Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

28th November 2018

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 28 NOVEMBER 2018
COMMENCING AT 9AM 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**		
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	5.1.2 Board Action Log Board Secretary	d	Page 17
6	**Chief Executive's Report** Chief Executive	d	Page 20
7. Quality and Safety			
7.1	**Patient Story** Head of Patient Experience	v	
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	Page 22
	8.1.2 Month 7 Finance Report Director of Finance	d	Page 46
9. Workforce			
	No Agenda Items		
10. Governance			
10.1	**Report of Quality and Safety Committee** Chair of Quality and Safety Committee	v	
10.2	**Report of Programme Board** Director of Transformation & Partnerships	d	Page 63

10.3	**Report of Trust Management Board** Director of Governance & Quality	d	Page 90
10.4	**CQC Action Plan Progress Update** Director of Governance & Quality	d	Page 95
10.5	**Consultant Revalidation and Appraisal Annual Report** Medical Director	d	Page 122

11. Standing Items

11.1	**Items for BAF/Risk Register** Chair	v
11.2	**Any Other Business** Chair	v
11.3	**Date and Time of Next Meeting** Wednesday 19th December 2018.	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

1 NOVEMBER 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 Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
John Coakley	Non-Executive Director

In attendance

Paul Moore	Director of Quality and Governance
Natalia Armes	Director of Transformation & Partnerships
Paul Charnley	Director of IT and Information
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Dr King Sun Leong	Associate Medical Director, Medical & Acute
Andrea Leather	Board Secretary [Minutes]
Steve Igoe	Associate Non-Executive Director
Joe Allan *	Associate Director of Nursing, IP&C
Gary Price*	Divisional Director, Women & Childrens
Dr Sue Wells	Chair, Healthy Wirral /CCG
Lyndsay Young	Communications & Marketing Officer
Steve Evans	Governor
John Fry	Governor
Jane Kearley*	Member of the Public

Apologies

Helen Marks	Director of Workforce
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 18-19/112	**Apologies for Absence** Noted as above.	
BM 18-19/113	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/114	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair explained there were no additional items to report outside of the agenda.	

Reference	Minute	Action
BM 18-19/115	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Nursing & Midwifery** – the Board learned that the Trust that since formally launching the Falls Strategy there has been significant improvement in performance which is detailed in the Quality & Performance Dashboard (see item BM 18-19/120). There are now four Quality buses which travel around the Trust sites with monthly themes identified eg 'Stoptober' – stop moving vulnerable patients out of hours. **Director of Quality and Governance** – the revised governance structure is now being enacted with the first cycle of the meetings currently underway. Mr Moore reported that subsequent to the introduction of the Serious Incident Review Group performance management regarding Serious Untoward Incidents (SUI's) had improved with no breaches since August 2018. **Mr John Sullivan, Non-Executive Director** – has recently visited the Surgery Division to observe the implementation of the improvement plan which encompasses culture, silo working, cross functional teams, performance management/compliance, turnover and the physical environment. Mr Sullivan along with Mr Chris Clarkson will continue to meet with Dr Ranjeev Mehra, Associate Medical Director by way of monitoring progress and opportunity to speak with staff. **Mrs Sue Lorimer – Non-Executive Director** – the Board was informed discussions were ongoing with NHSI regarding the forecast outturn for 2018/19. A meeting was to be convened to consider the options to provide a sustainable financial plan. **Mr Chris Clarkson, Non-Executive Director** – the Board was advised of the positive feedback received regarding the Bereavement Service. The Board requested a presentation at the next meeting to explain how this service provides support to families. **Associate Medical Director Medical & Acute** – newly appointed Dr Leong reported that he was currently evaluating and observing practices within the Division with a particular focus on A&E and streamlining. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that a Child Family hub is to be developed. Discussions are underway in relation to a neonatal services across Merseyside. The Board will be kept informed of the outcomes of those discussions. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board of development programme on the Clatterbridge site to maximise use and support winter pressures.	**GW**

Reference	Minute	Action
	Mrs Jayne Coulson, Non-Executive Director – having impromptu meetings with junior doctors has highlight some areas for improvement, mainly regarding technology. **Mr John Coakley, Non-Executive Director** – apprised the Board of matters regarding theatres particularly protecting elective / day case during the winter period. The Board were assured that this matter would be addressed via the Winter Planning arrangements. **Chief Operating Officer** – the Board was apprised that the tender process re the provision of additional staff car parking had closed earlier in the week. An initial review showed the costs higher than expected and this would be revisited as part of the capital spend review. In addition the tender specifications are to be benchmarked again NHSI guidance. **Medical Director** – Dr Stevenson apprised the Board of the long term planning being undertaken which will consider productivity growth of 1.1% per annum that mainly relates to pay and staffing. It will also encompass job planning, e-rostering and length of stay. Following the recent visit of Keith Ridge, Chief Pharmaceutical Office for NHSE extremely positive feedback of 'best in class' was received and how the Trust should promote the good practice. The Board requested a presentation at a future meeting regarding the medicines optimisation work and opportunity for providing a masterclass for other organisations. **Director of Finance** – Mr David Jago informed the Board that the negotiations regarding the lease with the RVS have now been concluded. Mr Jago reported that discussions were ongoing regarding the development of the residential facilities and negotiations with a third party. The Board be noted that the Director of Transformation and Partnerships, Natalie Armes, Director of IT and Information, Paul Charnley and Non Executive Directors, Steve Igoe and Graham Hollick had no items to report.	**JH/AL**
BM 18-19/116	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 25 July 2018 were approved as an accurate record with one minor amendment: **Item BM 18-19/098** (page 8), para 5 – should read *'Jayne Coulson had not received assurance that the number of complaints recorded, reflected receipt via nay means and not just those received in paper form.'* **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	

Reference	Minute	Action
BM 18-19/117	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Regulation 28: Prevention of Future Death** – the Trust has received correspondence from the Coroner 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. 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 Director of Quality & Governance has been instructed to lead on the Trust's response to the actions identified in the Coroner's letter. **Serious Incidents** - in September 2018 the Trust declared one incident that crossed the threshold for reporting as a serious incident. Duty of Candour was completed and staff have been supported as an investigation progresses. **Neonatal** – the clinical teams of Wirral University Teaching Hospital, Alder Hey Children's NHS FT and Liverpool Women's NHS FT are to establish a series of workshops to discuss issues pertaining to neonatal services (and wider women's and children's services). They will consider 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. **Cheshire & Merseyside Provider Group meeting** – at it's meeting on 16th October 2018, future commissioning models and Age Related Macular Degeneration (AMD) were discussed. A summary is provided within the Chief Executive report. **System Improvement Board** – following recent investigations and a CQC rating of 'requires improvement' NHS Improvement has placed the Trust on its 'Challenged' provider programme. The programme gives support to the Trust to successfully implement its improvement plan. The governance for this includes a System Improvement Board made up of partner organisations, regulators and patient representatives and will be chaired by NHS Improvement. The first System Improvement Board will be held on 8 November 2018 and thereafter meet on a quarterly basis. ***The Board noted the information provided in the October Chief Executive's Report.***	
BM 18-19/118	**Patient Story** The planned patient story was postponed as apologies were received due to sickness. Therefore the Director of Nursing & Midwifery shared two pieces of feedback received in October regarding Macmillan service and the bereavement service. The first regarding the Macmillan cancer service team - my father recently had bowel cancer and a resection at Arrowe Park hospital. Our MacMillan nurse was Angela Delaney. We first met Angela at my dad's pre-operative appointment. My dad is 86 and appreciated the way Angela took time to	

Reference	Minute	Action
	explain things clearly to him. He loved his patient diary and looked at it often. As his daughter, and a nurse myself, I appreciated Angela so much. She felt more like a friend by the end of everything. Angela liaised with us through all Dads' appointments and results. Unfortunately my Mum, and Dad's wife of 60 years passed away unexpectedly and delayed his surgery. Angela shared in our sorrow, and kept up with us until we were able to arrange his surgery date. He had his bowel resection successfully and is healing well. I felt Angela and the MacMillan team at Arrowe Park were exceptional in their care and expertise and would like to recognise the program at this hospital. Thank you MacMillan for having this wonderful service available! The second regarding bereavement service and support offered following a 20 year old gentleman who sadly died (expected) after diagnosis of cancer. I felt that it was only right to let you know about the experience my sister had at the Bereavement Office. Sadly she lost her only son last week, and as you can imagine was quite distraught and completely clueless as to what procedures she needed to follow. She said that Marsha and the staff in the Bereavement Office were absolutely wonderful. They were able to answer all her questions, provide her with all the information she would need and generally made sure she understood everything. She said that she left their office feeling as if a load had been taken from her shoulders. This Trust needs more Departments like this, and I really hope that you pass on my family's sincerest thanks and make sure that they all know what a difference they made as such an awful time. ***The Board noted the feedback received regarding the Macmillan and Bereavement services.***	
BM 18-19/119	**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 IPC practices within the Trust. The report outlined the Trust's current position of HCAI: • *Clostridium difficile* • Carbapenemase producing *Enterobacteriaceae* (CPE) • *E. coli* • MRSA • Ward / department cleaning scores, including thermal disinfection. The processes within the Trust to reduce the incidence of avoidable healthcare associated infections are currently being reviewed by the Infection Prevention Control Team. The review includes getting 'back to basics' with cleaning, hand hygiene, skin disinfection, education / training and ensuring that a number of measures in place are appropriate to deliver safe clean care.	

Reference	Minute	Action
	Below is a summary of the Trust's current position of 'alert' organisms: • 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* hospital attributable cases – 23 cases against a threshold of 23 cases (2018/19 threshold – 42 cases) • CPE all confirmed cases – 69 cases (screening specimens, currently no threshold). A discussion followed in relation to elements of the Improvement Plan, it was agreed that the plan should identify timeframes to monitor future progress. ***The Board noted the progress to date and were advised that future updates would be provided via the Chairs report of the Quality Committee.***	**GW**
BM 18-19/120	**Quality & Performance Dashboard and Exception Reports** The Chief Operating Officer presented the revised report which provided a summary of the Trust's performance against agreed quality and performance indicators. The 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 Board were advised that the Quality & Performance Dashboard is work-in-progress and will develop further over time. The report summary to indicate the main areas of discussion for the Board. Of the 52 indicators with established targets or thresholds 36 are currently off-target or failing to meet performance thresholds. The lead Director for each of these indicators provided a brief synopsis of the issues and the actions being taken. A query was raised regarding A&E performance and how this is linked to issues regarding ambulance handovers. The Chief Operating Officer informed the Board that at the November meeting of Finance, Business, Performance & Assurance Committee a 'deep dive' presentation regarding A&E performance would be take place. This will also reflect the concerns in relation to ambulance handovers which are impacting patient flow. In addition, attention was drawn to the current live consultation led by the CCG which proposes the development of an urgent treatment centre based at the Arrowe Park site. The Board will be appraised of progress regarding this matter. Director of Nursing & Midwifery reported the increase in nursing vacancy rate and the actions in progress to address the gaps such as the option to train Nursing Associates and how the Trust promotes the organisation during recruitment. The increase has predominantly been as a result of approval for funding to permanently establish three 'escalation/winter wards' and WAFFU from June 2018. In conjunction, the short and long term sickness policies are being reviewed which will emphasise the manager's role in supporting an employee's health and wellbeing.	

Reference	Minute	Action
	It was acknowledged that Trust performance was impacted by inefficiencies in primary care which means that approximately 30% of patients would not be in hospital if the appropriate services were in place. It was noted that as part of the Healthy Wirral Plan led by the Clinical Commissioning Group (CCG) the metrics to manage elderly frail patients are being considered and this may enable the Trust to review its bed capacity. Medical Director informed the Board that the Clinical lead for VTE is leading on a VTE redesign process within Cerner to include an automatic prompt for VTE assessment and treatment. Following introduction of this change improved compliance with this target should be seen. The Board welcomed and supported the development of the new quality performance dashboard. The Board discussed the benefit of incorporating a forecast, where applicable. This will be developed further for relevant indicators. It was agreed that future reports to include narrative as to how the failing indicators will achieve 'green' rating. Also consider if a target is currently unachievable would an interim target be appropriate. ***The Board acknowledged that the new dashboard has brought into sharp focus those areas where current performance requires improvement. The Board were satisfied for those indicators not yet under prudent control, that action is being taken to improve. This being overseen by the Trust Management Board.***	**AM,PM, GW,NS**
BM 18-19/121	**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 mobilisation of a robust Winter Plan. Specifically for the Trust this entails the provision of an additional 48beds to be phased in over the winter period. It was reported that this objective had been achieved although discussions regarding the funding of the additional beds are ongoing. The Surgery Division are reviewing options to maintain elective working during the winter period, this work is being led by the Associate Medical Director - Surgery. ***The Board noted the update provide in relation to the Wirral A&E Delivery Board.***	
BM 18-19/122	**Month 6 Finance Report** The Director of Finance apprised the Board of the summary financial position. At the end of month 6, the Trust reported an actual deficit of £18.1m versus planned deficit of £16.3m, an adverse to plan of £1.8m. The Board was apprised that the underlying deficit is closer to £20m given release of £1.1m of non-recurrent support during Quarter 1 and the sepsis accrual of £0.8 in month 6.	

Reference	Minute	Action
	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. It was reported that Outpatients is reporting below plan at £0.6m with an adverse performance in month at £69k. The Trust had achieved a Use of Resource (UoR) rating of 3, which had been in line with plan and had been supported by the deliverance of agency expenditure of £3.66m versus a cap of £3.74m. Additional key aspects apprised to the Board included: • Non pay expenditure was above plan at £2.1m, noting MSK outsourcing costs of £1.5m, therefore £0.6m above plan. • CIP had delivered £3.7m versus plan of £2.8m. • Cash balances at the end of September were £6.6m, exceeding plan by £4.5m driven by robust working capital management and below plan capital expenditure. The Director of Finance outlined to the Board that the likely forecast outturn deficit at the end of month 6, remained at circa £30m with a best case deficit and actions required to deliver this standing at £25m. The Board was not supportive of revising the year end forecast as detailed in the report. The Board requested Executive Directors to review the assumptions made when approving the £25m deficit and consider alternative options such as increase CIP, funding for winter beds and future job plans to reduce the proposed revised deficit of £30.5m by at least £2.5m. Proposals to be discussed at the next FBPAC meeting. ***The Board noted the M6 finance performance and requested the proposed year end forecast be reviewed further and provide an update at the next meeting.***	**DJ**
BM 18-19/123	**2019/20 Planning Guidance and Payment Reform** The Director of Finance notified the Board that the Trust had received tariff reform and planning guidance proposals in mid October 2018. A local impact assessment of the tariff proposals is currently underway and the Board of Directors will receive a verbal update on local impact at its end of November meeting given full tariff detail will be know by mid December. 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. The 2019/20 Planning Guidance highlights plans are 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.	

Reference	Minute	Action
	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. 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. The payment system reform proposals for 2019/20 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. The Director of Finance highlighted the main areas of risk: • relationship between the fixed and variable elements of the blended payment model - 2019/20, NHSI propose that the variable element be set at 20% of the HRG price; • market forces factor - 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). It is proposed to top slice Trusts clinical income by 0.35%(For WUTH currently proposed £1.3m) to fund SCCL overheads • maternity pathway - NHSI propose making all maternity prices non-mandatory and additionally 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. The Board were informed that 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.	**DJ** **DJ**

Reference	Minute	Action
	The Board noted the 2019/20 planning and tariff reform key issues.	
BM 18-19/124	**Freedom to Speak Up (FTSU) Six Monthly Update** Gary Price, Divisional Director, Women & Children introduced the Freedom to Speak Up six monthly update, highlighting the key areas for discussion. The last 12 months has seen a decrease in concerns raised of 40.8% compared to the previous 12 month period. The majority of individuals raising concerns are employed in a clinical capacity, which is a reflection of the national pattern. The recording of activity has evolved over a 2 year period and all Trusts now report against the same criteria. 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. To address this concern the Trust has arranged joint training with 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 managers with a range of tools and skills to enhance and promote good management practices. 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. The Board were notified that 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. Since the visit the Trust has received a 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. The Board requested future reports to include comparisons with Trusts who have better engagement. The Board discussed and subsequently approved the NHSI self-review tool which had been reviewed by the Workforce Assurance Committee. ***The Board noted the progress achieve during the past six months in relation to the Freedom to Speak up programme.***	**HM**
BM 18-19/125	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director, apprised the Board of the key aspects from the recent Workforce Assurance Committee (WAC), held on 25th October 2018.	

Reference	Minute	Action
	Values & Behaviours – the Trust is currently reviewing its values and behaviours. The Board were informed that the Staff Engagement Group will be driving the work and an area of focus is leadership credibility which has previously led to low organisational confidence and there will be real change in behaviours throughout the organisation. **Communications & Engagement Update** – the Board were advised that the Trust's response rate to the NHS staff survey was slightly below the national average of 21%. The survey has been circulate to all staff compared to previous years when only a proportion of staff were able to participate. All efforts to encourage participation are being promoted across the Trust. **Equality & Diversity –** 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. WAC was assured that the Trust 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 Trust's workforce and its patients. **Guardian of Safe Working Quarterly Report** – WAC received a summary of key areas from Dr Younis. 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. The Associate Medical Director – Medical & Acute stated that it was not unusual for low attendance at junior doctors meetings unless there was a issue to discuss. A WhatsApp group has also been established to support engagement with junior doctors. ***The Board noted the areas covered in the report.***	
BM 18-19/126	**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], held on 23rd October 2018. **M6 Finance Report** – the Director of Finance reported that the Trust had delivered a deficit of £18.1m against a plan of £16.3m. 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. 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 CiP performance.	

Reference	Minute	Action
	The Committee expressed concern with the deterioration of the forecast financial positon and the 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. **Integrated Performance Dashboard** – FBPAC highlighted 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 FBPAC. **Cheshire & Mersey HCP Update** – Director of Finance advised the Board that at recent meetings of the Cheshire & Mersey HCP key workstreams are being progressed and the work that would support the development of a long term financial model that delivered financial sustainability for the region. ***The Board noted the report of the Finance Business Performance & Assurance Committee.***	
BM 18-19/127	**Report of Trust Management Board** The Chief Executive provided a summary report of the Trust Management Board (TMB) meeting on 11th October 2018. The reports outlined matters agreed by the TMB for escalation to the Board: **Notification of Serious Incidents** – there were six serious incidents between July and August. One of those cases qualified as a Never Event and all cases are under investigation and close to conclusion. 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. **Central Alert System Assurance** – going forward PSQB will oversee delivery of actions in order to ensure better monitoring. **Mortality Reviews** – the Trust is to increase the number of deaths reviewed. Actions to support this process are: (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; (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. **Annual Complaints Report and Complaints Review** – due to an increase of complaints during winter 2017/18 the 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. 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	

Reference	Minute	Action
	issue has come to light as a causal factor in 7 serious incidents over the last 3 years. The report identified recommended actions to introduce additional safeguards relating to diagnostic testing requests in Cerner Millennium/Wirral Millennium. **Trainee Nurse Associate Roles** – an outline business case for the development of Trainee Nurse Associate roles was considered. The case is necessary to help mitigate current and anticipated the risk of nursing shortages going forward. Whilst the case for change was accepted in principle by TMB, further work is required to further develop the proposed funding model. ***The Board noted the report of the Trust Management Board.***	
BM 18-19/128	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the report provided progress pertaining to the CQC Action Plan. The paper summarised the outcomes following the recent 'check and challenge 'meetings, and outlined the corrective actions to bring the CQC Action Plan back on track where necessary. ***The Board noted the progress to date of the CQC Action Plan and the corrective actions required to meet the March 2019 deadline.***	
BM 18-19/129	**Report of Programme Management Board** The Director of Transformation & Partnerships appraised the Board of the positive external assurance received in relation to each element of work as detailed in the report. The Programme Management Board will enable a holistic view all development programmes whilst enabling challenge, rigour and support to unlock programmes. To date solid progress has been made against all of the key issues raised in the review of April 2018. The Strategic Transformation 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. ***The Board noted the Programme Management Board report and progress to date following the introduction of the programme development framework.***	
BM 18-19/130	**Report of Charitable Funds Committee** Mrs Sue Lorimer, Non-Executive Director, apprised the Board of the key aspects from the Charitable Funds Committee held on 17th October 2018. The Committee received a progress update from the Head of Fundraising	

Reference	Minute	Action
	which outlined the development of further promotional items, lottery progress, website development, newsletters, summary of future fundraising events 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. 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. Further proposals from clinicians for the smaller appeal have been requested by 31 October for further discussion and planning at the next meeting. ***The Board noted the progress to date regarding future development of fundraising opportunities and approved the smaller one year appeal with planning for a larger appeal in 2020.***	
BM 18-19/131	**Items for BAF/Risk Register** Board Assurance Framework The Director of Quality and Governance confirmed that the current BAF had been reviewed at FBPAC and work was being undertaken on an updated BAF format in preparation of the next financial year. ***The Board noted the future development of the revised Board Assurance Framework.***	
BM 18-19/132	**Any Other Business** The Chair on behalf of all Board members extended thanks to Graham Hollick for his services to the Board over recent years.	
BM 18-19/133	**Date of next Meeting** Thursday 28th November 2018.	

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Chair

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Date

Board of Directors Action Log
Updated – November 2018

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 1.11.18						
1	BM 18-19/115	Bereavement Service presentation to explain how this service provides support to families.	**GW**	Complete	December 2019	This item to be scheduled within Board development programme
2		Request Pippa Roberts, Director of Pharmacy and Medicines Management to present to the Board an overview of the medicines optimisation work	**AL**	Complete - request sent to Pippa Roberts who has agreed to provide overview of medicines optimisation	January 2019	This item to be scheduled within Board development programme
3		Discuss with Pippa Roberts the opportunity to provide a medicines optimisation masterclass for other organisations	**JH**		January 2019	
4	BM 18-19/119	IPC Improvement Plan to identify timeframes to monitor future progress	**GW**		January 2019	
5		Q&P - future reports to include narrative as to how the failing indicators will achieve 'green' rating. Also consider if a target is currently unachievable would an interim target be appropriate	**AM,PM, GW,NS**		January 2019	
6	BM 18-19/122	Proposed year-end forecast to be revisited and update to be provided at the next Board	**DJ**	Complete	November 2019	Incorporated in month 7 finance report
7	BM 18-19/123	Report outlining the local impact assessment of tariff proposals to be provided at the next meeting.	**DJ**	Verbal update to be provided pending full tariff details being released December 14th	December 2018	
8		detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received early in December 2018	**NA**		January 2019	

	BM 18-19/123	Future 'freedom to speak up reports' to include comparisons with Trusts who provide better engagement			January 2019	
Date of Meeting 27.9.18						
1	BM 18-19/095	Board to be provided with regular updates from the Serious Incident panel	**PM**	Complete	Ongoing.	Notification on a case by case basis, plus inclusion in the CEO report
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**	Complete	January 2019	Reported to October Board
3	BM 18-19/100	Winter Plan – key components of Winter Plan to be incorporated within Stakeholder Comms	**HM**	Complete	Ongoing	Wirral Health Econ Communications plan presented to Wirral A&E Development Board (Nov '18). Also storyboard for staff being finalised.
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**	Complete	Ongoing	Contained within implementation plan and will be monitored by the Workforce Assurance Committee
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	December 2018	Revised report to Dec FBPAC
Date of Meeting 25.7.18						
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**	Complete	Ongoing	
14	BM 18-19/084	Identified 7 key Board Assurance Framework themes to be incorporated within overall Strategic Plan.	**PM**	Complete	Ongoing	Reported to Board 1.11.18
15	BM 18-19/088	Review of Board Papers to be incorporated within overall governance review.	**PM**	Complete	Ongoing	Recognised standard of reporting to be developed
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**	Complete	October 2018	Associate Medical Directors now attend Board

3	BM 18-19/052	Post Board Away Day – engagement session with Board & Consultant Body re Vision and Strategy.	**NS/NA**	Complete	September 2018	Workshops for each Division underway.
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**	Complete	September 2018	Discussed at Risk Management Committee (Oct '18) – recognised the need to review and refocus emphasis on H&S management. H&S to transfer under governance support unit to achieve closer alignment with risk and quality.
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**	Complete	Ongoing as part of environmental work.	Ongoing – concurrent audit being undertaken and posters being removed & replaced.

BOARD OF DIRECTORS	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	28th 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 any important announcements in November 2018.

Quality & Risk Profile Meeting

At the end of October 2018 NHS England Cheshire & Merseyside held a Quality & Risk meeting. The aim of this meeting was to discuss the draft Quality Risk Profile (QRP), which had been developed by commissioners and regulators and shared with the Trust.

Subsequently the Trust has received a revised copy of the Quality Risk Profile. This will form the basis of the improvement plan along with the CQC action plan and will be monitored as part by the System improvement Board.

The inaugural meeting of the System Improvement Board was on the 8th November 2018 where the tracking of the improvement plan as described above was agreed.

Serious Incidents

In October 2018 the Trust declared three incidents that crossed the threshold for reporting as a serious incident. These concerned firstly a patient falling resulting in a subdural haemorrhage. The completed incident investigation report identified learning; however there were no causal errors or omissions identified in the care or treatment of the patient. Secondly a patient was over-sedated leading to unplanned admission to ITU and thirdly a delay in recognising serious complications for a patient who had returned a continuous ECG Monitor. The investigations for incidents two and three are currently on-going. Duty of Candour was completed and staff have been supported as an investigation progresses.

Undergraduate Medical Education Quality Visit

The undergraduate medical education quality visit occurred on 20th November. Preliminary feedback from the visit was positive with recognition of the improvements since the last visit in 2016. The organisation continues to get positive feedback from students. Formal feedback and any required improvement will be agreed & monitored through the workforce assurance committee

Wirral A&E Delivery Board

There are a number of system improvement actions being overseen by the Board in support of the winter plan. These include:

- 90 day improvement cycle with NWAS to improvement ambulance turnarounds.
- Single front door streaming programme in the emergency department
- Development of a system command centre over the winter period
- Executive review of stranded and superstranded patients
- Additional domiciliary care packages using the additional £1.8m social care funding for winter
- Go live of additional winter bed capacity
- 7 day working across all system providers
- Flu vaccination compliance

The regulators commended the Wirral winter plan and the additional actions to support resilience. In addition the regulators have requested that Wirral CCG share the financial risk of the additional 48 acute beds required for winter following the health economy demand and capacity work. The executive teams of both organisations are working through the financial impact of this.

Janelle Holmes
Chief Executive
November 2018

BOARD OF DIRECTORS	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	28.11.2018
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 October 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 55 indicators with established targets or thresholds:

- 32 are currently off-target or failing to meet performance thresholds
- 22 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 October 2018.

November 2018

Produced 22.11.18

Quality Performance Dashboard

		Indicator	Director	Threshold	Set by	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD	13 month Trend	In-year 2018/19 Trajectory
2	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	1.75	1.84		
3		Eligible patients having VTE risk assessment within 6 hours of decision to admit	MD	≥95%	WUTH	74.3%	78.6%	64.3%	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	77.0%	73.6%		
4		Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	MD	≥95%	SOF	95.90%	96.01%	95.38%	95.31%	95.55%	95.18%	95.25%	95.27%	94.65%	95.31%	95.04%	95.62%		95.2%		
5		Harm Free Care Score (Safety Thermometer)	DON	≥95%	National	95.0%	92.7%	94.3%	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.7%		
6		Serious Incidents declared	DQ&G	≤48 pa (= 4 per month)	WUTH	12	16	11	6	10	6	6	14	13	3	2	1	3	42		
7		Never Events	DQ&G	0	SOF	1	0	0	0	1	0	0	0	0	1	0	0	0	1		
8		CAS Alerts not completed by deadline	DQ&G	0	SOF	1	0	1	1	3	0	0	1	5	1	0	0	0	7		
9		Clostridium Difficile (avoidable)	DON	≤28 for FY18-19, 2.42 per month	SOF	3	1	2	1	1	3	4	1	3	1	3	0	3	15		A M J J A S O N D J F M
10		E.Coli infections	DON	≤42 pa (No more than 3 per month)	WUTH	6	7	2	4	1	2	4	2	6	7	2	3	5	29		
11		CPE Colonisations/Infections	DON	TBC	WUTH	16	21	20	16	13	10	11	14	17	18	18	15	13	106		
12		MRSA bacteraemia	DON	0	National	0	0	0	0	0	1	0	0	0	0	0	0	0	0		
13		IPC Audit of Practices and Procedures (random areas)	DON	≥75% (gold)	WUTH	76%	77%	77%	73%	73%	78%	83%	81%	78%	77%	78%	74%	75%	78.0%		
14		Hand Hygiene Compliance	DON	100%	WUTH	94%	93%	94%	89%	94%	99%	95%	97%	88%	89%	90%	81%		90.0%		
15		Medicines Storage audits - % of areas fully compliant	MD	100%	WUTH	78%	74%	-	52%	51%	52%	57%	70%	69%	71%	74%	72%	73%	69.4%		
16		Surgical Site Infections (data once per year over 3 months)	DON	TBC	WUTH	Indicator Under development															
17		Surgical Safety Checklist Compliance	MD	100%	WUTH	Indicator Under development															
18		Protecting Vulnerable People Training - % compliant (Level 1)	DON	≥95%	WUTH	89.2%	91.2%	90.9%	90.6%	89.9%	89.5%	89.2%	-	-	87.4%	-	85.6%	90.4%	88.1%		
19		Protecting Vulnerable People Training - % compliant (Level 2)	DON	≥95%	WUTH	80.0%	80.3%	81.1%	81.3%	80.7%	82.5%	84.8%	-	-	82.7%	-	82.2%	86.0%	83.9%		
20		Protecting Vulnerable People Training - % compliant (Level 3)	DON	≥95%	WUTH	80.8%	83.5%	84.6%	83.6%	83.8%	85.2%	85.6%	-	-	85.6%	-	86.5%	87.2%	86.2%		
21		Nursing Vacancy Rate	DHR	≤6.5%	WUTH	6.48%	5.96%	6.09%	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%		
22		Consultant Vacancy Rate %	DHR	≤6.5%	WUTH	5.30%	7.71%	7.75%	7.47%	8.26%	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	6.88%		
23		Sickness absence % (12-month rolling average)	DHR	≤4%	SOF	4.55%	4.58%	4.61%	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.78%		
24		Short-term sickness (in month rate)	DHR	TBC	WUTH	2.21%	2.43%	1.92%	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.13%		
25		Long-term sickness (in-month rate)	DHR	TBC	WUTH	2.18%	2.32%	2.88%	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.60%		
26		Care hours per patient day (CHPPD)	DON		WUTH	-	-	-	-	-	-	-	-	-	7.6	7.5	7.1	6.9	7.3		

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Quality Performance Dashboard

		Indicator	Director	Threshold	Set by	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
29	Effective	SHMI	MD	≤100	SOF	–	–	94.04	–	–	99.49	–	–	–	–	–	–		99		
30		HSMR	MD	≤100	SOF	91.0	73.0	89.0	88.0	88.0	88.0	88.7	93.0	93	95	–	–		91		
31		Mortality Reviews Completed				Indicator Under Development															
32		Nutrition and Hydration - MUST completed at 7 days	DON	≥95%	WUTH	–	–	–	–	–	–	44%	59%	71%	78%	67%	74%	80%	67.6%		
33		SAFER BUNDLE: % of discharges taking place before noon	COO/ DON	≥33%	National	16.3%	16.7%	18.1%	18.0%	18.4%	17.3%	17.9%	17.6%	18.8%	18.4%	17.5%	18.1%	19.1%	18.2%		
34		SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	COO/ DON	≤156	WUTH	370	369	369	412	417	422	418	405	341	386	387	411	383	390		
35		SAFER BUNDLE: Expected date of discharge achieved	COO/ DON	TBC	WUTH	Indicator Under Development															
36		Length of stay - elective (actual in month)	COO	TBC	WUTH	4.0	4.4	5.0	3.9	10.2	4.0	3.8	4.3	3.8	4.1	4.1	4.2	4.3	4.1		
37		Length of stay - non elective (actual in month)	COO	TBC	WUTH	4.8	5.0	5.2	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1		
38		Emergency readmissions within 30 days	COO	TBC	WUTH	880	884	891	849	840	814	886	923	873	913	961	888	936	911		
39		Delayed Transfers of Care	COO	TBC	WUTH	25	15	14	11	12	9	13	12	13	13	6	18	12	11.4		
40		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%	74.0%	74%		
41		% of national clinical audits participation / % required	DQ&G	100%	National	–	–	–	–	–	–	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%		
42		% Theatre Utilisation	COO	≥85%	WUTH	86.8%	89.3%	82.9%	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	89.5%	88.4%		

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Quality Performance Dashboard

	A	B	D	E	F	H	I	J	K	L	M	N	O	P	Q	R	S	T	V	AA	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
44		**Indicator**	**Director**	**Threshold**	**Set by**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**18/19 YTD**	**Trend**	**In-year 2018/19 Trajectory**												
45	**Caring**	Same sex accommodation breaches	DON	0	SOF	15	9	16	12	18	16	18	22	10	8	16	14	19	107													
46		FFT Recommend Rate: ED	DON	≥95%	SOF	91%	92%	88%	92%	87%	82%	85%	90%	91%	89%	89%	86%	87%	88%													
47		FFT Overall Response Rate: ED	DON	≥25%	WUTH	14.0%	12.0%	11.0%	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11%													
48		FFT Recommend Rate: Inpatients	DON	≥95%	SOF	97%	98%	98%	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%	98%													
49		FFT Overall response rate: Inpatients	DON	≥25%	WUTH	23.0%	19.0%	17.0%	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	19%													
50		FFT Recommend Rate: Outpatients	DON	≥95%	SOF	94%	95%	95%	95%	94%	94%	95%	95%	94%	95%	94%	94%	94%	94%													
51		FFT Recommend Rate: Maternity	DON	≥95%	SOF	100%	93%	93%	97%	98%	100%	97%	97%	99%	96%	100%	100%	96%	98%													
52		FFT Overall response rate: Maternity	DON	≥25%	WUTH	30%	27%	30%	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	32%													

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Quality Performance Dashboard

		Indicator	Director	Threshold	Set by	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
55	Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	COO	≥95%	SOF	87.8%	85.7%	78.4%	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	81.7%		A A A A A S O N D J F M
56		12 hour trolley waits	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
57		Ambulance Handovers >30 minutes	COO	TBC	National	268	252	651	528	427	623	414	327	291	213	326	474	371	345		
58		Patients leaving ED without being seen	COO	≤5%	WUTH	2.1%	2.0%	4.0%	2.4%	3.0%	4.5%	2.9%	2.8%	1.5%	1.7%	1.6%	2.3%	2.2%	2.1%		
59		18 week Referral to Treatment - Incomplete pathways < 18 Weeks	COO	≥92%	SOF	80.9%	80.9%	77.7%	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	76.5%		A M J J A S O N D J F M
60		Referral to Treatment - cases exceeding 52 weeks	COO	0	National	1	9	11	30	51	69	66	67	79	57	56	40	43	58		A M J J A S O N D J F M
61		Diagnostic Waiters, 6 weeks and over -DM01	COO	≥99%	SOF	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%		
62		Cancer Waiting Times - 2 week referrals	COO	≥93%	National	98.3%	98.8%	97.4%	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	94.4%		
63		Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	COO	≥96%	National	96.9%	96.6%	97.0%	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.3%	96.5%		
64		Cancer Waiting Times - 62 days to treatment	COO	≥85%	SOF	86.4%	85.5%	85.9%	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	90.9%	87.2%		
65		Cancelled outpatient appointments	COO	TBC	WUTH	6214	5937	5304	6437	5808	3451	6101	6017	6502	6864	6744	6169	7094	45491		
66		Cancelled elective admissions - TCIs	COO	TBC	WUTH	268	322	316	711	307	345	206	190	243	218	234	203	266	1560		
67		Cancelled Operations (on the day of planned surgery)	COO	TBC	WUTH	25	24	30	12	27	20	9	26	15	8	2	7	7	74		
68		Did Not Attend - Outpatient Appointments	COO	≤6.5%	WUTH	8.5%	8.3%	9.1%	8.6%	8.0%	8.1%	8.3%	8.6%	8.2%	8.7%	8.9%	8.7%	8.3%	8.5%		
69		Appointment slot issues (Outpatient Utilisation)	COO	TBC	WUTH	2701	2326	1730	1532	1703	1812	2325	2477	3646	3868	4076	4117	4383	3556		
70		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	111	886		
71		Patient Experience: Number of complaints received in month - Levels 2 to 4	DON	TBC	WUTH	20	22	21	44	31	30	35	21	37	24	27	24	20	188		
72		Complaint acknowledged within 3 working days	DON	100%	National	75%	95%	100%	96%	100%	97%	94%	81%	95%	72%	75%	80%	100%	85.3%		
73		First written response within policy timescale	DON	100%	WUTH	3%	0%	17%	27%	37%	17%	18%	29%	23%	22%	8%	30%	46%	25.1%		
74		Number of re-opened complaints	DON	≤5 pcm	WUTH	5	2	6	4	4	1	2	2	6	4	0	3	2	19		

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Quality Performance Dashboard

		Indicator	Director	Threshold	Set by	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
77	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		
78		Live employee relations cases	DHR	≤30	WUTH	–	–	–	25	22	29	30	33	35	36	32			33		
79		Duty of Candour compliance (for all moderate and above incidents)	DQ&G	100%	National	–	–	–	–	–	–	–	–	–	–	–	100%	100%	100.0%		
80		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		
81		% Mandatory Training compliance	DHR	≥95%	WUTH	–	–	–	–	–	have	73.0%	–	74.8%	75.1%	82.0%	81.4%	82.2%	82.2%		
82		% Appraisal compliance	DHR	≥88%	WUTH	86.8%	88.2%	85.5%	84.3%	83.4%	83.3%	84.9%	–	81.1%	79.2%	78.2%	77.5%	78.4%	78.4%		

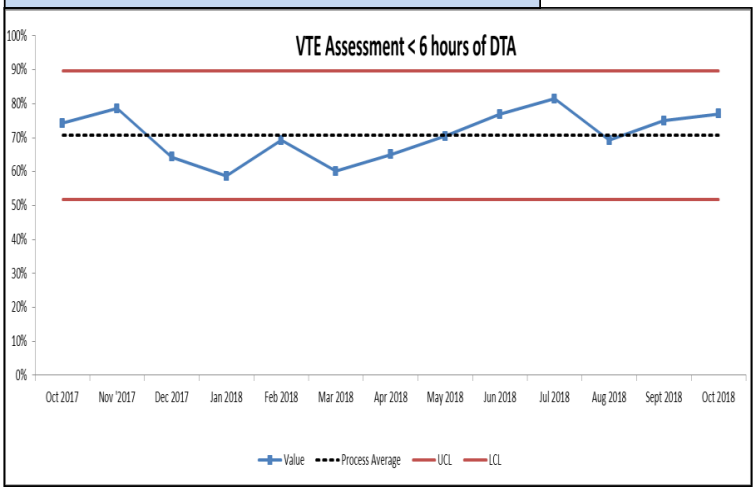
November 2018

Produced 22.11.18

Quality Performance Dashboard

	A	B	D	E	F	H	I	J	K	L	M	N	O	P	Q	R	S	T	V	AA	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ
84		**Indicator**	**Director**	**Threshold**	**Set by**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**18/19 YTD**	**Trend**	**In-year 2018/19 Trajectory**													
85	Use of Resources	I&E Performance	DoF	On Plan	WUTH	-2.039	-1.402	-3.712	-2.315	-1.614	6.485	-4.261	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-19.402									O	N	D	J	F	M
86		I&E Performance (Variance to Plan)	DoF	On Plan	WUTH	-2.219	-1.639	-2.898	-2.624	-0.424	0.162	-0.298	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-1.880														
87		NHSI Risk Rating	DoF	On Plan	NHSI	3	3	3	3	3	3	3	3	3	3	3	3	3	3														
88		CIP Forecast	DoF	On Plan	WUTH	-38.6%	-38.1%	-38.4%	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-10.6%														
89		NHSI Agency Ceiling Performance	DoF	NHSI cap	NHSI	36.9%	14.8%	19.6%	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	0.4%														
90		Cash - liquidity days	DoF	NHSI metric	WUTH	-20.3	-22.3	-17.5	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0															
91		Capital Programme	DoF	On Plan	WUTH	66.3%	65.5%	68.6%	53.1%	51.2%	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	35.8%														

Eligible patients having VTE risk assessment within 6 hours of decision to admit



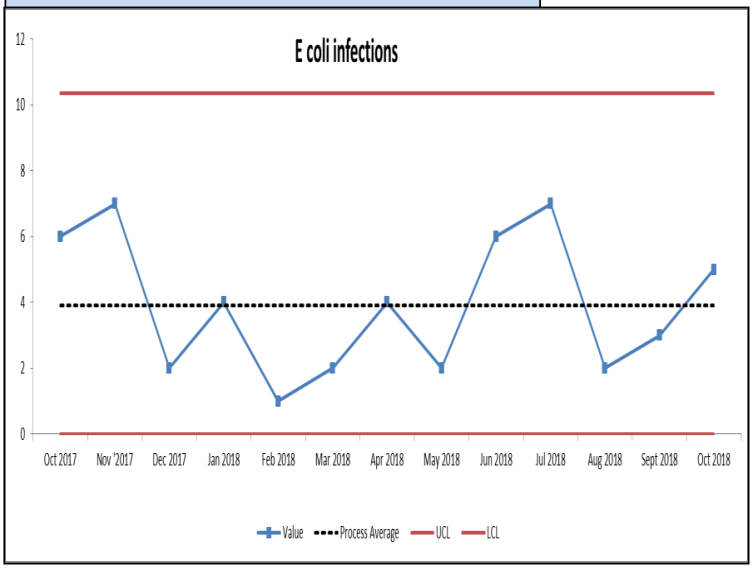
Executive Lead: Medical Director

Issue: The national target for VTE assessment within 6hrs is ⩾95%. The trusts current performance is 74%. 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

E.Coli infections



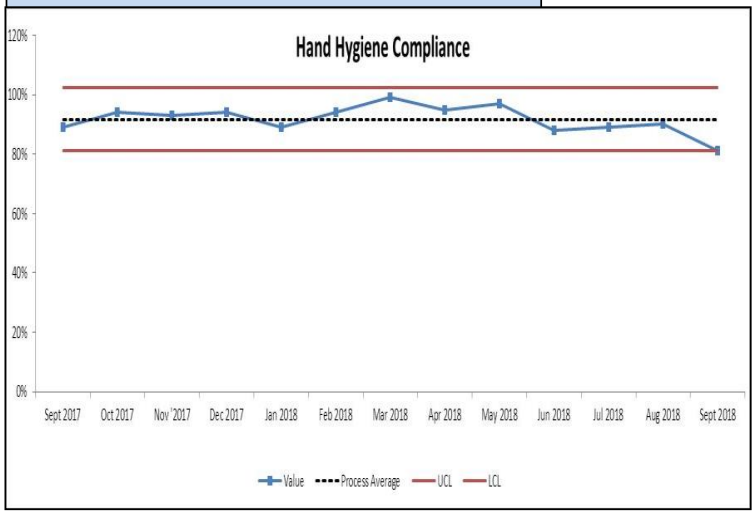
Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a control target of no more than 3 cases of E.coli per month. The performance for the first seven months of 2018/2019 is 29 recorded cases of E.coli infection.

Decision: Current performance Inadequate. Strengthen controls.

Action: Infection control regular report to PSQB (monthly) to monitor compliance following the relaunch hand hygiene competencies. Divisions to audit compliance via the Perfect Ward app.

Hand Hygiene Compliance



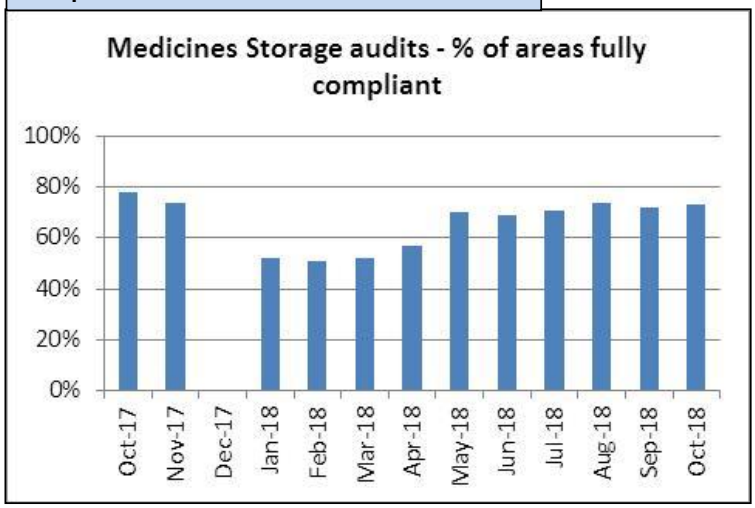
Executive Lead: Director of Nursing & Midwifery

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

Decision: Current performance Inadequate. Strengthen controls.

Action:
Infection control regular report to PSQB (monthly) to monitor compliance following the relaunch hand hygiene competencies.

Medicines Storage audits - % of areas fully compliant



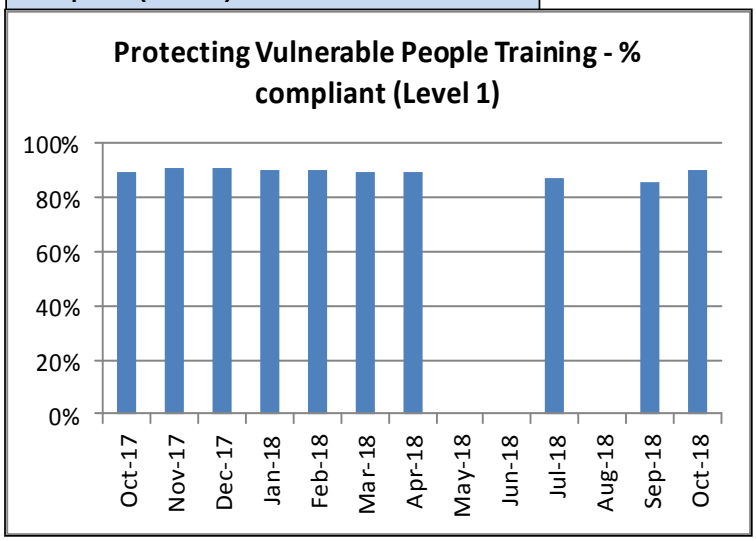
Executive Lead: Director of Pharmacy & Meds Optimisation

Issue: The trust currently has a Year to date compliance of 69.4% 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)



Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a target of 95% for vulnerable people training (level 1). The 2018/19 YTD performance is 88.1 which is below target and has remained relatively static throughout the year

Decision: Current performance Inadequate. Strengthen controls.

Action:
Compliance for all Divisions by March 2019.

Protecting Vulnerable People Training - % compliant (Level 2)

Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a target of 95% for vulnerable people training (level 2). The 2018/19 YTD performance is 83.9 which is below target and has remained relatively static throughout the year.

Decision: Current performance Inadequate. Strengthen controls.

Action:
Compliance for all Divisions by March 2019.

Protecting Vulnerable People Training - % compliant (Level 3)

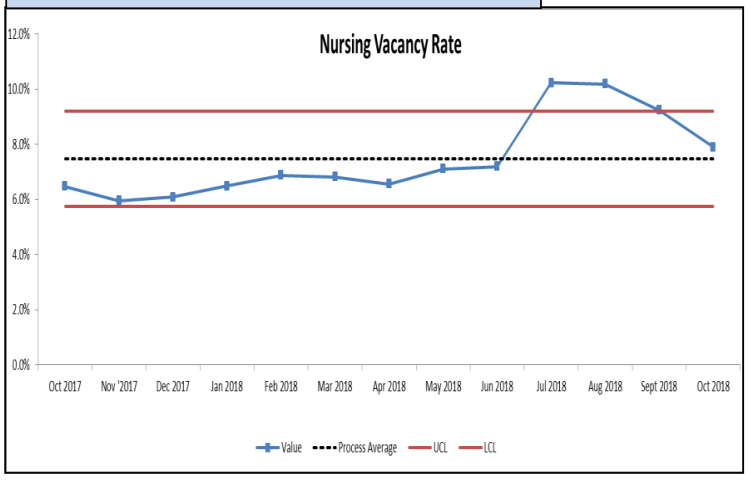
Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a target of 95% for vulnerable people training (level 3). The 2018/19 YTD performance is 86.2% which is below target and has remained relatively static throughout the year

Decision: Current performance Inadequate. Strengthen controls.

Action:
Compliance for all Divisions by March 2019.

Nursing Vacancy Rate



Executive Lead: Director of Nursing & Midwifery

Issue: The current Year to date Nursing vacancy rate is 7.90% which is above a target of 6.5%

Decision: Current performance Inadequate. Strengthen controls.

Action:
To participate in the Cheshire & Merseyside network for workforce programme to support future workforce planning. To introduce social media tools to promote vacancies and encourage application, monitoring via Workforce Assurance Committee.

Consultant Vacancy Rate

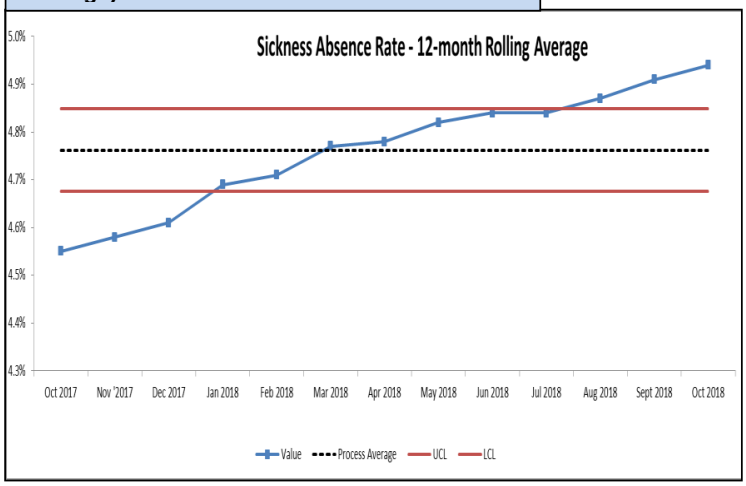
Executive Lead: Medical Director

Issue: The current Year to date Consultant vacancy rate is 6.88% which is above a target of 6.5%

Decision: Current performance Inadequate. Strengthen controls.

Action:
Continue to monitor consultant vacancies at Divisional Performance Reviews and Workforce Performance Group. Recently recruited 4 consultants, awaiting start dates.

Sickness absence % (12-month rolling average)



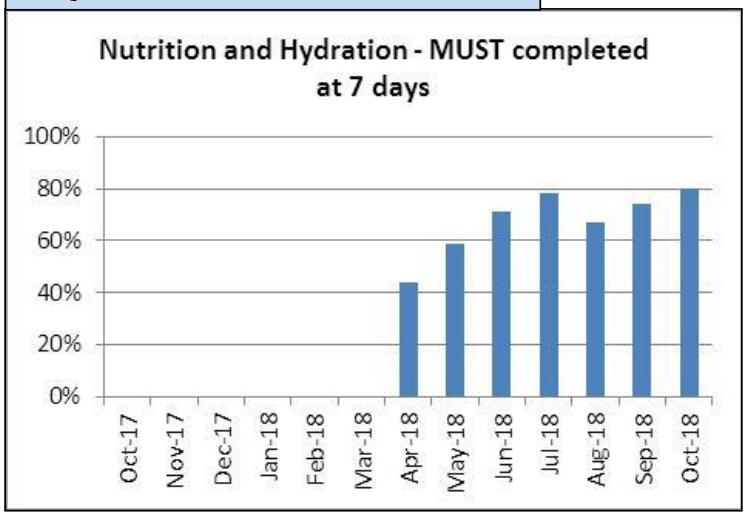
Executive Lead: Director of Workforce

Issue: The Year to date sickness absence rate is 4.94% which is above the trust target of 4%.

Decision: Current performance Inadequate. Strengthen controls.

Action: A position statement for each long term sickness case (over 4 weeks) to be provided to the Director of Workforce will be 30th November 2018. The plans will then be reviewed to test out the robustness of the plans.

Nutrition and Hydration - MUST completed at 7 days



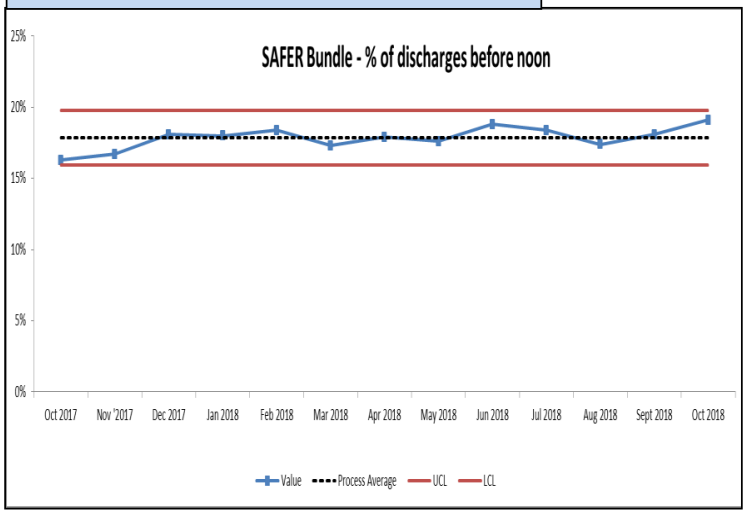
Executive Lead: Director of Nursing & Midwifery

Issue: The trust compliance with MUST completed at 7 days is 80% for October '18 which is below the trust target of 95%

Decision: Current performance Inadequate. Strengthen controls.

Action:
Introduction of daily monitoring at ward level, in addition to auditing via Perfect Ward app to achieve Trust target compliance by March '19.

SAFER BUNDLE: % of discharges taking place before noon



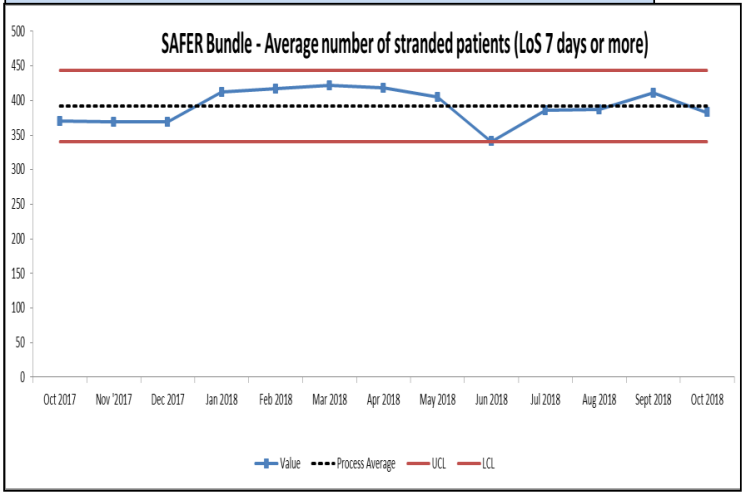
Executive Lead: Chief Operating Officer

Issue: The Trust currently has a Year to date 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: Recent service changes to support earlier discharge: Introduction of 'Early Ward Support' team in DHC, ward based Matrons in morning. Command Centre to commence w/c 3rd Dec.

SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual



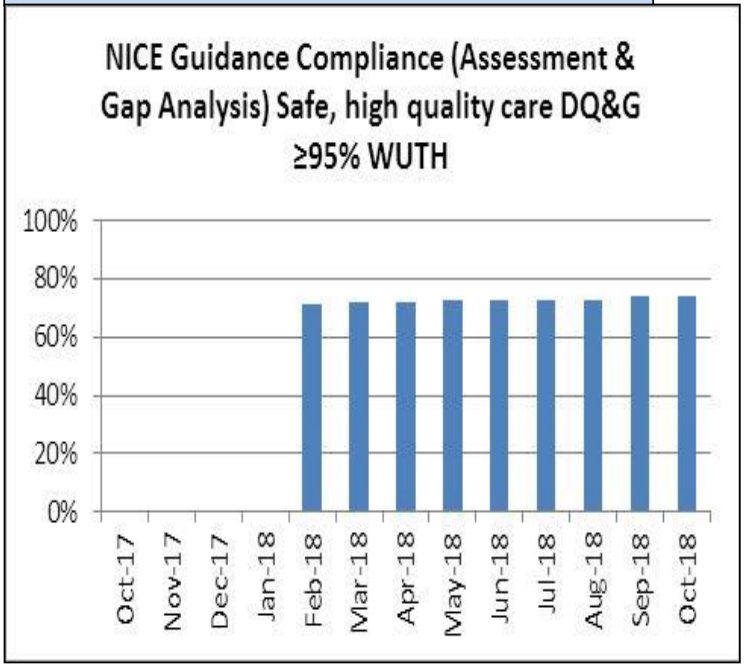
Executive Lead: Chief Operating Officer

Issue: The Year to date number of stranded patients at 10am in hospital for 7 days or more is 390, which is significantly above a target of 156

Decision: Current performance Inadequate. Strengthen controls.

Action: Recent service changes: Redesign of stranded patient review process- twice desk based review of all stranded patients with Matrons and IDT professional leads.

NICE Guidance Compliance (Assessment & Gap Analysis)



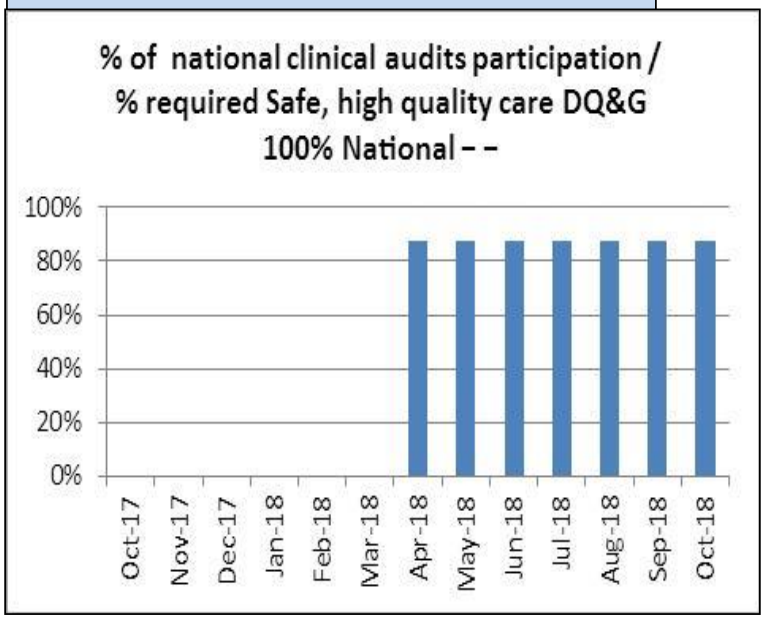
Executive Lead: Director of Governance & Quality Improvement

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

Decision: Current performance measures are incorrect, in that we are recording all variances from NICE guidelines as none compliant, including decisions where medical decision has been not to implement.

Action:
Adoption of NHS conventions for measuring compliance. Centralisation of NICE governance. New reporting commencing December 2018. Anticipate high levels of compliance.

% of national clinical audits participation / % required



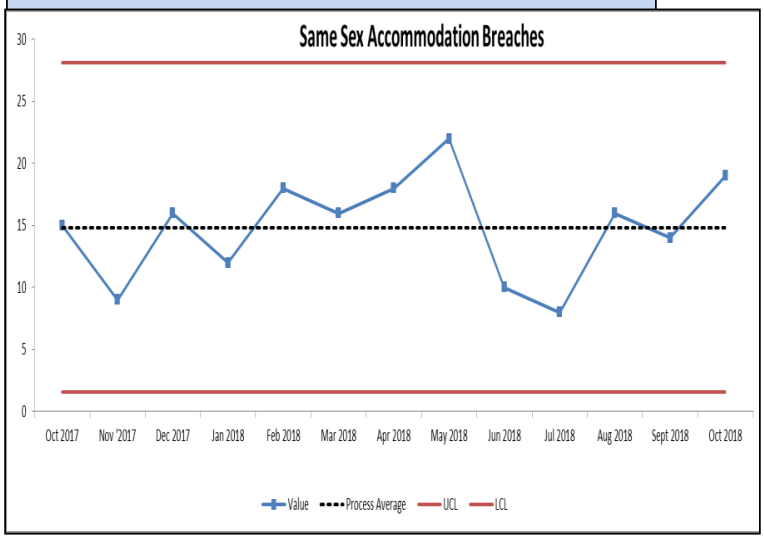
Executive Lead: Director of Governance & Quality Improvement

Issue: The Trust has not had a formal clinical audit programme in place for a number of years. The Trusts clinical audit function has not been fit for purpose.
As a result the Trust is not fully participating in all mandatory audits. The Trust cannot recover this position in 2018/19.

Decision: Consolidation on all audits currently in process.

Action
Prepare for fully participation in mandatory audits in 2019/2020
Develop formal Trust clinical audit plan 2019/2020.

Same sex accommodation breaches



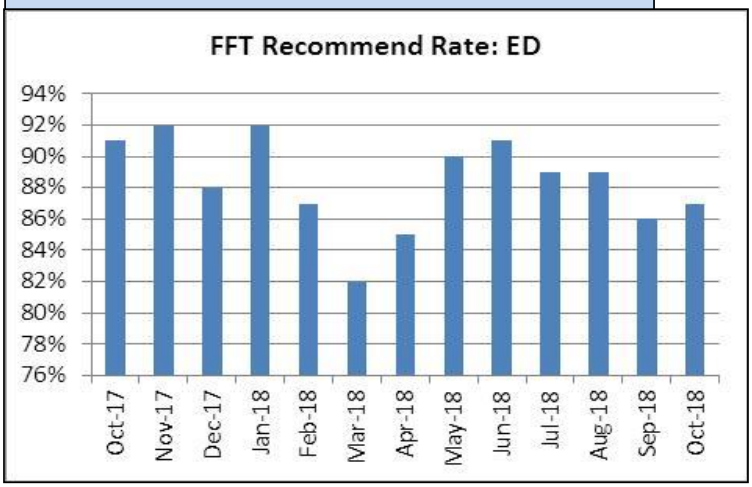
Executive Lead: Chief Operating Officer

Issue: The trust has a target of 0 case for same sex accommodation breaches. The 2018/19 Year to date performance is 107 incidents where patients have been treated in mixed ward accommodation.

Decision: Current performance Inadequate. Strengthen controls.

Action: Majority of breaches related to Critical Care(CC); CC developing step down prioritisation tool to support timely CC step down via Bed Bureau processes

FFT Recommend Rate: ED



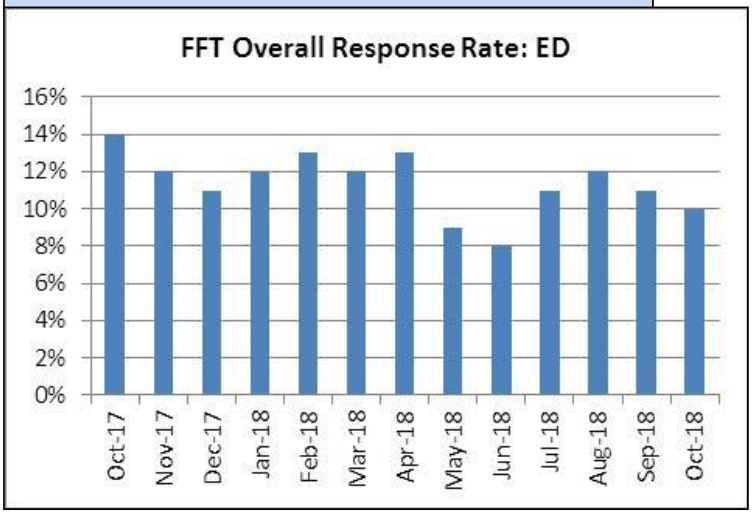
Executive Lead: Director of Nursing & Midwifery

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

Decision: Current performance Inadequate. Strengthen controls.

Action: PSQB to monitor progress following introduction of access to Envoy texting, touch screen FFT survey in department.

FFT Overall Response Rate: ED



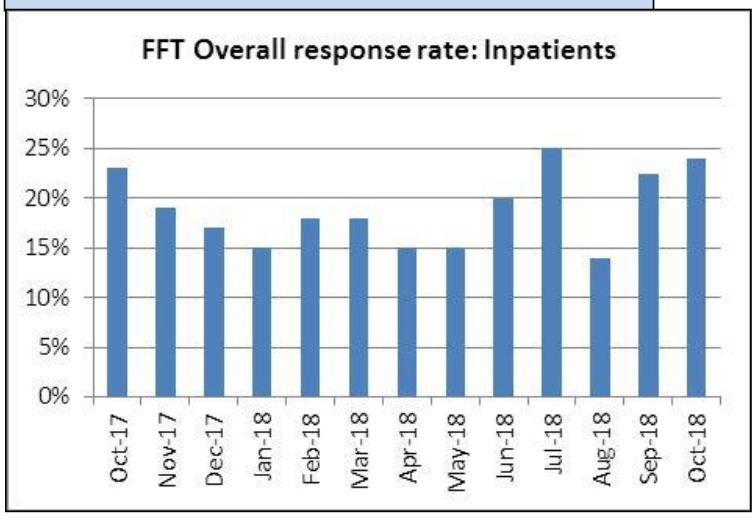
Executive Lead: Director of Nursing & Midwifery

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:
To improve response rate other methods of collecting feedback introduced in both adults and children's ED and will be monitored by PSQB.

FFT Overall response rate: Inpatients



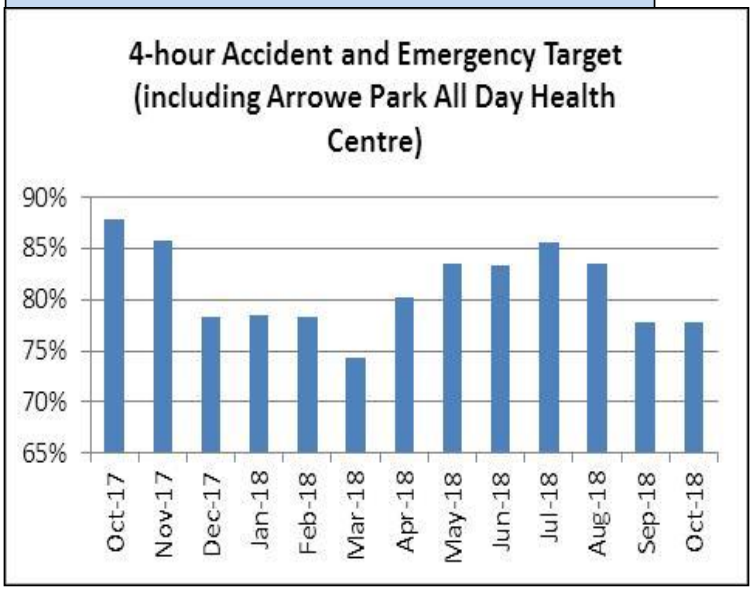
Executive Lead: Director of Nursing & Midwifery

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:
To continue with local management of response rate and to be monitored at Patient Family Experience Group.

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



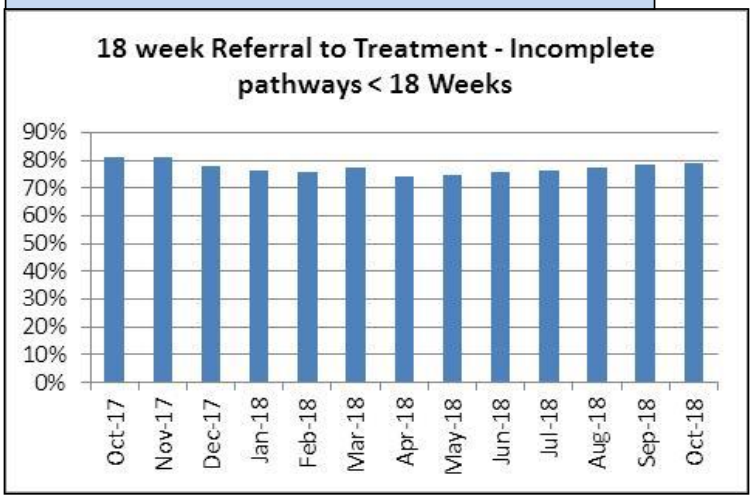
Executive Lead: Chief Operating Officer

Issue: The trust has a compliance target of 95% for 4-hour Accident and Emergency target. The 2018/19 Year to date performance is 81.7%.

Decision: Current performance Inadequate - Strengthen controls

Action: Patient Flow Improvement Group continues to develop flow improvement initiatives. Highlights: Ward Based Care w/s remit changed to focus on roll-out of SHOP model and afternoon board rounds. Transfer to Assess Unit at CGH opened 22nd November- this will bring an additional 30 beds for WUTH (2 week mobilisation period).

18 week Referral to Treatment - Incomplete pathways



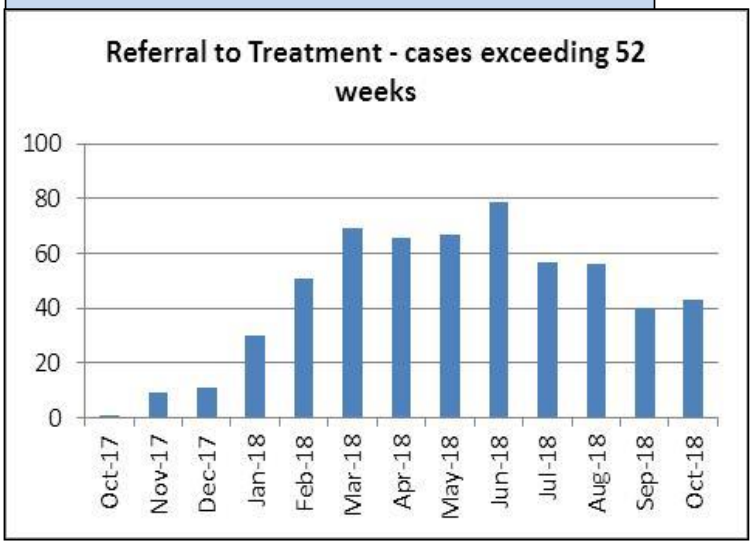
Executive Lead: Chief Operating Officer

Issue: The trust has a target of 92% for completed 18 week treatment pathway. The 2018/19 YTD performance is 76.5%.

Decision: Current performance Inadequate - Strengthen controls

Action: Surgery Central Validation Team have begun to track Surgery Division's RTT pathway, roll-out plan for validating their pathways from day 1 with daily tracking has begun.

Referral to Treatment - cases exceeding 52 weeks



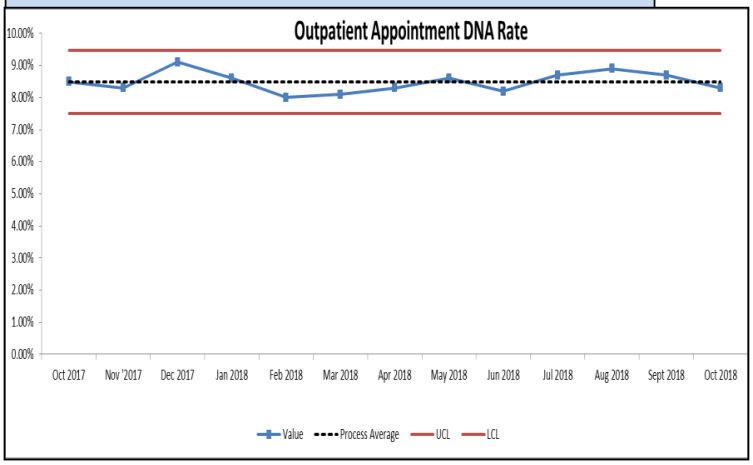
Executive Lead: Chief Operating Officer

Issue: The trust has a target of 0 case of referral to treatment where patients wait over 52 weeks. The 2018/19 YTD performance is 58 patients who have waited longer than 52 weeks for treatment.

Decision: Current performance Inadequate - Strengthen controls

Action: Surgery Central Validation Team have begun to track Surgery Division's RTT pathway, roll-out plan for validating their pathways from day 1 with daily tracking has begun.

Did Not Attend - Outpatient Appointments



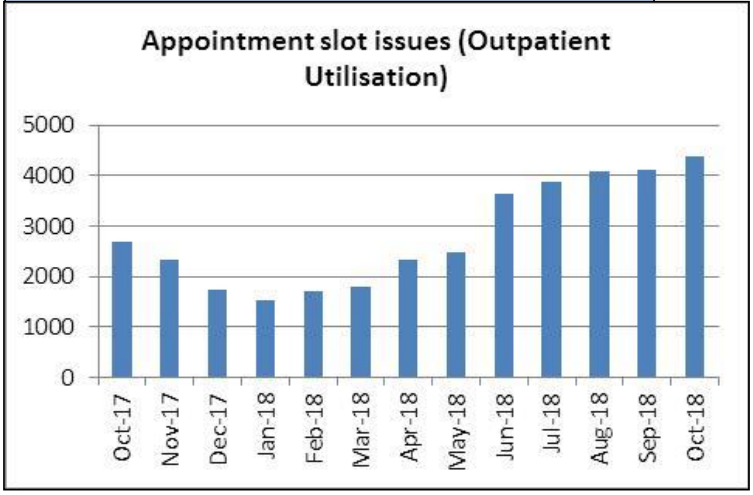
Executive Lead: Chief Operating Officer

Issue: The trust has a target rate of no more than 6.5% for patient DNA. The 2018/19 Year to date performance is 8.5%

Decision: Current performance Inadequate - Strengthen controls

Action: The Trust are implementing an outpatient improvement programme designed to improve clinic capacity, bookings, attendance and utilisation.

Appointment slot issues (Outpatient Utilisation)



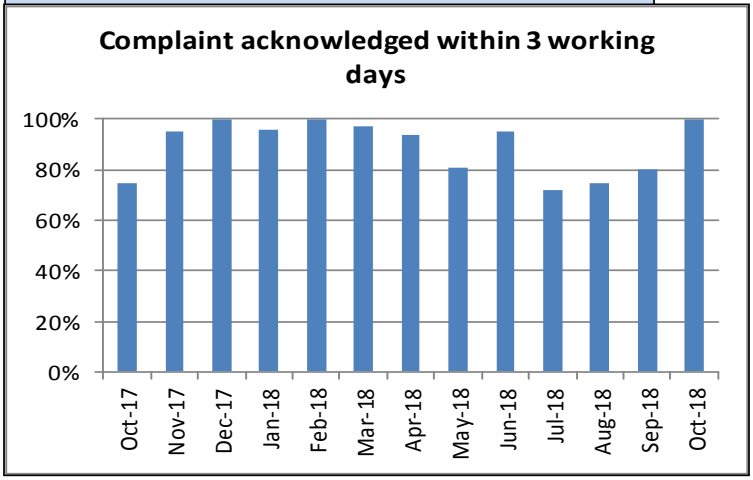
Executive Lead: Chief Operating Officer

Issue: The Appointment slot issues is Year to date 3556 with threshold to be confirmed

Decision: Current performance Inadequate - Strengthen controls

Action:
The Trust are implementing an outpatient improvement programme designed to improve clinic capacity, bookings, attendance and utilismation.

Complaint acknowledged within 3 working days



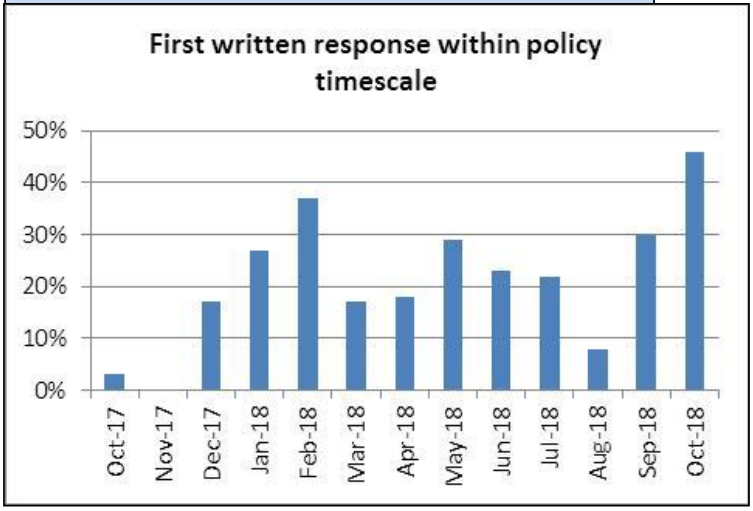
Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a target of 100% for complaints acknowledged within 3 working days. The 2018/19 Year to date performance is 85.3%

Decision: Current performance Inadequate - Strengthen controls

Action:
To comply with newly agreed process by the Patient Experience Team.

First written response to Complaints within policy timescale



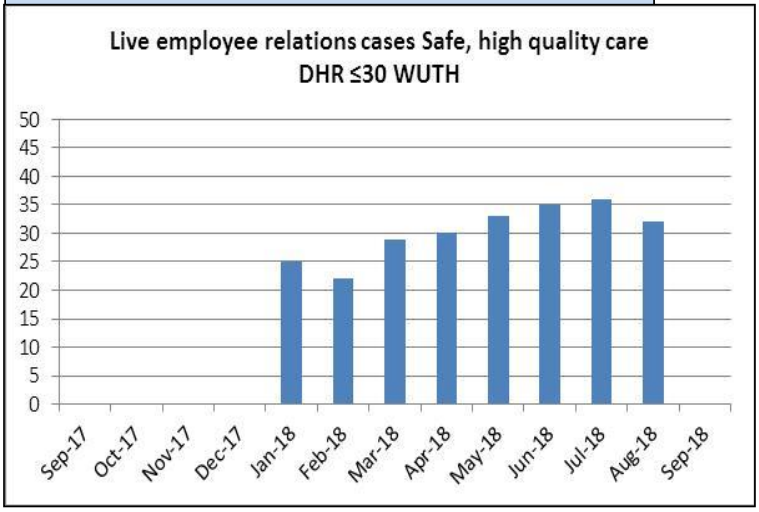
Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a target of 100%for first written response. The 2018/19 Year to date performance is 25.1%.

Decision: Current performance Inadequate - Strengthen controls

Action:
From January 2019 Divisional Performance Review meetings to monitor compliance with agreed end to end process (currently being monitored at SI Panel to improve performance)

Live employee relations cases



Executive Lead: Director of Workforce

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: Standard operational process in place in relation to taking forward employee relation cases. Weekly case reviews to track progress.

% Mandatory Training compliance

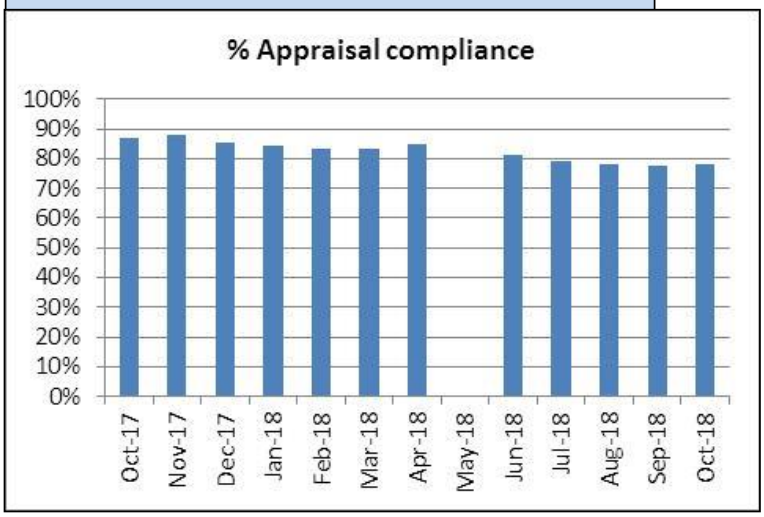
Executive Lead: Director of Workforce

Issue: Trust has a target of 95% for mandatory training compliance. The 2018/19 YTD performance is 82.2%. The compliance rates have increased significantly since March 2018.

Decision: Current performance Inadequate - Strengthen controls

Action:
Seven of the core 10 mandatory training subjects on e-learning packages (only three courses are face to face for clinical staff) by 30th November 2018.

% Appraisal compliance



Executive Lead: Director of Workforce

Issue: The trust has a target of 88% for appraisal compliance. The 2018/19 Year to date performance is 78.4%

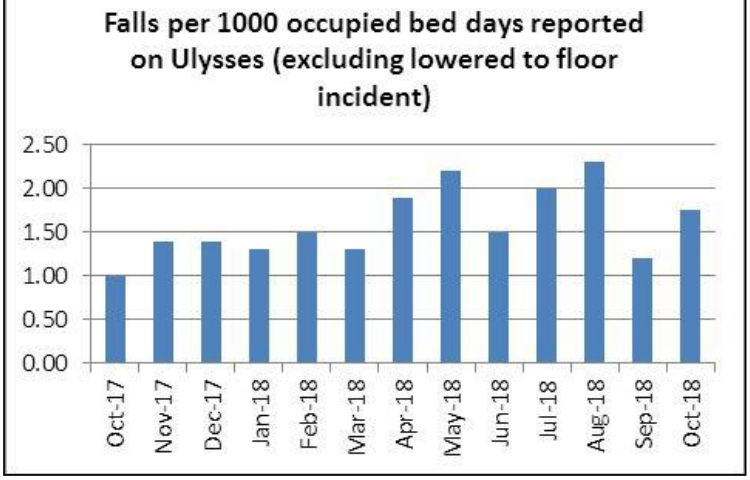
Decision: Current performance Inadequate - Strengthen controls

Action:
A review of the appraisal paperwork has taken place to reduce the documentation that needs to be completed. New paperwork out for consultation with a launch of date 1st January 2019.

Progress on Exception

The graphs below show good progress on data since the previous Exception Report and are currently achieving the Threshold:

Falls per 1000 occupied bed days reported on Ulysses



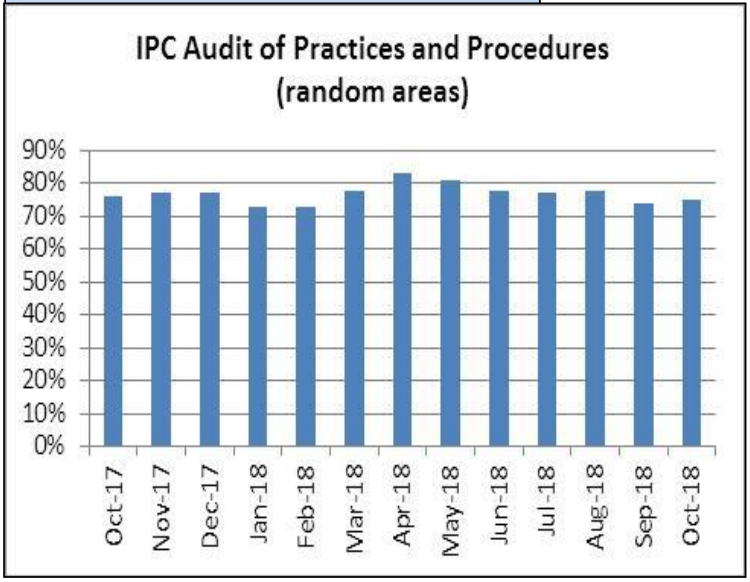
Executive Lead: Director of Nursing & Midwifery

Issue: The trust Year to date figure for falls per occupied bed days is 1.84 which is below the threshold of <=4.80

Decision: Current performance is adequate.

Action:
Continue to reduce bed moves for vulnerable patients.
Continue participation in national falls audit. Continue to implement falls action plan.

IPC Audit of Practices and Procedures (random areas)



Executive Lead: Director of Nursing & Midwifery

Issue: The trust has a compliance Year to date of 78% which is above the Compliance target of 75%

Decision: Current performance is adequate.

Action: Continue to ensure premises and equipment is adequately clean. Develop standard infection control audit which will include Environment cleanliness score, monitored through dashboard and ward accreditation.
Continue to ensure appropriate accountability through these measures

Board of Directors	
Agenda Item	8.1.2
Title of Report	Month 7 Finance Report
Date of Meeting	28th 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 7 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 the requirement to deliver a Cost Improvement Programme (CIP) of £11.0m.

The following summary details the Trust's financial performance during October (Month 7) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£19.4m) against a plan of (£17.4m), therefore an adverse to plan of (£2.0m).

The main areas driving the position is the under performance in elective and daycase activity, which is 2,446 spells (8.0%) behind plan, with a corresponding financial impact of (c£3.8m), and Outpatients attendances and procedures which are showing an adverse variance of 2,509 (1.4%), and a financial consequence of (£0.6m). Non-elective activity is 134 spells (0.5%) ahead of plan, from a financial perspective the complexity of the case mix against plan has improved during the month (c£0.5m), supporting the overall position cumulatively by some £0.3m.
Other activity areas, particularly deliveries in maternity and non-PbR improved during the month. The main areas in non-PbR showing improvement were, direct access Physio, Adult critical care, and Rehab.

Included within this position is c£0.8m benefit from the MSK "block" Prime Provider contract.

In addition the pay reform funding of £2.3m for Mths 1-7, is showing a benefit in income with the contra entry in pay costs.

The overall expenditure position is higher than plan by (£5.0m). However, pay includes (c£2.5m) that relates to the AFC pay award; funding to offset is in income (£2.3m) as noted above. The net pressure (£0.2m) has been mitigated internally by a less than expected incremental drift pressure. Non pay includes (£2.0m) associated with the MSK contracts which were not included within the original plan and again is offset in income. Hence the underlying overspend on expenditure is (c£0.7m).

The underlying pay position is £1.2m better than plan as at the end of M7 and continues to underspend largely due to high levels of qualified nurse vacancies and non-clinical vacancies that are delivering non recurrent CIP. The agency spend is largely to cover medical gaps and remains under scrutiny but it remains just within the NHSI cap.

The underlying non pay is showing a financial pressure of (£1.9m) ytd with outsourcing costs related to patient transfers earlier in the year to deliver patient waiting times (£1.1m) above plan across a number of surgical specialties (Orthopaedics, Pain and ENT) as well as significant outsourcing spend in radiology as a result of vacancies.

The delivery of cost improvements remains at £0.6m above plan as at the end of M7 but there is a (£0.3m) shortfall against plan this month largely due to the increased profile. The forecast for the year is £9.8m, an improvement of £0.1m since last month. There remains a (£1.2m) gap still unidentified but work is on-going to crystallise further opportunities to close this gap. Of the £4.6m delivered to date £1.9m 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 particularly in Q4.

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. To alleviate this pressure and to support delivery of the elective plan, particularly during the winter period, the Trust has commissioned a private provider to staff 30 additional beds at Clatterbridge at a cost of c£1.1m. Discussions remain ongoing with commissioning colleagues as to the funding of the agreed system required bed increase. If no external funding is provided this will impact upon the Trust forecast outturn position as noted.

The capital programme shows a year-to-date spend of £1.6m against a total programme budget of £12.9m. The current forecast is that the programme will be fully delivered, with £6.5m of schemes fully committed as at month 7. Work is progressing in securing commitments against the remaining schemes, to ensure that spend is delivered in year. Contingency schemes are being identified to militate against any slippage identified. The capital programme continues to be managed closely by the Finance & Performance Group.

2. Financial performance

2.1 Income and expenditure

Month 7 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	26,539	27,841	1,302	178,770	178,987	217
DOH - Pay Reform Income	0	0	348	348	0	2,322	2,322
Other income	29,428	2,475	2,599	125	17,065	17,452	387
Total operating income	336,589	29,014	30,789	1,775	195,835	198,761	2,926
Employee expenses	(247,732)	(20,794)	(20,937)	(144)	(145,118)	(146,218)	(1,101)
Operating expenses	(101,875)	(8,310)	(10,083)	(1,773)	(61,229)	(65,133)	(3,904)
Total operating expenditure	(349,607)	(29,104)	(31,020)	(1,917)	(206,346)	(211,351)	(5,004)
EBITDA	(13,018)	(90)	(232)	(142)	(10,512)	(12,590)	(2,078)
Depreciation and net impairment	(8,160)	(684)	(681)	3	(4,714)	(4,714)	(0)
Capital donations / grants income	0	0	0	0	0	90	90
Operating surplus / (deficit)	(21,178)	(774)	(912)	(138)	(15,225)	(17,214)	(1,989)
Net finance costs	(4,105)	(351)	(333)	18	(2,297)	(2,186)	110
Actual surplus / (deficit)	(25,282)	(1,125)	(1,245)	(121)	(17,522)	(19,400)	(1,878)
Reverse capital donations / grants I&E impact	243	20	21	1	142	54	(87)
Adjusted financial performance surplus/(deficit) [AFPD] excluding PSF	(25,039)	(1,105)	(1,224)	(120)	(17,380)	(19,346)	(1,965)

- In Mth 7 there has been a slight deterioration (£0.1m) in the planned position with a year to date adverse to plan deficit performance of (c£2.0m).
- The main driver of this position is the continued underperformance of the elective programme which was a further (£0.6m) below plan in M7 and (£3.8m) ytd. This is behind the expected elective recovery trajectory by £0.4m in month and £0.7m ytd.
- The overall income position includes the AFC pay reform funding of £2.3m ytd, income for MSK sub-contracting costs (£2.0m), and the benefit of the MSK "block" arrangement of £0.8m. The forecast position includes the net £0.3m AFC pay reform pressure. The underlying income position is (£2.2m) worse than plan.
- Total expenditure is (£5.0m) worse than plan; (£2.5m) relates to the AFC pay award and a further (£2.0m) is the sub-contracting costs of the MSK contract hence the underlying expenditure position is (£0.5m) overspent. Pay underspends are largely due to high levels of nursing vacancies and non- clinical vacancies which are mitigating recurrent CIP delivery whilst outsourcing costs remain high.
- It is 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	787	609	(178)	(22.63%)	5,041	4,085	(956)	(18.97%)
Daycase	4,002	3,735	(267)	(6.67%)	25,571	24,081	(1,490)	(5.83%)
Elective excess bed days	319	286	(33)	(10.27%)	2,417	1,443	(974)	(40.29%)
Non-elective	4,396	4,291	(105)	(2.39%)	29,271	29,405	134	0.46%
Non-elective excess bed days	788	850	62	7.91%	5,508	5,877	369	6.69%
A&E	7,869	7,908	39	0.49%	54,326	54,375	49	0.09%
Outpatients	26,927	27,648	721	2.68%	175,471	172,962	(2,509)	(1.43%)
Diagnostic imaging	2,574	2,764	191	7.41%	17,236	17,128	(108)	(0.62%)
Maternity	538	541	3	0.57%	3,714	3,462	(252)	(6.78%)
Total NHS patient care income	48,200	48,633	433		318,556	312,819	(5,737)	

- The main specialities driving the under performances in elective and daycase activity are Colorectal, Ophthalmology, Upper GI and Trauma and Orthopaedic surgery. “Booked” activity is being monitored on a weekly basis by Divisions and executive colleagues, the focus is to enact remedial action plans to ensure the position does not deteriorate further.
- Demand for emergency care during October was as planned, despite the underperformance seen in September. Internally this is being reviewed to understand whether this was related to the timing of admissions in September, who were not discharged until early October.
- Outpatient attendance activity also improved significantly during October, particularly in Cardiology, Dermatology and Diabetic Medicine. This was offset by the under performances in Ophthalmology, Oral Surgery, Pain Management, Urology and Gynaecology. The Outpatient improvement plan and associated impact on clinic activity will be robustly monitored over the coming months.

2. Financial performance

Income

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	2,523	2,134	(388)	(15.40%)	16,095	13,616	(2,479)	(15.40%)
Daycase	2,617	2,388	(228)	(8.73%)	16,617	15,307	(1,310)	(7.88%)
Elective excess bed days	78	71	(6)	(8.07%)	583	356	(227)	(38.94%)
Non-elective	8,357	8,825	468	5.60%	57,670	57,876	207	0.36%
Non-elective excess bed days	195	203	8	4.00%	1,356	1,443	87	6.40%
A&E	1,099	1,160	61	5.52%	7,589	7,829	240	3.16%
Outpatients	3,052	3,119	66	2.17%	19,932	19,377	(555)	(2.78%)
Diagnostic imaging	207	216	10	4.61%	1,372	1,334	(39)	(2.81%)
Maternity	458	484	26	5.71%	3,162	3,029	(133)	(4.21%)
Non PbR	5,936	6,290	355	5.97%	40,302	40,548	246	0.61%
HCD	1,284	1,621	337	26.22%	8,991	9,234	243	2.70%
CQUINs	563	430	(133)	(23.67%)	3,939	3,672	(267)	(6.78%)
Other	0	734	734	0.00%	0	4,080	4,080	0.00%
Total income from patient care (SLAM)	26,369	27,676	1,307	4.96%	177,608	177,701	93	0.05%

- Although the year to date position NHS Clinical Income position is balanced, there has been a significant underperformance in elective and daycases, which is showing a deficit of (£3.8m), reflecting both activity and casemix reductions. The recovery plan is being closely managed and performance continues to be of concern, and it is unlikely the under performance in the earlier part of the year will be recovered. This is offset by (c£2.8m) of MSK income which is supporting additional costs and hence the underlying position is (c£2.7m) worse than plan.
- The MSK "prime provider" contract commenced in July 2018; this was not included in the initial Trust plan. As this is a "block" contract, it is supporting the overall I&E position by c£0.8m year to date, this is included in the above values.
- Other PbR areas are not significantly behind plan, with the exception of outpatients, this under recovery is predominantly in outpatient first attendances and procedures. However, there has been an improvement during October. Neonatal activity also delivered against plan in month following significant under-performance in previous months. 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 point of delivery. 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)	(18,978)	(18,755)	223	(132,309)	(132,206)	103
Bank	(6,662)	(556)	(795)	(239)	(3,888)	(4,908)	(1,020)
Medical Bank	(7,057)	(588)	(623)	(35)	(4,116)	(4,224)	(108)
Agency	(7,469)	(597)	(692)	(95)	(4,279)	(4,350)	(71)
Other - Apprenticeship levy	(900)	(75)	(73)	2	(525)	(529)	(4)
Total	(247,732)	(20,794)	(20,937)	(144)	(145,118)	(146,218)	(1,101)

- The pay position in M7 is showing a net overspend of (£0.1m) and YTD is (£1.1m) worse than plan. However, the plan excluded the AFC pay reform funding of (c£2.3m) year to date which is offset in income. The underlying pay position (i.e. adjusted for pay award funding) is c£1.2m underspent ytd.
- The underlying pay position shows substantive vacancies offset with significant use of bank, agency and other non-core pay. 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 however fill rate remains low. Workforce plans and recruitment initiatives are continually under review with a proposed strategy on trainee nurse associate roles
- The agency figure is £0.7m this month and ytd is just in-line with the NHSI ceiling of £4.4m.
- Vacancies in Clinical Support and Corporate continue and non-recurrently they are supporting delivery of the CIP target.
- Pay CIP delivery is £1.0m higher than plan however to note £0.7m of the £1.2m ytd is non-recurrent. The CIP plan 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)	(329)	(846)	(517)	(2,184)	(5,296)	(3,112)
Supplies and services - clinical	(35,475)	(2,916)	(2,807)	110	(20,893)	(20,098)	794
Drugs	(25,395)	(2,109)	(2,355)	(246)	(14,851)	(14,927)	(76)
Other	(45,982)	(3,640)	(4,756)	(1,117)	(28,014)	(29,525)	(1,511)
Total	(110,035)	(8,994)	(10,764)	(1,770)	(65,942)	(69,847)	(3,904)

- Non pay expenditure is (£1.8m) overspent in M7 and YTD is (£3.9m) above plan but the plan excludes the MSK contract costs of £2.0m year to date which are offset in income. The underlying non-pay position (adjusted for MSK) is c(£1.9m) overspent ytd.
- Clinical supplies reflect the low levels of elective activity in earlier months and the associated prostheses/clinical supplies underspend.
- Drug costs are above plan in mth largely due to an increase in high cost drugs of £0.3m that is offset in clinical income.
- The position includes outsourcing costs to Spire in relation to gaps in elective capacity largely earlier in the year of c£1.5m for a number surgical specialties (Orthopaedics, Pain and ENT) with further radiology spend of £0.9m and the MSK contract of £2.0m.
- CIP delivery against the original plan is (£1.4m) lower and is currently offset in pay/income. 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 £1.9m ytd position is non-recurrent. The unidentified gap of £1.2m 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	787	**787**	1,000	1,337	**337**	0	1,337	**337**	1,000	1,200	**200**	0	1,200	**200**
Improving Productivity	Anthony Middleton	237	376	**139**	478	736	**258**	146	881	**403**	478	860	**382**	749	1,610	**1,132**
Collaboration	Janelle Holmes	282	315	**33**	952	552	**(400)**	342	893	**(58)**	952	998	**46**	550	1,548	**596**
Digital Wirral	Paul Charnley	583	702	**118**	1,000	1,143	**143**	117	1,260	**260**	1,000	1,000	**0**	0	1,000	**0**
Sub total - transformation		**1,103**	**2,180**	**1,077**	**3,430**	**3,768**	**338**	**604**	**4,372**	**942**	**3,430**	**4,058**	**629**	**1,299**	**5,358**	**1,928**
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	78	176	**98**	134	270	**135**	53	322	**188**	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	255	220	**(35)**	500	282	**(218)**	218	500	**(0)**	500	156	**(344)**	0	156	**(344)**
Procurement and Non Pay	Jane Christopher	534	185	**(349)**	1,150	268	**(882)**	881	1,150	**(0)**	1,150	178	**(972)**	899	1,077	**(73)**
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	912	1,880	**968**	1,936	2,929	**994**	560	3,489	**1,553**	1,936	2,493	**558**	434	2,928	**992**
Unidentified		1,124	0	**(1,124)**	3,850	0	**(3,850)**	0	0	**(3,850)**	3,850	0	**(3,850)**	0	0	**(3,850)**
Total		**4,005**	**4,641**	**636**	**11,000**	**7,517**	**(3,483)**	**2,315**	**9,833**	**(1,167)**	**11,000**	**6,906**	**(4,094)**	**2,662**	**9,568**	**(1,432)**

- YTD CIP performance is £0.6m ahead of the NHSI plan as at the end of M7 but the profile has been low and significantly increases in Q4.
- For the full year the Trust is currently forecasting £7.5m of fully developed schemes with a further £2.3m of plans in progress and opportunities and £1.2m remains unidentified at this stage. There are further opportunities to improve as the outpatient productivity work stream is validated. However, there continues to be significant risks associated with delivering the identified programme with £1.2m identified as red and £1.2m as amber with little mitigation to date.
- In addition non – recurrent CIP of £1.9m of the £4.6m delivered in M7 and is largely due to vacancies mitigating the CIP delivery as schemes come online. The gap of £1.2m remains in the NHSI forecast as non-recurrent in non-pay.

Wirral University Teaching Hospital NHS Foundation Trust

3. Financial position

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 31.10.18 £'000	Actual as at 31.10.18 £'000	Variance (to plan) £'000	Forecast 31.03.19 £'000	Plan 31.03.19 £'000
	Non-current assets						
159,754	Property, plant and equipment	↓	158,550	157,975	(575)	166,247	160,148
12,763	Intangibles	↓	11,760	11,437	(323)	11,016	12,369
903	Trade and other non-current receivables	→	903	835	(68)	834	903
173,420		↓	**171,213**	**170,247**	**(966)**	**178,096**	**173,420**
	Current assets						
4,171	Inventories	↑	4,171	4,155	(16)	4,155	4,171
18,423	Trade and other receivables	↑	20,121	20,441	320	18,460	18,424
0	Assets held for sale	→	0	0	0	0	0
7,950	Cash and cash equivalents	↑	2,344	6,969	4,625	2,117	1,773
30,544		↑	**26,636**	**31,565**	**4,929**	**24,732**	**24,368**
203,964	**Total assets**	↑	**197,849**	**201,812**	**3,963**	**202,829**	**197,788**
	Current liabilities						
(32,538)	Trade and other payables	↓	(28,563)	(33,262)	(4,699)	(35,497)	(27,752)
(3,224)	Other liabilities	↑	(3,224)	(4,367)	(1,143)	(3,224)	(3,224)
(1,074)	Borrowings	→	(1,075)	(1,076)	(1)	(1,076)	(1,076)
(548)	Provisions	→	(548)	(548)	0	(548)	(548)
(37,384)		↓	**(33,410)**	**(39,253)**	**(5,843)**	**(40,345)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	↑	**(6,774)**	**(7,688)**	**(914)**	**(15,613)**	**(8,240)**
166,580	**Total assets less current liabilities**	↓	**164,439**	**162,559**	**(1,880)**	**162,484**	**165,180**
	Non-current liabilities						
(8,812)	Other liabilities	↑	(8,613)	(8,613)	0	(8,471)	(8,470)
(49,258)	Borrowings	↓	(64,949)	(64,950)	(1)	(73,224)	(73,221)
(2,318)	Provisions	↑	(2,209)	(2,204)	5	(2,125)	(2,131)
(60,388)		↓	**(75,771)**	**(75,767)**	**4**	**(83,820)**	**(83,826)**
106,192	**Total assets employed**	↓	**88,668**	**86,792**	**(1,876)**	**78,664**	**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	↓	(29,783)	(31,659)	(1,876)	(42,243)	(37,541)
40,876	Revaluation reserve	→	40,876	40,876	0	40,876	40,876
106,192	**Total taxpayers' equity**	↓	**88,668**	**86,792**	**(1,876)**	**78,664**	**81,366**

Capital asset variances	£m
Capex underspend	-1.0
Donations above plan	0.1
Total variance of capital assets to plan	**-0.9**

Cash variances	£m
EBITDA and donation income below plan	-2.1
Working capital movements	6.1
Capital expenditure (cash basis) below plan	0.3
Other minor variances above plan	0.2
Total variance of cash to plan	**4.6**

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				4,714
Loan repayment	(1,015)	(1,015)	(1,015)	0				(508)
Finance lease	(60)	(60)	(60)	0				(36)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	135	132	3				114
Public Dividend Capital (PDC) - GDE	456	456	456	0				0
Public Dividend Capital (PDC) - Urgent and Emergency Care	0	2,000	2,000	0				0
Total funding	**10,791**	**12,926**	**12,923**	**3**				**7,534**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		153	153	0	153	92	61	46
Divisional priorities - *Surgery*		357	433	(76)	433	349	84	207
Divisional priorities - *Women and Children's*		286	290	(4)	290	283	7	168
Divisional priorities - *Clinical Support and Diagnostics*		826	821	5	821	109	712	41
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	229
Informatics	500	516	525	(9)	525	525	0	355
Estates - backlog maintenance	1,500	2,561	2,561	0	2,561	842	1,719	650
Cerner		(400)	(400)	0	(400)	(400)	0	(400)
All other expenditures		255	262	(7)	262	262	0	198
Urgent and Emergency Care		2,000	2,000	0	2,000	0	2,000	0
Contingency [3]	1,180	1,918	1,827	91	1,827	0	1,827	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	135	132	3	132	132	0	114
Total expenditure (accruals basis)	**10,791**	**12,926**	**12,923**	**3**	**12,923**	**6,513**	**6,410**	**1,608**

[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	**6,581**	**2,066**	**4,515**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(1,245)	(1,125)	(120)	(19,400)	(17,523)	(1,877)	(29,984)	(25,282)
Net interest accrued	141	157	(16)	848	942	(94)	1,617	1,806
PDC dividend expense	191	191	0	1,337	1,337	0	2,292	2,292
Unwinding of discount	0	3	(3)	2	21	(19)	3	6
Operating surplus / (deficit)	(912)	(774)	(138)	(17,214)	(15,223)	(1,991)	(26,072)	(21,178)
Depreciation and amortisation	681	684	(3)	4,714	4,713	1	8,160	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	0	0	0	(90)	0	(90)	(115)	0
Changes in working capital	(86)	(293)	207	4,143	(2,003)	6,146	1,653	(996)
Investing activities								
Interest received	11	3	8	66	21	45	111	48
Purchase of non-current (capital) assets [1]	(298)	(336)	38	(6,444)	(6,793)	349	(12,152)	(12,444)
Financing activities								
Public dividend capital received	0	0	0	0	0	0	2,456	456
Loan funding [2]	1,000	1,000	0	15,728	15,728	0	24,027	24,027
Interest paid	(0)	0	(0)	(689)	(818)	129	(1,586)	(1,845)
PDC dividend paid	0	0	0	(1,189)	(1,189)	0	(2,335)	(2,335)
Finance lease rental payments	(6)	(6)	0	(42)	(42)	0	(70)	(70)
Total net cash inflow / (outflow)	**388**	**278**	**110**	**(981)**	**(5,606)**	**4,625**	**(5,833)**	**(6,177)**
Closing cash	**6,969**	**2,344**	**4,625**	**6,969**	**2,344**	**4,625**	**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%	-11.2	3	-12.0	3	-12.9	3
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-3.7	4	-4.5	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-8.9%	4	-9.7%	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	-0.8%	2	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	-2.0%	1	-0.4%	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. It is important that this is managed throughout 2018/19. If the agency spend exceeds the cap significantly, and the Trust's other metrics also deteriorate, the overall UoR will be impacted.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 7 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

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 (£28.4m) "most likely" and "worst case" of (£29.9m).

	RAG rating	Best FOT £,000	Likely FOT £,000	Worst FOT £,000	Exec Lead	Comments and key actions, milestones required by Trust to achieve the Likely FOT
Annual Plan (excluding PSF) full year		**(25,042)**	**(25,042)**	**(25,042)**		
YTD Actual (CT excluding PSF)		**(19,346)**	**(19,346)**	**(19,346)**		
YTD run rate extrapolated for 18/19 full year		**(34,525)**	**(34,525)**	**(34,525)**		
Gross Income Risks						
CQUIN	Red	(275)	(575)	(575)	DJ	Staff and Wellbeing/Antibiotics/Improving Ill Health etc.
Readmissions	Amber	(500)	(500)	(500)	NS	Under query with WCCG
A&E Streaming	Red	(89)	(89)	(89)	DJ/AM	Transfer of funding to WCT
Other Penalties	Amber		(100)	(400)	DJ/AM	PLCP, ECDS impact on A&E activity
Income Upsides / Recovery Actions						
Income recovery plan EL/DC	Red	915	915	915	AM	Surgery EL/DC Recovery Plan
NEL Winter Profiling Adjustment	Amber	4,750	4,750	4,750	AM	Winter Profiling Medicine & W&C
Winter Funding (External)	Red	1,000			JH	Addl winter beds recognised by System and funded
Sepsis	Green	100	100		DJ	Mediation expected outcome
Activity Profiling	Amber	220	220	220	AM	Profiling improvments
MSK Contract	Green	1,200	1,200	1,200	AM	Reflects adjustment to run-rate income commencing M4
AFC Funding	Green	86	86	86	DJ	Scale Factor
National Support Funding	Green	98	98	98	DJ	Collorectal/UGI and Robotic activity - improve 62 day targets
Challenged Provider Funding	Green	200	200	200	DJ	In run rate
CIP Delivery						
Green schemes & Blue Schemes	Green					*In Run Rate £7,956*
Amber schemes	Amber	799	799		DJ/AM	Most Likely is £9.0m
Red schemes	Red	500	200		DJ/AM	Best Case £9.8m
Unidentified - gap	Red	560			DJ/AM	Worst Case £8m
Expenditure Risks / Commitments						
Step Down Ward	Red	(1,100)	(1,100)	(1,100)	AM	M3 Ward Contract
Additional Winter Beds	Red	(150)	(150)	(150)	AM	M3 Ward associated costs
Activity increase - Clinical Supplies	Red	(150)	(150)	(150)	AM	Related to Surgery EL/DC Recovery Plan
Seasonal Spend e.g energy	Red	(500)	(500)	(500)	AM	
MSK Contract	Green	(943)	(1,243)	(1,243)	AM	Reflects adjustment to run-rate costs commencing M4
Expenditure Upsides						
Elective Outsourcing	Amber	400	400	400	AM	Improvement in run-rate costs (no new transfers)
Activity Reserve	Amber	709	709	709	DJ	Central Reserve no longer required
RTT Delivery Reserve	Amber	400	400	650	DJ	Central Reserve no longer required
Balance Sheet Support	Red	1,253	503	25	DJ	Review of provisions and deferred income
Overall FOT		**(25,042)**	**(28,352)**	**(29,979)**		

The forecast analysis above is based on the current actual run rate of the deficit which stands at Month 7 at £34.5m. This has improved on last month due to the better in-month position primarily associated with non-elective casemix.

The run rate is then adjusted for known changes to the current average monthly income/spend to give a forecast outturn of best, likely and worst scenario's.

These key changes to the run rate fall into the following categories:

Income Risks – the key risks to income are non-delivery of Q3/Q4 CQUIN milestones, additional penalties associated with a higher than contract level of avoidable readmissions and other contractual movements.

Income Upsides/Recovery Actions – Upsides include the benefit of winter on non-elective casemix and improvements in the run rate for Neonatal and Maternity. Recovery actions include improvements in Elective performance, although the expected benefit has been reduced from last month as more detailed analysis of core and non-core capacity assumptions have been completed. In addition, a number of smaller non-recurrent

allocations have been consolidated. In the 'Best' case scenario, it is assumed that winter funding will be allocated to the Trust by the Health Economy.

CIP Delivery – improvements in the run rate to achieve £9.0m in the 'Most Likely' case have been made. This is deterioration from the previous month as a detailed review of schemes has been completed. The assumption here is that all Amber and a small amount of Red rated schemes will be delivered. The total value of identified schemes is £9.8m and this is the assumption in the 'Best' case scenario. CIP is under constant review month by month.

Expenditure Risks / Commitments – the key items here are the costs associated with winter plans and increases in the run rate of seasonal spend such as energy. The MSK costs are the changes required to the run rate due to the commencement of the contract mid-year and reflect the expected costs of sub-contracting arrangements. The 'Best' case scenario includes an assumption that these costs will reduce as a result of the new pathway but this has not as yet been evidenced in the charges received, however the contract is only in month 4 of commencement.

Expenditure Upsides – This includes a slowing down of outsourcing costs reflecting no new transfers being made since Q2 and in addition the release of central reserves. The 'Best' case scenario assumes Balance sheet reserves associated with Research accounts and deferred incomes are enacted although this is likely to be controversial.

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:

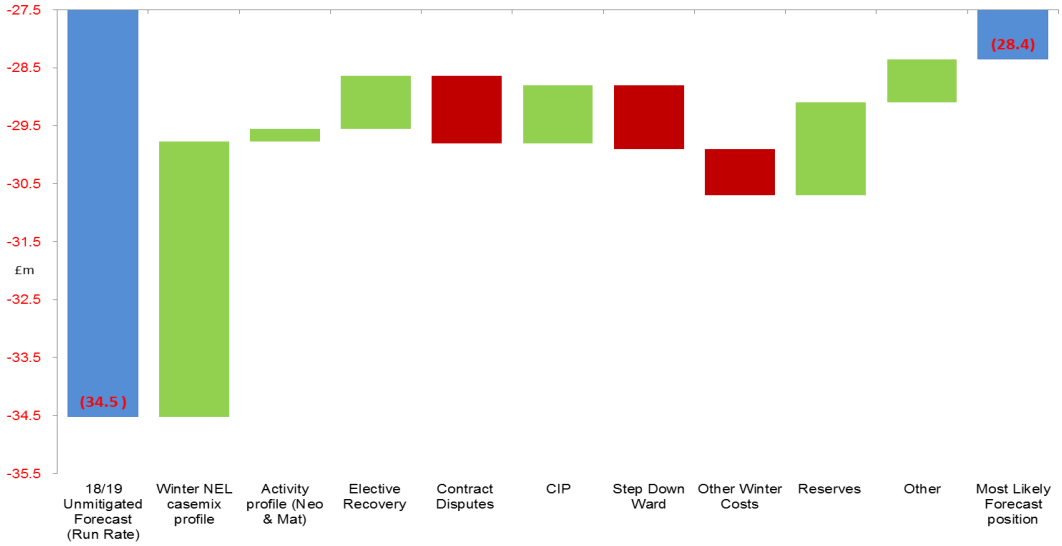
- The affordability of planned investments to improve service quality and performance;
- The acceleration of the delivery of productivity opportunities identified by the Carter Review;
- The acceleration of proposals for sub-scale service consolidation or closure;
- The impact on patient safety and experience 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 (£28.4m)

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 (£28.4.5m).

- 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 and maternity activity
- Improvement in CIP delivery
- Potential contract penalties, CQUINs and PLCPs
- 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	10.2
Title of Report	Report of Programme Board; Change Programme Assurance
Date of Meeting	28.11.2018
Author	Joe Gibson, External Assurance Natalia Armes, Director of Transformation & Partnerships
Accountable Executive	Janelle Holmes, Chief Executive
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
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	Programme Board
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This report provides a summary of the Trust's change programme and the independent assurance ratings undertaken to assess delivery. This report has been discussed at the Programme Board Meeting (the membership of which includes two non-executive directors) held on Thursday 15th November and the intention is this reporting format will be provided on a monthly basis. The Board of Directors is asked to note the first change programme assurance report and determine any required changes to the reporting format and specify any programmes of interest that require further discussion at Board.

2. Background

This report is intended to provide the Board of Directors with an accessible oversight of the Trust's performance of the Improvement Programmes of work against key assurance measures. The report has been undertaken by Joe Gibson, External Assurance and provides a detailed oversight of assurance ratings per programme along with the independent assurance statement and programme delivery narrative including key milestones and performance against intended benefits.

The Change Programme Assurance report is work-in-progress and will develop further iterations over time. This will include development of benefit trajectories and SPC charts so there is visibility of progress across all improvement activities and this is measureable at a process and outcome level.

3. Key Issues

Please refer to the first two pages of the Change Programme Assurance Report which provides a summary of each Programme and highlights key issues and progress.

4. Next Steps

WUTH remains committed to the delivery of all Improvement Programmes detailed within the report and will continue with external assurance processes to maintain visibility of progress.

5. Conclusion

Performance against the assurance indicators across all programmes is not where the Trust needs to be. The actions to improve are noted in the assurance statements of this report and continued independent monitoring will continue to measure progress and provide assurance.

6. Recommendation

The Board of Directors are asked to note the Trust's Change Programme assurance report and determine any required changes to the reporting format and specify any programmes of interest that require further discussion at Board.

Change Programme Assurance - Trust Board Report - November 2018

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Workforce Planning

- The 'Workforce Planning' programme of work is due to be initiated at the Programme Board on 20 Dec 18; therefore, there is no assurance report provided at this stage.

Improving Patient Flow

- The 'Right Patient, Right Bed, Right Time' programme of work has been in the pipeline category, at the request of the Programme Board – so not assessed as a whole programme – while the programme is being re-scoped. At the Programme Board on 15 Nov the Programme Lead requested that the revised programme should now be considered 'live'; assurance ratings will now re-commence and be prepared for the December Programme Board .
- The 'Command Centre' project work is being held up due to delays in the upgrade to Millennium by Cerner. The plan for the 'Command Centre' beyond the Millennium upgrade, as referenced at Programme Board, should be sent to the External Programme Assurance.
- Of the 4 metrics being measured across the work stream, 3 are red and 1 is amber.
- The Programmes 'Ward Accreditation' and 'Digital Care Pathways' are yet to be initiated at Programme Board.

Operational Transformation

- The 'Perioperative Medicine Improvement' programme has improved in terms of assurance ratings with 2 of the 4 metrics showing green, 1 amber and 1 red; at the Programme Board of 15 Nov 18 it was stated that the financial benefits of the improved performance are starting to be felt.
- The 'Outpatients Improvement ' programme has made similar strides in terms of improved assurance ratings and detailed metrics have now been developed to support the goals/expected benefits of which one key target is to achieve the planned outpatient activity for 18/19 by March 2019.
- The 'Diagnostics Demand Management' has gone 'live' in the last months and the amber ratings need to be seen in that context; however, a project board should be convened at the earliest possible juncture to ensure early, and broad, clinical engagement and to brings a focus on potential quick wins.
- The 'Paperless' programme of work is yet to be defined and initiated at Programme Board.

Partnerships

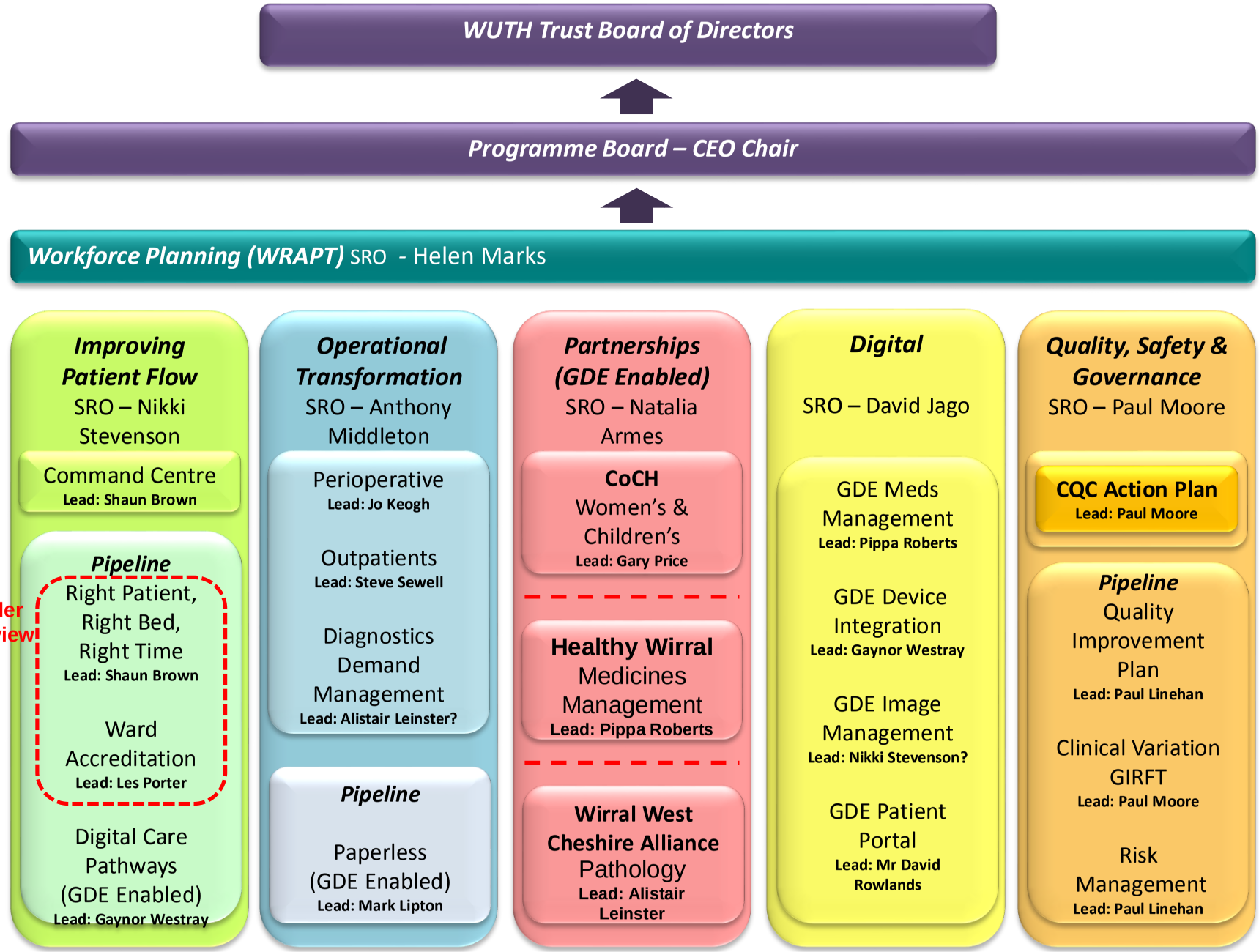
- While aspects of the governance of the 'Womens & Childrens' partnership programme with CoCH are amber rated, the delivery is red rated due to the lack of a current plan; moreover, there are 'common aims expressed by the partnership but just a single service measure to double the number of home births - which appears to be on track - and a CIP contribution.
- The Healthy Wirral 'Medicines Management' programme is amber rated for governance and the delivery is red rated due to the absence of a plan. There is a savings target of £500k for 'Biosimilars' of which £250k is reported as achieved.
- For the 'WWC Alliance: pathology' no assurance evidence has been received to date and, therefore, both governance and delivery are red rated. External Programme Assurance has discussed this with the Programme Lead and evidenced is expected prior to the December ratings.

Digital

- 'GDE Medicines Management' project is red rated for both governance and delivery – the key issue is a lack of defined benefits.
- 'GDE Device Integration' project is red rated for both governance and delivery – the key issue of a lack of credible measures for success has started to be addressed.
- 'GDE Image Management' project is red rated for both governance and delivery – the key issue is a lack of defined benefits.
- 'GDE Patient Portal' project is amber rated for governance and has 3 green ratings for delivery; however, the overall rating fro delivery remains red due to the absence of any measurable success criteria for the project.
- External Programme Assurance has agreed to provide some guidance and advice to GDE project managers – re- the assurance ratings – at a session on 27 Nov 18.

Quality, Safety & Governance

- CQC Action Plan is rated amber for both governance and delivery; however, the most recent submission of evidence was 8 Oct 18 and updated assurance material is now urgently required.
- The programmes for 'Quality Improvement Plan', 'Clinical Variation GIRFT' and 'Risk Management' all remain in pipeline status as they are yet to be initiated by the Programme Board.


WUTH Trust Board of Directors
Programme Board – CEO Chair
Workforce Planning (WRAPT) SRO - Helen Marks
Improving Patient Flow
SRO – Nikki Stevenson
Command Centre
Lead: Shaun Brown
Pipeline
Under Review
Right Patient, Right Bed, Right Time
Lead: Shaun Brown
Ward Accreditation
Lead: Les Porter
Digital Care Pathways (GDE Enabled)
Lead: Gaynor Westray
Operational Transformation
SRO – Anthony Middleton
Perioperative
Lead: Jo Keogh
Outpatients
Lead: Steve Sewell
Diagnostics Demand Management
Lead: Alistair Leinster?
Pipeline
Paperless (GDE Enabled)
Lead: Mark Lipton
Partnerships (GDE Enabled)
SRO – Natalia Armes
CoCH
Women's & Children's
Lead: Gary Price
Healthy Wirral
Medicines Management
Lead: Pippa Roberts
Wirral West Cheshire Alliance
Pathology
Lead: Alistair Leinster
Digital
SRO – David Jago
GDE Meds Management
Lead: Pippa Roberts
GDE Device Integration
Lead: Gaynor Westray
GDE Image Management
Lead: Nikki Stevenson?
GDE Patient Portal
Lead: Mr David Rowlands
Quality, Safety & Governance
SRO – Paul Moore
CQC Action Plan
Lead: Paul Moore
Pipeline
Quality Improvement Plan
Lead: Paul Linehan
Clinical Variation GIRFT
Lead: Paul Moore
Risk Management
Lead: Paul Linehan

Command Centre Programme Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Shaun Brown	Katie Bromley	Fully Developed	Amber	Red

Independent Assurance Statement

The PID lacks metrics by which benefits will be measured. There are well documented project meetings in place and the governance is described in the PID. There is now some evidence of wider stakeholder engagement. **Capacity Manager Status Report Nov 18 states:** Slippage this period & reasons (include items for escalation): It was agreed at Capacity Manager Project Board that without having sight of the system even in a test environment, it would be difficult for any further progress to be made. The group felt without having full sight of the system, its features and capabilities they could not begin to understand the impact this will have on agreeing future processes and understanding the training implications. Due to technical reasons the system cannot be built until the Trust have upgraded Millennium to the latest 2018 code which has now been delayed further to the 16th November. Cerner will then need to build the system in the test environment before demonstrations take place to key stakeholders who can then work together to formulate a plan for delivery.

Most recent assurance evidence submitted 8 Nov 18.

Joe Gibson , External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Command Centre	To implement a new real time bed management system, including a re-design of all relevant processes and practices to enable accurate reflection of the bed state	Gaynor Westray											

Programme Board
Patient Flow Improvement Programme

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

To increase flow within the hospital and reduce length of stay by ensuring that we have the right patients in the right beds at the right time enabled by technology and supported by the most appropriate staff.

This will reduce overall length of stay through earlier discharges in the day, a reduction in patients staying in hospital for longer than 7 days and ensuring patients are transferred to a less acute setting for ongoing assessments as soon as they no longer need an acute bed. This programme is enabled by technology and collaborative working with our health economy partners.

Key Prog. Metrics	Baseline	Q3 Ave	Q4 Target
To reduce length of stay in ambulatory care unit	6.7 hours	6.85 hours	6 hours
To maintain length of stay in assessment units	1.7 days	2.1 days	1.7 days
To reduce length of stay in base wards (non elective)	5.6 days		tbc
To reduce the number of patients staying in hospital for longer than 7 days	418 patients	403	360 patients
To achieve 33% of our total discharges by 12pm.	13.56 (time 33% achieved)	13:45	tbc

Programme actions on 'Assurance Statement'	Target date
• The test system remains unavailable, and there is concern that the predicted date of the upgrade may be delayed. However, the group have proposed a trial of dedicated domestics for cleaning bed areas to work through the processes and culture change required for these staff, and to build a view of the benefits of intervention.	• Tba • Tba

Programme Progress/Milestones

- Workshop to agree revised priorities for ward based care w/s planned for 9th Nov
- Mobilisation activities for the Independent Discharge unit are on track, although the go live date has slipped a couple of days (now 21st November) due to timings of Four Seasons CQC approval.
- A ward support team to facilitate earlier discharges has been piloted from 15th October, in November to date, the target of 33% discharges is being achieved around 10 minutes earlier than October & we have had more patients in Discharge Hospitality Centre before 12 than before
- Stranded patient review process being redesigned from w/c 15th Oct- IDT and Matrons to perform weekly desktop review of all Non-med fit and Medically Optimised stranded patients in Medicine & Acute (M&A) Division
- The Group approved a trial of dedicated domestics on an assessment ward and a base ward in preparation for capacity manager
- Informatics to work with M&A Division to review existing datasets on bed availability to be used to support flow on interim basis until Capacity Manager launched

Items for Escalation to the Programme Board (recommendations for action)

- Ability to progress on implementation of Capacity Manager limited due lack of visibility of Capacity Manager system until after Cerner 2018 upgrade

Perioperative Medicine Improvement– 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Jo Keogh	Vicky Clarke	Delivery	Green	Amber

Independent Assurance Statement

1. The scope document dated March 2018 needs to be completed (metrics for measures) and approved; the only measure mentioned is: 'Reduce specialty level variation so that all lists are achieving 85% utilisation target'. **2.** A Project Team is in place with a wide range of activity in evidence. **3.** The Perioperative Medicine Steering Group is governing and the minutes/notes from that meeting directing the project. **4.** There is evidence of detailed presentation explaining the work of the project and a range of evidence of wider stakeholder engagement. **5.** The QIAs, signed in February and May 2017 should be re-validated after over 1 year in place and cognisant of the development of the project. **6.** The project assessment of milestone progress at 'amber' appears in line with the evidence. **7.** KPIs are developed but some are off trajectory. **8 and 9.** Evidence in place concerning risk and issue management.

Most recent assurance evidence submitted 8 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Perioperative	The specific focus/brief of the Theatre Productivity Group, to achieve our objectives, was to: Reconfigure the Theatre Schedule; Enable the planning of theatre staff and anaesthetics; implement a system to track and monitor 45 week usage; reduce specialty level variation so that all lists are achieving 85% utilisation target; implement a weekly process to enable prospective and retrospective assessment of session utilisation.	Anthony Middleton											

Programme Board
Perioperative Medicine Improvement

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Improved visibility and delivery of utilisation of core theatre sessions by specialty
- Greater standardisation of the pre-operative pathway across all sites and specialties, whilst introducing more proportionate levels of assessment.
- More immediate access to investigations, diagnostics (for example, x-ray, echo, cardiology and haematology) and pharmacy.
- Enhanced IT systems to support real-time monitoring and enhanced reporting .

Programme actions on 'Assurance Statement'	Target date
• Scope Document review is underway and a revised scope document will be available for next Programme Board	15/11/2018
• KPI's and improvement trajectories have now been agreed and set, monthly monitoring against performance will be assured through Operational Transformation Group	17/11/2018
• 'Divisional Newsletter designed, first publication will be Issued in November 2018.	17/11/2018
• Risks and issues have been updated and are managed managed at Perioperative Medicine Steering group and escalated as appropriate to Operational Transformation Group chaired by COO.	Ongoing.
• Benefits realisation meeting planned for 19th November and will be brought back to Programme Board.	20/12/2018

Key Prog. Metrics	Baseline	Q3 Ave	Q4 Target
• Overall utilisation (all specialties)	• 85%	89.3%	
• % Sessions Delivered in core Capacity.	• 80%	77.6%	
• Zero session Cancellations within 28 days by December 18	• 38 to 0	57	
• Reduction in Cancellations on the day by 33%.	• 16 patients per day to 11 by March 19	12.8 On track	

Programme Progress/Milestones

- Theatre Lockdown now at 4 weeks- plan to move to 5
- IT work plan have been prioritised by Division , to include electronic booking of Patients and an electronic fit and well questionnaire for Pre-Op, all of which are in design and testing periods- decommissioned space will be utilised by medicine to support continued use of ward 1 beds for surgical patients.
- Ward 1 plans have been confirmed
- Funding to support Intra-Operative IT initiatives Such as implementation of tracker screens and hardware upgrades will be funded by GDE monies.

Items for Escalation to the Programme Board (recommendations for action)

- None Required at this time.

Outpatients Improvement Programme Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Steve Sewell	Sarah Thompson	Opportunity	Green	Amber

Independent Assurance Statement

1. The 'Trustwide OP Operational Structure - Workstream Brief' v0.1 describes the overall vision, approach and aims in a concise format while the context is explained in detail in the 'WUTH Outpatients Review' v0.5 dated 16 Oct 18. **2.** A project team is in place. **3.** The 'Outpatients Transformation Group' is in place with ToR agreed at the meeting of 1 Nov 18; this is supplemented by evidence of how this reports into the 'Operational Transformation Steering Group' (agenda and actions in evidence). **4.** Some evidence of stakeholder engagement is available but no evidence of forward communications plan. **5.** A QIA has been signed and submitted. **6.** The Trello' Board' is being used to create and track milestones; however, a high level summary of near term milestones is recommended for assurance and communications purposes. **7.** KPIs are now in place, with agreed metrics in the project assurance folder, from the (High Level) 'Clinical Capacity Benefits Map' again on the 'Trello Board'. **8 and 9.** Risks and issues are recorded on the 'Trello Board'; how risks may then escalate into the Trust system (scoring) and BAF (from Trello) needs to be worked through (a RAID Log might be a useful mitigation here)**.**

Most recent assurance evidence submitted 5 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Outpatients Improvement	To design and implement 21st century outpatient services to meet the needs of the Wirral population. Goals/Expected Benefits: to achieve the planned outpatient activity for 18/19 by March 2019; to design a Trust Wide Operational Structure for outpatients that is able to create and manage a consistent operational framework for outpatients right across the Trust; to design and implement 21st Century Outpatients and eliminate paper from outpatient processes; improve patient experience.	Anthony Middleton											

Programme Board
Outpatients Improvement Programme

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

To design and implement 21st century outpatient services to meet the needs of the Wirral population.

Goals/Expected Benefits:

- To achieve the planned outpatient activity for 18/19 by March 2019.
- To design a Trust Wide Operational Structure for outpatients that is able to create and manage a consistent operational framework for outpatients right across the Trust.
- To design and implement 21st Century Outpatients and eliminate paper from outpatient processes
- Improve patient experience

Key Prog. Metrics	October actual	November target	Q4 Target
To achieve contracted activity plan for:			
Medicine first appt.	2244	2891	2760
Medicine follow up	5454	5313	5072
Surgery first appt.	4096	4101	3914
Surgery follow up	8350	7301	6969
W&C first appt.	1344	1164	1111
W&C follow up	1063	1106	1055

Programme actions on 'Assurance Statement'	Target date
• High level stakeholder communications plan to be developed	•30 Nov 2018 – to be refreshed in Jan
• 3 milestones have been identified in the Outpatients Review paper. A high level project plan will be developed to overlay 'Trello Board' once the programme has been outlined	•31 Jan 2019
• Risks and issues are recorded on the 'Trello Board' however these will be transferred to a RAID log and scored in accordance with the Trust's risk scoring system	•20 Dec 2018

Programme Progress/Milestones

- Review approved at Trust Board on 1st November
- Outpatients Programme Manager commences 12th November
- Clinic capacity sessions with Directorate Managers and Business Support Managers have commenced.
- Room Booking Manager recruited
- Mapping of all clinic rooms being finalised
- Works to build a sluice at VCH Health Centre to commenced 7th November
- Discussions being held with regards to agreeing a suitable tariff rate for virtual clinics
- Action plans received for gynaecology and all medical specialties. Action plans outstanding for breast and surgical specialties (with the exception of Oral and ENT). PODs required for all specialties (with the exception of gynae & paeds).

Items for Escalation to the Programme Board (recommendations for action)

Diagnostics Demand Management Assurance Update– 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Will Ivatt	Opportunity	Amber	Amber

Independent Assurance Statement

1. BOSCARD together with 'Initiation Pack' delivered to Programme Board give a concise yet comprehensive scope and approach (which will also make use of an initiative identification template and a prioritisation matrix). **2.** A project team is defined and now the names of individuals need be populated in this dashboard matrix (as well as the wider project team)**. 3.** Meetings are commencing with divisional leads and now the programme governance forum will need to be put in place. **4.** There is some evidence of stakeholder engagement and a forward looking communications plan will need to be developed. **5.** A QIA will need to be signed off. **6.** There is an action planning log in the RAID Log ; a comprehensive milestone plan will be required in due course. **7.** There is a High level Driver Diagram and baselines, targets and trajectories will need to be agreed. **8 and 9.** Risks and issues are recorded; risk register would benefit from a 'date risk last reviewed' column.

Most recent assurance evidence submitted 5 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Diagnostics Demand Management	This programme aims: to reduce spend on diagnostic testing to acceptable levels as indicated by NHSI Model Hospital Data; to reduce demand for pathology tests (costs, patient experience); to reduce the number of units of blood transfused into patients (risk, cost); to create a template to reduce demand for diagnostic imaging (& other projects); and	Anthony Middleton											

Partnerships: CoCH: Women & Children's Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Gary Price/Joe Downie	TBD	-	Amber	Red

Independent Assurance Statement

1. Scope is in a 'Case for Change' with supporting presentations; however, there are no measurable benefits in the scope. **2.** 'Programme Core Team' in place but there is an outstanding request for support. **3.** ToR for the 'Women's & Children's Alliance – South of the Mersey Leadership Delivery Group' are in evidence. The W&C Alliance Leadership Group Agenda (with notes) for 20 Sep 18 is available but with no but no record of attendance / action log / minutes. **4.** There is no further evidence of wider communication with stakeholders. **5.** QIA and EA drafted but not signed off. **6.** There is no current milestone plan in evidence. **7.** The 'Common Aims' of 'Improving outcomes for women, children and families' have no metrics attached to them by which success may be measured (or project completion defined). The PID states that KPI's/Objectives/Measureable Outcomes…will be dependent on the final plans on a page; however, the 'plans on a page' of Feb 18 and do not include benefits and metrics. **8 and 9.** Risks and Issues updated in RAID log of 10 Oct (but gap in evidence since Jan 18); records of meetings no longer recorded, summary states all 5 risks are closed but risk tab has 3 open with no update.

Most recent assurance evidence received 11 Oct 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Womens and Childrens	The Cheshire and Mersey STP calls for local solutions for women and children's services to address workforce and quality challenges		●	●	●	●	●		●	●	●	●

Programme Board

Partnerships: CoCH: Women & Children's

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- The Cheshire and Mersey Health and Social Care Partnership Women and Children's Work stream calls for "local solutions" and devolved planning to tackle issues such as workforce, quality and sustainability. WUTH has 6 work streams to support this. 5 as part of Horizontal Integration with the Countess of Chester NHSFT and 1 with Wirral partners (Vertical Integration
- Horizontal integration focuses on 1) Shared Leadership 2) Shared Training 3) Shared Informatics & Back Office 4) Gynaecology Collaboration & 5) Neonatal collaboration
- Vertical Integration is the establishment of a freestanding Midwifery Lead Unit and a pilot Child and Family Hub

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
Increase in homebirth rate	• 17/18 data	• At q2 rate doubled vs 18/19	• 18/19 double of 17/18
• Secure funding for pilot child and family hub	• Secure funding and develop KPIs		
• Establish shared gynaecology services with Coch at Clatterbridge	• £120K efficiency CIP fye		• £60K

Programme actions on 'Assurance Statement'	Target date
• W+C paper for December DPR on shared leadership between WUTH and CoCH W&C services including QIA sign off	• December 18
• Development of KPIs for Child and Family Hub	• December 18
• Support from STT team for project to be clarified	• December 18

Programme Progress/Milestones

- In April 2018 a freestanding midwifery lead unit was established with the financial support of the Cheshire and Mersey Women and Children's Partnership. In the first 6 months of 18/19 we have seen double the homebirths than the whole of 17/18. Homebirths reduce pressure on acute services and are clinically evidenced as lower risk
- WUTH and CoCH have a clear vision and set of objectives for their 5 horizontal acute care alliance objectives and a programme of work has been scoped that now requires executive sign off
- In October 2018 a joint bid with WUTH and CoCH for a pilot child and family hub was awarded £70k from the Cheshire and Mersey Women and Children's Partnership. Work is underway with partners to develop KPI outcomes for this work

Items for Escalation to the Programme Board (recommendations for action)

- At November W&C DPR it was recognised that there are several actions on horizontal collaboration that need agreeing between WUTH and CoCH Executive Boards. A paper is to be tabled at December DPR for Executive consideration. The key issues are shared leadership in order to continue to drive through change and support the clinical intent

Partnerships: Healthy Wirral: Medicines Management Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Mike Treharne, DOF CCG	TBD	Pippa Roberts	-	Amber	Red

Independent Assurance Statement

1. In terms of 'scope' there is an (undated) 1 page document 'Medicines Management - Bid for Support - Full with Updates'; however, a 'PID' (or equivalent) should define the full programme of work. General Practice Clinical Pharmacist (GPCP) Implementation Group is meeting, ToR Issue 3 signed off in June 2018. Biosimilars has ToRs dated April 2018 and met in September 2018. **2.** Notes from Wirral Integrated Pharmacy/ MO Group of 4 Oct 18 are available; no minutes of the 'Medicines Optimisation Programme Board'. **3.** There is a governance structure showing how the 'Medicines Optimisation Programme Board' relates to the 'Healthy Wirral Executive Delivery Group' and the 'Healthy Wirral Programme Board'; version 5 of the Programme Board ToR is available but this needs a date to be entered to show when the document was authorised. **4.** There is evidence of GPCP stakeholder engagement and communications. **5.** There is no EA/QIA assessment. **6.** There is no milestone plan. **7.** Some KPIs are being tracked in terms of activity for GPCP but no sense of target thresholds for output / outcome. Biosimilars have a clear set of graphs to show adoption trends and the related financial savings. **8 and 9.** No evidence that risks and issues are identified, assessed and managed/mitigated.

Most recent assurance evidence submitted 8 Nov 18

.Joe Gibson External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Medicines Management	The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicines expenditure.	Mike Treharne, DOF CCG											

Programme Board
Partnerships: Healthy Wirral: Medicines Management

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicines expenditure.
It aims to:
-Enable people to access treatment that is clinically effective, based on the latest scientific discovery, at as low a price as possible
- Support people to take their medicines as intended, with appropriate medicines reviews, so that they get the health outcomes they want

Programme actions on 'Assurance Statement'	Target date
• Initial tranche of evidence submitted for review on 8th November.	• 8th Nov

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
GPCP • has activity data only to date . • Practices increased from initial 9 to 13 – eta Nov 18			
• Biosimilar Saving	0	250k	500k
• Other TBC			

Programme Progress/Milestones

- Presented at HWEDG in September– formal endorsement to programme
- Bid for funding approved but need to identify support
- Agreed multidisciplinary Programme Board to commence December 2018
- GPCP projects progressing well – 9 practices in April wave – 4 more in November wave. Existing practices increasing sessional commitment. Civic asking for 0.4wte for on site Care Home.
- Biosimilar- savings delivered on etanercept, rituximab and infliximab. Adalimumab framework to be launched in December.. Biosimilar meeting agreed switching programme, patient communications have occurred and liaising with homecare company ready for launch. 100k delivered in November – price reduction intended to limit switching. Care home project funding being determined.

Items for Escalation to the Programme Board (recommendations for action)

- The request for project/STT support to help progress the Multidisciplinary Programme Board which commences in December 2018

Partnerships: WWC Alliance: Pathology Assurance Update – 12th October 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Alistair Leinster?	TBD	-	Red	Red

Independent Assurance Statement

No assurance evidence submitted to date.

Joe Gibson
External Programme Assurance

Programme Title	Programme Description	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Pathology	SRO to arrange for this field to be populated as well as 'programme core team names'											

Digital: GDE Medicines Management Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	P Roberts	L Tarpey	-	Amber	Red

Independent Assurance Statement

1. AMS PID v3, 25 Oct 18, 1 benefit of £187k CQUIN (but no metrics). MAT NNU PID v2, 23 Oct 18, 1 benefit from EPMA implementation for maternity / neonates; baseline but no target. MED Eye PID v4, 25 Oct 18, 1 benefit 'closed loop meds admin' but no metrics. Paper Charts PID v1, 23 Oct 18, 1 benefit to improve safety etc but no metrics. **2.** The 'Programme Core Team' names on dashboard incomplete. **3.** ToR (undated) for Medicine GDE meeting available. No minutes of Project Boards described in the PIDs; however, there are notes of 'GDE Meetings' 28 Sep 18 and 9 Oct 18. PIDs yet to be approved by the 'Project Board'. **4.** Comms Plans outlined in the PIDs but only AMS has evidence of a 'live' (v3 12 Oct 18) list of actions. **5.** No EA/QIA in evidence. **6.** Milestone Plans: AMS PP v2 20180119 (date?) complete but 2 overdue comms actions; Mat and NNU PP v3 dated 9 Sep 18, appears largely on track; MED Eye PP v1, 16 Oct 18, largely up to date but overdue actions undated. Paper Charts PP v3 20181101, largely up to date but overdue Comms actions. **7.** No evidence of tracking of benefits. **8 & 9.** Risks & Issues: RAID Log v10, 18 Oct 18, risks reviewed 9 Oct but no record in notes of 'GDE Meeting', some 'AMS Go Live Issues' remain open.

Most recent assurance evidence submitted 2 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Meds Management	This meeting exists to monitor progress of the agreed and ratified GDE Medicine programme. To ensure that appropriate resources are available to meet the requirements of the programme and objectives and benefits are identified and realised. There is also an acknowledgement that it is essential that BAU work for the Pharmacy service is carried out in parallel. It is understood that BAU and GDE projects will impact on each other as essentially the same resources are required for both. This meeting will support prioritisation of work for both BAU and GDE projects.	David Jago											

Programme Board
Digital: GDE Medicines Management

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Programme comprises a number of different projects that aim to enhance various areas within Pharmacy and Medicines management by utilising the latest technology available
- To bring the Trust in line with the Local Service Delivery plan some key areas have been prioritised to focus on with the aim to improve patient safety and overall patient care.
- Prioritised areas : Digitising remaining paper charts, Closed Loop Medication, Antimicrobial Stewardship, EPMA Outpatients and Digital Chemo Trials

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Reduce missed doses in Mat and NNU	MAT -24.475% NNU – 1.613%	N/A	TBC
• AMS CQUIN Compliance	£0		£187,500
• Dispensary staff time savings			

Programme actions on 'Assurance Statement'	Target date
• Update Leads section on Dashboard	16/11/2018
• Update communication and project plans	16/11/2018
• Conduct full benefits review and document outcomes, including PIDS	07/12/2018
• Review Issues and Risks and update documentation	07/12/2018

Programme Progress/Milestones

Completed
- Anti-microbial Stewardship – **Feb 2018**
- Digitising first 5 paper charts – **March 2018**
- Digitising Chemotherapy Trials – **October 2018**
- Pharmacy Worklist Update - **October 2018**

Outstanding
- Maternity and Neonatal EPMA – **Jan 2019**
- VTE Updates completed – **May 2019**
- Closed Loop Medication – **May 2019**
- EPMA Outpatients – **June 2019**

Items for Escalation to the Programme Board (recommendations for action)

Digital: GDE Device Integration Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Gaynor Westray	Michelle Murray	-	Red	Red

Independent Assurance Statement

1. Infusion Pumps GDE PID v0.3, 02112018; benefits to save nurses time and stop inaccurate data going into EPR (no metrics). PCECG GDE PID v0.3, 01102018; benefits marked 'tbc'. Vitalslink GDE PID v0.7, 31102018; benefits: firstly, saving nursing time @ £696,911 per annum = more time to care for patients; secondly, ensuring all basic observation results are recorded accurately - details provided for March - May 2018 has shown a decrease of "in error" rate, down to 0.1119% (but no stated baseline). **2.** The 'Programme Core Team' names on dashboard yet to be completed. **3.** No evidence of governance meetings other than GDE Programme Board. PIDs yet to be approved in a 'Project Board'. **4.** 'Vitalslink Communication Plan', 30102018; however, it a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** Device Integration Project Plan v0.9 31102018 shows many elements completed but overdue 'Go Live' in Paediatrics since June 2018; plan completes end Nov 18. PCECG Project Plan appears on track. **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** RAID Logs for each project are in use but missing risk review dates and follow-up actions.

Most recent assurance evidence received 2 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Device Integration	SRO to arrange for this field to be populated as well as 'programme core team names'	David Jago											

Programme Board

Digital: GDE Device Integration

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Programme is mainly focussed around integrating key medical devices with Wirral Millennium
- Automation of recording results will free up time for clinical and nursing staff to provide direct patient care
- Reduction in transcription errors will improve overall patient safety
- Key areas: Observation Machines, ECG machines, Infusion Pumps

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Nursing time saved recording observations enabling more time for direct care	58, 275 hours	4,995 hours	31, 635 hours
• Reduction in observation recording errors	0.2161%	0.119%	0.09%

Programme actions on 'Assurance Statement'	Target date
• Update named leads on dashboard	09/11/2018
• Update Project and Communication Plans	16/11/2018
• Establish clinical leads for ECG and Infusion Pumps and set up relevant governance structure	08/12/2018
• Ensure all future meetings and associated minutes/actions are documented	Ongoing

Programme Progress/Milestones

Completed
- ECG integration in ED – **March 18**
- Welch Allyn integration for alll Adult Inpatients – **Nov 18**

Outstanding
- Welch Allyn Integration Paediatrics – **Jan 2019**
- Trust Wide ECG integration – **March 2019 TBC**
- Infusion Pump integration – **May 2019**

Items for Escalation to the Programme Board (recommendations for action)

Digital: GDE Image Management Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Nikki Stevenson	Michelle Murray	-	Red	Red

Independent Assurance Statement

1. PID Bronchoscopy PID v0.2 02112018 and PID Colposcopy v0.1 02112018 and Theatres Image Mgt PID 02112018; 1 benefit cited - for all 3 projects - is that all clinical images will be stored electronically in one central location (PAC's), therefore clinicians can access the images more efficiently. **2.** The 'Programme Core Team' names on dashboard yet to be completed. **3.** No evidence of governance or meetings other than references at GDE Programme Board; all PIDs yet to be approved at a Project Board. **4.** There is a 'Colposcopy Comms Plan' v0.1 02112018 which is a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** A Bronchoscopy Project Plan, 06092018, describes activities from 24 Apr 18 to 20 Sep 18 but does appear to be tracked / updated (a Colposcopy PP 07112017 started and finished in Nov 17 has been submitted but not clear why). **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** Risk and Issue Logs are in use for each project but no review dates, updating appears to be an issue.

Most recent assurance evidence received 2 Nov 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Device Integration	SRO to arrange for this field to be populated as well as 'programme core team names'	David Jago											

Programme Board

Digital: GDE Image Management

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)
• Image management programme contains a number of projects relating to consolidating the storage of all clinical images around the Trust into the PACS archive and ensuring the are digitally available in Millennium. • The projects will contribute towards the provision of a single electronic patient record which at the moment is split between paper and digital • The projects are aimed at the following areas: Medical Photography, Colposcopy, Bronchoscopy, Theatre Stackers, Cardiac and Endoscopy

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Contributing to a single electronic patient record			

Programme actions on 'Assurance Statement'	Target date
• Sign off Capital Spend at Digital Wirral Board	15/11/2018
• Update named leads on Dashboard	15/11/2018
• Work with Medical Director to identify clinical leads for Medical Photography and Theatre Stackers and establish relevant governance structure	23/11/2018
• Complete Project Closure reports for Colposcopy and Bronchoscopy	07/12/2018
• Agree scope, benefits, metrics and sign off PIDS for Medical Photography and Theatre Stackers	14/12/2018

Programme Progress/Milestones

Completed
- Colposcopy Images stored centrally in PACS – **Nov 17**
- Bronchoscopy images stored centrally in PACS – **Nov 18**

Outstanding
- Medical Photography images stored centrally in PACS – **May 2019 TBC**
- Theatre Stackers images stored centrally in PACS – **June 2019**
- Endoscopy images stored centrally in PACS - **June 2019**
- Cardiac images stored centrally in PACs - **TBC**

Items for Escalation to the Programme Board (recommendations for action)

Digital: GDE Patient Portal Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Mr David Rowlands	Katherine Hanlon	-	Amber	Red

Independent Assurance Statement

1. PID v1.3, 25 Oct 18, states it was approved by project board on 28 Jun 17. There are 3 benefits reducing follow-up O/P appts for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit cited for Urology). Patient Story defines patient benefit. **2.** The 'Programme Core Team' names on this dashboard to be completed. **3.** Minutes of the Project Board available to 26 Sep 18. **4**. There is a Comms Plan, v4 24 Oct 18, which has some activities recorded but lacks forward looking schedule. **5.** No EA/QIA in evidence. **6.** Milestone Plan, v1.2 of 25 Oct 18, is tracked and up to date but does not yet indicate the status of delivery for actions related to testing of Gynaecology (14 Sep to 5 Oct 18). **7.** No evidence of benefits/metrics tracking. **8 & 9,** Risks and Issues: RAID Log, 24 Oct 18, captures risks and issues and these were last reviewed at the Project Board of 27 Jul 18 as recorded in the minutes.

Most recent assurance evidence received 25 Oct 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
Patient Portal	One of the pieces of functionality Cerner Millennium offers is a "patient portal". Through patient portal individuals can have real-time access to specific requests such appointment changes and clinical information that can be viewed in the Cerner Millennium electronic medical record (EMR). The patient portal is essential for remote surveillance and self - management of patients living beyond cancer. The portal, along with a robust tracking system will allow for patients to be managed remotely and therefore reduce the amount of follow ups required within a hospital setting.	David Jago											

Programme Board
Digital: GDE Patient Portal

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Patient Portal aims to provide patients with better access to their health record and enable proactive management of their own health care.
- Provides the ability to place patients under remote surveillance and reduce the need for physical follow up appointments which in turn increases capacity to see new patients

Programme actions on 'Assurance Statement'	Target date
• Update named Leads on dashboard	09/11/2018
• Update Project and Communication Plans	16/11/2018
• Conduct full benefits review and update relevant documentation	14/12/2018
• Review risks and issues at Project Board	14/12/2018

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Urology – Reduction in follow ups and increased capacity for new Patients	0 additional new appts	TBC	65 new appointment slots
• Breast – Reduction in follow ups and increased capacity for new Patients	0 additional new appts	TBC	TBC
• Colorectal – Reduction in follow ups and increased capacity for new Patients	0 additional new appts	TBC	TBC

Programme Progress/Milestones

Completed
- Roll out to Maternity and Diabetes– **Nov 17**
- Roll out to Colorectal, Breast and Urology – **June 18**

Outstanding
- Trust wide roll out – **Feb 2019 TBC**

Items for Escalation to the Programme Board (recommendations for action)

CQC Action Plan – Assurance Update – 8th November 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Paul Moore	Paul Linehan	Vicky Clarke	-	Amber	Amber

Independent Assurance Statement

1. The extent of the CQC Action Plan is clear in terms of overall challenge and has been allocated by leader and by division. **2.** There are named individuals in charge of areas of the plan and support is also being received from the STT; however, the 'Programme Core Team' names (or equivalent) should be populated on this dashboard. **3.** From the evidence of reporting to Trust Board and the detail of the 'Check and Challenge' reports it appears that adequate governance is in place. **4.** The plans in place show engagement with the leadership and divisional structures of the organisation; however, it is not clear how progress is being reported to all staff. **6.** The 'Action Plans' and 'Check and Challenge' reports show progress across a broad front but many actions remain amber rated and some red rated; overall, the status is rated amber. **7.** Given the amber status of the action plans, the 'benefits' are also rated amber.

Most recent assurance evidence received 8 Oct 18.

Joe Gibson, External Programme Assurance

Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
CQC Action Plan	SRO to arrange for this field to be populated as well as 'programme core team names'	Paul Moore		●	●	●	●			●	●		

Division/ Department	Programme	Scheme Ref.	Scheme owner	Scheme Description	RAG rating	18/19 In year benefit (£)	Full Year Effect (£)	Reason for approval
Women & Children	Outpatient Improvement	19OP04	GP	Outpatients Utilisation - Paediatrics	Amber	38,940	77,880	FYE Value
Medicine & Acute	Outpatient Improvement	19OP05	SB	Outpatients Utilisation – Medicine & Acute	Red	114,000	342,000	Value
						152,940	**419,880**	


19OP04


19OP05

Board of Directors

Subject:	10.3 Proceedings of the Trust Management Board	**Date:** 28.11.2018	
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 currently represent a potential risk to quality or safety of care – exposure to infection, venous thromboembolism prevention, nursing vacancy rates and complaints responsiveness and water safety management.**		
Staff Impact	**Staff vacancy, attendance management and completion of core-10 mandatory training requirements represent a risk to workforce effectiveness**		
Services	**None identified**		
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.**		
Committees/groups where this item has been presented before			
N/A			
Executive Summary			

1. Executive Summary

- The Trust Management Board (TMB) met on 05/11/2018. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors.

2. Outpatient Transformation

- Steve Sewell outlined his key observations following a review of outpatient services.
- The Trust has a traditional approach to delivering outpatient services and is operating within a traditional delivery model. As such, the overall approach is lacking the creative tension to drive innovation and development. Staff have been tolerating poor facilities and out of date practices to such an extent that these have become normalised.
- If the Trust better utilised all available clinic capacity, this could lead to an estimated 38,000 additional outpatient slots being available to service users. This could simultaneously benefit service users by reducing the time spent waiting for an appointment, speed up treatment and improve financial health.

- The modernisation programme '*21st Century Outpatients*' will focus on three specific aims:

  (i) Increasing clinic capacity to return to or exceed planned activity levels before the financial year end;

(ii) Review and redesign outpatient structures
(iii) Develop and implement transformation which leads to the eradication of paper and drives innovation in delivery of outpatient transactions with service users.

- Divisional teams were actively encouraged to promote and support the requisite clinical leadership needed at every level to drive improvements in outpatient services.

3. Quality, Performance and Use of Resources Dashboard

- TMB received the revised Quality Performance Dashboard in the new format covering the 5 months ended 30th September 2018.
- 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.
- There are currently 28/66 indicators in the new dashboard outside tolerance. The revised format of the dashboard has made risks more visible. The matters of concern highlighted for escalation include:

  - **VTE prevention performance**. *Several actions are underway to address under performance including the utilisation of Cerner, a focus on the post-take ward round and reconvening the VTE Group to drive improvements*. *The Medical Director has agreed a short window with clinical teams within which to demonstrate improvement.*
  - **Hand hygiene compliance.** *The Board received a detailed action plan for preventing and controlling the risk of infection at their meeting held on 01/11/2018. TMB noted the action reported to the Board of Directors.*
  - **Completion of safeguarding training.** *TMB and divisions reached agreement to push completion of mandatory training. Links shall be developed and consulted on to consider introducing potential consequences on pay progression, or other restrictions where there has been an unreasonable delay or failure to complete mandatory training.*
  - **Unsustainable level of sickness/absence.** *TMB recognised the urgent need to grasp attendance management more directly and reverse recent increase in sickness/absence. This will be the focus of more direct accountability at the Divisional Performance Review meetings.*
  - **Completion of MUST assessments.** *The Director of Nursing & Midwifery indicated that there has been improvement in compliance and movement in the right direction. Improvements are expected to show through in subsequent performance reports.*
  - **Percentage of discharges before noon.** *TMB recognised that the Trust is currently below expectations in respect of the timeliness and readiness for discharge before noon each day. This remains the focus of efforts led by the Director of Nursing as part of the Patient Flow work stream.*
  - **Number patients with extended length of stay 7 days or more**. *Approximately 50% of beds currently occupied with a patient whose length of stay is 7 days or more. This remains the focus of efforts led by the Director of Nursing as part of the Patient Flow work stream.*
  - **Initial assessment and gap analysis of NICE guidelines.** *The Director of Quality & Governance outlined his intentions to review the current process for evaluating applicability and compliance with NICE guidelines. Other more pressing concerns in respect of quality governance had taken priority until now. Those guidelines currently awaiting gap analysis are known and direct discussions will soon take place with clinical leads to undertake an assessment. It is expected that this indicator will return to tolerance over the next 4-6 weeks. The Medical Director concurred that a lack of clinical service leads had adversely impacted on the Trust's ability to assess new guidelines when published. Identified clinical leads are now better placed to overcome the backlog that had accumulated.*
  - **Level of participation in national clinical audit programmes.** *The Director of*

Quality & Governance outlined that in the past the Trust has not participated fully in all national clinical audit programmes. The audits where the Trust appears not to participate have been identified and direct conversations are currently taking place with relevant clinical leaders to ascertain any specific problems and decide upon future participation where appropriate.

- **Same sex accommodation breaches.** *The Trust continues to experience gender-specific accommodation breaches within the Intensive Care Unit. These occur when a patient is deemed ready for transfer or step down but remains on the Unit. This is linked to discharge and patient flow as outlined elsewhere in this report. On a separate but related matter, the PSQB drew attention to the requirement for improvement following CQC inspection in respect of gender-specific breaches in ED. Operational colleagues understood that gender-specific accommodation does not apply to ED. As this is identified for improvement by CQC as a 'must do' recommendation, the Director of Quality & Governance took advice from the CQC. The local CQC Inspector's advice was that "the application of same sex rules apply to ED once the decision to admit has been made" and this was therefore the basis for including the improvement recommendation in the Trust's most recent CQC inspection report. The Chief Operating Officer and Director of Nursing & Midwifery have been briefed accordingly by the Director of Quality & Governance.*
- **Friends and Family**. *The Director of Nursing & Midwifery acknowledged the importance of FFT and reaching out to as many service users as possible in order to have greater confidence in the recommendation ratings. Although recommendation ratings overall are generally very good, it would build confidence in those results to increase the levels response rates. A range of methods are being used to support this including text messaging, electronic capture prior to leaving and encouraged from volunteers and staff.*
- **Complaints handling.** *TMB acknowledged the need to speed up and improve the quality of responses. The number of complaints overdue for a response has not materially improved and there remains an unacceptable backlog. This results from poor handling processes within divisions. The Chief Executive led the discussions by emphasising, from a patient's perspective, the importance of prompt, accurate and compelling responses. She expressed disappointment in the lack of progress and reflected upon what impact that may be having on people who need answers, explanations and apologies when care has fallen below the standard expected. She also reflected upon the Trust's ability to learn when responses are so far behind. Actions to improve complaints handling have been previously discussed and agreed. Refinements to the complaints handling process were discussed and agreed and a commitment from all leaders to support the Director of Nursing & Chief Executive and prioritise overdue responses obtained.*
- **Staff engagement scores** (Staff FFT). *TMB acknowledged staff engagement is of paramount importance. TMB reflected upon the correlation between staff satisfaction and quality of care; this being well publicised in the literature and also by the CQC. Currently the level of staff satisfaction is not where it needs to be. TMB emphasised the importance of leadership visibility and engagement – not just executive visibility – but all leaders using every opportunity to become increasingly visible to front line teams.*

Use of Resources

- M6 deficit – off plan by £1.8m
- Risk of expansion of underlying forecast deficit by the year end of £30m, £5m beyond the control total agreed by the Board of Directors.
- Deficit is being driven by lower than planned elective and day case activity.
- TMB discussed and agreed to revisit CIP plans and recover and return to the control total agreed. The Chief Executive led the discussion, setting out her expectations to manage expenditure better. Improving the flow of patients through the system leads to simultaneous benefit, it: (i) leads to a better experience for patients, carers and

relatives; (ii) enhances the quality of care and leads to better outcomes for people; and (iii) better supports a return to operating within the agreed financial control total.

4. Diversity & Inclusion Strategy

- TMB received and approved the Diversity & Inclusion Strategy 2018-22.

5. Report of the Patient Safety & Quality Board

- TMB received and considered the report from the PSQB meeting held on 25/10/2018.
- The escalations were reviewed and TMB's consideration reflected in the Quality, Performance and Use of Resource Dashboard notations above.

6. Report of the Risk Management Committee

- TMB received and considered the report from the PSQB meeting held on 23/10/2018.
- It was acknowledged that the Trust is developing its approach to risk management and time will be needed to increase the maturity, value and utilisation of risk registers.
- The Board's risk horizon scan, and subsequent clarification of the six strategic risk scenarios, has proved extremely helpful to divisional and corporate leaders envisioning and developing their risk profiles.
- A revised Risk Management Policy was approved; this being modelled on the British Standard Code of Practice for Risk Management and influenced by other international standards for risk management. The Policy included a simplification and rationalisation to the risk grading matrix which promoted colleagues to revisit current risk registers and re-evaluate exposure.
- It was confirmed that as part of a rolling programme of reviews, all divisions and major corporate functions will be called to present their 'reportable risks' to the Risk Management Committee. This started with a review of reportable risks within the Division of Clinical Support Services, and Informatics Department. It was agreed, for both risk registers, that further work would enhance their value and utility. Therefore, TMB agreed to allow additional time to develop accordingly.
- TMB recognised that the Risk Management Committee and revised risk management processes reflected recent changes introduced following the CQC's inspection. This represents encouraging progress, but important to be aware that both the Committee and Policy are new and at an early stage of development/implementation in the organisation.

7. Report of the Programme Board

- TMB received and considered the report from the Programme Board meeting held on 18/10/2018.
- TMB recognised the Programme Board is currently formulating its approach to oversight and reporting of the transformational programme, progress to date was noted as encouraging.

8. Strategy Update

- TMB received a presentation on the proposed strategic objectives and orientating Trust values.
- TMB supported and endorsed the draft objectives.
- The shift from PROUD values to values that reflected more directly the NHS values was discussed. The Executive reflected upon the various interpretations of PROUD that permeate the culture, specifically that the values are not universally accepted or seen as credible by all colleagues. It was proposed by the clinical body, and accepted by TMB, that a shift towards the nationally recognised NHS values would better support cultural development at the Trust at this time.

- The next steps will include: (i) communicating and engaging with front line teams to build a strong commitment towards our goals; (ii) focussing more directly on delivery; and (iii) building a culture of continuous improvement supported by transparency, openness, innovation and learning.

Written on behalf of the Chief Executive by
Paul Moore
Director of Quality & Governance
06/11/2018

BOARD OF DIRECTORS	
Agenda Item	10.4
Title of Report	CQC Action Plan Progress Update
Date of Meeting	28th 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: 21ST NOVEMBER, 2018

1. PURPOSE

1.1 The purpose of this paper is to 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

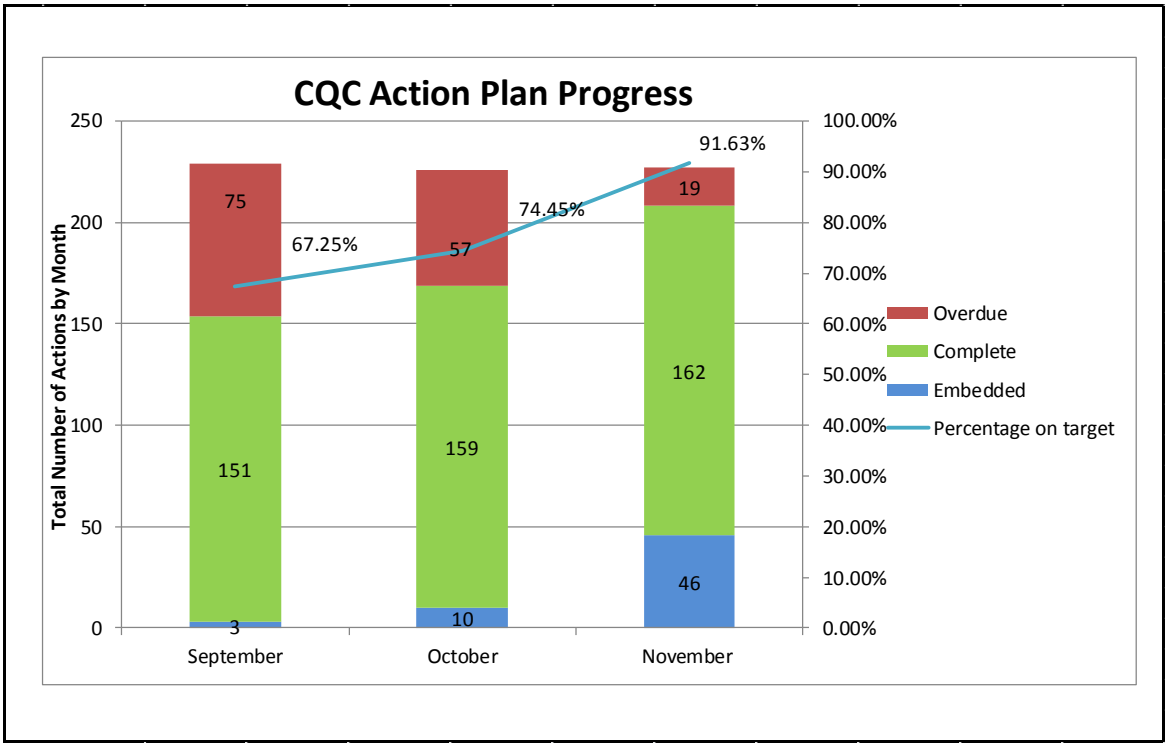
3.1 The CQC inspectors inspected the trust in March and May 2018 to check the quality of care at Wirral University Teaching Hospital NHS Foundation.

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 **227** 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.

CQC Action Plan Progress – November 18



3.2 Exceptions:

Following the Check and Challenge meetings held 21st November 18, there are 13 actions which have been 'red' rated and are to be reported as exceptions for this reporting period. However, assurances have been received from executive colleagues that these actions are being appropriately managed.

These are predominantly in operational areas and refer to actions specifically around the design and implementation of divisional dashboards and risk reporting tools, Health & Safety, Estates and Clinical related actions.

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

For this reporting period a list of the 'embedded' classified actions have also been included in annex B, to provide the Board with assurance and oversight of the significant progress that has been made.

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.
- ***NOTE*** the significant improvement in November 18 position, and the progress made to date

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
34	Must Do	Corporate / Trust-Wide Issues	HEALTH & SAFETY Surgery : The trust must ensure systems and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Emergency Department: The service should ensure that health and safety risk assessments are kept up to date.	Carry out a site survey at APH and CBH to ensure access to fire escapes is not obstructed. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	UPDATED: 14.11.2018 - This was raised as a serious issue for concern and COO agreed to escalate and to ensure that this action is carried out at the earliest opportunity. Evidence to be provided at next meeting.	31/10/2018	
35	Must Do	Corporate / Trust-Wide Issues	As at 35	Carry out a site survey at APH and CBH to ensure that extension leads are compliant with all safety requirements and only PAT-tested leads are in use. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	UPDATED: 14.11.18 The extension lead audit has been completed, report with findings to be compiled and submitted by end of November. ""Red"" rated as this action is overdue	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	Undertake environmental surveys (estates condition and mixed sex accommodation) for Critical Care, Ward 17 and Theatre Recovery	Chief Operating Officer	Effective	UPDATED: 14.11.2018 Environmental surveys undertaken by Health & Safety Adviser. His report is to be considered at the Risk Management Committee meeting to be held on 26th November 2018.	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
			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.						
38	Must Do	Corporate / Trust-Wide Issues	As 37 above	Develop a refurbishment plan for Critical Care	Chief Operating Officer	Effective	"UPDATED: 14.11.2018 - Action is 'red' rated as it is overdue and refurbishment plan is outstanding	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
39	Must Do	Corporate / Trust-Wide Issues	As 37 above	Agree a trajectory for completion of the remedial works	Chief Operating Officer	Effective	UPDATED: 14.11.2018 - Action is 'red' rated as it is overdue and refurbishment plan and trajectory completion dates remain outstanding	01/11/2018	
63	Should 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.	Identify and resolve any faulty or defective records cabinets or trolleys and obtain assurance from all ward managers / departmental heads that records cabinets / trolleys are fit for purpose	Director of IT and Information	Well Led	UPDATED 21.11.2018 - Audit has taken place and reconfirmed arrangements, steps are being taken to address issues with ward Managers. Red rated until we have confidence that appropriate actions have been taken. Delivery date has lapsed "	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
64	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 21.11.2018 – red rated until we can demonstrate that we have completed the review and are assured about the management of workflows that are not managed by Medical Records. Process to be tested.	01/09/2018	
66	Should Do	End of life Care (Acute & Medical Division)	ELECTRONIC PATIENT RECORD The service should consider reviewing the way documents are stored on the electronic patient record to ensure that important information such as capacity or pain assessments can be easily located by staff when needed.	In partnership with the vendor, review whether it is possible to modify Cerner Millennium whereby key patient information such as DNACPR, MCA, DOLS, patient level risk assessments are current, or could be more prominent within the medical record	Director of IT and Information	Effective	UPDATED 21/11/2018 - with EPR counsel. The Chief Medical Information Officer to developing an appropriate way forward and will in due course make recommendations for change	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
173	Must Do	Corporate / Trust-Wide Issues	"RISK REGISTER This issue affects all divisions but the report highlighted the Critical Care, Medicine and End of Life Care core services Critical Care : The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service. Medicine : The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way. End of Life Care : The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers. "	Review and refresh the divisional risk profile	Executive Director of Quality & Governance	Well Led	Relaunched Risk Committee October 2018 "21.11.2018 - In progress - Masterclass/training sessions currently underway with relevant areas. 'Red rated' as we are behind plan. The Director of Quality and Governance has taken steps to accelerate the production of divisional risk registers"	30/11/2018	
174	Must Do	Corporate / Trust-Wide Issues	As 173 above	Record those risks on the divisional risk register (inside Ulysses)	Executive Director of Quality & Governance	Well Led	"21.11.2018 - In progress - Masterclass/training sessions currently underway with relevant areas. 'Red rated' as we are behind plan. The Director of Quality and Governance has taken steps to accelerate the production of divisional risk registers"	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
197	Should Do	Medical Care (Acute & Medical Division)	"MEDICINES STORAGE The service should ensure the safe and proper storage of medicines on the wards. "	Rectify defects identified through the existing quarterly audits in all wards and departments	Executive Medical Director	Effective	"16/11/18 UPDATE: As at the 16th November Medical Director does not have assurance that all medicine storage concerns have been addressed. Action: Medical Director has requested a report and accountability to take place at the PSQB meeting to be held in December. RAG updated to Red"	01/11/2018	
203	Should Do	Surgery (Surgical Division)	"WHO CHECKLIST The service should audit the implementation of the World Health Organisation Surgical Safety Checklist Five Steps to Safer Surgery."	Conclude a review of the Trust's arrangements for Safer Surgery, specifically including NATSSIPs and LOCSSIPs	Executive Medical Director	Safe	"16.11.2018 UPDATED List of procedures complete in surgery and W&C with assurance received LOCSSIP and NATSSIP are in place. List not yet complete for Medicine. Mark Lipton to provide complete list to MD by 10/12/18. RAG changed to red"	01/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
221	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, mortality process requires development. 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 UPDATE 16/11/18 On track to roll out safeguard Ulysses mortality module as planned in November 18. The rate of reviews requires improvement.	01/09/2018	

ANNEX B

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
6	Must Do	Corporate / Trust-Wide Issues	FIT & PROPER PERSONS The trust must ensure that all fit and proper person's checks are completed in line with guidance for all directors and non-executive directors at board level and they are compliant with the fit and proper person's regulation at all times.	Review, clarify and approve the process for complying with FPP Requirement ensuring that the process meets all regulatory requirements and standards	Chairman	Well Led	**UPDATED: 16.10.18 - embedded action** as 3 months green	01/09/2018	
7	Must Do	Corporate / Trust-Wide Issues		Determine within the Trust's controls for complying with FPPR what roles qualify for FPPR testing	Chairman	Well Led	**UPDATED: 16.10.18 - embedded action** as 3 months green	01/09/2018	
8	Must Do	Corporate / Trust-Wide Issues		Provide assurance to the Chairman, for all qualifying roles, that the FPPR has been complied with in full	Chairman	Well Led	**UPDATED: 16.10.18 - embedded action** as 3 months green	01/09/2018	
21	Should Do	Urgent And Emergency Care (Acute & Medical Division)	MAJOR INCIDENT EQUIPMENT The service should ensure that staff are able to access major incident equipment in a timely manner and that major Incident equipment is checked and maintained in line with trust policy.	Obtain assurance from ED departmental lead that the Major Incident equipment is kept secure, checked regularly and accessed by authorised personnel only	Chief Operating Officer	Safe	**UPDATED: 14.11.2018 – embedded action** Evidence satisfies action	31/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
31	Must Do	Maternity Services (Women's & Children's Division)	SECURITY The service must ensure there are adequate security arrangements to keep babies safe at all times.	Carry out a survey and risk assessment in respect of access to the neo-natal wards ensuring that access is restricted and controlled at all times	Chief Operating Officer	Safe	**21.11.2018 – embedded process and spot check undertaken by Director of Governance**	16/10/2018	
32	Must Do	Maternity Services (Women's & Children's Division)		Provide assurance to the Executive Team setting out the outcome of this assessment and the agreed actions	Chief Operating Officer	Safe	**21.11.2018 – embedded process and spot check undertaken by Director of Governance**	16/10/2018	
33		Maternity Services (Women's & Children's Division)		Implement the identified controls required to deliver full security	Chief Operating Officer	Safe	**21.11.2018 – embedded process and spot check undertaken by Director of Governance**	16/10/2018	
152	Should Do	Urgent And Emergency Care (Acute & Medical Division)	FGM The service should consider ways in which to make sure that all staff have an understanding of female genital mutilation and aware of the legal requirement to report incidences of this.	Review and / or develop a policy for the management of suspected female genital mutilation	Executive Director of Nursing and Midwifery, Executive Medical Director	Effective	**21.11.2018 – embedded process**	01/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
153	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Incorporate the risk of FGM into the Safeguarding mandatory training programme	Executive Director of Nursing and Midwifery, Executive Medical Director	Effective	**21.11.2018 – embedded process**	01/08/2018	
155	Must Do	Corporate / Trust-Wide Issues	**GOVERNANCE** **Trust wide :** The trust must ensure that all governance, incident and risk systems and processes are effective and fully implemented. **Emergency Department:** The service must ensure that all incidents, including serious incidents are reported and investigated in line with trust policy and the NHS Serious Incident Framework 2015. **Surgery**: The service should ensure consistent reporting of incidents by all staff.	Establish control over serious incident handling: implement a Serious Incident Review Group Meeting for consideration, declaration and reporting of serious incidents (in accordance with NHS England's SI Framework)	Executive Director of Quality & Governance	Well Lead	**21.11.2018 – embedded process** Monthly review at PSQB and SIR can be evidenced	31/08/2018	
156	Must Do	Corporate / Trust-Wide Issues		Introduce multidisciplinary sign off of serious incident investigation reports	Executive Director of Quality & Governance	Well Lead	As above - commenced under control since Mid-August - evidence as above	31/08/2018	
157	Must Do	Corporate / Trust-Wide Issues		Redesign and utilise a more focussed serious incident tracker to performance manage investigations and Duty of	Executive Director of Quality & Governance	Well Lead	**21.11.2018 - Completed and embedded** Monthly review at SIRG and can be evidenced	31/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
				Candour					
158	Must Do	Corporate / Trust-Wide Issues		Redesign the serious incident process, and introduce consideration of action to be taken to enable rapid action to be taken within 48-hours of discovery	Executive Director of Quality & Governance	Well Lead	**21.11.2018 – embedded process** Monthly review at SIRG and can be evidenced.	31/08/2018	
160	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism to increase the visibility and accountability for serious incident exposure and patient safety at the Board and relevant committees for the Board.	Executive Director of Quality & Governance	Well Lead	CEO reports the number and nature of serious incidents in the preceding month and the action that has been taken to learn from them. For September report covering July/August 18 - assurance on SI will be monitored and overseen by PSQB and will be assure regularly at Quality committee commencing September 18 **21.11.2018 – embedded** SI's reported at PSQB and Duty of Candour and reported to Quality Committee, breakdown of SI's. SI log reviewed at execs on a weekly basis	19/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
161	Must Do	Corporate / Trust-Wide Issues	POLICIES The trust must ensure that all policies are reviewed and up to date with national guidance.	Re-establish a Trust-wide process for the effective management of Policies Management Group (by 01/09/18)	Executive Director of Quality & Governance	Well Led	Policy on Policies - fast track process - we have established a mechanism to scrutinise the standard of documents before they are recommended for approval The function of the Policy Management group has been reviewed and it has been agreed the function of the policy group will be absorbed into GSU **21.11.2018 – embedded process** Monthly review at PSQB and can be evidenced.	19/09/2018	
162	Must Do	Corporate / Trust-Wide Issues		Rapidly review the Policy on Policies and satisfy ourselves that the process is fit for purpose and effective. If not, make changes	Executive Director of Quality & Governance	Well Led	**21.11.2018 – embedded process** Monthly review at PSQB and can be evidenced.	01/10/2018	
163	Must Do	Corporate / Trust-Wide Issues		If necessary, redesign the process for developing and approving control documents (policies, SOPs and guidelines)	Executive Director of Quality & Governance	Well Led	**21.11.2018 – embedded process** Monthly review at PSQB and can be evidenced.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
164	Must Do	Corporate / Trust-Wide Issues		Undertake a review of the currency (i.e. In date, assigned, fitness) of existing policies and procedures	Executive Director of Quality & Governance	Well Led	**21.11.2018 – embedded process** Monthly review at PSQB and can be evidenced.	01/09/2018	
165	Must Do	Corporate / Trust-Wide Issues		Review and confirm, or where necessary allocate a lead officer to review out of date control documents	Executive Director of Quality & Governance	Well Led	Completed UPDATED 19/09/18 **21.11.2018 – embedded process** Monthly review at PSQB and can be evidenced. Named individual against each policies - system in place that can be used to provide assurance.	01/09/2018	
167	Must Do	Corporate / Trust-Wide Issues		Initiate the mechanism for reviewing out of date control documents	Executive Director of Quality & Governance	Well Led	Completed - New process in place UPDATED 19/09/18 **21.11.2018 – embedded** Monthly review at PSQB and can be evidenced. Named individual against each policies - system in place that can be used to provide assurance.	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
168	Must Do	Corporate / Trust-Wide Issues	DUTY OF CANDOUR The trust must ensure that people receive an apology when things go wrong in a timely way and that duty of candour is applied in line with national guidance and trust policy.	Review the policy and ensure clarity of process for all qualifying incidents	Executive Director of Quality & Governance	Well Led	Completed- review has taken place- process flow has been developed and we have opened discussion with CCG - policy approved by PSQB by end September 18 UPDATED 19/09/18 **21.11.2018 - embedded process -** monthly review at PSQB and can be evidenced. Named individual against each policy - system in place that can be used to provide assurance.	19/09/2018	
169	Must Do	Corporate / Trust-Wide Issues	Duty of Candour	Set up within the Patient Safety Management system (Ulysses) a Duty of Candour prompt to record stage 1 compliance (verbal explanation – provided by a clinician) and stage 2 compliance (written explanation and apology within 10 working days) for all qualifying incidents	Executive Director of Quality & Governance	Well Led	**Completed**- Standard agenda item on PSQB and monitored on tracker SI **21.11.2018 - Embedded process**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
170	Must Do	Corporate / Trust-Wide Issues	Duty of Candour	Build and establish a mechanism to performance manage and oversee at management level compliance with Duty of Candour	Executive Director of Quality & Governance	Well Led	Completed- Standard agenda item on PSQB and monitored on tracker SI **21.11.2018 - Embedded process**	01/09/2018	
172	Must Do	Corporate / Trust-Wide Issues	Duty of Candour	Produce and distribute a simple guide for staff to help them comply with Duty of Candour	Executive Director of Quality & Governance	Well Led	**Completed** - Flow chart, templated letter, posters **21.11.2018 - Embedded process**	01/08/2018	
177	Should Do	Maternity Services (Women's & Children's Division)	CLINICAL GUIDANCE The service should ensure that all guidance for staff has the latest version numbers documented to ensure up to date best practice is being followed by all staff.	The service will ensure that it adheres to all ten NHS Resolution safety standards for maternity	Executive Director of Quality & Governance	Effective	CNST monies - assurance provided **Updated: 21.11.2018 – embedded process, sufficient evidence submitted**	01/08/2018	
178	Should Do	Maternity Services (Women's & Children's Division)		Provide assurance to the 'Confirm and Challenge' meeting	Executive Director of Quality & Governance	Effective	CNST monies - **Updated: 21.11.2018 – embedded process, sufficient evidence submitted**	01/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
83	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.	Consider and develop a business case for the appointment of a Nutrition Lead Nurse Specialist	Executive Director of Nursing & Midwifery	Caring	**Updated: 21.11.2018 – embedded process, sufficient evidence submitted**	01/09/2018	
84	Must Do	Medical Care (Acute & Medical Division)		Establish and enhance effectiveness of the oversight provided by a Nutrition and Hydration Steering Group	Executive Director of Nursing & Midwifery	Caring	Minutes available from governance meeting and is presented at PSQB **UPDATED: 21.11.2018 - monthly monitoring in place. Standard agenda item for PSQB – embedded**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
88	Must Do	Medical Care (Acute & Medical Division)		Audit compliance with MUST	Executive Director of Nursing & Midwifery	Caring	ACTION: evidence of ongoing audits is available **Updated : 21/11/2018 – embedded process**	01/09/2018	
90	Must Do	Medical Care (Acute & Medical Division)		Develop for each area an escalation protocol to be followed in the event of escalation being required. The protocol must set out: - Equipment required to provide care in escalated areas - Arrangements for medical review - Arrangements for the provision of food and hydration - Standards for observation - How pressure area care, privacy and dignity are to be maintained - Provisions for medicines management and storage. - Confidentiality of medical records - Access to Cerner in escalation areas	Executive Director of Nursing & Midwifery	Caring	Major Incident link page **Updated : 21/11/2018 – embedded process**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
95	Must Do	Corporate / Trust-Wide Issues	**SAFEGUARDING** **Trust wide** : The trust must ensure that all application for deprivation of liberty safeguards are made in line with legislation; and The trust must ensure that safeguarding children training is in line with national guidance. **Medicine** : The service must ensure that safeguarding systems and processes are operated effectively and capacity assessments completed in a timely manner to ensure that patients are not deprived of their liberty without lawful authority. **Emergency Department** : The service should ensure that best interest decisions and mental capacity assessments are recorded in line with trust policy and legislation	Review the process for complying with MCA and DOLs requirements	Executive Director of Nursing and Midwifery	Safe	Introduction of Cerner Millennium tool - audit safeguarding assurance group and reports to PSQB - AGENDA October TF/PL ACTION: PSQB paper & Safeguard report for evidence **Updated : 21/11/2018 – embedded process**	01/09/2018	
98	Must Do	Corporate / Trust-Wide Issues		Develop and distribute a simple guide for complying with the requirements of the Mental Capacity Act 2005 suitable for use	Executive Director of Nursing and Midwifery	Safe	**UPDATED: 21.11.2018 - embedded**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
				by all clinical practitioners					
99	Must Do	Corporate / Trust-Wide Issues		Design and carry out a clinical audit to verify compliance with MCA and DOL safeguarding processes. Ensure action is taken to address gaps in control identified. Audit to be repeated quarterly.	Executive Director of Nursing and Midwifery	Safe	Completed - audits have taken place Presented at SAG Audit data presented straight through Millennium **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
100	Must Do	Corporate / Trust-Wide Issues		Introduce metrics to oversee compliance with MCA and DOLs as part of the prioritised quality indicators in the Quality Dashboard	Executive Director of Nursing and Midwifery	Safe	Safeguarding assurance dashboard PL to pick up with TF to be included in organisation dashboard - incorporated into Safeguarding Assurance dashboard which reports into PSQB **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
125	Should Do	Medical Care (Acute & Medical Division)	**FALLS** The service should improve performance across all metrics in the national falls audit.	Continue to participate in the NFFAP	Executive Director of Nursing and Midwifery	Safe	Done - data collection underway ready for submission UPDATED: Next audit due February 19 Work underway to address issues from last action plan. Plans to participate in audit and on track **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
126	Should Do	Medical Care (Acute & Medical Division)		Identify the improvements required following audit (1/10/18)	Executive Director of Nursing and Midwifery	Safe	UPDATED: Develop an action plan to address any identified action plan **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
127	Should Do	Medical Care (Acute & Medical		Complete implementation of the Trust's Falls Action Plan	Executive Director of Nursing and	Safe	Safeguarding assurance dashboard PL to pick up with TF to be included in organisation dashboard - incorporated	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
		Division)			Midwifery		into Safeguarding Assurance dashboard which reports into PSQB **UPDATED: 21.11.2018 – embedded process**		
132	Must Do	Maternity Services (Women's & Children's Division)	**RECOVERY STAFFING** The service must ensure that there are adequately skilled and competent recovery staff available at all times to recover women who have been in theatre.	Service to ensure sufficient numbers of staff competent in recovering patients following a general anaesthetic are available to work in Theatre Recovery at all times	Executive Director of Nursing and Midwifery	Effective	UPDATED: Recruited surgical recovery second cover practitioners from October 18 **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
133	Must Do	Maternity Services (Women's & Children's Division)		Develop a contingency plan to be used in the event that insufficient numbers of staff competent in recovering patients following a GA are available	Executive Director of Nursing and Midwifery	Effective	**UPDATED: 21.11.2018 – embedded process**	01/09/2018	
134	Should Do	Maternity Services (Women's & Children's Division)	**THEATRES - CLOTHING** The service should ensure that birth partners and staff attending theatre wear appropriate theatre attire at all times.	Provide appropriate attire and ensure that it is worn by birthing partners and visitors to theatres	Executive Director of Nursing and Midwifery	Safe	**UPDATED: 21.11.2018 – embedded process**	01/09/2018	
135	Should Do	Maternity Services (Women's & Children's Division)		Provide assurance to the 'Confirm and Challenge' meeting	Executive Director of Nursing and Midwifery	Safe	**UPDATED: 21.11.2018 – embedded process**	01/09/2018	
136	Should Do	Maternity Services (Women's & Children's Division)	**TRANSITIONAL CARE UNIT - STAFFING** The service should review the staffing arrangements of the transitional care unit to	Service to ensure sufficient numbers of staff are available to work on the Transitional Care Unit at all times	Executive Director of Nursing and Midwifery	Effective	**UPDATED: 21.11.2018 – embedded process**	01/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			prevent access and flow issues in the unit such as delayed inductions of labour.						
137	Should Do	Maternity Services (Women's & Children's Division)		Develop a contingency plan to be used in the event of shortfalls	Executive Director of Nursing and Midwifery	Effective	Confirm and Challenge meetings have taken place Daily acuity audit undertaken and submitted as assurance **UPDATED: 21.11.2018 – embedded process**	01/09/2018	
142	Should Do	Medical Care (Acute & Medical Division)	**NURSING LEADERSHIP** The service should ensure there are sufficient managers at senior nurse and clinical lead level to run a service providing high quality sustainable care. **LEADERSHIP VISIBILITY** The service should improve the visibility of leaders and improve communication between staff at ward level and leaders.	Appoint Associate Directors of Nursing to provide leadership within the division	Executive Director of Nursing and Midwifery, Executive Director of Workforce	Well Led	**UPDATED: 21.11.2018 – embedded process**	01/08/2018	
152	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**FGM** The service should consider ways in which to make sure that all staff have an understanding of female genital mutilation and aware of the legal requirement to report incidences of this.	Review and / or develop a policy for the management of suspected female genital mutilation	Executive Director of Nursing and Midwifery, Executive Director of Workforce	Effective	**UPDATED: 21.11.2018 – embedded process**	01/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
153	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Incorporate the risk of FGM into the Safeguarding mandatory training programme	Executive Director of Nursing and Midwifery, Executive Medical Director	Effective	Completed - component part of programme to be submitted as evidence **UPDATED: 21.11.2018 – embedded process**	01/08/2018	
191	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.	Relaunch and raise the profile of the FTSU Guardian and how staff can access them	Executive Director of Workforce	Well Lead	Anti-Bullying campaign - freedom to speak up guardians programme relaunched Training offered on Freedom to speak up National guardian visit and Masterclass Refreshing leaflet and comms Completed NHSi self-assessment **UPDATED 21.11.2018 - embedded process** relaunch has taken place, currently recruiting Freedom to speak up champions - embedded process	01/09/2018	
212	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**PAEDIATRIC LIFE SUPPORT** The service must ensure that there is a member of staff trained in paediatric advanced life support available at all times.	Establish a training programme which meets national standards	Executive Medical Director, Executive Director of Nursing and Midwifery	Responsive	Mark Lipton to look at this and provide updates ensuring that someone on duty at all times APLS trained **UPDATED 30.10.18** - Nursing OOO - always a Paediatric trained nurse on site **ACTION:** receive a copy of training programme **16.11.18 UPDATE** - RAG changed to blue.		

Appraisal & Revalidation Report 2017 - 2018

Agenda Item:	10.5	**Reference:**	
Report to:	Board of Directors	**Meeting Date:**	28.11.2018
Lead Director:	Dr Nicola Stevenson, Medical Director		
Lead Officer:	Dr Catherine Hayle, Medical Appraisal Lead		
Governance:	**Link to WUTH Strategic Goals**	*WUTH Strategic Goals 2017-18*	
	Link to Core Values	*WUTH Core Values*	

Summary:

Appraisal is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved.

WUTH has a system in place for appraisal of senior medical staff which is quality assured.

The Senior Medical Staff Appraisal Policy has been updated and was approved in September 2018.

Revalidation is the process by which doctors are assessed as being up to date and fit to practise by their Responsible Officer. This is based on satisfactory annual appraisal. Where concerns arise in a doctor's practice this is appropriately investigated and action taken including remediation when appropriate. WUTH developed a remediation policy for senior medical staff in 2013.

44 doctors were revalidated in the year April 2017/2018, and 7 had their revalidation deferred.

WUTH is compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England and is now monitored by providing a quarterly statement of compliance.

This is the ninth Board Report and the report refers to the appraisal year April 2017 - March 2018.

Recommendation:	**To Approve**	
	To Ratify	
	To Note	✔
	Comments	
Next Steps:		

Section 1

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the significant implications for the following (please state if not applicable):	
Quality & Safety	Successful annual appraisal provides the foundation upon which the Responsible Officer will confirm a doctor's fitness to practice. Following a cycle of five satisfactory annual appraisals the Responsible Officer will be able to recommend that a doctor is revalidated.
Financial (inc Value for Money)	Financial implications will occur when remediation is implemented as a consequence of revalidation identifying concerns about medical staff.
Risk (including legal)	The Responsible Officer legislation came into force in January 2011 outlining the requirement for annual appraisal of doctors. The current key risks are: • Nil hours doctors – monitoring their connection with WUTH, and providing the necessary supervision and educational opportunities to facilitate successful appraisal and revalidation. This is ultimately a patient safety issue. • Since appraisal has been removed from the job description of medical managers, it has become more difficult to recruit and retain appraisers. This is resulting in reduced capacity to meet current demand, and has impacted negatively on the resilience and sustainability of the current system.
Workforce	If doctors do not have satisfactory, quality assured appraisals they will be unable to retain their license to practice from the GMC and will be unable to work.
Equality & Human Rights	*Equality Analysis guidance and process to be introduced from 6 April 2011 to comply with Equality Act 2010 duties* http://www.whnt.nhs.uk/staff/documents/equality%20analysis.html

Equality Impact Assessment (EQIA)		
	Attached	
	N/A	✔
	Other	

Section 2

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. Other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**

If you require any additional information please contact the Lead Director/Officer.

Wirral University Hospital Teaching NHS Foundation Trust

Annual Medical Appraisal
For the year 2017/18

Introduction/Background

1. Medical revalidation was implemented in 2012 by the General Medical Council (GMC) to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

   Provider organisations have a statutory duty to support their Responsible Officer in discharging his/her duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

   - monitoring the frequency and quality of medical appraisals in their organisation
   - checking there are effective systems in place for monitoring the conduct and performance of their doctors
   - confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process
   - ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have the qualifications and experience appropriate to the work performed

2. The appraisal process at Wirral University Teaching Hospital has been in place since 2001, and is currently fit for purpose for the Revalidation process.

3. Successful annual appraisal will provide the foundation upon which the Responsible Officer will confirm a doctor's fitness to practice. Following a cycle of five successful annual appraisals the Responsible Officer will be able to recommend that a doctor should be revalidated.

4. During the appraisal year 2017/2018 44 doctors were revalidated and 7 had their revalidation deferred (deferral rate 14%). The GMC have reported a national deferral rate of 20.4% for acute trusts. All revalidation recommendations were completed in time.

5. During this appraisal year WUTH had an SLA in place to provide RO and appraisal services to Wirral Community Foundation Trust and Wirral Hospice St John's.

6. WUTH investigates when concerns are raised about a doctor's practice and the Responsible Officer decides on appropriate action following local policies and procedures. This includes formal remediation programmes.

Management of Appraisal and Revalidation

7. Responsibility for Appraisal and Revalidation lies ultimately with the Responsible Officer. The Associate Medical Director for Appraisal and Revalidation (AMD) and Clinical Lead for Appraisal (CL) were responsible for the successful performance of the process for all senior medical staff during the period covered by this report. The Appraisal and Revalidation Manager facilitates the process on a day to day basis. The AMD retired in June 2018 and the role has been replaced by a Medical Appraisal Lead.

8. Prior to the recent change in the medical management structure, medical managers were expected to appraise as part of their management duties. There are also non-managerial consultants who appraise, and this group have appropriate time allocated in their job plan or take time in lieu, as referenced in the Trust's Consultant Job Planning Policy. One appraisal equals 1 PA.

9. Doctors are expected to use their SPA time to complete documentation and for the actual appraisal meeting.

The charts overleaf detail the activity levels for appraisal in WUTH, including the numbers who have undertaken the process and details of the exceptions.

TABLE 1: ACTIVITY LEVELS FOR APPRAISAL IN WIRRAL UNIVERSITY TEACHING HOSPITAL						
April 2017 – March 2018						
	Number of Senior Medical Staff for whom the trust had responsibility for appraisal and revalidation		Number of doctors who had a completed appraisal within the agreed timeframe		Number of doctors for whom a PDP had been agreed	
	Consultants	SAS / Trust Grade	Consultants	SAS / Trust Grade	Consultants	SAS / Trust Grade
A & E	11	5	10	4	10	4
Acute Medicine	9	1	9	1	9	1
Anaesthetics	30	8	30	8	30	8
DME	17	5	17	5	17	5
Lab Medicine	14	0	14	0	14	0
Medicine (Incl ITU)	47	4	46	4	46	4
O & G	11	3	11	3	11	3
Occupational Health	1	0	1	0	1	0
Orthopaedics	14	6	14	6	14	6
Paediatrics	17	2	17	2	17	2
Radiology	19	1	19	1	19	1
Special Surgery	19	6	19	6	19	6
Surgery	25	6	24	6	24	6
Hospice	0	3	0	2	0	2
Wirral Comm Trust	0	0	0	0	0	0
TOTAL	234	50	231	49	231	49

In addition 33 doctors went through the Trust ARCP process managed by the Director of Education.

TABLE 2: EXCEPTIONS TO THE APPRAISAL PROCESS AT WIRRAL UNIVERSITY TEACHING HOSPITAL			
APRIL 2017 – March 2018			
Division	**Grade**	**Status**	**Reason**
Medicine	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Incomplete	Doctor did not forward MAF to appraiser within given timescale, appraisal was therefore delayed and MAF returned to A&R Department outside timescale
Surgery	SAS	Incomplete	MAF not returned to A&R Department within given timescale
Surgery	Consultant	Missed - Approved	Sickness absence
Surgery	SAS	Missed – Approved	On sabbatical
Women & Childrens	Consultant	Missed - Unapproved	Consultant did not return MAF

Missed appraisals are those which were due within the appraisal year but not performed, or MAF not returned.

Incomplete appraisals are those where the appraisal discussion has not been completed or where the MAF has not been returned to the A&R Department within two calendar months of the doctor's appraisal month. This accounts for the variance in the numbers in Table 1 above. Doctors may have a missed or incomplete appraisal but still have a PDP agreed.

WUTH compares well with similar designated bodies in the comparator report compiled by NHS England for the appraisal year 2017/2018

- WUTH had 96.2% completion of all appraisals compared to 91.3% for same sector appraisal rate
- WUTH had 0.9% approved missed or incomplete appraisals compared to 6.1% for same sector appraisal rate
- WUTH had 2.8% unapproved missed or incomplete appraisals compared to 3.9% for same sector appraisal rate

Quality Assurance

10. Quality assurance of the appraisal process is essential if it is to be effective. The responsibility for quality assuring the process lies within the Appraisal & Revalidation Department. Medical managers have responsibility to ensure that the process is fair and effective to meet the requirements of revalidation. The overall responsibility for the process lies with the Responsible Officer.

11. WUTH has a robust quality assurance process in place:

- 100% of the appraisal documents are subject to a quality assurance process
- The excellence tool is completed for one appraisal per appraiser per year. Its purpose is to quality assure the appraisal summary completed by the appraiser.
- Appraisers receive an annual written performance review which includes feedback from doctors they have appraised; feedback from observation by ARM.

Development

12. Appraisers:

- All appraisers MUST attend the Trust's 1 day training course before appraising. This course has an excellent reputation and is attended by many external delegates.
- There were 63 trained appraisers in WUTH as at 31 March 2018.
- The appraisers are invited to attend the Appraiser Support Group (ASG) twice a year for updates and where issues can be discussed with fellow appraisers.
- Appraisers are regularly asked to complete a self-assessment to identify gaps in their skills/knowledge. This was undertaken at the beginning of the 2017/18 round and an appraisal refresher day was developed to deliver training on what was highlighted.

13**.** Doctors

Medical staff should be kept up to date on changes to the process as revalidation progresses. This is done as follows:

- Doctors can apply to attend the Trust 1 day course which runs at least four times annually and is updated continuously.
- Their appraisers will provide necessary guidance. Appraisers are updated at the bi-annual ASG meetings, verbally and by e-mail as necessary.
- New consultants are encouraged to attend the appraisal course so they are aware of what is expected of them, and what they can expect from the process.
- New consultants are invited to meet the ARM to discuss the hospital appraisal and revalidation process.
- The AMD presents a session on Appraisal and Revalidation as part of the "New consultant development programme".
- Medical Board updated as necessary in meetings and by e-mail.
- The Appraisal & Revalidation Department Team are available to provide guidance and advice on an ongoing basis.

14. Responsible Officer:

These officers need appropriate training and support. The RO for WUTH attended the national RO training programme and was involved in the RO Networks in the North Region in order to continue to be up to date and fit to practice in the role of a RO. The RO is appraised externally by NHS England (North). There are specific requirements for RO's to keep up to date and fit to practice including attending three out of four RO Networks annually.

The RO meets with the GMC employer liaison advisor (ELA) every 3 months. This is to discuss concerns from both parties about a doctor's practice e.g. never events. The ELA also updates the RO on GMC processes.

Clinical Governance

15. Clinical Governance issues are detailed below:

- Clinical incidents, complaints and litigation are recorded on a database for medical staff and this summary is provided for appraisal so that the doctor can reflect on them at their appraisal.
- For a period of time during 2017-18, these reports were not routinely available due to changes within the Quality Governance Team. This issue was escalated to the Responsible Officer and has now been resolved.
- Doctors are expected to report clinical incidents or near-misses proactively, to contribute to a safety culture and enable organisation-wide learning.
- Dr Foster data is provided. This data is not useful for all specialties in terms of accurately recording the performance of an individual. Data cannot be provided for SAS doctors. Data may reflect the performance of a team rather than an individual and teams are constantly changing. There needs to be a method of retrieving data which is more useful and informs an individual on his/her performance. This is a national problem which is being discussed on an ongoing basis.
- All aspects of a doctor's professional work, including interactions with colleagues and patients, must be reflected upon. It is equally important that all doctors reflect on critical incidents and complaints as without this evidence a doctor cannot be revalidated.

Recruitment and engagement background checks

16. WUTH should ensure that there is RO to RO communication when a doctor is employed. This covers information on past appraisals, previous concerns or GMC restrictions to practice etc. There have been ongoing difficulties being informed of short term locums and in particular clarifying the RO of doctors on nil hours contract, and therefore the list of who the RO is responsible for is difficult to keep up to date.

Responding to Concerns and Remediation:

17. A Medical Staff Remediation Policy is in place. This document includes advice on remediation and resources available locally and nationally which WUTH can access.

18. There were 11 cases which required intervention in the period 1 April 2017 to 31 March 2018. The details are shown below:

Doctors	Type of concern (conduct/competence/health)	Type of Intervention (investigation/clinical review/MHPS/practice restricted
1	Competence	Restricted Practice/MHPS
1	Competence/Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Conduct	MHPS
1	Health	Attendance Capability/Job Planning

Conclusion and Next Steps

19. The conclusion and next steps are outlined below:

- A robust, quality assured appraisal process has been implemented successfully at WUTH since 2001 and continues to be “fit for purpose” for the revalidation process.

- Professor Debra King, AMD for A&R retired with effect from 31 May 2018 after leading the department since 2010, and the role of heading up the department as Medical Appraisal Lead has been taken by Dr Catherine Hayle. Dr Hayle has introduced a new structure for the department, with three Senior Appraisers to support her and ensure that WUTH’s appraisal process continues to develop.

- The Appraisal & Revalidation Department are working closely with the Director of Medical Education and HR to try to clarify the RO status of Trust employed trainees and nil hours doctors and to enroll them as necessary onto either the local ARCP process or the WUTH appraisal process. This has been a long process but progress is being made.

- Dr Nicola Stevenson was appointed Medical Director in October 2018 and is now the RO. She will undergo formal training in December.

Recommendations

20. The Board is asked to note the report and agree to receive the next report on the 2018 - 2019 position in November 2019.

Dr Catherine Hayle
Medical Appraisal Lead

Amanda Branson
Appraisal & Revalidation Manager

October 2018