Board of Directors Meeting

24 June 2015

**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 24 JUNE 2015
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL**

AGENDA

1.	**Apologies for Absence** Chairman	0900	v
2.	**Declarations of Interest** Chairman		v
3.	**Patient Story** Director of Nursing and Midwifery		v
4.	**Chairman's Business** Chairman		v
5.	**Chief Executive's Report** Interim Deputy Chief Executive	0910	d
6. Performance and Improvement			
6.1	**Integrated Performance Report**	0930	
	6.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics		d
	6.1.2 Month 2 Finance Report Director of Finance		d
7. Quality			
7.1	**CQC Update and Mock Inspection Summary** Medical Director	1015	d
7.2	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: April & May 2015** Director of Nursing and Midwifery		d
8. Governance			
8.1	**Report of the Finance Business Performance & Assurance Committee 19 June 2015** Chair of the Finance Business Performance & Assurance Committee	1115	d
8.2	**External Assessment** • **Monitor Governance Annual Board Statements** • **Monitor Q4 Feedback** Associate Director of Governance		d

8.3 Board of Directors d

8.3.1 Minutes of the Previous Meeting
- **27 May 2015**

8.3.2 Board Action Log
Associate Director of Governance

9. Standing Items

9.1 Items for BAF/Risk Register v
Chairman

9.2 Any Other Business v
Chairman

9.3 Date and Time of Next Meeting v
Wednesday 29 July 2015 at 9am

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	24 June 2015
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1, 4, 5, 6, 7 1B, 4A, 5A, 6A, 7C 1908, 1909, 2328
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. External Activities

CCG

The Trust continues to finalise the detailed components of the contract recognising that variance exist across the material elements of forecast growth, non-recurrent income and potential impacts of improved recording of clinical activities undertaken and delivered to patients. It is anticipated that the final contract detail will be concluded and signed by the next Board meeting.

New Models of Care

We have now received feedback letter from the New Models of Care Team on the back of the visit which took place on 5/6 May and this is attached at Appendix 1. Although broadly positive, the letter does contain some challenges for us in relation to the ability to access capital funds, which we have raised with the national team.

Wirral Partners has also applied to the Connecting Health Cities fund, being sponsored by HM Treasury for additional monies intended to support the initialisation money we need to commence the implementation of Population Health management.

The New Models of Care team have asked for an outline Business Case to be submitted to them by the end of June with more detail on our expected 'ask' and the benefits we expect to gain from the development and delivery of our model. In their feedback letter, they rightly point out that our proposals around Population Health are unique in England so we are therefore working hard with Cerner and with their partners to develop this case.

A revised governance structure has been proposed through the existing Strategic Leaders Group and will be finalised shortly. A Programme Director advertisement will have been published by the time of the Board meeting. This senior post will be expected to act as overall strategic lead for the programme – reporting to the SLG.

An engagement event for GPs and Consultants is being held on 2 July to catalyse clinical engagement in the programme.

2. Internal Activities

Emergency Preparedness, Resilience and Response (EPRR)

As a Category 1 responder under the Civil Contingencies Act (CCA) (2004), the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of Trust services in the event of a disruption. I can confirm that the Trust has the required Accountable and Responsible Emergency Officers in place alongside the appropriate Emergency Planning meeting structure. The Quality & Safety Committee recommended for approval the Major Incident Plan, and other associated Emergency and Business Continuity Plans but not the Annual Report at the May meeting. An update of which was provided to the Board of Directors in May 2015. However it is a requirement for the Board to formally approve the Major Incident Plan, Annual Report and note that other plans have been updated. To fulfil this requirement, Board members have been circulated, under separate cover, the Annual Report and Major Incident Plan, and are requested to approve this accordingly.

The Major Incident Plan was tested during the power outage in March 2015 and Business Continuity Plans were tested during the industrial action in the Autumn of 2014.

The Trust has self-assessed against the NHS England's EPRR core standards in November 2014; The Director of Delivery NHS England confirmed on 16 April 2015 that the Trust fully complied with the Core Standard Assurance Process.

Infection Prevention & Control

Against the objective of no more than 29 cases for 2015/16, the Trust have reported 9 avoidable cases of Clostridium difficile including 5 cases reported during May. There were no MRSA bacteraemias or pseudomonas infection reported during May.

Ensuring that positive and high risk contacts are transferred to the CPE cohort ward 14 at the earliest opportunity has been a key factor in managing and containing the outbreak of Carbapenamase Producing Enterobacteriaceae (CPE) with 5 new cases reported in May. A further increase in Vancomycin Resistant Enterococcus (VRE) within high risk areas during May resulted in a review of the existing cohorting strategies within Orthopaedics and Haematology.

Recovery Plan

The developed plan sets out the Trust's ambition to deliver productivity and income gains of £11.1m for 2015/16 through 17 workstreams, with a full year effect of £16.4m, and an indicative high level opportunity of £12.6m for 2016/17. The month 2 position shows good progress but the level of savings increases significantly as we move through the year and so emphasis on assurance and execution will be key moving forward.

A&E Update

The heightened focus on patient flow is having a positive impact on the Trust for both patients and staff as ambulance handover times are improving, discharges are happening earlier in the day to facilitate flow and nurses are moved less frequently. The escalation ward has closed and work has started on the isolation ward. Week commencing 8Th June the Trust achieved the ambulance handover target of 30 minutes with a performance of 28.02 minutes and also achieved the 4 hour Emergency Access Standard(EAS) with a performance of 96.87% as a site including the all day health centre and 95.88% as a Trust. It is possible to achieve the target as a site for the month of June providing there are not more than 10 breaches per day on average. Work is ongoing with ECIST who are supporting the Trust around the discharge process, therapy structure and roles and responsibilities in the Emergency Department; a workshop was held in June with further workshops planned for July.

Wirral Millenium

The implementation of Millennium is progressing well, with a number of key milestones being hit.

Work to directly attach vital signs monitors to the system has taken a major leap forward as the pilot has gone live on ward 17. The ability to send the results directly to the electronic patient record will have a major impact on timeliness, reliability as well as free up nursing time.

A rule that helps to identify patients who are at risk of Systemic Inflammatory Response Syndrome (SIRS) or Sepsis and hi-lights these patients to clinicians as well as prompting them to follow Trust pathways has also gone live. As one of the leading trusts in this area, based on international experience we expect that this will make a major contribution towards patient safety.

It is good to note that the Trust is increasingly getting externally recognised for its achievements and in particular that the Trust has been shortlisted for E-health Insiders "Digital NHS Trust of the Year and Best Use of IT to Support Clinical Treatment and Care" award.

Workforce & Organisational Development

Health & Wellbeing / Attendance

Trust sickness absence has reduced for the last 5 months resulting in a figure in May 2015 of 3.72%; this is the first time the Trust has achieved its target of 4%. Long Term Absence remains the main contributor to sickness absence. There has been a focus on closely managing those off long term and this continues to deliver improvements.

The Health & Wellbeing Plan 2015-2018 continues to be enacted. Having held a successful 'Well Being Event' at Arrowe Park with many staff receiving advice on staying healthy a further event is planned for 30 July. The event provides an opportunity for all staff to gain advice and make changes to their lifestyle to positively improve their health and wellbeing.

Priority actions continue to be discussed in full at the Quality & Safety Committee.

Education and Development Key Performance Indicators

As at 31st May 2015:

Mandatory Training Block A 97.05%; this meets the Trust's 95% KPI.

Mandatory Training Block B has increased from 74.78% to 77.74% since 31 May 15. As this falls below the 95% KPI, divisional action plans are being developed to address this.

Appraisals 86.94%; this falls below the 88% KPI and divisional action plans are in place to address this.

Safeguarding Training was taken over by HR&OD in April 2015; high levels of non-compliance were found and an action plan to resolve this is being enacted.

Organisational Development

In line with the Workforce and Organisational Development Strategy 2015 - 2018 the Leadership and Management Development Framework supports the Culture and Engagement Plan. The overarching aim is to enable the Trust to create a transformational leadership culture and behaviour styles to enable us to meet our key organisational challenges and staff satisfaction and engagement priorities.

The Trust's Nurse Recruitment Strategy is positive with 52 nurses who are due to graduate in September 2015 accepting positions at the Trust. The Trust will continue to look to recruit staff nationally and will be moving to overseas recruitment in the coming months.

Staff Engagement / Listening into Action / Values

The trust-wide staff satisfaction and engagement action plan is progressing well in advance of the next staff survey. Staff Charter launched on 12 May at Senior Leaders event which sets out what staff can expect from the Trust and what the Trust can expect from staff, aligned to our core values. This will also be communicated to our staff with June 2015 payslips. The Executive Team have partnered with in-patient wards and key clinical areas and started to visit to meet staff and offer support.

Celebrating Success

PROUD Team of the Quarter was won by the Endoscopy Unit. Nominations for Quarter 1 are now open and close on Tuesday 30 June.

The Trust has been shortlisted for the HPMA (Healthcare People Management Association) Appreciate Champion Award 2015 for staff engagement, in recognition of the significant improvements we have made across the organisation by engaging with our staff, primarily through Listening into Action. Winner will be announced on 18th June

David Allison
Chief Executive

June 2015

New Care Models Team
Skipton House
80 London Road
London SE1 6LH
england.newcaremodels@nhs.net
15 June 2015

Dear Anthony,

Firstly, thank you to you, your teams & partners for hosting and participating in the Vanguard site visit on 5th and 6th May 2015. It was a pleasure to meet with you, your senior leadership teams, front line clinical staff, and the wider stakeholders including citizens who are involved in developing and receiving care services. Please pass on our thanks to everyone who helped make the two days so informative and enjoyable.

As you know, we captured learning from the two days through observation, reflections and through our dialogue together. We have grouped our feedback into theme areas which we know need to be addressed for major change to succeed. I trust that this letter reflects our discussions when we met, and I look forward to working with you to develop the Wirral Partners PACS Vanguard.

Vision, objectives and progress

During the visit we heard about your Wirral Partners model to develop an integrated care system and vision for 2018 and the programmes of work that are in place to move this forward, such as the integrated care coordination teams (ICCT) and the community and discharge teams. Your recently developed strapline captures the mood and essence of your work “What is the matter with me” to “What matters to me”.

You have a number of emerging exemplars in the work you are doing including the early development of your ICCTs in the community, however the team wondered whether you are pushing enough the boundaries of what the possible, so for example the take up of these ICCTs is relatively low compared with the size of your ambition and vision. We would advocate that you quickly assess what is getting in the way of scaling up and focus on removing these barriers during 2015. Some of the issues you’re facing are local issues others might be things that national bodies can provide support.

We discussed the need to define the cohort that you focus on in your risk stratification and proposed that the multi-morbidity patient as common ground (needs based) with social and community care which also plays to your community ICCT teams strengths. By having a clear cohort will enable you to work through some of the critical transition issues such as the role of General Practice in participating in these teams and how payments will work between different contributors in these teams (in preparation for the commissioning for outcomes envisaged for 2016). By speeding up your early implementation will enable you to take bigger steps in your transition planning.

Leadership for change

You demonstrated a strong and committed leadership to deliver a sustainable model of care on the Wirral. The recent change of leadership at the CCG enables you to strengthen those relationships further and this is important as the stress on the system is increasing this year.

To achieve your ambition we also discussed the widening of your Chief Executives collaboration to include other key players such as the North West Ambulance Service and any 111 provider appointed. The Vanguard can support this greater reach, and the Five Year Forward View would ask for such ambition.

Communication and Engagement

We recognised together that a key enabler to you moving at pace, and to achieve the culture change you aspire to is in the involvement and engagement of staff. We discussed placing a greater priority on this aspect so staff can fully participate in the development of their skills, roles & ways of working.

You have some early exemplars through your ICCTs and community discharge teams. The next stage is to move from specific areas/pockets of engagement to systematic whole scale engagement implemented with clear metrics that enable you to assess the impact of your engagement with particular focus on behaviour change.

Workforce

You have great enthusiasm to enhance your approach to your workforce model to encompass greater collaboration, use of third sector partners and the wider determinants of health. You are open minded in your approach, recognising the need for flexibility and creativity in your workforce and have a clear will to support your workforce to think independently and imaginatively to solve the obstacles/pressures they face through change, this was demonstrated in the stakeholder event on day two.

You are aware that there is some struggle with capacity and dedicated leadership / expertise and that this needs to be resolved sooner rather than later. A key next step is to develop a whole health and care economy workforce plan to progress the development of your care model to be able to implement at scale. You are also aware that you have thus far only scratched the surface of the significant OD agenda, and need to maintain momentum with your progress in order to learn and evolve, and are excited to have the opportunity the Vanguard status brings to enabling this.

Finance, contracting and pricing

We discussed your progress with financial modelling for your new care model and how it would be useful to understand the financial impact on the system. You informed us that you have the expertise needed for this, whilst the capacity is the problem so your funding request is likely to include back-filling arrangements so the detailed work can be done to redesign the new outcomes based whole-system payment system.

The development of your new care model with your external partners (Cerner) requires a sophisticated IT system for the purpose of helping with stratification and management of healthcare across different providers. This is likely to be a significant capital cost which we will need to be worked through, as you are aware the Vanguard related transformation fund is not set up to provide capital investment, however other funding pots are that you are exploring.

We discussed the absence of GPs (and also 111 and Ambulance) during the wrap up session, in relation to the financial risk in that where there is shift out of primary care into ICCT in community hubs, it is not clear that one can readily disinvest from the GP there who is paid on a capitation basis and so there is a resultant risk of paying twice for those people who receive care through the ICCTs.

Informatics and information technology

Your population health platform work and partnership with Cerner is effectively a first of type for England and we are very keen to work with you to identity how this unique feature to your Vanguard can be utilised for a wider learning and replication.

The underpinning IT infrastructure and therefore ability to move quickly to maximise the potential of population health platform is a challenge although Cerner is embedded in the hospital and the partnership with EMIS (where most practices are moving to EMIS web) is encouraging. There is more work to do with the mental health trust, SystmOne in Community and social care.

There are a number of difficulties with information governance of which you are compiling ready for a follow up conversation.

Measurement and evaluation

It was encouraging to see that you have made some start to articulating the logic model, in that you were able to describe high-level outcomes and have identified the patient cohorts. A major challenge in the measurement process was identified as the development of outcomes-based commissioning based on the use of correct metrics. You recognise that there is still much ground to be covered before you can present the logic model on a page – learning from examples of best practice globally and your previous experience of logic modeling in social isolation via John Moores University will prove invaluable in this.

In terms of metrics, you are trying to develop those that will incentivise stakeholders and those that will identify micro-segments of healthcare where new care models can fit in. We note however that metrics which help people to take responsibility for their own health are lacking here. Integration of care, self-care satisfaction and workforce satisfaction need to be measured more appropriately.

We understand that there has been very early thinking in the area of evaluation, but no commitment has been made to any party. Although, it was reassuring to see that a PDSA approach has been used together with the Integration Team as part of rapid cycle evaluation. Ultimately, measurement needs to take into account of how patients and staff interact and capture softer metrics around 'culture' so that replicability can be realized.

You expressed to us a number of requirements in supporting you in this work stream. You showed particular enthusiasm in having a workshop to help develop your logic models and would like a link to expertise both at the workshop and in other areas. You would also like support in developing Patient Activated Measures and/or those that capture the essence of the new care model, such as shared decision-making. Finally, you asked for a single point of contact centrally who can help you understand what service change is required.

Next steps

We suggest that you dedicate time to consider the feedback received following the site visit before further developing your programme delivery plan for 2015/6 and the details of support you would need for your Vanguard. We asked that you think about not only the areas for support, but also how and when this support might best be delivered for you. In doing so, we suggest you focus on the following key areas:

1. An increase of pace in your ICCTs and discharge teams with worked through implications on primary care, the workforce and payment mechanisms.
2. Consider the inclusion of other key providers in the central leadership at CEO and operational levels.
3. Development of a systematic engagement strategy with your staff, patients and citizens.
4. Development of an integrated workforce strategy & plan.
5. Development of your Value Proposition for transformational funding.
6. Ideas on the sharing the learning and replication of the population health platform.
7. The assistance you require with the National team to support the development of your evaluation and metrics.

We look forward to receiving the above in writing from you by **26th June 2015**. We will then consolidate this with the feedback from other Vanguards before finalising the initial support package for Wirral Partnership PACS Vanguard.

Once again, please accept our thanks for welcoming the New Care Models team and colleagues to Wirral Partnership PACS Vanguard. Your mutual commitment to improve the care and support for local people was hugely energizing and embodies the spirit of the Vanguard programme. I know I speak on behalf of colleagues from the team regionally and nationally in saying that we are very much looking forward to working together in developing and delivering the new care model.

Yours sincerely,

Sue Loseby
PACS Lead
New Care Models Team

Board of Directors	
Agenda Item	6.1.1
Title of Report	**Integrated Dashboard and Exception Reports**
Date of Meeting	**24 June 2015**
Author	**John Halliday** **Assistant Director of Information**
Accountable Executive	**Mark Blakeman** **Director of Infrastructure and Informatics**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Full**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**To note**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

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 May 2015.

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 Business Performance & Assurance, 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 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

3. Key Issues

Individual metrics highlighted as Red for May are Staff Satisfaction, A&E 4-hours, Attendance, Infection Control, Attendance, Qualified Nurse Vacancies, Contract Performance, CIP Performance, Capital Programme, Non-core Spend, Advancing Quality and CQC concerns.

To avoid duplication, exception reports are only included in the dashboard for those metrics not covered by separate reports, or updates to the Board from the relevant associated Committee. For the annual Staff Satisfaction metric, the intention is to use the Friends and Family Staff Satisfaction results on a quarterly basis in 2015-16 to track progress. Commentary on the financial performance metrics is contained within the separate finance report to the Board of Directors.

There is currently a delay in data being released to Dr Foster from the HSCIC, hence the market share indicators are behind. A more recent position is expected for the next report.

Under Monitor's Risk Assessment Framework for 2015-16 the Governance status for WUTH is currently considered to be neither Green nor Red, with some issues identified and described accordingly.

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. Recommendation

The Board of Directors is asked to note the performance to the end of May 2015.

WUTH Integrated Performance Dashboard - May 2015

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F "Recommend" Rate			JG	95.0%	May 2015
Patient Satisfaction - F&F "Not Recommend" Rate			JG	2.0%	May 2015
Staff Satisfaction (engagement)			AH	3.48	2014
First Choice Locally & Regionally					
Market Share Wirral			AH	83.7%	April to Dec 2014
Demand Referral Rates			AH	2.8%	Fin Yr-on-Yr to May 2015
Market Share Non-Wirral			AH	8.3%	April to Dec 2014

Organisational Risk Issues

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Key Performance Indicators					
A&E 4 Hour Standard			SG	85.6%	May 2015
RTT 18 Weeks Standards			SG	All met	May 2015
Cancer Waiting Time Standards			SG	On track for qtr	Q1 to May 2015
Strategic Objectives					
Delayed Transfers of Care			SG	4	12-mth ave to May 2015
Readmissions			EM	8.4%	March 2015
Harm Free Care			EM	96.0%	May 2015
HIMMs Level			MB	5	May 2015
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	0	May 2015
Complaints			JG	39.7	12-mth ave to May 2015
Infection Control			JG	0 MRSA; 9 C diff	May 2015
Productivity					
Bed Occupancy			SG	91.60%	May 2015
Theatre Utilisation			SG	66.7%	May 2015
DNA Rate			SG	8.8%	May 2015
Workforce					
Attendance			AH	95.2%	12-mth ave to May 2015
Qualified Nurse Vacancies			JG	6.17%	May 2015
Mandatory Training			AH	97.1%	May 2015
Appraisal			AH	86.9%	May 2015
Turnover			AH	11.1%	May 2015
Finance					
Contract Performance			AM	-2.7%	To M2 May 2015
Expenditure Performance			AM	1.8%	To M2 May 2015
CIP Performance			AM	-46.0%	To M2 May 2015
Capital Programme			AM	-36.5%	To M2 May 2015
Non-Core Spend			AM	9.5%	To M2 May 2015

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	2 areas below target	March 2015
Mortality: HSMR			EM	90.16 (low ci 85.1)	April 2014 to Feb 2015
Mortality: SHMI			EM	1.0 (low ci 0.89)	July 2013 to June 2014
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	To M2 May 2015
Monitor Risk Rating - Governance			SG	Not Green or Red	To M2 May 2015
CQC			EM	5	May 2015
Local View					
Commissioning - Contract KPIs			SG	4	May 2015
Education			EM	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F "Recommend" Rate	Patient Satisfaction - Friends & Family "Recommend" Rate for Trust	>=95%	n/a	<95%
Patient Satisfaction - F&F "Not Recommend" Rate	Patient Satisfaction - Friends & Family "Not Recommend" Rate for Trust	<=2%	n/a	>2%
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 GP Referred New OP 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 Thermometer definition 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 in month, and cdiff less than cumulative trajectory	0 MRSA Bacteraemia in month, and cdiff equal to cumulative trajectory	>= 1 MRSA Bacteraemia in month or cdiff cases above cumulative trajectory
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 (Med, Surg and W&C)	<=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 inspection	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 April 2015

Indicator :
Staff Satisfaction (engagement)

Rating	Target	Actual	Period
Red	>= 3.69	3.48	2014

Issue:

The overall engagement score for the 2014 staff survey was 3.48, a deterioration from the 2013 score of 3.64. The national average for 2014 was 3.74, and WUTH is in the bottom 20% of trusts nationally and 4th from the bottom of 135 acute trusts.

Historic data:

Proposed Actions:

The findings have been to Trust Board with an action plan. Presentation and high level actions have been to the CoG. Q&S also have the results and will receive the action plan at the next meeting in May. Results and action plan are going to LiA Sponsor Group 23rd March, PSG 24th March, Staff Satisfaction Steering Group 25th March, and WCG 2nd April.

Quality health presented the results and management recommendations on the 27th March to invitees including the Trust board, CEO forum members, PSG, JLNC, and Staff Governors. Employee Engagement Event with 100 Senior Leaders and Managers held on the 12th May, with a 100-day Pledge from all those attending.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety, Staff Satisfaction Steering Group and Workforce and Communications groups. Quarterly Friends and Family surveys have been amended to incorporate staff engagement scores, and these will be reported to the BoD on a quarterly basis commencing in July 2015 on Q1.

Impact:

Low staff engagemant and morale will impact the Trust's ability to deliver quality services and achieve objectives.

Expected date of performance delivery:

2015 Staff Survey

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report May 2015

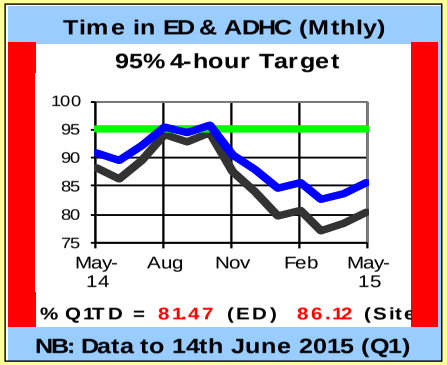
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	85.6%	May 2015

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for May was 85.6%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 80.47%.

Historic data:



Proposed Actions:

The pressures previously reported continued for much of the quarter, although in recent weeks there has been a reduction in admissions which coupled with the heightened focus on patient flow has allowed the closure of the escalation ward; we have also started to see some improvement in performance against the target.

The Trust has now received the report from the Emergency Intensive Support Team (ECIST) based on their walkthrough of the non-elective pathway and has run a 'Breaking the Cycle' initiative. The 8 day long initiative saw some improvements in performance, an increase in the number of discharges before midday and an improvement in ambulance handover times. During this initiative the "SAFER " care bundle was piloted, ECIST describe this as "a national best practice bundle that puts 5 clear steps in that are proven to reduce hospital blockages in the system and reduce mortality". Actions from the initiative and the recommendations from the ECIST report have been added to a refreshed urgent care recovery plan (in a new format recommended by ECIST) which should be signed off by the Systems Resilience Group on 16th June. The Trust has committed to fully implement the SAFER bundle on 2 wards by the end of June and across the Trust by the end of September. ECIST have agreed to support the Trust around 3 key areas namely discharge planning and processes, therapies structure and practice, and roles and responsibilities within ED. This work will take place during June and July.

The Trust is also reviewing internal systems and processes with the assistance of the Interim Deputy Chief Executive who has extensive experience in this area and has introduced a new capacity planning tool, a weekend discharge team and increased focus on the things within the Trust's control.

There are number of actions ongoing to improve patient flow which are monitored on a weekly basis as part of the patient flow work stream which will help promote a feeling of safe and calm, reduce occupancy, improve patient and staff experience which will help the Trust achieve this key performance target.

As well as focusing on the internal issues work is ongoing with economy partners, for example ECIST facilitated a workshop on discharge processes and planning took place on 8th June.

The ED escalation meeting was held on 14th May where Monitor and NHS England were updated on progress and advised of the trajectory that the economy will achieve in Quarters 3 and 4 of this year. A further meeting with Monitor is to be held on the 18th June 2015 when the Trust will explain the issues impacting on performance and outline the recovery plan.

Assessing Improvement:

For week ending the 14th June, the Trust achieved 95.89% on our own, and 96.87% jointly with the ADHC. The latest quarterly position is 86.12% as an economy. The standard will not be achieved this quarter.

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:

From quarter 3 in 2015/16

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report

May 2015

Indicator :
Infection Control

Rating	Target	Actual	Period
Red	Within trajectory	9 c diff cases	To May 2015

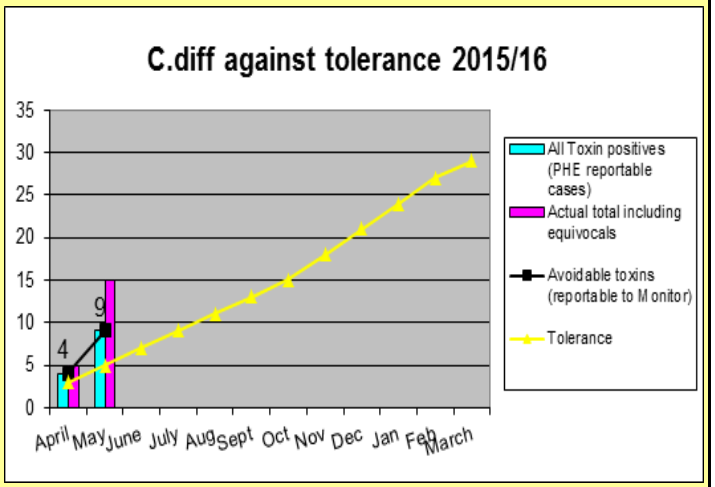
Issue:

The Trust has a maximum trajectory of 29 C.difficile cases for the year 2015-16 (toxin positive, hospital acquired). During May we reported 5 hospital attributed cases of toxin positive C.difficile with 5 equivocal (non-reportable) cases also identified. This brings the cumulative position to 9 against an expected 5 cases to the end of May 2015.

Post Infection Reviews performed by the IPCT have identified all 5 to be avoidable. All 5 cases had been exposed to C.diff either during an inpatient episode when there was a positive patient on the ward or through the environment that had not received a full ward HPV since C.diff had been reported on the ward. All 5 patients also received the trigger of antibiotics to then cause C.difficile infection following the exposure.

Ribotyping from C.diff cases on ward 26 has demonstrated a pattern seen previously whereby WUTH experienced a significant outbreak of C.diff with the ribotyping suggesting environmental contamination/covert C.diff carriage & excretion as key factors as opposed to patient to patient transmission. The outbreak was interrupted by full ward HPV decontamination.

Historic data:



Proposed Actions:

A plan to deliver a reactive HPV programme followed by an uninterrupted proactive programme to include PPM has been defined by the IPCT and Hotel Services Team. However it was still not possible to implement this plan during May as ward 25 remained open and therefore there was insufficient equipment to safely decant to ward 27. During May the pressure on beds also made it difficult to reduce beds to perform bay by bay HPV decontamination and therefore it was only possible to perform reactive HPV once a positive C.diff patient vacated a side room.

Recommendation:
- Divisional leads to ensure high risk priority areas are prepared to transfer to ward 27 for HPV decontamination prior to ward 27 no longer being available for this purpose.
- Prompt isolation of patients with symptoms of diarrhoea

Assessing Improvement:

The situation is constantly monitored by the IPCT, with weekly meetings including the DIPC and Executive Leads. Updated reports are provided to the Hospital Infection Control and Clinical Governance Groups.

Impact:

Effective infection control is vital to ensuring safe, high quality health services are delivered at our hospitals. Cases of infection not only affect the individual patients directly, but can have a negative impact on the overall capacity of the Trust, and are a high profile measure in the public domain.

Expected date of performance delivery:

Quarter 2 reporting

Director approval:

Jill Galvani, Director of Midwifery & Nursing

WUTH Performance Dashboard Exception Report May 2015

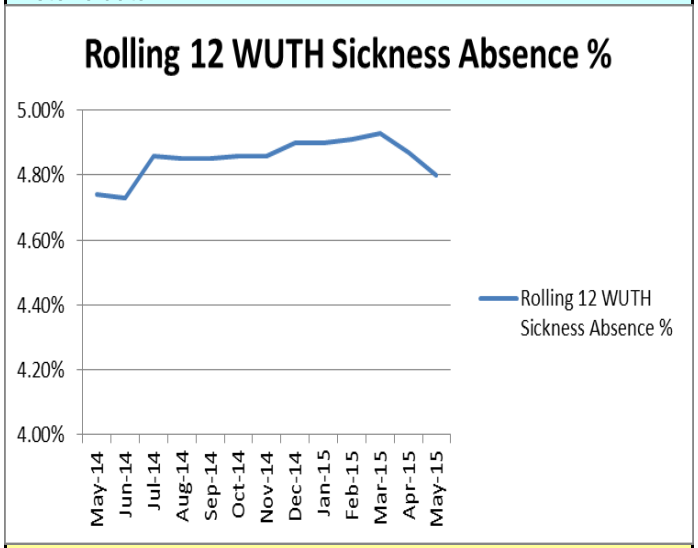
Indicator :
Attendance (Roling 12 Months)

Rating	Target	Actual	Period
Red	>= 96%	95.20%	Jun 14 - May 15

Issue:

Attendance (Rolling 12 months) was 95.20% at May 2015.
The new Attendance Capability Policy : training of over 400 managers, Health and Well Being Strategy, action plans for poor attenders, recognition of good attenders and focus on long term sick have produced reduced month only sickness rates since the new policy went live in January. This is now feeding through to a reducing rolling 12 months rate.

Historic data:



Proposed Actions:

Since the new policy went live sickness rates have reduced every month (May 2015 month only was 3.72% which was the first time the Trust bettered it's target of 4%), Strong focus on staff off long term sick has reduced numbers from 154 in December to 101 in May. Other actions include: Health and Wellbeing Strategy, monthly reporting and drill down, monthly workforce meetings, action plans for poor attenders, Occupational Health Service.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety and Workforce and Communications groups.

Impact:

Continued high sickness absence will impact the Trust's ability to deliver quality services and achieve objectives. High sickness absence will lead to high non core spend compromising financial position and increasing CIP pressure. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permanent employees this can lead to quality issues.

Expected date of performance delivery:

Quarter 2 reporting

Director approval:

James Mawrey, Director of Workforce

WUTH Performance Dashboard Exception Report — May 2015

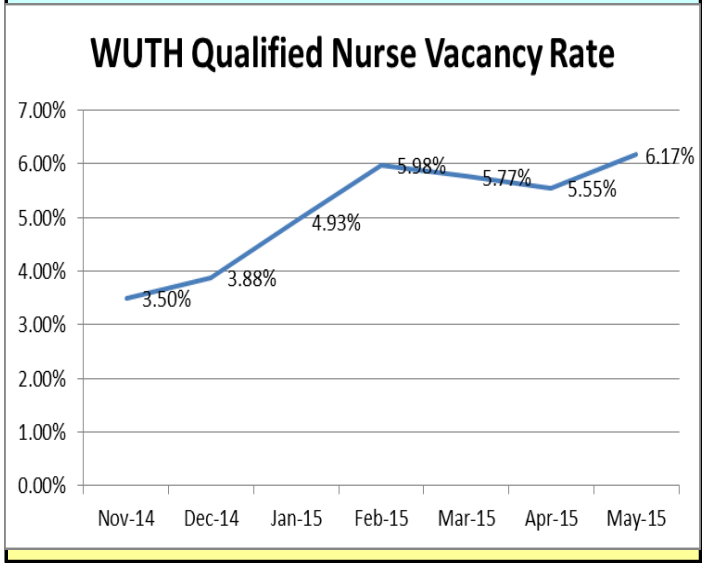
Indicator :
Qualified Nurse Vacancies

Rating	Target	Actual	Period
Red	>5%	6.17%	May-15

Issue:

Qualified Nurse Vacancies was 6.17% at May 2015 and although this has been reducing over recent months it is still 1.17% above the Trust target of 5%. Actions as detailed below are taking place to address this. A review of Nurse Turnover metrics is taking place including benchmark data from comparator Trusts in order to establish what is a healthy level of Nurse turnover and what level requires escalation.

Historic data:



Proposed Actions:

Exceptional nurse recruitment is taking place and 75 job offers were made in early 2015 (although many of these will not start for several months due to finishing qualifications or notice periods). Further generic Nurse recruitment is taking place. A paper on international recruitment is being prepared in order that this option is fully considered.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety and Workforce and Communications groups.

Impact:

Continued high vacancy rates will impact the Trust's ability to deliver quality nursing services and achieve objectives. High vacancy rates will lead to high non core spend compromising financial position and increasing CIP pressure. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permanent employees this can lead to quality issues.

Expected date of performance delivery:

Quarter 1 reporting

Director approval:

James Mawrey, Director of Workforce

WUTH Performance Dashboard Exception Report — March 2015

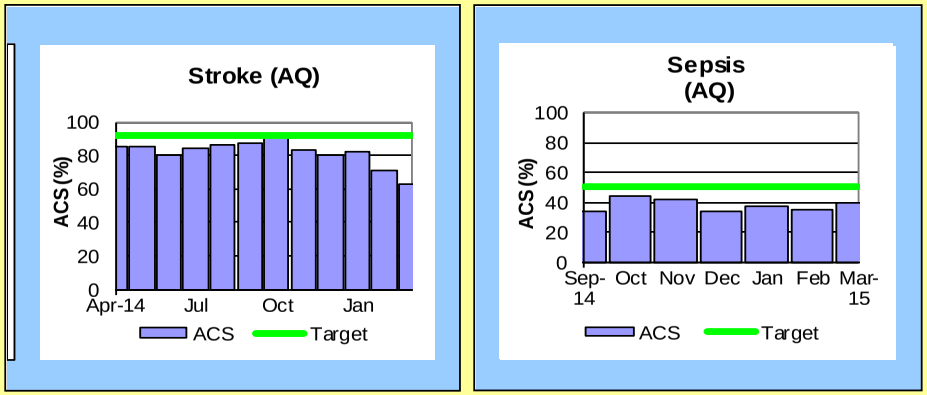
Indicator :
Advancing Quality

Rating	Target	Actual	Period
Red	All achieving	2 areas under target	March 2015

Issue:

The measures are composite scores, reflecting individual care to patients; the results are delayed up to 3 months and so lags behind improvement. At the end of March, Stroke and Sepsis were below target.

Historic data:



Proposed Actions:

STROKE - the key measure is access to a stroke unit bed and therefore is highly dependent on the flow of patients within the hospital; ring fenced stroke beds would achieve this. We will not achieve this target for the year as bed pressures continued into March and the target is over 97%. Other organisations are facing similar issues and we are currently the highest performer in the AQ hospitals group.

SEPSIS - Progress contunes on this new area. All Trusts are working to a target of 50%. The current actions are Cerner developments (expected June 2015), promoting the sepsis pathway and education and traiing for the staff. There are issues with the blood gas analysis not being available on Cerner and discussion is underway to see if this can be resolved.

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.

Expected date of performance delivery:

Improvement ongoing through 2015-16

Executive approval:

Evan Moore, Medical Director

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 2 Finance Report
Date of Meeting	24 June 2015
Author	Shahida Mohammed, Assistant Director of Finance – Income & Commissioning
Accountable Executive	Alistair Mulvey, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

Income and Expenditure Position

The actual in month position for Month 2 is a deficit of £1.9m against a planned deficit of £1.7m; cumulatively the Trust had planned the year to date deficit to be £3.4m, the actual deficit recorded is now £3.7m, resulting in a variance of £0.3m year to date, and £0.2m in month.

NHS clinical income is £1.2m below plan, other income is £0.1m better than plan and the pay and non-pay expenditure position is showing a positive variance of £0.7m. The combination of these elements delivering a cumulative deficit against plan of c£0.3m.

Cash Position & Continuity of Service Ratios (COS)

The cash position is £22.3m, £4.3m better than plan. This is due to the early receipt of key debtors and a delay in charges being billed and settled, including settlement of some balances with commissioners from 2014/15. It is anticipated that these payment and receipt timing differences will unwind in the coming months and the Trusts cash position will deteriorate accordingly. In mitigating a deteriorating cash position the Trust continues to actively manage its cash and working capital position.

The overall Continuity of Service rating at month 2 is a 2 which is in line with plan.

The headline Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 2 2015/16 (May)							Comparative 2014/15 Position (Month 2)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	25,194	24,450	(744)	50,225	49,098	(1,127)	48,864	48,723	(141)
Employee Expenses	(17,337)	(17,416)	(79)	(34,477)	(34,718)	(241)	(33,712)	(34,928)	(1,216)
All Other Operational Expenses	(7,720)	(7,657)	63	(15,124)	(15,101)	23	(13,050)	(13,801)	(751)
Reserves	(681)	(160)	521	(1,734)	(782)	952	(2,051)	(422)	1,629
EBITDA	(544)	(783)	(239)	(1,110)	(1,503)	(393)	51	(428)	(479)
Post EBITDA Items	(1,152)	(1,121)	31	(2,304)	(2,251)	53	(2,217)	(2,221)	(4)
Net Surplus/(Deficit)	(1,696)	(1,904)	(208)	(3,414)	(3,754)	(340)	(2,166)	(2,649)	(483)
EBITDA %	(2.2%)	(3.2%)	(1.0%)	(2.2%)	(3.1%)	(0.9%)	0.1%	(0.9%)	(1.0%)

Cost Improvement Programme (CIP)

The Trusts plan incorporates a requirement to achieve £13m of in year CIP, to date detailed plans of £11.1m have been identified. The remaining £1.9m still to be identified has been extracted from budgets in a flat profile (12ths). In month 2 the planned schemes have broadly achieved in line with expectations with the exception of patient flow which is currently subject to more detailed review.

£k	By Scheme Type		By Cost		Total
	Income Generation Net of Cost of Delivery	CIP	NHS Clinical Income	Divisional Budgets	
Plan YTD	59	668	206	522	727
Actual YTD	48	347	22	373	395
Variance YTD	11	321	183	149	332

Activities continue through the PMO to secure the planned savings and identify areas of over performance to close the gap.

2. Background

The plan position as at month 2 was a deficit of £3.4m; the actual position is showing a deficit of £3.7m. The main area of under-performance is clinical income which is £1.2m below plan.

This position provides the Trust with a risk rating of 2; although the metrics which underpin the overall rating have been weakened by the small adverse income & expenditure performance the rating of each metric remains the same.

The cash position is £22.3m, just £4.3m better than plan due predominantly due to timing differences on working capital.

3. Key Issues

The Trust has under achieved against its planned income target for month 2, delivery of the planned volumes of care is a prerequisite to the achievement of the overall financial plan. Under achievement is across both planned and unplanned care.

Surgery, Women's and Children's Division is showing the largest under recovery, which is attributed to a combination of reduced volumes of care and reduced casemix which translates into a reduced level of income per spell of care delivered.

Within Medicine although activity is below plan a richer casemix has mitigated some of the under recovery. Penalties incurred due to failure against the A & E target amount to £0.3m which further deteriorate the divisions financial performance. Discussions through the localities Strategic Resilience Group (SRG) as to the appropriateness of penalising the Trust for a position which is reliant to a significant degree on economy wide actions continue. On that basis within the reported month 2 position it has been assumed that the penalties applied would be re-invested into the Trust to support costs being incurred and to mitigate the financial under performance.

Activity plans for 2015/16 have been agreed and signed-off by Divisional leads during the planning process, it is imperative where plans have slipped remedial action plans are devised and enacted.

Divisional Analysis

The following table shows the summary Divisional position (Month 2). The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail (Appendix 1).

	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Corporate £000	Central £000	Total £000
NHS Clinical Income						
Planned Income	20,510	21,343	2,726	131	923	45,632
Actual Income	19,875	20,110	2,784	130	1,498	44,397
Variance	(635)	(1,233)	58	(1)	576	(1,235)
Net Expenditure						
Planned Expenditure	14,172	16,059	6,818	8,002	1,693	46,744
Actual Expenditure	14,314	16,020	6,629	8,202	737	45,902
Variance	(142)	39	189	(200)	956	842
Variance EBITDA	(777)	(1,194)	247	(201)	1,532	(393)
Post EBITDA						
Planned Post EBITDA					2,304	2,304
Actual Post EBITDA					2,251	2,251
Variance	0	0	0	0	53	53
Total Variance to Plan	**(777)**	**(1,194)**	**247**	**(201)**	**1,585**	**(340)**

Pay Analysis

The most significant area of expenditure for the Trust, relates to pay, during the month actual pay spend was broadly on plan with a marginal overspending of c£0.1m. Positively the quantum of cost in the first two months of the financial year is below the average monthly costs of the preceding 12 months indicating improved control against pay run rates. Additional costs, reflecting increased capacity within the organisation to support patient flow and the management of infection will continue to be closely monitored and minimized within the context of providing the safest possible clinical care.

The following figure provides further detail of the May pay costs analysed between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	14/15 Average £k	April £k	May £k	YTD £k
Budget	**16,916**	**17,140**	**17,337**	**34,477**
Pay Costs				
Permanent	15,875	15,604	15,783	31,387
Bank Staff	319	306	291	597
Agency Staff	518	698	712	1,410
Overtime	224	343	278	621
Locum	362	299	264	563
WLI (In Year)	155	52	88	140
Total	**17,451**	**17,302**	**17,416**	**34,718**
Variance	**(535)**	**(162)**	**(79)**	**(241)**

4. Next Steps

The Trust continues to work closely with external support partners in order to assist in improving the financial performance and in embedding deeper transformational change. The financial performances of the divisions are being closely monitored through the monthly performance review process. A clear message has been provided within the organisation, emphasing the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs.

Specifically the divisions are focusing on the delivery of activity plans as being pivotal in the overall achievement of the financial plan, this is specifically relevant as the year progresses and margin contribution schemes which form a component of the CIP programme being to increase in value.

Forecast activity is reviewed on a weekly basis and divisions are each developing a three month rolling financial forecast to increasingly consider necessary prospective actions to improve the forward look financial management of the organisation. The forecast swill be reported to the Board of Directors through the Chairs Report from the Finance Performance and Business Assurance Committee.

5. Conclusion

The overall I & E position for month 2, at an aggregate level, is marginally off plan with the Trusts cash position being marginally stronger than planned. The Trust has achieved its CoS rating of 2 as planned.

Whilst it is early in the financial year it is imperative that the Trust moves back towards delivery of its activity plans, specifically from a planned care perspective and that this is facilitated through improved patient flow across the organisation. Improvements in flow will also support a reduction in the penalties the Trust faces for non-achievement of the A & E target recognising that, at an economy wide level, discussions on the application of these penalties and their reinvestment in service delivery continues through the Strategic Resilience Group (SRG).

Within the totality of the position the Trust has achieved its planned level CIP however there remains c£1.9m of CIP requirement for which plans continue to be explored.

From a risk perspective the key considerations include the requirement to recover the lost income in the early part of the financial year, the requirement to improve patient flow to minimize financial penalties and the development of further CIP schemes to bridge the current CIP shortfall. In addressing these issues divisions are closely monitoring activity levels and seeking opportunities to maximize capacity, investments in patient flow have been supported to ensure the swiftest and most clinically appropriate transition of patients into and out of the organisation and weekly review of CIP development and delivery is undertaken at an executive level. These steps will be supplemented by enhancing the divisional input into rolling financial forecasts.

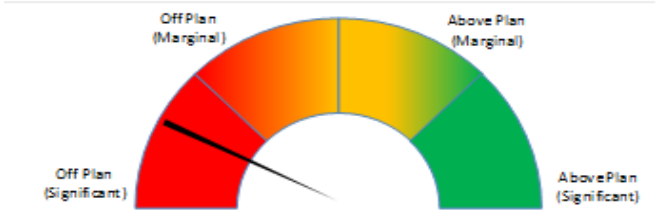
6. Recommendations

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

Alistair Mulvey
Director of Finance
June 2015

Divisional Overview (Month 2)

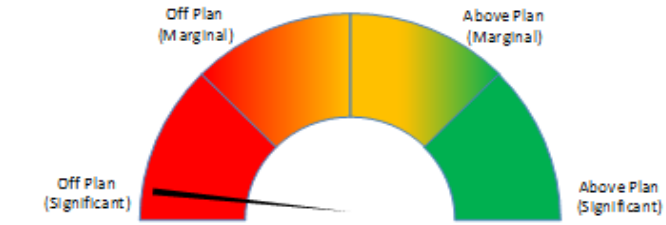
Medicine



Medicine - Key issues

- *Clinical Income behind plan by £0.6m.*
- *Net Expenditure exceeds budget by £0.2m .*
- *Overall position is £0.8m off plan.*

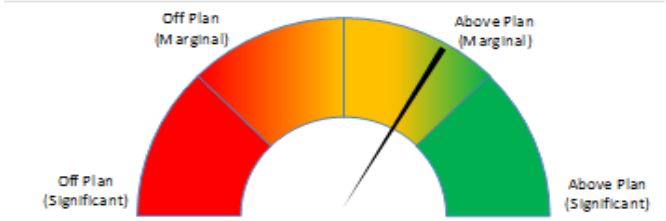
Surgery/ W&C



Surgery / W&C - Key issues

- *Clinical Income behind plan by £1.2m.*
- *Net Expenditure is on plan*
- *Overall position is £1.2m off plan.*

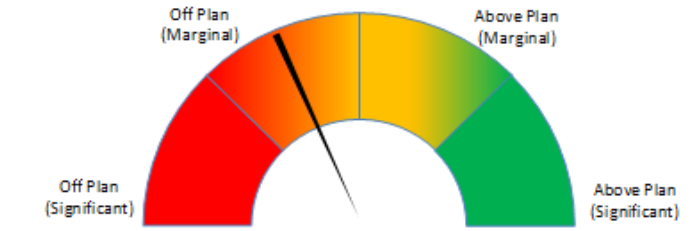
Clinical Support



Clinical Support - Key issues

- *Clinical Income is on plan.*
- *Net Expenditure is under plan by £0.2m .*
- *Overall position is £0.2m better than plan.*

Corporate Services



Corporate Services - Key issues

- *Divisional Income is on plan.*
- *Expenditure over plan by £0.2m .*
- *Overall position is £0.2m off plan.*

Medicine & Acute I&E

Acute and Medical Care – The division reported a £444k deficit in month 2 which brings the year to date deficit to £777k.

Clinical Income within the division is under achieving by £401k in month and £635k year to date. The main drivers of this is against Non Elective activity which has underperformed in activity by 606 spells year to date with a resultant underperformance against income of £442k (net of penalties of £206k). Elective activity has underperformed in month by £47k with the key area of this being attributable to Cardiology (£41k) due the gap in substantive consultants.
A&E has underperformed year to date by 706 attendances and by £25k, although there has been no penalties levied with the premise that these are to be re-invested within the trust to aid with meeting the A&E target.
Excess bed day activity has over performed by £101k for Non Elective and under performed by £13k relating to Elective activity.
Outpatient activity has seen an underperformance of £93k year to date. The key areas of this underperformance are Rheumatology (£27k) due to consultant absence due to personal reasons, Hematology (£23k) due to the application of follow up caps of £14k and the shortfall against plan to annual leave, Nephrology (£23k) due to a drop in referrals and the application of follow up penalties of £18k. Respiratory Medicine is also showing an underperformance (£14k) against outpatient activity but an investigation is currently underway to see if activity is being recorded properly to ensure income is received. Areas of outpatients that have had follow up penalties for non Wirral CCG will be reviewed to look at either discharging patients back to the relevant CCG or seeking a change to the rule of the application of the cap if this is not accepted.
High Cost drugs/bloods is showing an underperformance against plan of £214k which is offset by an under spend in expenditure.
The costs of service delivery have exceeded the planned budget by £142k year to date and £19k in month. The most significant element of pressure relates to unfunded bed areas relating to W26, escalation areas of W25 and W27 £345k. W14 which is the Infection Control Ward has a cost pressure of £159k due to the majority of the shifts being filled by premium costs. The cost of the Discharge Lounge, which was not budgeted to be open, has resulted in a pressure of £30k. There has been an under spend against High cost drugs/bloods year to date of £214k which is offset in income. CIP is showing an over performance year to date of £177k which is due to the fact that no enabling costs have been assigned to W26 due to the underperformance for Non Elective activity associated with this CIP scheme.
At the time of writing this report W27 is closed and is now being used to support the HPV programme. W25 has also now closed and it is not anticipated that either of these wards will be opened in the forthcoming months as escalation areas due to the reduction in Non Elective activity.
The Division is anticipating that there will be a continued shortfall against plan relating to Non Elective activity and is closely monitoring this to ensure that occupancy levels are reduced across the funded bed areas to facilitate the appropriate flow of patients and the achievement of the A&E target. The gaps in Cardiology and Gastroenterology substantive posts is anticipated to continue for the forthcoming months which is a concern for the Division in the achievement of planned activity.

Surgery, Women's & Children's I&E

Surgery, Women's and Children's Division – The division reported a £667k deficit in month 2 which brings the year to date deficit to £1,194k.

Clinical Income within the division is under achieving by £675k in month and £1,233k year to date. The main drivers of this are against Elective activity which has underperformed in activity by 430 spells year to date with a resultant underperformance against income of £867k. The key area of this being attributable to Orthopedics which is £493k year to date behind plan offset with £90k of additional Welsh activity. Work is being undertaken by the Division to recover the under performance in Months 1 & 2 over the next few months.

Non-Elective activity has underperformed in month by £27k with the key area of this being attributable to General Surgery (£95k) with Trauma being up £110k in month and £203k year to date.

Maternity is £101k above plan year to date.

Outpatient activity has seen an underperformance of £295k year to date including the new to follow up penalty of £73k. The key areas of this underperformance are Ophthalmology (£57k) and Orthopedics (£74k).

The Divisions expenditure position is showing a year to date underspend of £39k with £8k underspend in month. This is despite numerous gaps in the Deanery rotation which has meant agency doctors have had to be used to fill these gaps. The Division has seen a sustained reduction in the overall non-core spend.

Clinical Support I&E

Clinical Support Division — The Division reported a cumulative favorable movement of £246k as shown in the following table:

	Month £k	YTD £k
Clinical Income	21	58
Pay Costs	98	220
Non Pay Costs	(3)	(36)
CIP	3	5
Net Position	**119**	**247**

Clinical Income is performing well being £58k ahead of plan driven in the main by Direct Access. This is mainly due to Pathology which is £53k above budget; the expectation is that this benefit will reduce over the coming months as requests are expected to revert back to the simpler mix seen historically. Radiology DA income is up cumulatively however Ultrasound activity is tracking below plan; the team is investigating this. AHP income is behind plan but the teams are reviewing slot utilisation to maximize all opportunities.
Pay costs are underspent by £220k YTD in all areas bar Radiology. Therapies, Patient Flow and Outpatients are significantly below plan as a consequence of high vacancies, this has necessitated some agency spend to support activity. Therapies & Patient Flow are actively recruiting so it is expected that this underspend will reduce. Where appropriate vacancies are being held as the Division progresses its staffing restructures, particularly relevant in Outpatients.
Non-core spend totaled £425k (9.2% of core spend) of which £209k relates to Medical Staffing owing to the ongoing Histopathologist shortage and reporting/on call cover issues In Radiology. Two Histopathologists are due to start in post in August/September and Radiology is looking at the issues around on call cover.
Non pay budgets are £36k over plan with the main increase on Clinical Supplies as a result of higher DA activity levels. The CIP target was exceeded by £2k as a result of higher pension opt out uptake.
The performance by directorate is shown below; please note that some budgets are being held on Divisional Mgmt. until staff are recruited into the relevant areas.

	AHPs	Cancer Pathway	Labs	OP	Patient Flow	Radiology	Divisional Mgt	Total
Month	57	(0)	31	27	9	(44)	39	119
YTD	115	(2)	68	50	25	(85)	75	246

Corporate Services I&E

Corporate Services Division - The division reported a £96k overspend in month Divisional income is cumulatively £17k under-recovered and the expenditure budgets are cumulatively £183k overspent.
The table below details the financial net position for the key areas of the Corporate Services division:-

Directorate	Annual Budget	Current Month Budget	Current Month Actual	Current Month Variance	Ytd Budget	Ytd Actual	YTD Variance
CORPORATE NURSING	1,739	144	141	3	287	285	2
ESTATES	6,430	511	507	4	1,039	1,058	-20
EXECUTIVE MANAGEMENT	13,976	1,178	1,178	0	2,346	2,341	5
FINANCE & SUPPLIES	3,351	278	260	18	557	522	35
HOTEL SERVICES	13,085	1,117	1,133	-17	2,216	2,253	-36
HR & OD	2,332	196	194	1	382	380	2
INFORMATION & IG	1,587	131	182	-50	263	339	-76
IT	6,434	540	558	-18	1,074	1,101	-27
PHARMACY	5,107	424	424	0	846	846	0
QUALITY & SAFETY	919	76	65	11	152	135	17
TRANSFORMATION TEAM	2,160	73	63	9	138	120	17
CORPORATE SERVICES CENTRAL	-26	339	358	-20	374	412	-38
MISCELLANEOUS	-7,865	-819	-780	-39	-1,671	-1,589	-81
Grand Total	49,230	4,187	4,283	-96	8,002	8,202	-200

The areas of concern this month continue to be:-

Information Governance—there continues to be a significant pressure on Injury Cost Recovery (ICR) income. Income levels have worsened in May giving an under recovery of £45k in month and £63k year to date. In addition there is a pressure caused by Agency staff expenditure against the Clinical Coding Department budget.
Information Technology—continued overspends on IT due to cost pressures on maintenance and IT purchases are offset in part by vacancies in EBME.
Hotel Services budgets continue to be under pressure from supporting additional beds.

Pharmacy continues to be largely on plan in-month. This is despite the pressure on the Department from the impact of additional beds being open.

BOARD OF DIRECTORS	
Agenda Item	7.1
Title of Report	CQC Update and Mock Inspection Summary
Date of Meeting	24 June 2015
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective – Supported by financial, commercial and operational expertise Key Measure – Full Compliance with our registration with CQC
Level of Assurance • **Positive** • **Gap(s)**	Gaps: 10 of 13 standards currently rated as 'requires improvement' in latest self-assessment
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	None required

1. **Executive Summary**
   The purpose of this paper is to provide the Board with an overview of our current state of compliance with the Care Quality Commission's Fundamental Standards, ahead of the planned inspection which is due in September. The paper also includes highlights from the latest round of mock inspections and summarises the Intelligent Monitoring Report for the Trust which CQC published in May.

2. Background

In March the Board received a preliminary assessment of compliance with the Fundamental Standards of Safety and Quality. This assessment has been updated following a review of further evidence such as performance and audit reports, and meetings with Executive Directors to discuss progress made against each standard.

3. Key Issues/Gaps in Assurance

We are currently rating ourselves as 'requires improvement' for ten of the thirteen standards. This compares positively with the earlier assessment, where two standards were rated inadequate, nine as requiring improvement, and two as good.

With regard to the mock inspections, 32 clinical areas have been inspected and rated. Two have been rated inadequate, 11 as requiring improvement, 17 as good and one as outstanding. One area was not given a rating as there were very few patients on site at the time who we could interview.

The Intelligent Monitoring Report places the Trust in Band 1, the highest risk category. This is because a number of indicators within the report are categorised as elevated risks, for example our scores in some questions in the National Staff Survey. This is likely to influence CQC's approach to the inspection.

4. Next Steps

The matrix at the back of this paper provides a clear view of where our gaps are and what we need to do before the inspection. This is the basis of a series of much more detailed action plans which are being compiled and added to the risk register at present. These will be available for the Board to review at its next meeting if it wishes to do so.

Another round of mock inspections has just taken place in June although the reports are not yet available. We are also introducing out-of-hours mock inspections, at evenings and weekends, during July and August. We will also be re-visiting areas which performed poorly in their mock inspections.

5. Conclusion

Progress has been made in a number of areas but at this time we are not able to state that we are fully compliant with the Fundamental Standards.

6. Recommendations

The Board is asked to note the current state of progress.

CQC Project Plan - Progress

Action	Deadline	Current Status
Set up project team	March 2015	**Partially complete** Dr Melanie Maxwell (Associate Medical Director) is leading on preparations for the inspection. We have interviewed and selected a Compliance Manager (band 7) to work on a temporary basis until the inspection, but their secondment is still to be agreed. We have been unable so far to recruit to the administrative assistant post although a part-time secretarial employee in Quality and Safety is currently working some additional hours to support the programme of work.
Site visits to other Trusts	March 2015	**Complete** In March we met with the Medical and Nursing Directors, and Head of Governance, at Mid Cheshire NHS Trust, who achieved a 'good' rating. We are hoping to meet with our opposite numbers at Tameside NHS Trust once their inspection is complete.
Deploy mock inspection programme	March 2015 onwards	**Ongoing** So far, 35 clinical areas have been inspected, out of a possible 59. 104 members of staff have either taken part in the inspection teams or are booked to do so in the near future. We have also involved 19 patient experience volunteers recruited through the League of Friends and Health Watch Wirral, and 6 Student Quality Ambassadors (nursing students from Liverpool John Moores University).
Develop inspection checklists for specialist areas	March 2015	**Partially complete** We have developed separate inspection checklists for the Children's Ward, Outpatients and Maternity. We are still drafting the checklist for Accident and Emergency, which we intend to inspect in June.
Develop data packs for core services	March 2015	**Complete** We have produced a data pack of performance information for each of the eight core services (medicine, accident and emergency, critical care, surgery, maternity, children's services, outpatients and end of life care). This has taken longer than expected but we are now confident in the data, which will be updated monthly.
Develop communication strategy	March 2015	**Partially complete** We have a number of ways of communicating with staff. For example, we have already given presentations to several staff groups, produced newsletters (awaiting printing) and included articles in Start the Week and Clinical Update. However, much of the additional work which we need to do (such as reaching more front line staff, and motivational interviewing) is dependent on obtaining additional short-term staff resources for the team (see comments for 'set up the project team' above).
Develop information flow for ward assurance	April 2015	**Complete** This is set out in a flow chart which was approved by the Clinical Governance Group in May. It describes to whom the findings of ward inspections should be reported and when. It is now in use.

Action	Deadline	Current Status
Review and update evidence portfolio; identify gaps	April 2015	**Complete** A portfolio of evidence has been produced for each of the Fundamental Standards, along with a Directory of Evidence (effectively a simplified and more user-friendly version of the Provider Compliance Assessment documents which were used for the former Essential Standards).
Develop CQC Audit Plan	April 2015	**Partially complete** We have identified the following topics which should be audited to provide assurance before the inspection: safeguarding (mental capacity, deprivation of liberty, and restraint); consent for children; nutrition (availability of special diets, use of parenteral nutrition, and administration of dietary supplements); and quality of record keeping on Millennium. We are also going to audit whether the action plan from the last CQC inspection has been implemented in full. However, we still need to allocate resources and program the timing of these audits.
Organise public engagement events	April 2015	**Complete** The Trust recently organised an event at Hoylake Community Centre in conjunction with the Wirral Older Peoples' Parliament to celebrate International Nursing Day. This included a question and answer session. Further public engagement events are planned.
Timetable for external partner engagement	April 2015	**Pending** This is to be discussed and agreed with Executive Directors by the end of May.
Update to Executive development day	April 2015	**Complete** A Board development session took place in April and the Associate Director of Governance has produced a summary of the discussion.
Triumvirate review of Key Lines of Enquiry	May 2015	**Complete** Each clinical division has completed a standard self-assessment template for each of their core services, based on the five key questions (caring, safe, responsive, effective and well-led) that every CQC inspection aims to answer.
Add new CQC risks	May 2015	**Pending** This will happen after the meetings with Executives to review the Fundamental Standards. Following those meetings, the Head of Assurance will draft entries for the risk register which will be agreed with them.
Executive review of Key Lines of Enquiry	May 2015	**Pending** This will be based on the self-assessments which the divisions have completed. As these are very detailed and cumbersome documents, the Head of Assurance will need to produce a summary for the Executives, in a more digestible format.
Executive review of Fundamental Standards	June 2015	**Pending – not yet due** The Associate Director of Governance and Head of Assurance have arranged to meet individually during June with each of the Executives who have lead responsibility for CQC standards. Each will assess the compliance with those standards on which they lead.

Action	Deadline	Current Status
Practical arrangements for inspectors' visit	August 2015	**Ongoing** We have arranged for the Education Centre to be made available as a headquarters for the inspection team while they are on site. Practical arrangements such as catering will be made in August.

CQC Update and Mock Inspection Summary

Introduction

This is the monthly update for the Board of Directors on issues relating to the forthcoming Care Quality Commission inspection. The report summarises the findings of our mock inspections but does not include the full detailed feedback which was included in previous reports. This detail has been provided to divisional and local management in accordance with our agreed 'Ward to Board' information flow.

The report also summarises the results of self-assessments which have been completed by divisional leaderships at service level, and by the Executive Directors at Trust-wide level.

Intelligent Monitoring Report

In early May the CQC issued their latest Intelligent Monitoring Report to the Trust, although this could not be disseminated until after the general election due to the purdah regulations. It is now in the public domain, on CQC's website. The report analyses a range of externally published data including mortality statistics, staff and patient surveys, and findings of regulatory bodies. It aggregates and analyses this data to create a risk profile for the organisation.

In the latest edition, the Trust was placed into Band 1 – the highest risk band out of 6. In the previous edition (December 2014) we had been in Band 6 – the lowest risk band. The report identifies three indicators as elevated risks. These are:

- Composite indicator for in-hospital mortality from infectious diseases *(principally from septicaemia, although we have sought clarification from Dr Foster Intelligence, who produce the data for CQC)*
- NHS Staff Survey question about whether staff received support from their immediate managers
- NHS Staff Survey question about whether staff found that the incident reporting process was fair and effective

There are nine other risk factors highlighted by the report. These include the frequency of 'never events' (five in the past year, including wrong site surgery and retained foreign objects post-operation), various questions in the National Staff Survey in addition to those mentioned above as elevated risks, and how the Trust has been rated by Monitor for governance and continuity of service - a reflection of the acute financial pressures facing the organisation. We also have a poor score for Patient Recorded Outcome Measures (PROMS) for hip procedures, one question in the national inpatient survey, and the administration of secondary preventative medication for which patients were eligible.

Most of the indicators in the Intelligent Monitoring Report do not change often – for example, the national staff survey is done once a year – and the report is published three times per year. This means that we are likely to remain within the same risk band at the time of the inspection in September. CQC's approach to the inspection is likely to be heavily influenced by the data within the report.

Divisional Self-Assessments

Each clinical division has been asked to complete a self-assessment document based on the CQC Key Lines of Enquiry and the five key questions (whether services are safe, effective, responsive, caring and well-led). These were completed by Divisional Management Teams and each division has now responded. The purpose of completing these assessments was twofold: firstly so that each division

could clearly identify its strengths and weaknesses before the inspection; and secondly to form the basis for a Trust-wide self-assessment which we will be required to submit to CQC before their visit.

Many of the issues identified as gaps in the self-assessments were specific to particular departments or services but there were some common themes across all the responses, and some issues which would have an impact beyond the department / division where they arise. These are listed below.

Safe

- Challenging to maintain safe nurse staffing levels
- Poor compliance in Theatres with the WHO Safety Checklist, and with briefing and de-briefing
- Poor compliance with some patient assessments such as venous thrombo-embolism screening, and with MUST nutritional assessments in certain areas
- Inability or unwillingness to access web-based incident reporting

Effective

- Lack of understanding of the Mental Capacity Act, Deprivation of Liberty Safeguards, and other safeguarding issues
- Poor quality of discharge letters
- Lack of integration between health records held by the Trust and by community-based services

Caring

- The Trust's approach to end of life care is inconsistent

Responsive

- Inability to match capacity with demand for services, resulting in extensive use of contingency wards
- Variable awareness of how to meet the needs of people with dementia and their carers and relatives
- Response rates for the Friends and Family Test not yet consistently high in all areas
- Variability in how well complaints are handled

Well Led

- Poor results from National Staff Survey, reflecting low staff morale and lack of engagement
- Staff are not perceived to be aware of the Trust's strategy and the PROUD values
- Managers and clinical leaders feeling that time pressure may prevent them from leading effectively
- Failure to act promptly to mitigate risks which have been recorded on the risk register
- Members of staff raising concerns with regulators without raising them internally first
- Lack of awareness of the duty of candour among front-line staff

Mock Inspections

The pace of the mock inspection programme has accelerated, with sixteen clinical areas visited during April and May. In total, over 100 members of staff have participated in the inspections, which demonstrates a strong commitment to quality and service improvement, both on the part of the staff themselves, and their managers who have enabled them to take part. We have also involved approximately twenty volunteers from the League of Friends and Health Watch Wirral, as well as five Student Quality Ambassadors (nursing students from Liverpool John Moores University).

32 clinical areas have been visited since the inspections commenced in January 2015, and the results have been as follows:

Outstanding: 1 area
Good: 17
Requires Improvement: 11
Inadequate: 2
No rating given: 1

We aim to have visited all clinical areas by the end of July, although this is of course contingent on enough members of staff being available to take part. The areas visited during April and May, and the ratings given to each of them, were as follows:

Ward / department	Rating
Acute & Medical	
AMU	Good
Critical Care	Good
Endoscopy	Good
M2 (Rehab)	Requires Improvement
Ward 23	Good
Ward 31 (Dialysis)	Good
Ward 32	Good
Surgery	
Eye Clinic	Good
Fracture Clinic	Outstanding
M1 Clatterbridge	Good
Oral and Maxillofacial Clinic	Requires Improvement
Surgical Elective Admissions Lounge	Requires Improvement
Ward 1	Good
Ward 10	Requires Improvement

The issues identified as needing improvement are generally similar to those from previous months' inspections. Notable themes this month include:

- **Poor medicines storage practices:** medicines being left on counter tops; expired medicines left in fridges; medicines rooms not locked; temperature checks in medicines rooms not undertaken or recorded
- **Estates and equipment issues:** difficulty obtaining parts for an obsolete call bell system on Ward 1; male and female toilets / showers not clearly marked in other areas
- **Information Governance:** members of staff forgetting to log off computers meaning that patient records can be seen; case notes not stored securely
- **Safeguarding:** although staff know how to make referrals, awareness of live issues in safeguarding such as the Mental Capacity Act and Deprivation of Liberty Safeguards is variable
- **Patient information:** the majority of information leaflets available on wards have been found to be overdue for review and may include out of date information

On a positive note, we are pleased to have awarded the first, and so far, only, outstanding rating to a clinical area (the Fracture Clinic). The clinic performed very well in a number of areas – medicines storage was very tidy and secure; the health and safety files were very comprehensive; there was a

wide range of written information available for patients which was all in date; and there was a very low rate of non-attendance which was closely monitored. The staff who were interviewed spoke favourably of the clinic as a place to work and felt that there was good communication with their managers. Patients were satisfied with the care they were receiving and we were told that if they were delayed going home, staff from the clinic would go to the nearby Bowman's Restaurant to get sandwiches and drinks for them. The overall environment was tidy and spacious with plenty of light, and the clerical staff were friendly and efficient.

We rated the Eye Clinic as good. We have highlighted this because in the past this department had been the subject of frequent complaints, and this reflects the progress that has been made. We noted that the department had regular audit days at which lessons from incidents and complaints were discussed. This meant that staff had a good working knowledge of governance topics, and also of safeguarding. It was notable that clinic's clerical staff also answered these questions well and that knowledge was not limited to the clinical staff.

Across the areas visited, we have noted that staff are more familiar with Cerner and confident in using it than when these inspections started in January (two months after its initial implementation). Also some areas are starting to hold 'huddles' to discuss patient safety issues.

Most importantly of all, we spend a great deal of time talking to patients and relatives during the inspections, as CQC do themselves. Even in clinical areas which were under pressure, the great majority of patients to whom the inspection teams have spoken have commented very positively about their experience. We have consistently observed staff treating patients with compassion and kindness, as well as individual acts of 'going the extra mile' to meet their needs, for example supporting a young patient with learning difficulties who was extremely nervous about attending hospital.

Executive Self-Assessment against Fundamental Standards

In March 2015 we undertook a preliminary self-assessment of compliance at Trust-wide level for each of CQC's Fundamental Standards of Safety and Quality. This was based on a desktop review of our portfolio of evidence (policies, performance reports, audits, external inspections, etc). We have now repeated this exercise. This involved meetings with the Associate Director of Governance, the Head of Assurance, and each of the Executives who have lead responsibility for CQC standards. We went through CQC's *Guidance for Providers on Meeting the Regulations* line-by-line to identify any gaps. Each standard was rated according to the CQC's four grades (outstanding, requires improvement, good or inadequate). The outcomes of this exercise are shown in the table overleaf.

These meetings have been formally minuted and the additional issues identified are in the process of being added to the corporate risk register.

The ratings of three standards have improved since the original assessment in February 2015. These are listed below, along with the reasons why the rating has been changed.

Standard	Previous rating	New rating	Progress achieved
13 - Safeguarding	Inadequate	Requires Improvement	• Safeguarding team has been restructured, with a remit to provide professional advice and guidance, rather than day-to-day operational responsibility • Management of compliance with training has been transferred to Learning and Development department with a recovery plan to ensure that all who require training receive it

Standard	Previous rating	New rating	Progress achieved
15 – Premises and Equipment	Inadequate	Requires Improvement	• Work underway to audit adequacy of toilet and shower provision and to correct defects • Assurance provided that statutory requirements have been met • Vacant Security Manager post now filled
19 – Fit and proper persons employed	Requires Improvement	Good	• Improved compliance with staff appraisals at end of 2014/15, achieving Trust's own Key Performance Indicator

One standard has moved from 'good' to 'requires improvement' – Fit and Proper Person (Directors). This is because the standard is applied retrospectively and there are gaps in records held from several years ago, although more recent records are complete. Documentation is being collated to comply with the requirements of the standard.

Some standards have seen improvements, but the rating has not yet changed because other issues remain. Significant examples of progress being made include the following:

- **Flexible visiting and patient rounding** *(Standard 9 – Person-centred care):* These are examples of initiatives which we are implementing to ensure that patients' care reflects their own needs and preferences – for example, that they are comfortable and that their friends and family can visit them at a time which is convenient.
- **Dementia Care** *(Standard 9):* we have launched our Dementia Strategy and we have a Specialist Matron in post who is leading on delivery of the strategy.
- **Emergency Planning** *(Standard 12 – Safe care and treatment):* A full-time Emergency Planning Lead is now in post. We were able to respond effectively to a major incident in the form of a massive power cut in March 2015 and were praised by NHS England for our response.
- **Infection Control** *(Standard 12):* the past year has seen substantial investment in rapid testing, isolation facilities and 'getting the basics right'.
- **Nutritional Screening** *(Standard 14 – Nutrition and hydration):* During our discussions about this standard, colleagues from Dietetics expressed concern that the design of the Cerner Millennium system made it more difficult to record nutritional assessments. We were able to deal with this issue very quickly through joint working between Corporate Nursing and Informatics.
- **Complaints Handling** *(Standard 16 – Complaints):* a recent letter from the Ombudsman, while finding fault with how the Trust had responded to an old complaint from approximately two years ago, commented very positively on the changes we have made to our complaint handling process since then. We were invited to address a conference about good practice in complaints management.
- **Sickness Absence** *(Standard 18 – Staffing):* In April this year, the absence rate was 4.17%, which was the lowest for several years, and 0.6% lower than in April of the previous year. This appears to be because of more effective absence management measures included in the new policy.
- **Raising Concerns** *(Standard 17 – Good governance):* Three Staff Guardians have been appointed – a manager from the Learning and Development department, a trade union representative, and a non-executive director. Members of staff can raise concerns with the guardians if they do not feel able to speak to their own departmental managers.

Way Forward

An immediate priority is to complete the mock inspection programme – we have further visits planned in June and July, including out of hours visits. The results of the inspections are being

disseminated in accordance with the 'Ward to Board information flow' that was approved by Clinical Governance Group in May. Each division will be required to action those issues which arise within their area of responsibility.

The issues in the table overleaf are being collated into action plans with responsibility allocated to individuals to complete them within defined timescales. These action plans are being agreed and will be in place within the next fortnight. They will be available for the Board to review at its next meeting if required. However, it can be seen from the table that many of the actions are already underway and that we are not waiting for the formal action plans before we start work.

Joe Roberts
Head of Assurance
15th June 2015

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
5	Fit and Proper Person - Directors	*Executive:* Anthony Hassall *Operational:* James Mawrey, Carole Self	Requires Improvement	⇩	Some gaps have been identified in record keeping regarding appointments which took place in previous years	• *Remaining documentation being obtained and collated*
9	Person centred care	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Mike Chantler	Requires Improvement	⇔	Inconsistent approach to discharging patients across the Trust; new 'Ticket Home' process is not yet embedded; poor quality of some discharge letters	• Discharge Policy has been re-drafted • *Ratify and implement revised policy*
					Reliance on contingency wards in periods of high demand, meaning that patients are cared for by staff may not be familiar with their conditions and needs	• *Reduce / eliminate usage of contingency wards through more effective management of capacity and demand, working with community partners*
					Self-administration of medicines is considered good practice for many patients but has not been widely implemented in the Trust	• *Implement self-administration as a pilot project in areas where it would be suitable – elective surgery and post-partum women*
					Outdated patient information leaflets, including information which may no longer be correct or relevant	• New Patient Information Policy adopted in 2014 • Key performance indicators agreed with the Trust's print supplier • *Patient information leaflets to be managed through Covalent database in future – Quality and Safety department to facilitate* • *Leaflets to be reviewed and updated by the clinical divisions*
10	Dignity and Respect	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Mike Chantler	Requires Improvement	⇔	End of Life Care – adverse comments at previous CQC inspection	• Collaborative project to support identification of patients who are approaching the end of life • End of Life Care Strategy has been developed • End of Life Care Nurse Specialist has been appointed • *Implement End of Life Care Strategy* • *Undertake themed mock inspection focusing on end of life care across a range of wards*
					Single Sex Accommodation – not always clear on wards which toilets and showers are for male and female patients	• Review of toilets and showers being undertaken by Estates Department • *Provide removable signs so that facilities can be designated as male or female according to circumstances*
					Ability to demonstrate that we can meet the specific needs of minority communities and those who do not speak English	• NHS Equality Delivery System toolkit completed in November 2014 and reported to Trust Board • Re-establishment of Wirral Ethnic Health Advisory Group • *Make certain commonly-used patient leaflets more widely available in other languages*

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
11	Need for Consent	*Executive:* Dr Evan Moore *Operational:* Dr Melanie Maxwell	Requires Improvement	⇔	Consent Policy now due for three-yearly review	• A Consultant has been identified to lead on the review and updating of the policy
					Audit results are generally positive – however, see comments for regulation 9 regarding patient information leaflets, and regulation 13 regarding Mental Capacity Act	• See comments for regulation 9 regarding patient information leaflets, and regulation 13 regarding Mental Capacity Act • Audit underway to provide greater assurance regarding consent given by / for children
12	Safe Care and Treatment	*Executive:* Jill Galvani, also Sharon Gilligan (emergency planning only) *Operational:* Gaynor Westray, Pippa Roberts, Peter Bohan, Tracey Lewis, Jan Eccleston, Helen Nelson	Requires Improvement	⇔	Frequency of 'Never Events' – five were reported during the previous financial year	• External review of Theatres completed during February 2015 • Divisions are in the process of completing their own self-assessment against national guidance • *Implement actions in response to findings of the two exercises mentioned above*
					Early warning system (MEWS / PEWS / MEOWS / NEWTS) observations have not always been completed on a timely basis, or not escalated appropriately	• Laminated alert cards in use at end of patients' beds • Also monitored through Matron's Ward Rounds (weekly) and Sister's Checklists (daily) • Cerner Millennium to flag when observations are needed
					Medicines management – missed doses for which the reason is not valid or not documented	• Monthly auditing • Function in Cerner Millennium to flag up doses which have not been administered • Reinforcing process for protected drug rounds (red tabards) • Encouraging self-administration of medicines where appropriate
					Medicines management – secure storage of medicines	• Matrons' medicines management checklist
					Infection prevention and control	• Action plan developed in response to Public Health England report and monitored by Hospital Infection Control Team • Gap analysis against Health and Social Care Act requirements completed by Associate Director of Infection Prevention and Control • *Develop overall Infection Control Strategy to bring together these different programmes of work*

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
					Transfer of patients between organisations – the Trust received a Report to Prevent Future Deaths from the Coroner last year in response to one serious incident, and we are aware of another case subject to inquest	• Transfer of Patients Policy has been rewritten to include more guidance about inter-hospital transfers
					Supervision and preceptorship arrangements for students and newly qualified professionals – raised in previous inspection reports	• Regular audit of preceptorship framework • Database used to record preceptorship arrangements • *Plan preceptorship and supervision arrangements for the large cohort of new nurses who will be starting work later in the year*
13	Safeguarding	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Sue Fogarty	Requires Improvement	⇧	Mock inspections have highlighted gaps in knowledge about safeguarding practice among staff; compliance with Level 2 and 3 training is low	• New Level 1 training booklet circulated to all staff in May 2015 • Compliance with Safeguarding training now administered by the Learning and Development department • Recovery plan in place to achieve satisfactory compliance with level 2 training by September
					Past audits have shown poor awareness of the Mental Capacity Act and our policy on Do Not Attempt Resuscitation	• Monthly audit of DNAR policy • *Undertake a wider audit of awareness of the Act* • *Include information in CEO's Monthly Briefing*
					Isolated incidents where patients were not treated with dignity and respect and which have been managed through the disciplinary process	• New guidance being produced for staff about how to respond if they suspect a colleague of abuse / neglect of patients • *Review use of continence pads*
14	Nutrition and Hydration	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Tazeen Khatib, Sally-ann Connolly	Requires Improvement	⇔	Assistance with eating and drinking for patients who need it	• Monitored as one of the six priority areas in the Trust's Quality Account • Flexible visiting, allowing relatives and carers to visit at mealtime and help their family member • Protected meal times • *Make greater use of volunteers to help vulnerable patients to eat and drink*

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
					Findings of previous inspection regarding patients experiencing poor nutrition and losing weight	• Implementation of new food and fluid balance chart • New form developed to speed referral to dieticians • *Implement electronic version of food and fluid balance reporting – some areas still recording on paper*
					Recent decline in completion of MUST nutritional screening, attributed to design of Cerner system making these more difficult to complete	• Cerner screens are being amended following agreement between Corporate Nursing and Informatics teams
					CQC guidance says that each organisation should have a strategy to ensure service users receive sufficient food and drink of good quality – the Trust has systems and processes in place but these are not described in one single document	• *Corporate Nursing and Catering Departments to meet and produce a simple document which describes our strategy*
15	Premises and Equipment	*Executive:* Mark Blakeman *Operational:* Gary Lewis, Sally-ann Connolly, Peter Bohan	Requires Improvement	⇧	Backlog of planned and responsive maintenance work; concerns from wards regarding time taken to complete some routine repairs	• Funding allocated for work on 6-10 priority wards • Work prioritised for safety and statutory compliance, according to risk assessments based on national guidance from Department of Health
					Mock inspection process has identified that many showers on wards are out of order or not fit for purpose	• Audit of shower facilities completed by Estates Department • *Implement programme of remediation work*
					Lack of clear reporting arrangements for Estates in the corporate governance structure	• *Consider establishment of an Estates Group within the governance structure* • *Review risks relating to Estates on the corporate risk register to ensure that they are comprehensive, scored correctly and have been escalated to the right level in the organisation*
16	Complaints	*Executive:* Jill Galvani *Operational:* Mike Chantler, Mark McKenna	Good	⇔	Complaints handling performance has improved, with a reduction of about 10% in the number of formal complaints due to the new process whereby less serious complaints are dealt with locally, and response timescales achieved for >80% of formal complaints.	• *Print and distribute new posters and leaflets about how to complain*
17	Good Governance	*Executive:* Dr Evan Moore *Operational:* Dr Melanie Maxwell, Jan Eccleston, Joe Roberts, Mike	Requires Improvement	⇔	Cerner Millennium Phase 2B recently implemented – staff still familiarising selves with new system; paper-based 'work-arounds' being used in some areas	• *Re-commence record keeping standards audit for those records which are still kept on paper* • *Identify audit requirements for electronic records, focusing on the quality of record keeping* • *Reiterate the importance of using the Cerner Millennium system at all times and the risks associated with parallel paper records*

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
		Chantler			Poor information governance practice identified on several wards, e.g. computers left logged into Cerner Millennium while unattended, case notes not stored securely	• Information Governance walkarounds being done by the Caldicott Guardian (Associate Medical Director) • *Make information governance training mandatory (currently included in Essential Training)*
					Decline in levels of incident reporting observed following implementation of web-based reporting	• *Facilitate access to NHS Net e-mail for those staff who do not currently have accounts* • *Circulate 'Myth Buster' leaflets to correct common misunderstandings about the electronic system*
					Lack of confidence of staff to raise concerns through risk reporting and internal whistleblowing procedures, leading them to contact CQC directly	• Information included in CEO Forum, Start the Week and Risk Management Training • Raising Concerns Working Group established and action plan developed • Staff Guardians designated, including a manager, a Non-Executive Director, and a trade union representative
18	Staffing	*Executive:* Anthony Hassall *Operational:* James Mawrey, Lynne Benstead, Peter Bohan	Requires Improvement	⇔	Difficulties in ensuring safe nurse staffing levels	• Nursing Establishment Review and Acuity Audit • Initiatives such as 'Grow your Own' and encouraging nurses to return to the profession • New Attendance Capability Policy, which has already resulted in lower sickness absence levels • *Recruitment of nurses from other European Union countries*
					Challenging results of National Staff Survey 2014 and Organisational Cultural Inventory	• Listening into Action – team huddles, 100 day pledges, 100 Leaders briefing events • Executive Directors allocated as key point of contact for individual wards and departments, thus improving senior staff visibility and the ability of front line staff to escalate problems and concerns • Action plan in response to 2013 Staff Survey • Three-year Culture and Engagement Plan for 2015-18
19	Fit and Proper Persons Employed	*Executive:* Anthony Hassall *Operational:* James Mawrey, Lawrence Osgood	Good	⇧	Compliance with annual appraisals met 88% target at the end of 2014/15 and is at the highest level recorded, but the target has not consistently been met in the past	• Trustwide and divisional Appraisal action plans • Training for managers • Management information for individual managers and for Divisional Management Teams • Performance management of managers through Pay Progression Policy

Standard		Leads	Rating	Direction of travel	Concerns	Actions underway / *actions required*
20	Duty of Candour	*Executive:* Dr Evan Moore *Operational:* Jan Eccleston	Good	⇔	Limited number of breaches of the duty (approximately 5% of Root Cause Analysis investigations)	• Duty of Candour Policy revised and updated in September 2014 • Regular exception reporting both internally and to the Clinical Commissioning Group • Training – included in Level 2 Risk Management Training programme

Board of Directors	
Agenda Item	7.2
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: April & May 2015
Date of Meeting	24 June 2015
Author	Gaynor Westray, Deputy Chief Nurse Johanna Ashworth-Jones, Senior Analyst
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence. 1A: Improve our Patient Experience to deliver the Friends & Family score of 95% or better *; 1B: Create a strong culture of empowered employees, delivering a staff engagement score of 3.59 or better, through implementation of our nursing, midwifery and customer service strategy (risk number 1908 & 1909); 3A: Implementation of a quality improvement strategy to reduce mortality to 85 HSMR (risk number 2611); 3B: Ensure that our harm free care score is no lower than 93% & no lower than 95% for 3 months*; 7A: Full compliance with our registration with CQC*. *risks to be scored.
Level of Assurance • **Positive** • **Gap(s)**	*Gaps:* Additional Wards 25 and 27 were open during April and May and the interim Isolation ward (14) to enable the Trust's response to the CPE outbreak were staffed by a combination of Flexibank and agency nurses supplemented from other ward establishments; *Positive:* Ward 27 closed on 25 April 2015 and ward 25 closed on 22 May 2015 Ward Sisters and Matrons have resumed their roles; Staffing escalation guide in place.
Purpose of the Paper	Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	No

1. Executive Summary

This paper provides the nurse staffing data for April and May 2015. No target fill rate has been set nationally therefore the Trust has applied a target of 95%. This measure is that 95% of shifts both days and nights meet the planned requirement, given that 100% is optimum. Appendix 1 shows this report with the average fill rates for both April and May 2015 on all wards for both day and night shift.

There continued to be concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period. This has been impacted by the additional wards remaining in place to manage patient demand (wards 25 & 27), as well the need for an interim isolation facility (Ward 14) with cohort nursing to manage the outbreak of Carbapenamase Producing Enterobacteriaceae (CPE). Ward 27 was successfully closed on 25 April 2015 and Ward 25 closed on 22 May 2015.

Matrons and Ward Sisters have resumed their usual roles where staffing levels permit. Registered nurse vacancies continue to be reviewed weekly by the Director of Nursing & Midwifery and the Senior Nurse Team.

The predicted shortfall in Registered Nurse vacancies for June 2015 was 44.43 WTE, however the actual total shortfall reported by the divisions on 12 June 2015 was 63 WTE, with an acknowledgement that 52 WTE registered nurses who qualify in September 2015 have accepted posts in WUTH. This will further be supported by the agreed recruitment strategy that is in place.

The E-roster successfully transferred over to version 10 on 3 June 2015 which will now enable a more effective and efficient rostering of ward nursing staff, as well as the electronic recording of staffing data and the provision to produce good quality reports.

All aspects of the Nursing & Midwifery Workforce are included in the Nursing workstream Cost Improvement Plans.

2. Background

Following the publication of the Francis report in February 2013, the Government made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' to make this information more publically available. This report forms part of the Trusts' obligation to publish staffing levels on hospital wards. The new style format to present our data was introduced as a means of triangulating the average staff fill rates with key quality indicators and information around sickness at ward level.

The report shows the actual hours of nursing cover (both Registered Nurse and Care Support Worker) compared to the expected hours for both day and night shifts. It also presents data per ward on the number of falls (moderate and above); the number of patients with a hospital acquired pressure ulcer; the number of patients confirmed as Clostridium difficile positive, MRSA positive, of which both are reportable to Public Health England. The final part of the report presents data on the sickness levels per ward. 'Red flag' alerts are being recorded at ward level from June 2015 as per Nurse Staffing Escalation Guidance.

3. Key Issues

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the Hard Truths milestones set out in the guidance published on 31 March 2014; further work is in progress to enhance assurance on processes following receipt of the draft report on Nurse Staffing by Mersey Internal Assessment and Audit (MIAA). The nurse staffing escalation guide is part of improving assurance.

Relocating staff to support the additional wards and the interim isolation ward have been the main reasons for wards not achieving 95% fill rate for their shifts during April and May 2015.

This has been compounded by the low supply of Flexibank staff compared to what has been requested by the ward areas; this position is being reviewed as part of the Bank & Agency workstream.

Reported staffing incidents:

The number of staffing incidents reflects an open and honest reporting culture and is also a mechanism for concerns related to staffing to be recorded by staff. Each incident is reviewed at the time of raising it by the local manager and an overview is undertaken by the Strategic Nursing & Midwifery Team. The table below shows the number of incidents reported related to staffing levels. This demonstrates a slight reduction in the number of staffing incidents being reported by the staff at WUTH

Month	Number of incidents reported
December 2014	80
January 2015	102
February 2015	46
March 2015	75
April 2015	36
May 2015	52

Staffing escalation guide / Red flag alerts

An escalation guide for nurse staffing concerns has been developed and implemented, outlining an absolute minimum of 2 registered nurses per ward at all times. This guide supports decision making around the provision of safe staffing levels. The escalation guide also includes actions to address when a red flag alert is reported. Future reports will include red flag alerts that have been reported.

Nationally the red flag alerts are described as:
- Unplanned omission in providing patients medications
- Delay of more than 30 minutes in providing pain relief
- Patient vital signs (MEWS) not assessed or recorded as outlined in the care plan
- Less than 2 registered Nurses on a ward during any shift

Locally at WUTH we have added:
- Patient focused rounding not evident
- Patient repositioning not carried out as outlined in the care plan
- Staff unable to take breaks

Nursing workforce requirement

The workforce requirement within nursing for 2015 / 2016 is as follows:

Workstream	WTE
Routine replacement of Band 5 Nurses through turnover calculated at 8%	88
Outstanding additional Registered Nurses & Midwives to deliver the Headroom of 25% approved by the Board of Directors in January 2015	11
Maintenance of an interim isolation unit through to staffing the Isolation Unit planned to occupy Ward 25 in October 2015	12
The need to ensure that there are sufficient staff to allow the 'Contingency Wards' to be planned for Winter 2015/16 from October 2015 to April 2016	54
Total anticipated requirement	**165**

A comprehensive recruitment strategy is in place including local and overseas recruitment.

Clear expectations are set to exhaust all local options and opportunities to ensure we promote WUTH as the hospital of choice to work in.

National position with Safer Nurse Staffing

There has been a recent development nationally in that the Chief Nursing Officer for England has announced that the National Institute for Clinical Excellence (NICE) no longer has the mandate for developing the guidance on Safer Nurse Staffing. Instead, this work programme will be absorbed by the CNO office in NHS England. Concerns have been expressed by Directors of Nursing, the Unions and Academics as well as the Safer Staffing Alliance that was established in the wake of the Francis Report (2013).

In addition, work is progressing through NHS Workforce to develop a different level of nursing support to the Registered Nurse. It is not clear whether or not this work has been endorsed by the CNO at this stage. There are advantages and disadvantages in terms of regulation of nursing care and how care can be delegated through the Registered Nurse workforce.

The Director of Nursing & Midwifery will provide updates to the Board of Directors as this work develops.

4. Next steps

- Continue with the programme of Monthly Trust wide recruitment for Registered Nurses, including overseas recruitment
- Present an updated plan for nurse recruitment to Executive Directors Team on 16 April 2015
- Continue to review the use of Flexibank
- Continue to focus on the management of long and short term sickness

5. Conclusion

Current strategies to recruit registered nurses were unsuccessful to meet turnover in April and May 2015. The Executives have agreed that to meet the anticipated seasonal demand there is a requirement for 2 additional wards hence the need to pursue overseas recruitment. Recommendations on how the Trust will meet demand were presented to the Executives on 27 April 2015 and 16 June 2015. There continue to be serious concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period and the impact on the quality of patient care and experience. All mitigating actions are in place to ensure that patients and staff are safe.

6. Recommendations

The Board of Directors is asked to receive and discuss the paper prior to publication on NHS Choices.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

#PROUD TO CARE FOR YOU

Monthly Safe Staffing Report - April 2015

		Days						Nights						Quality indicators				
Specialty	Ward	Expected RN Hours	Actual RN Hours	Expected CSW Hours	Actual CSW Hours	% RN	% CSW	Expected RN Hours	Actual RN Hours	Expected CSW Hours	Actual CSW Hours	% RN	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence
Orthopaedics	10	1434.3	1290.5	906.75	869.25	90.0%	95.9%	713	713	713	690	100.0%	96.8%	1	1	0	0	14.38
Orthopaedics	11	2156.8	1965	1612	1545.3	91.1%	95.9%	1426	1414.5	713	678.5	99.2%	95.2%	0	2	0	0	9.05
Orthopaedics	12	1222.5	1074.5	906.75	864	87.9%	95.3%	713	678.5	356.5	356.5	95.2%	100.0%	0	0	0	0	4.37
Urology	20	2342.5	2159.8	1550	1362	92.2%	87.9%	1069.5	962.5	713	689	90.0%	96.6%	0	0	0	0	11.72
Colorectal	17	1947.5	1872.5	1302	1258.3	96.1%	96.6%	1069.5	977.5	713	690	91.4%	96.8%	0	0	0	0	3.61
General Surgery	18	1829.5	1662.8	1263.25	1240.3	90.9%	98.2%	1069.5	1046.5	713	713	97.8%	100.0%	0	0	0	0	4.91
DME	21	1800.3	1646	1263.25	1214.3	91.4%	96.1%	1069.5	885.5	713	713	82.8%	100.0%	0	1	0	0	4.71
DME	22	1916.3	1814	1550	1531.3	94.7%	98.8%	1263.25	1159.3	1069.5	1069.5	91.8%	100.0%	0	2	0	0	6.12
Stroke	23	1722.5	1705.3	1356.25	1356.3	99.0%	100.0%	1263.25	1239.3	713	713	98.1%	100.0%	1	0	0	0	0.61
DME	24 & Isolation	2110	1863.5	1162.5	1100	88.3%	94.6%	1069.5	1045.5	713	713	97.8%	100.0%	0	0	1	0	1.3
DME	OPAU	2098.5	1889.8	1619.73	1613.5	90.1%	99.6%	1426	1234	1426	1414	86.5%	99.2%	0	0	0	0	5.65
Haematology	30	2110	1896.4	1937.5	1723.8	89.9%	89.0%	1069.5	1069.5	1069.5	1069.5	100.0%	100.0%	0	0	0	0	7.62
Cardiology	32 & CCU	1722.5	1519	1162.5	1000.5	88.2%	86.1%	906.75	780.35	1069.5	1045.5	86.1%	97.8%	0	1	0	0	3.09
Cardiology	33 / HAC	3078.8	2870.3	1550	1466.4	93.2%	94.6%	1426	1407.7	1069.5	1058.5	98.7%	99.0%	0	0	0	0	0
Gastro	36	1722.5	1627.5	1162.5	1162.5	94.5%	100.0%	1069.5	1033.5	1069.5	1057.5	96.6%	98.9%	0	0	0	0	7.85
Respiratory	38 & Respiratory unit	2253.8	1936.4	1550	1485	85.9%	95.8%	1069.5	998.9	1069.5	1057.5	93.4%	98.9%	0	1	1	0	2.87
General Medicine	26	2497.5	2138.3	1743.75	1707	85.6%	97.9%	1426	1296	1069.5	1057.5	90.9%	98.9%	0	0	1	0	7.45
General Medicine	AMU	1598.5	1523.5	744	684	95.3%	91.9%	1426	1222	356.5	322	85.7%	90.3%	0	0	0	0	3.02
General Medicine	MSSW	885.5	791.5	713	675	89.4%	94.7%	713	713	0	0	100.0%		2	0	1	0	3.02
Emergency	EDRU	1955	1774.5	1426	1334.3	90.8%	93.6%	1069.5	1020.9	1069.5	998.5	95.5%	93.4%	0	0	0	0	0.59
Orthopaedics	Parksuite	2311.5	2181.5	1782.5	1682.5	94.4%	94.4%	1635.25	1569	1635.25	1619.3	95.9%	99.0%	0	0	0	0	10.97
Surgical Assessment	SAU	885.5	885.5	356.5	356.5	100.0%	100.0%	550.25	550.25	356.5	356.5	100.0%	100.0%	1	0	0	0	6.09
Critical Care	ITU	857	850.75	345	345	99.3%	100.0%	690	690	0	0	100.0%		0	0	0	0	7.53
Critical Care	HDU	1240.5	1203	533	495.5	97.0%	93.0%	533	423.25	356.5	345	79.4%	96.8%	0	0	0	0	7.53
Gynaecology	54	4822.5	4822.5	212.5	212.5	100.0%	100.0%	4278	4278	0	0	100.0%		0	0	0	0	0.38
Orthopaedics	M1	1722.5	1722.5	387.5	387.5	100.0%	100.0%	1426	1426	356.5	356.5	100.0%	100.0%	0	0	0	0	0.68
General Surgery	M2	3381	3351.5	690	690	99.1%	100.0%	3208.5	3162.5	690	690	98.6%	100.0%	0	1	0	0	0
Maternity	Delivery Suite	3381	3195	0	0	94.5%		3208.5	2748.5	0	0	85.7%		0	0	0	0	2.89
Maternity	53	2186	2162	356.5	332.5	98.9%	93.3%	1782.5	1770.5	356.5	344.5	99.3%	96.6%	0	0	0	0	7.3
Neo Natal	Neonatal	1443.8	1370.8	906.75	894.25	94.9%	98.6%	713	713	356.5	345	100.0%	96.8%	0	0	0	0	4.27
Children's	Children's	304	297.75	172.5	172.5	97.9%	100.0%	161	161	161	161	100.0%	100.0%	0	0	0	0	3.62
Neuro & Rehabilitation	CRC	1328.8	1304.8	1550	1526	98.2%	98.5%	713	706.7	906.75	899.75	99.1%	99.2%	0	0	0	0	5.02
Dermatology	Dermatology	1335	1335	968.75	968.75	100.0%	100.0%	713	713	356.5	356.5	100.0%	100.0%	0	0	0	0	4.11
DME	36 CBH	602.25	602.25	143.75	143.75	100.0%	100.0%	264.5	264.5	264.5	264.5	100.0%	100.0%	0	0	0	0	11.24

NB: RAG rating has been applied as 95% or above as "green" for % RN & % CSW and for sickness & absences equal to or below the Trust's target of 4% this is "Green" and Red if above Trust target of 4%.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

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Monthly Safe Staffing Report - May 2015

		Days						Nights						Quality indicators				
Specialty	Ward	Expected RN Hours	Actual RN Hours	Expected CSW Hours	Actual CSW Hours	% RN	% CSW	Expected RN Hours	Actual RN Hours	Expected CSW Hours	Actual CSW Hours	% RN	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence
Orthopaedics	10	1434.3	1290.5	906.75	84.65	90.0%	9.3%	713	713	713	701.7	100.0%	98.4%	0	0	0	0	10.42
Orthopaedics	11	2156.8	1992	1612	1444	92.4%	89.6%	1426	1380	713	713	96.8%	100.0%	0	2	0	0	5.51
Orthopaedics	12	1222.5	1057.8	906.75	778.5	86.5%	85.9%	713	678.5	356.5	345.2	95.2%	96.8%	0	0	0	0	2.75
DME	16 / OPAU	2342.5	2160.7	1550	1468.1	92.2%	94.7%	1069.5	960.5	713	689	89.8%	96.6%	0	0	0	0	4.82
Colorectal	17	1947.5	1816.3	1302	1277	93.3%	98.1%	1069.5	1040.3	713	678.5	97.3%	95.2%	1	2	0	0	0
General Surgery	18	1829.5	1729.5	1263.3	1250.8	94.5%	99.0%	1069.5	1052	713	713	98.4%	100.0%	0	1	0	0	2.71
Urology	20	1800.3	1538.7	1263.3	1208	85.5%	95.6%	1069.5	936.3	713	622.4	87.5%	87.3%	0	2	0	0	12.36
DME	21	1916.3	1885.3	1550	1543.9	98.4%	99.6%	1263.3	1187.3	1069.5	1069.5	94.0%	100.0%	0	1	0	0	5.68
DME	22	1722.5	1710	1356.3	1350	99.3%	99.5%	1263.3	1251.3	713	713	99.1%	100.0%	0	1	0	0	5.12
Stroke	23	2110	1714.3	1162.5	1156.3	81.2%	99.5%	1069.5	997.5	713	713	93.3%	100.0%	2	0	0	0	0
DME	24 &	2098.5	1932.4	1619.7	1602	92.1%	98.9%	1426	1335.7	1426	1426	93.7%	100.0%	0	0	0	0	3.89
General Medicine	26	2110	2033.5	1937.5	1912.5	96.4%	98.7%	1069.5	1021.5	1069.5	974.5	95.5%	91.1%	0	2	2	0	6.5
Haematology	30	1722.5	1547.9	1162.5	1084.4	89.9%	93.3%	906.75	744.25	1069.5	985.5	82.1%	92.1%	0	0	0	0	3.64
Cardiology	32 & CCU	3078.8	2791.3	1550	1411.5	90.7%	91.1%	1426	1379	1069.5	882.5	96.7%	82.5%	0	1	0	0	5.64
Cardiology	33 & HAC	1722.5	1617.1	1162.5	1162.5	93.9%	100.0%	1069.5	1057.5	1069.5	1051	98.9%	98.3%	0	1	1	0	1.97
Gastro	36	2253.8	2007.5	1550	1466.6	89.1%	94.6%	1069.5	1021.5	1069.5	1057.5	95.5%	98.9%	0	0	1	0	9.19
Respiratory	38	2497.5	2013	1743.8	1732.3	80.6%	99.3%	1426	1141	1069.5	1033.5	80.0%	96.6%	0	4	0	0	4.21
Maternity	53	1598.5	1406.5	744	732	88.0%	98.4%	1426	1252.5	356.5	344	87.8%	96.5%	0	0	0	0	7.27
Gynaecology	54	885.5	816.5	713	713	92.2%	100.0%	713	701.5	0	11.5	98.4%	-	0	0	0	0	0.41
General Medicine	AMU	1955	1846	1426	1261	94.4%	88.4%	1069.5	1017.4	1069.5	1010.5	95.1%	94.5%	1	0	0	0	5.45
General Medicine	MSSW	2311.5	1976.6	1782.5	1664	85.5%	93.4%	1635.3	1522.7	1635.3	1564.3	93.1%	95.7%	0	0	0	0	5.45
Emergency	EDRU	885.5	885.5	356.5	356.5	100.0%	100.0%	550.25	550.25	356.5	356.5	100.0%	100.0%	0	0	0	0	0
	Parksuite	857	857	345	345	100.0%	100.0%	690	690	0	0	100.0%		0	0	0	0	10.39
Surgical Assessment	ESAU	1240.5	1240.5	533	508	100.0%	95.3%	533	440.15	356.5	265.9	82.6%	74.6%	0	0	0	0	5.25
Critical Care	ITU	4822.5	4822.5	212.5	212.5	100.0%	100.0%	4278	4278	0	0	100.0%		0	2	0	0	1.81
Critical Care	HDU	1722.5	1722.5	387.5	387.5	100.0%	100.0%	1426	1426	356.5	356.5	100.0%	100.0%	0	0	0	0	1.81
Maternity	Delivery	3381	3320.5	690	690	98.2%	100.0%	3208.5	3137	690	690	97.8%	100.0%	0	0	0	0	0.91
Neo Natal	Neonatal	3381	3225	0	0	95.4%		3208.5	2945	0	0	91.8%		0	0	0	0	2.81
Children's	Children's	2186	2186	356.5	356.5	100.0%	100.0%	1782.5	1770.5	356.5	356.5	99.3%	100.0%	0	0	0	0	3.3
Orthopaedics	M1	1443.8	1274.8	906.75	810.75	88.3%	89.4%	713	713	356.5	299	100.0%	83.9%	0	0	0	0	0.91
General Surgery	M2	304	304	172.5	172.5	100.0%	100.0%	161	161	161	161	100.0%	100.0%	0	0	0	0	0
DME	CRC	1328.8	1266.5	1550	1495.1	95.3%	96.5%	713	713	906.75	906.75	100.0%	100.0%	0	0	0	0	4.74
Neuro & Rehabilitation	Ward 36	1335	1335	968.75	968.75	100.0%	100.0%	713	713	356.5	356.5	100.0%	100.0%	2	0	0	0	6.03
Dermatology	Dermatology	602.25	602.25	143.75	143.75	100.0%	100.0%	264.5	264.5	264.5	264.5	100.0%	100.0%	0	0	0	0	0.3

NB: RAG rating has been applied as 95% or above as "green" for % RN & % CSW and for sickness & absences equal to or below the Trust's target of 4% this is "Green" and Red if above Trust target of 4%.
Please note the Pressure ulcer data is sourced from clinical incident reporting and has not been validated by the Tissue Viability team at the time of this report.

Board of Directors	
Agenda Item	8.1
Title of Report	Report of the Finance Business Performance & Assurance Committee 19 June 2015
Date of Meeting	24 June 2015
Author	Graham Hollick, Chair of FBP & AC
Accountable Executive	Alistair Mulvey, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	5A, Risk 2718, 6B, 7B, Risk 1927 and 2550, 7C Risk 2328, 7D, Risk 2689
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating actions
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

M1 and M2 Financial Position

The Committee reviewed in detail the cumulative position at M2 and sought to understand the level of balance sheet flexibility applied in both months, which has been applied in discussion with the Chief Executive, to achieve the actual deficit of £3.7M against the planned deficit of £3.4M. In future reports the detail of the initial position and support applied to that position will be included within the reporting templates.

The pressures in the plan for M1 and M2 were reported as almost exclusively related to income. With under performance in this area attributed to volume, price and penalties. Assurance was sought that the performance for June would be back on plan including evidence for this and the mitigating action if this was not the case.

The Committee noted that there was an apparent discourse between the projected activity levels not including any element of growth. The Director of Finance confirmed that in establishing the levels of activity, which were supported by clinical leads etc, the additional activity undertaken last year reflected extraneous items which were discounted. Thus a comparison between the actual figures would indicate limited growth, which was not the case. The Committee sought assurance that the activity levels also include and were triangulated with CIPS, which the Director of Finance assured the Committee they were. A full review of activity, by the operational teams, against plan would be undertaken in July 2015.

The Committee was advised that the planned elements of the CIP Programme was broadly on track although the gap in schemes of c£2m remains and further plans to bridge this gap, and the ownership of this gap would need to be quickly resolved.

A summary of the working capital movements against plan by key areas was provided. In developing this new addition to the reporting framework the Director of Finance further advised that a narrative on key movements would be built into future reporting. The Committee agreed to review the outcome of the forecasting work being undertaken by the Cash Management Group at its next meeting in July 2015.

Monitor Commentaries

The Committee noted the commentaries submitted to Monitor, which have been reviewed by the Chairman and Chief Executive in advance of submission and in line with agreed processes.

Readmissions

The Medical Director presented the Audit of Readmissions papers which classified those readmissions which were avoidable or unavoidable. The audit was a joint piece of work across the health economy, but largely between the Trust and Wirral CCG. The Committee reviewed the reductions in readmissions over the last 3 years since the last audit and the focus of attention being applied by the Quality and Safety Committee on those cases that the Trust could affect in the future.

Progress Report on the Recovery Plan 2015-16

The Recovery Advisor provided an update on progress against the Recovery Plan which included:

- Granularity of workstreams had improved
- Recruitment to two posts in the Programme Management Office PMO completed with a further post being recruited into IT.
- PMO Director advertisement due out shortly.
- Workstreams work continued to be focussed on 4 main areas these being theatres, outpatients, patient flow and coding.
- Star chambers had now started which should provide confidence to the achievement of workstreams.
- The CIP programme was reported as broadly on track although only a small amount of the quantum associated with the first 2 months.
- No movement on the £2M shortfall was reported as efforts were concentrated on ensuring that robustness of the £11.1M programmes to identify any further opportunities.

- An initial meeting on Estates with PWC to be held to look at opportunities was confirmed for 15th July

The Committee sought and received assurance as to the accountability of the £2M CIP shortfall and the process for progressing the Coding workstream with CCG colleagues. The Committee did not receive assurance that the level of income associated with coding included in the plan of £3.75M was forthcoming and the Executive was asked to provide the necessary assurance as this was an integral part of our recovery plan.

Service Line Reporting and Reference Costs

The Committee received a progress update on service line reporting in the Trust which including the mechanisms for reporting; staff engagement and process and technical issues.

The Committee reviewed the procedures and systems for submitting its reference costs in line with guidance and sought to understand how this impacted upon allocation in Divisions. The Committee having reviewed the paper agreed to confirm to the Board that it was satisfied with the procedures and systems in place; and recommended that delegated authority be given to the Director of Finance and Chairman to authorise the Trust Reference Costs for Submission.

Performance Report

Key highlights included the work being undertaken to achieve the A & E 4 hour standard, the Committee agreed to request a breakdown of the actions or steps that had made the specific difference to performance. C difficile was raised as a concern with 10 cases reported against an annual target of 29.

Productivity/Transformation Steering Group (TSG) Amalgamation

Following a review by the PMO Director, the work of the two groups have been amalgamated as a high level of duplication was evident. The only exception to this was in relation to the business planning work and GP engagement which would now be reviewed and monitored by the Operational Management Team. The Committee approved the dissolution of the Productivity Group and the Terms of Reference of the Transformation Steering Group.

The Associate Director of Governance asked the Committee to note that the revised terms of reference would in effect move the TSG to the Assurance part of the Trust's Governance Framework from performance monitoring.

Items for the Risk Register

The Committee sought to ensure that volumes and activity risks were captured in the risk register and the Board Assurance Framework.

Graham Hollick
Chair of Finance Business Performance and Assurance Committee

Board of Directors	
Agenda Item	8.2
Title of Report	Monitor Governance Annual Board Statements
Date of Meeting	24 June 2015
Author	Carole Ann Self, Associate Director of Governance
Accountable Executive	David Allison
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	N/A
FOI status	Document to be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

The Board of Directors are required to respond 'confirmed ' or 'not confirmed' to each of the 20 Board statements that comprise the Corporate Governance Statement, setting out any risks and mitigating actions, and 'confirm' or 'not confirmed' to the statement pertaining to governor training and AHSCs and governance. The self-certification must be submitted to Monitor by 30th June 2015 .

The statements are presented with supporting evidence within a template suggested by KPMG/

The attached statements with evidence were presented as draft for review by the Board in April 2015.

The key areas for discussion are highlighted at 4a, 4c, 4d and 5f together with the key considerations.

2. Recommendation

The Board of Directors is asked to:

- Review each statement and the supporting evidence
- Approve the statements as recommended

1. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust applies those principles, systems and standards of good corporate governance, which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	
Lead: Associate Director of Governance	**Recommendation:** Confirm
Board Reports	Review of Standing Financial Instructions and Scheme of Delegation (Feb 2015) Annual Governance Statement (May 2015) Integrated Performance Report / Board Dashboards, exception reporting - Monthly Chair of Audit Committee Reports Board Assurance Framework reviewed by Board – (June 2014 & July 2014) Corporate Governance Reviews June 14, July 14 and January 15
Sub Board Evidence	Quality Governance Framework assessment was presented to Quality and safety Committee (November 2014) Review of Board Assurance Framework at Operational Management Team (Jan 15) Review of Board Assurance Framework at Q & S (Sept 14 and Jan 15) Review of Board Assurance Framework at FBP &AC (Oct 14 and Jan 15) Review of workings of Board Assurance Framework at Audit Committee (May 14, Sept 14, Dec 14 and Feb 15) Draft Annual Governance Statement reviewed at Audit Committee (April 15)
Independence Assurance	External Audit Plan Internal Audit Plan Head of Internal Audit Opinion – Significant Assurance Internal Audit Report on BAF – Compliant with requirements Internal Audit Report on QGAF – significant assurance

2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	
Lead: Associate Director of Governance	**Recommendation:** Confirm
Board Reports	Monitor Code of Governance (referenced in the Annual Report May 15) CEO Reports to the Board

	Annual Reporting Process – updates to the Board Fit and Proper Persons Test Board Update (Jan 15)
Sub Board Evidence	Trust response to KPMG technical updates report at Audit Committee
Independence Assurance	KPMG technical update reports to Audit Committee Monitor newsletter and updates sent by email to Chief Executive, Director of Finance, Director of Strategy and partnerships and Associate Director of Governance NHS Providers and Monitor training / seminars

3a. The Board is satisfied that the Wirral University Teaching Hospital NHS Foundation Trust implements effective board and committee structures	
Lead: Associate Director of Governance	**Recommendation:** Confirm
Board Reports	Committee Chairs reports to Board / minutes circulated to Board members Annual Governance Statement (May 2015) Audit Committee Annual Report (May 2015) Board Development Days (May and June 2014) on Governance Assurance and Performance Management structure Committee Terms of Reference reviewed and approved by Board (July 2014) Corporate Governance Review (Jan 15)
Sub Board Evidence	Committee Effectiveness discussed at Audit Committee and added to cycle of business
Independence Assurance	KPMG Review, which led to the creation of F,BP & A Committee and other improvements
3b. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees	
Lead: Associate Director of Governance	**Recommendation:** Confirm
Board Reports	Standing Financial Instructions and Scheme of Delegation (Feb 15) Committee Terms of Reference reviewed and approved by Board (July 2014) Corporate Governance Review and introduction of new Board template (Jan 15) Committee chairs reports to Board / minutes circulated to Board members
Sub Board Evidence	Committees cycles of business

	Minutes of Committee meetings
Independence Assurance	KPMG Financial Governance and Reporting Review – July 2014
3c. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organization	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Annual Governance Statement (May 2015) Board Assurance Framework reviewed by Board June and July 2014
Sub Board Evidence	Quality Governance Framework assessment was presented to the November 2014 Quality and safety Committee Standing Financial Instructions and Scheme of Delegation – Feb 2015 Executive Director role descriptions Governance, Assurance and Performance Management Structure Divisional organisational charts – structure communication Sept 14
Independence Assurance	Internal Audit Report on QGAF – Significant Assurance
4a. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust effectively implements systems and/or processes to **ensure compliance** with the Licensee's duty to operate efficiently, economically and effectively	
Lead: Director of Finance	**Recommendation:** Confirm
Board Reports	Annual Planning process Monthly Finance Reports to Board of Directors Monthly Updates to the Board on the Turnaround Plan Recovery Plan approved May 15 Quarterly/monthly compliance submissions to Monitor Annual Report and Accounts Monthly Integrated performance reports / dashboards/exception reporting
Sub Board Evidence	Finance, Performance and Business Development Committee review of quarterly returns Quality and Safety Committee

	Monthly and Quarterly Divisional Performance Reviews Quarterly licence review at Audit Committee Procurement Strategy Transformation Steering Group
Independence Assurance	Head of Internal Audit Opinion – significant assurance External ISA Audit Highlights Memorandum KPMG Cash Management Review
Considerations	Monitor has opened an investigation into financial governance concerns and A & E performance. The Trust is due to meet with Monitor on 18th June 2015 to determine whether it will be found in breach of its licence. CQC undertook a responsive inspection in September 2014 and found that 5 standards were non- compliant of a moderate and minor nature. The Trust achieved a positive Use of Resources outcome; however the challenge in achieving this result in future years will be greater and significantly influenced by external affordability factors. Recovery Plan approved by the Board in May 2015.

4b. The Board is satisfied that the Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licensee's operations	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Annual Plan submission Board Cycle of Business Board Assurance Framework reviewed by Board June and July 2014 Annual Governance Statement – May 2015 Quarterly/ Monthly Compliance Submissions to Monitor Monthly Integrated performance reports / dashboards/exception reporting Finance Monthly Report Reports from the Audit Committee, Quality and Safety and Finance, Business Performance and Assurance Committee

Sub Board Evidence	Quarterly licence review at Audit Committee Board Assurance Framework review by Quality and Safety Committee and Finance Business Performance and Assurance Committee
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance
4c. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions	
Lead: Medical Director	Recommendation: Not Confirm
Board Reports	Draft Quality Report – March 2015 Board Assurance Framework reviewed by Board June and July 2014 Monthly Integrated performance reports / dashboards/exception reporting Report from the Quality and Safety Committee CQC Compliance reports to the Board
Sub Board Evidence	Quality Governance Framework assessment was presented to the November 2014 and May 2015 Quality and safety Committee Infection control reports to Quality and Safety CQC Compliance Reports to Quality and Safety Committee and the Board
Independence Assurance	Internal Audit Report – Quality Spot Checks – Significant Assurance Internal Audit Report – QGAF – Significant Assurance Internal Audit Report – Quality Account – Significant Assurance
Considerations	CQC undertook a responsive inspection in September 2014 and found that 5 standards were non-compliant of a moderate and minor nature. The Trust has been the subject of two Quality Surveillance Group Meetings called by NHS England during 2015, as a result of concerns relating to Infection Prevention and Control, staff survey results and Cultural Issues.
4d. The Board is satisfied that the Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)	
Lead: Director of Finance	**Recommendation:** Confirm

Board Reports	Monthly Finance Reports Annual Plan submissions Annual Report and Accounts Board Assurance Framework reviewed by Board June and July 2014 Annual Governance Statement Going Concern Assessment Report from the Audit Committee Reports from the Finance, Business Performance and Assurance Committee Monthly Integrated performance reports / dashboards/exception reporting Turnaround Reports
Sub Board Evidence	Audit Committee – challenging of finances and accounts, accounting policies Audit Committee review of draft accounts and annual report Going concern challenge
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance External Audit Opinion Internal Audit Report – Combined financial systems – Feb 15 – High Assurance Internal Audit report – Budgetary Reporting – Significant Assurance
Considerations	Monitor has opened an investigation into financial governance concerns and the Trust is currently awaiting the outcome. The Trust has included in its draft Annual Plan a request for distressed funding in 2015. The External Auditors have agreed the going concern statement as part of the 2014/15 accounting process
4e. The Board is satisfied that the Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	
Lead: Director of Infrastructure and Informatics	**Recommendation:** Confirm
Board Reports	Board cycle of business Monthly Integrated performance reports / dashboards/exception reporting Briefings to Board members from the communication team on topical media interest stories or areas of immediate risk or concern
Sub Board Evidence	Committee cycle of business

	Governance Assurance and Performance Management Structure Monthly update of the work of the Board to the Operational Management Team EDT weekly performance reporting
Independence Assurance	

4f. The Board is satisfied that the Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence		
Lead: Medical Director		**Recommendation:** Confirm
Board Reports	Board Assurance Framework reviewed by Board (June and July 2014) Annual Governance Statement – May 2015 Committee reports to Board, including risk related matters on all agendas Part of standing item agenda Risk Management Strategy – reviewed 2014 (due again May 2015)	
Sub Board Evidence	Quarterly Licence Review at Audit Committee Board Assurance Framework reviews at Quality and Safety Committee and Finance Business Performance and Assurance Committee on a bi-monthly basis Monthly review of the risk register at the Operational Management Team Bi-Monthly review of risks at Quality and Safety Committee CQC risk register review at Operational Management Team	
Independence Assurance	Head of Internal Audit Opinion – significant assurance Internal review of risk management process Internal Review of incident reporting system – significant assurance	
4g. The Board is satisfied that the Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery		
Lead: Director of Finance		**Recommendation:** Confirm

Board Reports	Business plans presented and agreed at Board in accordance with SFIs Report from Finance, Performance and Business Development Committee Annual Plan Formal review of all Business Cases by the Board
Sub Board Evidence	Finance, Performance and Business Development Committee Finance Management Group Monthly and Quarterly Divisional Performance Review meetings Weekly Transformation Steering Group Monthly Operational Management Team review of Business Case Recommendations EDT approval of Business Cases
Independence Assurance	
4h. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Board Assurance Framework reviewed by Board June and July 2014 Quarterly and Annual Health and Safety Reports to the Board Annual Infection Prevention and Control Report to Board CQC compliance reports to the Board Review of Fit and Proper Persons Test by Remuneration Committee -update to Board – April 2015
Sub Board Evidence	Quarterly licence review at Audit Committee Board Assurance Framework reviewed by Quality and Safety and Finance, Business Performance and Assurance Committee Remuneration Committee review of Fit and Proper Persons Test for Directors – April 15
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance

5a. The Board is satisfied that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Remuneration and Appointments Committee reports Board Development Programme Board Questionnaire – Dec 14 Team Management Profile Work – April 2015 AQUA Board development – safety and quality – Sept 2014 Top Leaders Development Programme
Sub Board Evidence	Succession Planning Strategy North West Leadership Academy Executive Development Tool North West Leadership Academy Coaching for Clinicians LSP Executive Development Programme
Independence Assurance	

5b. The Board is satisfied that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	
Lead: Director of Strategic and Organisational Developments	**Recommendation:** Confirm
Board Reports	Robust Annual Planning Process Quality Report Reports of Quality And Safety Committee to Trust Board CQC compliance reports
Sub Board Evidence	Quality Account reports to Q&S Committee Workforce Dashboard to Q&S Committee Quality Impact Assessment at each Quality and Safety Committee
Independence	Internal Audit Report – Quality Account – significant assurance

Assurance	Internal Audit Report – QGAF – significant assurance

5c. The Board is satisfied of the collection of accurate, comprehensive, timely and up to date information on quality of care	
Lead: Director of Infrastructure and Informatics	**Recommendation:** Confirm
Board Reports	Quality Report Monthly Integrated performance reports / dashboards/exception reporting Nursing staffing reports to the Board CQC compliance reports
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee Nurse staffing performance data to Quality and Safety Committee Workforce Dashboard to Quality and Safety Committee CQC mock inspection reports to Quality and Safety Committee
Independence Assurance	External audit on Quality Report Internal Audit Report – Activity Data Capture Processes A & E and Cancer Targets – significant assurance

5d. The Board is satisfied that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Quality Report Monthly Integrated performance reports / dashboards/exception reporting Nursing staffing reports to the Board leading to significant additional investment Infection control reports to the Board leading to significant additional investment NHS staff survey and action plan Patient Stories at the Board
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee Patient Stories at Quality and Safety Committee

	Nurse staffing performance data to Quality and Safety Committee Workforce Dashboard to Quality and Safety Committee
Independence Assurance	External audit on Quality Report Internal Audit Report – Activity Data Capture Processes A & E and Cancer Targets – significant assurance
Additional Statement/ considerations	CQC responsive inspection; QSG concerns; A & E standards and implementation of escalation meeting

5e. The Board is satisfied that the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources		
Executive Sign Off: Medical Director		**Recommendation:** Confirm
Board Reports	Patient Stories Friends and Family Test results via Integrated performance report Clinical Service Reviews	
Sub Board Evidence	Governor led Annual Planning Advisory Committee Patient story at Quality and Safety Committee Patient Feedback Friends and Family Test Learning from Board Walkabouts Complaints reports	
Independence Assurance	External audit on Quality Report Response to Public England concerns and feedback Response to QSG concerns and feedback	

5f. The Board is satisfied that there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and **resolving quality issues** including escalating them to the Board where appropriate.	
Lead: Medical Director	**Recommendation:** Confirm
Board Reports	Board Assurance Framework reviews June and July 2014 Risk Management Strategy Monthly Integrated Performance Report / Board Dashboards Quality Report Nurse staffing reports Reports from Quality and Safety Committee Reports from Audit Committee CQC compliance Reporting Review of Whistleblowing Procedure 2014 Reports of infection control issues Urgent Care Updates Board Walkabouts Introduction of Guardian role
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee
Independence Assurance	
Considerations	NHS staff survey results and whistleblowing concerns to CQC

6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	
Lead: Chief Executive	**Recommendation:** Confirm
Board Reports	Remuneration and Appointments Committee reports

	Board Development Programme Board Questionnaire – Dec 14 Team Management Profile Work – April 2015 AQUA Board development – safety and quality – Sept 2014 Top Leaders Development Programme Nurse staffing reports Review of capability and capacity reports to the Board and recruitment of interim support posts
Sub Board Evidence	Succession Planning Strategy North West Leadership Academy Executive Development Tool North West Leadership Academy Coaching for Clinicians LSP Executive Development Programme
Independence Assurance	

Governor Training Statement: The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with skills and knowledge they need to undertake their role.	
	Recommendation: Confirm
Governors take part in Governor Workshops and Development Days, (including joint sessions with Board representatives) they also take part in PLACE Assessment training for Arrowe Park and Clatterbridge sites. All Nomination Committee governors are provided with Equality and Diversity training, prior to NED appointments. Governors are also offered external training from such groups as NHS Providers.	

For NHS foundation trusts:
- that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
- whose Boards are considering entering into either a major Joint Venture or an AHSC.

	Recommendation: N/A

The Board is satisfied it has or continues to:
• ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
• have appropriate governance structures in place to maintain the decision making autonomy of the trust;
• conduct an appropriate level of due diligence relating to the partners when required;
• consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
• consider implications of the partnership on the trust's governance processes;
• conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
• comply with any consultation requirements;
• have in place the organisational and management capacity to deliver the benefits of the partnership;
• involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
• address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
• ensure appropriate commercial risks are reviewed;
• maintain the register of interests and no residual material conflicts identified; and
• engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

4 June 2015

Mr David Allison
Chief Executive
Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital
Arrowe Park Road
Upton
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Making the health sector work for patients

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Dear David

Q4 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q4 submissions is now complete. Based on this work, the trust's current ratings are:

- Continuity of services risk rating: 3
- Governance rating: Under Review

As explained in our letter of 13 May 2015, these ratings will be published on Monitor's website later in June (for the governance rating) and July (for the continuity of services rating).

The trust's governance rating remains as 'Under Review' with a narrative of 'Monitor is investigating governance and financial sustainability concerns at the trust, triggered by multiple breaches of the A&E target and a continuity of services risk rating of 2'.

As per our letters of 3 March and 27 May, Monitor is investigating the trust for a potential breach of its provider licence and the trust's governance rating will remain 'Under Review' until such time as Monitor has concluded its investigation and determined what if any regulatory action may be appropriate.

Should Monitor decide not to take formal enforcement action, the Trust's governance rating will revert to 'Green'. Where Monitor decides to take formal enforcement action to address its concerns, the trust's governance rating will be 'Red'. In determining whether to take such action, Monitor will take into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

A report on the FT sector aggregate performance from Q4 2014/15 is now available on our website[3] which I hope you will find of interest.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf
[3] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-4-201415

We have also issued a press release[1] setting out a summary of the key findings across the FT sector from the Q4 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 0203 747 0352 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

[1] https://www.gov.uk/government/news/foundation-trusts-face-challenging-year-as-pressures-mount

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

27 MAY 2015

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Jill Galvani	Director of Nursing and Midwifery
Sharon Gilligan	Director of Operations
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Jeff Kozer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director

Apologies

Anthony Hassall	Director of Strategic & Organisational Development

In attendance

Carole Self	Associate Director of Governance
Jon Scott	Interim Deputy Chief Executive
Mark Blakeman	Director of Informatics and Infrastructure
Mark Taylor	Turnaround Advusir
James Mawrey	Director of Workforce

Reference	Minute	Action
BM 15-16/039	**Apologies for Absence** Noted as above	
BM 15-16/040	**Declarations of Interest** None	
BM 15-16/041	**Patient Story** The Director of Nursing and Midwifery presented a positive patient story concerning care which began in October 2014, and continued in May 2015 when the patient sought further help from the hospital in relation to an injury. The patient felt it was appropriate to write and acknowledge the care delivered as throughout their treatment they felt in safe hands and well cared for and could not praise staff highly enough**.**	
BM 15-16/042	**Chairman's Business** The Chairman welcomed Mr Jon Scott to his first Board Meeting and to Mr James Mawrey who was deputising for Mr Anthony Hassall. The Board was updated on the decision by Monitor to include A & E performance in its investigation and discussions to be held on 18th June 2015. The Chairman updated the Board on the following consultant appointments:	

Reference	Minute	Action
	Dr Keloth Pradeep – Consultant in Histopathology & Cytopathology Dr Mohanad Alalusi – Consultant in Histopathology & Cytopathology Dr Anand Natarajan – Consultant in Anaesthesia & Chronic Pain The Board was reminded of the Council of Governors meeting due to take place on 10th June 2015 at 5pm and of the next Board Meeting due to be held on 24 June 2015 commencing at 9am	
BM 15-16/043	**Chief Executive's Report** The Chief Executive presented his report and highlighted the following areas: **Better Care Fund –** confirmed that the Trust had written to the Clinical Commissioning Group highlighting its concerns with the proposed allocations under the Better Care Fund and had subsequently received a response asking for further details in order to progress. **Monitor –** the Chief Executive reiterated the widening of the investigation to include A & E although formal notification was still awaited. He confirmed that the Agenda for the Monitor Visit on 9th and 10th June had now been received and that the preparatory work was being undertaken**.** **CQC Unannounced Inspection**– the Board was updated on the unannounced inspection which took place on 18th May 2015. The Chief Executive was pleased to report that in his view the inspector was pragmatic, responsible and proportionate. Clarification was provided that Theatre Recovery was not part of the escalation policy although over the last couple of months this had been used on a couple of occasions for patients coming out of surgery. **Infection control –** concerns were highlighted with the number of incidences of C difficile which stood at 8 year to date. Concerns were also expressed with the impact of VRE on orthopaedics and the Trust's ability to carry out activity in a timely fashion. **Cerner Remote hosting –** thanks were given to the team for ensuring that the remote hosting exercise was undertaken efficiently and effectively. **Staff engagement –** the Board noted the significant amount of work being undertaken in this area, for which a full update would be provided later on in the meeting. **New Models of Care** – positive reviews were reported from the National events held on the 5th and 6th May 2015. The Chief Executive confirmed that the Trust had agreed in principle to meet up with other Vanguard sites in the North to share experiences of the process so far including best practice. He confirmed that a business case and detailed plans were being prepared for the end of June and July 2015 respectively. The Board discussed the Trust's capacity to deliver this new agenda alongside the work required internally to improve quality and safety. The uncertainty with regards to the funding from NHS England was shared together with the expectations of the Trust. **Contract Discussions** – The Board was advised that the largest material difference between the Commissioner and the Trust's views was in relation to the variance in Payment by Results with all other financial elements	

Reference	Minute	Action
	being considered minor. The Board debated the risk of the Trust being able to deliver the levels of activity required and in turn the Commissioners' ability to be able to afford this.	
BM 15-16/044	**Integrated Performance Report** The Director of Infrastructure and Informatics presented the Integrated performance dashboard and Executive Directors expanded on areas of focus as follows: **Friends and Family Test Results –** The Director of Nursing and Midwifery confirmed that the Trust had sustained performance in the areas of maternity and the Emergency Department Minors. The area of focus continued to be inpatients although the overall result of 93% was a slight improvement on the previous month. The case mix on Ward 36 was highlighted as an area of review. **Nurse staffing vacancies –** confirmation of the support for overseas recruitment together with recruitment locally and nationally was provided. The number of vacancies at Band 5 was confirmed as 59 which was in part as a consequence of the investment made by the Board. **Staff Engagement –** The Director of Workforce confirmed that the extra 9 questions that formed part of the staff engagement score had now been included in the quarterly Friends and Family Test. The Board was advised that this metric would be used to measure improvement in the future. **Staff Attendance-** significant improvement was recorded over the last month in comparison to the same time in the previous year. An outline of the work undertaken was provided **A & E Standard –** the Director of Operations provided an outline of the work undertaken with ECIST on the "Breaking the cycle" initiative, plans for discharge; acute physicians at the front door, therapies, pharmacy and ED processes in addition to the work being undertaken as part of the urgent care recovery plan. She outlined how the experience of Mr Scott was being utilised. The Board was advised that the Health Economy Urgent care recovery plan was due to be signed off in June however work internally was continuing with milestones for achievement being progressed. She confirmed that the plan would be circulated to the Board once finalised. Mr Scott confirmed that the Trust was keen to deliver good care not just the target and that there was a large degree of acceptance that change was required. Concerns associated with the delay with compliance until quarters 3 and 4 were highlighted together with the rationale for this. The Board concluded that it required an overview of the key timelines; plan and expected impact ahead of the meeting with Monitor on the 18th June 2015. **Demand Referral Rates** – The Director of Operations confirmed that this related to one month only and that this had been raised with the Divisions. She confirmed that this would continue to be monitored to ensure this was not a trend. **Advancing Quality** – The Medical Director confirmed that the year-end figures were awaited, although achieving stroke standards had been challenging all year. However there was a degree of confidence that this would improve once occupancy levels were reduced. He confirmed that	**SG** **SG/JS**

Reference	Minute	Action
	Acute MI should be better next year and that Heart Failure did have issues at the beginning of the year but that the Trust was predicting it would meet this for the whole year. The Board was advised that Sepsis was a new metric to be rolled out from start of this year, with improvements being seen as this was rolled out. **C difficile** – The Director of Nursing and Midwifery confirmed that there had been 4 cases in April and 4 cases in May 15. One of which was related to a death which was being investigated. She confirmed that monitoring and reporting would continue through the Quality and Safety Committee. **RTT** – The Director of Operations highlighted the risk in ophthalmology which would mean an underachievement of target over the next 3 months. The other risk area highlighted was gastroenterology due to the vacancy of a gastroenterologist. The Board debated the merits of resetting some of these targets for the year in light of the Recovery Plan in place. Mr Taylor confirmed that there would be scope to do this once the Recovery Plan had been approved.	**MB/MT**
BM 15-16/045	**Month 1 Finance Report** The Director of Finance presented the Month 1 Finance Report and highlighted the following: The Deficit at Month 1 was £1.8M against a plan of £1.7M although it was highlighted that this included £400k of reserves. The Board sought to understand how the use of reserves aligned with the plan. The Director of Finance confirmed that the plan was to use £162k of reserves in month 1. The driver for underperformance against the plan was confirmed as the under achievement of income targets together with penalties and fines as a consequence of operational performance associated with urgent care and VRE/CPE pressures. The Board was updated on the action being taken to address the performance in A & E standards together with the discussions with the CCG on the re-investment of penalties in the future. Cash was reported as marginally above plan at £22M at month 1. The Continuity of Services Rating was reported as 2 in line with the plan. The Director of Finance outlined the savings schemes that were planned to deliver in month 1 together with non-delivery of schemes which were covered by reserves. The Board was advised that the Division of Clinical Support and Diagnostics had delivered a surplus in month as a result of GP direct access although there were some pressures with turnaround times. The pay run rate in month 1 was reported as marginally below the average of the preceding 12 months at £17.3M against £17.4M this was due to the use of flexible labour spend as a result of the opening up of additional capacity.	

Reference	Minute	Action
	Mr Hollick raised concerns that the year was starting the same as the previous year; with little flexibility to improve upon this. He was concerned that the Trust was not addressing the issue of income and activity and sought assurance on the messages being given to the organisation. The Chief Executive provided an overview of the discussions held with Divisions on the previous day which included the under-performance on surgical activity which was the result of a series of factors including the shortfall in consultant capacity; the impact of urgent care and infection control issues. Mr Taylor asked whether the correct level of accountability was apportioned to the Divisions raising in particular the central use of reserves. The Chief Executive outlined the work being undertaken with Divisions to address the underperformance together with the monitoring and review process. The Director of Finance confirmed that he had requested that Divisions be more prospective in their views in the future which would then be built into the reporting structure. The Board confirmed that it would have greater confidence if it better understood where the Trust was not achieving in order that action could be directed to addressing this. The Board asked that this be made clear in future reports. Mr Scott advised that he would produce a monthly report linking operations, finance, quality, infection control and the recovery plan to show the whole position and action being taken to address areas of under-performance. The Board also sought and received an update on the issue with recruitment in therapies.	**JS**
BM 15-16/046	**CQC Compliance** The Medical Director presented the report which highlighted key elements of progress over the reporting period. The Board sought to establish whether the Trust was on track with its plans at this point in time. The Medical Director confirmed that the Trust was on track and that the mock inspections were proving invaluable by affording the Trust with the opportunity to identify issues and make improvements as well as highlighting areas of good and outstanding practice. The Medical Director provided an overview of the progress being made with recruitment to the Project team and how the Trust was utilising existing staff on a secondment basis to undertake this work. The key areas highlighted by the mock inspections continue to be aspects of nurse staffing, the physical environment and implementation of Cerner. The Medical Director reported that recruitment of additional nurses was progressing well although this will not have the impact required if the number of escalation wards open continues. The progress and prioritisation of work being undertaken to address the physical	

Reference	Minute	Action
	environment principally around showers and toilets was outlined with particular emphasis on ensuring compliance with single sex requirements. The Board was advised that this was reviewed on a monthly basis by the Operational Management Team. The Medical Director reported that there had been a culture change from the initial implementation stage of Cerner, where lots of learning was required, to a situation now where Cerner was producing a thirst and desire for more from the staff. The Director of Nursing and Midwifery reported positive reflections and stories from staff with regards to compliance and general improvements in quality and safety. The Board discussed the production of the data packs and the possibility of using external sources to expand on this. The Associate Director of Governance confirmed that the process of meeting with all Executive Colleagues, operational leads and Quality and Safety Assurance leads was in place to review in detail each of the fundamental standards. This review was identifying areas of good practice across all the standards as well as areas for continued focus. The Board was reminded of the plan for the CQC Inspection Manager to attend the Board Development session in June and that the plan was to also invite senior managers to this. The Medical Director provided an overview of the unannounced inspection which took place during that week together with some potential effects around the inspection in September.	
BM 15-16/047	**Risk Management Strategy** The Medical Director presented the Risk Management Strategy for approval by the Board and confirmed that following an annual review the Trust had decided to disband the risk management group in favour of progressing risks through the Operational Management Team, Quality and Safety and Finance Business Performance and Assurance Committee in the future. This was to ensure that greater clinical ownership and Divisional Accountability was achieved. The Board requested the following amendments to be included: • The reporting schedule to be included under Board responsibilities. • Duties and responsibilities of medicines management is to be included. • The responses to recommendations from Internal Audit should include a description as to how the Trust has addressed each of these. The Board approved the Risk Management Strategy subject to the amendments as requested.	
BM 15-16/048	**Report of the Quality and Safety Committee – 13 May 2015**	

Reference	Minute	Action
	Dr Quinn presented the Quality and Safety Committee Report and highlighted the following: **Chair's business –** The outcomes from the theatre review together with the action plan had been circulated to everyone as required with a further update due to be received in 6 months **Quality governance framework –** The Committee undertook a thorough review and identified a series of actions. Dr Quinn confirmed that the section on quality information which was previously green was downgraded to amber in light of the coding and RTT issues. **Assurance reports** – The Safeguarding; Business continuity and Emergency Preparedness Reports and Annual Plans were approved the End of Life Care report highlighted the absence of an approved strategy and that leadership was a problem. **Clinical support and diagnostics** –The update provided by the Division was reported as excellent. The issue of cytology was emphasised in terms of removal without evidence. The Committee was pleased to see that the Histopathology resource issue had been resolved. **CQC mock inspection reports** – Dr Quinn sought to provide further assurance to the Board on CQC compliance and preparedness by confirming that the Committee received regular detailed reports on the mock inspections and actions to be undertaken.	
BM 15-16/049	**Annual Report and Accounts 2014/15, Annual Governance Statement and Quality Report** The Associate Director of Governance presented the Annual Report for review and approval by the Board which included the process for development through the Annual Plan Task and Finish Group and the Audit Committee. The Annual Governance Statement in the Report was highlighted for specific review and approval together with the Remuneration Report and Quality Report all of which had been developed in line with Monitor requirements and audited by the External Auditors. The Director of Finance presented the Annual Accounts highlighted the methodology undertaken for the production of the Accounts and the key four statements contained within. The Treatment of the Sale of Springview in the accounts was highlighted. He confirmed that the Audit Committee in the previous week had reviewed in detail along with Internal and External Auditors the full set of accounts. He also confirmed that the accounts had been produced in line with all the prevailing guidance. The Board was advised that the Accounts in relation to Charitable funds did not form part of these accounts. The Director of Finance advised that the Trust was requested by the Auditors to increase the narrative around the "Going Concern Assessment" in the Annual Report and in the Annual Governance Statement, for no other reason other than for transparency. The Board was advised that the External Auditors were very complementary of the finance team in terms of the quality of working papers which were produced in a much shorter time frame than usual. The Director of Finance was pleased to report an unqualified opinion on	

Reference	Minute	Action
	the accounts although in the use of resources elements there were some complications associated with the data in relation to the quality account which had resulted in the Auditors not being able to provide a positive opinion although it was recognised that this was the same for most Trusts. The review process for the revaluation of the estate was outlined as recommended by the Audit Committee together with the Auditors Opinion on the Trust's approach to risk which was viewed as balanced and acceptable. The recommendations following the Audit and the management response was highlighted together with a slight amendment to the table on page 200 of the accounts due to an administrative error. Since the Audit Committee met the Auditors had confirmed that they wished to put a minor qualification in their report to the Governors which states that whilst they have issued Limited Assurance in relation to the Quality Report in total, which included a limited opinion on 62 week cancer waits but not on the 18 week process, the details of which had now been appended to their report. The Chair of Audit Committee clarified the situation with regards to the 18 week process which had led to the minor qualification. The Board was also updated on the issues with the local indicator chosen by the Governors due to this not being auditable and the Board sought to understand how to avoid this issue in the future. The Chair of the Audit Committee confirmed that the Auditors had agreed to work with the Trust and the Governors this year in order that an appropriate target for audit could be selected as well as requesting that Internal Auditors complement this work through the audit programme. The Board formally approved the following: The Annual Report and Accounts which included the remuneration report and Directors statements, The Annual Governance Statement The letters of representation were signed by the Director of Finance and the Chief Executive together with the Statement of Accounting Officers Responsibilities which was signed by the Chief Executive	
BM 15-16/050	**Report of the Audit Committee 21 May 2015 including Annual Audit Committee Report** The Chair of Audit Committee presented both the report from the meeting held on the 21st May and the Annual Audit Committee report. She highlighted the following areas in addition to the previous discussion: The Committee had received confirmation from both the Director of Finance and the Associate Medical Director that the level of rigour and detail outlined in the letters of representation had been applied by the respective teams. Furthermore she confirmed that the External Auditors had confirmed that they had not asked for any specific detail In those letters of representations that would normally be required.	

Reference	Minute	Action
	Matters arising from External Audit on the Use of Resources Assessment were the increasing difficulty the Trust, along with many Trusts, would face in maintaining a clean audit opinion in the future. Whilst the Trust would continue to do everything to achieve its financial plan, the likelihood that this would be impacted upon significantly in the future by the lack of affordability in the community was highlighted. The committee requested two improvements to be made in the coming year, the first in relation to the process and policy on impairment of assets to ensure this was reviewed and the second that the work on the management of cash should be highlighted in a way that excludes the sale of Springview or the ITFF loan in order that the Trust could evaluate the work undertaken on cash management more effectively. Ms Bond confirmed that the Annual Audit Committee Report had been modified slightly this year to take into account the actions taken by the Committee on the management of override controls, which includes the work undertaken by Internal Audit, the links into the Annual Governance Statement and Standing Financial Instructions. The Board thanked Ms Bond for her report.	
BM 15-16/051	**External Assessment** • **Board Declaration – General Condition 6** The Associate Director of Governance presented the recommendation from the Audit Committee in relation to the declaration on General Condition 6. The recommendation was to declare “confirm” to both statements due to the work being undertaken internally and externally on both finance and A & E and because of the positive comments from the External Auditors in relation to finance. The Board debated the second of the two statements in more depth due to the current investigations being undertaken by Monitor. The conclusion was that to declare anything other than “confirm” at this stage might prejudice the outcome of the investigations. The Board approved the recommendations of the Audit Committee as outlined in the report.	

Reference	Minute	Action
BM 15-16/052	**Health and Safety Annual Report** The Director of Workforce presented the Health and Safety Annual Report confirming that this covered by proactive and reactive work undertaken during the year. He confirmed that with the exception of 3 actions, all aspects of compliance were now complete. The Board sought clarity on the position with regards to the Asbestos Asbestos survey requested. The Board was assured that the survey had been undertaken and that work was being undertaken to address the findings which included continued testing. The Board asked whether the Trust had any major concerns with regards to themes being highlighted through RIDDOR incidents. The Director of Workforce confirmed that this was not the case and outlined the process for monitoring and improving RIDDOR incidents which was undertaken through the Health and Safety Group. Confirmation that the work being undertaken to address legionella did not cover pseudomonas was provided. The Board accepted the reported and noted the significant progress made in this area.	
BM15-16/053	**Board of Directors** The Minutes of the Board of Directors Meetings held on 29 April 2015 and 13 May 2015 were confirmed as an accurate record.	
BM 15-16/054	**Board Action Log** The Board action log was updated as recorded	
BM 15-16/055	**Items for BAF/Risk Register** The Board requested that clarity be sought as to whether the risk in relation to income and activity levels and commissioner alignment were included in the BAF.	**CS**
BM 15-16/056	**Any Other Business** None	
BM 15-16/057	**Date and Time of Next Meeting** Wednesday 24 June 2015 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors

Updated – June 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.05.15						
May 15	BM 15-16/044	Circulate the updated health economy urgent care recovery plan to the Board	SG		June 15	
May 15	BM 15-16/044	Provide an overview of timelines, plan and expected impact for A & E ahead of Monitor Investigation meeting	SG/JS	**Completed**		
May 15	BM 15-16/044	Debate the merits of resetting some of the performance targets in light of the recovery plan	MB/MT		July 15	
May 15	BM 15-16/045	Produce a monthly report linking operations, finance, quality, infection control and the recovery plan to show the whole position and action being taken to address areas of under-performance.	JS		July 15	
May 15	BM 15-16/055	Clarify whether the risk in relation to income and activity levels and commissioner alignment is included in the BAF	CS		July 15	
Date of Meeting 29.04.15						
Apr 15	BM 15-16/011	Ensure the narrative summaries in the performance report include the action being taken to improve performance rather than a description of the issue	MB	**Completed**	May 15	

Apr 15	BM 15-16/011	Update the Board on the work to align the Trust's arrangements for mandatory training with the expectations in the NHS Staff Survey	AH	**Completed**	May 15	
Apr 15	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**Ongoing – next update due June 15**	May 15	
Apr 15	BM 15-16/016	Consider adjusting the nurse staffing ratio targets when contingency wards used	JG		June 15	
Apr 15	BM 15-16/017	Consider which quality measures would be impacted upon as part of the staff engagement work	JM/AH	**Include as part of the review of the Integrated dashboard**	May 15	
Date of Meeting 25.03.15						
March 15	BM 14-15/224	Revise the staff attendance graph in the performance report	MB	**Completed**	May 15	
March 15	BM 14-15/226	Provide the trajectory of A & E Performance	SG	**A further update will be provided following the "Breaking the Cycle" work and the A & E Escalation Meeting**	April 15	
March 15	BM14-15/227	Provide a link to the CQC fundamental standards on the intranet	EM	**Completed**	April 15	
March 15	BM14-15/227	Prepare a briefing on how the Trust is addressing the issues highlighted in the mock inspections to assist with Board walkabouts	EM/AH	**Completed**	April 15	
March 15	BM14-15/230	Confirm the national audit requirements associated with the Quality Account	EM	**Completed**	April 15	
Date of Meeting 25.02.15						
Feb 15	BM 14-15/188	Ensure the integrated performance dashboard provides detailed actions for all high risks and consider how the Board might more easily interpret small incremental change to determine the level of risk	MB		March 15	
Date of Meeting 28.01.15						

Jan 15	BM 14-15/165	Review the changes to Corporate Governance agreed at the Board in January 15 in 6 months time	CS	**Review to be undertaken in July 15**	June 15	
Date of Meeting 26.11.14						
Nov 14	BM/14-15/138	Include how outpatient nurses were being utilised during period of high demand in the next nurse staffing paper	JG	**Update to be provided in June 15**	Jan 15	
Date of Meeting 29.10.14						
Oct - 14	BM14-15/114	Report against a trajectory of improvement in the future in relation to the Annual Plan	AH	**Ongoing**	Jan 15	
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM	**The research team are considering this recommendation**		
Date of Meeting 24.09.14						
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG	**Board requested in February for the inclusion of patient safety questions**	Oct 14	**To be included as part of programme from Dec 2014**