Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

30 July 2014

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 30 July 2014
COMMENCING AT 9.00AM IN THE
BOARD ROOM,
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Patient's Story** Director of Nursing and Midwifery	v
3.	**Chairman's Business** Chairman	v
4.	**Chief Executive's Report** Chief Executive	d
5. Strategy and Development		
5.1	**Urgent Care Recovery Plan** Chief Executive	d
6. Performance and Improvement		
6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard & Exception Reports Director of Informatics	d
	6.1.2 Finance Report Director of Finance	d
	6.1.3 Urgent Care Costs Director of Finance	d
6.2	**Report of the Quality & Safety Committee** Chair of the Quality and Safety Committee • **14th May 2014 Committee** • **11th June 2014 Committee** • **9th July 2014 Committee**	d
6.3	**Report of the Finance, Performance & Business Development Committee** Chair of the Finance, Performance & Business Development Committee • **27th June 2014 Committee** • **25th July 2014 Committee**	d

6.4 **Nursing and Midwifery Strategy – Progress update** d
Director of Nursing and Midwifery

7. Regulation and Assurance

7.1 **Monitor Q1 Board Statements** d
Associate Director of Governance

7.2 **External Assessment:**
Chief Executive
- **Q4 letter from Monitor 2013/14** d

7.3 **Health and Safety Update and future reporting**
Director of Strategy and Partnerships d

8. Governance

8.1 **Governance Review** d
Associate Director of Governance

8.2 **Report of the Remuneration & Appointments Committee** d
Chairman

8.3 **Board of Directors** d
8.3.1 Minutes of the Previous Meetings:
- **25 June 2014**

8.3.2 Board Action Log
Associate Director of Governance

9. Standing Items

9.1 **Any Other Business** v
Chairman

9.2 **Items for BAF/Risk Register**
Chairman

9.3 **Date and Time of Next Meeting:**
Wednesday at 24 September 2014 at 9am

Board of Directors		
Agenda Item	4	
Title of Report:	Chief Executive's Report – July 2014	
Date of Meeting:	30 July 2014	
Author:	David Allison, Chief Executive	
Accountable Executive :	David Allison, Chief Executive	
Corporate Objective Ref as outlined in the BAF	1, 3, 7, 9, 10, 11, 12, 13, 14 (Divisional Performance Review – ALL)	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	**n/a**	
FOI status :	**Document may be disclosed in full**	

1. External Activities

Commissioners

The Trust were advised by e-mail on 28 May 2014 of a review into the capability and governance issues at NHS Wirral CCG. As part of this investigation a meeting was held with John Bewick, Regional Director NHS England South, and Colin McIlwain, Head of Planning and Assurance NHS England North. The review was due to be completed by w/c 21 July 2014, however it is now apparent that this is only part of a wider process which will take longer than anticipated to conclude.

The 2014/15 contract reached agreement on 20 June at £221.5m.

Relations with the CCG are very open and constructive, and fortnightly meetings are held with the Acting Accountable Officer to discuss various initiatives.

As advised on 10 July following discussions with the Secretary of State and Acting Accountable Officer of the CCG, a consideration for Urgent Care Transitional Funding was forwarded to the Chair of the Urgent Care Board for the meeting taking place on 15 July 2014. This was supported and actions commenced on 21 July given verbal support from the CCG. Financial arrangements regarding invoicing are being discussed currently.

External Support

An element of closing the financial investigation undertaken in 2013/14 by Monitor was agreement that the Trust would undertake an externally facilitated review of its financial governance and reporting. In addition to this required element of work the Trust also identified that it could make improvements in its cash management activities and also required support in delivering both the in year savings programmes and the medium to longer term savings programmes. To support these three pieces of work the Trust undertook a formal procurement process and selected the following partners through that process:

- Financial Governance and Reporting Review – KPMG
    - commenced beginning of July - reporting end July

- Cash Management – KPMG
    - commenced beginning of July - reporting end July

- Transformational Turnaround – Atkins/FTI
    - commenced 7 July - anticipated conclusion October 2014 with periodic reporting

All partners have commenced with the Trust and outputs are being delivered. These will be reported through the Trust governance structure as they develop further.

Cardiology with Liverpool Heart and Chest Hospital

Further to joint discussions led by the Medical Director and Director of Strategy and Partnerships with Liverpool Heart and Chest Hospital, the two organisations have advertised for two joint posts in cardiology – one with a special interest in imaging and one in PCI intervention. There have been some strong applications for the latter post, but no applications for the imaging post. Interviews are scheduled to be held at the end of July. Following interviews, the two management and clinical teams will reconvene to establish next steps.

A joint MDT for cardiology patients has now commenced and more robust protocols are in place in relation to patient transfers between the two centres.

The two teams continue to meet to discuss areas for collaboration going forward.

Primary Care Engagement

Unfortunately the Primary Care Engagement Conference did not go ahead on 4 June 2014 as many GP's had other commitments. The Associate Medical Director (Strategy) and the Associate Director of Strategy and Partnerships, have discussed with Primary care colleagues the most effective way of gaining GP engagement, particularly at a time when they have expanding clinical workloads. There was an enthusiasm to hold themed events eg the sick child where both primary and secondary care clinicians could present and discuss conditions and cases.

Arrangements have been made for visits to 15 local practices between August and November with a further 3 visits awaiting confirmation of dates. These visits will be informed by a robust understanding of market share data to identify areas of influence to enable the Trust to deliver on its ambitions around market share maximisation. A further tranche of visits will be arranged December to March 2015.

Countess of Chester

A meeting with WUTH and CoCH Chairs and CEO's is scheduled for Friday 25 July and an update will be given at the Board meeting.

Collaboration in a number of service lines continues, driven by constructive clinical dialogue in a number of specialties, including urology, orthopaedics and breast screening. A full update will be brought to the Board in September, which will be jointly agreed with Countess of Chester Hospital.

Cheshire and Wirral Partnership Trust

Overseen by the Director of Strategy and Partnerships, the Trust has bid in partnership with CWP for the Healthy Child Programme covering Health Visiting, School Nursing and Child Measurement services. Both organisations delivered a joint presentation to commissioners on their integrated proposals on 14 July. A decision is expected in August.

Betsi Cadwaladr

Joint discussions led by the Director of Operations and the Director of Strategy and Partnerships have led to the commissioning of additional activity from North Wales in gynaecology, urology, orthopaedics and ophthalmology. Additional support from the Finance and Contracting teams has been invaluable in turning these strategic and operational discussions into a signed contract. We will meet the management team at Betsi Cadwaladr in September to understand how we can build on this initial relationship going forwards.

Wirral Chamber of Commerce

Through the Trust's membership of the Chamber of Commerce, introductions have been made with Senior Executives at Typhoo Tea, based in Moreton. Typhoo are keen to develop their local connections into local organisations and have agreed to support the Trust 'PROUD' Awards, which will replace the former Foundation Awards, recognising exceptional contribution by colleagues and which will be held in September.

Community Trust

Whilst relations remain cordial progress has been limited resulting in the July Board to Board and Exec to Exec meetings being cancelled.

Monitor

The latest steps in Monitor's efforts to make foundation trust data publicly available have been advised. Last year Monitor published foundation trust consolidation data for 2012/13 and in April this year they published annual individual foundation trust surplus / deficit information for the first time as a dataset. Monitor will be updating both datasets annually after the Consolidated Accounts are laid before parliament. Further to this, Monitor was recently asked for quarterly returns information.

In the interests of transparency they have decided to make quarter 3 information publicly available on their website some months after the relevant reporting period. They are in the process of establishing a policy to determine how and when they should release this information on a more regular basis in the future balancing transparency with the fact that this information may be commercially sensitive if it is released very shortly after the relevant reporting period. Monitor will keep us updated and will consult with the sector on a draft policy so that they have a clear framework in place to respond to such requests in future.

Monitor and NHS England are in the process of developing the 2015/16 National Tariff Payment System. Their proposals are in line with their long-term aim of developing a transparent, flexible and accountable NHS payment system that encourages the provision of good-quality, efficient services and the best possible outcomes for patients. This applies to mental health and physical health services equally.

They have published a series of documents, collectively known as the 2015/16 Tariff Engagement Document, which propose a number of changes for 2015/16.

Feedback in the first instance is being sought from the healthcare sector, including providers, commissioners, clinicians, and other interested stakeholders. This feedback will then be reflected in the proposals that they present for statutory consultation this autumn.

Our monthly update call took place with Monitor on 23 July 2014 and provided the Trust with the opportunity to be introduced to the Trust's new relationship Team, Carla Moody as the new Senior Regional Manager and Gill Brown the new Regional Manager. The Trust provided a comprehensive update on both financial and operational performance with specific focus being placed on the Month 3 position for finances and actions associated with improving our cash and liquidity position and the potential impact on Continuity of Services Risk Rating. The performance update include the current position relating to the outbreak of Carbapenemase Producing Enterobacteriaceae (CPE), A & E standards and the urgent care recovery plan, and the national initiative on referral to treatment times and how this was being undertaken locally. In addition the action plan from KPMG was reviewed together with the current status on the external assurances commissioned by the Trust as reported in the Director of Finance's Report.

CQC

The Trust is now required to report monthly to the Clinical Commissioning Group and therefore the Quality & Safety Committee received a new Compliance & Assurance Report.

The Safeguarding team continue to prepare for the Wirral-Wide CQC review of children's safeguarding to include Looked After Children. Internally, the team have reviewed Regulation 19 – Complaints – and rated this 'green'. Complaints handling is a feature of CQC inspections therefore performance improvement in this Regulation is important.

The Women's & Children Division is starting to provide some new services from St Catherine's Hospital (SCH) and as these come under the CQC guidance for separate registration, we are registering SCH as one of our locations.

The Essential Standards of Quality & Safety (the 16 regulations) are to be replaced by Fundamental Standards and we await the Department of Health's response to the consultation on these.

The Health and Care Performance Monitoring Panel

The Health and Care Performance Monitoring Panel will be reviewing the recommendations from the Francis Scrutiny report in the autumn – most likely September. The recommendations are largely around patient experience and nursing, therefore, it is appropriate for the Director of Nursing and Midwifery to attend with the Medical Director as support.

"Sign Up to Safety" Campaign

The "Sign Up to Safety" campaign has been launched and we are considering how this fits with the Quality Improvement Strategy and the Quality Account activity.

Local Authority

The Trust continues to meet with representatives of both the CCG and Local Authority in relation to revised proposals around the use of the 'Better Care Fund'. A revised process for reviewing schemes intended to support redirection of emergency flow has been established which recognises that schemes proposed to date will not have the impact initially desired on emergency admissions in 2015/16.

NHS North West Leadership Academy

The Trust has been successful in securing a placement for a NHS Graduate Trainee from September 2014 on the Informatics Graduate Training Scheme. This placement comes fully funded and the graduate trainee will be with the Trust for 12 months.

2. Internal Activities

Finance

Tight control of expenditure and income has resulted in much improved financial performance for June. This must be maintained moving forward.

Regarding CIP delivery, the Transformation Steering Group has been established and meets weekly. This meeting is chaired by myself and is helping to ensure strong focus and pace on CIP projects.

Infection Prevention & Control

The Trust declared an outbreak of Carbapenemase Producing Enterobacteriaceae on Wednesday 16 July 2014. Seven areas including Ward M2 (Rehabilitation) at Clatterbridge Hospital were affected. The Board of Directors will recall that Health Protection England were invited to review our processes and work is underway to implement the recommendations. Mr Terry Whalley, as part of the National Fast Track CEO programme is assisting the Director of Infection Prevention & Control in this. The current plan is to identify patients who are positive for CPE or those who have high risk of exposure through screening and isolate them on Ward 14. The situation is being reviewed on a daily basis to enable the Trust to return to 'business as usual' as soon as is safe and possible. A full review of the outbreak will be undertaken.

Referral to Treatment

NHS England has commissioned additional elective activity across the country with the aim of returning to the achievement of the 18-week standard for the whole NHS, then reducing waiting times further to maintain achievement through the winter months. This additional treatment of long-waiting patients by WUTH is likely to result in the standards not being achieved across Q2. NHS England and local commissioners have acknowledged this will be considered when assessing Q2 performance, and discussions are taking place between NHS England and Monitor around the Risk Assessment Framework targets.

Workforce

As part of the workforce planning process the Health Education North West (HENW) requires each North West NHS Organisation to provide the current estimate of their workforce forecast for all staff groups across the period up to 2018/2019. This return follows the Monitor 5 year plan and was submitted to Health Education North West (HENW) on 18 July 2014.

The Trust has signed the Learning and Development Agreement (LDA) with Health Education England (HEE). The purpose of this Agreement is to ensure that Wirral University Teaching Hospitals NHS Foundation Trust supports the learning and development of its staff and all the students/trainees. The Trust will receive an allocation of £9.2 million for 2014/15 in order to support the national workforce priorities and those identified locally through the Local Education and Training Board (LETB).

The Trust agreed a process for ensuring a clearer link between contribution and pay. Specifically all staff Band 7 and above will only move through their increments if they can demonstrate they have met the required performance management criteria. A similar process is already in place for the medical workforce.

Sickness absence remains above the 4% target (June, 2014 – 4.57%). A number of priority actions are being taken to address this as detailed in the Quality & Safety Committee reports.

The Appraisal compliance rates have been on an improving trend over the last 12 months The Appraisal compliance rate as at May 2014 is 85.85% and remains above the target level. Managers are being supported with additional Appraisal sessions to maintain the target of 85%. The HR and Organisational Development Department continues to work with the managers to improve the quality of appraisals. Key actions related to this include: quality review focus on

objective setting and Personal Development Plan's, strengthening skills training with focus on quality, improved guidance for appraiser and appraise and focussed group feedback.

Mandatory Training compliance rates have been on an improving trend over the last 12 months. The compliance rate as at May 2014 is 93.59% which is a 0.64% increase on the previous month but remains short of the 95% target set by the Trust. Divisional managers are informed of non-compliance and corrective action is being urgently pursued by the HR&OD department. Actions include Mandatory and Essential lead trainers targeting actions for subject areas outside of the block programme and contacting managers of staff in non-compliant categories to book on to training.

Once again proving that laughter is the best medicine, staff at Wirral University Teaching Hospital NHS Foundation Trust and their families turned out in force for a knockout day of fun, silly games and physical exercise at Arrowe Park Hospital on Sunday 29 June, with the attendance of over 1200. The Trust's pioneering Fitter for Health campaign aims to support and encourage staff and their families to take part in regular sport or physical activity.

National Institute for Health and Care Excellence: Safe Staffing for Nursing in Adult In-Patient Wards in Acute Hospitals

The Trust has received the guidance and is reviewing our staffing position against the guidance and how the guidance will impact on the Nursing and Midwifery Audit content.

Listening into Action (LiA)

We are approaching the end of Year 2 for LiA, and a detailed report is appended *(appendix i).*

Maternity Services Review

The Maternity Services Review commissioned by the Clinical Commissioning Group in early 2013 following 9 incidents May – September 2012 has been received by the Trust. The report is being checked for factual accuracy and a meeting between the Trust and the Clinical Commissioning Group Directors of Nursing and Medical Directors has been convened to discuss next steps. The review will be presented to the Quality and Safety Committee in September 2014.

Strategy

With the finalisation of the Strategic Plan, submitted to Monitor at the end of June, attention now turns to the implementation of both the Operational and Strategic Plan. The Board are reminded that Monitor expect to offer formal feedback on the Plan by October 2014. The Executive Team held the second of their Quarterly Strategic Review with each of the Operational Divisions on 25 July and updates were received against both 'Plan on a Page' performance and the deeper work, by specialty being undertaken in the Divisions to review and redesign services.

An update will be brought to the Board in September on these specialty reviews and a formal update on the progress against the organisational 'Plan on a Page' will be brought to the Board in October 2014.

Cerner

Phase 2b is on course for a mid-November go live as planned. Integration testing is currently underway with groups of staff from across the hospital, including Consultants, doctors, nurses and AHPs, testing both the electronic nursing and AHP documentation and the prescribing and medicines administration functionality. This round of testing and issues resolution will continue until 1 August with a final round of integration testing planned to start on 1 September.

Plans for the roll out of new hardware for Phase 2b are well underway following trials of various devices by members of each staff group. The training of the users of the system will start in early October with the detailed training plans being finalised at the moment.

Following the award of £3.5m to the Trust from NHS England's 'Safer Hospitals, Safer Wards' fund, a change control notice to the main Cerner contract has been agreed and signed to begin implementing some functionality which was either planned for future phases or was outside of the contract, for example chemotherapy prescribing, a patient portal, connecting ECG machines and other devices to Millennium, demand management, bar coded medicines and blood administration. We are working with Cerner on the detailed plans for these projects.

The £250k Nursing Technology fund allocation has been fully spent on laptops and trolleys for each ward which are currently in the final stages of being rolled out across the hospital.

Work has started on the Remote Hosting project which involves the move of Millennium from our on-site data centres to the Cerner data centre in Slough. This will take place by the end of March 2015.

Recruitment

I would like to formally welcome Carole Self to the Trust. Carole joined us on 16 June 2014 in her role as Associate Director of Governance and has fast become an integral part of the team.

Sam Armstrong, Interim Trust Secretary, left the Trust on 27 June 2014 after completing his 6 month fixed term contract.

Executive Fast Track Programme

I am pleased to welcome Terry Whalley who has now commenced his placement with the Trust and will be working closely with the Director of Nursing and Midwifery and the Infection Prevention and Control department.

As advised in an e-mail communication to the Board, it was deemed appropriate for Evan Moore, Medical Director, not to take part in the Executive Fast Track Programme at this time due to the various demands on the Trust at present.

Keeping Informed

The Leadership Alliance for the Care of Dying People, made up of 21 national health and care organisations, has published 'One Chance to Get it Right'. This is the response to the recommendations set out in More Care, Less Pathway, the independent review of the Liverpool Care Pathway.

This document sets out the approach to caring for dying people that health and care organisations and staff caring for dying people in England should adopt in future. The approach should be applied irrespective of the place in which someone is dying: hospital, hospice, own or other home and during transfers between different settings.

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours:

1. this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly;

2. sensitive communication takes place between staff and the dying person, and those identified as important to them;

3. the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants;

4. the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible;

5. an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

David Allison
Chief Executive

July 2014

Wirral University Teaching Hospital NHS
NHS Foundation Trust

CEO Board Report
Listening into Action
Update

July 2014

Contents

1 Executive Summary

This report provides an update on the implementation of Listening into Action within the Trust and a detailed sustainability plan beyond year 2 as a Beacon Trust. This follows the recommendations presented to and agreed by the LiA Sponsor Group on 6th May 2014. These recommendations have also been presented to and are supported by the Workforce and Communications Group, Partnership Steering Group and Staff Satisfaction Steering Group. The key recommendations were:

The Board is asked to:

- Note the progress of Listening into Action and sustainability plan post September 2014

2 Background and Context

In September 2012, the Trust formally entered the 2nd wave of the NHS National Pioneers Listening into Action (LiA) Programme, under the guidance of an external organisation, Optimize. This was launched in the Trust recognising that we want to achieve a *fundamental shift* in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the Trust as a whole.

Following the success of our 1st Year, we entered a 2nd Year with Optimise as a Beacon Trust within the National Pioneers Programme, following the submission of a business case.

As one of 7 National Beacon Trusts adopting Listening into Action (LiA) during 2013/4, the Trust has been a leader in the NHS in adopting a new way of working - engaging and empowering our frontline teams to deliver better outcomes for patients, staff and the Trust and 'unblocking the way' for them.

The paper presented in May 2014, outlined the achievements of LiA since Autumn 2012 and how we have focused on clinical engagement, quality and safety, patient experience and enabling teams to drive improvements across the organisation. In summary, the key achievement include:

2.1 Summary of LiA Achievements so far

- Introduced the Optimise Framework to deliver Listening into Action as a way of working supported by a Trust Sponsor Group and LiA Core Team (LiA Lead and LiA Administrator)
- Over 1000 staff have attended one of 14 conversations to put their own ideas forward and over 650 staff have attended team led conversations to make improvements
- 2,400+ staff completed the baseline LiA pulse check in 2012 and 1600 staff completed the 2nd LiA pulse check and improved on 7 of 9 comparable indicators in the LiA pulse check and shown significant improvement from those directly involved in LiA teams

- 49 teams have worked with LiA (Appendix 1) to create improvements for patients, staff and the Trust
- Over 120 High Impact improvement actions have been completed and over 200 Quick Win Improvements
- We held three excellent "Pass it On" Events in July 2013, December 2013 and June 2014 where our LiA Teams fed back to the organisation what they have achieved in response to what matters to staff and patients
- Used LiA to tackle other Trust priorities including : Primary Care Engagement Event, reducing waste, Health and Wellbeing, Learner evaluation
- Promoted key achievements via Trust Information Exchange, Start the Week, website, e bulletin, payslip leaflets, posters, displays, Pass it On Events and externally via Twitter, the National Pioneers Programme and external Listening into Action Blog

3 Current Position

We are coming towards the end of Year 2 as a Beacon Trust within the National LiA Programme. At the start of the Year, the LiA Sponsor group identified 15 focus area based on strategic priorities and what staff said matters to them. These areas were split into wave 3 and wave 4 teams and enabling schemes given the number of teams involved noting that one focus area covers all wards. Wave 3 teams completed on 19th June at the last "Pass it On" event, although a few have some outstanding actions. Our 4th Wave of teams and schemes commence in July and feedback to the organisation in December 2014. This will include a roll out of the ward LiA work streams to all wards by the end of the year following the pilot in Surgical Assessment Unit and Paediatric ward. Wave 4 Teams and Enabling Schemes are:

- LiA Patient Focused Wards
- Patient Safety 24/7 (MEWS/Supervision of Junior Doctors and Nurses at Night)
- Pressure Ulcer Prevention
- Handover
- World Class Dementia Care
- IT Enabled Healthcare (CERNER Maternity Review)
- Hospital Readmissions

In addition to the identified teams, there are a number of other additional work streams using LiA methodology to create improvements. These are:

- Medical and Acute Division
- Health and Wellbeing
- Clinical Service Leads
- Learner Experience
- HROD
- Junior Doctors
- Other Department specific teams identified for the National Staff Survey

3.1 The Workforce Friends and Family Test (FFT)

The Staff Friends and family test was introduced nationally in April 2014 by NHS England. Staff will be asked two questions in relation to FFT: whether they would recommend the Trust to family and friends and whether they would recommend the Trust as a place to work. All staff should be given an opportunity to complete the Staff FFT once during 2014/15. A plan to implement this is being monitored and reported back to the Workforce and Communications Group, Staff Engagement Steering Group and Partnership Steering Group with a plan for alignment of reporting with the Patient FFT, Quality and Safety Committee and workforce dashboards. The first Staff FFT closed on 30/6/14. Analysis awaited.

4 LiA Implementation Plan Beyond Year 2

An Implementation Plan in Appendix 2 outlines how the recommendations previously agreed by the LiA Sponsor group will be actioned. It is anticipated that the action plan will be monitored by the LiA Sponsor Group and reported to the partnership steering group and Workforce and Governance Group.

5 Conclusion

There has been an extremely positive response from staff to the work undertaken so far under Listening into Action. Through LiA, staff have had the opportunity to bring about change and improvement that have been for the benefit of patients, staff and the organisation.

Staff engagement is essential to improving quality and productivity within a challenging environment and this agenda needs to continue to sit firmly within our workforce strategic priorities, particularly at a time of significant challenge within the NHS and within this Trust. As a result of teams being directly involved in LiA, we have seen significant improvements in staff satisfaction and engagement, along with the benefits to our patients and the Trust. However, the NHS Staff Survey 2013 shows that whilst improvements have generally been made in staff engagement and staff satisfaction levels, the 'year on year' improvement results are not as positive as we would have wanted and in a number of areas the Trust remains in the lowest 20%. In adopting a more integrated approach to supporting the action required by linking staff satisfaction and engagement and Listening into Action more closely, we aim to make greater improvement next year.

In sustaining and embedding Listening into Action as a way of working we need to act independently of Optimise who have guided us so far, whilst ensuring we act within our contractual obligations.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Appendix 1

Listening into Action Teams and Schemes to Date

Wave	LiA Teams	Enabling Schemes
Wave 1 March – July 2013	• Discharge Planning (Surgical Division) • Pharmacy - Medicines management and Turnaround Times for TTH's • AHP Team – Communication and engagement of staff during major change • (Medicine - Older Peoples Short Stay Ward) - Right Patient, Right Bed • Emergency Department and Acute Admissions Process • Neonatal Unit • Medical Records • Ophthalmology Department • Day Unit CBH • Stroke Team	• Maximising Deployment and Recognition of Volunteers • Equipment & Linen • Effective Recruitment Process (RGN / CSW • Diabetes Eye Screening Team (Improving communication processes) • Reducing Bureaucracy / Paperwork
Wave 2 August – December 2013	• Community Paediatricians • Breast Services • Acute Care - (Duplicate Blood Requests) • Cancer Data Team • Medical Day Case Unit • Choose & Book • DME • Microbiology • Trauma & Orthopaedics - (Getting Better Together) • Integrated Discharge • Audiology Dept • Emergency department • Corporate Nursing	• Supplies/Oracle • Surgical Division * • IR/PDP* • Valuing Staff * • Communications * • Incident reporting process inc feedback*
Wave 3 February – June 2014	• Ward leadership pilot (SAU) • Ward leadership pilot (Paediatric Ward) • Infection Control Hand Hygiene • "Ticket Home" Pilot ward 17 and 38 • Alcohol Service • Patient experience • SAS Doctors	• Values and Behaviours • Corporate induction and Initial Mandatory Training
Other Teams/schemes applying LiA	• Education Team (ANP programme) • Education Team (Leaner Nurses) • HROD	• KPO Team – Every Penny Counts • Primary Care Engagement

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Appendix 2

LiA Beyond Year 2 Implementation Plan

	Objective	Action	Timescale	Ownership
1	Year 3 focus of LiA sponsor group is clear	Review the LiA Sponsor Group purpose and terms of reference	August 2014	LiA Sponsor Group
2	Complete Wave 4 LiA Teams aligned to the remaining focus areas agreed with LiA Sponsor Group for 2014	Based on feedback from ward LiA pilot and other Beacon Trusts, develop and agree a process for roll out at WUTH	1st August 2014	LiA Sponsor Group
		All in patient wards to host ward LiA working in partnership with nursing, medical and managerial leads	End December 2014	Ward Triumvirates
		Launch Wave 4 teams via Start the Week	June 2014	DA
3	Link LiA methodology to strategic planning process, by hosting annual CEO lead engagement events (Including manager engagement events)	Continue with annual CEO lead staff engagement events (formerly LiA Big Conversations), using the outputs to contribute to our strategic planning and transformational change and improvement	December 2014	LiA Sponsor Group
4	CEO visibility / staff feedback programme rolled out	Continue to manage CEO visibility / staff feedback programme through LiA team responsibilities within HROD ie planned and unplanned department visits, job shadowing	Monthly	LiA Core Team
5	Integrate Listening into Action with Staff Satisfaction and Engagement, taking forward an agreed integrated plan for 2014/ 15, monitored by the Staff Engagement Steering Group and assured by the Workforce and Communications Group	LiA lead and Associate Director HR to work with Staff Satisfaction Steering group to identify key Trust wide actions and where LiA methodology can support	May 2014	Staff Satisfaction Steering Group
		Develop Staff Satisfaction Survey Trust wide action plan from 2013 survey results and agree at Staff Satisfaction Steering Group and WCG	June 2014	CMcK
		Support divisions in identifying areas of local improvement and where LiA methodology can support	June 2014	CMcK/Divisional Leads
6	Engage our divisional leaders in leading the way in the implementation and sponsorship of LiA as a way of working	Extend LiA work stream sponsorship to divisional management teams	From July 2014	LiA Sponsor Group
7	Develop a network of LiA champions to support other teams as they adopt LiA	Establish and promote a network of divisional champions for Listening into Action based on previous work stream leads	July 2014	CMcK
8	Provide enabling support to the organisation through the HROD Department so that departments / teams can adopt LiA for themselves on a planned or ad hoc basis	Develop WUTH staff engagement framework based on LiA methodology	September 2014	CMcK
		Include managing LiA work streams in the HROD prospectus of development programmes	September 2014	CMcK
		Provide skills based training as required	September 2014	CMcK
		Integrate LiA into all relevant development programme's within HROD	October 2014	CMcK

		Educational portfolio		
	Objective	**Action**	**Timescale**	**Ownership**
9	The LiA Core team is reintegrate into HROD Department	LiA Core team to return to substantive posts within HROD within adapted job descriptions, inclusive of LiA Core support and guidance	August 2014	CMcK/AMcL
10	The organisation is able to work independently of Optimise consultancy	Cease work with Optimise at Contract end date, ensuring any contractual obligations are made clear prior to year 3 with specific reference to copyright and trademark	September 2014	CMcK
		Develop regional LiA network with other Trusts	October 2014	CMcK
10	Re-launch LiA for Year 3	Develop re-launch plan and agree with LiA Sponsor group	September 2014	CMcK/BC
11	The organisation is able to assess how staff feel as an employee of the Trust	Cease the use of the LiA pulse check with Optimise following last round in July 2014	September 2014	CMcK
		Utilise the Workforce Friends and Family Test as our measure of progress as a vehicle to receive staff feedback	September 2014	CMcK

Cathy Mckeown, LiA Lead

Wirral University Teaching Hospital

NHS Foundation Trust

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Board of Directors		
Agenda Item	5.1	
Title of Report:	Urgent Care Recovery Plan	
Date of Meeting:	30 July 2014	
Author:	Chris Oliver, Associate Director of Operations	
Accountable Executive :	Sharon Gilligan Director of Operations	
Corporate Objective Ref as outlined in the BAF	14 – Monitor green governance rating	
Level of Assurance		**Board Confirmation**
Concerned		
Data Quality Rating	**Silver – quantitative data that has not been externally validated**	
FOI status :	**Document may be disclosed in full**	

1. EXECUTIVE SUMMARY

This paper outlines the Trust's current performance against the 4-hour access target. The paper details the increases in patient demand and acuity across a range of years, as well as providing an update on measures taken to improve performance as a health economy.

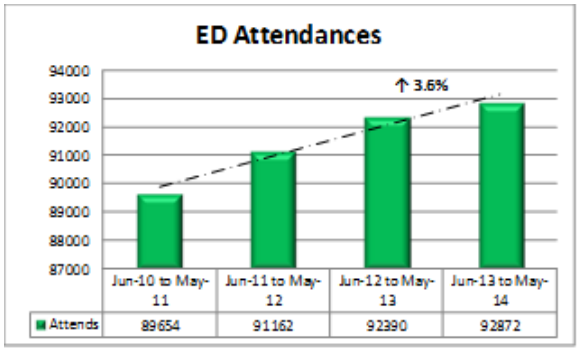
2. BACKGROUND

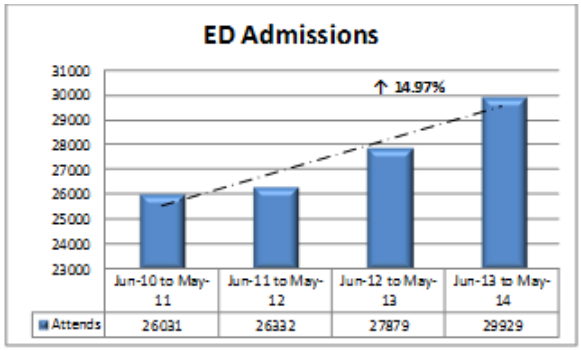
Wirral has failed to achieve the 4-hour access target for the last two quarters, with its performance now ranked within the bottom 30 Trusts nationally.

The impact of this on patients is wide-ranging; not just the extended stay within the Emergency Department (ED) but it has also been evidenced that an extended length of stay within an ED can lead to an extended inpatient stay, as well as increased mortality and hospital based harm, eg pressure ulcers. However, against the above Wirral's ED is currently ranked the best nationally by patients who have completed the Friends & Family Test.

3. DEMAND AND ACUITY

Since June 2010 the department has seen a 3.6% rise in attendances to the ED. Although this rise is small in comparison to a national picture, it does represent an increase of 3,218 patients. It should also be noted that whereas elsewhere in the country the local ED may be the only provision available to patients, over this time period the Wirral has seen the opening of 3 Walk In Centres (WIC) and 7 Minor Injury Units (MIU) which could be argued have diverted away from the ED, with the result of the ED seeing patients who require more complex healthcare interventions.

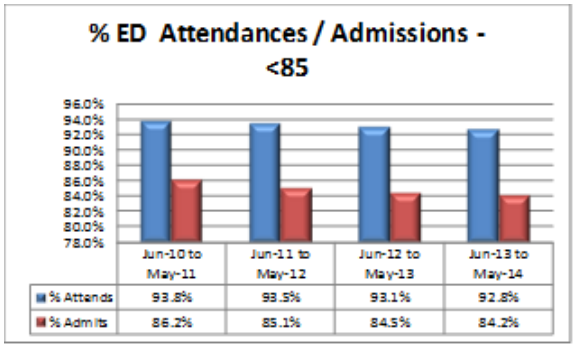


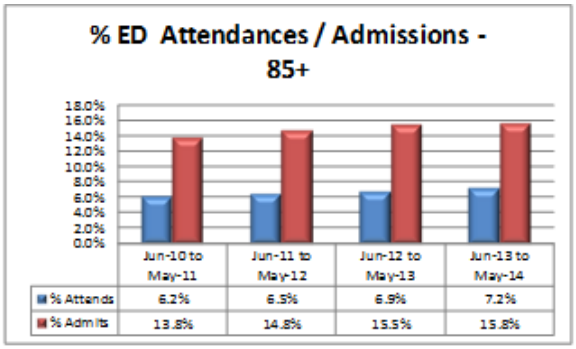


4. DEMOGRAPHIC CHANGES

In addition to the increase in admissions from ED, the Trust has also seen a significant growth in GP admissions. Quarter 1 2014/15 saw an 11.5% increase in GP admissions which equated to 364 additional admissions.

The change in Wirral's demographics and how this impacts on healthcare can be illustrated in the following graphs:-





Whereas the under 85 years age group has seen a decrease in both ED attendances and ED admissions, the opposite can be evidenced for those patients aged over 85 years.

The decrease in those patients under 85 years could be related to the increase in WICs and MIUs as well as an increase in self care. Against this assumption it is evidenced in the Joint Strategic Needs Assessment (JSNA) that Wirral's population of working age is decreasing, whilst the Wirral Peninsula health economy feels the impact of an increasing older population. The growth in the older population also needs to be reviewed in the context of the split of social deprivation on Wirral.

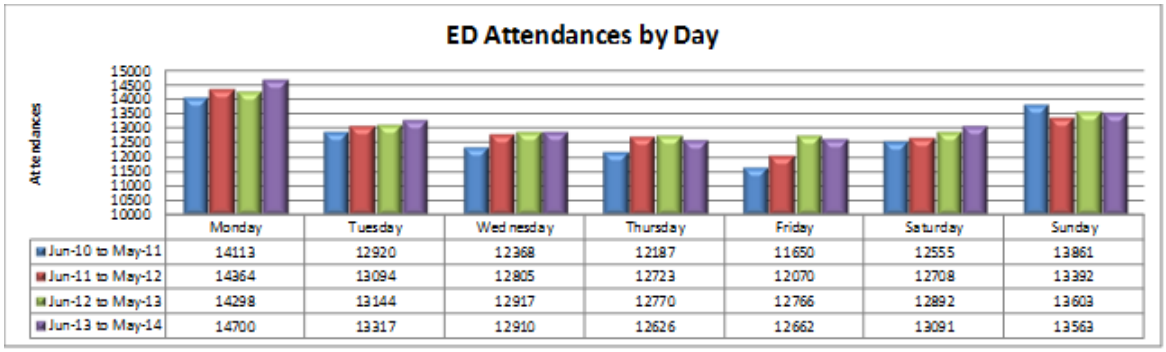
Patients presenting at the ED are frailer, sicker and tend to have more complex healthcare needs. One impact of increasing primary care provision is that patients will

be maintained in the community for longer, only presenting to hospital when in the crisis stage of health decline.

Over the preceding 4 years, those patients aged under 85 years have increased in attendance by 7% annually compared with a 9% annual increase for those aged over 85 years.

This data, whilst evidencing the 'feel' within the ED, does raise concern regarding Wirral's ability to reduce presentations at the acute site and gives an even greater reliance on the Vision 2018 workstreams.

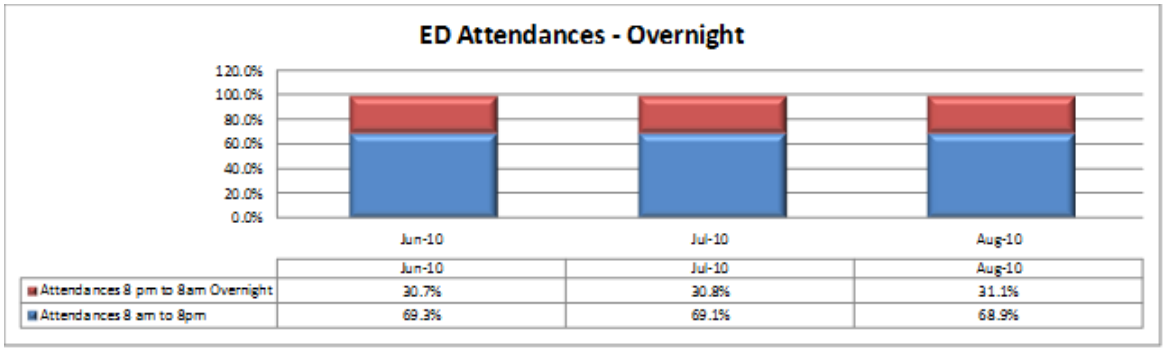
5. PATTERN OF PRESENTATIONS



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Jun-10 to May-11	14113	12920	12368	12187	11650	12555	13861
Jun-11 to May-12	14364	13094	12805	12723	12070	12708	13392
Jun-12 to May-13	14298	13144	12917	12770	12766	12892	13603
Jun-13 to May-14	14700	13317	12910	12626	12662	13091	13563

The table above illustrates the changes in daily presentations; however it is also key to reviewing changes in presentation during the overnight period. Historically this is a period when medical staffing reduces significantly.

The graph below illustrates a small increase in overnight presentations to the ED.

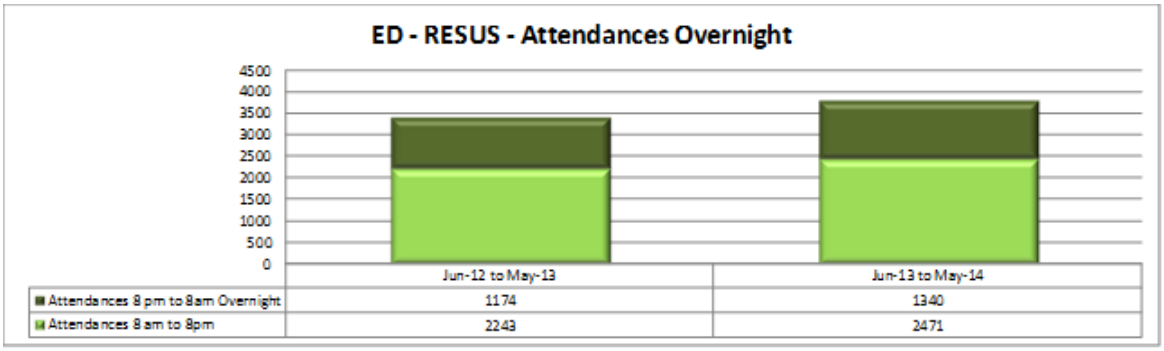


	Jun-10	Jul-10	Aug-10
Attendances 8 pm to 8am Overnight	30.7%	30.8%	31.1%
Attendances 8 am to 8pm	69.3%	69.1%	68.9%

Daytime (8am – 8pm) presentations have increased over the last 4 years by 2.6%, whereas at a time when medical numbers reduce the department has seen overnight (8pm – 8am) presentations increase by 5.7%, with a 1.4% increase in the last year.

Acuity Increases

In addition to the increase in overnight ED presentations, the department has also seen an increase in resus patients requiring treatment during the 8pm – 8am period.



The increase seen during the daytime for resus capacity has increased by 10% during the last year, whereas overnight demand has increased by 14%.

Wirral has been an accredited Trauma Unit for 3 years. During this time there has been an increase in trauma calls, with a 23% increase from Q4 2013/14 to Q1 2014/15. However, there has been a 97% increase when comparing Q1 2013/14 with Q1 2014/15.

A barometer of patient acuity within a hospital can be taken by reviewing the number of MET (Medical Emergency Team) calls. A MET call takes place when a patient's MEWS (Medical Early Warning Score) is 7 or above. MET calls have increased by 13% in Q1 2014/15 compared to Q4 2013/14.

ED Consultant Workforce

The Trust benefits from a 10 person Consultant rota. The rota provides comprehensive senior medical presence from 8 am until midnight 7 days a week, with an on call system from midnight to 8 am.

Currently against the 10 wte (whole time equivalent) requirement the Trust has 7 wte Consultants working within the department. The shortfall of 3 wte Consultants is currently being provided by agency Consultants to ensure the Trust continues to provide the required level of senior medical cover.

External Support

The Trust has worked jointly with the Wirral Commissioning Group (CCG) to review processes across the economy. The Greater Manchester Commissioning Support Unit (GMCSU) has assisted Trusts with non elective flow performance issues. The GMCSU has undertaken a review of ED processes, medical and surgical assessment processes as well as a point prevalence study across medicine and orthopaedics to identify any delays in patients' care plans. The initial feedback session given by the GMCSU found a range of process issues within the ED and assessment units ranging from the ED minors workstream and the redirecting of GP admissions to the ED. A final feedback session which will incorporate the point prevalence findings is scheduled for 31 July 2014.

In addition to the GMCSU reviews, the Trust has led 2 Wirral-wide 'Perfect Days'. The perfect day concept was recommended by the NHS Intensive Support Team and in the conference calls the Trust has had with Monitor. The main workstreams from this are community provision and the timeliness of these services in avoiding admissions and expediting discharge, in addition to the Trust better signposting patients to ambulatory care pathways.

Recovery Plan

The accumulation of the reviews and perfect days has been the creation of the Urgent Care Recovery Plan (UCRP, illustrated in Appendix 1).

The UCRP has been supported at the Urgent Care Working Group (formerly Urgent Care Board). The full implementation of the UCRP will not be until November 2014. To ensure rapid improvement in compliance with the 4-hour access target, seven schemes (Appendix 2) have been identified to bridge the timeframe to completion. The funding of the seven schemes has been agreed in principle by the CCG as part of the economy resilience funding and discussions are ongoing as to invoice and payment. The schemes are linked to key actions within the UCRP and can be stopped when specific actions have been implemented.

6. CONCLUSION

There are many factors impacting on the Trust's ability to deliver performance above 95% for the 4-hour access target.

The delivery of the recovery plan will see sustained improvement and is fully supported by the health economy.

7. RECOMMENDATION

The Board of Directors is asked to note the report and support the implementation of the Urgent Care Recovery Plan.

Appendix 1

Phase 1 Completion Date 28 July 2014

Resulting Performance Change 94%

	Action	Impact	Who	When	Update
1	Zero tolerance minors breaches Any minors patients at 3 hours without a plan to be transferred or discharged within the hours to be escalated to Rob Cooper / Naomi Holder and out of hours Hospital Coordinator	Increase % compliance Quarter 1 circa 582 minors breaches. Without these performance would have been circa 3% higher	Rob Cooper, Deputy Associate Director of Operations / Naomi Holder, Deputy Associate Director of Nursing	23/06/14	Communication to all areas circulated week commencing 16 June 2014 Challenge has been during the evening and night. Additional middle grade doctor has been approved, although the unit is not being able to cover all shifts
2	Commence GP phone line To start Monday & Tuesday	Reduce admission, decrease pressure in ED from redirects and reduced flow. 10% reduction in GP admissions	Rob Cooper, Deputy Associate Director of Operations / Sarah Quinn, Wirral CCG Manager	7/07/14	Additional sessions from renal team in acute to support rota Explore potential for GP to provide cover for phone line Complete
3	Zero tolerance redirects Matrons/Manager	Decrease pressure in ED Circa 10 less GP admission redirected from AMU to the ED	Chris Oliver, Associate Director of Operations / Rob Cooper, Deputy Associate Director of Operations	23/06/14	Communication to all areas circulated week commencing 16 June 2014 Complete
4	Increase capacity in assessment areas x3	Additional chaired capacity	Rob Cooper, Deputy Associate Director of Operations	23/06/14	Ward Sisters informed 20 June 2014 Complete
5	ESD – early commencement of pathway AMU / OPSSU / ED / DME (21/22/24)	Reduce length of stay. Impact currently being calculated	Andrew Cooper, Chief Officer WHCC / Julie Tunney, Associate Director of Nursing / Sarah Quinn, Wirral CCG Manager	23/06/14	CCG to confirm Initial review of impact of implementation highlighted fewer numbers than expected as Community Therapy Services do not have process in place CCG unable to expand Pull Team provision

6	Streamline pathway for detox patients	Decrease pressure in ED by avoidance of 2 admissions per day	Ann Taylor, Substance Misuse Nurse	04/07/14	Transfer in place and revised pathway to include homeless patients Complete
7	CCG to review services for substance misuse	To reduce LoS and admission by early signposting to community services.	Sarah Quinn Commissioning Manager, CCG	12/08/14	Outcome and recommendations to be presented at UCWG
8	Community Geriatrician in Acute Care	Specialist review for elderly patients. Admission avoidance rates currently being calculated	Chris Oliver, Associate Director of Operations / Rob Cooper, Deputy Associate Director of Operations	23/06/14	Job plan agreed with CSL Job plan devised, awaiting on CCG funding to recruit
9	Refine SPA questionnaire - Additional question regarding admission avoidance if specialty clinic could be accessed within 48 hours	Right patient, right place Linked to impact from GP Phone line	Community Trust	23/06/14	Complete
10	Managerial change in ED	Decrease pressure in ED ensure consistent management approach	Julie Tunney, Associate Director of Nursing / Naomi Holder, Deputy Associate Director of Nursing	01/06/14	Complete
11	9am – 5pm senior doctor in triage / Hub	Support earlier decision making/requesting of investigations to improve flow	Alan Pennycook, Clinical Service Lead, Emergency Department / Rob Cooper Deputy Associate Director of Operations	06/07/14	Complete

	Action	Impact	Who	When	Update
12	Daily teleconference with senior representatives across the Wirral Health and Social Economy	Support implementation of urgent care recovery plan and identify any issues early in order to address	Sarah Quinn, Commissioning Manager, Wirral CCG	28/07/14	Concept agreed at June's UCWG
13	Removal of admission rights for Nurse Practitioners. To ensure all nurse admissions have been discussed with a GP	Reduce inappropriate admissions	Sarah Quinn, Commissioning Manager, Wirral CCG	23/06/14	Complete
14	Implementation of "right care, first time"	Identify areas for improvement in care and patient flow.	Sharon Gilligan, Director of Operations / Chris Oliver, Associate Director of Operations / Maureen Wain, Associate Director of Operations, Diagnostics	June 2014	1st day completed. Further 2 days to run. Real buy in across economy. A number of detailed case studies followed up through Urgent Care Board. Action plan incorporated within phase 3 of the UCRP.
15	3 hour TNT	Reduce LoS for patients awaiting TNT. Currently 12 hours	Dr Dil Rittoo, Consultant Cardiologist / Anne McGinnity, Divisional Manager	28/07/14	Pathway complete and awaiting sign off for agreed start date To be approved via Clinical Governance in July 2014
16	CCG funded point prevalence audit to be carried by Utilisation Management Team	To review all inpatients in order to identify the number who need to be in hospital	Sharon Gilligan, Director of Operations / Chris Oliver, Associate Director of Operations	01/07/14	Completed 01/07/14 Feedback session arranged for 31st July 2014
17	Change function of "EDRU" to ED Assessment	Reduce pressure in ED for patients awaiting test results. Scope of unit being reviewed	Alan Pennycook, Clinical Service Lead, Emergency Department / Rob Cooper Deputy Associate Director of Operations	28/07/14	After a review of capacity this cannot take place until the building works within the ED have been completed

18	Change in function of EDRU will result in stopping ward round and increase medical workforce availability	Increase medical input into ED. Enables one DPC session back into main department	Alan Pennycook, Clinical Service Lead, Emergency Department / Rob Cooper Deputy Associate Director of Operations	28/07/14	After a review of capacity this cannot take place until the building works within the ED have been completed
19	Review function of the discharge lounge	Increased usage of the discharge lounge will free speciality bed base earlier therefore improving patients flow from the assessment areas and ED	Maureen Wain, Associate Director of Operations	24/04/14	Review has been undertaken and options appraisal paper completed which will be discussed at EDT
20	Provide CSW and porter for transfer team (accessible 3pm – 10pm)	Support improved flow out of the department	Chris Oliver, Associate Director of Operations / Rob Cooper Deputy Associate Director of Operations	28/07/14	Complete

Phase 2 Completion Date 31 August 2014
Resulting Performance Change 95%

	Action	Impact	Who	When	Update
1	Recruitment of substantive consultants to ED vacancies	Support sustainable rota and ED models of care such as SIFT	Alan Pennycook, Clinical Service Lead / Rob Cooper, Deputy Associate Director of Operations	Advertise July 2014 1st candidate expected to commence August 2014 2nd Candidate expected to commence October 2014	2 candidates have confirmed their interest in working at WUTH Additional consultant absent from rota expected to be back in the department in December 2014 Posts currently advertised
2	Roll out of standard operating procedure for board rounds	Reduce internal delays. Engage with agencies earlier in patient's journey	Jo Goodfellow, Associate Director of Strategy and Partnerships / Rob Cooper, Deputy Associate Director of Operations	August 2014	
3	Commence 8am ward rounds on acute assessment areas and PTWR to support flow out of ED	Discharge patients earlier in the day. Two patient from each consultant round discharged by 10am	Dr Indiver Daryanani, Clinical Service Lead / Rob Cooper, Deputy Associate Director of Operations	Commence August 2014	Rota to deliver in development To commence 6th August
4	Alter on call junior doctor rota from 9-9 to 8-8	Links to action 3	Deputy Associate Director of Operations	Commence August 2014	To commence 6th August

	Action	Impact	Who	When	Update
5	Medical handover to move from 9 am to 8 am	Links to action 3	Dr Ranj Mehra	Commence August 2014	To commence 6th August
6	Commence 8am board rounds across Medicine	Links to action 3	Dr Ranj Mehra, Clinical Head of Division / Chris Oliver, Associate Director of Operations	Commence August 2014	
7	Review ENP cover in ED	Support sustainable medical workforce to ensure capacity meets demand	Julie Tunney, Associate Director of Nursing / Naomi Holder, Deputy Associate Director of Nursing / Sarah Pickstock, Matron	EDT 29/07/14	Business case completed and to be discussed at EDT
8	Appointment of Clinical Fellows to increase senior doctor presence in ED	Increase senior medical input across the evening and night shifts	Dr Ranj Mehra, Clinical Head of Division / Chris Oliver, Associate Director of Operations	EDT 22/07/14	Business case completed and to be discussed at EDT
9	Review medical workforce model against demand and acuity	Support sustainable medical workforce to ensure capacity meets demand	Dr R Mehra Alan Pennycook Chris Oliver	EDT 22/07/14	Business case completed and to be discussed at EDT

Phase 3 Completion Date 2 November 2014
Resulting Performance Change 96% at end of September 2014

	Action	Impact	Who	When	Update
1	Triage appropriate older people directly from ED to Older Peoples Assessment Unit	Improve patient pathway for Older people requiring admission.	Rob Cooper, Deputy Associate Director of Operations / Amanda Pattullo, Divisional Support Manager	September 2014	CAS card documentation to include triage and criteria for admission to OPAU
2	Implementation of streaming and single front door	Redirect patients to alternative services to reduce avoidable hospital admissions. Circa 8 patients redirected from the ED to primary care options	Sarah Quinn, Wirral CCG Manager / Chris Oliver, Associate Director of Operations / Rob Cooper, Deputy Associate Director of Operations	October 2014	Trial of single front door carried out on 23rd June. Draft service specification for streaming via single front door circulated for comment with a view to finalising document by end of August 2014
3	Implementation of recommendations from Utilisation Management review	Improve patient flow by focusing on improvement of processes	Sharon Gilligan, Director of Operations / Chris Oliver, Associate Director of Operations / Rob Cooper, Deputy Associate Director of Operations	October 2014	Feedback and recommendations delivered verbally. Action log developed. Working with CCG to develop action plan. Feedback session with clinicians planned for July.
4	Roll out implementation of therapy led Early Supported Discharge model throughout organisation	Reduce length of stay Improve flow by freeing beds as patient requiring OT/Physio will receive this at their normal place or residence. Reduction in LoS being calculated	Maureen Wain, Associate Director of Operations, Diagnostics / Chris Oliver, Associate Director of Operations	October 2014	Progressing well
5	Implement CCG led discharge to assess model	Transfer patients no longer in need of acute care into the community setting for assessment with regard to ongoing care needs	Sarah Quinn, Wirral CCG Manager	October 2014	

	Action	Impact	Who	When	Update
6	Redesign of ED resuscitation area	To increase the capacity for critically ill patients to ensure appropriate clinical management is delivered. 4 additional cubicles	Rob Cooper, Deputy Associate Director of Operations	October 2014	Enabling work is underway - main project commenced 7 July 2014
7	Implementation of work streams identified following "right care, first time"	All work streams have been identified to ensure that patients receive the best possible care at the right time and that this is provided by the most appropriate provider by working collaboratively across the health and social care economy in Wirral		October 2014	Implementation of actions to be completed for October 2014. Progress against actions to be provided every 2 weeks to ensure that work is on track in order to realise benefits
7a	Work streams: Development of patient pathway for continence to prevent avoidable admission		Sheena Hennell, Commissioning Manager, Wirral CCG		
7b	Care Home pathways (including falls pathway, Intermediate Care capacity and availability, provision of bariatric care in the community)		Jacqui Evans, Principle Manager, Wirral Department of Adult Social Services		
7c	Develop pathway for management of frequent attenders (drug and alcohol misuse)		Rob Cooper, Deputy Associate Director of Operations, WUTH / Sarah Quinn, Commissioning Manager, Wirral CCG		
7d	Implementation of single front door, integrating staff from WUTH and Community Trust		John Lancaster, Director of Operations, Wirral Community Trust / Chris Oliver, Associate Director of Operations, WUTH		

7e	Development of Single Point of Access to improve specialty specific patient pathways		Ben Richards Associate Director of Operations, Surgical Division, WUTH / Chris Oliver, Associate Director of Operations, WUTH		
7f	Hot reporting of x rays requested by GPs to prevent admission into hospital		Maureen Wain, Associate Director of Operations, Diagnostics Division, WUTH / Sheena Hennell, Commissioning Manager, Wirral CCG		
7g	Review usage and model of delivery for the Discharge Lounge		Maureen Wain, Associate Director of Operations, Diagnostics Division, WUTH		
7h	Review ambulance response times for GP admissions and consider utilisation of alternative providers to improve compliance with patient collection times		Sarah Quinn, Commissioning Manager, Wirral CCG		
7i	Review current patient pathway for discharge of terminally ill patients requiring rapid discharge to appropriate, preferred place of care		Lynne Smith, Integrated Discharge Team Manager, WUTH		
7j	Review acute admissions and system for referral from GP out of hours		Dr Kathy Ryan, GP and Clinical Lead for GP out of hours service, Wirral Community Trust		

Consistent performance of 96% by end of November 2014

GLOSSARY TO THE URGENT CARE RECOVERY PLAN

AMU	Acute Medical Unit
CCG	Clinical Commissioning Group
CSW	Clinical Support Worker
DME	Older person's acute inpatient wards
ED	Emergency Department
EDRU	Emergency Department Review Unit Patients are referred to this Unit whilst either awaiting test results or for overnight observation
ENP	Emergency Nurse Practitioner
ESD	Early Supported Discharge This is a service where patients continue to receive their therapy requirements in their usual place of residence
GP	General Practitioner
HUB	Area within ED where ambulance arrivals are reviewed before being signposted to either minors or majors area within the department
Majors	Area within ED for acutely ill patients
Middle Grade Doctor	Registrar or Clinical Fellow level of qualification and experience
Minors	Patient pathway within the Emergency Department for lower acuity patients
OPSU	Older Person's Short Stay Unit
PTWR	Post Take Ward Round This is a system which ensures all patients are reviewed by a Consultant following admission to hospital
Redirect	A patient whose GP has assessed as needing admission to hospital is redirected from the receiving assessment unit to the ED due to lack of capacity on the assessment units
SPA	Single Point of Access
TNT (3-hour)	3-hour turnaround Troponin T Test that enables Clinicians to identify and treat high risk patients quickly using, for example, thrombolysis, and therefore reducing the rate of death from a cardiac event. It also provides a differential diagnosis where a patient's experience of acute chest pain is non cardiac in nature and therefore ensures they receive the right treatment
Triage	An assessment all presenting patients undergo on arrival to the ED

Urgent Care Recovery Plan – Seven Schemes

Introduction

The full implementation of the Urgent Care Recovery Plan will not be in place until November 2014; however it is imperative that as an economy, performance of the 4-hour access target improves and therefore the pace required to deliver the actions needs to be a key priority for the Urgent Care Working Group.

The schemes detailed below are required to 'bridge' the gap between July and the full implementation of the recovery plan.

The UCRP is detailed in Appendix 1. Linkages are made between the schemes listed below and actions within the recovery plan.

Scheme 1

Escalation ward to be opened for 30 beds (Ward 20 identified) to care for acute medical patients (not rehabilitation or stepdown)

Impact:
To improve timely patient flow from the assessment units

Cover to include:
Medical, nursing, admin, therapy, domestic, portering, pharmacy, diagnostic provision and non pay elements

Linkage to Urgent Care Recovery Plan:
Phase 2 actions – 2, 3, 4, 5, 6
Phase 3 actions - 4, 5, 7b, 7e, 7g, 7i

Scheme 2

Additional senior medic (Consultant or SpR availability dependent) to provide cover from 5 pm until 2 am

Impact:
To reduce patient waiting times to be seen during the evening and early morning
To provide additional support to the rostered SpR when attending resus patients

Linkage to Urgent Care Recovery Plan:
Phase 1 actions – 1
Phase 2 actions – 1, 7, 8, 9
Phase 3 actions – 7c, 7d, 7e, 7i

Scheme 3

Additional band 5 nurse to work night shift within the Emergency Department

Impact:
The additional RN will enable the shift leader to be supernumerary, therefore enabling management of patient flow and clinical care across the department

Linkage to Urgent Care Recovery Plan:
Phase 1 actions – 1
Phase 2 actions – 1, 7, 8, 9
Phase 3 actions – 7c, 7d, 7e, 7i

Scheme 4

GP phone line to operate Monday to Friday 10 am – 6 pm

Impact:
To reduce GP admissions by signposting patients to specialty clinics, ambulatory clinics or rapid diagnostic testing

Linkage to Urgent Care Recovery Plan:
Phase 1 actions – 2, 3, 9
Phase 3 actions – 7a, 7b, 7c, 7e, 7i, 7j

Scheme 5

Increase in Substance Misuse Nurse provision

Impact:
Reduce length of stay for patients admitted due to alcohol or drug issues by signposting to appropriate agencies (currently WUTH has 1 wte Substance Misuse Nurse)
To trial provision 9 am – 11 pm, 7 days a week

Linkage to Urgent Care Recovery Plan:
Phase 1 actions – 1, 6, 11
Phase 3 actions – 2, 7c, 7d, 7e, 7j

Scheme 6

Additional Consultant Geriatrician to be based within ED

Impact:
To reduce elderly admissions to hospital
Reduce patients' length of stay within the ED
Supported by FTN best practice
Linkage from ED to OPSSU

Linkage to Urgent Care Recovery Plan:
Phase 1 actions – 1, 8, 11
Phase 2 actions – 1, 8, 9
Phase 3 actions – 1, 7a, 7b, 7i

Scheme 7

Implement transfer team to assist with patient flow from ED to assessment units and assessment units to main wards.

Impact:
More timely patient flow
Ensures ED and assessment unit CSW can stay in department/unit assisting with patient care
Operational between 3 pm and 10 pm

Linkages to Urgent Care Recovery Plan:
Phase 1 actions – 20

Board of Directors		
Agenda Item	**6.1.1**	
Title of Report	**Integrated Performance Report**	
Date of Meeting	**30th July 2014**	
Author	**John Halliday** **Assistant Director of Information**	
Accountable Executive	**Mark Blakeman** **Director of Informatics**	
Corporate Objective Ref as outlined in the BAF	**Risks 1 to 9, and 11 to 14**	
Level of Assurance		**Board Confirmation**
Full		**Board confirmation**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**	
FOI status	**Document may be disclosed in full**	

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators.

The Board of Directors is asked to note the performance to the end of June 2014.

2. Background

The dashboard has been developed based on the principle that the report:

- should focus the Board's attention on the issues they should be focused on, particularly those issues reserved for the Board;
- should enable the Board to monitor the delivery of external regulatory requirements as well as the Trust's longer term strategic goals and importantly to gain assurance that the right conditions are in place to continue to do so;
- should recognise and support the delegation to the Finance Performance & Business Development, Audit and Quality & Safety Committees;

- sets out clear performance targets and where performance fails to meet the required level has a standardised format for providing further information.

With the new monthly performance reporting cycle to the Board, the metrics and thresholds will be reviewed to ensure they provide assurance against the key targets and milestones in both the new Annual and Strategic Plans. Cognisance will also need to be taken of the reporting requirements, including frequency, to all Board Committees.

New metrics have been added this month to reflect the Trust's Strategic Objectives not already covered by the report. Some of these will require further consideration to ensure the measure and RAG performance thresholds are appropriate.

3. Key issues

Individual metrics highlighted as Red for June are A&E 4-hour Standard, Attendance, Expenditure, CIP Performance, Capital Programme, Non-core Spend and Advancing Quality. Exception reports are included for all these metrics.

Details on all metrics and their associated performance RAG thresholds are included in the report.

4. Next steps

The list of indicators and associated thresholds will continue to be reviewed to ensure the report remains relevant and of value. Additional metrics will be incorporated to reflect any further Annual and/or Strategic Objectives not currently covered by existing indicators.

5. Conclusion

Performance across a range of metrics is provided for information.

6. Recommendations

The Board of Directors is asked to note the performance to the end of June 2014.

WUTH Integrated Performance Dashboard - June 2014

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F Achievement Score Inpatients			JG	94.4%	June 2014
Patient Satisfaction - F&F Net Promoter Inpatients			JG	73	June 2014
Patient Satisfaction - F&F Net Promoter ED			JG	86	June 2014
Patient Satisfaction - F&F Net Promoter Maternity			JG	85	June 2014
Staff Satisfaction (engagement)			AH	3.64	2013
First Choice Locally & Regionally					
Market Share Wirral			AH	80.9%	April 2013 to March 2014
Demand Referral Rates			AH	1.3%	Fin Yr-on-Yr to June 14
Market Share Non-Wirral			AH	9.1%	April 2013 to March 2014
Organisational Risk Issues					
Key Performance Indicators					
A&E 4 Hour Standard			SG	91.2%	Q1 April to June 2014
RTT 18 Weeks Standards			SG	All met	June 2014
Cancer Waiting Time Standards			SG	All met	Q1 April to June 2014
Strategic Objectives					
Delayed Transfers of Care			SG	3	12-mth ave to June 2014
Readmissions			EM	9.5%	June 2014
Harm Free Care			EM	95.0%	June 2014
HIMMs Level			MB	5	June 2014
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	0	June 2014
Complaints			JG	38.6	Ave July 13 to June 14
Infection Control			JG	0 MRSA; 0 C diff	June 2014
Productivity					
Bed Occupancy			SG	87.2%	June 2014
Theatre Utilisation			SG	65.6%	June 2014
DNA Rate			SG	8.7%	June 2014
Workforce					
Attendance			AH	95.3%	12-mth ave to June 2014
Qualified Nurse Vacancies			AH	2.6%	June 2014
Mandatory Training			AH	93.8%	June 2014
Appraisal			AH	83.4%	June 2014
Turnover			AH	8.6%	June 2014
Finance					
Contract Performance			AM	3	June 2014
Expenditure Performance			AM	1	June 2014
CIP Performance			AM	1	June 2014
Capital Programme			AM	2	June 2014
Non-Core Spend			AM	7.3%	June 2014

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	3 areas below target	April 2014
Mortality: HSMR			EM	84.6 (low ci 79.9)	April 2013 to March 2014
Mortality: SHMI			EM	1.08 (low ci 0.89)	Apr 2012 to March 2013
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	June 2014
Monitor Risk Rating - Governance			SG	Not Green or Red	Q1 June 2014
CQC			EM	0	June 2014
Local View					
Commissioning - Contract KPIs			SG	2	June 13
Commissioning - CQUINS			EM	tbc	tbc
Education			AH	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F Achievement Inpatients	Friends & Family Survey - Achievement Score : Inpatients	>=85%	>=71% to < 85%	<71%
Patient Satisfaction - F&F Net Promoter Inpatients	Friends & Family Survey - Net Promoter Score : Inpatients	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter ED	Friends & Family Survey - Net Promoter Score : ED	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter Maternity	Friends & Family Survey - Net Promoter Score : Maternity	+86 to +100	+65 to +85	-100 to +64
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG elective hospital inpatient activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	All RTT standards met for the Trust as a whole	All met at Trust level	n/a	Not all met at Trust level
Cancer Waiting Time Standards	All Cancer Waiting Standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Strategic Objectives				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	>4 and <6	>= 7
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Harm Free Care	Compliance with Safety Thermometerdefinition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMs level under Electronic Medical Record Adoption Model	5	n/a	<5
NIHR KPIs	tbc	tbc	tbc	tbc

A Healthy Organisation

Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurences of "Never Events"	0 per month	n/a	>= 1 per month
Complaints	Number of occurences of formal complaints	<30 per month	30 to 50 per month	> 50 per month

Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteraemia, and less than 3 cdiff cases per month	0 MRSA Bacteraemia and 3 or 4 cdiff cases per month	>= 1 MRSA Bacteraemia or > 4 cdiff cases per month
Productivity				
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
DNA Rate	Percentage of booked OP appointments that DNA	<=7.5%	>7.5% to <9.0%	>=9.0%
Workforce				
Attendance	Rolling 12-month staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Non Core Pay Spend	% of total spend year to date	<5%	>=5.0% to 6.5%	>=6.6%
Qualified Nurse Vacancies	% vacant posts	<=2.5%	>2.5% to 5%	>5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Finance				
Contract Performance	Delivering both contracted volumes and values	>=3	2	1
Expenditure performance	Delivering planned levels of expenditure	>=3	2	1
CIP Performance	Delivering a recurrent CIP in-year & deliverable future proposals	>=3	2	1
Capital Programme	A sound investment programme mainatained & resourced appropriately	>=3	2	1

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality	Combined rating	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Number of concerns raised by CQC following inspections	0	1 to 2	>2
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Commissioning - CQUINs	Number of CQUINs not being achieved	0	1 to 3	>=4
Education	GMC level	Level 3	Level 2	Level 1

WUTH Performance Dashboard Exception Report June 2014

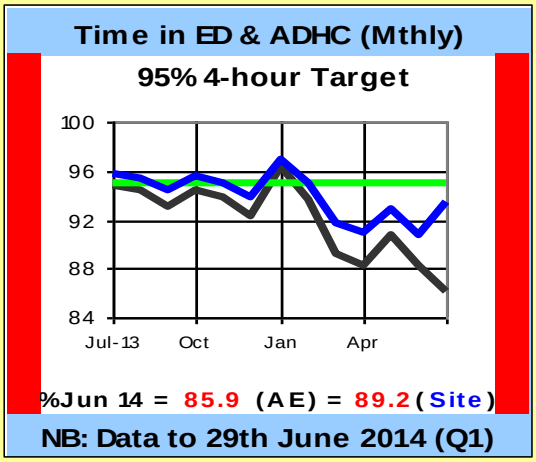
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	91.2%	Q1 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for June 2014 was 89.2%, including the All Day Health Centre at Arrowe Park site. For WUTH ED alone performance in June was 85.9%. The joint figure for quarter 1 combined was 91.2%

Historic data:



Proposed Actions:

A health economy urgent care recovery plan has been developed, building upon the initial findings of the Utilisation Management Team and the 'Perfect Day' initiative. The action plan will be further refined following the 'Perfect Day' review meeting on the 23rd July and once feedback is received on the point prevalence review which was carried out earlier this month by the Utilisation Management Team. A separate briefing on Urgent Care is provided in the Board paper's for the July meeting.

Assessing Improvement:

The difficulties with this standard are continuing, and it has now not been achieved for Q1. The continued collaboration of all stakeholders working together, both within the Trust and with external partners, is essential to deliver the necessary improvements.

Impact:

Patients can expect to be treated within 4 hours when attending A&E or WiCs. Waiting longer is a poor patient experience and will reflect on the reputation of the Trust. As a national target, non-achievement has Governance implications with Monitor, and financial consequences under the contract with local Commissioners.

Expected date of performance delivery:

Quarter 2 in 2014/15

Executive approval:

Sharon Gilligan, Director of Operations

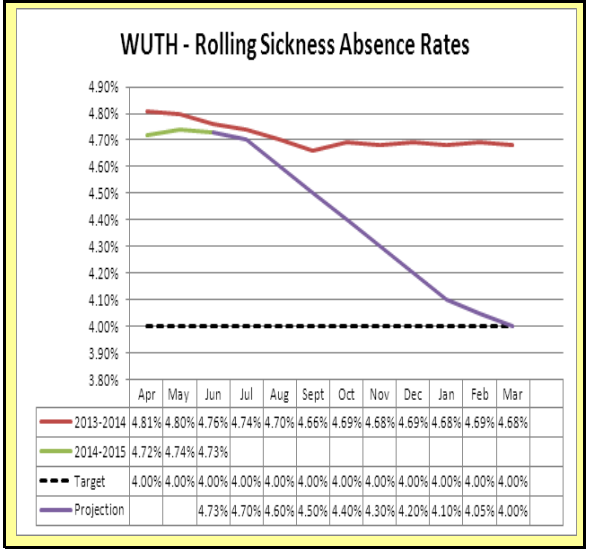
WUTH Performance Dashboard Exception Report — June 2014

Indicator :
Attendance

Rating	Target	Actual	Period
Red	>=96%	95.27%	12-mth ave to June 2014

Issue:
Attendance remains below the target of 96% however attendance has increased during the quarter. Diagnostics remains the only division under 4%. Surgery has consistently improving sickness absence rates in recent months. Medicine Division continues to have increasing rates of sickness absence and with W&C Division has the highest sickness levels. Numbers of staff off long term remains high. Audit shows many areas non-compliant with policy.

Historic data:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-2014	4.81%	4.80%	4.76%	4.74%	4.70%	4.66%	4.69%	4.68%	4.69%	4.68%	4.69%	4.68%
2014-2015	4.72%	4.74%	4.73%									
Target	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Projection			4.73%	4.70%	4.60%	4.50%	4.40%	4.30%	4.20%	4.10%	4.05%	4.00%

Proposed Actions:
Special measures to continue with particular support to those areas not improving, and a number of new areas to be supported have been placed on special measures. Health and Well-being work porgramme to continue with planned activities with particular focus on actions arising from stress working group action plan. Areas of non-compliance with existing policy to be addressed through the Executive team. The attendance capability policy is being re-written based on organisational policies who have low sickness absence rates.

Assessing Improvement:
Management of the delivery of Improvements Plans is through WCG. Target levels set for each division and each subset of absence e.g. long term, short term, stress/accident related. Compliance audit reports are considered at WCG and DMTs and escalation of "measures" developed to address persistent non-compliance.

Impact:
Sickness absence reduces the Trusts ability to deliver its objectives to a high standard, it increases none core spend compromising the Trust's financial position, the use of temporary staffing can impact on continuity of care and quality. Low attendance and associated staffing issues are often cited as a cause of poor staff satisfaction

Expected date of performance delivery:
Quarter 2 reporting

Executive approval:
Anthony Hassall, Director of Strategy and OD

WUTH Performance Dashboard Exception Report

June 2014

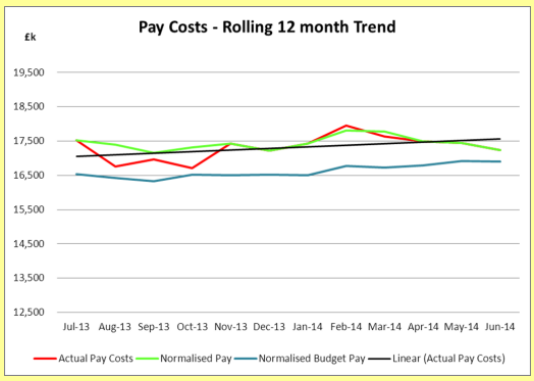
Indicator :
Expenditure

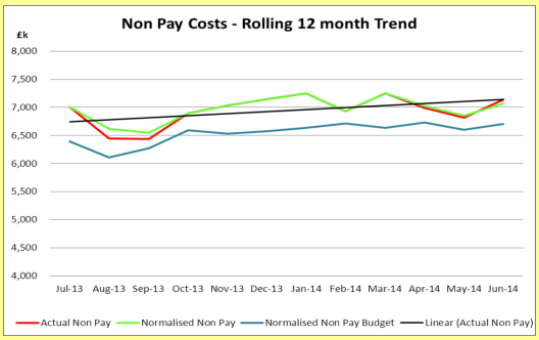
Rating	Target	Actual	Period
Red	3	1	June 2014

Issue:

The underlying operational expenditure is £0.7m overspent in month against plan which reflects an improvement on the first two months and is partly offset by an over-recovery of divisional income of £0.2m.
The underlying net I&E position for June is a deficit to plan of £0.1m. A more modest level of reserves has been applied this month to support the position in the month of £250k (compared with £1.4m for the first two months) resulting in a positive variance to plan of £0.2m for June. However cumulatively for Q1 there is still a £0.3m deficit to plan.
There has been an improvement on pay in June largely driven by the closure of unplanned capacity and tight controls around vacancy and non core spend however there are still financial pressures that need to be continuely monitored.

Historic data:





Proposed Actions:

Divisional performance reviews both with the Director of Finance and the Executive team closely monitor financial performance and to assess the realisation of plans to bring overspending divisions back on plan.
The Trust is now working with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change.

Assessing Improvement:

The divisional reviews will assess performance on a monthly basis and any corrective turnaround plans will be implemented as necessary.
Transformational reviews with FTI Consulting together with the Corporate review will realise the necessary savings to improve the financial position.

Impact:

Overspending against the expenditure financial plans will put at risk the financial sustainability of the Trust for 2014/15 and beyond and have a significant impact on liquidity.
Implementation of the deeper transformational programmes together with all divisional cost management schemes will need to fully realise benefits in a timely manner.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

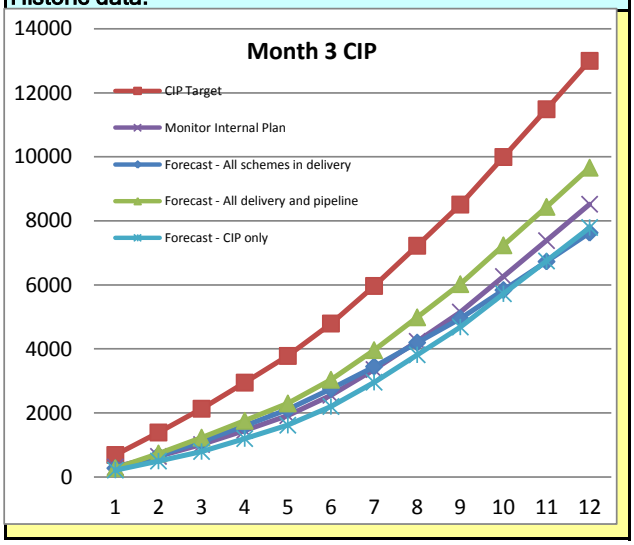
WUTH Performance Dashboard Exception Report — June 2014

Indicator :
CIP

Rating	Target	Actual	Period
Red	3	1	June 2014

Issue:
The gap between CIP target and forecast CIP schemes in delivery & pipeline is £5.2m. There is a £3.3m gap between CIP target and forecast of schemes in delivery and pipeline including cost avoidance schemes. It is essential that Sub Theme Leads are able to focus on both ensuring delivery of identified schemes and also proactively identify new ideas which can be worked up into schemes to fill this gap. It should be noted that approximately 68% of in year benefits are profiled to be delivered in the second half of the year.

Historic data:



Proposed Actions:
The appointment of an external support team is expected to further add to in year opportunities and delivery of CIP to help close the gap between forecast outturn and target. A Transformation Steering Group has now been set up chaired by the Chief Executive and with Executive Theme Lead and PMO Director membership. This group has the objective of leading a programme of major transformational change and supporting and monitoring the Cost Improvement Programme.

Assessing Improvement:
The CIP Steering Group will continue to monitor progress of the 2014/15 delivery and further development of the plans on a regular basis both with the sub theme leaders, with the Divisions and with the Executive team.

Impact:
Failure to achieve the CIP target will put at risk the financial sustainability of the Trust for 2014/15 and beyond.

Expected date of performance delivery:
On-going

Executive approval:
Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report June 2014

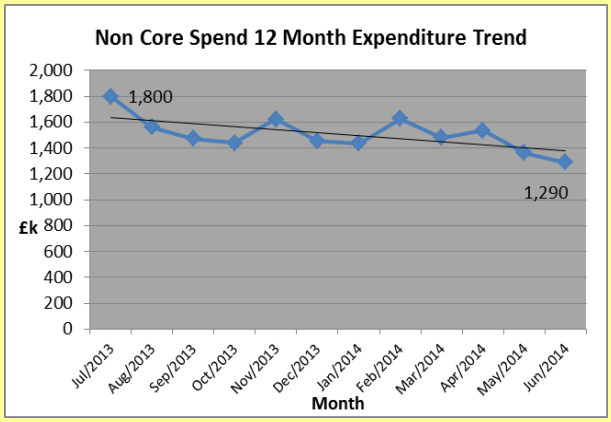
Indicator :
Non Core Pay Spend

Rating	Target	Actual	Period
Red	<5%	7.3%	Jun-14

Issue:

In June 2014 £1.3m has been spent on non core pay categories. This represents 7.3% of the total June pay expenditure, which is an improvement from 8.0% last month and circa 10% 12 months ago. The Medicine and Acute division is 11.8% and Surgery is 7.2% these are both rated as red against the target of 5%. Although the % are still above target and there are still pressures within the divisions, there is an improving trend over the last year.

Historic data:



Proposed Actions:

The Workforce Strategy is focused on primarily using core hours.
Continuation of tight control of Non-Core premium spend will continue in 2014/15.
Targeted actions have been taken to reduce sickness absence and to reduce numbers of vacancies. WLI rates have been substantially reduced for 2014/15.

Assessing Improvement:

Associate Director of HR&OD chairs monthly meetings with Senior managers, Finance managers and HR managers to review progress on reduction of non-core spend and further actions.

Impact:

Continued high premium non-core spend will potentially compromise the Trust's financial position. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permenent employees. High levels of temporary staffing can also lead to quality issues.

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report June 2014

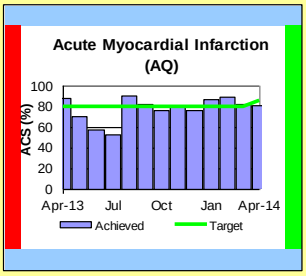
Indicator :
Advancing Quality

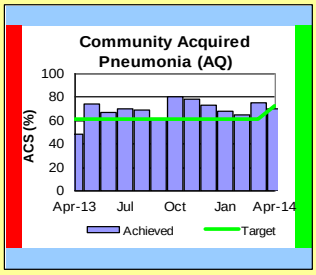
Rating	Target	Actual	Period
Red	All achieving	3 areas under target	April 2014

Issue:

The measures are composite scores, refllecting individual care to patients; the measure is a cumulative score and so lags behind improvement. Acute MI, Community Acquired Pneumonia and Stroke services all achieved the required target scores for the year 2013-14. However as stretch targets the thresholds have been raised for 2014-15, and for April all three areas are below the required scores.

Historic data:





Proposed Actions:

AQ AMI and Heart Failure are now a standard agenda item at the cardiology business meeting, with AQ Clinical Leads proactively feeding back to colleagues. For AMI there will be a continuous process throughout the year to raise awareness regarding cardiac rehab. For Stroke the issue is with getting the patients onto the appropriate unit within the prescribed timescales. For pneumonia there was poor performance against the smoking cessation measure and an action plan is now on the risk register to address the issue. Antibiotic choice and administration times are expected to improve off the back of the Trust-wide sepsis campaign. An educational programme is also currently underway to raise awareness.

Assessing Improvement:

Monthly reports are provided for the Clinical Governance Group. A Missing Measures meeting is held fortnightly to identify changes in performance.

Impact:

Patients are not receiving evidence-based interventions as described by Advancing Quality. These measures are not CQUINs for 2014-15

Expected date of performance delivery:

Improvement ongoing through 2014-15

Executive approval:

Evan Moore, Medical Director

Board of Directors		
Agenda Item	**6.1.2**	
Title of Report:	**Month 3 Finance Report**	
Date of Meeting:	**30th July 2014**	
Author:	**Jim Davies, Deputy Director of Finance**	
Accountable Executive :	**Alistair Mulvey, Director of Finance**	
Corporate Objective Ref as outlined per BAF	**13**	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	**Silver – quantitative data that has not been externally validated**	
FOI status :	**Document may be disclosed in full**	

1. Executive Summary

This report provides the Board of Directors with an overview of the Trusts high level financial performance to the end of quarter 1 2014/15 and the principle variances to the financial plan.

After three months of the financial year the Trust is reporting a cumulative deficit of £3.4m against a planned deficit of £3.1m giving an adverse variance year to date of £0.3m.

Whilst cumulatively the Trust remains off plan on a year to date basis the in month performance for month 3 delivered a marginal surplus against plan of £0.2m with an actual deficit of £0.7m being achieved against a planned deficit of £0.9m. This is a marked improvement on the previous two months financial performance.

Whilst the Trusts I & E performance is marginally off track the Trusts cash position is materially above plan at this point in the year with cash balances of £11.3m against a plan of £5.6m.

The current financial performance delivers a Continuity of Service (CoS) rating of 2 in line with the Trust overall financial plan submitted to Monitor earlier in the calendar year.

Table 1 and the following narrative provide additional detail of the in month and cumulative financial performance.

The Board of Directors is asked to note the financial position.

2. Background

The Trusts detailed financial performance in month three and year to date is reflected within Table 1 below

Table 1

SUMMARY FINANCIAL STATEMENT MONTH 3 2014/15 (JUNE)						
	In Month (£000)			Year to Date (£000)		
	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	24,575	25,196	621	73,439	73,920	481
Employee Expenses	(16,901)	(17,234)	(333)	(50,612)	(52,162)	(1,550)
All Other Operational Expenses	(6,991)	(7,140)	(149)	(20,042)	(20,942)	(900)
Reserves	(477)	(440)	37	(2,529)	(862)	1,667
EBITDA	206	382	176	256	(46)	(302)
Post EBITDA Items	(1,109)	(1,110)	(1)	(3,326)	(3,331)	(5)
Net Surplus/(Deficit)	(903)	(728)	175	(3,070)	(3,377)	(307)
EBITDA %	0.8%	1.5%	0.7%	0.3%	(0.1%)	(0.4%)
Capex Accruals Basis	650	2,625	1,975	5,086	4,116	(970)
Net Cashflow	(2,187)	464	2,651	(4,442)	1,259	5,701
Cash and Equity (Taxpayer's Equity)	(904)	1,487	2,391	149,471	148,662	(809)
COS Liquidity Days	(1.12)	(0.68)	0.44	(13.94)	(13.94)	(0.00)
CIP as % Op Expense	3.0%	2.0%	(1.1%)	2.9%	1.7%	(1.3%)
Net Current Assets (Less Liabilities)	(906)	1,806	2,712	(6,901)	(4,758)	2,143
Borrowing (Loans & Finance Leases)	27	27	0	(6,133)	(6,133)	0

The table highlights the following headline points;

- The Trust has over achieved against its income targets by £481k year to date with over performance in month three of £681k negating the under performance in the two preceding periods. The over achievement against income targets is largely associated with clinical income over recovery where c£0.4m above contract planned levels has been secured. Divisions continue to remain focused on achieving income plans as a minimum and are exploring opportunities for additional income most notably through national initiatives to support urgent care and referral to treatment (RTT) targets for planned care and providing care to other health bodies specifically Betsi Cadwaladr. This level of over performance may be at risk as commissioner budgets tighten.
- Employee expenses recorded a £333k overspend in month taking the cumulative overspending for the year to date across this expenditure category to £1,550k. Staff costs continue to represent the most significant cost to the organisation and pressures exist in the use of flexible labour through overtime, bank, agency and locum to ensure that all clinical areas

are safely and appropriately staffed. The month three performance, whilst continuing to show an overspend, also showed a slowing in the rate of overspending relative to the preceding two financial periods as staff costs reduced in line with tighter approval controls and most significantly capacity reductions across both Medicine and Surgery. Elements of these costs are also directly off set by income over achievement. The Divisions continue to closely focus on reviewing all staff costs with a view to reductions in expenditure, securing substantive appointments at lower cost than agency and locum costs whilst continuing to ensure balancing the need to ensure safe and high quality care provision is never compromised. The improvement seen may not continue if capacity, without additional resource, is opened in the future or key substantive appointments are not made.

- Other operational expenses, which largely includes drugs, estates and other variable costs associated with the provision of care followed a similar pattern of expenditure to staff costs in that there was an in month overspend (£149k) contributing to a cumulative overspend after three months of £900k with the rate of overspending in month reducing relative to the two previous months. Divisions, with the support of corporate functions such as procurement, continue to explore all avenues to reduce costs across these categories. Whilst improvement was seen in month three relative to previous periods further improvements are required to deliver a balanced in month run rate.
- In maintaining its financial position the Trust has applied £1.7m of reserves. The level of reserves applied in the first quarter is not sustainable throughout the full year and operational budgets must achieve planned levels for a sustainable financial position to be delivered.
- All figures are inclusive of CIP with the CIP target to month three being £2.1m and achievement after three months being £1.2m. The shortfall against plan is driven by the Trust having £9.7m of plans in place, inclusive of cost avoidance, income and cost reduction, against its required target of £13m, at the beginning of the financial period agreed plans totaled £8.5m and these have increased by £1.2m in the past three months. The current plans whilst short of the target in year will deliver in excess of £13m on a full year basis. To supplement immediate delivery the Trust has engaged Atkins/FTI to help in delivering greater levels of in year savings as well as develop a deeper transformational plan for delivery of sustainable cost reduction programmes over the short, medium and longer term. Atkins/FTI began their engagement with the Trust on 7th July 2014. All areas of the organisation must explore every savings opportunity to ensure the necessary target is achieved in year and on a recurrent basis.

The cumulative impact of the above issues is the generation of an adverse financial position of £0.3m against the Trusts financial plan.

- The Trust had anticipated that at this point in the year it would have used £5.1m of its capital resource, to date £4.1m has been applied with slippage across a range of programmes most significantly IM & T. The Trust is forecasting that through the remaining quarters this expenditure will move back towards plan as schemes pick up in their delivery.
- The Trusts cash position is £5.6m above planned levels largely due to early settlement of debtors, delays in the payment of creditors and slippage in the capital programme combined with improvements in the overall cash management systems which have been implemented in the past two months. The Trust continues to explore options to strengthen its cash and liquidity position in year.

The overall financial performance translates into a Continuity of Service (CoS) Rating of 2 which is in line with the plan submitted to the Trusts regulator, Monitor.

3. Key Issues

Whilst month three saw a slowing in the rate of the Trusts adverse financial performance the Trust does remain £0.3m away from its forecast deficit plan of £3.1m as at the end of q1.

Financial pressures persist across most cost categories as CIP plans are slow to deliver; poorer expenditure and CIP performance is off set with over recovery of income and the application of reserves. The off set of spending with income and reserves is not sustainable through the remainder of the financial year and costs must be reduced for financial targets to be achieved.

Whilst the current cash position remains stronger than plan this will deteriorate without an improvement in the I & E position and as capital expenditure increases. Increased focus on cash management including the establishment of a fortnightly cash group to review the thirteen week rolling cash forecast will enhance control and management however options to improve cash and liquidity will need to be explored and enacted to ensure sufficient cash throughout the financial year and beyond.

4. Next Steps

The Trust is now working with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change. The financial performance of the divisions are being closely monitored through the monthly performance review process and enhancements to all systems of control continue to be implemented.

As noted a cash group, including key operational spending functions, has been established to enhance cash management and forecasting and the Trust continues to explore additional in year funding options.

5. Conclusion

While the in month position shows an improvement on the trend for the first two months of the year, the actual deficit position has increased further in month. The Trust must continue to deliver against its planned financial position on a month by month basis to achieve its overall financial goals.

6. Recommendations

The Trust Board is asked to note the contents of this report

Alistair Mulvey
Director of Finance

Board of Directors		
Agenda Item	**6.1.3**	
Title of Report	**Urgent Care Costs**	
Date of Meeting	**30th July 2014**	
Author	**Alistair Mulvey, Director of Finance** **Sharon Gilligan, Director of Operations**	
Accountable Executive	**Alistair Mulvey, Director of Finance** **Sharon Gilligan, Director of Operations**	
Corporate Objective Ref as outlined in the BAF	**13**	
Level of Assurance		**Committee Confirmation**
Full		
Data Quality Rating	**Silver – quantitative data that has not been externally validated**	
FOI status :	**Document may be disclosed in full**	

1. **Executive Summary**

During 2013/14 the Trust saw a series of financial pressures across the composite of its urgent care areas these pressures were largely driven by the continued increase in volume of urgent care presenting but also by the way in which the Trust had to manage the delivery of this care. The costs incurred largely related to;

- Maintaining medical staff rotas
- Maintaining urgent care capacity
- Specialing costs associated with specific patient requirements and
- Covering staff absences due to a variety of causes including sickness and maternity leave which has in part been exaggerated by lower levels of headroom in staffing complements.

In addition to costs incurred from an urgent care perspective there were also costs associated with maintaining planned access targets, these costs were largely attributable to “waiting list initiative (WLI)” payments to medical staff. Although it should be noted that a level of income was attracted to over performing from an elective perspective and this underpinned securing a total contract value of £219.7m at the year end.

Whilst elements of these costs have persisted into 2014/15 it should be noted that from an urgent care perspective, capacity and rota numbers have been reduced and systems of control and approval have been supplemented for the use of flexible labour. Whilst these changes have reduced costs they have also contributed to longer waits within ED and additional breeches against the 4 hour target in the first quarter of 2014/15.

From a planned care perspective the most significant action relates to a negotiated reduction in the WLI payment rate which has reduced the cost incurred for these activities and, in part, reduced the willingness of participants and therefore the volume of these activities also. The balance to this position is that some reductions have led to instances of increased costs where we have not been able to fill a WLI with a substantive staff member and therefore have had to resort to the use of agency/locum although this is largely related to ED.

Additionally the Trust, through a procurement process, developed a system and process for booking locum/agency staff which came with additional service elements and resulted in a lower cost through the ability to reclaim VAT on the service elements of the costs. Furthermore through the budget setting process the plan for elective care was reduced by c£1.2m as a detailed exercise of aligning capacity was undertaken.

Whilst it is difficult to wholly disaggregate additional costs from core costs it has been identified that the ED incurred an overspend of c£2.1m with additional bed costs within the organisation of c£1.3m, against this the Trust secured c£1.2m of winter pressures funding. Elements of the costs are historic and detailed discussions are ongoing for their resolution and a sustainable way.

From a planned care perspective the excess costs incurred at premium rates have been identified as being c£1.5m within surgical care specialties and £0.8m within medical specialties. It should be noted that these planned sessions also attract a level of income to abate these

The costs incurred are deemed conservative as they do not include costs associated with the provision of diagnostics, catering, cleaning, portering and other such support costs.

2. Background

Whilst acute hospitals have historically seen increases in volumes of patients, and greater levels of acuity and complexity of care requirements from patients, through the winter months the peaks and troughs of this form of demand are levelling out such that pressures do not occur specifically in a finite winter period but increasingly throughout the full year.

In responding to sustained challenges, specifically to achieve and maintain access targets, providers have traditionally opened additional capacity during the winter months, however the Trust has seen that this capacity has increasingly been maintained through the full year and supplemented with the use of additional capacity in areas such as day wards and areas which do not ordinarily house patients over night such as theatre recovery suites. The maintenance of capacity attracts a cost which has not always been covered by additional income, although some income via “winter pressures monies” has invariably been received and where activities are delivered under a PbR contract additional income is secured.

The distribution of costs driven from an urgent care perspective through 2013/14 are reflected within the table below;

2013/14 Unplanned Care Excess Costs	£000's
A & E Medical Staff Costs	-1,325
A & E Nursing Staff Costs	-218
A & E other staff costs	-35
Total A & E Staff Costs	-1,578
A & E Non Pay costs	-210
AAU/AMU/EDRU Costs	-297
Total Acute Costs	-2,085
Unfunded Bed Costs	-1,303
Total Costs	-3,388
Winter Pressure Resource	1200
Excess Costs	**-2,188**

From an urgent care perspective the core bed base in excess of that funded was always at least 30 beds above the planned norm at points of extreme pressure stretched beyond this level with bed capacity being opened in other areas where safely available. Moving into 2014/15 the medicine division has, through April and May closed 40 beds, with the surgical division closing 17 beds in a similar timeframe.

In addition to attracting additional costs of either opening unplanned capacity or stretching existing capacity this approach also attracts increased risk in terms of the management of infection, prevention and control with the Trust seeing a cessation of its HPV programme, risks associated with the provision of safe nursing staffing levels and deterioration in the perception of the patients experience often see through an increase in the number of complaints. Whilst these are undoubtedly real and live challenges the Trust has maintained its risk rating from the CQC of level 6 as being amongst the safest organisations based on the collated measures and has similarly seen marked improvements in its Friends and Family scores significantly through its ED area and will need to work effectively in the coming periods to maintain these excellent levels of achievement within a shrinking resource envelope.

The costs associated with maintaining a planned care position through WLI are reflected by specialty below;

2013/14 Planned Care Excess Costs	£000's
Gastroenterology	-675
Endoscopy Nurse Costs	-114
Respiratory Medicine	-29
Rheumatology	-14
Total Medicine	**-832**
Theatres and Anaesthetics	-1,337
Breast	-168
Dermatology	-55

GI	-213
Head and Neck	-58
Ophthalmology	-116
Seal and Pre Op	-3
T & O	-30
Urology	-441
Vascular	-60
Divisional Reserve	1,015
Total Surgical Specialities	**-1,468**
Total All	**-2,300**

The above reflects a position where excess costs were incurred both non electively and in planned care workstreams elements of which were balanced by income however the net position is one which significantly contributed to the Trust delivering a deficit rather than a surplus position as planned.

3. Key Issues

The key issues and learning from the experience of 2013/14 identifies that opening additional capacity in an unplanned way attracts both additional costs and risk across a range of fronts. These pressures are only heightened as the financial pressures increase and the demands for increased nursing numbers also rightly increases. The balance to this being that as capacity closes achieving access targets is increasingly difficult without behavior and pathway change.

In recognising the immediacy of these issues the Trust has reduced its capacity through April and May and into June is beginning to see the financial benefits of this although it must be recognised that the 4 hour access target has not been achieved and there is undoubtedly a link with capacity. There is a cohesive approach to supporting changing behaviors specifically with medical staff to achieve the target within available capacity and the urgent care recovery plan coupled with the external review undertaken by Seamus McGirr will all feed into maintaining both the access targets and the financial position positively as we move forwards, although it should be recognised that underlying issues in A & E recruitment and rota levels will need to be resolved before a balanced position will be achieved.

In addition to all of the internal actions undertaken the Committee should also note that in managing these pressures going forwards there is a significantly greater emphasis and alignment between operations, nursing and finance and the consequences of specific actions discussed in detail through Executive Team Meetings. This is evidenced through the recent bid to the Urgent Care Board in support of the opening of additional capacity and supplementary actions as described within the urgent care plan where in advance of actions being undertaken they have been fully discussed and costed in a cohesive way. The critical change being that the funding is to be secured before the operational changes are fully enacted.

Additionally there has a been a cohesive approach to the development of the RTT plan requested for elective care in the recent weeks, this again has focused on balancing the requirements of resource use, delivering the required outputs and ensuring that plans are in place for nursing and appropriate bed capacity in advance of the operational actions being taken.

4. Next Steps and Conclusion

The pressures seen through urgent care and changes demanded across planned care are likely to persist to a degree in the coming financial year. The critical next steps are that the increased level of discussion and transparency on the links between operational actions and financial consequences need to be maintained and the proactive approach to securing the appropriate financing and nursing in advance of additional capacity similarly need to be embedded into the daily fabric of operational delivery within the organisation whilst continually maintaining and not compromising on safe high quality delivery of care.

5. Recommendations

For the Committee to note the report

Alistair Mulvey
Director of Finance

Sharon Gilligan
Director of Operations

Board of Directors		
Agenda Item	6.2	
Title of Report	Report of the Quality and Safety Committee	
Date of Meeting	30 July 2014	
Author	Dr Evan Moore, Medical Director Dr Jean Quinn, Non Executive Director/Chair of Quality and Safety Committee	
Accountable Executive	Dr Evan Moore, Medical Director	
BAF Reference	Risks 1, 2, 3, 6, 9, 10, 15, 22, 23, 26	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

Report of the Quality and Safety Committee

14 May 2014

The meeting was quorate and began on time.

4.1 Patient Story

The meeting began with a patient story which took the form of a collection of comments made by patients and their families praising the care received at the Trust. A lively debate around the use of social media followed. Of particular interest is that all the comments were positive and that it should be remembered that not all patients have access to IT resources.

5.1 Workforce Dashboard

The monthly dashboard was presented by the Director of Strategy and Partnerships. The Committee noted that attendance levels remained below target, the improvements seen in filling vacant posts and the continual high levels of appraisal and mandatory training. Concern was raised around the sheer number of bank staff needed. Director of Nursing and Midwifery to report back in three months.

Assured

5.2 Staff Satisfaction Update and Engagement Plan

The Committee received the 2013 National NHS Staff Survey. The Committee noted the excellent increase in response rate and the number of measures of satisfaction which had increased albeit this was a modest improvement. The action being taken by the Trust to ensure that “year on year” improvement in staff satisfaction were also presented.

Assured

6.1 Clinical Quality Dashboard

The Committee received the Quality Dashboard for May 2014 and noted the continued fall in Mortality, an HSMR of 66.9 for April 2013 to February 2014. The improvement in AQ compliance and the re-introduction of the MEWS infogram with improved compliance was also noted.

Under reducing harm a low volume of STEIS incidents and pressure ulcers was recorded with continued good performance in falls prevention, VTE readmission and avoiding giving patients medication they are recorded as being allergic to.

Under the patient experience metric a Friends and Family Test score above 80 was recorded for the third consecutive month. The Committee noted the increase in patients reporting discharge delays and requested a “deep dive” on the issue from the Head of Patient Experience.

The Committee reviewed the assessed impact of serious incident histogram and noted no new deaths or never events in month against a background of low harm.

The Committee received two risks scored at 20 which had already been discussed at Board of Directors and a 15 risk around Ophthalmology sustainability which it took the opportunity to discuss with the Surgical Division under agenda Item 7.1.

The Committee noted our self-assessment of our ongoing compliance with CQC regulation and triangulated this against the Risk Register and a MiAA audit of this process which had recorded significant assurance.

Assured

6.2 Quality Impact of Cost Improvement Programme Report

The Committee studied this extensive metric and could discern no apparent trends.

Assured

7.1 Quality Review Update – Surgical Division

The Surgical triumvirate and the Deputy Associate Director of Operations attended the Committee and presented the ongoing work in the Division using the presented Committee template.

This extensive presentation covered the considerable breadth and depth of the work required to successfully lead this Division, the knowledge, passion and clear commitment to high quality, safe and sustainable services generated significant competence. The evidence of plans described, improved Friends and Family Test scores, reduction in pressure ulcers, achieved ward turnaround plans (eg Ward 14), closure of a full ward following the vascular transition, excellent Briggs report generated assurance.

Difficult areas needing improvement – specifically the SAU and orthopaedic LoS were highlighted and plans to tackle these issues briefly discussed.

The Deputy Associate Director of Operations returned to the Committee as requested at the meeting on 9 October 2014 to provide an update on Ophthalmology services. Ms Kendall reported good evidence of progress in all areas eg increased productivity, reduced complaints and waiting times although problems are being experienced due a reduction in cataract referrals.

Assured

7.2 Preliminary Strategic Actions to address End of Life Care Provision for Adults in Wirral University Teaching Hospitals

The Committee explored the current issues with End of Life Care provision in our health economy; there is clear evidence of unmet need and an opportunity to improve care. The Director of Nursing and Midwifery presented action already underway to address these and agreed to share a full action plan with the Committee at a later date.

Assured

7.3 Setting the Direction for Dementia Care in Wirral University Teaching Hospital

The Director of Nursing and Midwifery presented the high level strategy to improve the care of patients with Dementia. The Committee were pleased with the level of ambition in the plan and also noted the collaboration needed with other partners. The Committee was keen to learn more about the implementation of this strategy over time.

Assured

9.1 Items for the Risk Register

The Committee noted the comment in Item 6.1 (page 36) around the Trust providing services from external premises and asked that the Director of Facilities explore the legal implications of this and whether it needs to be entered onto the Risk Register.

The Committee noted the comment in Item 7.2 (page 54) around external NHS staff delivering services on our site and asked that the HR service explore the legal implications of this and whether it needs to be entered onto the Risk Register.

9.2 Recommendations to the Board

There were no recommendations to the Board of Directors.

Report of the Quality and Safety Committee

11 June 2014

The meeting was quorate and began on time.

3 Chair's Business

The Quality and Safety Committee agreed to receive the monthly nurse staffing report and report this to the Board of Directors through the Chair's Report.

4.1 Patient Story

The meeting began with a patient story from a member of staff who is also a patient with a long term condition. The staff member related examples of poor "manners and "attitudes" to patients portrayed by some members of the clinical support staff. The examples mentioned will be explored in detail with the Director of Nursing and Midwifery.

The Committee requested further information the operation of the Flexi-bank which the Director of Nursing and Midwifery undertook to bring back in October.

4.2 CLIPPE Report

The Head of Patient Experience gave feedback on actions taken following the last two patient stories at the Committee.

The Quarter 4 CLIPPE update was given with details of issues added to and removed from the concerns log and the rationale detailed.

A specific long standing concern which appeared to be deteriorating was delays in their journey reported by patients. The Head of Patient Experience will report this issue in detail at the 10 September Committee meeting.

There was a good discussion round Ward 14, SAU and the increase in pressure ulcers seen in quarter in the Medical and Acute Specialties Division.

The report was triangulated with the minutes of the Clinical Governance Group.

Assured

4.3 National Inpatient Survey 2013 – Results Summary

The Head of Patient Experience presented the results of the National Inpatient Survey. The Committee triangulated these results with the Friends and Family Test score from that period. The results re-highlighted some disappointing results, already known to the Committee. Action already taken to improve care and performance were noted, the Committee hoped the sustained improvement in Friends and Family Test would be reflected in next year's scoring.

Assured

5.1 Workforce Dashboard

The Director of Strategy and Partnerships presented the Workforce Dashboard and highlighted action to address attendance rates, workforce vacancies including medical staff, mandatory training rates, appraisal rates and ongoing work to improve our leadership and culture.

Assured

6.1 Clinical Quality Dashboard

The Associate Medical Director presented the most recent HSMR, which for the year to date, is 85 and one of the lowest in the Northwest region. The issues with Advancing Quality, which the Committee are well aware of, are improving and the evidence for this was reviewed, as was the evidence of better MEWS scoring and continual low harm from medication errors.

The Committee noted the reduced STEIS events, reduced falls with harm and continual reduction in pressure ulcers, readmissions with VTE disease and readmissions.

The Committee noted the maintained high Friends and Family Test scores and improved scores with patient experience generally.

The Associate Medical Director presented the Impact of Serious Incident Harm and a good discussion followed around the deaths reported, receiving assurance of lessons learnt from these events.

Assured

6.2 Quality Impact of Cost Improvement Programme Report

The Committee received the Quality Impact of Cost Improvement Programme Report and concluded no trends were apparent.

Assured

7.1 Quality Review Update – Medical and Acute Specialties Division

The Medical and Acute Specialties leadership team attended the Committee meeting.

An overview of the work undertaken in leading this large part of the hospital was given following the template provided by Q&SC (see Appendices)

The team presented their operational dashboard, the measures of quality of care employed and the improvements evidence from them, in addition to these successes (Friends and Family Test, Pressure Ulcers, Mortality) a number of significant challenges and the plans to progress were discussed (4 hour care standard, decision and discharges earlier in the day, nursing capacity). Plans to improve financial performance were discussed in tandem with planning to enhance clinical performance, deliver the Nursing Strategy and develop sustainable services into the future.

The breadth and depth of activity clearly came across and gave the Committee real confidence in the work of the Team and their leadership

Assured

7.2 Safeguarding Annual Report

The Director of Nursing and Midwifery presented the Safeguarding Annual Report which provided significant assurance across the full range of our statutory obligations. The Committee described a number of pieces of information which it felt would enhance the report, the Director of Nursing and Midwifery undertook to provide these as an addendum. The Lead Nurse for Safeguarding also reported that all actions from a MiAA, audit which had previously been reported to the Committee were now complete.

Assured

7.3 Infection Prevention and Control Exception Report – Position Report May 2014

The Director of Nursing and Midwifery presented an Infection Prevention and Control Exception Report, detailing the current position and the actions ongoing to prevent deterioration of this challenging metric.

Assured

7.4 Risk Management Group Revised Terms of Reference

The Committee received and approved an updated Terms of Reference for the Risk Management Group. The main changes being to membership (reduced) and a change to less frequent meetings.

7.5 Risk Management Group Annual Report

The Committee received the annual report from the Risk Management Group and triangulated the following sources of assurance: review of minutes, CQC unannounced inspection November 2013, MiAA Risk Management Review November 2013 which recorded significant assurance, the monthly DMT Dashboards and DMT performance at monthly programme reviews.

Assured

9.1 Items for the Risk Register

There were no new items for the Risk Register.

9.2 Recommendations to the Board

The Quality and Safety Committee recommended that they receive the monthly nurse staffing report and report this to the Board of Directors through the Chair's Report.

The Board is asked to note the content of this request and consider any changes to the level of assurance described in the BAF.

9.5 Action Log

The Action Log was reviewed.

Report of the Quality and Safety Committee

9 July 2014

The meeting was quorate and began on time.

3 Chair's Business

- Maternity Services Review received;
- Local Authority Health and Care Scrutiny Committee update from Director of Nursing and Midwifery;
- Sign up to Safety Campaign

4.1 Patient Story

The Committee listened to a patient story concerning chest pain attending the Emergency Department and transfer to the Assessment Unit – good experience in both areas with improvements to be made on decision to discharge.

5.1 Workforce Dashboard

Overall Trust average sickness at 4.74%; specific focus on review of staff on long term sickness, compliance with policy and recognition of good attendance. The Committee scrutinised performance towards improvement and there was specific attention on the Emergency Department. Also the 10 most challenged areas will be included in the next report. Legislative compliance in terms of an asbestos survey is part of a paper to the Board of Directors; challenge about risk scoring at "amber" when asbestos is rated "red". Stress/anxiety/depression as a cause of absence was noted and this has been a focus of a LiA event in June 2014.

Assured

6.1 Clinical Quality Dashboard

Mortality at 66.1 in February 2014. Advancing Quality targets met apart from Heart Failure. Medication errors measures needs review. Harm from Falls data to be amended: 5 for Quarter 1. Friends and Family Test for ED Minors is 89; Friends and Family Test for in-patients for June 2014 is 73.

New risks included requirements for capital investment and the consequence of impact on capital availability.

The Committee received the monthly compliance and assurance report. To note are the forthcoming review of looked after children and safeguarding; registration of new location; health records checklist. The Committee requires further assurance on the health records checklist.

Assured

6.2 Quality Impact of Cost Improvement Programme Report

The Committee noted the numbers of falls and requested that this be monitored and also: C Diff; use of flexible labour; delayed transfers of care to be reviewed. In context of Atkins – FTI partnership discussion took place about whether there might be more sensitive and specific indicators to be used in the CIP Quality Impact Report.

Assured

7.1 Quality Impact of Cancelled Procedures Report

The Committee received a report on the quality impact of cancelled procedures with a further update required in September 2014.

7.2 Outpatient Improvement Review Group Update

A paper was presented to update the Committee on the Outpatient Review Group with a further update required in November 2014.

7.3 Director of Nursing and Midwifery Performance Report Quarter 1

The Director of Nursing and Midwifery presented the Quarter 1 performance.

Focus is on improving MEWS scoring and the Trust Resuscitation Group to provide further assurance to the Committee.

Wards 10 and 26 are under observation; Ward 26 of particular concern in view of additional beds opened and implications for Care Quality Commission. Ward 14 continues to be monitored in view of additional beds. Patient falls requires further attention.

7.4 Nurse Staffing Report

The June 2014 (the second) nurse staffing report was presented. The Trust presents wards staffed at 90% and over as "green". Overall, the Trust submitted data to NHS Choices with a score of 96%. Areas of concern were EDRU and Neonatal Unit. The challenges of short term sickness and provision of one to one nursing for patients who require this level of care were noted.

National guidance on nurse staffing is anticipated in July 2014.

Assured

7.5 Annual Clinical Incident Report

The report was presented; the decline in the number of incidents reported was noted; the majority of incidents resulted in no or low harm to patients. An increase in unexpected deaths was noted and there is further work on morality. External reporting of incidents eg safeguarding and reporting of disciplinary issues was discussed.

Assured

7.6 Quality Improvement Strategy

A report on the Quality Improvement Strategy was presented. Specific areas requiring further attention were patient readmissions, never events, MEWS and prevention of MRSA bacteraemias.

Assured

8.1 Items for the Risk Register

There were no new items for the Risk Register.

8.2 Recommendations to the Board

The Board is asked to note the content of this request and consider any changes to the level of assurance described in the BAF.

8.5 Action Log

The Action Log was reviewed.

Board of Directors		
Agenda Item	6.4	
Title of Report	Nursing and Midwifery Strategy Progress Update	
Date of Meeting	30 July 2014	
Author	Jill Galvani, Director of Nursing and Midwifery	
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery	
BAF Reference	1, 2, 3, 4, 5, 6, 7, 8, 11/12 & 14	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Bronze – qualitative data	
FOI status :	Document may be disclosed in full	

1. Executive Summary

The Nursing and Midwifery Strategy was developed during the first 6 months of 2013/14 in response to the Francis Report published in February 2013. The Board of Directors approved the Strategy on 30 October 2013 and there was a celebratory, but formal launch event in December 2013. All nurses and midwives in the Trust have received a copy of the Strategy and these are being signed with a record of this held by the Assistant Directors of Nursing and Midwifery. The Strategy has 67 patient focused actions. Of these 38 are completed or implemented with an associated audit or monitoring process – these actions are ticked (√) on the 'Strategy on a page' document attached. There are 23 actions (denoted by →) that are in progress that will be completed during 2014/15. Only 6 actions have not started yet (marked with x) and these are held until the infrastructure to support the Director of Nursing and Midwifery is in place. None of these 6 actions are immediately essential, but are part of the development of the Strategy and the nursing and midwifery professions towards 2018.

The fundamental standards of nursing care are audited through the Nursing and Midwifery audit processes. There is a requirement to undertake further work on areas such as nail and mouth care for example. Once the Care Quality Commission (CQC) launches its Fundamental Standards programme, the fundamentals in the Nursing & Midwifery Strategy will be reviewed to ensure that all elements of the CQC compliance requirements are met and evidenced.

The outcomes for nursing and midwifery are captured in the Director of Nursing and Midwifery's quarterly reports to the Quality and Safety Committee; monthly reports on nurse staffing are presented to the Quality and Safety Committee and a six monthly report has been presented to the Board of Directors.

The Nursing and Midwifery agenda is not static and new areas for attention have emerged since the Strategy was developed. For example the National Institute of Clinical Excellence Guidance on nurse staffing was published on 16 July 2014, and initiatives such as raising concerns through national campaigns: 'Speak out Safely' are topical and high profile and not part of the Strategy.

The Board of Directors is asked to discuss and note the substantial progress being made on delivering the Strategy by the nursing and midwifery workforce. Progress will continue to be reported to the Quality and Safety Committee.

2. Background

The Trust's Nursing & Midwifery Strategy: 'Modern Patient-Focused Nursing & Midwifery based on Traditional Values, 2013/18' was developed in response to the publication of the Francis Report in 2013. Subsequent key documents informed the Strategy:

Keogh review into the quality of care and treatment provided in 14 Hospital Trusts in England (2013);
Berwick Report on improving the safety of Patients in England (2013);
Cavendish Review, an independent enquiry into healthcare assistants and support workers in the NHS & Social Care setting (2013);
How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity & capability (National Quality Board 2013);
Hard Truths: The Journey to putting patients first (Department of Health 2013).

Nursing and how it is managed was a key focus of the Trust's unannounced CQC inspection in November 2013. In particular was the focus on safe nurse staffing levels and how these were managed. The Health and Care Scrutiny review focused on all aspects of patient care and safety but was particularly focused on nursing care. Having a Strategy such as this provides a framework for the Director of Nursing & Midwifery to set out what is expected of nurses and midwives but also identifies the ingredients of excellent nursing care: leadership, sufficient numbers of correctly trained staff working in a culture of support and constructive challenge that is focused on putting patients first.

3. Key Issues

The Strategy document has been well received both internally and externally, although a small number of nurses were reluctant to 'sign up' to it initially. This issue has been resolved.

Focus has been on the essential compliance work and this has been completed. Areas such as health and well-being have not progressed as quickly, apart from smoking cessation, and this needs focus in preparation for pending CQC inspections. This is on the risk register.

The Fundamentals of Care need further work alongside CQC requirements; there is also work to be done on ensuring these are evidence-based where the evidence exists.

There has been a major focus on nurse staffing levels since the appointment of the Director of Nursing and Midwifery. Having sufficient numbers of nurses is fundamental to enabling excellent nursing care to be delivered.

The link between ward leadership capacity and capability, staffing levels and nursing outcomes in a challenging operational climate continues to be a theme in the Director of Nursing & Midwifery's quarterly reports. The Nursing and Midwifery audit system, linked with the Complaints, Concerns, Litigation and Patient Experience processes alongside 'soft' intelligence enable senior nurses to quickly identify and act on areas of concern.

In addition to the Patient Focused actions, corporate nursing and lead nurses have picked up significant work on CQUINs and the need to deliver specific cost improvement programmes. Both of these areas serve to focus attention on quality and the best use of resources. Nursing related CQUINs have a framework for delivery that is new to the Corporate Nursing Support Team this year.

4. Next Steps

There is an action plan in place for delivering the actions in the Nursing & Midwifery Strategy; this will be the main focus of the Interim Deputy Chief Nurse. In preparation for the next report to the Board of Directors, there will be a review of the strategy to ensure that nursing and midwifery is covering the different areas of nursing and midwifery such as midwifery, neonatal nursing, paediatric nursing, school nursing, emergency nursing and critical care nursing.

5. Conclusion

Substantial progress has been made on delivering the Strategy by the nursing and midwifery workforce in the first 6 months since its launch. Monthly progress will continue to be reported to the Quality and Safety Committee, and 6 monthly reports will continue to be presented to the Board of Directors.

6. Recommendations

The Board of Directors are asked to discuss the report, and note the progress that has been made.

Nursing and Midwifery Strategy 2013-2018

Modern, Patient-Focused Nursing and Midwifery Based on Traditional Values

Patient Focused Values and Behaviours

Caring	Compassion	Competence	Communication	Courage	Commitment
Caring is what I do – I am proud when I have cared for patients and their carers really well and I have made a difference.	I am kind, thoughtful, a good listener and anticipate the patient's needs – I will go the extra mile for my patients and their carers.	I am knowledgeable and competent. I am responsible for finding out about my patients' care and I will always ask for help if I am unsure because my patients' safety matters to me.	I will introduce myself to patients and visitors, establish eye contact and smile. I will use the patients' preferred name. I will not talk over patients and will be polite, calm and approachable.	I will speak out and be responsible for taking action if my patients' care is being compromised. I will adhere to my Code of Conduct at all times.	I will come to work and be focused on the patients in my care and the needs of my team members. I will be fit and well to care. I inspire confidence through my professional appearance and I am proud to wear my uniform.

Patient Focused Actions

Patient Focused Values & Behaviours

Launch Nursing & Midwifery values & behaviours; ✓
Director of Nursing to see all nurses, midwives & Care Support Workers; →
Review of all job descriptions to reflect 6Cs values & patient focused outcomes; →
Monitor the appearance of nurses & midwives to inspire trust & confidence; ✓
Introduce a distinctive new uniform for staff nurses & care support workers; →
Provide name badges to avoid confusion & promote transparency; →
Introduce value-based 'compassionate' recruitment; ✓
Potential recruits to meet the Director of Nursing & Midwifery; X
Develop a system of monitoring disciplinary issues & referrals to NMC; ✓
Create a culture of challenge; ✓
Excellence in patient experience & Friends and Family Test. ✓

Patient Focused Population Health & Well Being

Work with partners to support people to remain independent & healthy; →
Maximise the contribution of School Nurses; ✓
Promote immunisation & vaccination for patients & staff; →
Deliver excellence in Infection Prevention & Control in the hospital setting; ✓
Excellence in safeguarding for adults & children; ✓
Excellence in dementia nursing; ✓
Make 'every contact count' to promote health & well-being; →
Prepare nurses to care for older people & promote healthy ageing; X
Ensure nurses & midwives are fit & well to care; →
Promote safe sleeping; ✓
Support breast feeding; ✓
Promote social models of midwifery care to increase normal birth and reduce interventions. ✓

Patient Focused Safe & Effective Nursing & Midwifery Care

Develop the Cerner Millennium function to support excellent nursing & midwifery care & reduce bureaucracy; →
Set performance outcomes for Ward Sisters; →
Support university lecturers to retain clinical procedures; →
Introduce an individual annual meeting with the Director of Nursing & Midwifery with all Ward Sisters; →
Build on safety performance for pressure ulcer prevention; prevention of falls with harm; prevention of deterioration: MEWS; VTE assessment & plan; avoidance of infection; ✓
Registered nurse on every ward round; →
Patient focused ward rounds; →
Deliver the patient-focused fundamentals – every patient, every time; ✓
Introduce patient focused rounding; ✓
Review how care is organised & introduce a model of nursing; →
Review & refresh the nursing & midwifery audit reporting system & develop strategies for improvement; ✓
Midwives will receive proactive supervision; ✓
Ensuring all staff have the required clinical competencies and academic requirements to deliver safe compassionate care. →

Patient Focused Nursing and Midwifery Staffing

Maximise the benefits of E Roster; →
Review shift patterns to meet patient need; ✓
Optimise OLM – Talent & Self Serve; X
Work towards national nurse & midwifery staffing levels; ✓
Display nursing & midwifery staffing levels; ✓
Supernumerary & supervisory Ward Sisters; ✓
Develop new approaches to skill mix & care providing roles; ✓
Participate in the pre-training pilot for RNs; ✓
Introduce the role of housekeeper; ✓
Complete 6 monthly acuity & dependency audits; ✓
Six monthly report on safe staffing levels to the Board of Directors; ✓
Develop a framework for commissioning nurses & midwives to meet population need; ✓
Modernise the nurse specialist service & introduce team job planning; ✓
Modernise out-patient nursing; ✓
Introduce Named Nurse. →

Patient Focused Nursing and Midwifery Management and Leadership

Develop a Research & Development Strategy for Nursing & Midwifery; X
Progress academic relationships with Chester & JMU at pre – and post-registration level; ✓
Increase the visibility of senior nurses in clinical areas & at night and weekends; →
Reassert the role of the Matron with daily matron rounds; ✓
Accredited leadership & management training for Ward Sisters, Charge Nurses and Staff Nurse; ✓
Develop a succession plan for Ward Sisters & Charge Nurses; X
Implement & monitor the impact of contribution-based progression; →
Develop the ward routine: involve former nurses; ✓
Clarity about who is 'in-charge' of the ward; →
Display 'who to contact' details in case of concerns; ✓
Celebrate success through an annual celebration of Nurses' Day; ✓
Promote nursing & midwifery through presentations, publications & awards; →
Arrange regular lectures from national & international speakers; →
Select & prepare the next generation of nursing & midwifery leaders: "Tall Poppies"; X
Develop & support 'Link' Nurses in specific specialist areas; ✓
Support the re-validation of Nurses & Midwives. ✓

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors		
Agenda Item	**7.1**	
Title of Report:	**Monitor Compliance Report - Quarter 1 - 2014/2015**	
Date of Meeting:	**Wednesday 30th July 2014**	
Author:	**Emma Pridgeon, Assistant Director of Finance – Corporate Financial Services** **John Halliday, Assistant Director of Information**	
Accountable Executive :	**Alistair Mulvey, Director of Finance** **Sharon Gilligan, Director of Operations**	
Corporate Objective Ref as outlined in the BAF	**13 & 14**	
Level of Assurance		**Board Confirmation**
Full		**Committee Confirmation**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**	
FOI status :	**Document may be disclosed in full**	

1. EXECUTIVE SUMMARY

Foundation Trusts are required to submit a report to Monitor on a quarterly basis using templates provided, covering targets and indicators, governance and finance. The basis of the report for Quarter 1 2014/15 is described below, with further financial detail attached in Appendices 1-4.

As the Trust is on monthly monitoring it also submits monthly financial information and a briefer commentary for months that do not fall at a quarter end.

The Board are required to self certify the statements that accompany the year end monitoring returns that are detailed in Appendix 5. The Board is also asked to accept the reforecast of the capital programme as detailed in Appendix 6. Both actions have been recommended by the Finance, Business Performance and Assurance Committee.

2. BACKGROUND

Governance Targets & Indicators

Under Monitor's Risk Assessment Framework, each indicator has an equal weighting of 1 point for each standard not achieved. The overall Governance ratings are now Green for no concerns (i.e. all targets met), and Red for 4 points or more. A score between these two positions will result in a potential concern being raised, but no RAG status being assigned by Monitor.

Wirral University Teaching Hospital NHS Foundation Trust(WUTH) will be considered neither Green nor Red for Q1 and issues of note with the Risk Assessment Framework standards are detailed below.

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the final Q1 position was 91.2% as measured across a combined Emergency Department (ED) and All Day Health Centre performance at the Arrowe Park site.

A comprehensive Urgent Care Recovery Plan has been agreed, with the following actions already taking place:

- Working with the Utilisation Management Team who have reviewed processes in the ED and have analysed patient data. They are also currently carrying out a point prevalence study to identify whether patients need to occupy acute beds. Initial verbal feedback so far is that a number of patients could be discharged if the capacity was available in the community.
- Run two of a planned three 'Perfect Day' events with the health economy. Agreed on ten projects from a list of 70+ actions. Details on the Urgent Care Recovery Plan.
- Introduced a multi-disciplinary Pull Team to ED to prevent admissions.
- Changed / changing medical job plans to give greater presence in ED
- Redesigned minors area and doubling size of resus
- Working with the Urgent Care Board to introduce a number of initiatives such as Discharge to Assess before winter 2014.
- All initiatives are fed into a joint WUTH/Clinical Commissioning Group Urgent Care Recovery Plan. Fortnightly joint monitoring meetings in place. Daily monitoring in the Trust.

Although every effort is being made across the health economy to achieve for Q2, demand continues to increase. The anticipated trajectory to achieve across the quarter at site level is 93.5% in July, 95.5% in August and 96% in September.

All Referral to Treatment (RTT) standards were achieved at Trust level for Q1. However across the NHS in Q2 providers and commissioners have been provided with additional central funding for additional activity to reduce waiting times further to both get the national position back to delivering '18 weeks' and create some headroom before the Winter months, so ensuring the standards are maintained. This additional treatment of long-waiting patients by WUTH is likely to result in the standards not being achieved across the quarter. Although NHS England and local commissioners have acknowledged this will be considered when assessing Q2 performance, Monitor has so far indicated there will be no relaxing of their Risk Assessment Framework targets.

For infection control, the number of Clostridium Difficile cases was slightly above trajectory for April and May in Q1 however the C Diff plan is in place and balanced against day to day operational pressures the Trust is now back in line with the trajectory for the year.

CQC Standards

WUTH continues to be compliant against all Care Quality Commission (CQC) checks. This position is reflected in the current ratings for Arrowe Park and Clatterbridge Hospitals on the CQC website.

Compliance Rating

WUTH will be rated neither Green nor Red for Q1 under Monitor's Risk Assessment Framework. The rating will be described as "Issues Identified" by Monitor.

Governance Information

Information relating to relevant election results will be updated to Monitor separately.

Finance Declaration

The Trust has submitted a 2 year operational plan showing a deficit for 2014/15 and 2015/16 and a resulting COS rating over this period of 2. Therefore the Board cannot confirm the finance governance statement that "The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months".

3. KEY ISSUES

Quarter 1 2014/15 Financial Commentary for Monitor

The following commentary covers the key reasons for the Q1 variations against the 2014/15 plan.

The financial position of the Trust shows a year to date deficit of £3.4m against the planned deficit of £3.1m, therefore an adverse variance of £0.3m.

NHS Clinical Revenue

To Q1 there is a gain of £0.3m against planned levels.

Key variances for Q1 are as follows:

Point of Delivery	Cum variance to plan £m	Commentary
Day case	0.5	On a cumulative basis there has been an over-performance in Gastroenterology (£0.3m) and Cardiology (£0.1m), Clinical Hematology (£0.1m) and Vascular (£0.2m) partly offset by underperformances in Ophthalmology and Trauma & Orthopedics of £0.1m each. In month the £0.2m gain was generated principally by Gastroenterology and Vascular Surgery.
Elective	(0.1)	On a cumulative basis the majority of the variance is caused by an underperformance in Surgical specialties of £177k, partly offset by an over performance in Medicine of £72k. In month there was an underperformance of £0.3m mostly caused by underperformances in Trauma & Orthopedics and Breast Surgery.
Non Elective	0.8	Over performance in Medicine & Acute continues across specialties (£0.4m) and also in Women's and Children's by £0.2m with a small underperformance in Surgery. There is a £0.1m reduction for activity over and above the non elective block which is more than offset by the readmission cap and other income risk adjustments totaling £0.4m. In month the £0.3m gain reflects the fact that Medicine continues to improve and Women's and Children's regained some of the previous month's underperformance with a significant over performance in the number of actual deliveries.
Outpatients	(0.1)	Outpatient procedures are cumulatively above plan by £42k, within this there is a number of low value under and over performances. Outpatient Attendances (both first and follow up) are continuing to underperform across most specialties with a

		total value of £0.2m. The key areas of concern are Cardiology, Gastroenterology, Ophthalmology and Trauma & Orthopedics. Included in this total is a reduction of £0.2m for the outpatient follow up cap, which represents approximately 2,215 attendances which the Trust is not paid for, discussions continue with the CCG on patient pathway changes to abate these penalties. In month the £0.1m gain was due to several small variances.
A&E	(0.2)	This area continues to over perform due to increased activity, but is offset by a penalty for activity that has breached the 4 hour wait threshold. This trend continued in month.
Other - tariff	(0.1)	The year to date underperformance on Unbundled Diagnostic Imaging of £0.1m is marginally offset by some smaller over performances. There was little in month variance.
Other non tariff	(0.5)	On a cumulative basis there are over performances in Direct Access Radiology (£0.2m) and Pathology (£0.1m) and Critical Care (£0.1m) offset by under recoveries for Rehabilitation (£0.1m), Renal (£0.1m) and Critical Care (£0.2m) and AMD (£0.2m). There is also an under recovery of High Cost Drugs and other pass through costs which is offset by lower spend. The balance comprises a number of smaller variances. In month the £0.1m variance is primarily generated by over recovery of Direct Access Radiology and Critical Care (Neonatal).
Total	**0.3**	

Included in the above figures is a £0.3m increase in income due to income generation schemes across a range of points of delivery. This is £0.1m behind planned levels.

Contractual status

The Trust can confirm that it has it has now agreed and signed finance and activity figures with its main commissioners Wirral CCG and NHS England – as at 30 June 2014. Associate signatures are being collated. Full document sign off is being coordinated and is expected imminently.

Other Income and Operating Expenditure

These net costs are above plan at Q1 by £0.6m. The key elements are:

Reason for variance	Cum variance to plan £m	Commentary
Cost Improvement Plan (CIP) delivery	(0.8)	At the outset of the year, it was recognized that not all the recurring and cash CIP schemes would be implemented and delivered from the start of the year, as noted in more detail below. The consequence of this is that cash slippage for the year against the CIP and cost avoidance plan for divisional

		expenditure and income (net of costs of delivery) is £0.8m, across most cost categories.
Reserves release	1.7	As at month 3 the Trust has released £1.7m of reserves. The current full year level of reserves available for release is circ. £4.7m. In month only £250k of reserves were released which was considerably lower than in previous months.
Emergency care	(0.4)	This variance has increased by £0.1m in month.
Unplanned beds / capacity	(0.2)	This variance has only increased marginally in month as the Trust has reduced capacity and associated costs in bed stock to support unplanned care.
Premium costs	(0.5)	Planned and unplanned activity at premium prices. This has increased by £0.1m in month and largely relates to gastro services where planned over recovery of income off sets this cost.
Non PBR offset	0.1	There has been an underspend of over £0.1m on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions). There has been an increase of just under £0.1m in month in this variance.
Other	(0.5)	There has been a year to date overspend of £0.5m on "other" expenditure / loss of income such as specialling, sickness and maternity cover, loss of private patient income etc.
Total	**(0.6)**	

Overall there has been a fall in the level of overspend in month 3, therefore the Trust has had to apply lower levels of reserve support. In particular the pay costs for the month were lower that that of month 2 and the average for the preceding periods.

Achievement of the 2014/15 Cost Improvement Programme

£13.0m of CIP was extracted from the budget at the start of the year. Identified CIP plans (c£8.5m) were extracted according to the profile of the schemes identified (including cost avoidance), with the balance extracted in a flat profile (12 ths). At the time of the plan the balance was £4.5m so under £0.4m was unidentified each month.

To date schemes have delivered £1.2m (net of costs of delivery). Of this £0.3m is within Income Generation schemes and £0.9m within Cost Improvement schemes, including cost avoidance.

Therefore there is slippage of £0.9m against the year to date target of £2.1m. Total delivery against planned schemes was on target and some shortfall had been expected against plans. Template figures have been adjusted to reflect any non recurrent savings to date.

In year CIP delivery (including Income Generation schemes and cost avoidance) currently forecast to be £9.7m which exceeds the schemes identified at the time of the plan by £1.1m. This is due to further schemes being identified across the Workforce and Technology for Transformation schemes which have now been included in the forecast. The Trust recognizes that it needs to increase its in year delivery further to support the financial position.

The schemes identified have a recurrent value of £14.3m which exceeds the annual target of £13m.

The appointment of an external support team (Atkins FTI) is expected to further add to in year opportunities and delivery of CIP to help close the gap between forecast outturn and

target. The team started on site on 7th July. A Transformation Steering Group has now been set up with the objective of leading a programme of major transformational change and supporting the cost efficiency programme.

EBITDA

The favourable NHS clinical variance and the operational adverse variance therefore give an unfavourable Q1 EBITDA variance of £0.3m.

Post EBITDA Items

There is little variance to the post EBITDA budget at Q1.

Latest Trust Forecast

The Trust has undertaken a reforecast exercise as at Q1. The results of this commentary are to be included following discussion at Finance, Business Performance and Assurance Committee.

Statement of Position (Balance Sheet)

The actual Total Assets Employed and Total Taxpayers Equity equal £148.7m.

The main variations against plan are as follows:

- Overall NHS / non NHS receivables are slightly above plan. Although some debtors have paid early there is a £1.0m balance for maternity prepayment which has not yet been settled and is offset by a corresponding increase in creditors. In addition, there are now debtor balances for over performance to date.

- The imminent sale of the Springview building has been included as a current debtor under “assets for sale” at £2.4m and therefore long term NHS trade receivables are lower than planned.

- Trade creditors differ significantly from plan due to the timing of charges received, the offset for the maternity prepayment, some balances due to underperformance and timing of commissioner receipts and the increase in expenditure.

- Capital spend (on an accruals basis) for the year was £4.1m against a plan of £5.1m. Full details are given below.

- The cash balance at the end of Q1 was £11.3m being £5.6m above the planned £5.7m. As noted above the key reasons are the timing of charges received and paid, slippage on the capital programme and early receipt of debtors.

Capital spend and reforecast

The level of capital spend for the year to date of the year was £4.1m against a plan of £5.1m. The key reasons for the variance to date are the decision to lease (rather than purchase) a key piece of equipment (£0.6m), small slippage on the Cerner plan (£0.2m offset by lower Public Dividend Capital drawn down), a £0.3m underspend on general IT spend (due to timing) and minor variances on other schemes which are due to timing differences.

This variance means that the capital expenditure is outside the tolerance levels for the annual planning process and a reforecast therefore been included within the Q1 submission template.

The revised forecast has been compiled with engagement with capital budget holders and contains the following key differences:

- the above decision to lease equipment rather than purchasing which moves general equipment spend into the latter half of the year.
- the re profiling of the general IT capital spend towards the second half of the year due to the prioritisation of the tender for the wireless system
- the re profiling of the additional Cerner spend generated by the award of the £3.5m of PDC following more detailed discussions with Cerner regarding implementation planning. Resource and spend are now profiled more heavily in the second half of the year.

The overall impact being £1.3m of spend moving to the second half of the year.

The declaration to support the Capital reforecast is detailed in Appendix 6 and the Monitor return.

Continuity of Service Rating (COS) & Certification

The Trust has achieved a COS rating of 2 against a planned rating of 2.

The Capital Servicing Capacity (CSC) metric is lower than planned due to the fall in the EBITDA achieved against plan.

The Trust had a lower opening liquidity position than planned and the fall in this year's EBITDA levels has reduced liquidity further. However, this has been offset by slippage in the capital programme and other balance sheet movements.

The Trust has submitted an operational 2 year plan showing a deficit for 2014/15 and 2015/16 and a resulting COS rating over this period of 2. Therefore the Board cannot confirm the financial governance statement that "The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months".

Cash and Liquidity measures

The Trust is continuing to implement the internal actions identified from the external review by KPMG. This has had a significant impact on the average daily cash balance, although not all actions cause month end cash levels to increase.

The Trust has started the second stage of the programme with KPMG, with the external validation of these actions, the implementation of a detailed 13 week rolling cash forecast and the creation of a cash group, (which includes operational representation) to run the model on a regular basis.

The Trust is also continuing to progress the agreement of an overdraft facility with Barclays.

These actions will increase or support the cash position of the Trust but will not impact on its liquidity.

The Trust had planned to sell one of its buildings ("Springview") to Cheshire and Wirral Partnership Trust in August 2014. This sale has slipped and therefore this will impact on the liquidity (and cash balances) of the Trust in the short term. The sale is expected to go ahead, at a greater value than that included in the plan, but the sale is now not expected until the Autumn.

The Trust is also exploring undertaking a loan with the Independent Trust Financing Facility (ITFF) in the range of £6.5m to £7.5m for 10 years to support the funding of its capital programme. Proposals and information have been submitted to the ITFF and the Trust expects to have a response to this proposal early in August 2014. The loan would also support the liquidity and cash position of the Trust.

There is a risk that the neither the sale of the building or the capital loan are in place at the end of month 5 and under these circumstances the Trust's COS rating would fall to a 1.

Validation Errors

All "validation errors" identified on the template have been reconciled and explained on the excel template.

Quality

Our Annual Plan identified four key risks to the quality of services provided by WUTH, each having a series of measures and controls and being considered areas for improvement.

The risks identified in the plan are:

(i) Insufficient capacity to manage patient demand
(ii) Achieving the Trust's transformation programme whilst improving patient safety, clinical effectiveness, and patient experience
(iii) Delivering care closer to home
(iv) Infection prevention and control

Access time targets for elective patients are consistently achieved at trust level. The additional activity to be undertaken in Q2 may result in a short-term deterioration of performance, but ultimately will provide a further improvement in patient waiting times. Increased patient demand on urgent care services is proving a considerable challenge to achieving the A&E 4-hour target and a joint recovery plan for the Wirral health economy is underway. The financial situation has been fully detailed earlier in this report. The Trust continues to explore opportunities with other local community hospitals and primary care partners for offering WUTH services 'closer to home' and away from the two main hospital sites. Infection prevention and control remains a top priority, and the Trust continues to work on implementing the recommendations of the Public Health England review in 2013/14.

Executive Team membership

There has been no change to the Executive Team membership in the quarter.

Conclusion

The Trust has faced a challenging start to the year. As the contract position is now finalised it can focus on delivering the planned activity and reducing the level of operational overspend.

The Trust recognizes that it has just met its annual plan for the quarter and that it has applied proportionately more reserve resource than expected to do so.

However, it is taking positive steps to address it's operational and CIP challenges through the engagement of external support, with them starting on site in early July. It is also addressing the cash and liquidity challenges through a series of actions including external validation of actions undertaken, the establishment of a cash group and the development of a 13 week cash forecasting model.

Alistair Mulvey
Director of Finance
July 2014

INCOME STATEMENT

APPENDIX 1

June Reporting - Income Statement

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan June 2014 Year to Date £m	Actual June 2014 Year to Date £m	Variance June 2014 Year to Date £m
Operating			
NHS Clinical Revenue			
Elective revenue, long stay:			
Tariff revenue	£5.924	£5.817	£(0.107)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£18.854	£19.693	£0.839
Planned same day (day case):			
Tariff revenue	£6.709	£7.237	£0.528
Outpatients:			
Tariff revenue	£8.681	£8.525	£(0.156)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£2.535	£2.342	£(0.193)
Other NHS Activity:			
Direct access & Op. all services (Tariff revenue)	£0.701	£0.556	£(0.145)
Maternity Pathway (Tariff revenue)	£1.526	£1.561	£0.035
CQUIN revenue (Non-Tariff revenue)	£1.289	£1.289	£0.000
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£1.070	£1.308	£0.238
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£2.993	£3.071	£0.078
High cost drugs revenue from commissioners (Non-Tariff revenue)	£2.209	£2.029	£(0.180)
Other drugs revenue (all types all bands including Chemotherapy) (Non-Tariff revenue)	£0.611	£0.653	£0.042
Other (Non-Tariff revenue)	£13.233	£12.579	£(0.654)
Total	**£66.335**	**£66.660**	**£0.325**
Non Mandatory / non protected revenue			
Private Patient revenue	£0.393	£0.212	£(0.181)
Other Non Mandatory / non protected clinical revenue	£0.366	£0.307	£(0.059)
Total	**£0.760**	**£0.519**	**£(0.241)**
Other operating income			
Research and Development income	£0.081	£0.125	£0.044
Education and Training income	£2.308	£2.330	£0.022
Donations & Grants received of PPE & intangible assets	£0.000	£0.000	£0.000
Donations & Grants received of cash to buy PPE & intangible assets	£0.000	£0.000	£0.000
Parking Income	£0.299	£0.318	£0.019
Catering Income	£0.488	£0.500	£0.012
Revenue from non-patient services to other bodies	£1.914	£2.136	£0.222
Misc. Other Operating Income	£1.337	£1.407	£0.070
Total	**£6.428**	**£6.816**	**£0.388**
Total Operating Income	**£73.523**	**£73.995**	**£0.472**
Operating Expenses			
Employee Benefits Expenses	£(52.108)	£(50.845)	£1.263
Employee Benefits Expenses - agency and contract staff	£0.000	£(2.042)	£(2.042)
Drug Costs	£(5.266)	£(4.956)	£0.310
Clinical Supplies and Services	£(7.528)	£(7.682)	£(0.154)
Non Clinical Supplies and Services	£(1.265)	£(1.435)	£(0.170)
Consultancy expense	£0.000	£(0.048)	£(0.048)
Movement of Impairment of receivables	£0.000	£0.072	£0.072
Misc other Operating expenses	£(7.099)	£(7.105)	£(0.006)
Total operating expenses	**£(73.267)**	**£(74.041)**	**£(0.774)**
EBITDA	**£0.256**	**£(0.046)**	**£(0.302)**
Non operating income and expense			
Interest income	£0.074	£0.076	£0.002
Interest expense on Non commercial borrowings	£(0.059)	£(0.057)	£0.002
Interest expense on finance leases	£(0.018)	£(0.019)	£(0.001)
Depreciation and amortisation - owned assets	£(1.996)	£(2.027)	£(0.031)
Depreciation and amortisation - donated assets	£(0.072)	£(0.049)	£0.023
Depreciation and amortisation - finance leases	£(0.072)	£(0.072)	£0.000
Other Finance Costs - Unwinding Discount	£(0.013)	£(0.013)	£(0.000)
PDC dividend expense	£(1.170)	£(1.170)	£(0.000)
Loss on asset disposal	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - purchased / constructed assets	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - donated / granted assets	£0.000	£0.000	£0.000
Net Surplus / (Deficit)	**£(3.070)**	**£(3.377)**	**£(0.307)**
Comprehensive income and expense			
Revaluation gains /(losses) of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Revaluation gains / (losses) of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Fair Value gains / (losses) straight to reserves	£0.000	£0.000	£0.000
Other recognised gains and losses	£0.000	£0.000	£0.000
Total comprehensive income and expense	**£(3.070)**	**£(3.377)**	**£(0.307)**

BALANCE SHEET

APPENDIX 2

June Reporting - Balance Sheet

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan June 2014 £m	Actual June 2014 £m	Variance June 2014 £m
Non current assets			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£12.282	£12.135	£(0.147)
Property, Plant and Equipmen - Donated or granted	£2.276	£2.332	£0.056
Property, Plant and Equipment - Purchased or constructe	£157.743	£157.056	£(0.687)
NHS Trade Receivables, Non-Current	£2.388	£0.000	£(2.388)
Other non current receivables	£2.134	£2.157	£0.023
Impairment of Receivables for Bad & doubtful debts	£(0.405)	£(0.224)	£0.181
Total non current assets	**£176.418**	**£173.456**	**£(2.962)**
Current Assets			
Inventories	£4.446	£4.278	£(0.168)
NHS Trade Receivables	£7.873	£7.861	£(0.012)
Non-NHS Trade Receivables	£1.052	£1.658	£0.606
Other Receivables	£1.724	£2.102	£0.378
Assets Held for Sale	£0.000	£2.435	£2.435
PDC Receivables	£0.000	£0.000	£0.000
Impairment of Receivables for Bad & doubtful debts	£(0.067)	£(0.468)	£(0.401)
Accrued Income	£1.394	£1.308	£(0.086)
Prepayments	£3.011	£2.315	£(0.696)
Cash and cash equivalents	£5.711	£11.293	£5.582
Total Current Assets	**£25.144**	**£32.782**	**£7.638**
Current liabilities			
Current loans	£(0.265)	£(0.265)	£0.000
Deferred income	£(2.333)	£(2.623)	£(0.290)
Provisions, current	£(0.745)	£(0.753)	£(0.008)
Trade Creditors	£(9.000)	£(14.094)	£(5.094)
Taxation payable	£(3.917)	£(3.847)	£0.070
Other Creditors	£(3.121)	£(3.205)	£(0.084)
Capital Creditors	£(1.100)	£(0.912)	£0.188
Accruals	£(9.101)	£(9.257)	£(0.156)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.334)	£(0.334)	£0.000
Interest payable on non commercial loans	£(0.059)	£(0.065)	£(0.006)
PDC creditor	£(1.170)	£(1.285)	£(0.115)
Total Current Liabilities	**£(32.045)**	**£(37.540)**	**£(5.495)**
Net Current Assets / (Liabilities)	**£(6.901)**	**£(4.758)**	**£2.143**
Liabilities, non current			
Loans, non current, non commercial	£(5.174)	£(5.174)	£0.000
Deferred income, non current	£(11.922)	£(11.922)	£0.000
Provisions for Liabilities and Charges	£(2.590)	£(2.580)	£0.010
Finance leases, non current	£(0.360)	£(0.360)	£0.000
	£(20.046)	**£(20.036)**	**£0.010**
Total Assets Employed	**£149.471**	**£148.662**	**£(0.809)**
Taxpayers equity			
Public Dividend Capital	£71.388	£71.100	£(0.288)
Retained earnings	£31.257	£30.508	£(0.749)
Revaluation reserve	£46.826	£47.054	£0.228
Total Taxpayers Equity	**£149.471**	**£148.662**	**£(0.809)**

CASHFLOW

APPENDIX 3

June Reporting - Cashflow

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan Year to Date June 2014 £m	Actual Year to Date June 2014 £m	Variance Year to Date June 2014 £m
Surplus/(deficit) after tax	**£(3.070)**	**£(3.377)**	**£(0.307)**
Finance income/charges	£0.003	£0.013	£0.010
Donations & Grants received of PPE & intangible assets (not cash)	£0.000	£0.000	£0.000
Other operating non-cash movements	£0.000	£0.000	£0.000
Depreciation and amortisation, total	£2.140	£2.148	£0.008
Impairment losses/(reversals)	£0.000	£0.000	£0.000
Gain/(loss) on disposal of property plant and equipment	£0.000	£0.000	£0.000
PDC dividend expense	£1.170	£1.170	£0.000
Other increases/(decreases) to reconcile to profit/(loss) from operations	£0.000	£0.000	£0.000
Non-cash flows in operating surplus/(deficit), Total	**£3.313**	**£3.331**	**£0.018**
Movement in Working Capital			
Inventories	£0.000	£(0.141)	£(0.141)
NHS Trade receivables	£0.770	£1.672	£0.902
Non NHS Trade receivables	£(0.070)	£(0.428)	£(0.358)
Other receivables	£(0.412)	£(0.234)	£0.178
Assets held for sale	£0.000	£(2.435)	£(2.435)
Accrued income	£(0.212)	£(0.045)	£0.167
Prepayments	£(1.431)	£(0.464)	£0.967
Deferred income	£(0.152)	£(0.034)	£0.118
Provisions for Liabilities and Charges	£0.030	£0.018	£(0.012)
Tax payable	£(0.001)	£(0.029)	£(0.028)
Trade Payables	£(0.554)	£1.904	£2.458
Other Payables	£(0.021)	£0.445	£0.466
Payment on Account	£0.000	£0.000	£0.000
Accruals	£0.465	£1.113	£0.648
	£(1.588)	**£1.342**	**£2.930**
Net cash inflow / (outflow) from operating activities	**£(1.345)**	**£1.296**	**£2.641**
Investing activities			
Property - new land, buildings or dwellings	£(0.550)	£(0.640)	£(0.090)
Property - maintenance expenditure	£(0.150)	£(0.249)	£(0.099)
Plant and equipment - Information Technology	£(0.619)	£(0.006)	£0.613
Plant and equipment - Other	£(0.664)	£(0.038)	£0.626
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(3.103)	£(3.183)	£(0.080)
Increase/(decrease) in Capital Creditors	£(0.501)	£(0.451)	£0.050
	£(5.587)	**£(4.567)**	**£1.020**
Net cash inflow / (outflow) before financing	**£(6.932)**	**£(3.271)**	**£3.660**
Financing activities			
Public Dividend Capital received	£2.503	£2.215	£(0.288)
Public Dividend Capital paid	£0.000	£0.000	£0.000
Interest (Paid) on non commercial loans	£0.000	£0.000	£0.000
Interest element of finance lease rental payments	£(0.018)	£(0.019)	£(0.001)
Capital element of finance lease rental payments	£(0.081)	£(0.081)	£0.000
Interest (Paid) / Received on cash and cash equivalents	£0.074	£0.075	£0.001
Drawdown of non commercial loans	£0.000	£0.000	£0.000
Repayment of non commercial loans	£0.000	£0.000	£0.000
Non current receivables	£0.012	£2.340	£2.328
Other Non current receivables	£0.000	£0.000	£0.000
Other cash flows from financing activities	£0.000	£0.000	£0.000
Net increase / (decrease) in cash and cash equivalents	**£(4.442)**	**£1.259**	**£5.700**
Opening cash and cash equivalents	£10.152	£10.034	£(0.118)
Net cash (outflow) / inflow	£(4.442)	£1.259	£5.700
Closing cash and cash equivalents	**£5.711**	**£11.293**	**£5.583**

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

Key Ratios / Risk Rating 2014/15

Based on June 2014 Reported Performance

			Risk Rating			
Financial Criteria	**Weight %age**	**Metric to be scored**	**1**	**2**	**3**	**4**
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	<-14	-14	-7	0
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	<1.25 x	1.25	1.75	2.50

Wirral Hospital Position

Financial Criteria	**Weight %age**	**Metric to be scored**	**2014/15 ratings - Actual**		**2014/15 ratings - Plan**	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-13.94	**2**	-13.94	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	0.02	**1**	0.25	**1**
		Weighted average risk rating		**1.50**		**1.50**
		Overall Risk Rating		**2**		**2**

1. Introduction

Under the Provider Licence, the Trust is required to prepare and submit a quarterly return to Monitor detailing its financial and governance risk ratings.

The quarterly submission must be made to Monitor by 4 p.m. on 31st July 2014.

The Board is asked to review the assurances received in this report, as provided by the Director of Operations and Director of Finance respectively, and to self certify three statements as set out below.

2. Recommendation

It is recommended that the Board:

i) does not confirm for finance, that the Board anticipates the Trust will continue to maintain a Continuity of Service Rating of 3 over the next 12 months;

ii) does not confirm for governance that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework, and a commitment to comply with all known targets going forwards.

iii) otherwise confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 Diagram 8 and page 58 and the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

	For finance, that:	Board Response
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed

For governance, that:

11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed

Otherwise:

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	Confirmed

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	David Allison	Name	Alistair Mulvey
Capacity	Chief Executive	Capacity	Director of Finance
Date	30th July 2014	Date	30th July 2014

0

Notes: *Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.*

In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A: The Trust has submitted a 2 year operational plan showing a deficit for 2014/15 and 2015/16 and a resulting COS rating over this period of 2. Therefore the Board cannot confirm that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

B: 1. Having failed the A&E target for Q4 the Trust identified in its Annual Plan submission the continued risk to this target, and performance for Q1 was below the 95% standard. An Urgent Care Recovery Plan has been jointly agreed across the health economy, and the actions are well underway, with external support from the Utilisation Management Team. Whilst the Board of Directors are assured that the internal and external plans are being implemented, demand on the Trust's urgent care services continue to rise, and this remains a risk to the achievement of the A&E standard for Q2. 2. NHS England have commissioned additional elective activity across the country to reduce waiting times further and ensure the NHS as a whole returns to achieving, and consistently maintains, the 18 week Referral to Treatment standard. The additional long-waiting activity WUTH has been commissioned to deliver in Q2 may result in the Trust not achieving the RTT threshold standards for the quarter. NHS England and local commissioners have accepted this will be taken into account when assessing Q2 performance on RTT, however at present Monitor are not relaxing their Risk Assessment Framework targets in this area.

C:

1. Introduction

Where year to date capital expenditure is less that 85% or greater than 115% of levels in the latest annual plan, an NHS Foundation Trust must submit a capital expenditure reforecast for the remainder of the year as part of the Q1 return.

The Board is asked to review the assurances received in this report, as provided by the Director of Finance, and to agree the statement below.

Recommendation

It is recommended that the Board declares that it anticipates that the Trusts capital expenditure for the remainder of the financial year will not materially differ from the reforecast plan.

Capital Expenditure Declaration for Wirral University Teaching Hospital

Where year-to-date capital expenditure is less than 85% or greater than 115% of levels in the latest annual plan (or any later capital expenditure reforecast) an NHS foundation trust must submit a capital expenditure reforecast for the remainder of the year. This is set out at the bottom of page 22 of the Risk Assessment Framework issued by Monitor April 2014.

If you have triggered one of these criteria (see worksheet "Capex Reforecast Trigger") then you must complete the worksheet "Capex Reforecast" and sign one and only one of the declarations below. If you have not triggered one of these criteria then please do not input into this worksheet and the worksheet "Capex Reforecast" at all.

Declaration 1

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the attached reforecast plan.

Signed: 

On behalf of the Board of Directors

Acting in Capacity as: Director of Finance

Declaration 2

The Board cannot make Declaration 1 and has provided relevant details on documents accompanying this return.

Signed:

On behalf of the Board of Directors

Acting in Capacity as: [job title here]

Note: Monitor will accept either an electronic signature or a hand written signature on this declaration

Board of Directors		
Agenda Item	**7.2**	
Title of Report:	**External Assessment – Q4 Letter from Monitor 2013/14**	
Date of Meeting:	**30th July 2014**	
Accountable Executive :	**David Allison. Chief Executive**	
Corporate Objective Ref as outlined in the BAF	**13,14**	
Level of Assurance		**Board Confirmation**
Data Quality Rating	**Gold – externally validate**	
FOI status :	**Document may be disclosed in full**	

1. **Executive Summary**

   The following external assessments are presented to the Board for information:

   Q4 letter from Monitor 2013/14

   - The continuity of services risk rating – CoSRR 3
   - Governance Risk Rating – GREEN

   2014/15 Annual Plan review

   - The Trust will remain on monthly financial monitoring until such time that it can deliver a sustainable CoSRR 3
   - The Trust is progressing with the additional items required from the Trust with the exception of the re-submission of the 2015/16 plan as agreed at the June Board of Directors Meeting.

2. Recommendations

   The Board is asked to receive and note the external assessment.

6 June 2014

Mr David Allison,
Chief Executive
Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

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Dear David

Q4 2013/14 monitoring and 2014/15 annual plan review of NHS foundation trusts

I am writing to you in respect of our review of the two year operational plan phase of the 2014/15 annual plan review (APR) as well as the Q4 2013/14 monitoring cycle.

The purpose of Monitor's review of operational plans is to assess whether foundation trusts (FTs) are effectively planning for the future while maintaining and improving quality. This enables Monitor to make a more informed judgement about future risks to the Trust's compliance with its licence conditions.

Under the APR process all FTs are subject to high-level review of two-year operational plans. Following this, and alongside our Q4 monitoring, Monitor determines if a change in regulatory approach is required on a trust by trust basis. This may include specific planning focused actions[1] or Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[2] and the Risk Assessment Framework[3].

As set out in our letter dated 16 May 2014[4], at an aggregate level, Monitor's review has highlighted significant concerns about the quality of the sector's planning, particularly that year two of the plans may, on aggregate, be overly optimistic. We ask that you bear this in mind when completing your strategic plan.

In addition, where Monitor has identified specific weakness in individual plans we may ask individual FTs to resubmit their plans as part of the strategic plan submission.

[1] Please see section 2.5 of Monitor's Annual plan review 2014/15 guidance
[2] www.monitor-nhsft.gov.uk/node/2622
[3] www.monitor.gov.uk/raf
[4] APR update letter 16 May 2014

Risk ratings

Monitor has now completed the review of your two-year operational plans[5] and Q4 submissions.

Based on this work, the current and forecast risk ratings are:

	Q4 13/14 (actual)	Q1 14/15 (plan)	Q2 14/15 (plan)	Q3 14/15 (plan)	Q4 14/15 (plan)
Continuity of service risk rating	3	2	2	2	2

Governance risk rating	Green

The governance rating represents Monitor's current view of governance at the Trust. The Trust therefore has a single rating.

These ratings will be published on Monitor's website in June. We would emphasise that the forecast continuity of service risk ratings are the FT's own risk ratings as submitted in the operational plan and as such are never adjusted by Monitor.

The Trust has been assigned a Green governance risk rating but has failed to meet the A&E 4 hour wait target in Q4 2013/14.

Monitor uses the above target (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence.

We expect the Trust to address the issues leading to the target failure and achieve sustainable compliance with the target promptly. Monitor does not intend to take any further action at this stage, however should these issues not be addressed promptly and effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

We have identified specific concerns in respect of your operational plan for 2014/15 and 2015/16:

- The Trust forecasts a Continuity of Services Risk Rating (CoSRR) of 2 in every quarter of its two-year operational plan;
- The forecast cash position appears very low for the size of Trust (£4.3m in 2015/16 compared to c. £300m turnover) and this forecast cash position is partly reliant on sale of property in 2014/15. Liquidity starts off weak (metric = 2) and deteriorates during the plan (metric = 1), although liquidity days stabilise in 2015/16. We note that the Trust has yet to incorporate any liquidity benefit arising from implementing the

[5] Please note that these findings are interim as we consider both the operational and strategic plans part of the same process. As previously communicated in our guidance, final APR findings will be provided to FTs in October 2014 following review of the five-year strategic plan submissions.

recommendations from KPMG's review of cash management in its two-year operational plan;
- The Trust's 2014/15 plan includes contingency of c. £3m, which could be used to mitigate risks to income and expenditure, but the Trust has stated that it would struggle to mitigate financial risks above £3m. Some flexibility has been noted in the Trust's capital scheme, especially in relation to funding options. The latter is not, however, sufficient though to drive improvements in liquidity; and
- The Trust has made some progress in developing CIPs but an external review by KPMG has highlighted that the Trust has to do more to identify CIPs sufficient to deliver its two-year operational plan and it needs to significantly improve its financial governance, such that the link between the central finance team and divisions allows robust reporting and that the Board has sufficient assurance that underlying budgets are accurate.

We closed the investigation into the Trust's finances on 5 March 2014 due to the Trust outlining that it would achieve CoSRR 3 from Q1 2014/15 and agreeing to:

- Obtaining external assurance over its 2014/15 financial plan;
- Implementing the recommendations from KPMG's Root Cause Analysis review and Cash Management review; and
- Obtaining external assurance that the above have been effectively implemented.

We are concerned that the Trust has lacked pace in implementing some of the recommendations from these external reviews, which revealed a number of significant concerns around financial governance and lack of pace of CIP development, and that the plan shows a significantly worse financial position than that articulated by the Trust at the investigation meeting. This leads us to be concerned that the Trust may not have sufficient capacity and capability to address these finance concerns and/or to implement the recommendations from its external reviews with sufficient pace.

However, we are pleased to note that the Trust is currently tendering for additional external support being:

- Financial governance and reporting review;
- Support in developing a 13-week cash flow forecasting model; and
- Transformational turnaround support to help the Trust to deliver its two-year operational plan.

Therefore, we are not taking formal regulatory action at this time. However the Trust will remain on monthly financial monitoring until such time that it can deliver a sustainable CoSRR 3.

Additionally, we require the Trust to:

- Consider re-submitting its 2015/16 financial plan, as part of the next APR submission, given the concerns raised by KPMG over the lack of Board visibility of the Trust's financial plans until a late stage of the approval process and Monitor's concerns over the achievability of 2015/16 financial plans, especially those forecasting an increased surplus, as outlined earlier in this letter;

- Implement the recommendations of KPMG's cash management review with pace to address the low liquidity levels as outlined in the Trust's two-year operational plan, including showing the impact in the next APR submission; and
- Submit to Monitor the outputs of the additional pieces of external support as outlined above, including monthly progress updates.

As we discussed in our call to you on 22 May 2014, we remain very concerned about the financial outlook for the Trust and we may decide to re-open the investigation into the Trust's finances should we become concerned that:

- The Trust report's financial performance significantly below plan, especially in relation to cash and liquidity; and
- Should there be adverse findings from the financial governance review being commissioned by the Trust or significant concerns arise over the pace of implementation of existing external review recommendations.

Next steps

A report on the FT sector aggregate performance from Q4 2013/14 will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the FT sector from the Q4 and APR monitoring cycle.

We will also publish on our website, under your entry in the Public Register of NHS foundation trusts, the commentary/summary document of the operational plan excluding any appendices in a similar format to previous years.

Please note that as previously communicated in April's FT bulletin[6] we are not attaching an executive summary of our quarterly review as we have done previously.

If you have any queries relating to the above, please contact me by telephone on 02037470352 or by email (Tania.Openshaw@monitor.gov.uk).

Yours sincerely

Tania Openshaw
Senior Regional Manager

cc: Mr Michael Carr, Chairman
Mr Alistair Mulvey, Director of Finance

[6] FT Bulletin April 2014

Board of Directors		
Agenda Item	**7.3**	
Title of Report:	**Health & Safety Quarterly Update**	
Date of Meeting:	**30th July 2014**	
Author:	**Peter Bohan, Head of Organisational Health & Effectiveness** **James Mawrey, Associate Director of Human Resources & Organisational Development**	
Accountable Executive :	**Anthony Hassall, Executive Director of Strategy & Partnerships** **David Allison, Chief Executive Officer**	
Link to Corporate Objectives	• To be the top NHS Hospital Trust in the North West for patient, customer and staff satisfaction • Ensuring our people are aligned with our Vision	
BAF Reference	**1,2,5,12**	
Level of Assurance		**Board Confirmation**
Data Quality Rating		
FOI status :	**Document may be disclosed in full**	

Executive Summary

1. There have been positive developments in the management of Health and Safety across the Trust during this quarter, with the Health & Safety (H&S) Team continuing to work on all key areas of compliance of systems and processes since the last report to the Board in April 2014. There remains work to do in a number of areas and plans are being progressed.

2. There has been a decrease in employee incidents during the reporting period and RIDDOR incidents reported have decreased from 12 in Quarter 4 to 7 Quarter 1. The Health and Safety Partnership Team (HSPT) ensures that external reports and risks relating to safety are assessed by the Health & Safety Partnership Group.

3. With the Executive Director of Strategy and Partnerships now overseeing the agenda, the Health and Safety Partnership Group (HSPG) will be restructured to maintain a much more strategic focus. Revisions to the governance and assurance process for Health & Safety have been refined and the details of this are set out in the paper.

4. The bi-monthly meetings of the HSPT have contributed to raising the profile of Health and Safety across the Trust. Mandatory Health and Safety training

compliance has increased from 92.92% Quarter 4 to 93.76% Quarter 1 with the target for compliance being 95%. The focus of Health and Safety training has been streamlined.

5. The Trust Board is asked to:
    a. Note the details of the Report.
    b. Highlight any specific additional assurance / information required.

Employee Incidents

1. A total of 233 employee accidents were recorded during Q1 2014/15, compared with 385 reported in Q1 2013-14, representing a decrease of 39%. Of the incidents reported by employees the top three categories reported were: Disruptive / Aggressive behavior, Manual Handling and injuries as a result of staff using clinical sharps.

   There has been a decrease in the number of physical assaults when compared to the same period in the previous year. Specifically 28 physical assaults were recorded during Quarter 1 2014/15 compared with 40 in 2013/2014, however there was a rise in assaults on staff from 22 in Quarter 4 2013/14 to 24 in Quarter 1 2014/15 of these the majority were carried out by patients due to their clinical condition, a further 2 were carried out by visitors. Audits have been undertaken to ensure all risk assessments were in place and actions arising are being implemented.

Incident Reporting RIDDOR

1. The Health & Safety team is responsible for ensuring incidents are logged onto the Safeguard system database in accordance with the Trust's Incident & Serious Incidents Management policy. Improvements to online reporting of incidents has generally been very successful in the Trust allowing staff to report incidents in real time and making the process much more refined and economic. There are issues that still require addressing in relation to web reporting, accessing the system and issues regarding the design which are being managed through monitoring of the system reports and improved training for both staff and managers.

2. The Trust is required to report specific incidents to the HSE in accordance with the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013. There were 7 RIDDOR reportable incidents reported to the HSE during Q1 2014-15 and quarter 1 2013/14 were 9, all of which were subject to a root cause analysis (RCA) investigation.

Health & Safety Inspections

1. The HSE stipulates that all areas of the Trust must be subjected to Health and Safety Inspections on a regular basis. The Health & Safety Inspections checklist is available on the Health and Safety intranet for staff to conduct their inspections. Inspections are undertaken on a quarterly basis.

2. Quarter one 2014-15 training provided by the Health and Safety Team was as follows:

Training description	Number of sessions
Induction Presentation - Health and Safety	3
Induction Presentation - Inanimate Loads	3
Induction - People Handling	4
Mandatory Training Presentation – Manual Handling	12
Mandatory Training – People Handling	24
Mandatory Practical Training for W&C	6
Link Training	3

*Please note the above includes training provided by the Health & Safety Team, there are of course further training programmes that are supplied by infection control and security management team. If required this can be included in future reports.

3. The Health & Safety Executive will be visiting the Trust on the 8th August 2014 to investigate a needle stick injury to a member of staff in A&E from a patient with Hepatitis C. The organization has a robust reporting regime and the incident was reported to the HSE in accordance with the Reporting of Injuries Diseases and Dangerous Occurrence Regulations. The initial inquiry by the HSE will determine if process and systems to manage high risk patients are in place and compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013. They have asked to speak to the Staff Side Representatives, Head of Procurement, Head of Phlebotomy, Clinical Skills Manager, H&S Team and the responsible board level Director for H&S (Director of Strategy & Partnerships). There is currently a thorough Root Cause Analysis being carried out and will be provided to the Health & Safety Executive prior to the visit. Although the HSE's visit will focus on the needlestick incident they have stipulated that they may look at other topics of interest whilst on site during their visit. A process is in place to prepare for this visit.

Health & Safety Key Issues / Update

1. The main regulatory updates during this quarter arose out of several consultations and audits that commenced during the reporting period, which have fallen out of the previously initiated review of compliance with Health and Safety legislation and guidance. These are:

1. An external review – The Clearwater Report - of Legionella Management and control at both Arrowe Park and Clatterbridge Sites.

   The Legionella review received in the Trust in June 2014 has highlighted a number of risks that require completing and a risk has been placed on the risk register with specific actions to be completed. The existing action plan for the Legionella risk is being expanded to reflect issues identified following the review and this is being led by the Director of Estates with support from the Head of Organisational Health and Effectiveness.

   The Chief Executive has asked for a summary of the report, action plan and lead responsible officer for each action to be monitored through the Health and Safety Group and for an update to be provided to Executives in August. A work plan to remove flexible hoses has been developed with funding being made available to identify dead legs in the systems. As areas of the Trust are refurbished the management of legionella is reviewed and action taken to ensure pipework is replaced.
2. A review of asbestos management has highlighted the need for additional management surveys to be undertaken to provide a baseline for asbestos management throughout all premises. The tender process has

begun with an assessment of the competence of surveyors to be undertaken by the 1st August, the detail of work plan will be placed on the risk register and centrally monitored, a specific timeline is provided within Appendix 1**.**

The post graduate Centre on the Clatterbridge site, requires the asbestos to be managed and removed. The Estates department will inform the Trustees about the asbestos and inform them it is their duty to procure a competent contractor to remove the Asbestos as this may pose a risk to maintenance staff.

3. The workplace transport risks particularly in the delivery area at Arrowe Park Hospital require specific actions which have been placed on the risk register with specific timeframes. A capital bid is being developed and intermediate work has been undertaken.
4. A review of roof edge protection has been undertaken and a capital bid of £84k funding was approved at the July 2014 Capital Monitoring Group. A prioritized program has been agreed between Estates and Health & Safety team to identify and understand the frequency of access to high risk areas. Specific risk assessments are now routinely undertaken to protect staff and contractors by the Estates team where edge protection is not available.
5. There are currently generic risk assessments in place for work at height. The Maintenance Manager has advised all staff / contractors (in writing) not to work within 2 meters of edges and fragile roofs.
6. Further information on guard rails has been provided and a plan has been developed to review guard rails, with high risk areas being targeted.
7. Stress is a major concern with a significant number of stress related absences being evidenced in sickness data. The Trust will ensure the Stress Policy/Risk assessment and actions are being evaluated and implemented. A Standard Operating Procedure (SOP) is developed in compliance with the HSE management standards, with its statutory health & safety obligations and duties.

Health & Safety Team Activity

1. Training on Corporate Manslaughter & Homicide Act 2007 - The Trust's roll out programme has begun and details that all Band 8B and above must attend these training sessions. A communication plan has been developed via the Communications Team to ensure improved / maximum take up.

2. Three policies have been completed in June which include COSHH, Control of Contractors (non-notifiable projects), and Electrical Safety. Work continues on all other policies and the Health & Safety team is making good progress in these.

3. Health & Safety audits are already planned for September 2014 with key services piloted prior to launch.

4. Health surveillance for specific work activities has progressed. For example the Occupational Health Physician has reviewed the risk of maintenance staff developing vibration white finger (VWF). Estates will be assessing the vibration level of equipment.

5. Additional surveillance has taken place for staff using COSHH products with exposure limits within endoscopy and consideration of current control measures for the quality of maintenance of extraction systems and Personal Protective Equipment provided.

6. The Associate Director of Human Resources & Organisational Development and the Head of Organisational Health & Effectiveness have initiated several strategic work streams during this quarter in response to emerging concerns reported to the Health & Safety Partnership Team. For example the Listening into Action action event that focused on the wellbeing agenda and specifically stress.

7. The Associate Director of Human Resources & Organisational Development and the Head of Organisational Health and Effectiveness have developed and documented the Trust's Flu Vaccination Programme for Winter 2014 / 2014 which will be agreed by the Workforce & Communication Group on 1st August, 2014.

Strengthening Governance and Assurance

1. In order to align Health and Safety Reporting with the schedule of Health and Safety Forum meetings, the Board is asked to note a revised programme of reporting which will be then be reflected in the Trust Board's Cycle of Business.

2. Health and Safety reporting to the Trust Board:-
    - Annual Health & Safety Report submitted in April, 2014
    - Update Report July 2014
    - Update Report November 2014
    - Update Report January 2015
    - Annual Health & Safety Report April 2015
    - Quarterly Update Reports throughout 2015 / 2016

    If issues need to be brought to the attention of the Board more urgently, this will be managed through the agenda setting process in discussion with the Chairman and Chief Executive.

3. The Health and Safety Partnership Team will continue to meet on a bi-monthly basis to review pertinent health and safety issues within the Trust. The Group has previously lacked Executive attendance and to remedy this the Group will now be chaired by the Director of Strategy & Partnerships and report directly to the Risk Management Group and the Workforce & Communication Group (ensuring vertical alignment to the Quality & Safety Committee and ultimately Trust Board). Attendance from the Estates department and Divisional Management will be reviewed by the Executive Director with overall responsibility.

4. From September, 2014 the Quality & Safety Committee will receive a regular Health & Safety Update report. This will be a separate report focusing on Health & Safety matters (out-with the regular Workforce Dashboard report).

Conclusion & Summary

1. The documented system has been improved considerably with all previous red risks now having policies in place, further work is required on implementation and escalation and communication of safety information. Risks including asbestos that have been externally assessed will be entered on the risk register to be centrally monitored along with stress and legionella. The action plan (Appendix 1) is being regularly updated and will be monitored through the Health and Safety Group to ensure incremental improvements in compliance.

2. The improved governance and assurance processes outlined in this document are intended to provide the Trust Board with an improved level of

assurance as to the rigor being placed on the Health & Safety agenda. Focus will continue on this agenda going forward.

Recommendations

1. The Trust Board is asked to:
   - Note the details of the Report
   - Highlight any specific additional assurance / information required.

Appendix 1

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
Corporate Manslaughter & Corporate Homicide Act 2007	There was no policy covering Corporate Manslaughter & Corporate Homicide Act within the Trust	Existing Health & Safety Policy 118 to be updated to reflect Corporate Manslaughter and Corporate Homicide Act	A Haynes	31-01-14	14-02-14	Policy 118 updated	Compliant	Compliant
Corporate Manslaughter & Corporate Homicide Act 2007	There was no signed statement of intent within the existing Health & Safety Policy 118	Existing Health & Safety Policy 118 to be updated with signed statement of intent	A Haynes	31-01-14	Signed 25-02-14	Statement of intent included within revised Policy 118 has been signed	Compliant	Compliant
Corporate Manslaughter & Corporate	The Board had not received training on the	Board require training covering	P Bohan	31-01-14	26-03-14.	A training presentation has been	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
Homicide Act 2007	requirement of Corporate Manslaughter & Corporate Homicide Act 2007.	Corporate Manslaughter & Corporate Homicide Act 2007				completed 26th March to Board members. Training dates for staff 8B and above have been set for the next 6 months.		
Corporate Manslaughter & Corporate Homicide Act 2007	The Trust had no Health & Safety Strategy in place	Health & Safety Strategy to be developed and implemented	P Bohan	31-03-14	Accepted 25-2-14	Health & Safety Strategy has been developed and has been signed by the CEO. The Trust Board will be kept informed on a quarterly basis on progress with H&S Matters via the Quality & Safety committee.	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	The Trust had no policy covering all the requirements of the Control of Substances	A policy detailing the requirements of COSHH will be developed	A Haynes	28-02-14	14-02-14	A COSHH policy has been approved in accordance with Trust procedure.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	Hazardous to Health Regulations 2002							
Control of Substances Hazardous to Health Regulations 2002	Not all areas within the Trust are carrying out appropriate COSHH risk assessments	Appropriate COSHH assessments to be audited using H&SMF to ensure COSHH is implemented in service areas including facilities and estates.	A Haynes / D Hounslea	Revised to 31-08-14. Note the April Board paper detailed a due date of 31.05.14. By this date all staff were seen by however following these assessments it was recognized that further specialist advice regarding sensitization was needed for some staff. These will be completed by the revised due date.		An Occupational Health & Safety framework has been developed and includes a section on COSHH. A number of site visits have taken place to evaluate current control measures. Staff members have been referred to Occupational Health for surveillance where necessary they will be referred to the Occupational Health Physician.	Partial Compliant	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
						Contact has been made with the manufacturer to determine if alternative products are available.		
Control of Substances Hazardous to Health Regulations 2002	The Trust was not carrying out appropriate Health Surveillance for VWF, Noise, night work, latex & pesticide.	An Occupational Health & Safety Policy will be developed	P Bohan	31-05-14	25-05-14	The process for undertaking Health surveillance for grounds maintenance is complete along with a policy. Further work is required to complete all aspects of health surveillance identified through the risk assessment process.	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	The Trusts Control of Legionellosis Policy does not reflect recent HSE	The Trusts Control of Legionellosis Policy requires updating to reflect recent	D Hounslea / A Haynes	28-02-14	14-02-14	The Policy has been reviewed in line with latest guidance, to be updated to	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	guidance although it was reviewed in June 2013 and is in date	HSE guidance published Nov 2013				reflect latest guidance		
Control of Substances Hazardous to Health Regulations 2002	There are currently approx. 130 fire hose reels that are not flushed in accordance with legionella legislation or as they are not fitted with a double check valve	Clearwater to undertake bi-annual inspection as per plan to review monitoring of risks and flushing regime	D Hounslea	31-03-14	31-03-14	Clearwater have reviewed fire hoses and dead legs and provided a timescale for action. Flushing regime in place from Jan 2014 and specific risk assessment were put in place to reduce the risk of legionella.	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	There is a policy in place the bi-annual report by Clearwater will be undertaken to identify systems are in place for flushing and	The planned review of the Legionella management systems including the flushing regime and audit process will be carried out	D Hounslea	31-03-14	Review has been undertaken by Clearwater of the Clatterbridge and APH site.	Clearwater has identified a number of areas of risks that require action. The Chief Executive has asked for a full action plan and	Partial Compliance	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	water management.					summary to be presented through the Executive Team and Health and Safety Group to ensure actions are completed within timescales.		
Control of Asbestos Regulations 2006	The Trust had no policy covering the statutory requirements of the Control of Asbestos Regulations 2006.	The Trust to develop a policy covering the requirements of The Control of Asbestos Regulations 2006	D Hounslea / A Haynes	31-03-14	14-02-14	A Control of Asbestos policy has been developed and has been sent out for approval in accordance with Trust policy	Compliant	Compliant
Control of Asbestos Regulations 2006	Asbestos survey undertaken in Nov 2013 raises several concerns over the quality of the survey.	The findings from the original Asbestos survey in 2006 to be provided and reviewed to determine if actions have been completed	D Hounslea	28-02-14	14-02-14	Initial survey has been reviewed and established that the whole organizational survey is not complete.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
Control of Asbestos Regulations 2006	Asbestos survey carried out may be not sufficient and suitable for Willow House	A full non-destructive asbestos management re-survey is required of Willow House	D Hounslea	27-09-14. Note Board Paper in April noted due date of 31.05.14. The initial survey was completed for Willow House within timescales. The survey then indicated that it would be helpful to have additional survey for wider organization.		The re-survey has identified that the asbestos sample taken in the duct is different to the one described in the 2006. Quotes for the removal of asbestos are to be obtained and no one is permitted to enter the area. An additional 50 items of asbestos have been identified within the premises however it is in good condition and is safe if undisturbed. A management	Partial Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
						plan developed by Estates is required to monitor the asbestos condition annually and train staff appropriately.		
Control of Asbestos Regulations 2006	High priority risk assessments for areas the survey prompted the development of an action plan which requires placing on the risk register entry	High priority assessment and action plan will be placed on risk register	D Hounslea	20-09-14.		1. PQQs issued 11th July. 2. Asked for PQQs to be received by 25th July. 3. Evaluated and shortlist confirmed by 1st August. 4. Tenders issued 4th Aug (assuming specification complete & ready to go out). 5. Tenders received 25th August. 6. Evaluated by 29th August.	Partial Compliant	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
						To commence work 1st September. A full survey of the whole estate or a phased, risk-based approach to spread the cost. Potential cost 100k plus VAT. All plans will require updating & any remedial work undertaken.		
Work at Height Regulations 2005	The Trust had no policy covering the statutory requirements of the Work at Height Regulations 2005 although some aspects are covered with the STF Policy 012	The Trust to develop a policy covering the statutory requirements of the Work at Height Regulations 2005	A Haynes / D Hounslea	31-01-14	14-02-14	A Working at Height Policy has been completed. A specific permit system has been developed to be implemented for all staff and contractors.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
Work at Height Regulations 2005	Not all fragile roofs have a site-specific risk assessment in place.	A process for carrying out site-specific risk assessments for fragile roofs/surfaces to be developed.	D Hounslea	15-08-14 * Note Board Paper in April noted due date of 30.04.14. The capital scheme was approved in July 2014 for the high priority areas. Risk assessments for all areas will be in place by the revised due date.		Site specific risk assessments that reviews the tasks for work at height are provided by Dewi Jones. A capital bid for roof edge protection was approved at the July Capital Monitoring Group and a prioritized programme has been agreed between Estates and H&S team with risk mitigations in place for the lower priority areas.	Partial Compliance	Partial compliance
Work at Height Regulations 2005	There is no permit to work system for high risk working at heights for	A process similar to a permit to work system in existence for contractors and	D Hounslea	31-03-14	31-03-14	There is controlled access to all roofs. Memo has been sent out to all works	Compliant	Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	estates and facilities personnel and contractors requires review	estates and facilities personnel needs to be further developed.				personnel instructing them not to work near the roof edges or fragile roofs. Permit to work now in place.		
Confined Space Regulations 1997	The Trust has no policy covering the statutory requirements of the Confined Space Regulations 1997	The Trust to develop a policy covering the statutory requirements of the Confined Space Regulations 1997	A Haynes / D Hounslea	31-01-14	14-02-14	A Working in Confined Spaces policy has been developed and will be sent out and approved in accordance with Trust policy	Compliant	Compliant
Confined Space Regulations 1997	Confined spaces across APH and CGH to be identified	All confined spaces across APH and CGH have been identified.	D Hounslea	31-01-14	14-02-14	All confined spaces at APH and CGH have been identified.	Compliant	Compliant
Confined Space regulations 1997	Ensure a specific task is assessed for confined spaces to determine	Ensure task specific assessment undertaken.	D Hounslea/D Jones/A Haynes.	30-7-14	01- 07-14	If a task specific risk assessment has been put in place. This is described	Compliant	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	risks and controls.					within the policy.		
Confined Space Regulations 1997	Not all relevant staff within Estates and Facilities have received training on working in confined spaces	All key personnel within Estates and Facilities will receive training on working in confined spaces	D Hounslea	31-01-14	07-02-14	All key personnel received training on working in confined spaces week commencing the 07-02-14	Compliant	Compliant
Confined Space Regulations 1997	The site specific risk assessments for working in confined spaces are dated 2010	Site specific risk assessments to be reviewed	D Hounslea	30-06-14	01-07-14	Working in confined spaces assessment completed in 2010, DJ reviewed risks and signage to be placed in all areas identified as confined spaces. A specific assessment will be undertaken when entering confined spaces based	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
						on the risks identified.		
Control of Noise at Work Regulations 2005	The Trust had no policy covering the statutory requirements of the Control of Noise at Work Regulations 2005.	The Trust to develop a policy covering the statutory requirements of the Control of Noise at Work Regulations 2005	A Haynes / D Hounslea	28-02-14	14-02-14	A Control of Noise at Work policy has been developed and sent out and approved in accordance with Trust policy	Compliant	Compliant
Control of Noise at Work Regulations 2005	There are no site specific risk assessments for noise control within Estates and Facilities	A rolling program of site specific risk assessments which will be prioritised according to the degree of risk will be developed	D Hounslea	30-08-14 * Note Board Paper in April noted due date of 31.05.14. The initial noise assessment survey was completed within these timescales however, further work on individual assessment is needed, hence revised date		A baseline assessment has been undertaken; risk assessments will be completed within specified time period.	Partial Compliance	Partial Compliance
Pressure Systems Safety Regulations	The Trust had no policy covering the statutory	The Trust to develop a policy covering the statutory	D Hounslea / A Haynes	31-03-14	31-03-14	Currently Alliance Insurance undertakes	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
2000	requirements of the Pressure Systems Safety Regulations 2000	requirements of the Pressure Systems Safety Regulations 2000				pressure systems tests for insurance purposes. A written scheme of work is in place by the external assessor. Policy developed in accordance with internal process.		
Health and Safety At Work Act 1974	The is no signed statement of intent by the CEO within the Health & Safety Policy 118	The Health and safety Policy requires a signed statement of intent from the CEO	A Haynes	31-01-14	14-04-14	The Health and safety Policy 118 has been amended and includes a statement of intent which will be signed by the CEO.	Compliant	Compliant
Health and Safety At Work Act 1974	The Health and safety Policy requires further guidance on risk assessment	The Health and safety Policy will be amended to include further guidance on risk assessments and reference to	A Haynes	31-03-14	14-02-14	The Health and safety Policy has been amended to include further guidance on risk	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	processes and references to new policies	newly developed policies				assessments and reference to newly developed policies and will be available on the intranet once new policies have been approved.		
Health and Safety (Consultation with Employees) Regulations 1996	Although the Health and safety Policy includes some of the requirements of the Health & Safety (Consultation with Employees) further detail is required within Trust policy	The Health and safety Policy requires further detail on the consultation with employees processes OR a new policy will be developed	A Haynes / L Ferrie	31-03-14	31-03-14	Policy Complete	Compliant	Compliant
Electricity at Work Regulations 1989	The Trust had no policy covering the statutory	A policy covering the requirements of the Electricity at	D Hatch / D Hounslea	31-03-14	31-03-14	Competent staff are trained on 17th Edition wiring	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	requirements of the Electricity at Work Regulations 1989 although staff are competent and work in accordance with the revenant HTM's	Work Regulations 1989 will be developed				regulations and are deemed competent to undertake this work. There are two permit to work systems in place for working with electricity used within the Trust which are included within existing HTM's The Policy once developed will reflect SOPs and HTM processes.		
Provision and Use of Work Equipment Regulations 1998	The Trust has no policy covering the statutory requirements of the Provision and Use of Work Equipment	A policy covering the statutory requirements of the Provision and Use of Work Equipment Regulations	D Hatch / D Hounslea	30-04-14	01-05-14	Policy complete and out for consultation.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	Regulations 1998.	1998 will be developed						
Lifting Operations and Lifting Equipment Regulations 1998	The Trust has no policy covering the statutory requirements of the Lifting Operations and Lifting Equipment Regulations 1998	A policy covering the statutory requirements of the Lifting Operations and Lifting Equipment Regulations 1998 will be developed	D Hatch / D Hounslea	27-07-14	25-7-14	Policy complete and is out for consultation.	Compliant	Partial compliance
Management of Health and Safety at Work Regs 1999. To cover RA's on activities including Young Workers.	The Trust has no policy covering the statutory requirements to protect Young Workers	The Trust will develop a policy covering the statutory requirements to protect Young Workers	A Haynes	31.04.14	31.04.14	Guidance document has been completed for this item and this is reflected in the H&S Policy.	Compliant	Partial compliance
Occupational Health	The Trust has no policy describing the Occ Health Services	Specific policy is required to describe all OH Services- This is to be	P Bohan	30-04-14	31-03-14	Policy Complete.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	which will include arrangements for appropriate Health Surveillance	developed and describe requirements for Health Surveillance of staff and appropriate documented system						
Security	The Management of Violence and Aggression (including lone workers) 068 Policy in place requires reviewing to ensure risks associated with violence and aggression appropriately managed.	Policy in place will be reviewed to ensure risks associated with violence and aggression appropriately managed	E Garner	30-06-14	05-06-14	Clarity within the Policy on the exclusion criteria for violent patients is required New LSMS has reviewed the policy as part of Security review.	Compliant	Compliant
Workplace (Health, Safety and Welfare) Regulations	The Trust has no policy covering the statutory requirements	Internal guidance covering these regulations is required in the	A Haynes	27-08-14 * Note Board Paper in April noted due date of 30.04.14.		Guidance to be produced as part of H&S Policy. Draft available.	Partial Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
1992	of all the requirements within the Workplace (Health, Safety and Welfare) Regulations 1992	policy – will include ventilation, thermal comfort, and other general requirements.		Draft has been completed and is now subject to consultation process.				
Workplace (Health, Safety and Welfare) Regulations 1992	The Trust has no guidance covering the statutory requirements for Transport Safety	A policy covering the statutory requirements for workplace transport is to be developed to ensure delivery area at APH evaluated	A Haynes / D Hounslea	15-08-14 * Note Board Paper in April noted due date of 30.04.14. Draft has been completed and is now subject to consultation process.		Considerable work has been undertaken on workplace transport and is discussed at the HSPT.	Partial Compliant	Partial compliance
Workplace (Health, Safety and Welfare) Regulations 1992	The Trusts loading bay at APH requires assessment due to the high risk activities 'carried out within this workplace.	Issues identified as part of the assessment process will be entered onto the risk register	D Hounslea	15-08-14 * Note Board Paper in April noted due date of 30.04.14. Some improvements have been made and a capital Bid is being developed for further improvements.		Specific risks identified at the loading bay at APH have resulted in a risk register entry (2506) with specified actions. DH has ensured work such as line markings and a chain has now been	Partial Compliant	Partial Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
						put in place to discourage staff from entering the area. Meeting held for additional capital bid with Estates & Facilities BJ & SAC currently working on capital bid.		
Health and Safety (First Aid) Regulations 1981	The Trust has no policy covering the statutory requirements for The Health and Safety (First Aid) Regulations 1981	A policy will be developed covering the statutory requirements of the Health and Safety (First Aid) Regulations 1981	A Haynes	30-07-14	28-07-14	Policy has been completed as per planned date	Compliant	Partial compliance
Personal Protective Equipment at Work Regulations 1992	The Trust has no policy covering the statutory requirements for Personal Protective Equipment at	The Trust will develop a policy covering the statutory requirements for Personal Protective Equipment at	A Haynes	30-07-14	28-07-14	Policy has been completed as planned.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	Work Regulations 1992	Work Regulations 1992						
Ionising Radiation Regulations 1999	Although the Health & Safety policy covers some of the requirements of the Ionising Radiation Regulations 1999 a more detailed and separate policy is required.	The Trust will develop a policy detailing the statutory requirements of the Ionising Radiation Regulations 1999	J O'Connor	30-07-14	28-07-14	Policy has been developed as planned.	Compliant	Partial compliance
Gas Safety (Installations and Use) Regulations 1998	The Trust has no policy covering the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998.	The Trust will develop a policy detailing the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998	A Haynes / D Hounslea	31-03-14	30-04-14	Policy is complete and in consultation.	Partial Compliance	Partial Compliance
Fire Regulatory	Existing fire risk	A rolling program of	B Jones	31/01/2014	31-01-14	Fire Safety advisor Brian	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
Reform Order 2005	assessments will require review on a rolling basis	site/department specific fire risk assessment updates to be developed which will be prioritised according to the degree of risk.				Jones has developed a working plan to cover a review of all fire risk assessments over the next 12 months.		
The Health & Safety at Work etc. Act 1974	The Trust has no specific policy on non-notifiable projects	The Trust will develop a policy covering the statutory requirements to ensure robust management and control of contractors working on non-notifiable projects.	A Haynes / D Hounslea	30-07-14	28-07-14	Policy has been written in timeframe noted.	Compliant	Partial compliance
Manual Handling Operations Regulations 1992 (as amended)	The Trusts manual handling policy to be reviewed to ensure it reflects statutory requirements	The Trust's manual handling policy has been reviewed and reflects current legislation	D Hatch	30-05-14	31-01-14	Policy review completed.	Compliant	Compliant
Employers Liability	The Trust's policy requires	The Trust will review its policy	A Haynes	30-06-14	31-01-14	Insurance procedure in	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
(Compulsory Insurance) Act 1969	reviewing to ensure the Statutory requirements are reflected	to ensure the Statutory requirements are reflected within				place Claims Handling Policy and Procedure 108 in place.		
Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013	The reporting arrangements for Riddor reportable Occupational health diseases require review to ensure robust reporting to the HSE	The reporting arrangements for Riddor reportable Occupational health diseases will be reviewed as part of the Occ Health review	P Bohan	30-04-14	31-01-14	P. Bohan will ensure all recognised diseases that are directly related to work activities and have an Occupational Health Physician view on this will be reported to the HSE.	Compliant	Compliant
Health and Safety (Display Screen Equipment) Regulations 1992	The Trusts policy covering the requirements of the DSE regulations require review	The Trusts Policy for DSE will be reviewed	D Hatch	31-03-14	31-01-14	Policy will be reviewed in accordance with Trust Policy	Compliant	Compliant
Construction (Design and Management) Regulations 2007	The Trusts policy covering the requirements of the	The Trusts Policy for Construction (Design and Management)	D Hounslea	31-09-14	31-01-14	Policy will be reviewed in accordance with Trust Policy	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	Construction (Design and Management) Regulations 2007.	Regulations 2007 will be reviewed						
Hazardous Waste (England and Wales) Regulations 2005	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 requires review	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed	D Hounslea	31-09-14	31-01-14	Policy will be reviewed in accordance with Trust Policy	Compliant	Compliant
HTM 07-01 - Safe Management of Healthcare Waste 2006	The Trusts policy covering the requirements of the Hazardous Waste (England & Wales) Regulations 2005 requires review to	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed to ensure it reflects	D Hounslea	31-09-14	31-01-14	Policy will be reviewed in accordance with Trust Policy	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	ensure it reflects statutory requirements	statutory requirements						
Health & Safety at Work etc Act 1974.	The Trusts procedure and process for managing stress in the workplace requires reviewing as sickness absence figures indicate stress as the highest area of sickness absence.	Stress Policy and procedure to be reviewed.	P. Bohan/J. Mawrey	30-09-14		A stress working group has been established. A LiA event on the 23rd June focused on the requirements to implement specific targeted programme to deal with hotspots and raise the profile of the wellbeing agenda, thus improving sickness absence.	Partial Compliant	Partial Compliant
H&S (Sharp Instruments in Healthcare) Regulations 2013.	The Trusts procedure and process for managing sharps will be reviewed by the HSE in relation to a	Review RCA and ensure procedures are robust and if necessary learn lessons from incident.	P. Bohan/A Haynes/ D. Hatch	08-08-14		A RCA is currently underway looking at the work activity, equipment, time frame for referral, PPE &	Partial Compliant	Partial Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance July	Compliance June
	RIDDOR incident when a staff member received a needle stick injury from a Hep C patient.					support provided to staff member. The NITs group has undertaken considerable work on safety devices and this will form part of the RCA.		

Board of Directors		
Agenda Item	**8.1**	
Title of Report:	**Corporate Governance Review**	
Date of Meeting:	**30 July 2014**	
Author:	**Carole Ann Self, Associate Director of Governance**	
Accountable Executive :	**David Allison, Chief Executive**	
Corporate Objective Ref as outlined in the BAF	**ALL**	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating		
FOI status :	**Document may be disclosed in full**	

1. Introduction and background

The Trust implemented a revised governance structure through 2012/13 and 2013/14 in line with guidance received from McKinsey and committed to reviewing the impact of these changes during the course of 2013/14. The subsequent internal review was further supplemented by an external review, undertaken by KPMG, specifically related to the Trust's financial governance and planning.

The Board has reviewed the recommendations from both the internal and external reviews during their development sessions in order to ensure that the final governance arrangements provide them with the rigour and assurance they require as well as fulfilling the requirements of the Trust's Regulator, Monitor.

2. Key Issues

The key issues from the KPMG external review on financial governance and planning undertaken in February 2014 highlighted the following themes for consideration:

- Reassurance vs Assurance
- Speed of decision making
- The frequency of the Board and Assurance Committee meetings
- Membership and attendance at Assurance Committees
- A complexity and blurring in the decision, approval and assurances processes resulting in timelines being difficult to achieve and the focus of meetings not aligning to the terms of reference.

- The capacity required to service the structure was felt to be onerous and not adding value to the achievement of the Trust's objectives
- The relationship between the Finance, Business Performance and Assurance Committee and the Board of Directors
- Reflection of discussion in the minutes

3. Governance and Assurance Proposals

3.1 The Board

In response to the recommendations from KPMG the Board proposes to meet 10 times per year on a monthly basis with the exception of August and December. The Board will also undertake Board Development 6 times per year immediately following a public Board Meeting as per the Board Agenda Cycle attached at **Appendix A.**

The increase in frequency will improve the speed and influence of Board decision making and re-establish the primacy of the Board.

3.2 The Finance, Business Performance and Assurance Committee

The Terms of reference for the groups reporting to FBPAC will be reviewed and approved by the Committee itself in line with the Trust's scheme of delegation.

The Terms of Reference for the Committee have also been reviewed and amended to ensure that the delegated authority from the Board is appropriate and that the focus is on assurance and not operational performance. The membership of the Committee has been streamlined to limit the number of Non-Executives and Executives appointed to ensure a greater degree of objectivity and scrutiny is undertaken at the Board. The number of groups reporting to the Committee has also been streamlined reducing this from 8 to 4 following a full review of the work to be undertaken. A copy of the draft Terms of Reference are attached at **Appendix C.**

As a result of the above and of the Board meeting more frequently the Finance, Business Performance and Assurance Committee (FBPAC) need only meet 6 times per year to discharge its responsibilities. This would allow sufficient time between meetings to prepare papers and observe change over the period. The amended cycle of business for the Committee is attached at **Appendix B**.

In line with the KPMG recommendation, it is proposed that the Associate Director of Governance, will attend each sub-committee of the Board, produce the minutes and review the quality of papers to ensure continued development.

The Trust will also undertake a full review of its standing financial instructions, scheme of delegation and standing orders in quarter 2 in conjunction with its Internal Auditors. Changes resulting from this review will be incorporated into the relevant Terms of Reference and formally approved by the Board.

3.3 The Quality and Safety Committee

The Terms of Reference for the Quality and Safety Committee remain largely unchanged with the exception of the membership which has been streamlined as outlined above, and a reduction of the number of meetings to 6 per year. The cycle of business and a copy of the draft Terms of Reference for this Committee are attached at **Appendix D and E** respectively.

3.4 The Audit Committee

The KPMG review highlighted little impact for the Audit Committee. The membership and cycle of business will therefore remain largely unchanged.

4. Performance Management Proposals

To balance the recommendation from KPMG that assurance committees should focus more on strategic and assurance issues and less on management issues, the Trust has taken the opportunity to review its performance management structure.

The proposal is that the Executive Directors Team which meets on a weekly basis and includes all Executive Directors and the Associate Director of Governance is supported by 3 principal mechanisms in order that they are able to discharge their responsibilities.

The 3 principal mechanisms have been identified as the Operations Management Team, the Transformation Steering Group and the Divisional Performance Reviews. Each of these will provide the Executive Directors with the structure to be able to hold the Divisions to account for financial and operational performance as well as ensuring good clinical and corporate engagement. The membership of the Operations Team has been fundamentally changed to include all the Executive Directors as well as the clinical leaders from each of the Divisions. Associate Directors will be in attendance as required.

The revised Governance, Performance Management and Assurance Structure is attached at **Appendix G**.

5. The Board Assurance Framework

The Trust has an established Board Assurance Framework BAF which traditionally has been used to check compliance with Monitor's Corporate Governance requirements. The Board of Directors have reviewed the BAF as part of this process and now proposes to use this to monitor progress against its strategic objectives as detailed in the Strategic Plan.

The BAF identifies key measures for each strategic objective along with the principal risks and examples of positive assurance or gaps in assurance, as applicable.

Formal monitoring of the BAF will be undertaken in the first instance by the Finance, Business Performance and Assurance Committee and the Quality and Safety Committee as highlighted on the BAF attached at **Appendix F**.

The Board of Directors will also review the BAF as part of its annual cycle of business.

The proposal is that the corporate governance statements will now be monitored by the Audit Committee in line with its review of the Trust's compliance with its Provider Licence.

The Board will continually review the BAF to ensure that it continues to provide the assurance required.

6. Evaluation

Subject to formal approval by the Board of Directors the Associate Director of Governance will undertake a formal evaluation of the changes in January 2015.

7. Recommendations

The Executive Directors recommend to the Board of Directors approval of the following:

- **Appendix A** - The Board Agenda Cycle of Business
- **Appendix B** – The Finance Business Performance & Assurance Committee Cycle of Business
- **Appendix C** – The Terms of Reference for the Finance Business Performance and Assurance Committee
- **Appendix D** - The Quality and Safety Committee Cycle of Business
- **Appendix E** – The Terms of Reference for the Quality and Safety Committee
- **Appendix F** – The revised Board Assurance Framework
- Formal evaluation of the revised Corporate Governance structure to be undertaken in January 2015.

Appendix A

Board of Directors – Business Cycle 2014/15

Agenda Items	BAF REF	April	May + Dev	June + Dev	July	Sept + Dev	Oct	Nov + Dev	Jan	Feb + Dev	Mar + Dev
Standing Items											
Apologies for absence		*	*	*	*	*	*	*	*	*	*
Declaration of Interests relating to agenda		*	*	*	*	*	*	*	*	*	*
Minutes of Previous Board meeting		*	*	*	*	*	*	*	*	*	*
Action log		*	*	*	*	*	*	*	*	*	*
Chairman's Business		*	*	*	*	*	*	*	*	*	*
Chief Executive's Report	10, 13	*	*	*	*	*	*	*	*	*	*
Patient Story	1	*			*		*		*		
Strategy and Development											
5-Year Plan – including statement on vision (sign off and milestone reviews)	Code of Gov 9, 10, 13			*					*		
Annual Plan incl Financial Plan (2-year operational plan) and midyear review	Code of Gov 12	*					*				
Business cases requiring BoD approval (as required)	13										
Significant Transactions (as required)											
Update on contract settlement and budgets	13		*				*				
Performance and Improvement											
Board Dashboard	Code of Gov 1 -6 9,13,14	*	*	*	*	*	*	*	*	*	*
Financial Report	Code of Gov 13	*	*	*	*	*	*	*	*	*	*
Regulation and Assurance											
Monitor Quarterly Return	13	*			*		*		*		

Appendix A

Agenda Items	BAF REF	April	May + Dev	June + Dev	July	Sept + Dev	Oct	Nov + Dev	Jan	Feb + Dev	Mar + Dev
External Assurances: (incl Monitor Q letter)	13		*			*		*		*	
Committee Reports											
Chair's Report – Quality and Safety	1 - 6, 8, 10 - 12, 14		*		*		*		*		*
Annual report of Quality & Safety inc. review of Terms of Reference	1 - 6, 8, 10 - 12, 14		*								
Exceptions Reports – Quality targets (as required)											
Chair's Report – Finance, Business Performance and Assurance (FBPAC)	7, 9, 10, 13, 14	*			*	*	*		*		
Annual report of FBPAC inc. review of Terms of Reference	7, 9, 10, 13, 14		*								
Exceptions reports – targets (as required)											
Chair's Report - Audit Committee	7, 13, 14		*		*	*			*		*
Annual report - Audit Committee inc. review of Terms of Reference	7, 12, 13		*								
Chair's Report - Charitable Funds Committee							*			*	
Annual report of Charitable Funds Committee inc. review of Terms of Reference							*				
Chair's Report - Remuneration Committee (inc. annual report and remuneration policy)	Code of Gov				*				*		
Governance											
Monitor Governance Annual Board Statements	14		*	*							
Review of Register of Interests – Board of Directors	Code of Gov	*					*				
Annual Governance Review including SO, SFI and SoD	Code of Gov						*				

Appendix A

Agenda Items	BAF REF	April	May + Dev	June + Dev	July	Sept + Dev	Oct	Nov + Dev	Jan	Feb + Dev	Mar + Dev
	13										
Changes to Constitution (As required)											
Approval of Annual Report and Accounts including Quality Report / receipt of audit opinion – confirm going concern	Code of Gov 13		*								
Approval of Charitable Funds Annual Report and accounts / receipt of audit opinion							*				
Review of the Board Assurance Framework	Code of Gov/AGS	*			*		*		*		
Receipt of Governor Election Reports						*					
Francis: Safe Staffing	1	*					*				
Amendments to CQC registration (As required)											
Annual evaluation of BoD and Board Development Plan	Code of Gov							*			
Strategies and Annual Reports											
Approval of Risk Management Strategy	3, 4, 14					*					
Workforce Annual report	2, 6, 8, 12	*									
Health & Safety Annual report and regular updates	Code of Gov	*			*update						
Emergency Plan Review (include NHSLA annual report)	Code of Gov					*					
Approval of Quality Governance Framework	Code of Gov 8, 11, 4, 12									*	
Approval of Quality Improvement Strategy	Code of Gov 1, 8, 11, 4, 12					*					

Appendix A

Agenda Items	BAF REF	April	May + Dev	June + Dev	July	Sept + Dev	Oct	Nov + Dev	Jan	Feb + Dev	Mar + Dev
Approval of Whistle Blower Policy	Code of Gov 2										*
Equality and Diversity Annual Report	Code of Gov						*				
National In-Patient Survey	1, 4, 12, 13					*					
Research Annual Report	8				*next year		*				
NHS Staff Survey	2, 6		*								
Consultant Appraisals	4, 8										
Primary Care Engagement Strategy	Code of Gov 9										*
Safeguarding Annual Report	1, 5			*							
Nursing and Midwifery Strategy	1, 5				*update						
Infection Prevention Annual Report	1, 11, 14					*					
Items requested by the Board											
Update on IT strategy following review at FBP & A							*				

Appendix B

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Finance Business Performance and Assurance Committee cycle of business
April 2014 – March 2015

Standing Agenda Items		Apr		June		July		Oct		Nov		Jan
Apologies		✓		✓		✓		✓		✓		✓
Declarations of Interest		✓		✓		✓		✓		✓		✓
Minutes of the Previous Meeting		✓		✓		✓		✓		✓		✓
Chair's Business		✓		✓		✓		✓		✓		✓
Matters Arising		✓		✓		✓		✓		✓		✓
Action Log		✓		✓		✓		✓		✓		✓
Items for Risk Register		✓		✓		✓		✓		✓		✓
Any other Business		✓		✓		✓		✓		✓		✓
Recommendations to the Board		✓		✓		✓		✓		✓		✓
Assurance												
Committee Annual Report inc review of Terms of Reference		✓										
Review of Service Level Agreements				✓								✓
Service Line Reporting and Update		✓						✓				
Review Reference Cost Submission				✓								
Review Benchmarking Data		✓				✓		✓				✓
Private Patients Income/Strategy		✓				✓				✓		
Review Cerner										✓		
Financial Strategy Review		✓						✓		✓		✓
Regulation												
Monitor Quarterly Return		✓				✓		✓				
Monitor Monthly Returns		✓		✓		✓		✓		✓		✓
Performance and Improvement												
Financial Report		✓		✓		✓		✓		✓		✓
Performance Report		✓		✓		✓		✓		✓		✓
CIP/PMO		✓		✓		✓		✓		✓		✓
Capital Report				✓						✓		
Board Assurance Framework		✓				✓				✓		
Review of business cases – 6 months post approval (as required)												
Minutes with Reports												

Appendix B

Finance Management Group		✓		✓		✓		✓		✓		✓
Information Group		✓		✓		✓		✓		✓		✓
Productivity Group		✓		✓		✓		✓		✓		✓
Risk Management Group		✓		✓		✓		✓		✓		✓
Finance Management Group Annual Report								✓				
Information Group Annual Report		✓										
Productivity Group Annual Report						✓						
Risk Management Group Annual Report				✓								
Items requested by the Committee												
KPMG Report Update						✓						
Cash Facility						✓						
Sale of Springview						✓						

Appendix C

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Finance Business Performance & Assurance Committee

Terms of reference

Authors Name & Title: Sam Armstrong	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: Finance, Performance and Business Development Committee	
To be read in conjunction with the following documents: **Board Assurance Framework** **Board Assurance Framework Policy** **Corporate Governance Manual (including Scheme of Reservation and Delegation and Standing Financial Instructions)**	
Document for public display? Yes	

Unique Identifier:	**Review Date: July 2015**	
Issue Status: Approved	**Issue No: 1.0**	**Issue Date: July 2014**
Authorised by: Board of Directors	**Authorisation Date: July 2014**	
After this document is withdrawn from use it must be kept in an archive for 10 years		
Archive: Document Control	**Date added to Archive:**	
Officer responsible for archive: Author		

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance on behalf of the Board of Directors with regards to the Trust's financial and operational performance delivery of the in-year plans and the development of future plans within the context of the requisite regulatory requirements. .

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any reasonable request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources within the delegated limits of the Committees members.

The Committee has authority delegated by the Board of Directors to:

2.1 Receive assurance on all aspects of the effective outturn delivery of financial, operational performance targets and significant variances to planned levels of achievement, either under or over performance.

2.2 Ratify and review policies and procedures required for effective management of financial, performance and business development practice across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups

2.3 Review proposed new investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.

2.4 Review investment of surplus cash in line with the Board approved Treasury Management Policy.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk

3.1.1 To receive and monitor risks relating to finance and operational performance referred in accordance with the Risk Management Strategy

3.1.2 To ensure that gaps identified through or within the Board Assurance Framework, which relate to the activities of this committee, have appropriate measures in place to be resolved and are appropriately reported to the Board

3.2 Financial Management

3.2.1 To review the Trust's Financial Plan in accordance with agreed timescales and in line with the Trust's strategic objectives, making appropriate recommendations to the Board of Directors

3.2.2 To review and recommend business, operational and financial plans to the Board of Directors

3.2.3 To review and monitor the financial performance of the Trust including, income, expenditure, activity, Monitor metrics and contract performance

ensuring that actions are taken as necessary to remedy and adverse variation

3.2.4 To monitor delivery and seek assurance of the CIP programme – in year and forward plan, obtaining assurances in relation to quality and safety impact assessment

3.2.5 To review the capital programme bi-annually and monitor the capital expenditure plan quarterly

3.2.6 To review and ensure effective due diligence in respect of business cases, ratifying those within the financial limits delegated and referring on to the Board with recommendations, those in excess of delegated limits.

3.2.7 To review benefits realisation of approved business cases 6 months after implementation of the planned change

3.2.8 To review and recommend to the Board the monthly, quarterly, annual, returns (including Board declaration statements) to Monitor

3.2.9 To consider future options for all non NHS income with specific reference to private patient income and ensure that income derived from activities related to the Trust's principal purpose of the NHS meets the limits as set by national governing bodies

3.2.10 To review contracts compliance (including capital)

3.2.11 To review and monitor the achievement of value for money through use of benchmarking data, including reference costs

3.2.12 To monitor financial performance against provider to provider and third party SLA's with regards to service costs and operational targets

3.2.13 To review the development, implementation and clinical engagement in the Service Line Management (SLM) process.

3.2.14 To seek assurance on the Trust overall cash management position

3.3 Performance

3.3.1 To monitor the operational performance and agree, as necessary, corrective action for all national targets that contribute to Monitor's Governance Risk Rating and other key performance indicators

3.3.2 To monitor the operational performance and agree corrective action for contract performance targets including the financial elements of CQuINs

3.3.3 To instigate investigation into any aspect of performance that gives cause for concern, providing exception reports to the Board of Directors, as required

3.3.4 To monitor the Wirral Millenium Programme and associated action plans

3.4 Business Development

3.4.1 To oversee the implementation of the Trust's Business Development Strategy

3.4.2 To approve and seek assurance on the implementation of the Trust-wide Procurement Strategy

3.5 Governance

3.5.1 To review and seek assurance on compliance against relevant legislation

3.5.2 Consider and seek assurance on the implementation and compliance of relevant national guidance, including directives from Monitor, CQC, Audit Commission, Department of Health, and national and local commissioning guidance where these have a new or significant financial impact on the Trust

3.5.3 Approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee

3.5.4 Respond to and refer actions to the Audit Committee as necessary

4. Equality and Diversity

The Committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Integration

The Committee will support the integration of clinical, organisational and financial risk management with that of the business planning process.

It will promote a holistic approach to managing risk that will encourage all staff to integrate the management of finance into achieving their objectives in order to provide safe, effective, timely and efficient care to patients.

The Committee Chair and Director of Finance will work with the Executive Team and Board to integrate clinical, financial and organisational governance and risk management processes and systems. The chair of the Quality and Safety Committee shall be a member of the Committee.

The Committee will work with other Committees including the Audit Committee to provide assurances required to support the Annual Governance statement.

6. Membership

- Nominated Non-Executive Director (Chair)
- Two additional nominated Non-Executive Directors (one of whom shall be a member of the Quality and Safety Committee and the other a member of the Audit Committee)
- Director of Finance (Nominated Deputy – Deputy Director of Finance)
- Director of Operations
- Director of Informatics
- Medical Director (Nominated Deputy – Director of Nursing and Midwifery)

7. Attendance

The following officers will attend the Committee as required:

- Deputy Director of Finance
- Director of Strategy & Partnerships
- Associate Director of Governance

Other officers of the trust will be invited to attend on an ad hoc basis to present papers or to advise the committee.

All members are expected to attend all meetings with attendance being reviewed annually; attendance below 80% will be discussed with the Committee Chairman at the earliest opportunity.

8. Quorum and Frequency

The quorum shall be four members, to include two Non Executive Directors, the Director of Finance (or Nominated Deputy) and either the Non-Executive member of the Quality and Safety Committee or, as nominee, the Medical Director or the Director of Nursing & Midwifery.

The Committee shall meet at least 6 times a year, in accordance with a planned business cycle that is agreed at the start of each year (April).

9. Reporting

The Committee will report to the Board following each meeting via a Chair’s report, and an annual report which will include a review of the Terms of Reference.

Unapproved minutes will be circulated to Board Members by email as soon as is practicable following the meeting.

The Committee will receive reports from the following:

- Executive Directors Team – Report on decisions taken with financial implications as appropriate
- Finance Group(monthly) – exception reports and annual review
- Productivity Group (monthly) –exception reports and annual review
- Information Group(monthly) – exception reports and annual review
- Risk Management Group – exception reports and annual review

10. Conduct of Committee Meetings

The Executive Director Lead, in liaison with the Chair of the Committee will ensure that the appropriate processes are followed:

- An annual work plan reflecting the Committee's business cycle will be prepared by the end of March each year for the forthcoming year.
- Minutes and action log will be kept by the Committee Secretary on behalf of the Chair
- The agenda will include the following standing items:
    - Minutes of last meeting
    - Action Log
    - Risk
    - Financial Management
    - Performance
    - Business Development
    - Governance
    - Group Minutes
    - Items for Escalation
    - Evaluation of Meeting and Papers
    - Date of next meeting

- The agenda and supporting papers will be sent out 4 working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.
- Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.
- Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.
- Distribution of minutes and archiving of documentation will be managed by the Committee Secretary in accordance with standard procedures.

Appendix D

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee Cycle of Business
April 2014 – March 2015

Standing Agenda Items	May	July	Sept	Nov	Jan	March
Apologies	✓	✓	✓	✓	✓	✓
Declarations of Interest	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	✓	✓	✓	✓	✓	✓
Chair's Business	✓	✓	✓	✓	✓	✓
Matters Arising	✓	✓	✓	✓	✓	✓
Action Log	✓	✓	✓	✓	✓	✓
Items for Risk Register	✓	✓	✓	✓	✓	✓
Any other Business	✓	✓	✓	✓	✓	✓
Recommendations to the Board	✓	✓	✓	✓	✓	✓
Assurance						
Annual Review of Monitor Quality Governance Framework and Review of Cycle of Business				✓		
Patient Story	✓	✓	✓	✓	✓	✓
RCA Trend Analysis Report including Never Events	Q4		Q1	Q2		Q3
Quality Improvement Strategy		✓				
CLIPPE Report (quarterly) (including Friends and Family Test)	Q4		Q1	Q2		Q3
CQC Monthly Briefing	✓	✓	✓	✓	✓	✓
Director of Nursing and Midwifery Performance Report (quarterly)	Q4		Q1	Q2		Q3
Quality Account (quarterly)	Q4		Q1	Q2		Q3
Quality Impact of Cost Improvement Programme Report	✓	✓	✓	✓	✓	✓
Annual Plan and Assurance						✓
Accountable Officer Controlled Drug Report			✓			
Emergency Planning – Annually					✓	
Winter Plan - Annually			✓			
Divisional Framework with CIP Schemes						
Acute and Medical Specialties (once per year)		✓				
Surgery, Women and Children (once per year)				✓		
Clinical Support (once per year)						✓

Appendix D

Performance												
Clinical Quality Dashboard		✓		✓		✓		✓		✓		✓
Workforce Dashboard		✓		✓		✓		✓		✓		✓
Risk Register 15+ Risks		✓		✓		✓		✓		✓		✓
Board Assurance Framework		✓				✓				✓		
Annual Reports		**May**		**July**		**Sept**	**Oct**	**Nov**		**Jan**		**March**
Consultant Appraisals												
Clinical Audit Annual Report				✓								
Quality and Safety Annual Report												
Safeguarding Annual Report		✓										
Quality Account Annual Report		✓										
Risk Management Annual Report				✓								
Incident Annual Report				✓								
Non Clinical Incidents and EL/PL Claims) Annual Report						✓						
Claims Annual Report												
Infection Control Annual Report						✓						
Complaints and Concerns Annual Report						✓						
Medication Incidents Annual Report						✓						
Dementia Annual Report												✓
For Information												
Advancing Quality Update		✓		✓		✓		✓		✓		✓
Minutes with Reports												
Workforce and Communication Group		✓		✓		✓		✓		✓		✓
Clinical Governance Group		✓		✓		✓		✓		✓		✓
Patient and Family Experience Group – LWP's		✓		✓		✓		✓		✓		✓
Risk Management Group		✓		✓		✓		✓		✓		✓
Workforce and Communication Group Annual Report								✓				
Clinical Governance Group Annual Report		✓										
Patient and Family Experience Group Annual Report						✓						
Risk Management Group Annual Report				✓								

Appendix E

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee

Terms of Reference

Authors Name & Title: Director of Nursing and Midwifery	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: N/A	
To be read in conjunction with the following documents: **Board Assurance Framework** **Board Assurance Framework Policy (from April 2013)** **Standing Financial Instructions**	
Document for public display? Yes	

Unique Identifier:	**Review Date: July 2015**	
Issue Status: Approved	**Issue No: 2.0**	**Issue Date: July 2014**
Authorised by: Board of Directors	**Authorisation Date: July 2014**	
After this document is withdrawn from use it must be kept in an archive for 10 years		
Archive: Document Control	**Date added to Archive:**	
Officer responsible for archive: Document Control Administrator		

1 Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of delivery of the Trust's Quality Improvement Strategy and service delivery in respect of clinical effectiveness, safety, and patient and staff experience. This will incorporate measures of performance and compliance with national and local requirements.

2 Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources.

The Committee has authority delegated by the Board of Directors to ratify and review policies and procedures within its remit, and where appropriate delegate responsibility for this to associated committees or groups.

3 Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk

3.1.1 To assess, receive and monitor risks relating to quality and safety in accordance with the Risk Management Strategy.

3.1.2 To receive and monitor Serious Untoward Incidents including never events, and gain assurance that actions plans effectively mitigate the concerns identified, and are implemented.

3.1.3 To receive and monitor relevant areas of the CQC's Quality & Risk Profile (as determined by the Executive Team) that are rated red ('worse than expected' or 'much worse than expected').

3.1.4 To receive assurance that potential impact of cost improvement programmes upon the future quality of care has been risk assessed and actions taken to mitigate recognised risks in advance of implementing the programme.

3.1.5 To receive assurance that Trust policies and processes for risk management are being actively managed in line with the requirements of the NHS Litigation Authority.

3.1.6 To ensure that gaps in controls and/or assurance relating to service delivery are reported to the Board by exception, with recommendations to update the Board Assurance Framework where necessary.

3.2 Clinical Effectiveness and Safety

3.2.1 To support the development and oversee the delivery of the Trust's Quality Improvement Strategy and be assured the associated actions are being implemented.

3.2.2 To seek assurance that clinical performance is of acceptable quality and improving through use of selected KPIs / quality dashboard; these will include (but not be limited to) CQUINs, Quality Account priorities, Safety Express indicators; external benchmarking data and measures linked to continuous improvement in patient and staff experience

3.2.3 To seek assurance that Divisional Quality Performance is meeting the requirements of the Quality Improvement Strategy and demonstrates continuous improvement using available intelligence.

3.2.4 To ensure effective arrangements for monitoring and continually improving the quality of healthcare provided through use of Monitor's Quality Governance Framework.

3.2.5 To seek assurance that there is ongoing compliance with CQC Essential Standards of Care.

3.2.6 To receive the integrated complaints, claims and incidents report and consider trends, appropriateness of actions taken and impact of organisational learning.

3.2.7 Review actions arising from Ombudsman's recommendations following patient complaints and seek assurance that resultant actions are implemented.

3.2.8 Receive and ratify the Clinical Audit Annual Report and Forward Plan annually.

3.3 Patient Experience

3.3.1 To monitor performance from our "learning with patients" systems including the friends and family test.

3.3.2 To review and monitor Divisional performance against delivery plans for patient experience as set out in the Quality Improvement strategy

3.3.3 To oversee the delivery of strategy to embed a patient and family centred approach to care delivery.

3.3.4 To receive a summary of national patients' surveys and seek assurance that any action plans required to drive improvement are delivered.

3.4 Workforce

3.4.1 To review and monitor performance against the Workforce and OD Strategy.

3.4.2 To receive assurance on the safe staffing of all clinical areas.

3.5 Staff Satisfaction and Engagement

3.5.1 To monitor Divisional performance against key metrics relating to staff experience and engagement.

3.5.2 To receive the results of the national staff survey and seek assurance that improvement plans are identified and delivered.

3.5.3 To ensure investigation and learning from concerns raised by staff.

3.6 Governance

3.6.1 To ensure compliance with specified NHSLA standards that relate to the remit of the Committee.

3.6.2 To receive and be assured that the Trust has responded appropriately to the findings and recommendations from the CQC and Healthwatch, as required.

3.6.3 Receive and ratify the Safeguarding Adults and Children annual report and forward plan, annually.

3.6.4 Consider and ensure appropriate response / implementation of relevant national guidance and external reviews, including directives from CQC, DH, Monitor and external inquiries where there is an impact on patient care, quality or safety.

3.6.5 Approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee.

3.6.6 Respond to actions referred to and by the Audit Committee.

3.6.7 To receive an annual divisional assurance report.

3.6.8 To receive and ratify the Annual Quality Accounts.

3.6.9 To undertake deep dives as appropriate.

4 Equality and Diversity

The Committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5 Integration

The Committee will support the integration of clinical, organisational and financial risk management with that of the business planning process.

It will promote a holistic approach to managing risk that will encourage all staff to provide safe, effective, timely and efficient care to patients.

The Committee Chair will work with the Executive Team and Board to integrate clinical, financial and organisational governance and risk management processes and systems.

The Committee will work with other Committees including the Audit Committee to provide assurances required to support the Annual Governance statement.

6 Membership

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors (one of whom shall be Vice Chair of the Committee – each member shall be a member of either the Audit Committee or the Finance, Business Performance Assurance Committee)
- Medical Director(Nominated Deputy - Associate Medical Director)
- Director of Nursing & Midwifery (Nominated Deputy – Deputy Director of Nursing)
- Director of Strategy and Partnerships
- Head of Patient Experience and Involvement
- Nominated Governor
- Nominated Patient Representative (rotated every 12 months)

7 Attendance

- *Associate Director of Governance*

Other officers of the Trust will be invited to attend on an ad hoc basis to present papers or to advise the committee.

All members are expected to attend all meetings with attendance being reviewed annually; attendance below 80% will be discussed with the Committee Chairman at the earliest opportunity.

8 Quorum and Frequency

The quorum shall be four members, to include at least two Non Executive Directors, one of whom must be the Chair or Vice Chair and either the Medical Director or the Director of Nursing & Midwifery.

The Committee shall meet at least 6 times a year, in accordance with a planned business cycle that is agreed at the start of each year (April).

9 Reporting

The Committee will report to the Board following each meeting via a Chair's report, and an annual report which will include a review of the Terms of Reference.

Unapproved minutes will be circulated to Board Members by email as soon as is practicable following the meeting.
The Committee will receive reports from the following:

- Clinical Governance Group (monthly) – minutes and annual review
- Patient & Family Experience Group (quarterly) – minutes and annual review
- Workforce and Communication (bi-monthly) – minutes and annual review
- Risk Management Group (quarterly) – minutes and annual review

10 Conduct of Committee Meetings

The lead Executive Director, in liaison with the Chair of the Committee will ensure that the appropriate processes are followed:

- An annual work plan reflecting the Committee's business cycle will be prepared by the end of March each year for the forthcoming year

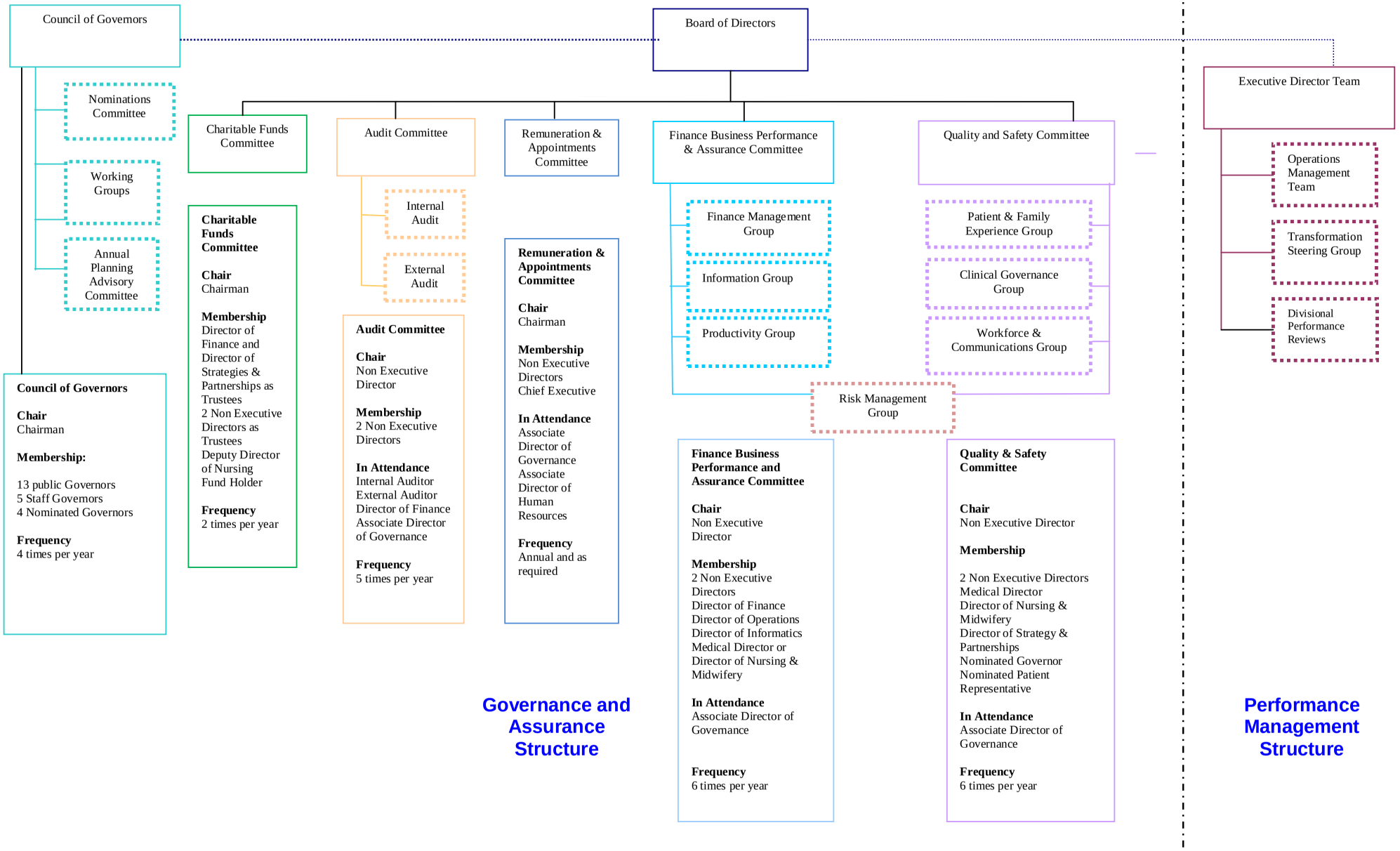
- Minutes and action log will be kept by the Committee Secretary on behalf of the Chair

- The agenda will include the following standing items:
  - Minutes of last meeting
  - Action Log
  - Risk
  - Clinical Effectiveness and Safety
  - Patient Experience
  - Workforce
  - Staff Experience and Engagement
  - Governance
  - Group Minutes
  - Items for Escalation
  - Evaluation of Meeting and Papers
  - Date of next meeting

- The agenda and supporting papers will be sent out 4 working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.
- Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.
- Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.
- Distribution of minutes and archiving of documentation will be managed by the Committee Secretary in accordance with standard procedures.

Appendix F

Governance, Performance Management & Assurance Structure



Governance and Assurance Structure

Performance Management Structure

Strategic Objective – To be the Top NHS Hospital Trust in the North West for Patient, Customer and Staff Satisfaction					
Key Measure(s)	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	**Positive Assurance and/or Gaps**
Improve our patient experience to deliver a Friends and Family Net promoter score of 65 or better **Director of Nursing and Midwifery**	1	That the Trust fails to deliver on the Quality Improvement Strategy and Nursing and Midwifery Strategy to secure positive patient experiences and public confidence in care.	C1b – Medical Director C1c – Director of Nursing & Midwifery C2 - Organisational Structure C3 – Performance Management System C6a - Quality & Safety Committee C12c – CQC C12a – Monitor C12e – LINK / local Healthwatch C12f - Other	• Patient Stories • Dashboard Reports • Friends and Family Test • Safeguarding Reports to Quality and Safety Committee & Annual Report to Board • Francis: Safe Staffing Data to Board & Q&SC • Board Walkabouts • Nursing and Midwifery audits to Q&SC • Board approval of Quality Improvement Strategy and Nursing & Midwifery Strategy • Quality Accounts • Quality Governance Framework • NHS In-Patient Survey • Staff Friends & Family Test • CLIPPE Report • Complaints Annual Report	Friends & Family Net Promoter Score May 2014 = 84 (Nationally one of the best for A & E) 2013 Inpatient Survey – overall average performance with other Acute Trusts. Areas of decline: • noise at night • Cleanliness • Discharge • Emotional Support • Dignity & Respect • Quality of letters
Create a strong culture of empowered employees, delivering a staff	2	That the organisational restructure impacts negatively on staff engagement leading to a more disengaged staff	C1a – Chief Executive C1b – Medical Director C1c – Director of Nursing & Midwifery C1f – Director of Strategy	• Quarterly Workforce Reports to Q&S Committee • Annual Workforce Report to Board • Review of Nursing and	Staff Engagement score per NHS staff survey 2013 = 3.64

engagement score of 3.59 or better, through implementation of our nursing, midwifery and customer service strategy **Director of Strategic & Organisational Development**		and resulting in a lower staff engagement score	& Partnerships C2 - Organisational Structure C6a - Quality & Safety Committee C12f – Other C16 Operating Policies and Procedures	Midwifery Strategy • Annual NHS Staff Survey Report to Board • Whistleblowing Policy and Report to Board	
Strategic Objective – To lead on integrated shared pathways of care with Primary, Social and Community Care					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	Positive Assurance and/or Gaps
Work with partners in Wirral to reduce delayed transfers of care to no more than 4 per month and reduce readmissions to 7.5% of total admissions, by developing a range of plans to deliver care closer to home **Director of Operations**	3	The Trust and its local partners fail to implement a redesigned health economy to achieve more care in the community resulting in more delayed transfers and readmissions	C1a – Chief Executive C1b – Medical Director C1c – Director of Nursing & Midwifery C1f – Director of Strategy & Partnerships C1g – Dir of Operations C3 – Performance Management System C6a - Quality & Safety Committee C12e – LINK / local Healthwatch C12f – Other C14 – Annual Planning Process	• Vision 2018 Meetings and Updates • Chief Executive's Report updating strategic and health economy progress • Monthly Dashboard Reports • Impact of cost management programmes on quality, staff satisfaction& efficiency measures Report • Board Review of Risk Management Strategy	Delayed transfers of care – 12 month rolling average at May 2014 = 3 No. of Emergency Readmissions within 30 days was 7196 = 9.3%

			C15 – Risk Management Strategy	• RCA on annual planning process • Dr Foster	
Strategic Objective – To deliver consistently high quality secondary care services enhanced through the provision of regional specialist services					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	**Positive Assurance and/or Gaps**
Implementation of our quality improvement strategy to reduce mortality to 85 (HSMR) **Medical Director**	4	That other pressures lead to less focus on clinical outcomes leading to a rise in HSMR	C1b – Medical Director C1c – Director of Nursing & Midwifery C1f – Director of Strategy & Partnerships C2 – Organisational Structure C6a - Quality & Safety Committee C15 – Risk Management Strategy C16 – Operating Policies and Procedures	• Quality Improvement Strategy approved by Board • Dashboard Reports to Board • Clinical Outcomes reported at Quality and Safety Committee • Mortality Reviews at Clinical Governance Group • Appraisal and Revalidation Report to Board • Quality Governance Framework • Quality Accounts • NHS In-Patient Survey	HSMR – April 2013 – Feb 2014 = 84.9 one of the lowest in the North West SHMI – July 2012 – June 2013 = 1.04
Ensure that our harm free care score is no lower than 93% and no lower than 95% for 3 months	5	That patient care falls below safe acceptable standards leading to harm of patients.	C1b – Medical Director C1c – Director of Nursing & Midwifery C2 - Organisational Structure C3 – Performance	• RCA Trend Reports • Quality and Safety Dashboard • Root Cause Analysis presented to Q&SC • Safeguarding Reports	July 2013 dipped to 94.33% otherwise above 95%

Medical Director			Management System C6a - Quality & Safety Committee C12c – CQC C12a – Monitor	to Quality and Safety Committee and Annual Report to Board • Nursing and Midwifery audits to Q&SC • Board approval of Quality Improvement Strategy and Nursing and Midwifery Strategy	
Strategic Objective – To ensure our people are aligned with our vision					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Board Assurance**	**Board Evaluation (and gaps)**
Re-launch our values and behaviours strategy and improve attendance rates to 96% and appraisal rates to 88% **Director of Strategic & Organisational Developments**	6	That the organisational restructure impacts negatively on staff engagement and resources, resulting in attendance and appraisal rates dropping	C1f – Director of Strategy & Partnerships C2 – Organisational Structure C3 – Performance Management System C6a - Quality & Safety Committee C11 – Internal audit function	• Values and Behaviours Strategy • Dashboard Report to Board • Quarterly Workforce Reports to Q&S Committee • Annual Workforce Report to Board • Annual NHS Staff Survey Report to Board	Attendance 12 month average to May 2014 = 95.3% Appraisal rates May 2014 = 85.9%
Strategic Objective – To Maximise innovation and enabling technologies					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	**Positive Assurance and/or Gaps**
Implement the	7	That training and staff buy in	C1h – Dir of Informatics	• Weekly meetings with	Phase 2b of the

next stage of our CERNER IT system and deliver full electronic nursing documentation, pilot paper free outpatients and the ability to share documents with primary care **Director of Infrastructure & Informatics**		is not achieved to a sufficient level resulting in CERNER not being imbedded in the hospital and the benefits of efficiency not being achieved	C2 – Organisational Structure C6b – FBP & A Committee C7 – Audit Committee	CERNER • Project plan for implementation • Good engagement with clinicians • Advisory groups for medicine, clinical staff and administration • Training and communications being developed	programme is on course for a mid-November go live as planned. Work has started on the Remote Hosting project this will take place by the end of March 2015.
Participate in research and ensure patients are notified of opportunities to participate in suitable studies to ensure the agreed recruitment goal of 400 patients is met **Medical Director**	8	That clinicians won't maintain the PA capacity required to focus on research and opportunities to drive this forward resulting in too few studies being secured and too few patients being signed up which would lead to NIHR funding being withdrawn	C1b – Medical Director C1f – Director of Strategy & Partnerships C2 – Organisational Structure C6a - Quality & Safety Committee C14 – Annual Planning Process	• Annual Research Report • Consultant Appraisal • Report from the Quality and Safety Committee • Workforce Report • Appraisal and Revalidation Report to Board	In 2013/14 860 patients recruited to 41 studies (NIHR) and 17 non-NIHR studies which was twice the previous recruitment levels.
Strategic Objective – To Build on partnering for value					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	**Positive Assurance and/or Gaps**
Deliver an	9	Robust referral processes	C1a – Chief Executive	• Trust 5-Year Planning	Demand Referral

increased market share to 77% of Wirral CCG referrals, through engagement with local GPs **Director of Strategic & Organisational Development**		and competition from CCG commissioning intensions leads to a decline in market share for the Trust	C1f – Director of Strategy & Partnerships C6b – FBP & A Committee C12e – LINK / local Healthwatch C12f – Other C14 – Annual Planning Process	process with Board • Primary Care Engagement Strategy and impact • Market analysis reports to Board	Rates although higher than 2013/14 have taken a dip. Variance reduced from 5.6% to 1.9% below expected levels
Develop a range of partnerships with NHS and non-NHS providers to secure clinical sustainability, participate in relation to our regionally significant services **Director of Strategic & Organisational Development**	10	That engagement of neighbouring providers in active collaboration and definition and agreement of tangible outcomes cannot be achieved resulting in synergies and collective work not being undertaken	C1a – Chief Executive C1f – Director of Strategy & Partnerships C1g – Dir of Operations C3 – Performance Management System C6a - Quality & Safety Committee C6b – FBP & A Committee C12e – LINK / local Healthwatch C12f – Other C14 – Annual Planning Process	• Trust 5-Year Planning process with Board • Engagement of neighbouring providers in active collaboration and definition of key tangible outcomes • Chief Executive Reports to Board	Agreement with Countess of Chester Hospital NHS Foundation Trust to collaborate in a number of service line areas. Agreement with Liverpool Heart and Chest Hospital to collaborate in cardiology services. Joint bid with Cheshire and Wirral Partnership for Healthy Child Programme.
Strategic Objective – Supported by financial, commercial and operational expertise					
Key Measure	**Risk Number**	**Principal Risk to Objective**	**Key Controls**	**Potential Board Assurance**	**Positive Assurance and/or Gaps**

Full compliance with our registration with the CQC **Medical Director**	11	That the Trust does not maintain good control and prevention of infection resulting in possible warning notices or loss of registration of services	C1b – Medical Director C1c – Director of Nursing & Midwifery C2 - Organisational Structure C3 – Performance Management System C6a - Quality & Safety Committee C12c – CQC C12a – Monitor	• CQC Report to Q&SC and Audit Committee • Q&S Dashboard • Safeguarding Reports to Quality and Safety Committee and Annual Report to Board • Annual Workforce Report to Board, quarterly report to Q&SC • Annual Infection Control Report • Board Walkabouts • Mock CQC Reviews • Quality Governance Framework • Quality Improvement Strategy • Chief Executive reports to Board • NHS In-Patient Survey • CLIPPE Report	MRSA at May 2014 = 1 C Diff at May 2014 = 3 CQC visits record the Trust as compliant in all areas reviewed with exception of infection control – minor concern CQC risk register – highest concerns relate to the management of medicines and end of life care
	12	That the Trust does not maintain its clinical and corporate standards resulting in either warning notices or loss of registration			
Delivery of the planned CoS rating of 2 **Director of Finance**	13	Failure to deliver the requisite financial position resulting in a lower CoS than planned on either a monthly or quarterly basis as the Trust remains on monthly monitoring.	C1d – Director of Finance C2 – Organisational Structure C3 – Performance Management System C6b – FBP & A Committee C7 – Audit Committee C11 – Internal audit	• Trust 2-Year Operational Plan • Trust Standing Financial Instructions and Scheme of Delegations • Trust Business Case Approvals • Trust Standing Financial	May 2014 - £0.8m overspent against plan although £0.1m improvement on previous month. Gap of £3.7m between CIP plan and forecast. Capital spend is 34%

			function C12a – external audit C14 – Annual Planning Process C16 – Operating Policies and Procedures Executive led Steering Group Engagement of external turnaround partner	Instructions and Scheme of Delegations • Contracts Report to Board • Annual Report and Accounts • Financial reports to FBP & A Committee and BoD Feedback from CEO on financial performance and delivery	of plan, outside of Monitor acceptable range of +/- 15% variance
Monitor green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer **Director of Operations**	14	That demand pressure will continue on the ED resulting in the Trust missing the A&E 4-hour target threatening the green governance rating.	C1b – Medical Director C1g – Dir of Operations C3 – Performance Management System C6a - Quality & Safety C6b – FBP & A Committee C12b – Monitor C12c – CQC C15 – Risk Management Strategy C16 – Operating Policies and Procedures	• Monitor Quarterly Submissions • Monitor Corporate Governance Statements • Dashboard Reports to Board • Weekly monitoring meetings for activity • DMS and cancer meet monitor performance in the Trust • Reviewing pathways for cancer to reduce delays • RCA 62-day breach analysis • Urgent Care Recovery Plan report to OMT • Commissioning support team	Monitor Q1 Governance Rating is neither Red or Green. Concerns relate to A & E and infection control standards

Board of Directors		
Agenda Item	8.2	
Title of Report:	Report from the Remuneration and Appointments Committee	
Date of Meeting:	30 July 2014	
Author:	Michael Carr, Chairman	
Accountable Executive :		
BAF Reference	All	
Level of Assurance		**Board Confirmation**
Data Quality Rating	N/A	
FOI status :	Document may be disclosed in full	

1. Executive Summary

The Remuneration and Appointments Committee met on the 25th June 2014 to review the annual performance of the Chief Executive and Directors which also included a review of salaries and organisational structures. The Committee also considered a proposal to apply a cost of living award for very senior managers on a "spot rate" salary.

The organisational structure, agreed by the Committee is outlined at **Appendix A**. This includes each Director's responsibilities along with the Divisional Structure to take place from September 2014.

A small salary adjustment was agreed in the case of those Executive Directors whose duties had been materially enhanced as a result of the organisational restructure, the Committee being satisfied that these were both appropriate and consistent with benchmarking data.

The Committee agreed to a 1% non-consolidated cost of living increase for all very senior managers on a "spot salary" from the 1st April 2014 until 31st March 2015. The award ensures that there is no pay differentiation between those staff on a "spot salary" and those on Agenda 4 Change.

2. Recommendations

The Board of Directors is asked to note the report.

Appendix A

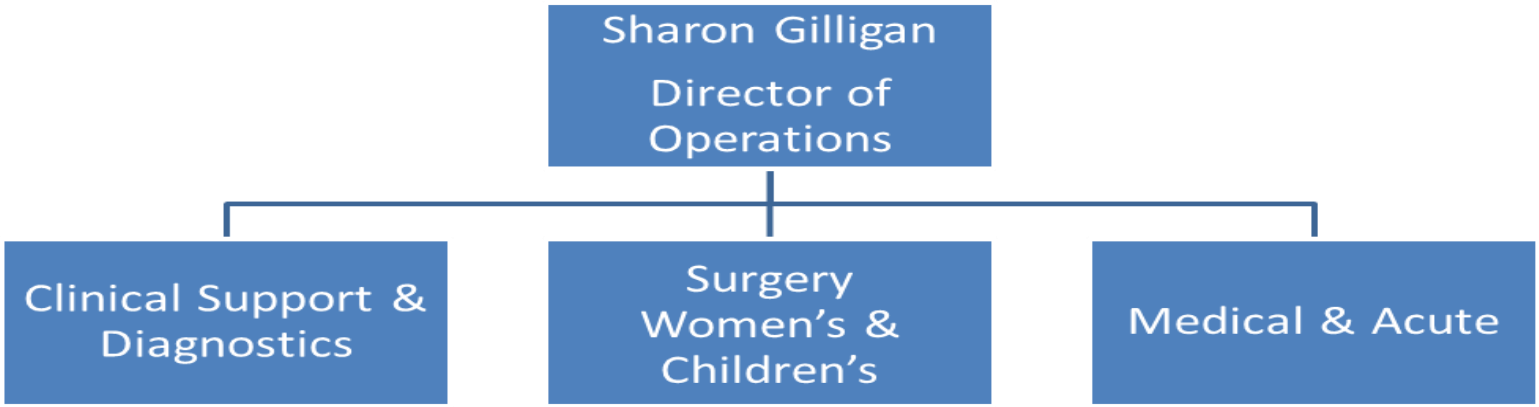
Directors responsibilities

Alistair Mulvey Director of Finance	Dr. Evan Moore Medical Director	Jill Galvani Director of Nursing & Midwifery	
Finance & Procurement Clinical Coding Programme Management Office/Health economy efficiencies	Quality, Safety & Risk Pharmacy	Corporate & Nurse Management Chaplains Complaints/ Patient Experience	Infection Prevention & Control Safeguarding Bereavement
	Medical Workforce In Divisions	Nurses in Divisions	Therapists in Divisions

Directors responsibilities

Sharon Gilligan Director of Operations	Anthony Hassall Director of Strategic & Organisational Development	Mark Blakeman Director of Infrastructure & Informatics
Surgery, Womens & Childrens Medical & Acute Clinical Support & Diagnostics (including: Bed Management; Theatres, Anaesthetics & Sterile Services; Booking & Outpatients; Hotel Services and Cancer Pathway Management)	Strategy & Partnerships Communications HR & OD/Education &Training Occupational Health	Information Information Governance Estates IT Informatics Medical Records

New Divisional Structure



Clinical Support includes:
Bed Management; Theatres, Anaesthetics & Sterile Services; Booking & Outpatients; Hotel Services and Cancer Pathway Management

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

25th JUNE 2014

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present:	
Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Richard Dutton	Non-Executive Director
Sharon Gilligan	Director of Operations
Anthony Hassall	Director of Strategy and Partnerships
Cathy Maddaford	Non-Executive Director
Lyn Meadows	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director
Graham Hollick	Non-Executive Director
Apologies:	
Jeff Kozer	Deputy Chair & Senior Independent Director
Jill Galvani	Director of Nursing & Midwifery
In attendance:	
Carole Self	Associate Director of Governance (minutes)
Sam Armstrong	Interim Trust Secretary
Mark Blakeman	Director of Informatics
Governors:	Brian Beechey, Public Governor
Members of Staff:	None
Members of the Public:	None

Reference	Minute	Action
BM 14-15/049	**Apologies for Absence** Apologies were noted as above.	
BM 14-15/050	**Declarations of Interest** There were no declarations of interest.	
BM 14-15/051	**Chairman's Business** The Chairman welcomed Mrs Carole Self to the meeting in her role as the new Associate Director of Governance. The Board were advised of a new consultant appointment in Gastroenterology this being Dr Paul Flanagan.	

Reference	Minute	Action
	The Chairman provided an overview of the current focus from the Health regulator Monitor this being financial planning; A & E performance; the advice to progress with external support and the request to reconsider the 2014-16 Operational Plan against the national context. The Board were reminded of the decision not to amend the 2014-16 plan following further discussion. The Board was advised that John Berwick OBE would be undertaking a capability and governance review on behalf of NHS England of the Trust's principal commissioner. The Chairman confirmed that the report should be due in the next 6 weeks and made available to the Regional Director of NHS England in the first instance. The Chairman confirmed that the latest NHS Choices Patient Safety data had now been published and the Trust had performed well in all areas.	
BM 14-15/052	**Trust 5 Year Strategic Plan** The Chief Executive presented the Trust 5 year Strategic Plan and outlined the work undertaken to date in developing the plan which included working with external stakeholders; the feedback from KPMG on the planning process which was favourable and the engagement with the Board through a variety of workshops and Board meetings. The Board were also reminded of the previous discussions on the 2015/16 baseline position which was highlighted in the executive summary. The Director of Strategy and Partnerships drew the Board's attention to the summary document and confirmed that the full strategic document was contained in the private part of the meeting due to the commercial in confidence nature of this. The Director of Strategy and Partnerships reiterated the previous Board decision to show the 2015/16 baseline position as detailed in view of the position of the Clinical Commissioning Group CCG in relation to Vision 2018, the Better Care Fund, and the range of uncertainties that this brought. The Board considered the advantages and disadvantages and agreed to leave the baseline unchanged. Board Members were referred to the summary of outstanding risks which were included in the main body of the plan together with associated mitigating actions along with the outputs from the Monitor Strategic Planning Self-Assessment. The Board were asked to: a) Note the process of review and iteration which the plan had been through since January 2014 b) Note the risks associated with the plan and approve the Declaration of Sustainability contained within the plan c) Approve the Monitor Strategic Plan for submission by 30th June 2014, together with the accompanying summary document d) Agree to grant delegated authority to the Chairman and Chief Executive to make any final changes necessary to the Monitor	

Reference	Minute	Action
	Strategic Plan prior to submission on or before 30th June 2014. The Board asked if there might be a possibility that the External Support team would re-base the Trust completely. The Chief Executive confirmed that there would be flexibility in the process and this would be supported by Monitor. The Board recorded their thanks for the huge amount of work undertaken in producing the plan in terms of the engagement, the level of detail and the triangulation of financial and clinical outcomes. The Board approved the recommendations as outlined above.	
BM 14-15/053	**Monitor Corporate Governance Statements** The Interim Trust Secretary presented the Corporate Governance Statements and tabled the draft Monitor template for approval. The Board was reminded of previous discussions at the Board Development Day and at Audit Committee along with the recommendation from KPMG in terms of the use of the template, as presented, with supporting evidence for each statement. The Chief Executive outlined the discussions undertaken with Monitor in relation to Statement 4d on the template with regards to the Trust's ability to continue as a going concern in light of the current financial difficulties. The Board was assured from the conversations with Monitor and the Auditors statement of the accounts 2013/14 of the appropriateness of confirming the statement. The Chief Executive drew the Board's attention to statement 4c and the highlighted risk in relation to the A & E performance standard. The Board agreed to include an additional sentence in the risk statement which recognised the Trust's view that failure of the Q1 target was expected. The Board debated the statement in some detail to ensure that their declaration was accurate and balanced. The Board reviewed the statement against the Trust's performance as a whole together with the plans that had been put in place to address this isolated area of under-performance and agreed that on balance they were happy to confirm as they were assured that the plans were robust. In summary the Board approved the recommendation to confirm each of the statements, noting the risks presented as financial, A & E performance and infection control as per the template.	
BM 14-15/054	**Integrated Performance Report** **Integrated Performance Dashboard and Exception Reports** The Director of Informatics presented the Integrated Performance Dashboard for review by the Board. The Board raised concerns at the level of reserves used in the reporting period and sought assurance that the situation would improve. The Director of Finance outlined some specific action taken to mitigate the risk which included the bed closures that had been instigated in May and June,	

Reference	Minute	Action
	the benefit of which had not been seen as yet. The Board was advised of some of the issues attributable to the financial position which included staffing the consultant and medical staffing rotas in A & E and the increase in the level of demand all of which had to be managed in a safe way. The Director of Operations reiterated the actions put in place as part of the Urgent Care Recovery Plan to address the situation which included the need to make greater use of Enhanced Nurse Practitioners ENPs in the future. The Board sought assurance that the dip in demand referral rates was not a trend and was in fact impacted by the Easter Holidays as in previous years. Assurance was given that referrals were higher overall on the previous year and the gap in variance from April to May 2014 had reduced significantly from 5.6% to 1.9% although close monitoring of June and July performance would be undertaken to ensure no trend was identified. The Chairman asked whether the Cancer targets should be on the integrated dashboard as the Board were well sighted on all other targets with the exception of this. The Director of Operations agreed to include the cancer targets in future reports.	**MB**
BM 14-15/055	**Minutes of the previous meeting** The minutes of the meeting held on 28th May 2014 were agreed as a correct record of the meeting. **Board Action Log** The Board reviewed the Action Log and agreed to close the completed actions as presented. The Associate Director of Governance also confirmed the following: Minute Ref BM 14-15/016 this action would now be completed in July 2014 Minute Ref BM 14-15/005 had now been completed Minute Ref BM 13-14/093 would be actioned through the Quality and Safety Committee	
BM 14-15/056	**Any Other Business** The Chairman recorded his thanks to Mr Armstrong for his work as Interim Trust Secretary. The Board recorded their thanks to both Mr Dutton and Ms Meadows for their support since 2006 and 2008 respectively as Non-Executives of the organisation. Recognition of contributions and the loss were noted. The Chairman recommended that Mr Hollick undertake the role of Chair of the Finance, Performance and Business Development Committee	

Reference	Minute	Action
	following the departure of Mr Dutton. The Board approved the recommendation.	
BM 14-15/057	**Items for BAF / Risk Register** There were no additional items for the BAF or Risk Register.	
BM 14-15/058	**Date and Time of Next Meeting** Wednesday 30th July 2014 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……

Chairman

……..

Date

ACTION LOG
Board of Directors
Updated – 30 July 2014

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting: 28.05.14						
May 14-	BM 14-15/039	Undertake a review of headroom percentages for nurse staffing once NICE guidelines were published.	JG		October 14	
May 14-	BM 14-15/042	Audit Committee recommendations to the Board Assurance Framework to be followed-up.	SA	Discussed at EDT on 17.06.14; 2013/14 BAF will be presented at the July Board.	July 14	
Date of Meeting: 30.04.14						
Apr 14-3	BM 14-15/016	Provide a statement of the additional resource that had been expended in 2013/14 in seeking to achieve the A&E target	SG / AM	To be completed in July 2014	June 14	
Apr 14-4	BM 14-15/016	Additional information to non-core spend data to be developed	MB / AM	To be completed in September 2014	July 14	
APR 14-5	BM 14-15/017	Provide proposed financial reporting areas, and related data, for the Board to focus on for 2014/15	MB / AM	To be completed in September 2014	July 14	

Apr 14-8	BM 14-15/024	Assurance to be gained that roof safety actions had been completed	AM	Update provided as part of the Health and Safety Update Paper	May 14	
No.	**Minute Ref**	**Action**	**By Whom**	**Progress**	**BoD Review**	**Note**
Date of Meeting : 24.01.14						
Jan14-2	BM 13-14/093	The Medical director to request further information on the clinical pathways for patients using the new SMArt network from the Clinical Director of the service.	EM	Action to be progressed through the Quality and Safety Committee	April 14	
Jan 14-7	BM 13-14/097	Explored the option of reinstating the working capital facility.	AM	In progress	April 14	Discussions with Barclays taking place
Date of Meeting : 30.10.13						
7	BM13-14/080	Executive Directors Team to ensure appropriate facilities for infection prevention & control both in short term in readiness for winter and longer term strategic solution	DA/JG		n/a	Health Protection England report received. Isolation part of work plan.