUTH	840	880	884	891	849	840	814	886	923	873	913	961	888	907		
	Delayed Transfers of Care	COO	TBC	WUTH	27	25	15	14	11	12	9	13	12	13	13	6	18	11.4		
	NICE Guidance Compliance (Assessment & Gap Analysis)	DQ&G	≥95%	WUTH	–	–	–	–	–	71.0%	72.0%	72.0%	73.0%	73.0%	73.0%	73.0%	74.0%	74%		
	% of national clinical audits participation / % required	DQ&G	100%	National	–	–	–	–	–	–	–	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%		
	% Theatre Utilisation	COO	≥85%	WUTH	88.9%	86.8%	89.3%	82.9%	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.2%		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2018

	Indicator	Director	Threshold	Set by	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Caring	Same sex accommodation breaches	DON	0	SOF	19	15	9	16	12	18	16	18	22	10	8	16	14	88		
	FFT Recommend Rate: ED	DON	≥95%	SOF	90%	91%	92%	88%	92%	87%	82%	85%	90%	91%	89%	89%	86%	88%		
	FFT Overall Response Rate: ED	DON	≥25%	WUTH	12.0%	14.0%	12.0%	11.0%	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	11%		
	FFT Recommend Rate: Inpatients	DON	≥95%	SOF	99%	97%	98%	98%	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%		
	FFT Overall response rate: Inpatients	DON	≥25%	WUTH	11.0%	23.0%	19.0%	17.0%	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	19%		
	FFT Recommend Rate: Outpatients	DON	≥95%	SOF	94%	94%	95%	95%	95%	94%	94%	95%	95%	94%	95%	94%	94%	95%		
	FFT Recommend Rate: Maternity	DON	≥95%	SOF	98%	100%	93%	93%	97%	98%	100%	97%	97%	99%	96%	100%	100%	98%		
	FFT Overall response rate: Maternity	DON	≥25%	WUTH	23%	30%	27%	30%	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	36%		

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Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	COO	≥95%	SOF	87.5%	87.8%	85.7%	78.4%	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	82.4%		A A A A A S
	12 hour trolley waits	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Ambulance Handovers >30 minutes	COO	TBC	National	243	268	252	651	528	427	623	414	327	291	213	326	474	341		
	Patients leaving ED without being seen	COO	TBC	WUTH	178	169	162	322	185	209	337	211	226	115	139	119	175	164		
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	COO	≥92%	SOF	80.4%	80.9%	80.9%	77.7%	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	76.1%		A M J J A S
	Referral to Treatment - cases exceeding 52 weeks	COO	0	National	3	1	9	13	30	51	69	66	67	78	57	56	40	61		A M J J A S
	Diagnostic Waiters, 6 weeks and over - DM01	COO	≥99%	SOF	99.9%	99.1%	99.5%	98.7%	98.8%	99.2%	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	98.4%		
	Cancer Waiting Times - 2 week referrals	COO	≥93%	National	95.2%	98.3%	98.8%	97.4%	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	94.2%		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	COO	≥96%	National	96.9%	96.9%	96.6%	97.0%	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.3%	96.5%		
	Cancer Waiting Times - 62 days to treatment	COO	≥85%	SOF	87.0%	86.4%	85.5%	85.9%	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.6%	86.6%		
	Cancelled outpatient appointments	COO	TBC	WUTH	6013	6214	5937	5304	6437	5808	3451	6101	6017	6502	6864	6744	6169	38397		
	Cancelled elective admissions - TCIs	COO	TBC	WUTH	252	268	322	316	711	307	345	206	190	243	218	234	203	1294		
	Cancelled Operations (on the day of planned surgery)	COO	TBC	WUTH	23	25	24	30	12	27	20	9	26	15	9	4	7	70		
	Did Not Attend - Outpatient Appointments	COO	≥6.5%	WUTH	8.3%	8.5%	8.3%	9.1%	8.6%	8.0%	8.1%	8.3%	8.6%	8.2%	8.7%	8.9%	8.7%	8.6%		
	Appointment slot issues (Outpatient Utilisation)	COO	TBC	WUTH	3471	2701	2326	1730	1532	1703	1812	2325	2477	3646	3868	4076	4117	3418		
	Patient Experience: Number of concerns received in month - Level 1	DON	TBC	WUTH	-	87	117	68	122	133	144	118	135	109	139	121	153	775		
	Patient Experience: Number of complaints received in month - Levels 2 to 4	DON	TBC	WUTH	22	20	22	21	44	31	30	35	21	37	24	27	24	168		
	Complaint acknowledged within 3 working days	DON	100%	National	67%	75%	95%	100%	96%	100%	97%	94%	81%	95%	72%	75%	80%	82.8%		
	First written response within policy timescale	DON	100%	WUTH	31%	3%	0%	17%	27%	37%	17%	18%	29%	23%	22%	8%	30%	21.7%		
	Number of re-opened complaints	DON	≤5 pcm	WUTH	2	5	2	6	4	4	1	2	2	6	4	0	3	17		

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Quality Performance Dashboard

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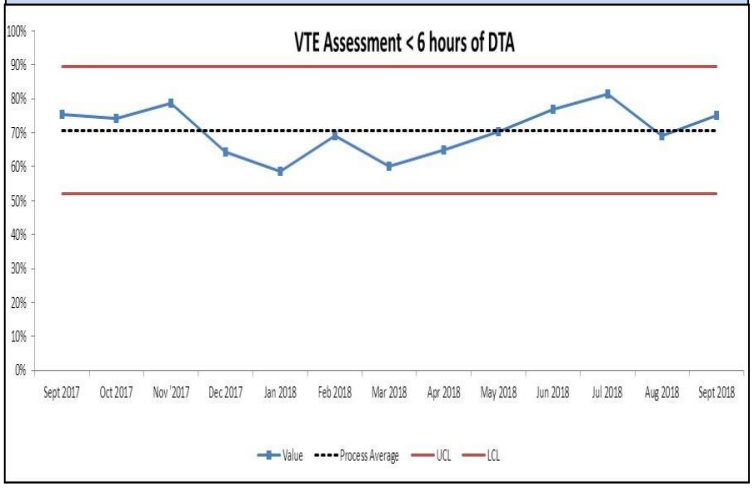
Well-led	Staff Friends and Family Test - overall engagement score	DHR	≥3.88	National	-	3.70	-	-	3.75	-	-	3.60	-	-	3.72	-	3.63	3.65		
	Live employee relations cases	DHR	≤30	WUTH	-	-	-	-	25	22	29	30	33	35	36	32	-	33		
	Duty of Candour compliance (for all moderate and above incidents)	DQ&G	100%	National	-	-	-	-	-	-	-	-	-	-	-	-	-	100.0%		
	Number of patients recruited to NIHR research studies	MD	650 for FY18/19 (= average 55 per month)	National	-	-	-	-	-	-	-	37	48	331	66	45	40	567		
	% Mandatory Training compliance	DHR	≥95%	WUTH	-	-	-	-	-	-	have	73.0%	-	74.8%	75.1%	82.0%	81.4%	81.4%		
	% Appraisal compliance	DHR	≥88%	WUTH	84.4%	86.8%	88.2%	85.5%	84.3%	83.4%	83.3%	84.9%	-	81.1%	79.2%	78.2%	77.5%	77.5%		

	Indicator	Director	Threshold	Set by	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Use of Resources	I&E Performance	DoF	On Plan	WUTH	-2.995	-2.039	-1.402	-3.712	-2.315	-1.614	6.485	-4.261	-2.337	-2.659	-3.139	-3.426	-2.334	-18.156		
	NHSI Risk Rating	DoF	On Plan	NHSI	-2.456	-2.219	-1.639	-2.898	-2.624	-0.424	0.162	-0.298	-0.103	-0.340	-0.184	-0.515	-0.319	-1.719		
	CIP Forecast	DoF	On Plan	WUTH	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
	NHSI Agency Ceiling Performance	DoF	NHSI cap	NHSI	-40.2%	-38.6%	-38.1%	-38.4%	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-11.7%		
	Cash - liquidity days	DoF	NHSI metric	WUTH	29.2%	36.9%	14.8%	19.6%	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	2.3%		
	Capital Programme	DoF	On Plan	WUTH	-18.8	-20.3	-22.3	-17.5	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7			

Appendix 2

WUTH Quality Performance Dashboard Exception Report - October 2018

Eligible patients having VTE risk assessment within 6 hours of decision to admit (Medical Director)

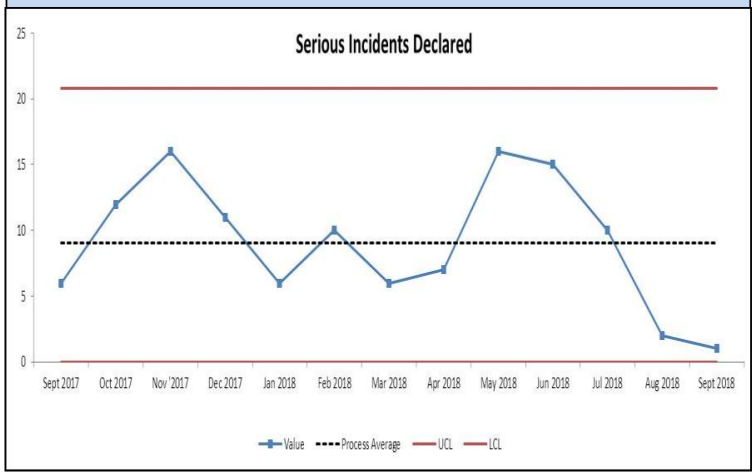


Issue: The national target for VTE assessment within 6hrs is ⩾95%. The trusts current performance is 73%. In addition the end-to-end compliance with VTE standards is 23%

Decision: Current performance Inadequate. Strengthen controls.

Action: Clinical lead for VTE is leading on VTE redesign process within Cerner – Objective to auto prompt VTE assessment and treatment

Serious Incidents declared (Director of Quality Governance)

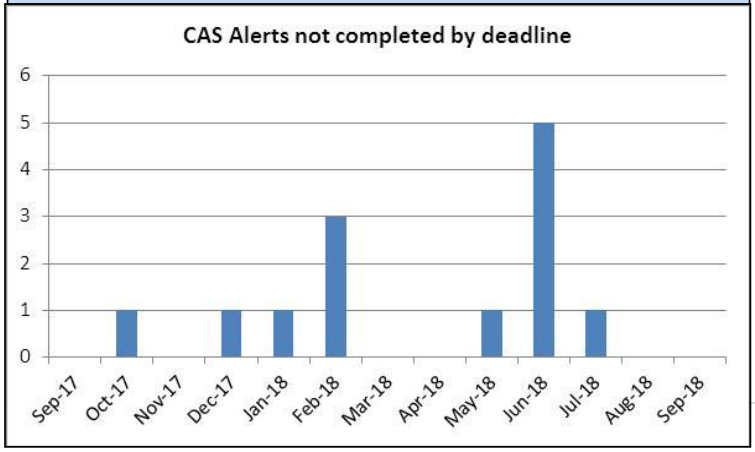


Issue: The Trust has set a target of no more than 48 Sis declared for 2018/19;
April to September the trust declared a total of 51 Sis

Decision: Current performance Inadequate. Strengthen controls.

Action: From July 2018 significant action has been taken to strengthen SIRG and ensure the Trust adheres to NHSE SI National framework. Q1 SIs declared averaged 13 per month; Q2 averaged 4 SIs per month

CAS Alerts not completed by deadline (Director of Quality Governance)

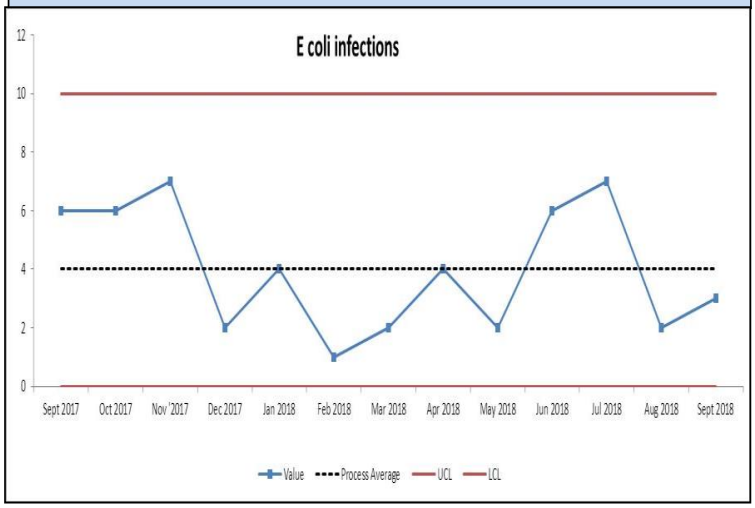


Issue: CAS Alerts not completed by stipulated deadline. As of September the Trust had breached on 7 mandatory CAS alerts

Decision: Current performance Inadequate. Strengthen controls.

Action: Immediate action taken to close all outstanding CAS alerts by the end of October 2018. Implementation of Ulysses CAS module (automated CAS tracking system)

E.Coli infections (Director of Nursing & Midwifery)

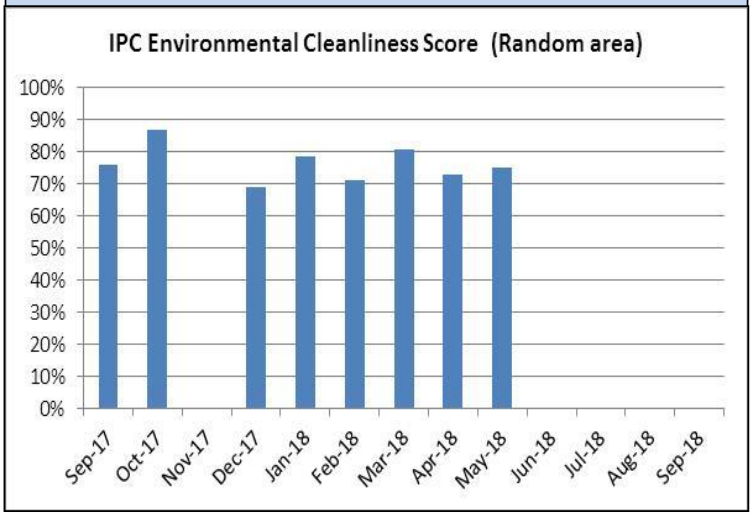


Issue: The trust has a control target of no more than 3 cases of E.coli per month. The performance for the first six months of 2018/2019 is 24 against a trajectory of 18 recorded cases of E.coli infection

Decision: Current performance Inadequate. Strengthen controls.

Action: ANTT rolled out to Critical care and ED with ongoing roll out to clinical areas. Hand hygiene audits part of Perfect Ward and compliance monitored by IPC. Infection control report to PSQB to include hand hygiene. WUTH part of phase one NHSI UTI collaborative.

IPC Environmental Cleanliness Score (Random area) (Director of Nursing & Midwifery)

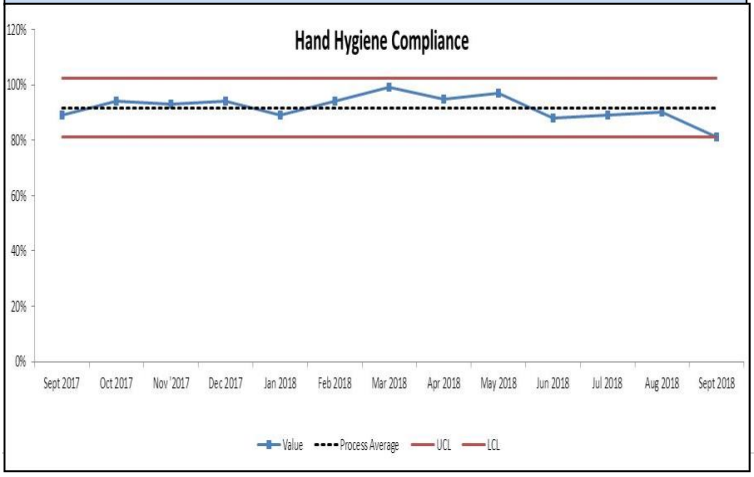


Issue: The trust has a compliance Year to date of 74.1% which is below the Compliance target of 85%

Decision: Current performance Inadequate. Strengthen controls.

Action: Ensure premises and equipment is adequately clean. IPC environmental audit programme in place along with Ultra-Violet light monitoring to determine adequate cleaning of environment and equipment. Work with estates and facilities addressing environmental issues and cleaning standards

Hand Hygiene Compliance (Director of Nursing & Midwifery)

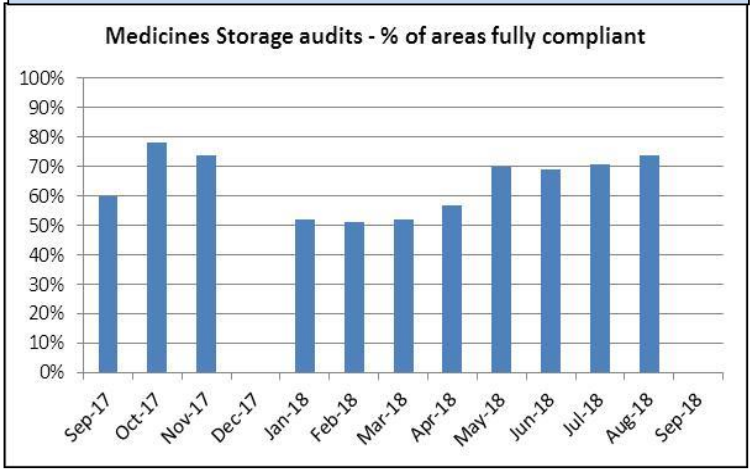


Issue: The Trusts YTD current hand hygiene compliance is 90% which is below the 100% target

Decision: Current performance Inadequate. Strengthen controls.

Action:
Hand hygiene education reviewed for mandatory training. Roll out of hand hygiene competency for all staff on induction and annually. Infection control report to PSQB to include hand hygiene. High impact intervention audits completed weekly via perfect ward

Medicines Storage audits - % of areas fully compliant (Medical Director)



Issue: The trust currently has a YTD compliance of 68.2% which is below the target of 100%

Decision: Current performance Inadequate. Strengthen controls.

Action:
Improve monitoring through pharmacy audits and perfect ward audit with appropriate accountability. Increase education and training via various forums.

Protecting Vulnerable People Training - % compliant (Level 1) (Director of Nursing & Midwifery)

Issue: The trust has a target of 90% for vulnerable people training (level 1). The 2018/19 YTD performance is 87.4 which is below target and has remained relatively static throughout the year

Decision: Current performance Inadequate. Strengthen controls.

Action:
Additional emphasis on managers to drive mandatory training compliance. Letters sent to individual staff members re noncompliance. Additional sessions arranged. Divisional trajectories set monitored via SAG.

Protecting Vulnerable People Training - % compliant (Level 2) (Director of Nursing & Midwifery)

Issue: The trust has a target of 90% for vulnerable people training (level 2). The 2018/19 YTD performance is 83.2 which is below target and has remained relatively static throughout the year.

Decision: Current performance Inadequate. Strengthen controls.

Action
Additional emphasis on managers to drive mandatory training compliance. Letters sent to individual staff members re noncompliance. Additional sessions arranged. Divisional trajectories set monitored via SAG.

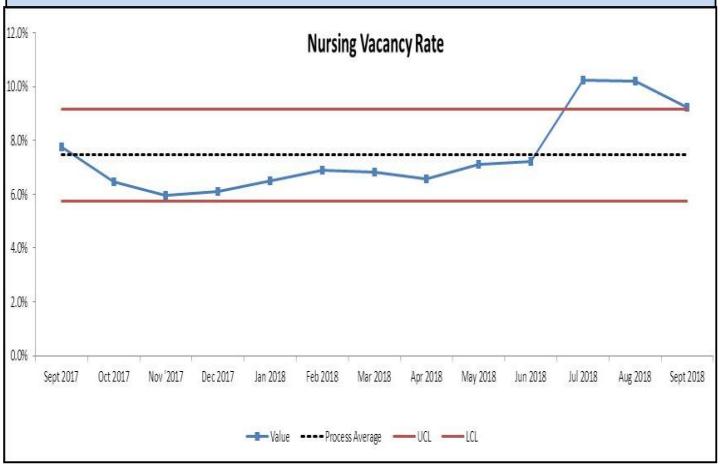
Protecting Vulnerable People Training - % compliant (Level 3) (Director of Nursing & Midwifery)

Issue: The trust has a target of 90% for vulnerable people training (level 3). The 2018/19 YTD performance is 85.9% which is below target and has remained relatively static throughout the year

Decision: Current performance Inadequate. Strengthen controls.

Action:
Additional emphasis on managers to drive mandatory training compliance. Letters sent to individual staff members re noncompliance. Additional sessions arranged. Divisional trajectories set monitored via SAG.

Nursing Vacancy Rate (Director of Nursing & Midwifery)

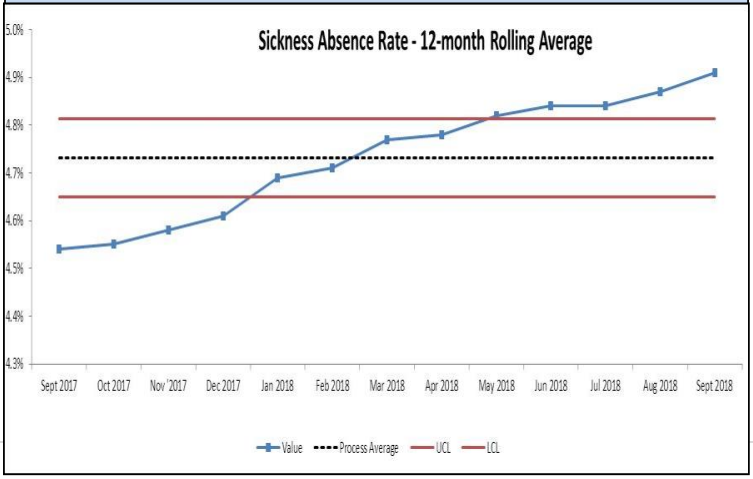


Issue: The current YTD vacancy is 9.25% which is above the target of 6.5%. This increase has predominantly been as a result of approval for funding to permanently establish three 'escalation/winter wards' and WAFFU from June 2018

Decision: Current performance Inadequate. Strengthen controls.

Action: Deep dive into recruitment underway. Options appraisal to strengthen the effectiveness of our recruitment system. Establishment review for presentation to board Nov 2018. International recruitment being revisited. Exploring options to train Nursing Associates to bridge gap between RN, CSW.

Sickness absence % (12-month rolling average) (Director of Human Resources)

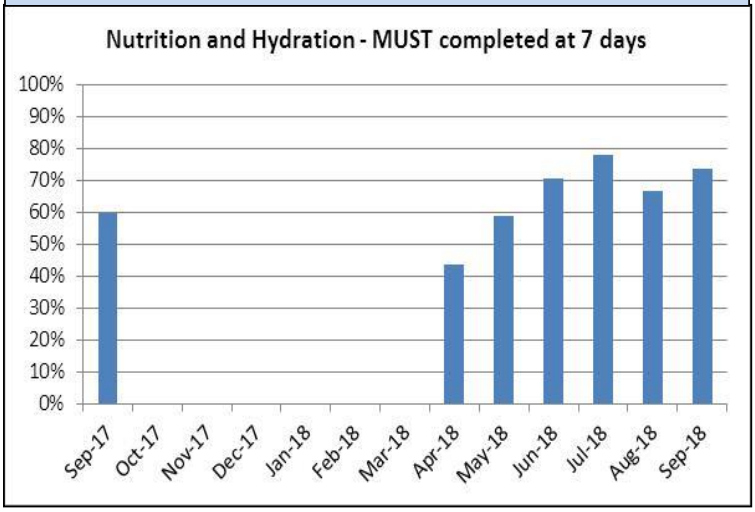


Issue: The YTD sickness absence rate is 4.91% which is above the trust target of 4%.

Decision: Current performance Inadequate. Strengthen controls.

Action: To monitor the workforce performance dashboard provided monthly to Workforce Assurance Committee and Divisional Management Team meetings with a focus long term sickness. Developing new policies for short term and long term sickness which emphasise the manager's role in supporting an employee's health and wellbeing.

Nutrition and Hydration - MUST completed at 7 days (Director of Nursing & Midwifery)

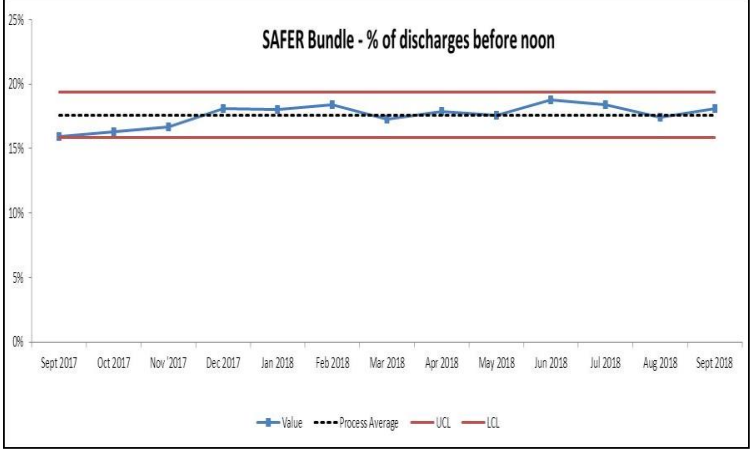


Issue: The trust YTD compliance with MUST completed at 7 days is 65.5% which is below the trust target of 95%

Decision: Current performance Inadequate. Strengthen controls.

Action: Lead identified for Nutrition and Hydration, monitored weekly. MUST compliance meetings proving effective latest in week compliance 80%. Being monitored via perfect ward from November.

SAFER BUNDLE: % of discharges taking place before noon (Director of Nursing & Midwifery)

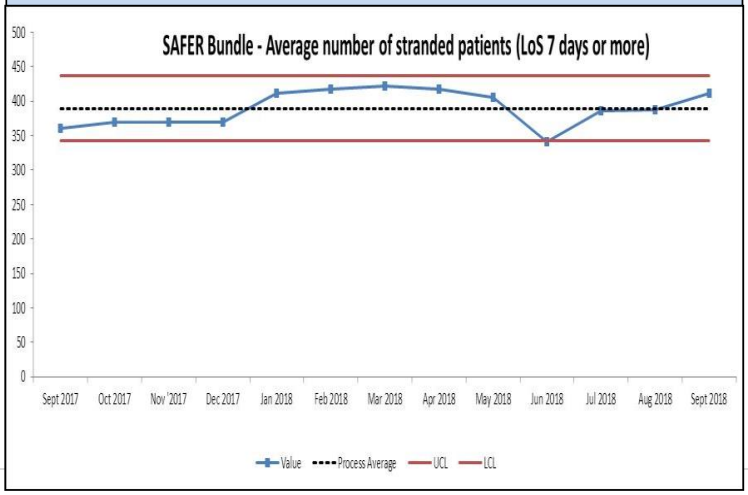


Issue: The Trust currently has a YTD compliance of 18% of discharges taking place before noon which is below target of 33%. This impacts negatively on patient flow.

Decision: Current performance Inadequate. Strengthen controls.

Action: This will be captured in patient flow improvement group and associated work streams and monitored through the quality dashboard.

SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) – actual (Director of Nursing & Midwifery)

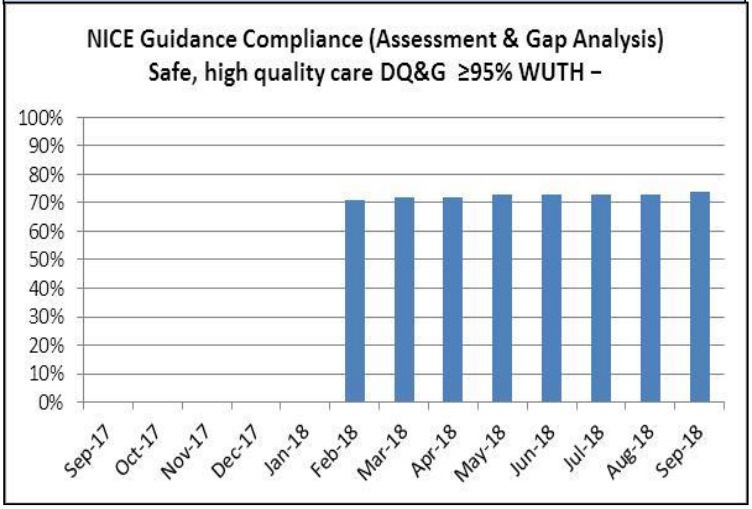


Issue: The YTD number of stranded patients at 10am in hospital for 7 days or more is 391, which is significantly above a target of 156.

Decision: Current performance Inadequate. Strengthen controls.

Action: This will be captured in patient flow improvement group and associated work streams and monitored through this Dashboard.

NICE Guidance Compliance (Assessment & Gap Analysis) (Director of Quality Governance)

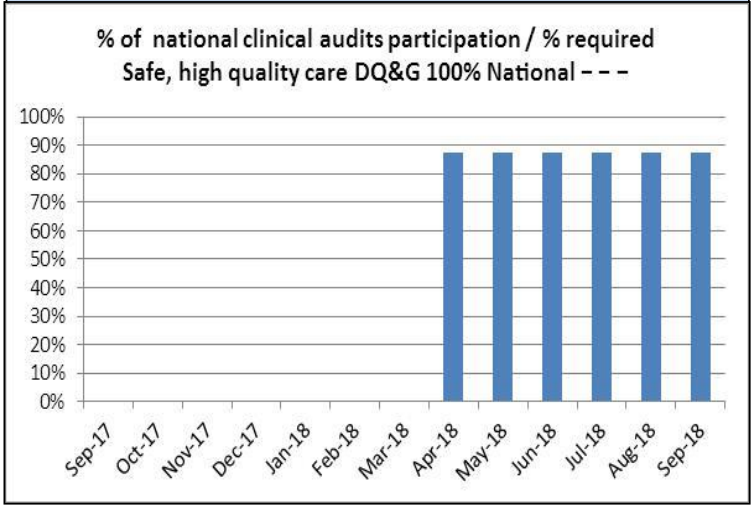


Issue: The Trusts YTD compliance of completion of nice guidance and gap analysis is 74%, which is below a target of 95%

Decision: Current performance Inadequate. Strengthen controls.

Action:
Focused area of work on nice compliance within Quality and Safety commencing October. A Deep dive is to be commenced to establish and improve compliance of NICE.

% of national clinical audits participation / % required (Director of Quality Governance)

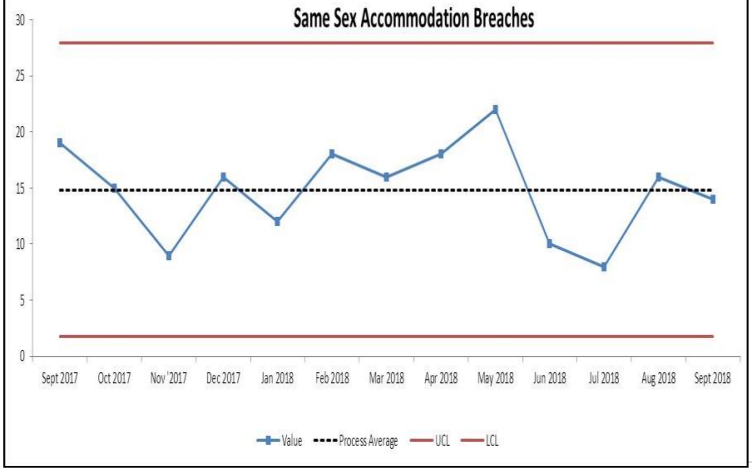


Issue: The trusts has completed 87.5% of national clinical recommended audits which is below the target of 100%

Decision: Current performance Inadequate. Strengthen controls.

Action:
Focused area of work in Quality and Safety and deep dive has commenced Mid October in order to establish and improve compliance.
Clinical audits with priority 1 and 2 to be focused upon.

Single sex accommodation breaches (Director of Nursing & Midwifery)

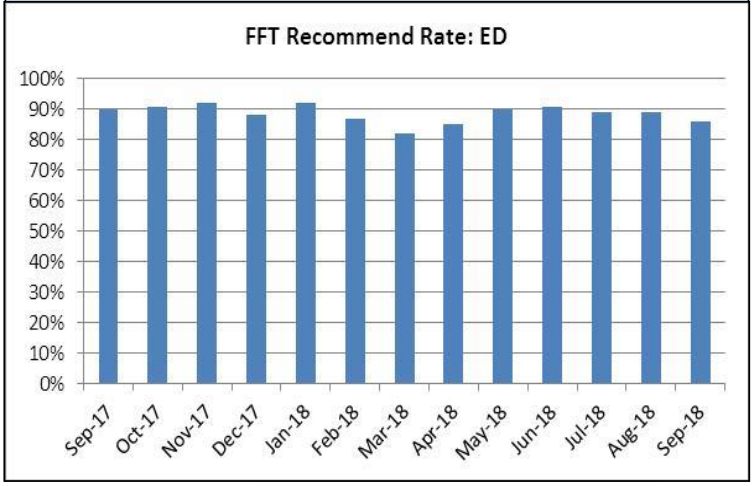


Issue: The trust has a target of zero tolerance for mixed sex accommodation breaches. The 2018/19 YTD performance is 88 incidents where patients have been treated in mixed ward accommodation. (critical care)

Decision: Current performance Inadequate. Strengthen controls.

Action: This will be captured in patient flow improvement group and associated work streams and monitored through this Dashboard.

FFT Recommend Rate: ED (Director of Nursing & Midwifery)

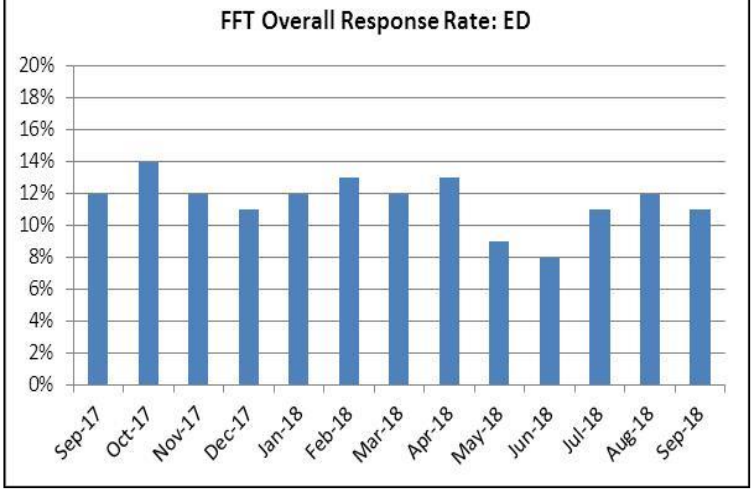


Issue: The trust has a response rate target of 95% for ED FFT recommendation. The 2018/19 YTD performance is 88%

Decision: Current performance Inadequate. Strengthen controls.

Action: Access to Envoy and SMS texting, electronic board to display Touch screen in departments. Focus on Children's ED, volunteers utilised to increase returns

FFT Overall Response Rate: ED (Director of Nursing & Midwifery)

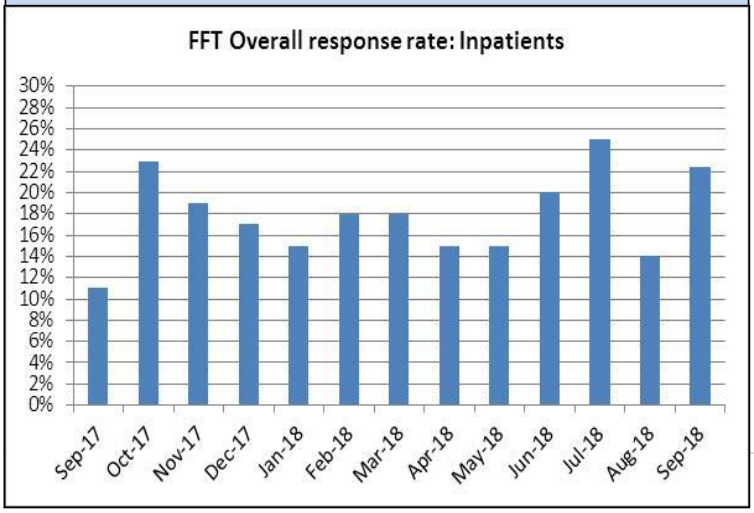


Issue: The trust has a response rate target of 25% for overall FFT patient response rate in ED. The 2018/19 YTD performance is 11%

Decision: Current performance Inadequate. Strengthen controls.

Action: Access to Envoy and SMS texting, electronic board to display Touch screen in departments. Focus on Children's ED, volunteers utilised to increase returns

FFT Overall response rate: Inpatients (Director of Nursing & Midwifery)

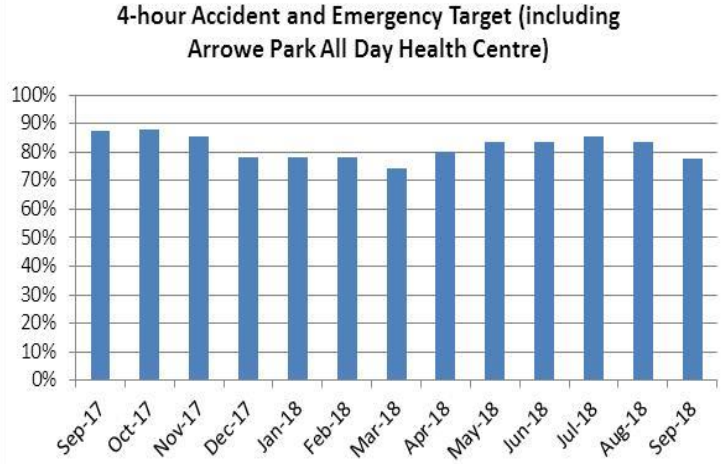


Issue: The trust has a response rate target of 25% for overall FFT response rate for inpatients. The 2018/19 YTD performance is 19%

Decision: Current performance Inadequate - Strengthen controls

Action: Access to Envoy and SMS texting, electronic board to display Touch screen in departments

4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre) (Chief Operating Officer)

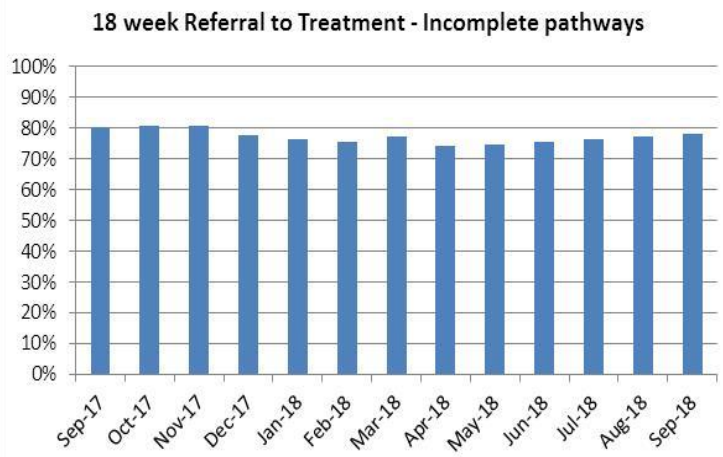


Issue: The trust has a compliance target of 95% for 4-hour Accident and Emergency target by March 2019. The 2018/19 YTD performance is 82.4%.

Decision: Current performance Inadequate - Strengthen controls and prioritise service elements.

Action: A revision to the GP streaming model is under discussion with economy partners and a new model for medically optmised patients will be implemented in November. Workstreams are overseen by the patient flow improvement group and associated work streams and monitored through this Dashboard

18 week Referral to Treatment - Incomplete pathways (Chief Operating Officer)

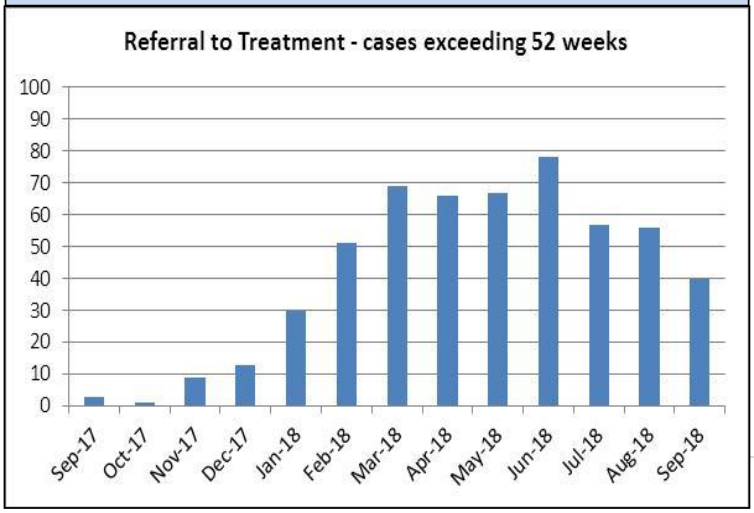


Issue: The trust has a locally agreed target of 80% for completed 18 week treatment pathway. The 2018/19 YTD performance is 76.1%.

Decision: Current performance Inadequate - Strengthen controls

Action: There are programmes of improvement for both theatres and outpatients. A key component of the programmes is active management of the PTL to reduce 18 week waiting maximum waiting times as well as improved utilisation rates.

Referral to Treatment - cases exceeding 52 weeks (Chief Operating Officer)

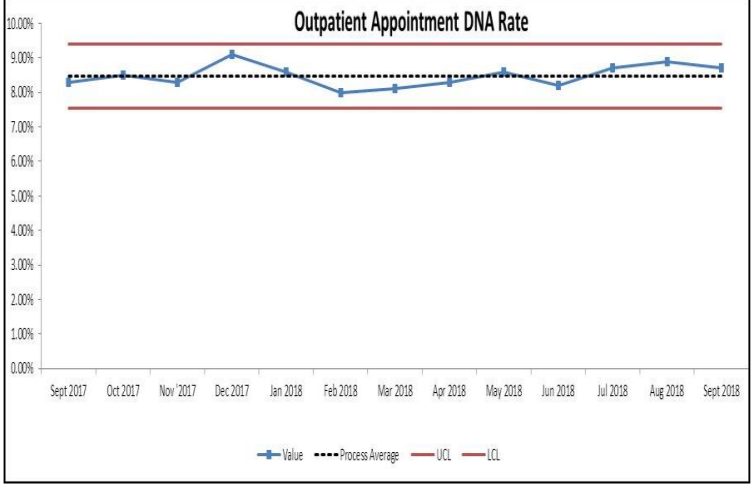


Issue: The trust has a target of 0 case of referral to treatment where patients wait over 52 weeks by March 2019. The latest position is 3 patients above that trajectory.

Decision: Current performance Inadequate - Strengthen controls

Action: The improvement programme feature a strong dailt focus on the managemet of the maximum wait times. Any breach of the 52 week standard is subject to a clinical harm review.

Did Not Attend - Outpatient Appointments (Chief Operating Officer)

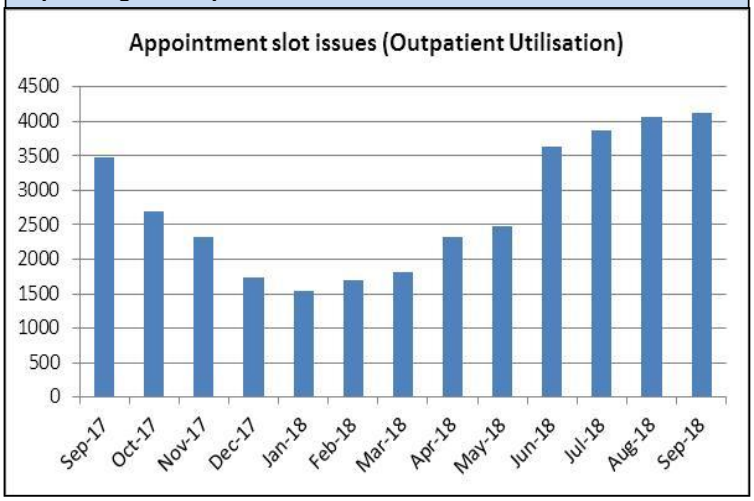


Issue: The trust has a target rate of no more than 6.5% for patient DNA. The 2018/19 YTD performance is 8.6%

Decision: Current performance Inadequate - Strengthen controls

Action: The trust is implementing an outpatient improvement programmer designed to improve both clinic utilisation and patient communication and experience.

Appointment slot issues (Outpatient Utilisation) (Chief Operating Officer)

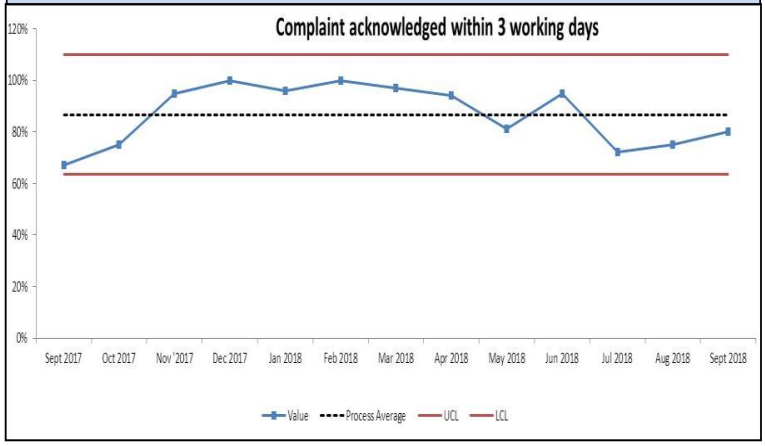


Issue: The Appointment slot issues is YTD 3418 which is significantly above the threshold of 0

Decision: Current performance Inadequate - Strengthen controls

Action: The trust have implemented an outpatient improvement programmer designed to improve clinic utilisation and lower maximum waiting times

Complaint acknowledged within 3 working days (Director of Nursing & Midwifery)

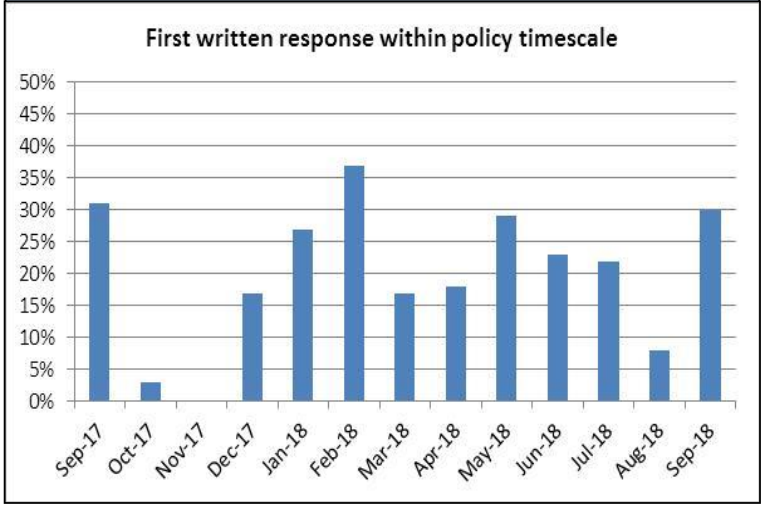


Issue: The trust has a target of 100%for complaints acknowledged within 3 working days. The 2018/19 YTD performance is 82.8%

Decision: Current performance Inadequate - Strengthen controls

Action: The trust has appointed new complaints team leadership and increased staff resourcing/number of staff.

First written response within policy timescale (Director of Nursing & Midwifery)

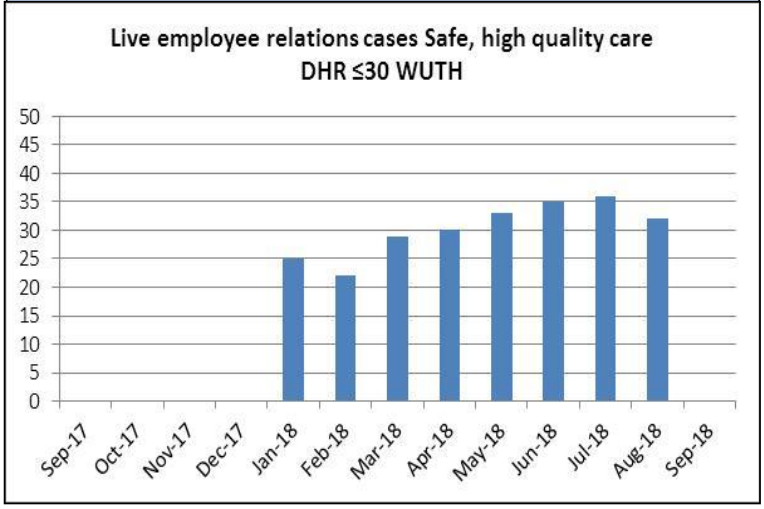


Issue: The trust has a target of 100%for first written response. The 2018/19 YTD performance is 21%.

Decision: Current performance Inadequate - Strengthen controls

Action: The trust has appointed new complaints team leadership and increased staff resourcing/number of staff.

Live employee relations cases (Director Human Resources)



Issue: The trust has a target of 30 or less live employee relation cases per month. The 2018/19 YTD performance is 33 and compliance rates have increased significantly since March 2018

Decision: Current performance Inadequate - Strengthen controls

Action: Implement the OD Plan that is focused on, Leadership, Values & Behaviours, engagement and valuing our Workforce.

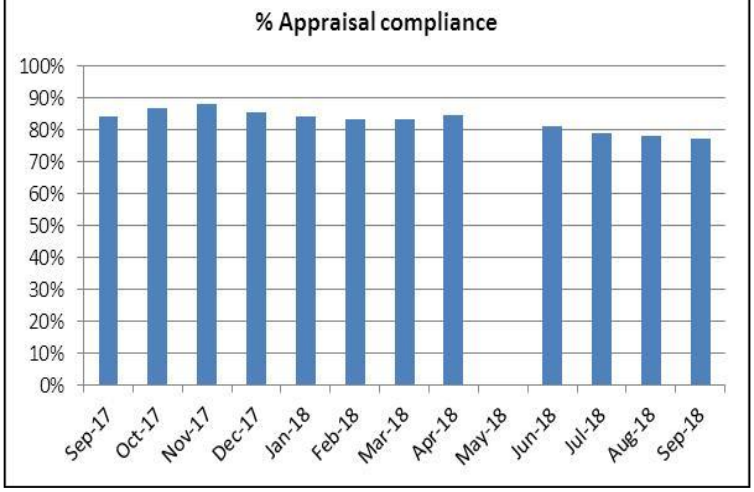
% Mandatory Training compliance (Director Human Resources)

Issue: The trust has a target of 95% for mandatory training compliance. The 2018/19 YTD performance is 81.4%. The compliance rates have increased significantly since March 2018

Decision: Current performance Inadequate - Strengthen controls

Action:
Compliance reduced earlier this year whilst a review was undertaken. Reduced from 21 pieces of mandatory training to 11. We have worked with departments and lead trainers to shape how best to deliver the required training. Most of the mandatory training is on e-packages. We are also finalising a review of essential training as the review of mandatory has had an impact on this.

% Appraisal compliance (Director Human Resources)



Issue: The Trust has a target of 88% for appraisal compliance. The 2018/19 YTD performance is 77.5%

Decision: Current performance is inadequate – strengthen controls

Action: Streamlining appraisal process to focus on quality of appraisal and clear and simplified guidance. Continued support for divisions rather than documentation

Board of Directors	
Agenda Item	8.1.3
Title of Report	**Month 6 Finance Report**
Date of Meeting	1st November 2018
Authors	Shahida Mohammed – Assistant Director of Finance Julie Clarke – Assistant Director of Finance Deborah Harman – 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 6 Finance Report 2018/19

Contents

The Trust did not accept the Control Total issued by NHSI for 2018/19 of a surplus of £11.0m; it is hence unable to access the Provider Sustainability Fund (PSF) 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 September (Month 6) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£18.1m) against a plan of (£16.3m).

The main areas driving the position is the under performance in elective and daycase activity, which is 2,001 spells (7.7%) behind plan, with a corresponding financial impact of (c£3.2m), and Outpatients attendances and procedures which are showing an adverse variance of 3,230 (2.2%), and a financial consequence of (£0.6m). Although non-elective activity is 239 spells (1.0%) ahead of plan, the run-rate has reduced in month and from a financial perspective a reduction in the complexity of the case mix against plan has offset the benefit.
Other activity areas from a financial perspective are broadly in-line with plan.
Included within this position is c£0.3m benefit from the MSK Prime Provider contract, and following the conclusion with Wirral CCG of the disputed coding of Sepsis activity, during 17/18, the accrual held of £0.8m has been released.

In addition the pay reform funding of £2.0m for Mths 1-6, is showing a benefit in income with the contra entry in pay costs. The £0.1m AFC pay reform additional scale factor funding is in the forecast position.

The overall expenditure position is higher than plan by (£3.1m). However pay includes c(£2.2m) that relates to the AFC pay award as discussed above and is largely offset in income. Non pay includes (£1.5m) associated with the MSK contracts which were not included within the original plan and again is offset in income. The underlying expenditure position is therefore (£0.6m) worse than plan
The underlying pay position continues to underspend largely due to non-clinical vacancies which are delivering non-recurrent CIP. High levels of qualified nurse vacancies continue and consequently result in a high use of bank nurses. The agency spend is largely to cover medical gaps and remains under scrutiny but is still c£0.1m below the NHSI cap. Non pay is showing a financial pressure overall with outsourcing costs to deliver the patient waiting times remaining high in a number of surgical specialties (Orthopaedics, pain and ENT).

The underlying in-month position prior to the release of the sepsis accrual is (£1.1m) worse than plan. The key driver of the variance is the under-performance of income with elective (£0.4m) worse, non-elective (£0.5m) worse and critical care/neonatal £0.2m worse. The under-performance on non-elective was unexpected and reflected lower levels of activity and complexity in month.

The delivery of cost improvements is £0.9m above plan as at the end of M6 and the forecast for the year is £9.7m, an improvement of £0.4m since last month. There remains a (£1.3m) gap still unidentified but work is on-going to crystallise further opportunities to close this gap. Of the £3.7m delivered to date £1.6m is non-recurrent where vacancies have mitigated the delivery of recurrent CIP. The plan for the delivery of cost efficiencies has been largely profiled to be achieved during the latter part of the year (c74%). The recurrent CIP for 2019/20 is £8.9m at M6 but further opportunities including the outpatient productivity programme are progressing.

The overall position includes £1.9m of non recurrent balance sheet support.

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 impact on flow. Plans for winter capacity have been developed but will result in a further financial pressure if funding it not identified from the Wirral system.

Cash balances at the end of September were £6.6m, exceeding plan by £4.5m. This is primarily due to positive working capital movements and capital outflows below plan offset by EBITDA below plan.

The capital programme shows a year-to-date spend of £1.9m against a total programme value of £10.9m. The current forecast is that the programme will be fully delivered, with £6.6m of schemes fully committed as at month 6. Work is progressing with ensuring commitments are made against the remaining schemes in a timely way to ensure spend is delivered in year. Contingency schemes are being identified to mitigate against any slippage identified at the end of Q2. The capital programme is managed closely in the Finance & Performance Group.

The Trust's most likely forecast is a deficit of (£30.50m) against the planned deficit of (£25.0m); this includes the current recovery plan in place to manage the elective programme. Unless, a further recovery plan can be agreed there will be a need to gain formal agreement of the increased deficit in line with the NHSI protocol. This is outlined in detail in Section 5.

2. Financial performance

2.1 Income and expenditure

Month 6 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
Income from patient care activity	307,162	25,723	26,058	335	152,231	151,145	(1,085)
DOH - Pay Reform Income	0	0	329	329	0	1,974	1,974
Income - PSF	0	0	0	0	0	0	0
Other income	29,428	2,428	2,439	11	14,590	14,853	263
Total operating income	336,589	28,151	28,826	675	166,821	167,972	1,151
Employee expenses	(247,732)	(20,694)	(20,850)	(156)	(124,324)	(125,281)	(957)
Operating expenses	(101,875)	(8,454)	(9,327)	(873)	(52,919)	(55,050)	(2,131)
Total operating expenditure	(349,607)	(29,148)	(30,177)	(1,029)	(177,243)	(180,330)	(3,088)
EBITDA	(13,018)	(997)	(1,351)	(354)	(10,422)	(12,358)	(1,936)
Depreciation and net impairment	(8,160)	(674)	(676)	(1)	(4,029)	(4,033)	(4)
Capital donations / grants income	0	0	16	16	0	90	90
Operating surplus / (deficit)	(21,178)	(1,672)	(2,011)	(339)	(14,451)	(16,302)	(1,850)
Net finance costs	(4,105)	(343)	(322)	20	(1,945)	(1,854)	92
Gains / (losses) on disposal	0	0	0	0	0	0	0
Actual surplus / (deficit)	(25,282)	(2,015)	(2,333)	(319)	(16,397)	(18,155)	(1,759)
Reverse capital donations / grants I&E impact	243	20	5	(15)	121	33	(88)
Reverse net impairments other than DEL impairments	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	(25,039)	(1,995)	(2,328)	(334)	(16,275)	(18,122)	(1,846)

- In Mth 6 there has been a further (£0.3m) deterioration in the position with a year to date deficit of c(£1.8m).
- The main driver of this position is the continued underperformance of the elective programme which is (£0.5m) below plan in M6 and (£3.2m) ytd. This is behind the expected elective recovery trajectory.
- The overall income position includes the AFC pay reform funding of £2.0m with a further £0.1m forecast for the additional scaling factor allocation. The forecast position includes the net £0.3m AFC pay reform pressure.
- Total expenditure is (£3.1m) worse than plan; (£2.2m) relates to the AFC pay award and a further (£1.5m) is the sub-contracting costs of the MSK contract hence the underlying expenditure position is £0.6m better. Pay underspends are due to non- clinical vacancies which are mitigating recurrent CIP delivery whilst outsourcing costs remain high.
- It has to be noted the overall year to date position also includes £1.9m non-recurrent balance sheet support.

2. Financial performance

2.2 Income

Activity

	Activity							
	Current month				Year to date			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%
Income from patient care activity								
Elective	720	609	(111)	(15.37%)	4,254	3,476	(778)	(18.29%)
Daycase	3,562	3,313	(249)	(6.98%)	21,569	20,346	(1,223)	(5.67%)
Elective excess bed days	340	220	(120)	(35.38%)	2,098	1,157	(941)	(44.85%)
Non-elective	4,312	4,042	(270)	(6.26%)	24,875	25,114	239	0.96%
Non-elective excess bed days	799	1,013	214	26.82%	4,721	5,027	306	6.49%
A&E	7,616	7,624	8	0.11%	46,457	46,467	10	0.02%
Outpatients	24,727	23,740	(987)	(3.99%)	148,544	145,314	(3,230)	(2.17%)
Diagnostic imaging	2,428	2,544	116	4.78%	14,662	14,364	(298)	(2.03%)
Maternity	521	513	(8)	(1.46%)	3,176	2,921	(255)	(8.02%)
Total NHS patient care income	45,023	43,618	(1,406)		270,356	264,186	(6,170)	

- The main specialities driving the under performances in elective and daycase activity are Colorectal, Ophthalmology, Urology and Trauma and Orthopaedic surgery. “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.
- Demand for emergency care during September was below plan levels and reduced the cumulative over performance; the main areas under performing are Geriatric Medicine, Diabetes and A&E.
- 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, Gastro, Colorectal and Trauma and Orthopaedics.

2. Financial performance

Income

	Income							
	Current month				Year to date			
	Plan £'000	Actual £'000	Variance £'000	%	Plan £'000	Actual £'000	Variance £'000	%
Income from patient care activity								
Elective	2,326	2,115	(211)	(9.06%)	13,572	11,482	(2,090)	(15.40%)
Daycase	2,339	2,110	(230)	(9.82%)	14,000	12,919	(1,081)	(7.72%)
Elective excess bed days	82	52	(30)	(36.20%)	505	285	(221)	(43.67%)
Non-elective	8,377	7,921	(457)	(5.45%)	49,312	49,051	(261)	(0.53%)
Non-elective excess bed days	197	248	51	26.02%	1,161	1,240	79	6.80%
A&E	1,064	1,114	51	4.75%	6,490	6,669	179	2.76%
Outpatients	2,812	2,669	(143)	(5.10%)	16,879	16,258	(621)	(3.68%)
Diagnostic imaging	195	201	5	2.77%	1,166	1,073	(92)	(7.91%)
Maternity	443	440	(3)	(0.73%)	2,704	2,545	(159)	(5.89%)
Non PbR	5,875	5,850	(25)	(0.43%)	34,366	34,258	(108)	(0.32%)
HCD	1,284	1,501	216	16.82%	7,707	7,613	(94)	(1.22%)
CQUINs	563	470	(93)	(16.56%)	3,376	3,242	(134)	(3.97%)
Other	0	1,214	1,214	0.00%	0	3,389	3,389	0.00%
Total income from patient care (SLAM)	25,559	25,904	345	1.35%	151,239	150,025	(1,214)	(0.80%)

- Of the year to date under recovery in NHS income c(£1.2m), the main driver is the elective and daycases, which is showing a deficit of (£3.4m), reflecting both activity and casemix reductions. The recovery plan is being closely managed, although it is unlikely the under performance in the earlier part of the year will be recovered.
- The position also reflects the commencement of the MSK "prime provider" contract from July 2018, as this is a "block" contract. This has supported the overall position by c£0.3m year to date.
- Other PbR areas are not significantly behind plan, with the exception of outpatients, this under recovery is predominantly in outpatient first attendances and procedures. Neonatal activity is also behind plan by c(£0.6m) given the unpredictable nature of this activity and the reliance on the Neonatal network for a large proportion of this work, it is difficult to predict the recovery of this. There is an expectation that the position to recover.
- Included in the position is the successful conclusion with Wirral CCG of the disputed coding of Sepsis activity, during 17/18. This supported the position by c£1.3m in total, this is recorded in the "Other" category in the above table. In addition income related to the MSK prime provider contract of £2.1m was not included in the original plan, this is also recorded in "Other" category.

2. Financial performance

2.3 Expenditure

The 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	(225,643)	(18,892)	(18,830)	62	(113,331)	(113,452)	(120)
Bank	(6,662)	(542)	(750)	(207)	(3,332)	(4,113)	(781)
Medical Bank	(7,057)	(588)	(615)	(27)	(3,528)	(3,602)	(73)
Agency	(7,469)	(597)	(571)	26	(3,682)	(3,658)	25
Other - Apprenticeship levy	(900)	(75)	(84)	(9)	(450)	(457)	(7)
Total	(247,732)	(20,694)	(20,850)	(156)	(124,324)	(125,281)	(957)

- The pay position in M6 is showing a net overspend of (£0.2m) and YTD is (£1.0m) worse than plan however the plan excluded the AFC pay reform funding of c£(2.0m) year to date which is offset in income. The underlying pay position (i.e. adjusted for pay award funding) is c£1m underspent ytd.
- The underlying pay position shows substantive vacancies offset with the higher use of bank than plan and agency largely in line with plan.
- The bank figure is above plan and is largely due to supporting the substantive nursing vacancies and acuity particularly in the Medicine division. There remains substantial nursing vacancies across the Trust that bank are being used to cover gaps. Workforce plans and recruitment initiatives are continually under review.
- The agency figure is £0.6m this month and is in-line with the NHSI ceiling of £3.7m.
- Vacancies in Clinical Support and Corporate continue and non-recurrently they are supporting delivery of the CIP target.
- Pay CIP delivery is £0.8m higher than plan however to note £0.6m is non-recurrent. The planned CIP was heavily weighted to non-pay.

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
Purchase of Healthcare	(3,184)	(313)	(1,124)	(811)	(1,855)	(4,450)	(2,595)
Supplies and services - clinical	(35,475)	(2,913)	(2,972)	(59)	(17,976)	(17,292)	685
Drugs	(25,395)	(2,109)	(2,155)	(47)	(12,742)	(12,572)	170
Other	(45,982)	(3,794)	(3,752)	42	(24,374)	(24,769)	(394)
Total	(110,035)	(9,129)	(10,003)	(874)	(56,948)	(59,083)	(2,134)

- Non pay expenditure is (£0.9m) overspent in M6 and YTD is (£2.1m) above plan but the plan excludes the MSK contract costs of £1.5m year to date which are offset in income. The underlying non-pay position (adjusted for MSK) is c(£0.6m) overspent ytd.
- Clinical supplies reflect the low levels of elective activity in earlier months and the associated prostheses/clinical supplies underspend.
- Drug costs are below plan YTD largely due to high cost drugs that is offset as a variance in clinical income.
- The position includes outsourcing costs to Spire in relation to gaps in elective capacity earlier in the year of c£1.3m for a number surgical specialties (Orthopaedics, Pain and ENT) with further radiology spend of £0.7m and the MSK contract of £1.5m.
- CIP delivery against the original plan is (£0.8m) lower and is offset in pay. The original plan was heavily weighted to non pay as the £4m unidentified gap at the time of submitting the plan was allocated to non pay. Again similar to pay £0.3m of the ytd position is non-recurrent. The unidentified gap of £1.3m remains as non-recurrent in the forecast until schemes are identified.
- In Q1 £0.3m supported the non pay position non-recurrently.

2. Financial performance

2.4 CIP by programme and division

Programme	Director	YTD			In Year Forecast						Recurrent Savings					
		NHSI Plan £k	Actual £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	Pipeline £k	Total £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	Pipeline £k	Total £k	Variance £k
Transformation																
Improving Patient Flow	Anthony Middleton	0	677	**677**	1,000	1,337	**337**	0	1,337	**337**	1,000	1,200	**200**	0	1,200	**200**
Improving Productivity	Anthony Middleton	189	301	**112**	478	705	**227**	153	858	**380**	478	402	**(76)**	411	813	**335**
Collaboration	Janelle Holmes	175	175	**0**	952	452	**(500)**	442	893	**(58)**	952	948	**(4)**	450	1,398	**446**
Digital Wirral	Paul Charnley	500	613	**113**	1,000	1,143	**143**	117	1,260	**260**	1,000	1,000	**0**	0	1,000	**0**
Sub total - transformation		**864**	**1,766**	**902**	**3,430**	**3,637**	**208**	**711**	**4,348**	**919**	**3,430**	**3,550**	**120**	**861**	**4,411**	**982**
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	67	144	**77**	134	242	**107**	53	294	**160**	134	19	**(115)**	30	49	**(85)**
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	206	131	**(75)**	500	183	**(317)**	318	500	**0**	500	183	**(317)**	149	331	**(169)**
Procurement and Non Pay	Jane Christopher	411	172	**(238)**	1,150	271	**(879)**	879	1,150	**(0)**	1,150	301	**(849)**	954	1,256	**106**
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	712	1,513	**801**	1,936	2,835	**899**	587	3,422	**1,486**	1,936	2,337	**401**	524	2,860	**925**
Unidentified		566	0	**(566)**	3,850	0	**(3,850)**	0	0	**(3,850)**	3,850	0	**(3,850)**	0	0	**(3,850)**
Total		**2,826**	**3,727**	**901**	**11,000**	**7,167**	**(3,833)**	**2,547**	**9,714**	**(1,286)**	**11,000**	**6,390**	**(4,610)**	**2,518**	**8,908**	**(2,092)**

- YTD CIP performance is £0.9m ahead of the NHSI plan as at the end of M6 but the profile has been low and significantly increases in Q3 and Q4.
- For the full year the Trust is currently forecasting £7.2m of fully developed schemes with a further £2.5m of plans in progress and opportunities and £1.3m remains unidentified at this stage. There are further opportunities to improve as the outpatient productivity work stream is validated. However there are significant risks associated with the £1m identified as red and progressing the amber schemes to delivery.
- In addition non –recurrent CIP of £1.6m of the £3.7m delivered to M6 is largely due to vacancies mitigating the CIP delivery as schemes come online. The gap of £1.3m remains in the NHSI forecast as non-recurrent in non-pay. The non-recurrent in-year CIP is partly mitigated by full year impact of schemes but recurrent CIP remains £0.9m lower for the 2019/20 baseline.

3. Financial position

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 30.09.18 £'000	Actual as at 30.09.18 £'000	Variance (to plan) £'000	Forecast 31.03.19 £'000	Plan 31.03.19 £'000
	Non-current assets						
159,754	Property, plant and equipment	⇩	158,643	158,487	(156)	165,846	160,148
12,763	Intangibles	⇩	11,844	11,893	49	11,388	12,369
903	Trade and other non-current receivables	⇩	903	835	(68)	834	903
173,420		⇩	**171,390**	**171,215**	**(175)**	**178,068**	**173,420**
	Current assets						
4,171	Inventories	⇧	4,171	4,147	(24)	4,147	4,171
18,423	Trade and other receivables	⇧	19,879	18,819	(1,060)	18,468	18,424
0	Assets held for sale	⇨	0	0	0	0	0
7,950	Cash and cash equivalents	⇧	2,066	6,581	4,515	2,117	1,773
30,544		⇧	**26,116**	**29,547**	**3,431**	**24,732**	**24,368**
203,964	**Total assets**	⇧	**197,506**	**200,762**	**3,256**	**202,801**	**197,788**
	Current liabilities						
(32,538)	Trade and other payables	⇧	(28,039)	(31,789)	(3,750)	(36,586)	(27,752)
(3,224)	Other liabilities	⇩	(3,224)	(4,493)	(1,269)	(3,224)	(3,224)
(1,074)	Borrowings	⇩	(1,074)	(1,076)	(2)	(1,076)	(1,076)
(548)	Provisions	⇨	(548)	(548)	0	(548)	(548)
(37,384)		⇩	**(32,885)**	**(37,906)**	**(5,021)**	**(41,434)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	⇧	**(6,769)**	**(8,359)**	**(1,590)**	**(16,702)**	**(8,240)**
166,580	**Total assets less current liabilities**	⇧	**164,621**	**162,856**	**(1,765)**	**161,367**	**165,180**
	Non-current liabilities						
(8,812)	Other liabilities	⇧	(8,641)	(8,642)	(1)	(8,471)	(8,470)
(49,258)	Borrowings	⇩	(63,955)	(63,956)	(1)	(73,224)	(73,221)
(2,318)	Provisions	⇧	(2,232)	(2,221)	11	(2,117)	(2,131)
(60,388)		⇩	**(74,828)**	**(74,819)**	**9**	**(83,812)**	**(83,826)**
106,192	**Total assets employed**	⇩	**89,793**	**88,037**	**(1,756)**	**77,555**	**81,366**
	Financed by Taxpayers' equity						
77,575	Public dividend capital	⇨	77,575	77,575	0	80,031	78,031
(12,259)	Income and expenditure reserve	⇩	(28,658)	(30,414)	(1,756)	(43,352)	(37,541)
40,876	Revaluation reserve	⇨	40,876	40,876	0	40,876	40,876
106,192	**Total taxpayers' equity**	⇩	**89,793**	**88,037**	**(1,756)**	**77,555**	**81,366**

Capital asset variances	£m
Capex underspend	-0.2
Donations above plan	0.1
Total variance of capital assets to plan	**-0.1**

Cash variances	£m
EBITDA and donation income below plan	-1.9
Working capital movements	5.9
Capital expenditure (cash basis) below plan	0.3
Other minor variances above plan	0.2
Total variance of cash to plan	**4.5**

3. Financial position

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				4,033
Loan repayment	(1,015)	(1,015)	(1,015)	0				(508)
Finance lease	(60)	(60)	(60)	0				(31)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	110	107	3				90
Public Dividend Capital (PDC)	456	456	456	0				0
Total funding	**10,791**	**10,901**	**10,898**	**3**				**6,834**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		682	682	0	682	46	636	46
Divisional priorities - *Surgery*		208	284	(76)	284	220	64	167
Divisional priorities - *Women and Children's*		268	273	(5)	273	183	90	67
Divisional priorities - *Clinical Support and Diagnostics*		826	821	5	821	109	712	25
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,518	1,518	0	1,518	1,518	0	0
Divisional priorities - contingency [3]	500	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Informatics - *Digital Wirral / Global Digital Exemplar*	2,811	2,801	2,801	0	2,801	2,801	0	262
Informatics	500	500	509	(9)	509	509	0	282
Estates - backlog maintenance	1,500	2,561	2,561	0	2,561	709	1,852	570
All other expenditures		448	452	(4)	452	452	0	387
Contingency [3]	1,180	979	890	89	890	0	890	n/a
Reallocated funding	3,250	n/a	n/a	n/a	n/a	n/a	n/a	n/a
NHSI plan subtotal	**10,791**							
Donated assets	0	110	107	3	107	92	15	90
Total expenditure (accruals basis)	**10,791**	**10,901**	**10,898**	**3**	**10,898**	**6,639**	**4,259**	**1,896**

[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. Financial position

3.3 Statement of Cash Flow

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening cash	**6,190**	**2,007**	**4,183**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(2,333)	(2,016)	(317)	(18,155)	(16,398)	(1,757)	(31,093)	(25,282)
Net interest accrued	131	150	(19)	706	785	(79)	1,620	1,806
PDC dividend expense	191	191	0	1,146	1,146	0	2,292	2,292
Unwinding of discount	0	3	(3)	1	18	(17)	3	6
Operating surplus / (deficit)	(2,011)	(1,672)	(339)	(16,302)	(14,449)	(1,853)	(27,178)	(21,178)
Depreciation and amortisation	676	674	2	4,033	4,029	4	8,163	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(16)	0	(16)	(90)	0	(90)	(90)	0
Changes in working capital	545	(293)	838	4,230	(1,710)	5,940	2,840	(996)
Investing activities								
Interest received	14	3	11	55	18	37	111	48
Purchase of non-current (capital) assets [1]	(714)	(332)	(382)	(6,146)	(6,457)	311	(12,261)	(12,444)
Financing activities								
Public dividend capital received	0	0	0	0	0	0	2,456	456
Loan funding [2]	3,692	3,692	0	14,728	14,728	0	24,027	24,027
Interest paid	(600)	(818)	218	(688)	(818)	130	(1,586)	(1,845)
PDC dividend paid	(1,189)	(1,189)	0	(1,189)	(1,189)	0	(2,335)	(2,335)
Finance lease rental payments	(6)	(6)	0	(36)	(36)	0	(70)	(70)
Total net cash inflow / (outflow)	**391**	**59**	**332**	**(1,369)**	**(5,884)**	**4,515**	**(5,833)**	**(6,177)**
Closing cash	**6,581**	**2,066**	**4,515**	**6,581**	**2,066**	**4,515**	**2,117**	**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.

4. Use of Resources

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%	-11.3	3	-12.7	3	-12.9	3
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-4.1	4	-5.0	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-9.8%	4	-10.8%	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	-1.0%	2	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-1.6%	1	-2.3%	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. Later in the year, this rating may prevent the overall UoR rating from dropping to 4 — which would place the Trust in the highest risk category with NHSI. It is therefore vital that this is maintained at 1 throughout 2018/19. This rating will increase to 2 if the Trust breaches the cap. For the year to date, the Trust is £86k away from scoring 2.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 6 UoR rating is 3 overall, which is in line with the 2018/19 plan UoR rating of 3.
- Forecast UoR rating is 3.

5. Forecast

Based on the year to date position the forecast outturn using the "run rate" would deliver a year end deficit of (£40.0m).

The forecast scenarios are detailed in the table below and reflect the range of deliverables from the "best case" (£25m) to a forecast deficit of (£30.5m) "most likely" and "worst case" of (£34.6m).

		Best FOT £,000	Likely FOT £,000	Worst FOT £,000
Annual Plan (excluding PSF) full year		**(25,042)**	**(25,042)**	**(25,042)**
YTD Actual (CT excluding PSF)		**(18,122)**	**(18,122)**	**(18,122)**
Run rate		(3,020)	(3,020)	(3,020)
Non Recurrent support		(317)	(317)	(317)
		(3,337)	**(3,337)**	**(3,337)**
YTD run rate extrapolated for 18/19 full year		**(40,048)**	**(40,048)**	**(40,048)**
Gross Income Risks				
CQUIN	Red	-	(135)	(873)
Readmissions	Amber		(500)	(500)
Other Penalties	Amber			(100)
Income Upsides / Recovery Actions				
Income recovery plan EL/DC	Red	3,643	3,168	2,534
NEL Winter Profiling Adjustment	Amber	5,000	4,700	3,500
Winter Funding (External)	Red	1,000		
Sepsis	Green	100		
Neo Natal	Amber	300	200	175
MSK Contract	Green	1,000	1,500	1,500
AFC Funding	Green	119	119	119
CIP Delivery				
Green schemes & Blue Schemes	Green			
Amber schemes	Amber	1,292	1,292	1,292
Red schemes	Red	967	967	254
Unidentified - gap	Red	1,287	287	
Expenditure Risks / Commitments				
Step Down Ward	Red	(1,000)	(1,000)	(1,000)
Additional Winter Beds			(200)	(300)
EL/DC Activity increase - Clinical Supplies	Red	(344)	(317)	(253)
Seasonal Spend e.g energy		(400)	(600)	(600)
MSK Contract	Green	(1,000)	(1,500)	(1,500)
Expenditure Upsides				
Elective Outsourcing	Amber	400	200	-
Activity Reserve	Amber	858	858	600
RTT Delivery Reserve	Amber	531	531	650
Balance Sheet Support	Red	1,253	-	-
Overall FOT		**(25,042)**	**(30,477)**	**(34,550)**

5. Forecast

The main driver of the (£30.5m) forecast deficit is lower CIP (£1m), lower elective activity (£0.5m), no external "winter pressures" funding (£1m), no balance sheet support of (£1.3m), CCG imposing CQUIN and readmission penalties (£0.6m), and other pressures amounting to some (£1.1m).

"Worst" case increases the forecast deficit to (£34.6m)

- deteriorations in CIP of (£2m),
- lower elective recovery of only (£0.7m),
- loss of CQUIN income of (£0.9m),
- Lower non-elective income

In line with guidance issued by NHSI the Trust will need to follow a set protocol in order to vary any financial outturn position and the variations can only be completed at the end of Q2 and Q3 reporting. As part of the process the Trust will be required to:

- Explain and analyse the key drivers of the deterioration.
- Formally evidence the actions that have been undertaken to recover the financial position.
- Confirm that the Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.
- Confirm that the senior clinical decision making body with the Trust has been engaged with and are party to the identification and delivery of the recovery actions.

This recovery plan described must explicitly reference:

- Detail the additional measures which will immediately be implemented to improve financial control and working capital/cash management, including capital programme review. This will need to include all discretionary spend, agency/locum spend, supplies and consumable spend and delegated commitment range and levels.

  Details of how the Trust is reviewing:

- The affordability of planned investments to improve service quality and performance;
- The acceleration of the delivery of productivity opportunities identified by the Carter Review;
- The acceleration of proposals for sub-scale service consolidation or closure;
- The impact on patient safety and experience of recovery actions;
- Demonstration of quarter on quarter improvement in I&E run-rate from the point the revision is submitted and how CIP delivery is being maximised.

5. Forecast

"Most Likely" Forecast outturn (£30.5m)

The table below details by theme, the "known" risks and opportunities during the remainder of the year which would mitigate/manage the current position to achieve a revised deficit of (£30.5m).

- Elective recovery plan (including a benefit from the MSK block contract),
- Increase in non-elective activity as part of Winter profiling
- Benefits of the profiling of neo-natal activity
- Improvement in CIP delivery
- Release of RTT reserve.
- Offsetting these are the anticipated winter costs (step down ward) as part of the winter plan.

BOARD OF DIRECTORS	
Agenda Item	8.1.4
Title of Report	2019/20 Planning Guidance and Payment Reform
Date of Meeting	1st November 2018
Author	David Jago Director Of Finance
Accountable Executive(s)	David Jago Director of Finance Natalia Armes Director of Transformation and Partnerships
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	All
Level of Assurance **Positive** **Gap(s)**	N/A
Purpose of the Paper **Discussion** **Approval** **To Note**	To inform the Board of Directors on both planning guidance received and tariff reform proposals.
Reviewed by Assurance Committee	N/A
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1. Executive Summary

The Trust received tariff reform and planning guidance and proposals on the 9th and 16th October 2018 respectively. A local impact assessment of the tariff proposals is currently underway and the Board of Directors will receive an update on local impact at its end of November meeting. A consultation process is underway in respect of tariff reform and this will be fed back to NHSI in line with on line consultation deadline of the 29th October.

2. Key issues from guidance/proposals

A) 2019/20 Planning Guidance

The Government has announced a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24 - an annual real-term growth rate over five years of 3.4% aiming to support the ability for the NHS to develop credible long term plans. In return for this commitment, the Government has asked the NHS to develop a Long Term Plan which will be published in late November or early December 2018.
The ambition is for plans to;

- improve productivity and efficiency;
- eliminate provider deficits;
- reduce unwarranted variation in quality of care;
- incentivise systems to work together to redesign patient care;
- improve how we manage demand effectively; and
- make better use of capital investment.

During the first half of 2019-20 it is expected that all Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) will have developed and agreed their strategic plan for improving quality, achieving sustainable balance and delivering the Long Term Plan. The planning timetable will give NHS organisations sufficient time to consider the outputs of the NHS Long Term Plan in late autumn and the Spending Review 2019 capital settlement; and to engage with patients, the public and local stakeholders before finalising your strategic plans.

Individual organisations are expected to submit one-year operational plans for 2019/20, which will also be aggregated by STPs and accompanied by a local system operational plan narrative. Organisations, and their boards / governing bodies, will need to ensure that plans are stretching but deliverable and will need to collaborate with local partners to develop well-thought-out risk mitigation strategies. These will also create the year 1 baseline for the system strategic plans, helping forge a strong link between strategic and operational planning. It is expected that 5-year commissioner allocations will be published in December 2018, giving systems a high degree of financial certainty on which to plan.

From 1 April 2019, the current CQUIN scheme will be significantly reduced in value with an offsetting increase in core prices. It will also be simplified, focussing on a small number of indicators aligned to key policy objectives drawn from the emerging Long Term Plan.
Planning guidance, with confirmation of the detailed expectations, will follow in December 2018. In the meantime, commissioners and providers are expected to work together during the autumn on aligned, profiled demand and capacity planning.

A high level planning timetable is set out below;

Outline timetable for planning	**Date**
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning Publication of • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and disputeesolution guidance	Mid December 2018

- 2019/20 CQUIN guidance
- Control totals for 2019/20

2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019

Strategic planning

Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

B) Payment system reform proposals for 2019/20

Within the guidance received NHS Improvement want to develop payment approaches that:

• support a more effective approach to resource and capacity planning that focuses commissioners and providers on making the most effective and efficient use of resources to improve quality of care and health outcomes

• provide shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions by providing the right care in the right place at the right time – and shared financial responsibility for levels of hospital activity

• fairly reflect the costs incurred by efficient hospitals in providing care and provide incentives for continuous improvements in efficiency

• minimise transactional burdens and provide space to transform services.

Summary of Proposals

Duration of the tariff

NHSI are proposing to set the next national tariff for one year. They believe that the flexibility of a one-year tariff will be necessary to be able to respond effectively to developments taking place within the NHS, including the forthcoming release of the long-term plan for the NHS. Fixing a tariff for a longer period they believe would limit their ability to make changes to support necessary strategic developments.

Blended payment approach for emergency care

NHSI are proposing the introduction of a 'blended' payment approach for emergency care. This would comprise a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity.
The payment model would cover A&E attendances, non-elective admissions (excluding maternity and transfers) and, potentially, ambulatory emergency care. It is expected that it would serve as the new 'default' reimbursement model, but would not stand in the way of local systems continuing to move faster towards population-orientated payment models.

Under a blended payment approach:

- Prices would still be calculated at an HRG level and would be used as a basis for contract negotiation and for continued episodic payment where required, for example cross-border activity
- The marginal rate emergency tariff (MRET) and the 30-day readmission rule would be abolished as national rules, on a financially neutral basis between providers and commissioners
- Contracts would include a 'break glass' clause which applies when activity is significantly higher or lower than assumed and requires the emergency care payment elements of the contract to be reviewed and potentially renegotiated

The consultation guidance is seeking feedback on the construct of this blended approach and two options;

The first concerns the relationship between the fixed and variable elements of the blended payment model. For 2019/20, NHSI propose that the variable element be set at 20% of the HRG price, which broadly reflects current data on variable costs; over time, NHSI would seek to adjust the levels to more accurately reflect costing data. There is then a choice as to whether:

A: The fixed element of payment (based on locally agreed forecast levels of emergency activity) should correspond to 100% of costs (based on HRG prices), with additional payments (at 20% of the HRG price) for activity above this forecast level and deductions (at 20% of the HRG price) for activity below the forecast level. Local areas would be able to agree to make these additional payments on an alternative basis if that would better suit their local system.

B: The fixed element of payment should be a capacity payment corresponding to fixed and semi-fixed costs (for 2019/20, as a proxy, we would use 80% of expected revenue), with the variable element (20% of the HRG price) paid for all units of activity, not just activity in excess of plan.

Outpatient Attendances

NHSI believe that the way outpatient activity is funded could be improved. The aim is to design a payment mechanism for outpatients which maintains quality of care and:

• incentivises increased use of non-face-to-face (eg telemedicine) and non-consultant-led activity where clinically appropriate

• reduces incentives for unnecessary consultant-led face-to-face activity
• helps support lower unit cost of outpatient services
• helps providers meet the referral to treatment (RTT) standard by freeing up consultant time to deliver more first attendances.

The proposal is to create non-mandatory prices for non-face-to-face follow-ups for specialties with national prices. NHSI will also create non-mandatory prices for non-consultant-led first and follow-up attendances. The pricing structure would continue to front-load first attendance prices but it is proposed to change the level of front-loading for services that require regular ongoing follow-up appointments as part of good practice: ophthalmology (decrease from 30% to 20%), dermatology (decrease from 30% to 20%) and nephrology (decrease from 10% to 0%).

Market Forces Factor

The market forces factor (MFF) estimates the unavoidable cost differences between healthcare providers, based on their geographical location. Each NHS provider is assigned an individual MFF value. MFF values are used to adjust national prices and commissioner allocations. The MFF is an important part of the NTPS. However, it has not been updated for almost 10 years. The updated MFF values would mean a significant change in income and allocations for several providers and commissioners if implemented without a transition path. NHSI therefore propose implementing the changes over a number of years and are proposing a 4 year transition period.

The Trusts current MFF is 3.89% and this will be reduced to 2.92%.

Centralised Procurement

NHS Supply Chain is being reorganised and managed by a new organisation, Supply Chain Coordination Limited (SCCL). SCCL aims to increase NHS purchasing power and give providers access to lower procurement prices.
Currently, NHS Supply Chain is funded through a mark-up on the prices it offers.
It is proposed to top slice Trusts clinical income by 0.35%(For WUTH currently proposed £1.3m) to fund SCCL overheads.

Maternity Pathway

The maternity pathway payment involves national prices for the integrated package of care offered to all pregnant women and their new born babies. The pathway consists of three integrated packages of care covering the antenatal, birth and postnatal phases.

NHSI propose making all maternity prices non-mandatory and additionally
We also propose increasing the number of payment levels for delivery from two (with or without complications) to six or 36. The 36-level payment approach would mean providers are reimbursed on the basis of each of the 36 birth HRGs; the six-level approach groups the HRGs together, reflecting clinical complexity.

3. Next Steps

As noted the Trust will undertake a local impact assessment of tariff proposals and update the Board of Directors at its next meeting. A more detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received early in December 2018.

4. Recommendations

That the Board of Directors note the planning and tariff reform key issues.

Board of Directors	
Agenda Item	9.1
Title of Report	Freedom to Speak Up Guardian Report
Date of Meeting	1 November 2018
Author	Carol Skillen, Health & Wellbeing Manager
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	*To Note the contents of the report* *To approve the NHSI self-review tool*
Data Quality Rating	
FOI status	yes
Equality Impact Assessment Undertaken • **Yes** • **No**	

Introduction

The following report provides the board with the necessary information to enable it to maintain a good oversight of Freedom to Speak Up matters and issues across the Trust.

Background

In Sir Robert Francis final report which investigated the failings in Mid Staffordshire he made a recommendation for every trust to nominate a Freedom to Speak up Guardian (FTSUG) to foster an open and transparent culture around raising concerns in the NHS.

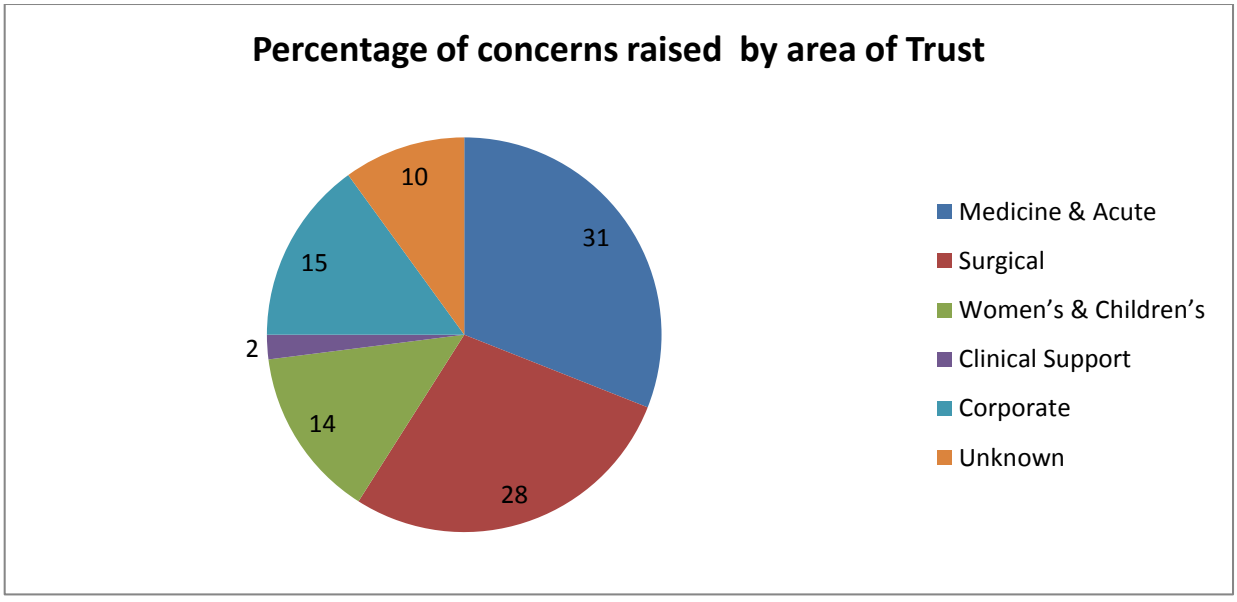
Having effective speaking up arrangements helps to protect patients and improve the experience of NHS workers as well as being an indicator of a well-led trust. The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections.

The Trust developed the role of FTSUG in 2015 prior to the guidance being issued by Sir Robert Francis and has been significantly involved in shaping national policy and guidance around this agenda. Currently the Trust has three FTSUGs in place.

In line with guidance issued by NHSI in May 2018 ("Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts". **See Appendix 1** reports should be presented to Trust Board to enable a good oversight of FTSU matters and issues on a six monthly basis. Reports should be presented by the FTSU Guardian or a member of the trust's local Guardian network in person. It is imperative that any data presented has to maintain the confidentiality of individuals who speak up. The FTSUG also provide information to the national guardian's office.

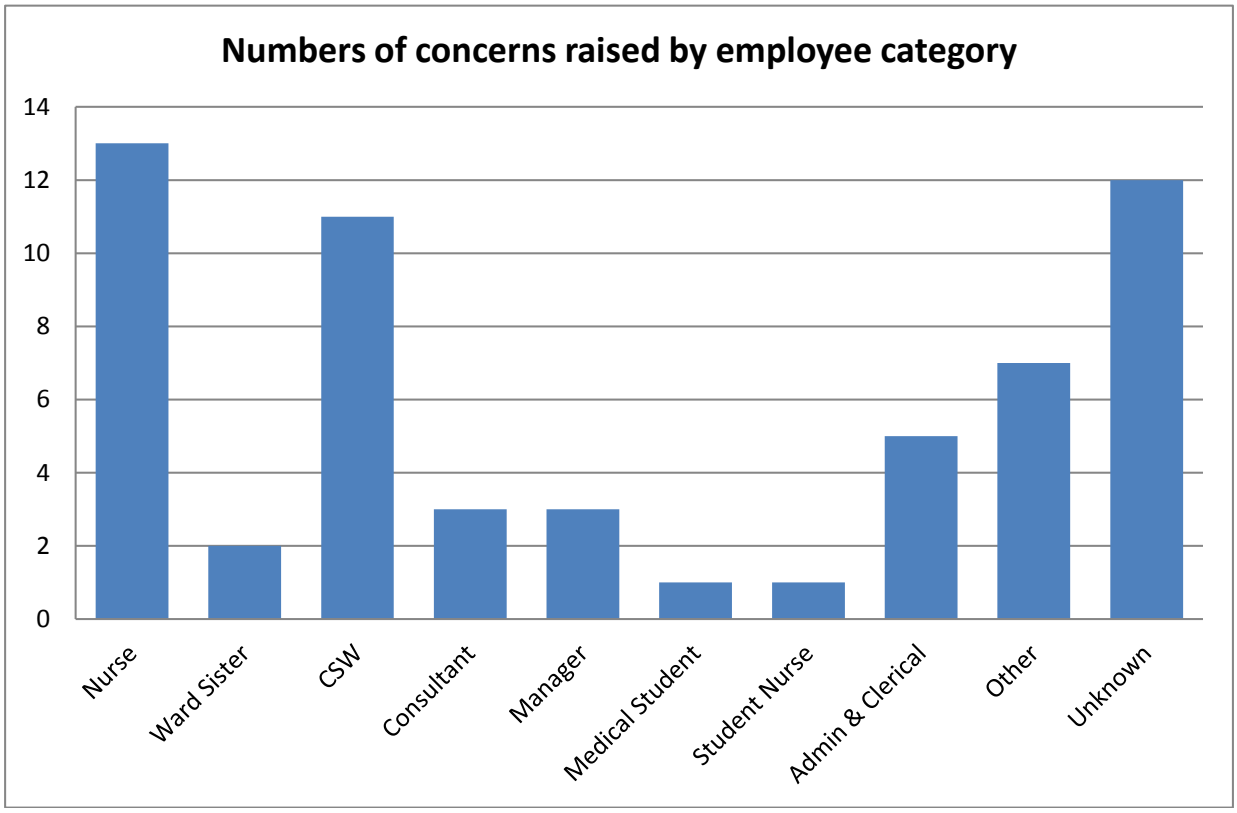
Reflection on the past 12 months

From Q2 17/18 to the end of Q1 18/19 the FTSUGs received 58 concerns, which is a 40.8% decrease from Q2 16/17 to Q1 17/18. The chart below shows which part of the Trust the concerns were raised about.



This data has been collected from staff attending the Speak Up training and using a questionnaire adapted from the Patient 2030 survey

The majority of those individuals raising concerns were employed in a clinical capacity, which is a reflection of the national pattern. Detailed below is the breakdown of the number of concerns by employee category.



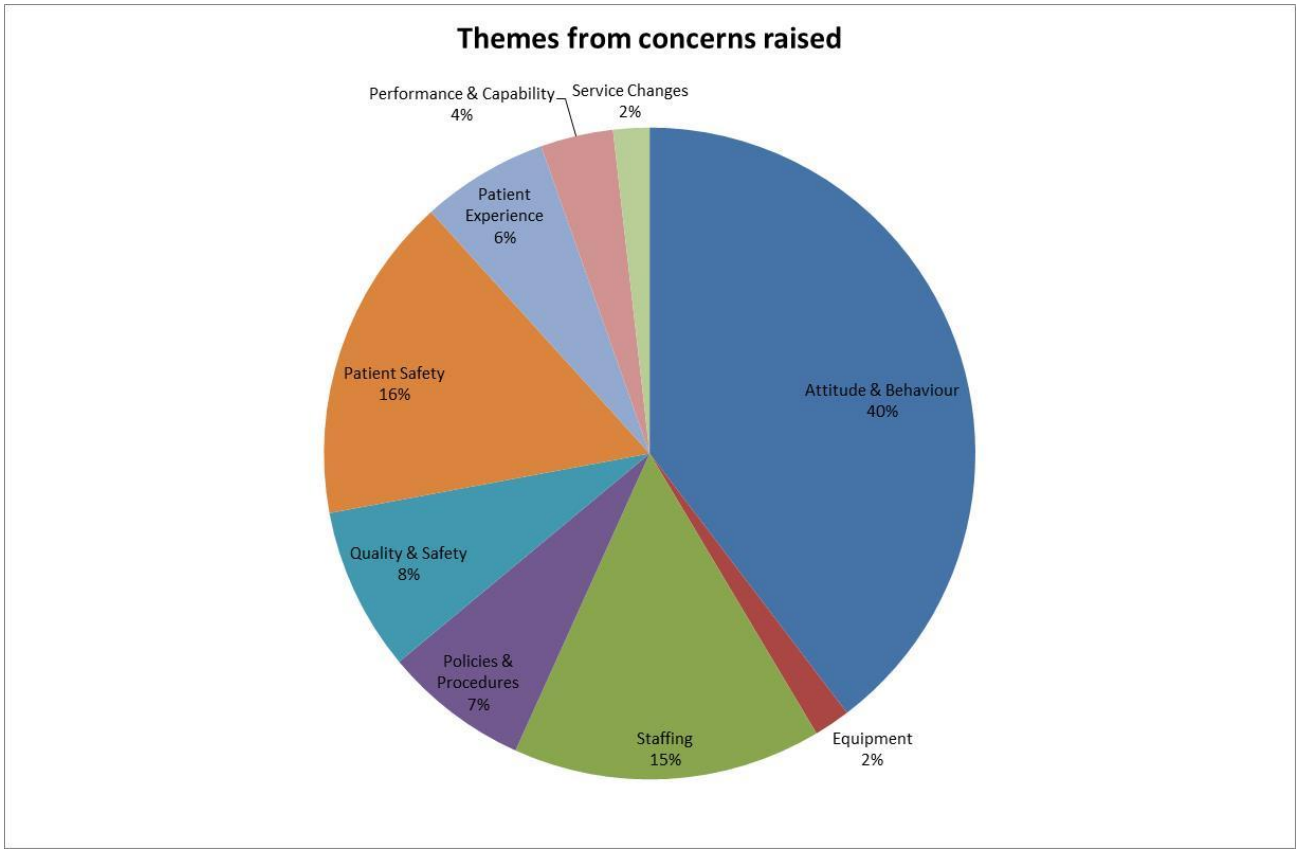
Both nationally and regionally in Q4 of 17/18 the average number of concerns raised per trust was12 with the range being from 0 – 87. The Trust was a little above average with 15.

It is acknowledged that more work needs to be undertaken to develop a monitoring system that captures information in relation to protected characteristics.

Assessment of issues

Attitude and behaviour continues to be the most reported theme in concerns. However, it is possible for a concern to have a number issues so therefore, to have a greater understanding of the data from Q1 18/19 we have been breaking down the reported attitude and behaviour theme to show Bullying as a separate matter.

From the complaints identified above the following themes have been identified:



Many concerns have more than one theme so the numbers below will not correlate with the number of concerns raised as detailed above

One of the main issues for the FTSUGs is individuals submitting anonymous complaints, which makes it difficult to be able to extract all of the required data, to personalise the support offered and to give feedback.

Potential barriers to speaking up appear to be:-

- Fear of disciplinary action
- Limiting career progression
- Fear of negative response from co-workers
- Nothing will change
- Lack of anonymity and confidentiality

The profile of the Freedom to Speak Up Guardians within the Trust

The roles, the support and the Trust's approach to speaking up are part of the organisation's induction processes, which include junior doctors. Leaflets and posters are available, although it is recognised that these do need refreshing. The Trust has strengthened the Freedom to Speak Up Guardian support by investing in a dedicated position that has direct access to both the Chief Executive and the Executive Director of Workforce. There are currently three Freedom to Speak Up Guardians. The organisation is seeking to recruit a Freedom to Speak Up Guardian from the medical body and the Trust Board has recently identified one of the NEDs to oversee the Freedom to Speak Up process.

Learning from the themes for improvement

As detailed above one of the main theme of attitude and behaviours and in particular bullying. The Trust has responded by arranging joint training with our staff side colleagues

on anti-bullying for all staff. It is also being addressed in the Speak Up training, Levels 1 & 2. Currently a suite of management development programmes are being shaped to provide our managers with a range of tools and skills to enhance and promote good management practices.

NHSI Self –Assessment

Appendix A details the draft NHSI self-review tool that all Trusts are expected to complete. This was been presented at the Workforce Assurance Committee on 25th October 2018 but requires approval by Trust Board.

Recent visit from the National Freedom to Speak up Guardian

Dr Henrietta Hughes, National Freedom to Speak up Guardian, visited the Trust on 30th August 2018. Within her visit she presented a leadership masterclass on the importance of creating a speaking up culture. The Trust received a formal letter from Dr Hughes thanking the organisation for providing the opportunity for her to meet with the leaders of the Trust and to understand the work that is taking place to create a culture where employees feel able to speak up.

Next Steps

- Review the FTSU action plan against the NHSI Freedom To Speak Up self-review tool
- A FTSU Guardian from the medical body to be appointed
- The current work in process to develop a new FTSU leaflet, poster and other communications to be completed and a FTSU campaign to be planned for later in the year including a FTSU screensaver
- A number of FTSU Champions will be appointed, whose roles will be to communicate the role of the FTSU guardians to all staff and signpost staff who wish to raise a concern to the FTSU Guardians.

The refreshed action plan will be signed off and progress monitored through the established workforce assurance structures.

Recommendation

The board is asked to:

- note the contents of the paper
- to approve the draft NHSI self-review tool
- to agree that the refreshed action plan will be signed off and monitored through the workforce assurance structures

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	The Trust has had FTSU Guardians since 2015. There is a nominated NED with oversight of the FTSU agenda. Annual reports have been presented to Trust Board via NED/Director of Workforce	• To ensure six monthly reports are presented to Trust Board from the FTSU Guardian • Quarterly reports to be presented to Workforce Assurance Committee • FTSU Guidance to be presented to Board and Workforce Assurance Committee	There is a nominated NED with responsibility for FTSU FTSU Guardian report at Trust Board FTSU training across the organisation with activity data. FTSU Guardian member of the Workforce Assurance Committee which a sub-committee of Trust Board.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Senior leaders are aware of the FTSU and will have been involved in understanding the issues that have been raised. Regular communications from CEO to organisation to encourage reporting and the importance of FTSU Raising Concerns Policy	• To shape the vision from FTSU as part of the strategy refresh in relation to the People element. This will be integral to the renewal of our Values and Behaviours in 2018/19 which has been commissioned at Trust Board and will be signed off at Trust	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee. OD Plan assured at the Workforce Assurance Committee.

	in place.	Board post completion. This work is integrated into the Organisational Development Plan 2018-21. • To undertake a 12 month review to obtain information on lessons learnt and improvements that have been made. • To undertake a confidential audit on the experiences and confidence from individuals using the service.	
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	FTSU agenda is included in Trust Induction programmes for all staff and we now have face to face training Level 1 and Level 2 as essential training for all staff and managers in FTSU, delivered by lead FTSU Guardian. Bullying and Harassment training for staff and managers introduced in 2018 as part of OD Cultural Improvement Plan.	• This needs to be explicit in the shaping of leadership offerings. • Include in leadership development framework for all levels of the organisation. • To be part of the leadership programmes at every level •	National Guardian was key note speaker at the Leadership Masterclass August 2018 FTSU level 2 training is now in place for all leaders and managers regarding FTSU and mangers responsibility.

Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	The organisation is currently refreshing the trusts strategy and vision. Senior leaders have supported the implementation of FTSU including resources. FTSU is included within OD Plan 2018-21 which has been agreed by senior leaders.	• To be explicit with the trust strategy and in particular to the people element of that strategy. • To be included in values and behaviours renewal 2018/19.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report.
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Included in OD Plan 2018-21 FTSU development action plan for 2018/19 in place following previous self assessment, review of national guidance and case reviews by NGO.	• Key objective in OD Plan to renew values and behaviours in 2018-19.	FTSU action plan 2018 FTSU Communications Plan 2018 6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Raising Concerns Policy in place that is aligned to national guidance.	Policy to be reviewed 2018.	Policy to be ratified at Workforce Assurance Committee once reviewed.
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	We have a dedicated FTSU Guardian and other non substantive Guardians. Raising Concerns policy	Policy to be reviewed 2018.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance

	and process developed following engagement with staff and key stakeholders including staff side representatives and is inclusive of Francis Report national guidance. FTSU strategy part of Trust strategy and values and behaviours work as part of OD plan 2018-21.		Committee and OD Plan report. Policy to be ratified at Workforce Assurance Committee once reviewed.
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Progress against improvement plan has been made and reported via Workforce Assurance Committee.	Policy Requires review in 2018 to ensure that it meets latest national guidance and that agreed KPI's are being met	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Leadership Masterclasses focused on organisational culture introduced in 2018. National Guardian visit included August 2018 Master Class. Leadership Walkabouts in place and increasing. Open Forums now in	• Establish confidential listening network. • Considering Speak Up Champions. • Continued reinforcement of commitment via internal communications and visibility. • Refreshed Communications	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report

	place for staff to meet with Executive team and other Directors. CEO and Execs meet with FTSU Guardian. Quality Bus used to promote FTSU with Director of N&MW. Invested in substantive post and resources to support.	campaign launch in line with Speak Up Month, October 2018	
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Weekly Safety Summits in place. New Director of Governance and Quality Post in place and Governance Review undertaken. Service Transformation Team supporting QI projects. Schwartz Rounds in place and active. External stories used in FTSU training and feedback on themes.	• Service Transformation Team introducing QI programme in 2018/19 • FTSU confidential staff stories to come to Workforce Assurance Committee to share learning. • Refreshed communications under development (Posters, banners, leaflets etc). • Need to link with patients stories/learning with patients.	

Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Ward to Board Programme active including: Leadership Walkabouts in place and increasing. Directors shadowing staff in place. NED's out on shop floor and Chairman walkabouts. Open Forums now in place for staff to meet with Executive team and other Directors. CEO and Execs meet with FTSU Guardian. Quality Bus used to promote FTSU with Director of N&MW. New monthly Board communication to staff.	• Need to ensure director and divisional leadership visibility is sustainable. • Include importance of this in all leadership development. • Need assurance that leaders are feeding back to staff on actions taken by them identified via visibility schemes eg walkabouts. Need to develop process for this. • Need clear process and engagement to close off concerns raised with assurance of actions taken.	OD Plan updates bi monthly to Workforce Assurance Committee which is sub Group of the Board.
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Senior leaders have open door approach to meeting with FTSU Guardian as well as regular meetings with CEO and Director of Workforce.	• Need clear process and engagement to close off concerns raised with assurance of actions taken.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report.

	Senior leaders and managers are responsive when contacted by any FTSU Guardian. Regular messages from CEO re importance of speaking up.		FTSU Guardian meetings. Escalation process to relevant senior leader or CEO where any barriers or lack of progress exists.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Schwartz Rounds Weekly Safety Summits and Safety Bites communication re learning from cases. CEO Communication to Trust eg post CQC. Messaging via leadership cultural masterclasses	• Review the follow up process / support for staff who raise issues via safety summit. • Lead Guardian to liaise with Medical Director as Safety Summit chair to agree how above can be addressed.	Board Reports Investigation reports following safety incidents
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Not assured for all workers due to pockets where staff may not be aware. FTSU Level 1 training in place for all staff Level 1 FTSU Level 2 training in place for all managers which is inclusive of the process to follow and managers responsibilities.	• Refreshed communications plan under development. • Make use of staff FFT data in 6 monthly Board reports re confidence in the speak up process	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.

	Quarterly monitoring via staff FFT additional question. Since 2015, 2 reporters have expressed detriment as a result of raising concerns which has been acted upon by the FTSU Guardian.		
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Lead Guardian meets regularly with CEO, Director of Workforce and NED with responsibility for FTSU. New NED briefed on role by Lead Guardian.	• NED with responsibility for FTSU to attend Level 2 training for managers.	6 monthly FTSU report to Trust Board.
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Yes	N/A	6 monthly FTSU report to Trust Board.
Other senior leaders support the FTSU Guardian as required.	Yes and all directors including CEO and chair have “open door policy” for Lead FTSU Guardian. Senior leaders are responsive to FTSU Guardian when concerns are raised.		6 monthly FTSU report to Trust Board.

Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	FTSU Guardian has access to all incident reports.	• Lead FTSU Guardian to work with Head of Patient Experience to develop process to enable triangulation of speaking up issues and actions to address.	6 monthly FTSU report to Trust Board.
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Yes	• Policy is due for update and needs to consider if any strengthening of roles and responsibilities outlined within the policy is required and include this in training programmes.	6 monthly FTSU report to Trust Board.
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	This is covered in staff training: FTSU Level 1 training in place for all staff Level 1 FTSU Level 2 training in place for all managers which is inclusive of the process to follow and managers' responsibilities.	• Further communications as part of refreshed and on going communications plan.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.

	Regular communications. Quarterly monitoring via staff FFT additional question.		
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	FTSU training delivered to vulnerable groups eg students. FTSU Lead Guardian is member of new Inclusion & Diversity Steering group.	• Planning for awareness sessions at new Inclusion & Diversity Network groups. • Continue awareness sessions for all vulnerable groups including learners, volunteers etc	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
Speak up issues that raise immediate patient safety concerns are quickly escalated	Yes, usually direct to an executive director subject to concern raised and is supported.	Continue	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Since 2015, 2 reporters have expressed detriment as a result of raising concerns which has been acted upon by the FTSU Guardian. Training programmes include how the reporter is protected.	• Continue to raise awareness via communications plan	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
Lessons learnt are shared widely both within relevant service areas and across the trust	Training updated as required to take into consideration lessons	• Policy due to be reviewed.	6 monthly FTSU report to Trust Board.

	learnt.	• Case studies re lessons learnt to be presented to Workforce Assurance committee.	FTSU Quarterly report to Workforce Assurance Committee.
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Yes by FTSU Guardians	• Consider alternative impartial method of audit	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
FTSU policies and procedures are reviewed and improved using feedback from workers	Staff provided feedback prior to the introduction of FTSU Guardians at WUTH in 2015. This was reviewed with staff in 2016. Outputs informed the development of policy and procedures supported by national guidance.	• SOP's to be updated in line with policy review. • Further work needed re "closing off the loop" ensuring cases closed and feedback to reported. • Policy amendments will be subject to consultation on changes made.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
The board receives a report, at least every six months, from the FTSU Guardian.	Previously report was annual via NED with responsibility for FTSU.	• 6 monthly report to Board by the lead FTSU Guardian.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee.
Leaders engage with all relevant stakeholders			

A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	2015 survey undertaken with staff and focus groups re FTSU. This informed policy and processes and was reviewed using same methodology in 2016. Visibility walkabouts and FTSU sessions on Quality Bus with directors and senior leaders in place.	• Need to embed FTSU in new values and behaviours 2018/19	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee and OD Plan report.
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Discussed with CQC and NHSi recently. Included in CQC Inspection Report. FTSU to be part of workforce dashboard indicators.	• Not met with commissioners re FTSU.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee. CQC Inspection Report.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Not currently in place	• Include in 2018/19 FTSU action plan.	6 monthly FTSU report to Trust Board.
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Not currently in place	• For inclusion in 2018/19 annual report	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Reviews and audits are shared externally to support improvement elsewhere.	FTSU Guardian attends regional and national network to share current practice and developments.	• Internal audit for review in line with policy update 2018	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance

			Committee
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	FTSU Guardian attends regional and national network to share current practice and developments.	• Continue to use feedback from NGO, emerging guidance and networks to improve speaking up culture locally.	6 monthly FTSU report to Trust Board.
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Lead FTSU Guardian is trainer for NGO. Lead FTSU Guardian is active member of regional network to support shared learning and improvement. Lead Guardian has developed relationships with NHSi and CQC.	• Will use national case reviews on on going basis to align with FTSU policy, processes and training • Lead Guardian will continue to maintain relationships as required with NGO, NHSi, CQC as part of FTSU agenda	Regulator and Inspection Reports
Senior leaders request external improvement support when required.	NGO and NHSi contacted by Lead FTSU Guardian as required	• Lead Guardian will continue to seek support of NGO, NHSi, as required as part of FTSU agenda.	6 monthly FTSU report to Trust Board. Regulator and Inspection Reports.
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Bullying and Harassment campaign introduced in response to FTSU concerns raised re attitudes and behaviours	• Continue to review lessons learnt and any implications for improvement needed	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance

	and under reporting.		Committee
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Yes at regional and national network meetings and annual NGO Conference and Training. Lead Guardian communicates with other regional guardians to share ideas via groups emails	• Continue	6 monthly FTSU report to Trust Board as required re any changes or matters of escalation/recommendations. FTSU Quarterly report to Workforce Assurance Committee as required
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Yes and included in 2018 action plan for FTSU.	• Continue • Relevant changes from national guidance will be presented to the Trust Board and Workforce Assurance Committee	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.		• Need to develop process to address this.	
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Action Plan 2018 reviewed by CEO March 2018. Business case agreed to support substantive post to enable plan to be delivered and meet national guidance and		6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee

	best practice.		
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Raising Concerns Policy in place that is aligned to national guidance.	Policy to be reviewed 2018.	Policy to be ratified at Workforce Assurance Committee once reviewed.
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		Requires development	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Feedback from FTSU training indicates that staff are more confident to speak up as better informed.	• Communications Plan to continue to promote awareness and training available. • Confidential case studies to be used at Workforce Assurance Committee	Minutes Workforce Assurance Committee. National Staff Survey and Staff FFT question on confidence their concern would be addressed.
Individual responsibilities			
Chief executive and chair			

The chief executive is responsible for appointing the FTSU Guardian.	CEO appointed substantive FTSU Guardian role in 2018	Further Medical FTSU Guardian in non substantive role to be recruited and appointed.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	CEO and Chairman meet regularly with lead FTSU Guardian to ensure arrangements meet the needs of staff	CEO/Chairman to seek feedback from staff in Open Forums and Walkabouts	6 monthly FTSU report to Trust Board.
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Annual Report 2017/18 was inclusive of information related to FTSU	Engage with CEO/Chairman and NGO to understand how content could be developed for annual report	Annual Report to Trust Board
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Stipulated as part of Lead Guardian role. CEO and Chairman meet regularly with lead FTSU Guardian and discuss updates from regional and national network.	Continue to support lead Guardian in attending regional and national FTSU network events and training.	6 monthly FTSU report to Trust Board.
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Yes with open door policy and scheduled regular meetings	Continue with open door policy and scheduled regular meetings	6 monthly FTSU report to Trust Board.
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	The Executive Director of Workforce is lead for FTSU and is aware of latest guidance. Also has regular 1:1 meetings with Lead FTSU Guardian.	Lead Guardian under line management of Executive Director of Workforce will continue to meet regularly to discuss the role, implementation, latest guidance and any implications for the Trust. New Guidance will be reported to Trust Board and Workforce assurance Committee.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Overseeing the creation of the FTSU vision and strategy.	The FTSU Vision and implementation plan has been developed and is integrated into the new Organisational Development Plan 2018-21.	Vision and Strategy monitored through OD Work Programme and FTSU Implementation Plan.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	FTSU Guardians have been in place since 2015. In 2018, the National example JD has been used to inform the new JD of Lead FTSU Guardian. Existing non substantive Guardian has been appointed to substantive role to strengthen the service.	Further Medical FTSU Guardian in non substantive role to be recruited and appointed.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	The FTSU Guardian has been provided with a dedicated office and equipment and funding for development. The	Continue to monitor and support any additional requirements via 1:1 meetings between Lead FTSU Guardian and	6 monthly FTSU report to Trust Board.

	Lead FTSU Guardian is covered by other guardians for planned and unplanned absence.	Executive Lead for FTSU.	
Ensuring that a sample of speaking up cases have been quality assured.	FTSU Guardian Meetings include QA of work across the team. 1:1 meetings with executive lead	Review current process and identify how this could be enhanced	6 monthly FTSU report to Trust Board.
Conducting an annual review of the strategy, policy and process.	Strategy integrated into OD Work Programme 2018-21 and FTSU Implementation Plan in 2018. Policy amended in line with agreed review dates or as required due to national changes.	Policy for Review 2018/19	FTSU Quarterly report to Workforce Assurance Committee
Operationalising the learning derived from speaking up issues.	Actions from FTSU mainly sit within divisions to operationalize but some key outputs that require central changes are driven by Executive Lead. Eg Bullying and Harassment Campaign.	Themes from speaking up will continue to be used to inform further development	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Lead Guardian has investigated cases and reported to Executive Lead/Director of Workforce with assurance of actions taken. Training includes detriment and policy	Continue current practice	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee

	requirements.		
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Reports on OD Work Programme. FTSU Reports including national data requirements. Meetings with CEO/Chair/Executive and NED leads. Assurance of processes following national guidance.	Implementation and Development Plan 2018 Policy for review 2018/19	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	New NED Lead briefed by Lead FTSU Guardian	NED to attend FTSU Training	6 monthly FTSU report to Trust Board.
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Chief executive, executive FTSU lead and the board are aware of their accountability	Latest National Guidance to Trust Board	Trust Board have sight of latest national Guidance. 6 monthly FTSU report to Trust Board.
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	New NED lead for FTSU in 2018. Board walkabouts/visibility	NED to provide assurance at Trust Board and Challenge	Discussions and Board meetings
Role-modelling high standards of conduct around FTSU.	New and previous NED aware of responsibilities. Visible and actively promote FTSU.	New NED to attend training and undertake FTSU walkabouts	6 monthly FTSU report to Trust Board.
Acting as an alternative source of advice and support for the FTSU Guardian.	NED and Lead FTSU Guardian clear of their roles and responsibilities and advisory / support	Processes being reviewed in line with policy update in 2018/19	Discussions and Board meetings

	role of NED Lead.		
Overseeing speaking up concerns regarding board members.		Report to Board re latest national guidance, best practice and responsibilities.	Board Meetings
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	The Executive Director of Workforce is also the Executive Lead for FTSU. The agenda is supported within the HROD department. The Lead FTSU Guardian comes under HROD Department portfolio and is supported by HROD staff to enable closer working around culture.	Enhance workforce dashboard to include FTSU. Learning from FTSU via case studies	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	HR is committed to and supports the speaking up culture and learning from this.	Working with Communications and OD, develop processes further to share learning from speaking up, including case studies.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee Internal communications
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Training in place for all staff. Cultural reviews have highlighted support for staff and this is being provided via HROD and managers.	Continue to roll out training plan and support.	6 monthly FTSU report to Trust Board. FTSU Quarterly report to Workforce Assurance Committee

Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Always responsive and committed when contacted by FTSU Guardians	Ensure new medical director is briefed on commencement.	6 monthly FTSU report to Trust Board
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Prompt action take supported by MD and DoN.	Continue	6 monthly FTSU report to Trust Board
Ensuring learning is operationalised within the teams and departments that they oversee.	DoN and MD engage with operational managers to address issues and learn from them by making changes to practice.	Continue	6 monthly FTSU report to Trust Board

BOARD OF DIRECTORS	
Agenda Item	10.1
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	1 November 2018
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance	Gaps
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 fourth meeting took place on Thursday 25 October 2018. Two new NED committee members, Jayne Coulson and Steve Igoe were welcomed to the committee recorded it's thanks to Graham Horlick at this his last attendance at the WAC meeting. Participation within the meeting was strong and the agenda proved to be over ambitious for the 2 hours available.

The Committee detoured somewhat into detailed discussions of HR policy and will need to refocus on its terms of reference to improve its assurance role and focus.

2. Key Agenda Discussions

2(a) Values & Behaviours

There were gaps in assurance reported against this important work for the Trust. The decision to replace the PROUD campaign with an updated values and behaviours roll out (based on NHS core values) was cautiously welcomed.

Concerns were raised and included:

- low participation in current Values & Behaviours engagement events indicating a more widespread apathy
- risk of change initiative overload -- many do not allocate time to engage in change events due to day to day pressures
- risk of communication messages overlapping with new Trust Vision communications
- omission to learn the lessons from the PROUD campaign -- why those relevant values were never sustainably embedded
- a reflection that the NHS core values seemed somewhat dated (e.g. did not include Duty of Candour)

Overall there was Committee consensus that the main issue is observed to be leadership credibility leading to low organisational confidence that there will be real change in behaviours throughout the organisation.

The committee were informed that the Staff Engagement Group will be driving the work and it will be a change journey with disconnections from the past behaviours.

2(b) Communications & Engagement Update

Despite the positive level of assurance reported the committee heard that response rates to the NHS national staff survey are currently 19% with the NHS generally achieving 21%. These figures are so low that making meaningful conclusions and recommendations for change may not be as robust as they could be. It was reported that WUTH Trust managers were generally negative about the survey.

The merits of a national survey for WUTH (with low participation --1000 out of 5000+ employees) versus locally focused Listening in Action type events were discussed at some length.

The committee were assured by the annual influenza prevention campaign communications and look forward to the feedback from the recent NHS70 celebration and staff awards.

2(c) Recruitment Update

Anne Lucas presented a recommendation to cease the shared recruitment service contract with HRWBS at Countess of Chester Hospital. The recommendation was not supported by the assurance committee as the options presented were not fully costed and the TUPE, financial and business continuity risks of the recommended in house option were unclear. The steer from the WAC was to work up the proposed change through the TRUST's management and executive before presenting again to WAC or the Trust Board.

2(d) Equality & Diversity Update

Sharon Landrum reported a positive level of assurance with the Diversity & Inclusion (D&I) agenda at WUTH.

The Equality Delivery System (EDS2) framework of 2010 includes 18 outcome areas. Feedback from commissioners is to focus finite resources on one or two key areas each year and rotate in future years until all outcome areas are covered.

The committee was assured that WUTH is moving forward with the D&I agenda and is linking successfully with internal and external stakeholders. The vision is that D&I considerations will run through all elements of work for the WUTH workforce and its patients.

2(e) Guardian of Safe Working Quarterly Report

Dr Younis presented his quarterly report highlights. These included:

- a lower number of Exception reports from Junior Doctors than comparable benchmarks (136/ month versus 200 / month).
- low attendance at junior doctor meetings
- junior doctor satisfaction reported as high

2(f) Freedom to Speak Up (FTSU) Update

The NHSI Freedom to Speak UP self review tool for NHS trusts and foundation trusts was provided for review. It will be used to assess the WUTH FTSU action plan
Carol Skillen provided her Freedom to Speak Up Guardian report (for the Board). It was accepted by the WAC.

2(g) Medical Staffing Update

Liam Reeve presented the report and the following gaps in assurance were discussed:

- Locum spend -- running at > £ 1 million / month (mainly in ED, T&O and Cardiology)
- Job plans not meeting the demands of the service
- High Waiting List Initiative spend
- Difficulty in recruiting to certain consultant posts
- Not utilising Advanced Nurse Practitioners fully to fill medical rotas

2(h) OD Work Programme Update

An update on the 2018-2021 Organisational Development Programme was presented by Cathy McKeown. Gaps in assurance included:

- The programme requires the commitment of the whole WUTH organisation.
- Measures of success currently rely on the data from the national staff survey where responses are currently 19% of the target population (< 1 in 5).
- Divisional OD plans need to be monitored regularly
- Speak Up training needs more attendees
- Managers need to release staff to engage in the development of Trust behaviours
- National CQUIN for Health and Well Being is at risk this year due to resource constraints
- The implications of the mandatory and essential training review
- The new Leadership Development Framework will impact all levels and change job descriptions.

Steady progress is reported and priorities are clear.

2 (i) Workforce Planning

The committee has previously accepted the urgent need for a new effective and robust workforce planning process within WUTH.

Unfortunately the three Workforce planning awareness sessions planned have had a very low take up.
The workforce planning tool (WRAPT) that has been developed for North West NHS organisations is being recommended. The tool would allow for an integration health and social care approach.
Further communications will be made.

2(j) Medical Education Undergraduate Quality Visit

Unfortunately there was no time available to discuss this item.

2(k) Workforce Dashboard

Committee review was very time limited. Key priority issues were reported to be sickness absence levels and band 5 nurse vacancy levels.

2 (l) Workforce Performance Group (September 2018)

The minutes of the first meeting were noted. No risks were to be escalated to this committee from the first meeting.

3. Next Meeting

Thursday 6 December 2018 2pm to 4pm

4. Recommendations to the Board of Directors

- To note the contents of this report

BOARD OF DIRECTORS	
Agenda Item	10.2
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	1 November 2018
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee 23 October 2018

This report provides a summary of the work of the FBPAC which met on the 23rd October 2018. Key focus areas are those which address the gaps in assurance in the Board Assurance Framework and areas of development work to bring to the attention of the Board of Directors.

1. Chair's Business

SL expressed concern with the deterioration of the forecast financial positon included in the committee papers and adverse reputational impact this would potentially have with regulators given the Trust had rejected the Control Total and set its own plan which had been agreed as realistic by the Committee and the Board of Directors.

2. M6 Finance Position

DJ reported that the Trust had delivered a deficit of £18.1m against a plan of £16.3m, an adverse variance of £1.8m. However, this reported position incorporates non recurrent benefit of £0.6m from balance sheet adjustments and £1.3m non-recurrent release of the Sepsis provision leading to an underlying position of £20.0m deficit and an underlying adverse variance to plan performance of £3.7m.

The main areas driving the adverse position as previously reported to the Committee are the under performance in elective and day case activity, which is 2,001 spells behind plan, with a financial impact of (c£3.2m), and Outpatients attendances and procedures which are showing an adverse variance of 3,230, and a financial consequence of (£0.6m). Although non-elective activity is 239 spells ahead of plan, the run-rate has reduced in month and from a financial perspective a reduction in the complexity of the casemix against plan has offset the benefit.

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

The Committee noted the lack of progress on the Surgical recovery plan predominantly as a result of the uptake of additional sessions against the original expectations. High levels of outsourcing to the private sector continue and while this provides treatment for patients it means the Trust gains no financial benefit from tariff income. AM noted the further interventions in improving processes that were underway and which would lead to improvements in future months.

DJ reported actual delivery of CIP at £3.7m versus a plan of £2.8m (noting £1.6m delivered non recurrently). The Committees attention was brought to the profiling of CIP which sees significant increases in Q3 and Q4.The Committee was updated on total CIP identified to date with £7.2m of fully developed schemes with a further £2.5m of plans in progress and opportunities. This still leaves material risk to delivery of the required £11.0m CIP contained in the plan of the order of £1.3m albeit the Committee noted that the unidentified gap had improved by £0.4m.

The Committee noted actual cash balances of £6.6m compared to plan of £2.1m with strong performance on working capital balances and gains from capital programme slippage. There was an upper and lower cash balance expectation set by NHSI which is £8.2m as the upper limit.

An overall Use of Resources (UoR) rating of level 3 had been achieved with performance against the agency metric preventing potential deterioration to a rating of 4, the lowest rating possible.

The Committee discussed the forecast outturn scenarios contained within the paper noting a "likely" forecast at £30.5m deficit against a plan of £25.0m deficit. The Committee expressed concern that the plan was at risk of not being achieved and what actions the Executive team were taking to mitigate and improve the position. It was noted that the requirement to invest at risk in winter capacity was a contributing factor to the deterioration (£1.2m) but that CIP and elective recovery were areas that should be considered for improvement. The committee noted the protocol to be undertaken to amend the forecast with NHSI which would need to be enacted at the end of Q3 if mitigation is not found.

3. 2018/19 Capital Plan

The committee received a detailed report on the Capital programme and approved under the Trust's scheme of delegation the two schemes identified in the report against existing allocations. The year to date spend was £1.9m against a full year budget of £10.9m. Commitments totalling £6.6m had been made and a further 2.5m identified schemes are forecast for delivery within the year. There remained £1.8m of funding unallocated as a result of contingency and lapsed schemes and a brought forward value of £0.4m. In addition the Committee noted the Urgent and Emergency Care central capital allocation of £2m. In light of the available funding and the time constraints in bringing new schemes to delivery in year, the committee delegated authority for the prioritisation of additional schemes to the Executive team with a paper to the Board of Directors setting out the full programme and explaining how new schemes had been prioritised.

4. Board Assurance Framework(BAF)

The Committee received the BAF noting key areas of risk that fell under the remit of the committee. The Committee were apprised of the work being undertaken on an updated BAF format which was to be welcomed.

5. Diagnostics & Clinical Support CIP

The Committee received a presentation from the Divisional Director of Diagnostics and Clinical support on the progress made in delivery of the CIP target for 2018-19, the emerging opportunities and the element as yet unidentified. A presentation from the Director of Pharmacy & Medicines Management was also received which detailed the progress on CIP delivery from a drugs perspective and the qualitative benefits the pharmacy team were supporting in optimisation of medicines within the Trust and in the community. The committee encouraged the Divisional Director in delivering fully against the target allocation to ensure the Trust financial plan was achieved.
An issue was raised by the Director of Pharmacy regarding potential drug incidents and the safeguards the Pharmacy team used to prevent them. It was agreed that this be examined in detail at Quality and Safety Committee at its next meeting.

6. Month 4 NHSI report

The Committee noted the report that had been submitted in line with prescribed NHSI timetable.

7. One-to-One Midwifery

The Committee received an update on the nature of the legal action that could be pursued in respect of the outstanding balances from this provider and the opportunity to take joint action with Warrington & Halton Hospitals and Liverpool Womens Hospital to strengthen the legal case and share legal costs. This approach was supported by the committee.

8. Cheshire & Mersey HCP Update

DJ updated the committee on recent meetings of the Cheshire & Mersey HCP. He explained the key workstreams being progressed and the work that would support the development of a long term financial model that delivered financial sustainability for the region.

9. Integrated Performance Dashboard

The committee were concerned to note A&E performance at 77.77% for the APH site, worse than the NHSI trajectory of 90% for the month and deterioration from the previous month. Poor performance on discharges was a contributory factor to this and the patient flow group sponsored by GW continues to work to improve on this area as well as meetings between the Medicine and Acute Division and senior operational managers. RTT performance stood at 78.34%, in line with the NHSI trajectory although there were 40 patients waiting over 52 weeks which exceeded the NHSI trajectory by 3. Diagnostic breaches were better than the NHSI standard being a return to achievement predicted from the deterioration in earlier months. Cancer targets were being achieved but there is variation in performance in individual tumour pathways that was a cause for concern and required specific interventions from management teams to optimise performance.

GW reported performance against the c-diff trajectory which is in line with the year to date target. Other quality indicators included in the report were also relayed. The committee noted the potential duplication of assurance of these metrics with the role of the Quality & Safety Board and the different style of the presentation of the metrics.

It was agreed going forward that the quality metrics would not be reviewed by the committee. It was also highlighted by PM that a new presentational style of performance data was to be introduced to all committees which gave 'one version of the truth'.

10. Reports from Sub-Committees

The committee received reports from:

- Finance and Performance Group
- Digital Wirral Programme Board
- Information and Coding Group

PC noted particularly a delay in the code upgrade of Millenium which is a pre-requisite of the roll out to the CoCH. A go live date had now been confirmed for the 2/3 November.

SL requested clarity on where the assurance in respect of the delivery of the Digital Wirral plan was to be measured as the report did not give the committee sufficient information to assess performance. It was suggested that this would be through the Programme Board which reported direct to the Board of Directors and PM would confirm this for future reporting.

SL reiterated comments made in previous meeting that that she could not gain assurance from the Information and Coding report as the report highlights gaps in assurance but with no mitigating actions.

PC agreed to review the content of the report.

11. Items for the attention of the Board

- Risk in achievement of the financial plan due to low performance on elective activity and unidentified CIP
- The detail of the Capital programme.
- The delegation to the Executive team of prioritisation of capital schemes against the remaining available contingency funds and the criteria to be adopted
- The deteriorating performance against the A&E target
- The emerging risks on the cancer performance at tumour group level

Board of Directors

Subject:	Item 10.3 Proceedings of the Trust Management Board	**Date:** 11/10/2018	
Prepared By:	Paul Moore - Director of Quality & Governance		
Approved By:	Janelle Holmes, Chief Executive		
Presented By:	Janelle Holmes, Chief Executive		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**Risk associated with non-delivery of financial control total based on M6 outturn.**
Patient Impact	**Several areas pose a risk to quality of care – exposure to infection, venous thromboembolism prevention, administration of CAS Alerts, nursing vacancy rates, complaints responsiveness and use of chemical sedation as a first-line intervention for managing challenging behaviour**
Staff Impact	**Staff vacancy and attendance management represent a risk to workforce effectiveness**
Services	**None**
Reputational/ Regulatory	**Several areas pose a risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above, but also completion of mortality reviews**

Committees/groups where this item has been presented before

N/A

Executive Summary

1. Executive Summary

- The Trust Management Board (TMB) met on 11/10/2018. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors. It was agreed that in future a patient or staff story would be used to open the meeting, with the discussion led by the relevant division.

2. Quality Dashboard

- TMB received the draft Quality Dashboard in the proposed new format dated October 2018.
- TMB agreed that the new Quality Dashboard represented a step forward, and helpfully clarified more directly the risks and gaps in control relating to performance.
- A substantial amount of time was spent considering this report and it will be developed further in order to provide assurance to the Board of Directors, divisional teams and external stakeholders.
- TMB received a report of the proceedings of the Patient Safety & Quality Board (PSQB) which escalated the following matters:

<u>Infection Prevention</u>

a) **Clostridium *difficile* infection is above trajectory (no more than 2 cases per month).** The Trust is above trajectory in the current year to date; there being 12 cases reported against a trajectory of 9 (a mean run rate of 2.4 cases per month). It was noted that the PSQB is following up with scrutiny of the infection prevention action plan in light of reported concerns regarding the standard of environmental cleaning in clinical areas,

poor compliance with hand hygiene standards amongst staff, adherence to documentation standards for reporting of stools and insufficient communication between clinical teams.

b) **MRSA:** There was 1 case of MRSA colonisation in August. The cumulative position for MRSA colonisation in the current year to date is 27. This is equal to the Trust's 2015/16 position and would appear to indicate an increase in colonisation cases compared to last year and also 2013/14, 2014/15 and 2016/17 and points to issues of environmental cleaning, hand hygiene and infection prevention practices.

c) **Flushing of low-use water outlets**. The flushing of low-use water outlets is a safety-critical control to minimise the risk of water contamination from P*seudomonas* and *Legionalla*. Assurance provided to PSQB introduced some uncertainty for TMB that the flushing of low-use water outlets is reliable and sufficient to achieve control. TMB noted that the PSQB are following this up with both the Director of Estates & Facilities and also the Health & Safety Advisor to advise on corrective action as a priority.

d) The TMB sought and received information from the Director of Infection Prevention and Control regarding the Infection Prevention Improvement Plan. TMB were informed that the plan is being implemented and is monitored closely by the Infection Prevention and Control Committee.

e) TMB expressed concern about the apparent deterioration in infection prevention overall and control across the Trust and reiterated the requirement for compliance. Infection metrics will feature prominently in the Divisional Performance Review meetings, to be held every month from this point forward, commencing in November 2018.

Staffing

f) Nursing Vacancy Rates. The Trust's nursing vacancy rate is reported as 10.24% overall. Of concern is that the vacancy rate for Band 5 positions for inpatient and ED has increased from 7.03% in March 2018 to 18.28% in July 2018 as a result of establishment changes. TMB were advised that this represents a significant risk going into the Autumn and Winter. The priority is Band 5 positions. The Workforce Performance Group are overseeing delivery of actions to address the shortfall.

g) The sickness absence rate continues to increase and remains above target. The Workforce Performance Group are overseeing delivery of actions to address the shortfall.

Other matters from the dashboard

h) **Medicines storage**. 1 in 4 clinical areas are not compliant with medicines storage requirements. TMB held divisional colleagues to account for compliance at the meeting. TMB noted that the PSQB were advised that no harms have been reported as a consequence of the gaps in control, although there are stock losses attributable to unusable medicines following inappropriate storage in clinical areas. Medicines management metrics will feature prominently in the Divisional Performance Review meetings, to be held every month from this point forward, commencing in November 2018.

i) **Friends and Family Response Rates**. Patient satisfaction is high. The response rates in ED appear to have dropped considerably in the last few months. Whilst in line with the peer group and England average (13%), this could be increased and restored to previous position. Actions will continue to be monitored by PSQB.

3. Notification of Serious Incidents

- TMB were briefed on the number of serious incidents since July 2018.
- There were six serious incidents between July and August. (n=5 in July, and n=1 in August).
- One of those cases qualified as a Never Event (misplaced nasogastric tube).
- Cases are under investigation and close to conclusion.
- TMB were informed that the Trust is following NHS England's Serious Incident

Framework (2015) to examine cases that may cross the threshold for reporting as a serious incident. The proper application of the 2015 Serious Incident Framework has had the effect of reducing the number of cases reported as serious incidents. TMB were aware of the reduced incidence of qualifying incidents and satisfied itself that incidents continue to be reported, decisions on their significance are multi-disciplinary and subject to consensus. Members were informed that cases that do not meet the criteria for reporting as SI are nonetheless reviewed and responded to. Matters that are verified as moderate harm or higher are subject to formal Duty of Candour and, from September 2018, compliance is positive.

4. Central Alert System Assurance

- The Director of Quality & Governance advised TMB that upon joining he initiated an urgent position statement in relation to CAS alert compliance. The stress test had helpfully revealed gaps in acknowledging alerts within the specified time, and also gaps in auctioning some alerts as required by the issuing authority. TMB were advised of the action taken for the four alerts overdue for action. The PSQB will continue to oversee delivery of these actions in order to bring this under better control.

5. Mortality Review

- The TMB were advised that the process to ensure every death is reviewed is not yet effective. In Quarter 1, 1 in 5 deaths had evidence of review. This impedes the Trust's ability to learn from deaths and improve care where required.
- The TMB received information about the action being taken to increase the number of deaths reviewed. These actions cover: (i) purchasing and utilising the mortality review tool available in Safeguard Ulysses – this will provide an electronic and simple interface to record information following review; and (ii) to change the source information on deaths to that provided by the Bereavement Service rather than via coding (which has a lag time). This will enable clinicians to target deaths for review soon after a patient has died and capture more cases on a contemporaneous basis.

6. Annual Complaints Report and Complaints Review

- TMB noted the PSQB's judgements regarding the Trust's complaints handling arrangements. Whilst there had been some improvement recently, complaints handling remains fragile and is not yet under sufficient control.
- It was acknowledged that during the Winter of 2017/18 the volume of complaints almost doubled. TMB used this opportunity to reflect upon the importance of patient flow as a control for safe, high-quality patient care.
- It was acknowledged that significant and rapid improvement in complaints handling is needed across all areas of the Trust. All divisional teams expressed a commitment to delivering the action plan and to minimising the number of concerns which become formal complaints through proactive and rapid action by the PALS service and front-line teams. TMB were advised that extra care and efforts will be targeted at learning lessons and using feedback to improve services for people who use them.

7. Policy Exception Report

- TMB were satisfied that action is being taken to address a backlog of policies and procedures overdue for review. A deadline of January 2019 to clear the backlog had been set by the PSQB.

8. Venous Thromboprophylaxis

- The TMB received and considered an escalation concerning compliance with VTE risk

assessment and chemoprophylaxis. The assurance concerned data collected in January 2018. This demonstrates that the Trust is not meeting the standards set out within Trust policies and NICE guidance. Overall, only 23% of patients received appropriate VTE prevention in accordance with expected and required standards. This represents a 7% drop compared to January 2017.

- Only 56% of patients received VTE prophylaxis within 6 hours
- 1 in 5 patients did not have VTE assessment undertaken

- TMB considered that this represented a serious and intolerable risk of harm. TMB noted that the PSQB were not satisfied with the action plan provided to their meeting and would be following up the action at their next meeting as a priority.

- TMB judgement was that the current compliance rates are failing patients, control is unsatisfactory and well below that standard expected and achievable at WUTH.

- TMB endorsed the immediate actions agreed at the PSQB meeting under the leadership of the Executive Medical Director:

  (i) Require urgent confirmation of implementation dates and action owners in the action plan
  (ii) The Interim Medical Director and Medical Director (Designate), Drs Lipton and Stevenson, to facilitate an urgent discussion (week commencing 1st October and agree the mechanism for ensuring VTE assessment and prophylaxis within Cerner. Report outcome and plan to Trust Management Board on 11th October.
  (iii) Review and address the training needs of medical staff to ensure VTE is undertaken on every eligible patient as required by national guidance.

9. Endorsement of Clinical Results

- TMB received details of an analysis of endorsement and response to abnormal or unexpected clinical findings arising from diagnostic investigations carried out as part of patient care. This issue has come to light as a causal factor in 7 serious incidents over the last 3 years. The risk principally concerns a finding of cancer or an unexpected serious clinical finding in radiological imaging what was either not recognised by the responsible clinical team and/or not acted on in sufficient time to minimise harm to the patient. Recommendations were made to introduce additional safeguards. These were approved as follows:

Actions relating to diagnostic testing requests in Cerner Millennium/Wirral Millennium

1. The Trust will establish a system in Cerner/Wirral Millennium whereby all diagnostic tests identified as **'*serious unexpected findings*'** emanating from the radiology services will be emailed to an administrator email account (proposed that this post is based in clinical support services): Note: this email will be in addition to email notification to the ordering clinician
2. The administrator within Clinical Support Division will be specifically responsible for manually tracking these 'serious unexpected findings' test reports and where a clinical review has not been undertaken escalate this matter for action to the Divisional AMD.
3. The Trust will establish a system within Cerner/Wirral Millennium whereby all unendorsed tests over 30 days old will be moved to a speciality-specific pooled in-box governed by service level SOPs
4. The administrator will be responsible for ensuring that un-reviewed diagnostic email reports over 30-day are re-directed to a pooled serviced based inbox, governed by a speciality specific SOP
5. In order to fully ensure the safety of patients the Trust will undertake a targeted review of 'serious unexpected radiology findings' results and a system review of unendorsed

tests held within Cerner/Wirral Millennium and, where necessary, recall any patients for action/further investigation as needed

10. TMB confirmed that implementation will be overseen by the Executive Medical Director.

11. MSK

- TMB received assurance regarding the implementation of MSK services. The results are encouraging and demonstrate improvements in patient experience, reduction on overall waiting times for people accessing the service and supporting a more sustainable financial position.
- This represents an excellent achievement and will help establish the approach to developing clinical pathways more generally.

12. Financial Update

- The financial position at Month 6 represents a cause for concern. This shall be considered in greater detail at the FBPAC and subsequently at Board of Directors.

13. Trainee Nurse Associate Roles

- TMB considered an outline business case for the development of Trainee Nurse Associate roles. The case is necessary to help mitigate current and anticipated the risk of nursing shortages going forward.
- The case for change is accepted in principle by TMB, however further work is required to further develop the proposed funding model.

Written on behalf of the Chief Executive by
Paul Moore
Director of Quality & Governance
18/10/2018

BOARD OF DIRECTORS	
Agenda Item	Item 10.4
Title of Report	CQC Action Plan Progress Update
Date of Meeting	1st November 2018
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	To be confirmed.
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

QUALITY IMPROVEMENT PROGRAMME UPDATE REPORT: OCTOBER, 2018

1. PURPOSE

1.1 The purpose of this paper is the ensure the Board of Directors are up to date on the progress of the CQC Action Plan, and to highlight to the Board, by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation.

2. BACKGROUND OR CONTEXT

2.1 The CQC Action Plan brings together the actions required to address the CQC compliance concerns identified following inspection in March 2018. The plan takes account of: (i) all the 'must do' and should do' recommendations contained within the inspection reports; and (ii) some improvement interventions identified locally as immediate quality priorities by the Trust. After sufficient progress has been made the plan will develop to incorporate matters highlighted as high risk within the Quality & Risk Profile for WUTH, and also evolve from a compliance plan to a broader quality improvement strategy.

2.2 The CQC Action Plan has implications for NHS Improvement's enforcement undertakings and, in this regard, it would be prudent to assure, no later than August 2019, that the Board can demonstrate: (i) it has addressed all the 'must do' and 'should do' recommendations to the CQC, NHSI and CCG satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all CQC domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

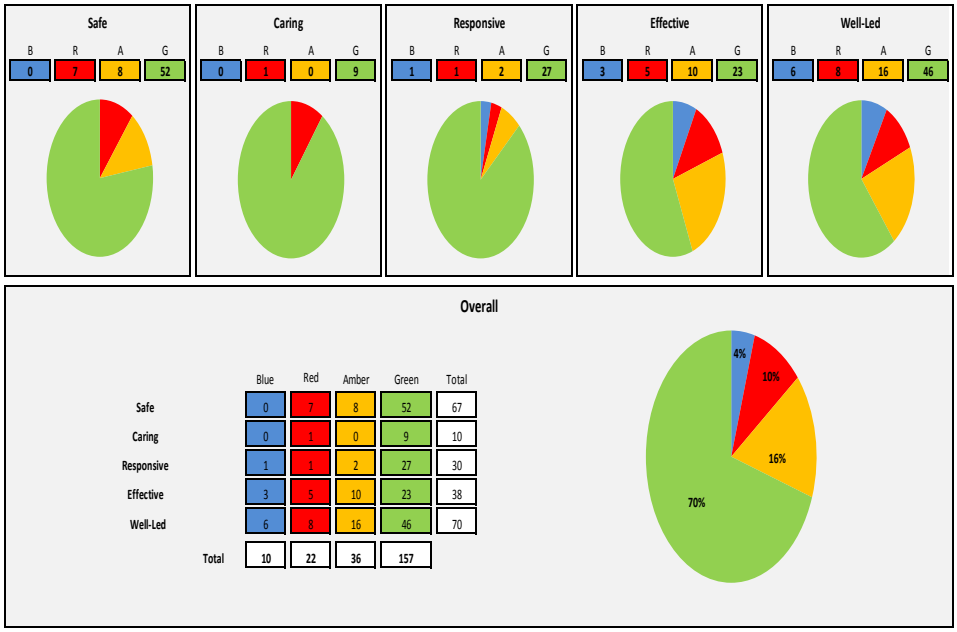
3. ANALYSIS

3.1 The CQC inspectors inspected the trust in March and May 2018 to check the quality of care at Wirral University Teaching Hospital NHS Foundation.

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	

The Trust has developed a quality improvement action plan to address all areas of shortfall in standards identified in the CQC inspection report. The quality improvement action plan has **225** specific actions/work-plans for implementation by **(31st March 2019).**

The quality improvement action plan is monitored monthly and performance is reported through to the board through the trusts Quality and safety Committee.



3.2 Exceptions:

As at the Check and Challenge meetings held 16th October 18, there are 22 actions which have been 'red' rated and are to be reported as exceptions for this reporting period, essentially due to limited or no assurance, which has given us low confidence that these actions are being suitably managed.

These are mainly in operational areas and refer to actions specifically around the design and implementation of divisional dashboards and reporting tools, Estates and COSH related actions.

A list of the 'red rated' actions are listed in annex A.

4. IMPLICATIONS

Risks

I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;
II. The Trust fails to comply with CQC Registration Regulations and has it's Certification of Registration revoked; and/or
III. A failure to resolve basic compliance concerns in respect of CQC regulations leads to further NHSI enforcement undertakings and compromise the Trust's Provider Licence.

Legal/Regulatory

Compliance with:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015;
- Care Quality Commission (Registration) Regulations 2009; and
- The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.

5. RECOMMENDATION

The Board of Directors are invited to:

- consider and discuss corrective actions to bring the CQC Action Plan back on track where necessary; and
- advise on any further action required by the Board.

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
17	Should Do	Corporate / Trust-Wide Issues	PERFORMANCE REPORTING Trust wide : The trust should ensure that divisional review of performance is undertaken effectively. Emergency Department : 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.	Design a consistent divisional dashboard that ensures review of all performance (operational and financial) metrics	Chief Operating Officer	Well Led	**UPDATED: 16.10.2018** Agreed at EMT Divisional Level dashboards modelled on new corporate quality and performance dashboard to be available on or before 30th November 18.	**01/10/2018**	
18				Implement divisional performance reporting dashboard on a monthly basis	Chief Operating Officer	Well Led	**UPDATED: 16.10.2018** Agreed at EMT Divisional Level dashboards modelled on new corporate quality and performance dashboard to be available on or before 31st December 18.	**01/10/2018**	
22	Should do	Urgent And Emergency Care (Acute & Medical Division)	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	The service should consider ways to make sure that all equipment in the department is stored appropriately.	Chief operating Officer	Well Led	**Update: 15/10/2018** The monthly IPC walk arounds will be starting again imminently. Nominated lead identified.	**31/01/2019**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
25	Should do	Urgent And Emergency Care (Acute & Medical Division)	**MIXED SEX BREACHES** The department should consider ways to ensure that all breaches of mixed sex accommodation in the emergency department review unit are recorded appropriately.	Clarify precisely the arrangements to record mixed sex accommodation breaches in ED	Chief operating Officer	Caring	Clear definition on a ward - ED is usually exempt ED excluded - to be picked up with CQC to confirm if this action is relevant. **PM to follow up with CQC** - Completed on 09.10.18 (the CQC view is that mixed sex accommodation breaches occur within ED and need to be addressed) **UPDATED 26.10.2018** – Chief Operating Officer to pick up with NHSIA or correct definition for reporting purposes.	**01/10/2018**	
37	Must Do	Corporate / Trust-Wide Issues	**PREMISES & EQUIPMENT** **Surgery :** The trust must ensure all premises are maintained and fit for purpose. The service should ensure the paediatric theatre recovery area is suitably decorated for children **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 service should review the reception and entry system arrangements for visitors to the unit.	Undertake environmental surveys (estates condition and mixed sex accommodation) for Critical Care, Ward 17 and Theatre Recovery	Chief operating Officer	Effective	Mixed sex breaches are as a result of not being able to step down - allowed for 24 hours. Because flow is not running effectively breaches occur, crit care review every month but this needs strengthening. Patients staying in crit care too long as a result of flow. 14.10.18 Action: Obtain the results of the environmental surveys undertaken by Nursing leads & Estates - these are complete. Estates risk register includes piped O2 requirement - there is an operation to manage the risk around this. **Updated: 16.10.2018** – We have been advised that this action has been completed however this is subject to confirmation from Chief operating Officer.	**01/09/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
38	Must Do	Corporate / Trust-Wide Issues		Develop a refurbishment plan for Critical Care	Chief operating Officer	Effective	In progress - plan being developed. Risk around affordability **UPDATED 20/09/18** 12/10/2018 - DS - The trust does not have a refurbishment programme in place for ward, and has not done so for around 4 years, the Estates strategy has been presented to executives, and following the agreement of the document, a refurbishment programme can be defined (subject to availability of finance) **UPDATED 26.10.2018** – Design / Feasibility study complete. Costings underway.	**01/10/2018**	
39	Must Do	Corporate / Trust-Wide Issues		Agree a trajectory for completion of the remedial works	Chief Operating Officer	Effective	In progress - plan being developed. Risk around affordability UPDATED 20/09/18 12/10/2018 - DS - The trust does not have a refurbishment programme in place for ward, and has not done so for around 4 years, the Estates strategy has been presented to executives, and following the agreement of the document, a refurbishment programme can be defined (subject to availability of finance) **UPDATED 26.10.2018** – Estate conditional survey to be complete by the end of December 2018.	**01/11/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
40	Must Do	Corporate / Trust-Wide Issues		Provide assurance to PSQB that Critical Care, Ward 17 and Theatre Recovery are fit for purpose	Chief Operating Officer	Effective	In progress - plan being developed. Risk around affordability 12/10/2018 - DS - The trust does not have a refurbishment programme in place for ward, and has not done so for around 4 years, the Estates strategy has been presented to executives, and following the agreement of the document, a refurbishment programme can be defined (subject to availability of finance) **UPDATED 26.10.2018** – Estate conditional survey to be complete by the end of December. Minor remedial works on Ward 17 will be complete by the end of November	**01/12/2018**	
41	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**SECURITY** The service should ensure that the paediatric area is secured at all times, reducing the risk of unauthorised access to the department.	Carry out a survey and risk assessment in respect of access to the Children's ED ensuring that access is restricted and controlled at all times	Chief Operating Officer	Safe	**UPDATED 26.10.2018** – ED lockdown solution design completed. Out to tender for capital works with estimated completion date before end of December 2018.	**15.08.2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
42	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Provide assurance to the Executive Team setting out the outcome of this assessment and the agreed actions	Chief Operating Officer	Safe	**UPDATED 26.10.2018** – ED lockdown solution design completed. Out to tender for capital works with estimated completion date before end of December 2018	**01/09/2018**	
43	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Implement the identified controls required to deliver full security	Chief Operating Officer	Safe	**UPDATED 26.10.2018** – ED lockdown solution design completed. Out to tender for capital works with estimated completion date before end of December 2018	**01/10/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
48	Must Do	Medical Care (Acute & Medical Division)	**PREMISES** 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.	Undertake an environmental survey of the discharge hospitality centre and day case unit	Chief Operating Officer (executive lead for Estates)	Well Led	12/10/2018 - DS -Environmental audit for Day Case or Discharge Lounge has yet to be undertaken whilst design and function is finalised. Working group has been formed for this purpose which will complete design work by December.	**01/10/2018**	
49	Must Do	Medical Care (Acute & Medical Division)		Make recommendations for improvement	Chief Operating Officer (executive lead for Estates)	Well Led	12/10/2018 - DS -Environmental audit for Day Case or Discharge Lounge has yet to be undertaken whilst design and function is finalised. Working group has been formed for this purpose which will complete design work by December	**01/10/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
65	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery :** The service should ensure all medical records are stored securely. **Maternity :** The service must ensure that women's care records are kept securely in locked cabinets at all times.	Review and assure the security of records during transit	Director of IT and Information	Well Led	**UPDATED 16.10.2018** – Due to the unavailability of the Chief Operating Officer and/or the relevant action owner no assurance was available to evaluate the progress of this action.	**01/09/2018**	
79	Must Do	Corporate / Trust-Wide Issues	**COMPLAINTS** **Trust wide :** The trust must ensure that complaints are managed effectively in line with trust policy. 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. **Emergency Department** The service should consider ways to make sure that complaints are dealt with in both a timely manner and in line with trust	Review and develop at pace the training needs for those involved in handling complaints and/or drafting responses to complaints, and provide training as required	Executive Director of Nursing & Midwifery	Responsive	**UPDATED:** Training evidence provided - date agreed 7th November - training plan in place. ***ACTION red rated due to slippage on completion date***	**01/09/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			policy. **Maternity :** The Service should ensure responses to all complaints are in line with trust policy.						
90	Must Do	Medical Care (Acute & Medical Division)	**NUTRITION & HYDRATION** The service must ensure patients' nutrition and hydration needs are met including supporting patients to eat and drink.	Hold divisional teams to account for performance in the Divisional Performance Review meetings	Executive Director of Nursing & Midwifery	Caring	**ACTION: UPDATED 10.10.2018** - *There was slippage on commencement of Divisional Performance Review meetings - action has been taken to commence DPR in November wherein colleagues will be held to account for the delivery of MUST assessment amongst other priority indicators identified*	**01/10/2018**	
113	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**PATIENT SAFETY ASSESSMENTS** 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.	Establish SOP for completion of patient safety checklists	Executive Director of Nursing and Midwifery	Safe	Aim to have operational procedures in place for all areas by end Oct 2018 **UPDATED: 10.10.2018** ACTION: Clarification from Wirral Millennium on build, and renegotiate implementation timeframes ***ACTION red rated due to slippage on completion date***	**01/09/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
115	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**MEDICINES MANAGEMENT** The service must ensure that all medicines, including controlled drugs and patient group directions are managed in line with trust policy and legislation.	**Controlled Drugs :** Implement formal action plan developed from Q1 2018/19 audit results (30/9/18). Impact is not expected to be fully evident until Q3 audit. Q2 audit is being planned for August/September 2018. Strengthen corporate and divisional accountability	Executive Director of Nursing and Midwifery	Safe	***UPDATED:* 10.10.2018 -** Implementation of action plan not on track. Deputy DoN confirmed full compliance will not be met until end December 18 ***ACTION red rated due to slippage on completion date***	**01/10/2018**	
195	Should Do	Corporate / Trust-Wide Issues	**RAISING CONCERNS** **Emergency Department** The service should ensure that staff are able to raise concerns when needed and that they are acted on in a timely manner. **Medicine :** 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.	Review, and if necessary, update the Raising Concerns at Work Policy	Executive Director of Workforce	Well Led	Review to take place. HM to CONFIRM details **Updated 10.10.2018 -** Review will take place by end November 18 ***ACTION red rated due to slippage on completion date***	**01/10/2018**	
218	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** 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.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing SOPs (1/8/18)	Chief Operating Officer	Effective	**UPDATED 26.10.2018** – The patient flow improvement group oversees the actions for general improvement against all ED standards. The ED department has created a matron post to provide real time support and oversight in addition to the shift leader role.	**01/09/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
221	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**mews SCORES** 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.	Review the provision of Critical Care Outreach Team to ensure service provision meets the needs of those patients who are escalated to it (including out of hours). Develop an action plan to meet any identified shortfalls	Executive Medical Director, Executive Director of Nursing and Midwifery	Safe	**UPDATED: 16.10.2018** MD confirmed an anticipating an increase in MET calls. A business case will be developed for outreach services. Implications of introducing NEWS2 need to be further evaluated to inform what future provision is required. ***ACTION red rated due to slippage on completion date***	**01/10/2018**	
227	Must Do	Corporate / Trust-Wide Issues	**MORTALITY REVIEWS** The trust must ensure that there is an increase in the number of primary mortality reviews undertaken to ensure effective learning.	Review and provide assurance regarding the fitness for purpose of the existing Learning from Deaths policy making changes as necessary	Executive Medical Director, Executive Director of Quality & Governance	Well Led	A rapid review has been completed, system is not 'fit for purpose' Mortality review group data to be provided as supporting evidence and purchased a new Ulysses system module Some discussion and agreement required with Bereavement services which is yet to take place ML to provide details of a nominated consultant lead to drive this forward **UPDATED 16.10.18** Roll out of new system planned for November 18 ***ACTION red rated due to slippage on completion date***	**01/09/2018**	

BOARD OF DIRECTORS	
Agenda Item	10.5
Title of Report	Programme Board Report
Date of Meeting	1st November 2018
Author	Joe Gibson (External Assurance)
Accountable Executive	Janelle Holmes – Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance **Positive** **Gap(s)**	Note for Report Writers - Ensure the mitigating action is included where gaps in assurance have been identified or alternatively where the gaps will be monitored
Purpose of the Paper **Discussion** **Approval** **To Note**	To note
Reviewed by Assurance Committee	Programme Board meeting, held on Thursday 18th October 2018
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. Introduction

At the meeting of the WUTH Board of Directors on 25 April 2018, the External Programme Assurance advised that the Board should consider the following in respect of the portfolio of change programmes and projects underway across the Trust:

1. The need for a compelling vision that will drive change
2. A strategy that provides the framework for the change programme
3. Establishing a Programme Board to drive and manage change
4. Dealing with CIP at the right time in the right place
5. Agreeing the change tools and techniques that fit the context
6. Having one, concise, version of the assurance evidence
7. Receiving monthly updates of the progress of change
8. Engaging with and fully employing the STT capabilities

It was agreed that this list of 8 key actions was essential to get the right grip of, and establish tempo within, the change programme.

2. Vision and Strategy

It is understood that the Trust Board have been actively pursuing the refresh of both item '1 Vision' and '2 Strategy' in the intervening period. This short paper provides Directors with a view on the progress of actions 3-8.

3. Establishing a Programme Board

The final Transformation Steering Group was held on 18 Jul 18. Since that time there have been 3 meetings of the Programme Board on 16 Aug, 20 Sep and 18 Oct 18. The role of the Programme Board includes, but is not limited to:

- directing and leading a programme of major transformational change as identified in the 'scope'.
- monitoring the development, implementation and delivery of the relevant work-streams in Trust's change programme, including the identification and monitoring of the delivery of the associated projects.
- ensuring that all new concepts/ideas submitted are considered for formal sponsorship and, if adopted, are registered within the 'Programme Assurance' framework.
- assuring that the 'Programme Assurance' framework holds each work stream project responsible for developing a benefit realisation plan as well as identifying and mitigating potential risks to quality and service.
- monitoring sustainability of completed projects, and review regularly in order to ensure the project is going to plan.

The Programme Board, chaired by the Chief Executive, has proved extremely well attended to date and has a Non-Executive Director in attendance. It is starting to now refine the scope of the programme (see current scope at Annex A), address the need to prioritise time and effort and bring a benefits-led approach to the conception and delivery of change.

4. Dealing with CIP at the right time and place

The CIP management is now managed through the Finance, Business and Performance Group which feeds into the Finance, Business and Performance Assurance Committee. While the financial contribution of major change programmes is a key part of the delivery of benefits, the Programme Board places this element within the context of the overall engagement of staff and management of change.

5. Agreeing the Change Tools and Techniques

There is a wealth of change tools and techniques in use across the portfolio, some gaining more traction than others. An action was agreed at the October Programme Board to define and issue a core set of templates as the minimum compliant standard across the programmes. This toolkit is nearing completion and will be issued before the November Programme Board (where it will be ratified).

6. One Concise Version of the Assurance Evidence

There is now a 'single version of the truth' in the form of a dashboard providing ratings in 9 domains of assurance across each programme to answer the questions:

- Is the scope and approach defined?
- Is an effective project team in place?
- Are all stakeholders engaged?
- Is project governance in place?
- Has a Quality Impact Assessment been completed?
- Is a milestone plan defined/on track?
- Are KPIS on track?
- Are risks identified and being managed?
- Are issues being identified and managed?

These ratings are applied in line with an objective guide, laying out criteria – the standard – for each domain; it is used to populate all programme/project reports to the Programme Board. It will also be used to inform future monthly reporting to the Trust Board of Directors.

7. Receiving Monthly Updates (at Trust Board)

This reporting will commence for the November Board of Directors meeting to an initial format to be agreed with the Chief Executive, Chair of the Programme Board.

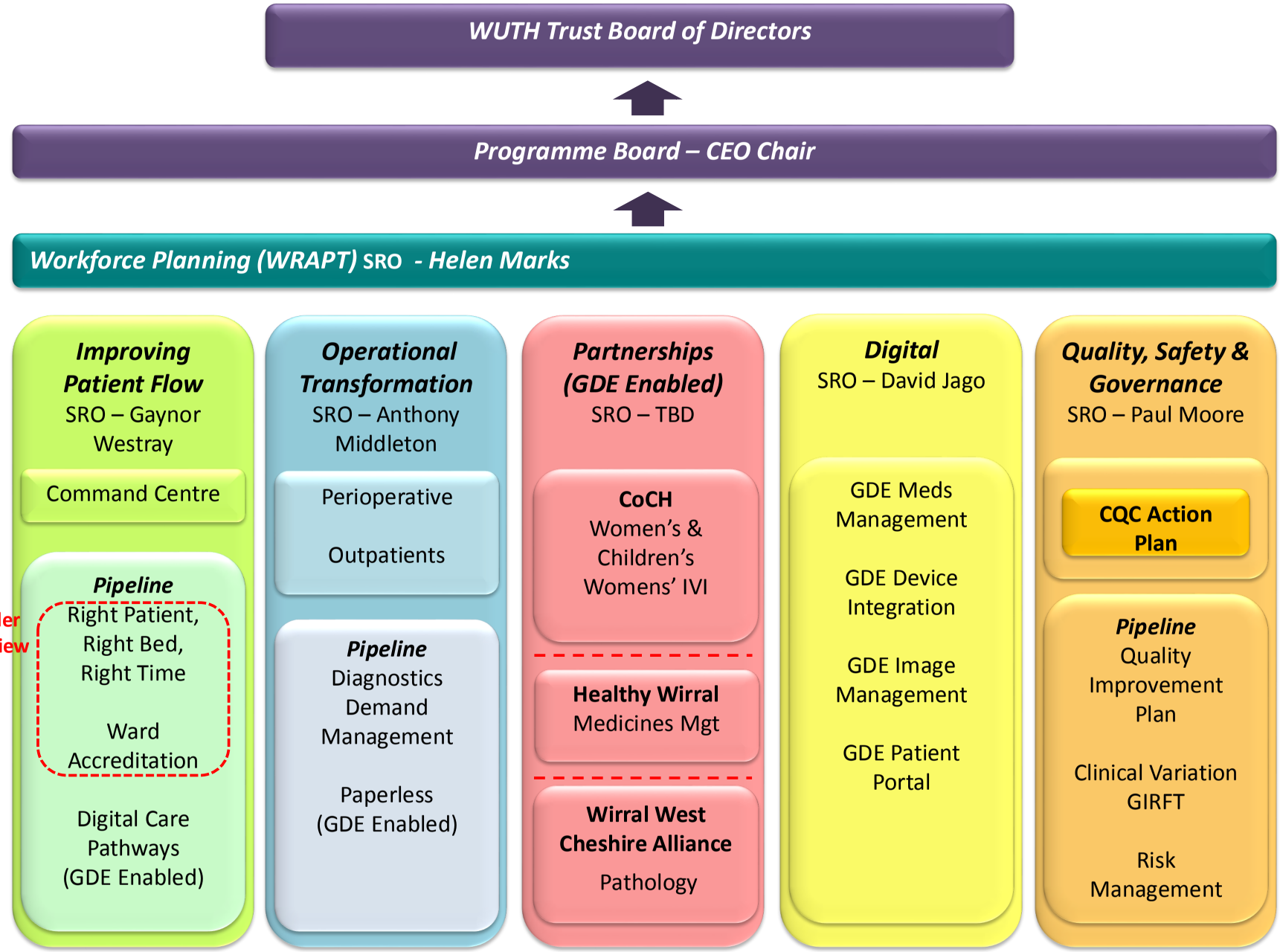
8. Fully Employing the STT capabilities

The formation of a Programme Board and the appointment of the Director of Transformation and Partnerships has created much more fertile ground for the work of the Strategic Transformation Team. The team is working closely with the 'External Programme Assurance' to address all areas of concerns and bring all programmes to an acceptable assurance standard as quickly as possible.

9. Conclusion

Solid progress has been made against all of the key issues raised in the review of April 2018. The leadership, engagement and focus at the Programme Board is particularly noteworthy. While there remain a range of significant issues to fix across the piece, the framework is now in place to facilitate this and growing signs of conviction in the programme as a delivery vehicle.

Joe Gibson
External Programme Assurance


WUTH Trust Board of Directors
Programme Board – CEO Chair
Workforce Planning (WRAPT) SRO - Helen Marks
Improving Patient Flow
SRO – Gaynor Westray
Command Centre
Pipeline
Under Review
Right Patient, Right Bed, Right Time
Ward Accreditation
Digital Care Pathways (GDE Enabled)
Operational Transformation
SRO – Anthony Middleton
Perioperative
Outpatients
Pipeline
Diagnostics Demand Management
Paperless (GDE Enabled)
Partnerships (GDE Enabled)
SRO – TBD
CoCH
Women's & Children's Womens' IVI
Healthy Wirral
Medicines Mgt
Wirral West Cheshire Alliance
Pathology
Digital
SRO – David Jago
GDE Meds Management
GDE Device Integration
GDE Image Management
GDE Patient Portal
Quality, Safety & Governance
SRO – Paul Moore
CQC Action Plan
Pipeline
Quality Improvement Plan
Clinical Variation GIRFT
Risk Management

Board of Directors	
Agenda Item	10.6
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	1 November 2018
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8. Strategic Objective – Enabled by financial, commercial and operational excellence
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Charitable Funds Committee 17 October 2018

This report provides a summary of the work of the Charitable Funds Committee which met on 17 October 2018.

1. Chair's Business

New Non-Executive Director members Jayne Coulson and John Coakley were welcomed to the Committee. The Chair extended thanks to Graham Hollick for his services to the Committee over recent years.

2. Head of Fundraising Report

The Head of Fundraising presented a summary of progress since August's meeting. This included the development of further promotional items, lottery progress, website development, newsletters, and the new Arrowe Park office. It is hoped that the new office will have a ceremonial opening in December, which represents significant progress. Difficulties to date were noted in recruiting support staff and volunteers at speed.

There was also a summary of future fundraising events, and outline proposals for appeals.

Taking into account risks and resourcing in the near future, it was agreed that a smaller 1 year appeal should be established as soon as possible, with planning for a larger appeal (exceeding £1m, launch 2020) occurring concurrently. The Committee requested further proposals from clinicians for the smaller appeal by 31 October, with approval of recommendations to follow shortly thereafter, and further planning information to be presented at the next meeting.

The focus of the larger appeal might be identified during the forthcoming capital planning process, but it was noted that the current availability of capital funding introduces difficulties in earmarking potential appeals schemes. The Committee recognised that WUTH Charity is in its infancy, with a significant number of competing neighbouring charities, whilst also expressing a keen interest in enabling accelerated income growth.

3. Finance Report

The income, expenditure and closing positions, as at 31 August 2018, for each of the Charity's 'Big 8' funds were reviewed. Incomes were noted to be low and growing, in line with the Head of Fundraising's inward-facing Workplan during the early months of this year, with significant incomes 'in the pipeline' but not yet recognised.

The Head of Fundraising's remit extends to cover voluntary income 'straight to Trust', and this grants work was also noted.

The basis of the apportionment of overheads to the 8 funds was discussed, and it was agreed that the apportionment should be weighted more towards the Patient Wish (general) fund. This will be considered in further detail in January's meeting.

4. Cycle of Business

It was agreed that the Committee would meet three times per year. The workplan of the Committee would be adequately covered by the new Cycle.

5. *Fundraising and Income Guidance* and *Expenditure Guidance* - policy documents

These two key Charity policies are binding on staff via the Standing Financial Instructions, and as such, act as Trust policies, outlining the Committee's intentions for income generation and charity-granted expenditure undertaken by staff. The policies were re-approved, including minor updates, having been re-presented in line with the Cycle of Business. It was agreed that they are comprehensive and clear. The Assistant Director of Finance gave assurance to the Committee that supplementary materials and participatory sessions delivered by the Head of Fundraising had offered a friendly, accessible route into key areas of these policies.

6. *Reserves Policy* and *Treasury Management Policy*

Revised annual policies were approved for 2019/20, which are broadly in line with the 2018/19 policies. Progress on improving treasury returns on cash will be reported back to the Committee in January. The Committee noted a non-material, decreasing variance between the reserves as at 31 August 2018 and the target reserves of £125k.

7. Recommendations to the Board of Directors

The Committee wishes to bring to the Board's attention the following items.

- WUTH Charity is now coming to the end of 'phase 1', which was inward-facing and focused on *brand, networks, systems and governance*. It is now entering an outward-looking growth phase.
- The rate of growth will largely depend on resource, and more detailed plans are to be drawn up once future appeal schemes have been confirmed.
- The Committee intends to approve the focus of the first 'smaller' appeal in early November.