Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

25 November 2015

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25 NOVEMBER 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** Chief Executive	0930	d

6. Strategy and Development

6.1	**Strategic Recovery Plan** Chief Executive/Director of Strategy	0945	d

7. Performance and Improvement

7.1	**Integrated Performance Report**	1015	
	7.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics		d
	7.1.2 Month 7 Finance Report Chief Executive / Acting Director of Finance		d

8. Quality

8.1	**NHS England Core Standards Compliance Report** Director of Operations / Business Continuity & EPRR Op Lead	1045	d
8.2	**Cancer Operational Policy** Director of Operations		d
8.3	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: October 2015** Director of Nursing and Midwifery		d

9. Governance

9.1 **Report of the Finance, Business Performance and Assurance Committee 20 November 2015** — d
Chair of the Finance, Business Performance and Assurance Committee

9.2 **Report of the Quality & Safety Committee 11 November 2015** — d
Chair of the Quality & Safety Committee

9.3 **Board of Directors** — d

9.3.1 Minutes of the Previous Meeting
- **28 October 2015**

9.3.2 Board Action Log
Director of Governance / Corporate Secretary

10. Standing Items

10.1 **Items for BAF/Risk Register** — v
Chairman

10.2 **Any Other Business** — v
Chairman

10.3 **Date and Time of Next Meeting** — v
Wednesday 27 January 2016 at 9am

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	25 November 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

Work with the CCG centres around the Vanguard project, and in particular resolving the phasing of funding with NHS England, and resolving concerns regarding Community Paediatric Services.

Monitor

The Progress Review Meeting between Monitor and the Trust took place on 19 November 2015 as part of the requirements of the licence breach. The meeting focussed on the Trust's Recovery Plan; Strategic Plan; A & E performance and the trajectory for reported cases of C difficile. The informal feedback was largely supportive and there was recognition of the work the Trust was undertaking to ensure the Recovery Plan remained on track for 2015/16 although there remains concern with the amount of savings that need to be delivered in 2016/17. Early sight of the Trust's economic appraisal in relation to the Strategic Plan was requested; albeit that this would be in the developmental stage. The review of A & E Performance was followed by a health economy wide meeting to ensure that the challenge associated with the 4 hour access standard and the plans to improve this were being addressed on a collective basis. Monitor advised that the full review of C difficile would be undertaken as part of the Q2 review process although there was recognition for the actions put in place to date to improve the situation.

2. Internal Activities

Workforce & Organisational Development

NMC Revalidation

From April 2016 the NMC are introducing a new process of revalidation. Nurses and midwives have started preparing for revalidation by making sure they have an NMC Online account and familiarising themselves with the provisional revalidation requirements and have started to developing their portfolio. The Clinical excellence team HR/OD have benchmark information showing all registrants who will need to revalidate QTR 1, and have commenced a pilot to review our readiness to revalidate. Revalidation roadshows and revalidation clinics are available and 21 Registrants have already attended with many more booked into sessions in November and December

HSJ

Dr Beverley Oates was shortlisted for the HSJ Clinical Leader of the Year Award and Early Supported Discharge Hip Fractures was shortlisted for Specialised Service Redesign and the awards ceremony took place on 18 November 2015. I am pleased to advise that Dr Oates won the prestigious award and discussions are being progressed with communications regarding associated publicity.

David Allison
Chief Executive

November 2015

Board of Directors	
Agenda Item	6.1
Title of Report	Strategic Recovery Plan
Date of Meeting	25 November 2015
Author	Mike Coupe - Director of Strategy
Accountable Executive	David Allison - Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: all Key measure: n/a Principal risk: n/a
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This report

- Profiles progress to date on the work programme
- Highlights the emerging implications of this work for the Trust's financial position
- Provides a briefing on emerging planning themes for 2015/16 in particular
- Confirms the arrangements for Governor engagement.

2. Background

At its meeting on 30 September, the Trust Board considered a report on the development of the Strategic Recovery Plan. It approved the approach proposed with the caveat that it would wish to build into the development process opportunities to take stock of progress and review next steps.

3. Strategic Recovery Plan – Phase 1

The objective of Phase 1 was to secure stakeholder understanding of key factors determining WUTH strategic financial outlook to 2019/20. Headlines on progress were provided at the October Board. The workshop on 5/11 generated both a vision of high quality, clinically and financially sustainable services and a draft set of criteria to support the appraisal of options for the future size and shape of the Trust.

4. Strategic Recovery Plan – Phases 2 and 3

The objective of Phase 2 is to identify options for the Trust's future model of care and service portfolio. The objectives of phase 3 are to identify the costs and PbR income associated with each option. The workshop on 12/11 generated a 'narrative' which will allow the generation of the options. Once costed, the options identified will be appraised at the workshop planned for 4/12.

5. Financial Implications

The Board is aware that the CCG is looking to move a new contracting regime potentially including some or all of the following

- A focus on outcomes, care pathways and population programmes rather than providers
- Use of a prime contractor or a prime provider or an alliance model
- Funding on a per capita basis with a move away from traditional funding mechanisms.

The outputs from phases 2 and 3 of the Strategic Recovery Plan will provide WUTH with the basis of a high level cost based contract offer consistent with this new regime.

6. 2016/17

The Senior Management Team organised a planning away day on 22 October to explore objectives and KPIs for 2016/17. These are currently being refined prior to inclusion in the draft of WUTH 2020 to be submitted to the Board in the New Year. Key themes include

- Further roll out of the Quality Strategy and the Trust's response to the expected CQC action plan
- Further roll out of the HR and OD Strategy
- Further roll out of the IT strategy and Cerner benefits realization
- Delivery of FIP Year 2 commitments
- Delivery of Vanguard/ Healthy Wirral commitments.

Progress within Divisions and Directorates on the development of complementary plans is on track. The development of a more robust approach to demand and capacity planning is being managed through the PMO and monitored by the Transformation Steering Group.

7. Governor Engagement

The Annual Planning Advisory Committee (APAC) has been reconvened with a new Chair and Deputy Chair in post. Briefings on the SRP, WUTH 2020 and the FIP have been provided. Members of APAC have also attended the WUTH 2020 workshops.

8. Recommendation

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

Board of Directors	
Agenda Item	**7.1.1**
Title of Report	**Integrated Dashboard and Exception Reports**
Date of Meeting	**25 November 2015**
Author	**John Halliday - Assistant Director of Information**
Accountable Executive	**Mark Blakeman - Director of Infrastructure and Informatics**
FOI status	**Document may be disclosed in full**
BAF References • Strategic Objective • Key Measure • Principal Risk	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • Positive • Gap(s)	**Partial with gaps**
Purpose of the Paper • Discussion • Approval • To Note	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • Yes • No	**No**

1. Executive Summary

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 October 2015.

2. Summary of Performance Issues

Whilst the Trust continues to make good progress in delivering its performance targets in the Meeting our Vision and A Healthy Organisation domains, the Trust continues to struggle to achieve against its objectives in the Operational Excellence and External Validation domains.

The key issue relating to external validation are;

- Achievement of the A&E target.
- Advancing quality indicators.
- The CQC risk assessment, though this is predominately associated with poor outcome of last year's staff survey which is expected to improve this year.

Delivering the operational excellence KPIs remains a significant issue with poor performance in;

- Medicine length of stay, which in turn is having an impact on delivery of the A&E 4 hour target.
- Delivery of the expected activity volumes and income targets, particularly in elective surgery, which is also impacting on the 18 week RTT target.
- Non-core expenditure
- CIP performance.
- Cash – working days, though noting that the cash position does remain significantly above plan.

3. Achievement of the A&E Target / Non Elective Performance

Despite the range of actions being put in place in, performance against the Emergency Access Standard deteriorated further in October to 88.57%.

Key issues being addressed by the division with an aim of resolving the underperformance are;

- **The level of ED attendances -** in October there were 513 more attendances at ED compared with October 2014, an increase of 6.9%.

This continues the year-on-year increase seen across the last three months, though the cumulative year-to-date position remains below 2014/15 levels due to lower activity levels earlier in the year.

- **Changing responsibility for the NHS111 service** – the Trust continues to see an increased number of ambulance arrivals to the ED. However, the number of admissions from ambulance presentations has not increased. Discussions are ongoing with NWAS regarding this increase and their ability to deflect attendances to ED with alternative providers.

- **Patient flow processes** – the Trust has reviewed length of stay (LoS) within the Medical Division. LoS has increased since April 2015 by circa 1 day in patients aged 74 years and above. There is a direct correlation between this increase in LoS and an increase of the number of medically optimised patients within the Trust.

- **Discharges at week-ends** – The Trust has introduced three additional consultant led ward rounds on both a Saturday & Sunday, these ward rounds are in addition to the planned speciality ward rounds already in place. Whilst there has been some improvement in weekend discharge rates, weekend social care capacity remains a limiting factor.

- **Community Beds** - The local authority has now opened further beds and pressure is being applied via the System Resilience Group to ensure the remaining planned community beds are opened up to reduce the numbers of medically fit patients awaiting discharge. The Trust has agreed with the System Resilience Group to fund 28 additional beds in the community. The beds will open w/c 14.12.15 with full occupancy by 24.12.15 with the last admission being 31.3.16

- **Discharge Lounge** - Consistent high usage of discharge lounge continues across both divisions. Further work is underway to try to ensure transfers are happening before 12 noon.

- **ECIST** – the department have engaged with the ECIST team and a diagnostic review is taking place 23/24 November to assist with SAFER implementation & monitoring. The board will receive an update following the visit.

- **External Review** - The division are exploring with the Royal College of Emergency Medicine the potential of an external review of the Emergency Department in conjunction with the CSL. Progress on this will be reported at a future meeting.

- **In-depth LoS review** – (Age, speciality, consultant) has been actioned to ensure a continued focus on specialities were length of stay has increased especially with patients who require social care to aid safe discharge.

- **COPD Early Supported Discharge** has been implemented from November 2015.

- **Roll out of rapid access clinics** continues, with cardiology and respiratory adding services in November.

- **Single front door project** is due to commence 30th November as a joint concept between the Community Trust and WUTH to further stream ED attendances to the post appropriate care facility

4. Advancing quality indicators

In line with all other organisations, the Appropriate Care Score (ACS) targets for WUTH have been reset for 2015-16, based on the twin principles of raising the bar on minimum attainment and continuous system-wide improvement and stretch. The national reporting programme runs approximately three months behind.

The three indicators that are currently at risk of failing are;

- **Hip and Knee replacements –** In August the Trust passed all the AQ measures for knee, with some issues around VTE prophylaxis that we need to work on.

  The AQ measures for Hip Fracture remain a challenge and the target was failed in August. Previous consistent achievement of this standard led to the allowance of a smaller sample population, with the results that a single missed measure can lead to failure against the target. The team has reverted to full caseload review from October 2015. Performance against the individual measures is as follows:

Pain assessment and analgesia	41.5%
Admitted to appropriate ward	36.4%
Admitted under joint protocol	72.7%
Documented can fully weight bear	100%
Pressure ulcer assessment	36.4%
Consultant supervision	70%
Physiotherapy assessment	20%
Nutritional assessment	47.3%

- **Sepsis -** the improved position of 49% in June slipped back to 40% in August. The promotion of the paper pathway continues, and it is expected that the electronic alerting will continue to help to raise awareness with staff. The potential for a fully electronic pathway is being developed. A “Sepsis September” event was held that focussed on the electronic alert and subsequent actions.

  There are now two issues for the Trust that are holding the score down;

- The requirement for a blood lactate level at the time of senor review. To help resolve this, work is underway to interface the blood gas analysis machines directly with Cerner and remove paper from the process
- The other issue relates to adequate fluid challenge and fluid balance recording in the Trust which is being reviewed.

- **Community Acquired Pneumonia** – there are delays in patient flow such that timely delivery of antibiotics is an issue. This will become even more challenging as the year progresses with the introduction of tighter time measures in quarter 3.

5. Elective Performance

Delivery of the Trust's elective activity plans remain a concern and are essential to the delivery of both the core and cost improvement plans, as well as ongoing achievement of the RTT waiting time target.

For October elective activity elective activity was down 278 cases (3.2%) against the original plan.

Key issues being addressed by the division to resolve the underperformance are;

- Patient availability and suitability for lists, (particularly at a sub-speciality level within orthopaedics and ENT)
- Consultant sickness and leave.

At specialty level, Orthopaedics, Oral Surgery, ENT and Ophthalmology and Gynaecology remain the specialties causing most risk to activity levels. In part mitigation, there is the potential of some additional work for Betsi Cadwaladr.

Orthopaedics

There has been some improvement and the re-forecast plan is being achieved.

Additional actions that were put in place since the beginning October to improve performance will be monitored over the next month to assess their impact, including;

- Booking patients straight from fracture clinic
- Trauma cases who are discharged to come back are being booked onto elective lists

- Regular management meetings with TCI staff every Monday to ensure lists are filled,

- Cerner data is now being used to build up lists in blocks of time increasing theatre utilisation,

- Whilst lower than the division wanted, consultants have now provided availability for additional outpatients clinics and 89 patients have been booked. To date there has been a 50% conversation rate to surgery.

Discussions with the team remain ongoing.

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Oral surgery

The Division have successfully appointed a locum who took up post in mid-October. The absent Consultant has returned on a phased return. Assuming he returns to full clinical practice within the agreed timeframes the division will achieve original plan by year end. Discussions with a local Trust to support a transfer of activity has not yet materialised, though the division continue to pursue this interest.

ENT

The two main reasons for the underperformance are Consultant sickness and an increase in non-elective activity (which is over performing against plan by 49 cases (18.1%)

The Consultant has now returned to work and the Division are working on ensuring that theatre utilisation is maximised. The service is also managing an imbalance in the waiting list for outpatient and elective surgery and therefore a range of theatre sessions are being converted to clinics to address this. The consequence is that whilst there will be an underperformance in November of 57 cases it is expected to recover by year end.

Ophthalmology

The current forecast is for an underperformance of 294 cases (£272K). Whilst efforts are continuing to try and reduce this, the speciality doctor in this area has been offered a consultant post (in another country) it is unlikely there will be an improvement on the 294.

Gynaecology

Gynaecology is showing a deficit of 31 cases in month. As previously reported, this is due to a consultant being unable to operate due to a knee injury. The

consultant is expected to return to full operating in February 2016. In the interim;

- the remaining consultants continue to picking up lists where possible, and registrars are backfilling,
- additional Saturday operating has been agreed,
- three patients have had their treatment in Liverpool Women's hospital in order to ensure their treatment has been timely, particularly in relation to cancer treatment,
- the division are trying to recruit a locum consultant.

A further update will be provided at the next board.

Additional Elective Activity

Betsi Cadwaladr (BCU) have enquired about availability of capacity to receive outsourced work, specifically in the areas of pain, urology and gynaecology. WUTH have confirmed they could potentially support pain and gynaecology and have requested additional information from BCU.

6. 18 Weeks RTT

Ongoing achievement of the RTT standard is directly linked to the delivery of the required activity levels. Although the RTT incompletes standard has been consistently achieved at Trust level, there are a few specialties that do not achieve in their own right. Of continuing concern are Anaesthetics (pain management) and Community Paediatrics which is commissioned by the CCG on a block payment basis.

- The focus of RTT is now solely on the incomplete standard, and from October the financial penalty of failing the minimum 92% is doubled to £300 per 'excess' breach over the allowed 8% tolerance. Performance continues to be measured at Trust level for Monitor's Risk Assessment Framework, and at main specialty level for the calculation of contractual financial penalties.
- The Trust's operational policies and practices were reassessed in October to ensure the rules are adhered to whilst still managing patients on RTT pathways in their best clinical interests. In particular improvements were made in the way that patient pauses, planned patients and patients referred through the national e-referral system were recorded. This has had a minor impact on the reported performance levels. To reduce the amount of validation that is required

by senior staff each month, refresher training is taking place during December and January to ensure that all staff fully understand the RTT rules.

- The Department of Health have recently started to publish a monthly RTT monitoring tool which shows that in September 2015, 27 Trusts failed the target and 7 did not report. The Trust is identified as one of the next 20 "at risk" of failing the target with a 44% chance of failing in the next 6 months.
- Most specialties within the Trust are achieving the target at a nationally defined specialty level. The 2 national specialties which will not achieve this target are General Surgery which includes breast, colorectal, general surgery, upper gastrointestinal and vascular and "Other" which includes numerous specialties but notably anaesthetics (pain management) and community paediatrics.
- Within General surgery the specialties failing the target are upper gastrointestinal and vascular. In upper gastrointestinal this is due mainly to a Consultant vacancy. The Consultants in this areas are doing additional lists and clinics and have transferred some operative procedures to Colorectal colleagues. The team are reviewing all pathways in an attempt to reduce waiting times and will then consider whether additional substantive resource is required. Vascular is due mainly to a Consultant vacancy which has now been filled and the availability of Consultants to backfill lists; discussions are ongoing with the SMART network.
- Within the "other category" the specialties failing are anaesthetics and community paediatrics. In pain management this is due to lack of capacity because of a previous Consultant vacancy and ongoing consultant sickness. Work has been outsourced to the independent sector to help clear the backlog of referrals and address the capacity issues from November onwards.
- The situation in community paediatrics is worsening and it remains the specialty which impacts most on an already challenging RTT target. At the end of October 380 patients of the 814 on an incomplete pathway had waited in excess of 18 weeks. If community paediatrics were achieving this target then the Trust position at the time of writing would be 93.41%. Discussions are ongoing with partners to try and improve this situation.

7. Infection Control

During October the trust reported 5 hospital attributed cases of toxin positive *C.difficile* with 2 equivocal (non-reportable) cases also identified.

The Post Infection Review performed by the IPCT identified the 5 toxin cases to be avoidable. All the patients had been exposed to C.diff, then receiving the trigger of antibiotics resulting in C.diff associated infection.

The increase in the number of cases during October is likely due to the pressures experienced during August and September which resulted in the C.diff cohort unit being used for medical patients.

Additionally during August and September, there were occasions when increased occupancy on the C.diff unit and on the wards resulted in a delay in patients being stepped down from the unit.

Compliance with isolation audits performed by the IPCT also identified during Quarter 2 that 53% of patients with diarrhoea were not isolated until a positive result had been reported.

The HPV programme re-established for 2 weeks during September allowed 4 of the high risk wards to have a full HPV clean. Remaining wards were then included in a rolling deep cleaning programme initiated in replace of the HPV programme when the decant ward was no longer available.

Reporting 5 avoidable cases during October means that we have breached the C.diff trajectory for 3 consecutive months. A report has been submitted to Monitor identifying the issues that have resulted in the breaches and describing the actions initiated to reduce the risk of further cases. These actions include:

- The introduction of a 48 hour target for “step down” from the C *diff* unit has been introduced, is monitored by the IPCT and reported to the weekly Senior Management Team in order that the discussion can be part of the holistic review of beds in the hospital.

- Weekly reporting also includes the number of patients suspected to have *C.diff (or any other diarrhoeal associated infection)* split between those which have been effectively isolated to a side room within 2 hours; the number of positive C *diff* patients who have been transferred to the Cohort Ward and the number of patients either suspected to have C *diff* or C *diff* positive that are on the ward

- The C *diff* cohort ward to be protected for C *diff* patients only.

- A full ward HPV cleaning programme has been commenced to target all high risk areas. During a 6 week period it will be possible to HPV clean 18 wards.

- Further funding has been approved to allow continuation of the improvement work to ensure all bed pan washers are replaced with macerators and all hand washing facilities are of the required specification within clinical areas and is scheduled for completion 31st March 2016.

8. Non Core Spend

In October 2015 £1.8m has been spent on non-core pay categories.

Expenditure on non-core pay categories is lower than the previous months but has increased in comparison to 2014/15 averages. There is continued focus on the non-core spend across the divisions and they are a part of the performance dashboards at the divisional performance reviews.

Agency spend still remains higher than the 14/15 average spend;

- Medical agency spend this month is due to critical medical consultant vacancies however plans are in place to continue to recruit substantively to the consultant gaps.
- Qualified nurse agency costs have improved this month and has reduced to 2.7% cumulatively compared to the Monitor ceiling/cap of 3% of agency spend on qualified nurses as a % of total qualified nursing spend.

Locum spend was higher this month to cover medical staff vacancies across the divisions.

9. Summary Financial Position

The Trust continues to deliver a financial performance broadly in line with its plan. In month the Trust delivered a deficit of (£0.652) which is adverse to the original profile used within the Monitor plan but marginally better than the re-forecast figures presented at Board in October. The cumulative deficit as at the end of October is (£8.824m) which is an (£0.354m) adverse variance to the plan of (£8.470m).

The Trust continues to forecast achievement of the full year plan with a deficit of (£13.431m) assuming that none of the identified risks are realised that are discussed later within the report. Included within the forecast is a central allocation of £2.2m to fund winter and other pressures currently not within the Divisional forecasts.

The cash position continues to be positive, with the end of the month balance being £13.343m which is £9.271m better than plan. The Trust is forecasting to finish the financial year with c£2m cash available and is no longer forecasting the need for distress funding. The Trust has developed a robust process to minimize the risk of cash balances falling below the Monitor threshold before year end.

The current financial performance translates into a Continuity of Services (CoS) Rating of 2, which remains in line with plan.

The Executive Directors continue to develop further detailed plans to mitigate any risks that may be realised in the latter half of the year to enable delivery of the financial plan.

Further financial information is contained in the separate Finance briefing paper.

10. Recommendation

The Board of Directors are asked to;

Note the Trust's current performance to the end of October 2015, with particular regard to;

- The risks associated with the delivery of the emergency access target where performance remains challenging despite a range of actions taken.
- Risks against Elective and outpatient activity volumes and contract performance.
- 18 week RTT where ongoing performance is dependent on delivery of at least the activity volumes identified in the annual plan, particularly in light of the increased GP referrals.

Support the range of actions to resolve the current underperforming areas;

- The recovery plans in place to deliver the non-elective access target.
- Ongoing work with the surgical division to improve the performance against the elective and outpatient programmes.
- The additional attention within the organisation being put on the 18 week RTT incomplete target.

Mark Blakeman
Director of Informatics and Infrastructure

WUTH Integrated Performance Dashboard - Report on October 2015 for November BoD

Area	Indicator / BAF	August	Sept	Oct	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	97%	97%	97%		>=95%	October 2015	JG
	Patient - F&F "Not Recommend" Rate	1%	1%	1%		<=2%	October 2015	JG
	Staff Satisfaction (engagement)	3.83	3.83	3.83		>=3.69	Q2 2015/16	JS
	First Choice Locally & Regionally							
	Market Share Wirral	85.7%	85.2%	85.5%		>= 85%	April to July 2015	MC
	Demand Referral Rates	3.7%	2.6%	2.0%		>= 3% YoY variance	Fin Yr-on-Yr to Oct 2015	MC
	Market Share Non-Wirral	9.5%	9.4%	9.2%		>=8%	April to July 2015	MC
	Strategic Objectives							
	Harm Free Care	94%	96%	95%		>= 95%	October 2015	JG
	HIMMs Level	5	5	5		5	October 2015	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	92.51%	90.25%	88.57%		>=95%	October 2015	SG
	RTT 18 Weeks Incomplete Position	92.3%	92.0%	92.0%		>=92%	October 2015	SG
	Cancer Waiting Time Standards	On track	On track	On track		All met at Trust level	Q3 to Oct 2015	SG
	Infection Control	0 MRSA; 19 C diff	0 MRSA; 22 C diff	0 MRSA; 27 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	October 2015	JG
	Productivity							
	Delayed Transfers of Care	4.1	3.7	3.2		<= 4	12-mth ave to Oct 2015	SG
	Delayed Complex Care Packages	60	62	59		<= 45	October 2015	SG
	Bed Occupancy	90.4%	92.4%	94.3%		<=85%	October 2015	SG
	Bed Occupancy Medicine	94.1%	92.1%	93.3%		<=85%	October 2015	SG
	Theatre Utilisation	70.3%	71.0%	70.5%		>=85%	October 2015	SG
	Outpatient DNA Rate	9.3%	8.8%	8.1%		<=6.5%	October 2015	SG
	Outpatient Utilisation	83.3%	83.1%	83.2%		>90%	October 2015	SG
	Length of Stay - Non Elective Medicine	7.5	7.5	7.4		<= 6.5	October 2015	SG
	Length of Stay - Total	4.8	5.0	4.8		<=4.2	October 2015	SG
	Contract Performance (activity)	-3.2%	-3.1%	-2.0%		0% or greater	October 2015	SG
	Finance							
	Contract Performance (finance)	-1.7%	-1.5%	-1.5%		On Plan or Above YTD	October 2015	GL
	Expenditure Performance	1.4%	1.2%	1.0%		On Plan or Above YTD	October 2015	GL
	CIP Performance	-22.0%	-25.0%	-12.0%		On Plan or Above	October 2015	GL
	Capital Programme	-2.5%	12.1%	6.1%		On Plan	October 2015	GL
	Non-Core Spend	9.6%	9.6%	9.7%		<5%	October 2015	GL
	Cash Position	218%	108%	228%		On plan or above YTD	October 2015	GL
	Cash - working days	-12.53	-14.33	-14.9		> 14 days	October 2015	GL
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	0	1	1		0 per month	October 2015	EM
	Complaints	40.3	40.9	41.3		<30 per month	12-mth ave to Oct 2015	JG
	Workforce							
	Attendance	96.1%	96.2%	95.8%		>= 96%	October 2015	JS
	Qualified Nurse Vacancies	7.8%	7.3%	7.4%		<=6.5%	October 2015	JG
	Mandatory Training	95.3%	94.4%	93.8%		>= 95%	October 2015	JS
	Appraisal	85.2%	84.95%	83.61%		>= 85%	October 2015	JS
	Turnover	9.9%	9.7%	9.6%		<10%	October 2015	JS
	Nursing Agency Costs	3.4%	3.4%	1.9%		<=2.5%	October 2015	JS
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	4	2	3		All areas above target	October 2015	EM
	Mortality: HSMR	90.03	89.25	90.53		Lower CI < 0.90	April to July 2015	EM
	Mortality: SHMI	0.967	0.967	0.967		Lower CI < 90	Oct 2013 to Sept 2014	EM
	Regulatory Bodies							
	Monitor Risk Rating - Finance CoS	2	2	2		4	October 2015	GL
	Monitor Risk Rating - Governance	Red	Red	Red		Green	October 2015	SG
	CQC	5	5	5		0	October 2015	EM
	Local View							
	Commissioning - Contract KPIs	4	4	4		<=2	October 2015	SG
	Monitor enhanced monitoring							
	A&E 4 Hour Standard	92.51%	90.25%	88.57%		>=95%	October 2015	SG
	Medical Outliers	6.9	1.54	6.14		<=5	October 2015	SG
	Bed occupancy	90.4%	92.4%	94.3%		<=85%	October 2015	SG
	Staff Friends and Family	62%	62%	62%		>= 75%	Q2 2015/16	SG
Financial Recovery	**Financial Recovery Plan**							
	Contract / Inventory Management	-2.3%	-4.3%	-5.8%		0% (ie on plan) or greater	October 2015	MT
	Income	-2.5%	-0.8%	-1.4%		0% (ie on plan) or greater	October 2015	MT
	Workforce Value for Money	-0.2%	-1.8%	-4.7%		0% (ie on plan) or greater	October 2015	MT
	Utilisation - Outpatients	-8.5%	-5.7%	-3.7%		0% (ie on plan) or greater	October 2015	MT
	Utilisation - Theatres	-12.1%	-13.4%	-17.1%		0% (ie on plan) or greater	October 2015	MT
	Productivity - Patient Flow	-9.1%	-13.4%	-10.2%		0% (ie on plan) or greater	October 2015	MT

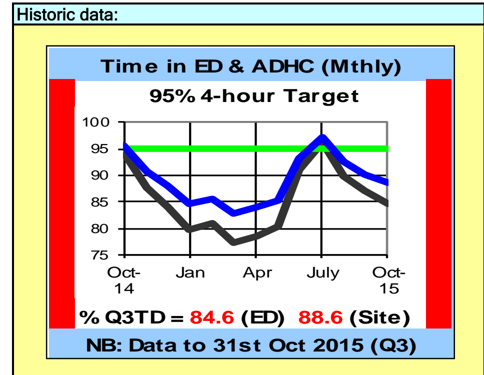
WUTH Performance Dashboard Exception Report

Indicator :	Rating	Target	Actual	Period
A&E 4-hour Standard	Red	>= 95%	88.57%	Oct 2015

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for October was 88.57%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 84.61%.

Historic data:



Proposed Actions:

The Trust has undertaken a detailed analysis of length of stay within medicine. The analysis has shown an increase length of stay in patients over 74 years. The increase correlates with the change in the Health & Social Care act in April 2015. Discussions with social care partners have been productive and various new ways of working are due to start within November with a specific focus on discharge.
A full analysis of past and current actions undertaken within the Emergency Department to improve compliance is underway to evaluate actions.

Assessing Improvement:

Across the first two weeks of November joint performance has been 87.16% and 87.02%. The current combined Q3 performance to the 16th November is 87.8%.

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

Indicator :
Infection Control

Rating	Target	Actual	Period
Red	Within trajectory	27 c diff cases	To Oct 2015

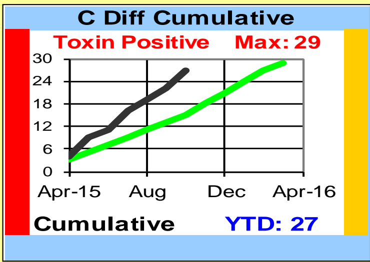
Issue:

The Trust has a maximum trajectory of 29 C.difficile cases for the year 2015-16 (toxin positive, hospital acquired). During October we reported 5 hospital attributed cases of toxin positive C.difficile with 2 equivocal (non-reportable) cases also identified. This brings the cumulative position to 27 cases.

The Post Infection Review performed by the IPCT identified the 5 toxin cases to be avoidable. All the patients had been exposed to C.diff, then receiving the trigger of antibiotics resulting in C.diff associated infection.

The profiled trajectory to the end of December 2015 is a maximum 21 cases. As there are already 27 confirmed cases this will be the third consecutive quarter where the cumulative trajectory profile is breached, and so will automatically trigger a governance concern at Monitor.

Historic data:



Proposed Actions:

The increase in the number of cases during October is likely due to the pressures experienced during August and September which resulted again in the C.diff cohort unit being used for medical patients. Additionally during August and September, there were occasions when increased occupancy on the C.diff unit and on the wards resulted in a delay in patients being stepped down from the unit, resulting on one occasion in potential re-infection.

Compliance with isolation audits performed by the IPCT also identified during Quarter 2 that 53% of patients with diarrhoea were not isolated until a positive result had been reported.

The HPV programme re-established for 2 weeks during September allowed 4 of the high risk wards to have a full HPV clean. Remaining wards were then included in a rolling deep cleaning programme initiated in replace of the HPV programme when the decant ward was no longer available.

A report has been submitted to Monitor identifying the issues that have resulted in the breaches and describing the actions initiated to reduce the risk of further cases. These actions include:

- The introdcution of a 48 hour target for "step down" from the C diff unit has been introduced, is monitored by the IPCT and reported to the weekly Senior Management Team in order that the discussion can be part of the holistic review of beds in the hospital.
- Weekly reporting also includeS the number of patients suspected to have C.diff (or any other diarhoeal associated infection) split between those which have been effectively isolated to a side room within 2 hours; the number of positive C diff patients who have been transferred to the Cohort Ward and the number of patients either suspected to have C diff or C diff positive that are on the ward
- The C diff cohort ward to be protected for C diff patients only.
- A full ward HPV cleaning programme has been commenced to target all high risk areas. During a 6 week period it will be possible to HPV clean 18 wards.
- Further funding has been approved to allow continuation of the improvement work to ensure all bed pan washers are replaced with macerators and all hand washing facilities are of the required specification within clinical areas and is scheduled for completion 31st March 2016.

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 4 reporting

Director approval:

Jill Galvani, Director of Midwifery & Nursing

WUTH Performance Dashboard Exception Report

Indicator :
Advancing Quality

Rating	Target	Actual	Period
Red	All achieving	3 areas under target	Oct 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. Areas behind target at the end of August were Hip & Knee Replacements, Community Acquired Pneumonia and Sepsis.

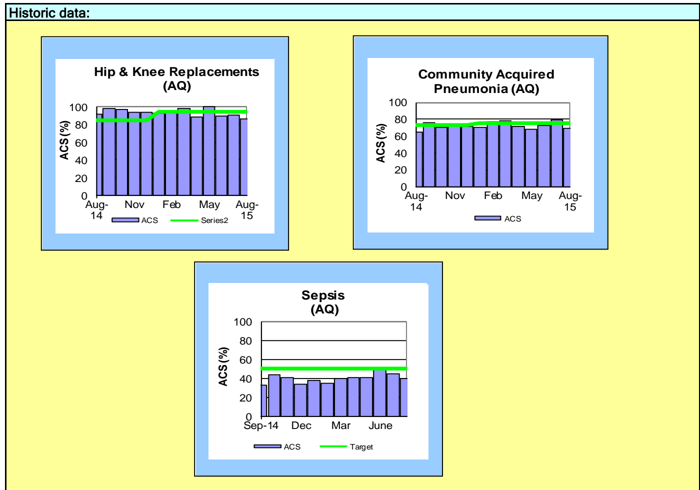
Proposed Actions:
In line with all other organisations, the Appropriate Care Score (ACS) targets for WUTH have been reset for 2015-16, based on the twin principles of raising the bar on minimum attainment and continuous system-wide improvement and stretch.

HIP & KNEE - this is now based on a small sample population so that one missed measure can lead to failure to achieve target. The Team have reverted back to full caseload audit from October 2016 and anticipate they will improve. Missed measures tend to be in the hip rather than knee population over the course of the year. No particular measure is an issue.

CAP - this is due to a delays in patient flow such that timely delivery of antibiotics is an issue. This will become even more challenging as the year progresses with the introduction of tighter time measures in quarter 3.

SEPSIS - There are two issues with Sepsis that are holding the ACS down. The requirement for a blood lactate level at the time of senor review; this is measured on blood gas analysis and the result is not in Cerner and the paper result is not always with the casenote/ timed properly. There is work in progress with IT to address this. The other issue relates to adequate fluid challenge and fluid balance recording in the Trust and needs further work.

Historic data:



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

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 (rolling 3 months)	>= 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%
Strategic Objectives				
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

Organisational Excellence

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	RTT "Incompletes" standard met for the Trust as a whole	>=92%	n/a	<92%
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
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				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	> 4 and < 6	>= 7
Delayed complex care packages	Average No of patients on the complex discharge list in the month	<= 45	>= 46 and <= 70	>= 71
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Bed occupancy - Medicine	Average % of Medial & Acute beds occupied at midday	>=85%	>=65% to <85%	<65%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
Outpatient DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<= 6.5%	>6.5% and <= 9%	> 9%
Outpatient Utilisation	Percentage of OP appointments that DNA (Med, Surg and W&C)	>90%	>=80% to <90%	<80%
Length of stay - Non-elective Medical Division	Average length of stay per finished admitted spell (Medical Division)	<= 6.5	> 6.5 to 8.0	> 8.0
Length of stay - Trust total	Average length of stay per finished admitted spell (Trust total)	<= 4.2	> 4.2 to 5.5	> 5.5
Contract performance (Activity)	Cumulative activity % variance against plan for all PODs combined	0% or greater	-2.0% to <0%	< -2.0%
Finance				
Contract Performance (Finance)	Delivering both contracted volumes and values	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD
Expenditure performance	Delivering planned levels of expenditure	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD
CIP Performance	Delivering against the in-year CIP forecast.	On Plan or Above	10% below plan	>10% below plan
Capital Programme	A sound investment programme maintained & resourced appropriately	On Plan	+/- 15% against plan	+/- 25% against plan
Non-Core Spend	Non core as a % of total pay spend	<5%	>=5.0% to 6.5%	>=6.6%
Cash Position	Delivering against cash plan	On plan or above YTD	n/a	Below plan

Cash - working days	Liquidity Days: The number of days the Trust could support it's pre EBITDA expenditure with it's liquid assets i.e.((Current Assets - Inventories - Current liabilites) / Pre EBITDA expenditure)) x number of days elapsed in financial year	> 14 days	>= 7 days to 14 days	< 7 days

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
Workforce				
Attendance	Monthly staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Qualified Nurse Vacancies	% vacant posts	<=6.5%	>6.5% to 9.5%	>9.5%
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%
Nursing Agency Costs	Nursing agency costs as a percentage of total nursing costs	<=2.5%	>2.5% to <3.0%	>=3.0%

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality (not achieving)	Number of areas not achieving	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
Monitor Enhanced Monitoring				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
Medical Outliers	Average daily medical outliers in non-medical beds	<=5	>5 to 10	>10
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Staff Friends and Family	Recommend Trust to work	>= 75%	>= 50% to <75%	<50%
Financial Recovery Plan				
Contract / Inventory Management	Total non pay expenditure against plan, excluding CNST premium and high cost drugs	>=0%	<0% to -5%	<-5%
Income	Total income against plan	>=0%	<0% to -5%	<-5%
Workforce Value for Money	Total pay expenditure against plan	>=0%	<0% to -5%	<-5%
Utilisation - Outpatients	Percentage of available resource utilised against plan	>=0%	<0% to -5%	<-5%
Utilisation - Theatres	Percentage of available resource utilised against plan	>=0%	<0% to -5%	<-5%
Productivity - Patient Flow	Reduction in non-elective length of stay against plan	>=0%	<0% to -5%	<-5%

Appendix B : Cancer Waiting Time 62-Day Standard

Quarter	3
Period	01/10/2015 - 31/12/2015

Target	62 Day Wait
Indicator	GP Urgent Referral to First Definitive Treatment
Threshold	85.00%
Risk	£1000 for each excess breach above the threshold in t

Quarter 3 - Total

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	1	0	1	4	7	11	75.00%	90.91%
	Lung	1	0	1	4.5	10	14.5	77.78%	93.10%
	Other	0	0	0	1.5	2	3.5	100.00%	100.00%
Med & Surg	Upper GI	4	2	6	10.5	15	25.5	61.90%	76.47%
Surgery	Breast	0	0	0	10.5	28.5	39	100.00%	100.00%
	Colorectal	3	0	3	10.5	14	24.5	71.43%	87.76%
	Head & Neck	0	0	0	1	10	11	100.00%	100.00%
	Skin	0	0	0	13	42	55	100.00%	100.00%
	Urology	10	7	17	21.5	29.5	51	53.49%	66.67%
Women's	Gynaecology	1	3	4	3	11	14	66.67%	71.43%
	Total	**20**	**12**	**32**	**80**	**169**	**249**	75.00%	87.15%

Quarter 3 - October

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	1	0	1	3	0	3	66.67%	66.67%
	Lung	1	0	1	4	0.5	4.5	75.00%	77.78%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	4	2	6	10	0	10	60.00%	40.00%
Surgery	Breast	0	0	0	9.5	5.5	15	100.00%	100.00%
	Colorectal	3	0	3	8	0	8	62.50%	62.50%
	Head & Neck	0	0	0	1	1	2	100.00%	100.00%
	Skin	0	0	0	12	3	15	100.00%	100.00%
	Urology	10	5	15	20.5	5	25.5	51.22%	41.18%
Women's	Gynaecology	1	2	3	2	2.5	4.5	50.00%	33.33%
	Total	**20**	**9**	**29**	**70**	**17.5**	**87.5**	71.43%	66.86%

Quarter 3 - November

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	0	0	0	1	3	4	100.00%	100.00%
	Lung	0	0	0	0.5	3.5	4	100.00%	100.00%
	Other	0	0	0	1.5	1.5	3	100.00%	100.00%
Med & Surg	Upper GI	0	0	0	0.5	5.5	6	100.00%	100.00%
Surgery	Breast	0	0	0	1	10	11	100.00%	100.00%
	Colorectal	0	0	0	2.5	4.5	7	100.00%	100.00%
	Head & Neck	0	0	0	0	4.5	4.5	N/A	100.00%
	Skin	0	0	0	1	23	24	100.00%	100.00%
	Urology	0	2	2	1	11	12	100.00%	83.33%
Women's	Gynaecology	0	1	1	1	5.5	6.5	100.00%	84.62%
	Total	**0**	**3**	**3**	**10**	**72**	**82**	100.00%	96.34%

Quarter 3 - December

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	0	0	0	0	4	4	N/A	100.00%
	Lung	0	0	0	0	6	6	N/A	100.00%
	Other	0	0	0	0	0.5	0.5	N/A	100.00%
Med & Surg	Upper GI	0	0	0	0	9.5	9.5	N/A	100.00%
Surgery	Breast	0	0	0	0	13	13	N/A	100.00%
	Colorectal	0	0	0	0	9.5	9.5	N/A	100.00%
	Head & Neck	0	0	0	0	4.5	4.5	N/A	100.00%
	Skin	0	0	0	0	16	16	N/A	100.00%
	Urology	0	0	0	0	13.5	13.5	N/A	100.00%
Women's	Gynaecology	0	0	0	0	3	3	N/A	100.00%
	Total	**0**	**0**	**0**	**0**	**79.5**	**79.5**	N/A	100.00%
	Total	**0**	**0**	**0**	**0**	**139.5**	**139.5**	N/A	100.00%

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 7 Finance Report
Date of Meeting	25 November 2015
Author	Julie Clarke – Assistant Director of Finance – Operational Financial Management
Accountable Executive	Gareth Lawrence, Acting 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

Overview

The Trust continues to deliver a financial performance broadly in line with its plan. In month the Trust delivered a deficit of (£0.652) which is adverse to the original profile used within the Monitor plan but marginally better than the re-forecast figures presented at Board in October. The cumulative deficit as at the end of October is (£8.824m) which is an (£0.354m) adverse variance to the plan of (£8.470m).

The Trust continues to forecast achievement of the full year plan with a deficit of (£13.431m) assuming that none of the identified risks are realised. Included within the forecast is a central allocation of £2.2m to fund winter and other pressures currently not within the Divisional forecasts.

The cash position continues to be positive with the cash position at the end of the month being £13.343m which is £9.271m better than plan. The Trust is forecasting to finish the financial year with a c£2m cash balance without any injection of resilience funding. The Trust has developed a robust process to ensure that the cash balances do not fall below the Monitor threshold before year end with relevant escalation triggers.

The financial performance in month and at month 7 translates into a Continuity of Services (CoS) Rating of 2, which remains in line with plan.

Income and Expenditure Performance

TOTAL TRUST	Month 7			Year to Date			Full Year Forecast		
	In Month			Year to Date					
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k	£k	£k	£k
NHS Clinical Income	23,857	23,528	(329)	162,284	159,853	(2,431)	279,420	277,977	(1,442)
Other Income	2,295	2,540	245	15,831	17,172	1,340	27,317	29,554	2,237
Employee Expenses	(17,743)	(17,723)	20	(124,076)	(123,319)	757	(212,807)	(212,750)	57
All Other Operational Expenses	(7,758)	(8,032)	(274)	(54,266)	(54,733)	(467)	(93,178)	(94,759)	(1,582)
EBITDA	652	313	(339)	(227)	(1,027)	(801)	752	21	(730)
Post EBITDA Items	(1,193)	(965)	228	(8,243)	(7,797)	447	(14,220)	(13,452)	768
Net Surplus / (Deficit)	(541)	(652)	(110)	(8,470)	(8,824)	(354)	(13,468)	(13,431)	37
EBITDA %	2.5%	1.2%	(1.3%)	(0.1%)	(0.6%)	(0.5%)	0.2%	0.0%	(0.2%)

Specifically the table highlights;

- In-month NHS clinical income under-performed by (£0.3m) against plan increasing the cumulative deficit to (£2.4m). Elective values and volumes remain behind plan significantly in Surgery and is volume driven rather than casemix, this activity performance is in line with the Surgical recovery plan discussed at the September Board. The forecast for NHS clinical income is (£1.4m) adverse variance to the plan.

- Other income continues to over perform at the current run rate circa half the over-recovery is one off income gains and the other half offsets overspends in expenditure.

- Pay costs are marginally below plan in month and cumulatively £0.8m better than plan largely driven by earlier vacancies and slippage on planned pay reserves. The forecast for pay is to be largely on plan at the year end and costs will step up in the remaining months to reflect the winter period and challenges on managing agency/ premium pay, patient flow, infection control and urgent care access during the winter period.

- Non pay costs are (£0.3m) higher than plan in-month and (£0.5m) cumulatively. The overspend in non-pay is the continuation of IT cost pressures, and clinical supplies pressures largely in Diagnostics and theatres however some non-pay costs are offset in other income.

- The EBITDA position is currently behind plan as a result of operational pressures mentioned above but is being supported by savings in PDC as a result of the stronger cash balances and a marginal saving on depreciation as a result of capital timing differences.

Cash Position & Continuity of Service Ratio (COS)

The cash position is £13.343m, £9.271m better than plan at the start of the year. Capital spend (on accruals basis) to month 7 was £4.5m spend against a plan of £4.2m. This variance of £(0.3)m relates to ward improvement scheme variances of £(0.3)m due to early progression of ward refurbishment and the new Isolation facility works, IT spend is behind plan by £0.2m due to some slippage/timing issues and other minor schemes and profiling of £(0.2)m. The capital programme is expected to remain within plan in year as long as £0.6m unallocated resource is sufficient enough for unexpected urgent capital requirements.

It is anticipated that the majority of these timing differences will unwind in the coming months and the Trusts cash position will reduce. The Trust is forecasting to finish the financial year with a c£2m cash balance without any injection of resilience funding.

The overall position returns a Continuity of Service rating of 2, which is in line with plan. The risk rating has been calculated using Monitors revised metrics.

Cost Improvement Programme (CIP)

The 2015/16 plan assumed delivery of £13m of CIP with £11m of identified opportunities at the time of the Plan submission. These plans were extracted according to the profile of the schemes identified, with the unidentified balance of £2m extracted in a flat profile (12ths).

The latest forecast outturn position has improved from the previous month to c. £11.5m. Although £1.5m below initial plans the in month improvement reflects additional schemes that have been identified through the respective Divisions.

The PMO and Executive team (via TSG) are working closely with Divisions and workstreams to quantify any residual risk against plans whilst at the same time continuing to explore opportunities to mitigate the shortfall. Recurrently schemes are expected to deliver c. £12.6m against a plan of £16.4m. The Trust is mindful of the pressure this places on plans going into 2016/17, and is currently taking action to address the shortfall.

Risks inherent in the CIP plans had been identified as part of the planning process, some mitigation is also available within reserves; this is applied on a monthly basis.

The CIP position at Month 7 (including non-recurrent schemes) can be summarised as follows:

	BY SCHEME TYPE		BY COST		TOTAL
	Income Generation (net of cost of delivery) £m	CIP £m	NHS Clinical Income £m	Divisional Budgets £m	£m
Year to date Plan (including unidentified at time of plan)	2.49	2.96	2.82	2.64	**5.46**
Year to date Actual	2.80	2.17	2.87	2.11	**4.98**
Year to date Variance	0.31	(0.79)	0.05	(0.53)	**(0.48)**

2. Non-Core Spend

Non-core spend has been identified nationally as one of the main drivers in explaining the deterioration in Trusts finances. Nursing agency guidance and thresholds have already been issued and October is the first month that the Trust has been required to report on this measure. Monitor are also out to consultation regarding Medical and other agency spends rates with potential guidance being issued later in November in relation to the allowable value the Trust will be able to pay per grade of staff.

The table below analyses the current Pay expenditure within the Trust in comparison to the average last financial year.

Detail	14/15 Average £k	April £k	May £k	June £k	July £k	August £k	September £k	October £k	YTD £k
Budget		17,634	17,878	17,763	17,725	17,725	17,609	17,743	124,076
Pay Costs									
Substantive	**15,875**	**15,911**	**15,990**	**15,937**	**15,868**	**16,046**	**15,696**	**15,957**	**111,404**
									-
Bank Staff	319	306	291	295	293	289	278	281	**2,033**
Agency Staff	518	698	712	605	683	606	747	694	**4,745**
Overtime	224	343	278	282	263	276	388	281	**2,111**
Locum	362	299	264	332	356	410	300	405	**2,366**
WLI (In Year)	155	52	88	126	100	91	98	105	**660**
Non Substantive Total	**1,577**	**1,698**	**1,633**	**1,640**	**1,695**	**1,672**	**1,811**	**1,766**	**11,915**
Total Pay	**17,451**	**17,609**	**17,623**	**17,577**	**17,563**	**17,718**	**17,507**	**17,723**	**123,319**
Variance		**24**	**255**	**186**	**162**	**7**	**102**	**20**	**757**

In October 2015 £1.8m has been spent on non-core pay categories as detailed in the above table.

Expenditure on non-core pay categories is lower than the previous months but has increased in comparison to 2014/15 averages. There is continued focus on the non-core spend across the divisions and they are a part of the performance dashboards

at the divisional performance reviews.

- Agency spend still remains higher than the 14/15 average spend and reasons are detailed below:-
    - Medical agency spend this month is due to critical medical consultant vacancies however plans are in place to continue to recruit substantively to the consultant gaps.
    - Qualified nurse agency costs have improved this month and has reduced to 2.7% cumulatively compared to the Monitor ceiling/cap of 3% of agency spend on qualified nurses as a % of total qualified nursing spend.

- Locum spend was higher this month to cover medical staff vacancies across the divisions.

While the increase is disappointing it also gives the Trust an opportunity to improve the overall run-rate of the Trust by identifying relevant staff strategies to reduce this spend. In order to review these opportunities a review will take place in Decembers FMG in order to help expedite any potential improvements.

3. Conclusion

The overall I & E position continues to deliver a financial performance broadly in line with its plan. The Trusts cash position continues to be stronger than planned and the forecast cash position will not require the injection of resilience funding. The Trust has achieved its CoS rating of 2 as planned.

It is imperative that the Trust continues to deliver its activity plans in the remaining months of the year; 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. The forecast full year CIP has improved to £11.5m and work continues to identify further schemes. The work to improve the in year gap has also resulted in a £0.4m improvement to the recurrent forecast.

From a risk perspective the key considerations include the requirement to ensure planned activity for the remainder of the year is achieved, in addition to improve patient flow to minimize financial penalties, to deliver the CQUIN targets and the delivery of the CIP schemes. 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.

At an aggregate level the Trust continues to deliver against its financial plan and is forecasting, recognising the risks specifically associated with achievement of income targets and delivery of CIP schemes, that its planned deficit of £13.5m will be achieved. Close management of cash and working capital balances continues to afford the Trust a stronger cash position than planned.

4. Recommendations

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

Gareth Lawrence
Acting Director of Finance
November 2015

Appendix 1 –Income

2015-16 NHS Clinical Income -
October 2015 (Month 7) FT PLAN

	ACTIVITY								VALUE inc MFF @ 3.8864%							
	Full Year Plan	Plan	Actual	Penalties	Adjusted Actual	YTD Variance	Previous Month Variance	In Month Movement	Full Year Plan £000s	Plan £000s	Actual £000s	Penalties £000s	Adjusted Actual £000s	YTD Variance £000s	Prior Month Variance £000s	In Month Movement £000s
Elective & Day Case	50,170	29,093	28,049	0	28,049	(1,044)	(862)	(182)	54,421	31,390	28,458	(168)	28,290	(3,100)	(2,593)	(507)
Elective Excess Bed Days	3,854	2,277	1,837	0	1,837	(440)	(329)	(111)	849	502	400	0	400	(102)	(80)	(22)
Non Elective	44,924	25,909	25,553	(582)	24,971	(938)	(797)	(141)	69,222	39,802	40,645	(1,625)	39,020	(782)	(734)	(48)
Non Elective Non Emergency	5,291	3,014	2,908	0	2,908	(106)	(48)	(58)	8,333	4,795	4,706	0	4,706	(89)	(39)	(50)
Non Elective Excess Bed Days	17,434	10,123	11,811	(410)	11,401	1,278	1,281	(3)	3,722	2,160	2,554	(87)	2,467	307	283	24
A&E Attendances	89,442	53,436	54,033	0	54,033	597	(25)	622	10,100	6,034	6,224	0	6,224	190	27	163
Outpatient First Attendances	93,074	53,771	51,238	0	51,238	(2,533)	(1,927)	(606)	14,060	8,123	7,793	(52)	7,741	(382)	(275)	(107)
Outpatient Follow Up	192,923	111,918	108,475	(3,426)	105,049	(6,869)	(5,391)	(1,478)	17,223	9,980	9,619	(292)	9,327	(653)	(502)	(151)
Outpatient Procedures	45,597	26,767	25,088	0	25,088	(1,679)	(1,356)	(323)	7,294	4,271	4,153	0	4,153	(118)	(107)	(11)
Outpatient Unbundled Diagnostic Images	27,234	15,914	16,438	0	16,438	524	670	(146)	2,468	1,443	1,508	(6)	1,502	59	67	(8)
Maternity	6,498	3,816	3,753	0	3,753	(63)	(46)	(17)	5,272	3,096	3,289	0	3,289	193	177	16
Total PbR	**576,441**	**336,038**	**329,183**	**(4,418)**	**324,765**	**(11,273)**	**(8,830)**	**(2,443)**	**192,964**	**111,596**	**109,349**	**(2,230)**	**107,119**	**(4,477)**	**(3,776)**	**(701)**
Non-PbR									**66,836**	**39,246**	**40,546**	**(3)**	**40,543**	**1,297**	**1,098**	**199**
PbR Excluded Drugs									**12,942**	**7,550**	**7,295**	**0**	**7,295**	**(255)**	**(361)**	**106**
CQUIN									**6,322**	**3,685**	**3,685**	**0**	**3,685**	**0**	**(2)**	**2**
Contracted Income Sub Total									**279,064**	**162,077**	**160,875**	**(2,233)**	**158,642**	**(3,435)**	**(3,041)**	**(394)**
North Wales - Additional Activity									**0**	**0**	**385**	**0**	**385**	**385**	**351**	**34**
Other Income									**356**	**207**	**826**	**0**	**826**	**619**	**588**	**31**
Grand Total									**279,420**	**162,284**	**162,086**	**(2,233)**	**159,853**	**(2,431)**	**(2,102)**	**(329)**

Activity includes 675 U codes which have been valued at the average specialty price based on plan, a prudent estimation has been made for the possible Excess Bed Days that may be associated with U-codes.

Negative Values are an under-performance and are shown in brackets.

Board of Directors		
Agenda Item	8.1	
Title of Report	NHS England Core Standards Compliance Report	
Date of Meeting	25 November 2015	
Author	Helen Nelson Head of Emergency Preparedness	
Accountable Executive	Sharon Gilligan Director of Operations	
FOI status	Document may be disclosed in full	
BAF Reference	7D Compliance with regulatory requirements	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR). Under the Act, the Trust is identified as a Category 1 responder. Category 1 responders are those organisations at the core of emergency response.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet and are included in the NHS standard contract and, through this, the NHS Commissioning Board Emergency Planning Framework (2013). The director level accountable emergency officer and/or governing body in each organisation are responsible for making sure these standards are met.

This report is to assure the board of the process and the self assessed compliance with the revised core standards for EPRR and to approve the actions identified.

2. Background

The 2015/16 EPRR Assurance Process is based on the revised Core Standards. To comply with the national requirements NHS England requested that each organisation:

1) Undertake a self-assessment against the revised core standards identifying the level of compliance for each standard (red, amber, green)

2) Submit an action plan addressing any areas of improvement required

3) Complete the statement of compliance identifying the organisation's overall level of compliance - full, substantial, partial, non

4) Present the above outcomes to the Board of Directors or through appropriate governance arrangements where the Board has delegated their responsibility for EPRR

Following assessment, the organisation has to declare to the NHS England as demonstrating compliance from the four options in the table below against the core standards.

This statement of compliance is signed by the organisations' Accountable Emergency Officer, and is reported to the organisation's Board/ governing body.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	**The plans and work programme in place do not appropriately address one or more the core standard themes, resulting in the organisation being exposed to unnecessary risk.**
Partial	The plans and work programme in place do not adequately address multiple core standard themes; resulting in the organisational exposure to a high level of risk.
Non-compliant	The plans and work programme in place do not appropriately address several core standard themes leaving the organisation open to significant error in response and /or an unacceptably high level of risk.

3. Outcomes and Key Issues

The Trust has completed the required self-assessment against the 47 core standards applicable to Acute Trusts and has concluded that there are no Red areas of concern, 8 Amber areas requiring further improvement with the remainder being green.

The self-assessment has been discussed in detail between the Head of Emergency Preparedness at WUTH and the Head of EPRR at NHS England, Jim Deacon. He is in agreement with the outcome of the assessment and the subsequent actions.

The Trust overall therefore is evaluated as being substantially compliant as described above.

Areas identified as requiring improvement to achieve compliance are:

- Business Impact Assessments to be undertaken trustwide to identify critical functions and inform departmental business continuity plans
- Formal 'Strategic leadership in a Crisis' training to be identified for strategic level leadership
- Communications exercise to be undertaken by the end of November 2015
- The current Pandemic Influenza Plan is reviewed and approved in line with the Core Standards, and tested locally during March 2016
- A programme for regular calibration of the RAM GENE(radiation monitor) is put in place.

4. Next Steps

- The plan will be submitted to the Quality & Safety Department for inclusion on the Trust Risk Register and monitored in line with the Risk Management Strategy & Policy
- Progress with the actions will be reported to the Quality & Safety Committee in July 2016
- Following the departure of the Director of Operations, Mrs Sharon Gilligan on 27th November 2015, the interim lead for Emergency Planning and Business Continuity will be Mr Chris Oliver, interim Director of Operations. The substantive holder of this role will be the new Chief Operating Officer, once appointed.

5. Conclusion

The Trust has self assessed against the NHS England's revised Core Standards for Emergency Preparedness, Resilience and Response and is declaring Substantially Complaint.

6. Recommendations

The Board of Directors is asked to note the content of this report and the proposed governance arrangements for the development and monitoring of the improvement plan.

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2015-16

STATEMENT OF COMPLIANCE

Wirral University Teaching Hospital has undertaken a self-assessment against the NHS England Core Standards for EPRR (v3.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating **Substantial** compliance against the EPRR Core Standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the Core Standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more Core Standard that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address multiple Core Standards that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address several Core Standards that the organisation is expected to achieve.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**[1]	Standards rated as **Amber**[2]	Standards rated as **Green**[3]
xx	0	8	39
Acute providers: **47** Specialist providers: **38** Community providers: **38** Mental health providers: **38** CCGs: **30**	*[1] Not complied with and not in an EPRR work plan for the next 12 months*	*[2] Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	*[3] Fully complied with*

Where areas require further action, this is detailed in the attached *EPRR Core Standards Improvement Plan* and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

25/11/2015
Date of board / governing body meeting

16/11/2015
Date signed

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan

Organisation: Wirral University Teaching Hospital NHS Foundation Trust

Plan owner: Helen Nelson

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Full review of the current published Business Continuity Plans required to include business impact analysis in line with ISO 22301	Business Impact Assessments to be undertaken trustwide, to identify critical functions and inform departmental business continuity plans	31/12/16
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	Local training is in place, however formal external training is required to comply fully with the standard	Formal 'Strategic leadership in a Crisis' training to be identified for strategic level leadership.	31/12/16
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Communication exercise to be planned.. Table top exercise was undertaken in July 2015	Communications exercise to be undertaken by the end of November 2015	30/11/15
DD1	Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	Current plan is too long and needs review to ensure that it is succinct and reflects the relevant changes as defined in the core standard	Plan requires full review.	28/02/2016

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
DD2	Organisations have developed and reviewed their plans with LHRP and LRF partners	Ensure that the relevant agencies are included in the review of the current plan.	Plan to be approved via the WUTH Emergency Planning Team which includes external agencies. Other agencies not included in the team will be sent a draft copy via e-mail.	31/03/2016
DD3	Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	Exercise of updated plan to be undertaken	WUTH to take part in the NHS England exercise planned for 13/04/16 WUTH to undertake a local exercise in March 2016 to test the new plan, and in readiness for the NHS England exercise	13/04/2016 31/03/2016
DD4	Organisations have taken their plans to Boards / Governing bodies for sign off	Subject to the completion of action DD1	Ensure Board sign off for the plan	tbc
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment.	Calibration required for RAM GENE (radiation monitor)	Identify company to ensure that the RAM GENE (radiation monitor) is calibrated regularly.	31/05/16

BOARD OF DIRECTORS	
Agenda Item	8.2
Title of Report	Trust Cancer Operational Policy
Date of Meeting	25 November 2015
Author	Alison Quinn, Deputy Associate Director of Nursing Lynsey Gorman, Cancer Services Manager Evelyn Rogansky, Cancer Services Data Manager
Accountable Executive	Sharon Gilligan, Director of Operations
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1A; 3A; 3B; 5B; 6A; 7C
Level of Assurance	Positive
Purpose of the Paper	Approval
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Yes

1. Executive Summary

In the interests of improving and sustaining cancer performance and in line with the recently published '8 Key Priorities' cancer compliance requirements identified by Monitor, the Trust Development Authority (TDA) and NHS England, all acute Trusts are now required to have a Cancer Operational Policy in place and approved by their Trust Board

The attached Trust Cancer Operational Policy sets out how Wirral University Teaching Hospital (WUTH) will manage the pathway of patients who are waiting for an out-patient appointment, diagnostic investigation, in-patient or day-case admission on a cancer pathway.

It identifies how WUTH staff will approach the management of patients against national cancer waiting time targets and has been developed using current guidance from the Department of Health, including Cancer Waiting Times (CWT) – A Guide (2011), and other sources of best practice.

It encompasses all national recommendations with the exception of the suggested '2 new appointment' offer for patients referred on a two week wait (2WW) pathway where a local agreement is place for patients referred to the breast service. These patients will only be offered 1 new appointment; should the patient 'DNA' this, the GP will be informed, asked to see the patient again and if appropriate re-refer the patient.

The policy has been presented to key stakeholders, discussed at relevant advisory cancer group meetings and has been out for the 2 week Trust-wide consultation period.

The Board of Directors are asked to approve this policy.

2. Background

The overall purpose of the document is to establish a consistent and equitable approach to the management of cancer waiting times across the organisation.

The key principles of this policy are to:

- improve individual patient experience as they move through the clinical pathways, minimising unnecessary delays where possible
- ensure patients receive treatment according to clinical priority
- escalate bottlenecks in cancer waiting time pathways at an early stage to Directorate/Divisional Management Teams
- provide timely, consistent and accurate data-recording for patients on cancer waiting time pathways

The draft Cancer Operational Policy was presented to members of the Trust's Operational Management Team (OMT) on 11th September 2015. Following discussion by those present, a request to hold an extraordinary meeting of the Trust Cancer Steering Group was made. The intention of this was to discuss the policy and the national recommendations specifically regarding the recommended offer of two 'new' appointments for patients who are referred on a two week wait (2WW) pathway, and whether this could be amended (locally) to one new appointment only for breast patients as this system was working well; in this case the patient's GP is informed and asked to review the patient and re-refer if appropriate.

The extraordinary meeting of the Trust Cancer Steering Group was held on Friday 16th October 2015 and included attendance by a representative from Wirral Clinical Commissioning Group (WCGG) who, in line with DH Cancer Strategy recommendations, advised that patients with a potential risk of cancer on a 2WW pathway be afforded two appointments. However, a caveat was agreed that endorsed the existing practice of one new appointment only for patients referred to the Breast Care Team.

The policy has been presented to key stakeholders, discussed at relevant advisory cancer group meetings and has appeared on the Trust intranet site for the two week Trust-wide consultation period.

3. Conclusion

This policy has been written in order to provide organisational assurance that robust and comprehensive operational plans, processes and procedures are in place to support patient safety, quality and experience, in line with Trust, regional and national cancer pathways.

4. Recommendations

The Board of Directors are asked to approve the Trust Cancer Operational Policy

Policy Reference: 285

Trust Cancer Operational Policy

Version: 1

Name and Designation of Policy Author(s)	Alison Quinn, Deputy Associate Director of Nursing Lynsey Gorman, Cancer Services Manager Evelyn Rogansky, Cancer Data Manager
Ratified By (Committee / Group)	Board of Directors
Date Ratified	(Draft – not yet approved)
Date Published	(To be updated once published)
Review Date	(To be updated once published)
Target Audience	All staff who are involved in cancer waiting times management for patients on a suspected cancer pathway, including diagnosis and treatment and/or referral to other providers
Other Associated Strategies, Policies, Procedures, etc	Trust Wide Policy 058 - Wirral Patient Access Policy Improving Outcomes: A Strategy for Cancer (DH, 2011) Cancer Waiting Times (CWTs) - A Guide (Version 8.0) DH 2011 Cheshire and Merseyside Clinical Networks - Policy for 62 day cancer waiting time breach reallocation for inter-provider transfers (2015) NHS England - Everyone Counts: Planning for Patients 2013/14 NHS Interim Management and Support - Delivering Cancer Waiting Times; A Good Practice Guide (2015) NHS England Improving and Sustaining Cancer Performance (2015) Cheshire & Merseyside Strategic Clinical Networks - Going Further on Cancer Waiting Times; Eight Key Priorities for 2015/16

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CONTENTS

Content **Page**

1 Introduction 1
2 Purpose 1
3 Scope 2
4 Policy 2
4.1 Relevant Access Standards 2
4.2 Clock Starts 3
4.3 Timeliness of General Practitioner (GP)/General Dental Practitioner (GDP) Referral 3
4.4 Clinically Inappropriate 2WW Referrals 4
4.5 Management of Booking and Did Not Attend (DNA) 2WW Appointment 4
4.6 Avoidable Versus Unavoidable Breaches 5
4.7 Patients who Choose an Appointment Outside of 14 Days 6
4.8 Adjustments Allowed Across the Whole Cancer Pathway 6
4.9 Removal of a Patient from a Cancer Pathway 6
4.10 Patient Tracking 6
4.11 Escalation 7
5 Performance Management 8
5.1 Inter Trust Referral/Inter Provider Transfers 8
5.2 Data Validation 8
5.3 Reporting 9
5.4 Breach Analysis and Reporting 9
6 Roles and Responsibilities 10
7 Training and Resources 12
8 Associated Documents and References 12
9 Monitoring and Audit 13

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1 Introduction

The NHS has set maximum waiting time standards for access to healthcare. In England, waiting time standards for cancer care come under two headings:

- the individual patient right (as per the NHS Constitution)
- the standards by which, individual providers and commissioners are held accountable by the Department of Health for delivering (as per the NHS Operating and NHS Performance Frameworks)

Achievement of the national Cancer Waiting Time (CWT) standards is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver.

Cancer diagnosis, associated treatment or referral to another provider requires a coordinated, organisation-wide response that cross-cuts into the vast majority of specialties and diagnostic services. To maintain its importance as one of the Trust's major clinical priorities, it is important that there are formal and timely communication channels both from the 'core' Cancer Services Team to Specialties/Divisions and the wider organisation, and vice versa, that Specialties keep the Cancer Services Team abreast of any challenges or planned service developments.

In areas where local interpretation is required, this will always be in the 'spirit' of national guidance and at all times in the patient's best interests. The overall purpose of the document is to establish a consistent and comprehensive approach to the management of cancer waiting times across the organisation.

2 Purpose

This document describes the governance processes relevant to access for patients on a suspected cancer pathway at Wirral University Teaching Hospital (WUTH). It details how the Trust approaches the management of patients against national cancer waiting times standards and has been developed using current guidance from the Department of Health, including Cancer Waiting Times: A Guide (V8.0 2011) and other sources of best practice recommendations.

All staff working within the Trust who are involved in cancer waiting times management must be aware of and follow the processes outlined in this document in order to provide equitable access for patients through effective tracking and to enable the Trust to achieve or exceed the required access standards taking into account national rules and guidelines. The key principles of the policy are:

- Improvement of the patient experience, minimising any delays where possible
- Ensuring that patients receive treatment according to clinical priority in the first instance
- Escalation of bottlenecks in pathways at an early stage to Directorate and Divisional Management Teams
- Provision of timely, consistent and accurate data recording for patients on a cancer pathway

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3 Scope

The guidance in this policy applies to all staff members who are involved in the care of cancer pathway management for WUTH patients and sets out the standards required, irrespective of which site it is delivered on (i.e. Arrowe Park Hospital or Clatterbridge Hospital).

4 Policy

4.1 Relevant Access Standards

Care must be provided for all patients in line with national standards as follows:

1) Maximum two weeks from:

a) Urgent GP (GMP or GDP) referral for suspected cancer to first outpatient attendance (Operational Standard 93%)
b) Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment (Operational Standard 93%)

2) Maximum one month (31 days) from:

a) Decision to treat to first definitive treatment (Operational Standard 96%)
b) Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients, including those diagnosed with a recurrence where the subsequent treatment is:

(i) Surgery (Operational Standard 94%)
(ii) Drug treatment (Operational Standard 98%)
(iii) Radiotherapy treatment (Operational Standard 94%)

3) Maximum two months (62 days) from:

(a) Urgent GP (GMP or GDP) referral for suspected cancer to first treatment - 62 day classic (Operational Standard 85%)
(b) Urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment (Operational Standard 90%)
(c) Consultant upgrade of urgency of a referral to first treatment (no Operational Standard set as yet)
d) Maximum one month (31 days) from urgent GP referral to first treatment for children's cancer, testicular cancer, and acute leukaemia (no separate Operational Standard - monitored within 62 day classic)

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4) All patients with suspected or diagnosed cancer will be managed in line with NHS cancer targets and within the guidance set out in Cancer Waiting Times: A Guide (V8.0 2011).

5) All patients on a cancer pathway will have a full and comprehensive record maintained on the Somerset Cancer Register Database (SCR) which will include pathway information, tracking notes, Multidisciplinary Team (MDT) discussion details, staging and a full Cancer Outcomes and Services Dataset (COSD).

6) Patients will be tracked against the appropriate local and national standards and any identified bottlenecks or pathway breaches will be escalated as appropriate to the Directorate/Divisional Management Teams by the cancer Services Manager.

7) Compliance with and breaches of the targets will be reported in line with national reporting guidance. Data quality checks will be undertaken by the Cancer Services/Data Team.

8) Cancer Service Team members will receive comprehensive induction and refresher training to allow them to undertake their duties efficiently and effectively.

4.2 Clock Starts

The clock starts for urgent/suspected cancer referrals as follows:

- Two week wait (2WW) and symptomatic breast referrals. For Choose and Book (C&B) referrals, the clock start date is the date the Unique Booking Reference Number (UBRN) is created
- For non Choose and Book referrals (such as dental), the date the referral received is the clock start date
- Breast screening - receipt of referral for further assessment (i.e. not back to routine recall)
- Bowel screening - receipt of referral for appointment to discuss suitability for colonoscopy with a Specialist Screening Practitioner (SSP)

4.3 Timeliness of General Practitioner (GP)/General Dental Practitioner (GDP) Referral

- The patient should be referred by their GP/GDP to the Trust at the very earliest opportunity. The patient’s GP has the responsibility to ensure the correct 2WW proforma is used and that all correct patient contact details (including a day time telephone number) are submitted on the proforma.
- The GP should inform the patient of the reason for referral, that an appointment will be made to attend the hospital within 14 days and that the patient should be able to make themselves available within that timeframe. The GP should offer the patient a copy of the Cheshire and Merseyside Strategic Clinical Network (C&MSCN) leaflet which explains the urgent/suspected cancer referral process

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- Choose and Book is the preferred method of referral at WUTH, however paper copy referrals and e-referrals are accepted via the dedicated fax (number) situated in the Choose and Book Office.
- Receipt of the referral is ‘Day 0’ for the national target

4.4 Clinically Inappropriate 2WW Referrals

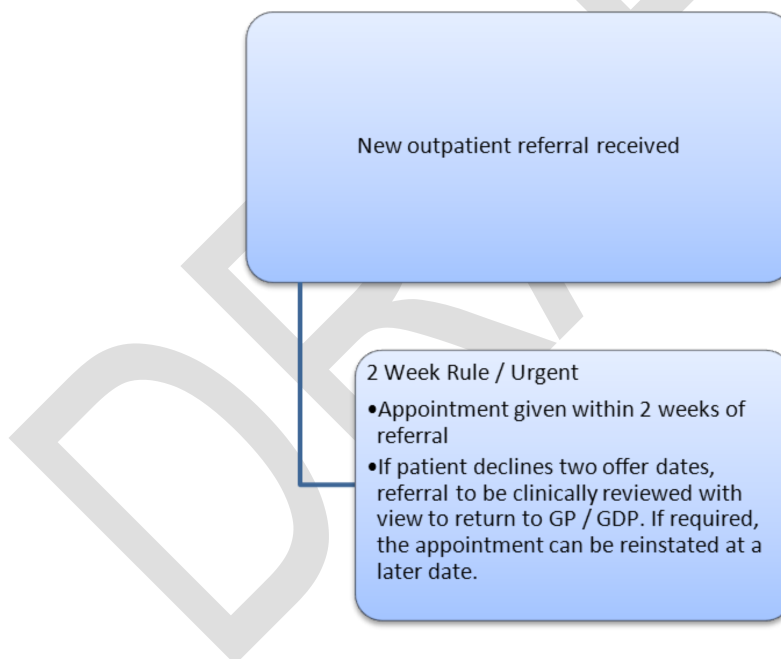
Should the Consultant consider the 2WW referral to be clinically inappropriate then this should be discussed with the referring GP/GDP.

Clinically inappropriate patients who are seen will be monitored and feedback will be provided to the referring GP.

4.5 Management of Booking and Did Not Attend (DNA) 2WW Appointment

Patient bookings and DNAs are managed according to the Trust Wide Wirral Patient Access Policy as follows:

Process Flow - Booking of a New Appointment



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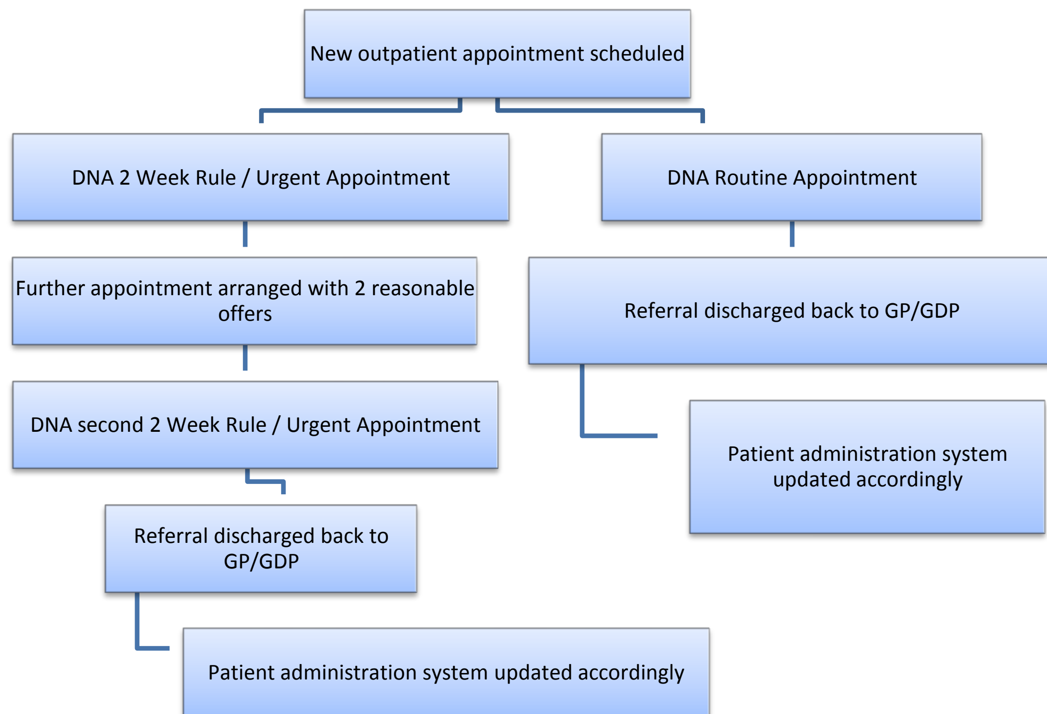
Process Flow - New Outpatient Appointment DNA



NB: A local caveat is in place for Breast Cancer MDT

4.6 Avoidable Versus Unavoidable Breaches

Analysis of waiting time standard breaches helps organisations identify and distinguish between 'unavoidable' breaches (e.g. patient choice, a more complex diagnostic pathway, or that the wait was a clinical exception and that waiting longer was in the best clinical interest of the patient), and 'avoidable' breaches due to administrative and capacity issues.

Where breaches were not for clinical reasons or patient choice (i.e. avoidable breaches), analysis should identify where there are systemic problems which need to be understood and addressed in order to eliminate unnecessary waits and introduce improvements in patient experience.

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4.7 Patients who Choose an Appointment Outside of 14 Days

Patients who cancel and rebook an appointment outside of 14 days must be kept on the pathway. This group are classed as still engaged with the Trust and will be recorded as a breach of the 2WW target. If a patient has multiple cancellations (2 or more) they must only be referred back to the GP following discussion with the patient or them being informed in writing.

4.8 Adjustments Allowed Across the Whole Cancer Pathway

Adjustments are allowed in two situations:

1) If a patient DNAs their initial out-patient appointment, this would allow the clock to be re-set from the receipt of the referral (recorded as the 'Cancer Referral to Treatment Period Start Date') to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer 2WW and the 62 day standard.

2) If a patient declines an offer of admission for treatment in an in-patient (ordinary admission or day case) setting provided the offer of admission was "reasonable".

For cancer patients under the 31 or 62 day standard 'reasonable' is classed as any offered appointment between the start and end point of 31 or 62 day standards (i.e. any appointment within a 'Cancer Treatment Period' or 'Cancer Referral to Treatment Period'). The adjustment would be the time between the date of the declined appointment (the 'Offered To Come In' date) to the point when the patient could make themselves available for an alternative appointment.

Adjustments cannot be made for patient choice, medical unfitness or patient thinking time during the diagnostic phase of the pathway and the operational standards have taken this into account.

4.9 Removal of a Patient from a Cancer Pathway

Patients should only be removed from a cancer pathway following a clinical review and cancer has been excluded or deemed highly unlikely and the patient has been informed of this. This should be clearly documented in the patient notes and the decision and associated rationale communicated to the patient's GP.

Patients may also be removed if they either decline all investigations and/or treatment, or choose to have private treatment.

4.10 Patient Tracking

- Patients will be tracked through their pathway using the SCR by the named MDT Coordinator(s) for that specialty
- An Electronic Daily Record (EDR) is sent via e-mail each day to the Cancer Services Team for all patients referred the day before on a GP 2WW referral, or any patients upgraded to 'Consultant 62 Day Upgrade'. The relevant MDT Coordinators manually enter the patient's details onto the SCR database

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- MDT Coordinators will produce (their own) full tracking lists weekly from SCR and update every patient's information via the tracking notes, documenting the patients' progress
- MDT Coordinators will ensure that a complete record is maintained for each patient that includes details of any/all diagnostic investigations performed, MDT discussions, target information, diagnosis, treatment, staging and full COSD dataset
- MDT Coordinators will measure the patient's progress against timed pathways (Cheshire & Merseyside Strategic Clinical Networks - Going Further on Cancer Waiting Times; Eight Key Priorities for 2015/16). If a patient deviates from the pathway or is experiencing unnecessary delays, the patient's details and corresponding information must be appropriately escalated in a timely manner to the corresponding Directorate/Divisional Management Team
- The Cancer Services Team Leader will produce a weekly Patient Tracking List (PTL) for each specialty. This list will be reviewed by the relevant MDT Coordinator who will attend a weekly PTL meeting with the Cancer Services Team Leader in order to provide an update and discuss any issues, concerns and/or forthcoming breaches with regard to individual patients. Any patient issues that require escalation will be taken forward from the PTL meeting and will be discussed with the corresponding Directorate/Divisional Managers at the weekly Cancer Performance Management Meeting.

- A Cancer Performance Management Meeting is held each week, attended by the appropriate Directorate/Divisional Manager (DM) for each speciality in order to support information sharing and timely escalation of any identified patient pathway delays. Subsequent actions that are required in order to support timely and appropriate patient management/target delays are e-mailed to the DMs (immediately) afterwards.

4.11 Escalation

- **Outpatient Capacity -** the MDT Coordinator will discuss out patient capacity with the Team Leader at the weekly PTL meeting. Issues arising outside of the PTL meeting will be raised with the booking clerk for the corresponding specialty
- **Diagnostics Capacity Including Reporting -** the MDT Coordinator will discuss diagnostics capacity including reporting with the Team Leader at the weekly PTL meeting. A weekly email with regard to any outstanding Radiology queries is e-mailed for Radiology staff to action
- **Treatment Capacity -** the MDT Coordinator will discuss treatment capacity with the Team Leader at the weekly PTL meeting. Issues arising outside of the PTL meeting will be raised with the Business Support Manager for the corresponding specialty

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5 Performance Management

5.1 Inter Trust Referral/Inter Provider Transfers

Where a patient is referred by one NHS provider to another NHS provider for cancer treatment, this is known as an Inter Trust Referral (ITR) or an Inter Provider Transfer (IPT). Whilst from a patient perspective, timeliness of investigation and treatment should not depend on the hospital to which they are initially referred, in practice, intervals between referral and treatment are generally longer for patients who require an ITR/IPT than for those treated at the hospital to which they were initially referred by their GP. For these pathways to be effective from a patient experience perspective, both the referring and receiving organisations have important roles to play.

The Trust works to the Cheshire and Merseyside Clinical Networks Policy for 62 day cancer waiting time breach, which uses a system of automatic breach reallocation when patients are transferred to a 'treating' Trust after day 42. Potential/actual late referrals from within the Trust will be escalated and discussed at the weekly PTL meeting in order to support the smooth transition of the patient across the corresponding pathway, in line with the agreed minimum dataset and clinically agreed criteria.

Issues arising outside of the PTL meeting should be escalated by the MDT Coordinator to the Cancer Services Team Leader/Cancer Services Manager. A pre and post reallocation position is produced for monitoring.

5.2 Data Validation

Performance data is validated on a weekly basis by the Cancer Services Team Leader/Cancer Services Manager. Weekly downloads from 'Open Exeter' for 62 day target treatments occur to ensure that patient treatment with other Trusts are updated on SCR and performance can be predicted more accurately. The MDT Coordinators, Cancer Services Team Leader and Cancer Services Manager also maintain communication with tertiary care centres in order to track the progress of referrals.

All breaches are validated by the Cancer Services Manager before upload to Open Exeter takes place. Bulk uploads to Open Exeter are stopped one week before the monthly deadline in order to ensure that reconciliation between data on SCR and data on Open Exeter can be completed and that both sets of data are seen to align/match.

Numbers of patient treatments recorded are monitored weekly by the Cancer Services Team Leader/Cancer Services Manager in order to ensure that the anticipated/expected numbers for a Trust of Wirral Hospital's size are being recorded accurately. The Trust takes part in external audit undertaken by Mersey Internal Audit Agency (MIAA) to ensure that processes and procedures are robust and accurate.

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5.3 Reporting

Cancer performance and associated management is discussed in several Trust forums that include the weekly PTL meeting, the weekly Divisional Performance Management Meeting and the bi-monthly Cancer Steering Group Meeting and Cancer Specialist Nurse (CNS) Forum.

Cancer performance and associated management is also included on the Trust Board agenda and Operational Management team (OMT) agenda, and information is provided via specialty breakdown so that specific tumours groups that are e.g. performing exceptionally well or (conversely) not achieving targets can be highlighted and discussed (including remedial action plans) rather than potentially concealed under the Trust 'overall' aggregate.

In addition, information with regard to the Trust's cancer performance and associated management is shared by representatives of the Cancer Services and Senior Management Team who attend internal (hospital-based) specialty-related business meetings as appropriate, and external meetings including the bi-monthly regional Cheshire and Merseyside Clinical Networks and quarterly Wirral Clinical Commissioning Group (WCCG) Quality, Innovation, Productivity and Prevention (QIPP) meetings to update on cancer performance issues and discuss/feed back on relevant national or local initiatives that may significantly impact on service delivery e.g. national cancer awareness campaigns.

5.4 Breach Analysis and Reporting

The 'tolerances' provided by the national Cancer Waiting Time standards are to take into account patients who choose to wait longer for their treatment, for whom waiting longer is clinically appropriate, or where pathways include a complex diagnostic element.
Any/all patient breaches are subject to scrutiny and analysis via 'Root Cause Analysis' (RCA). Investigations and associated findings are discussed at the weekly Divisional Performance Management Meeting. Themes and/or trends in particular specialties or significant numbers of breaches in one area caused by a specific issue/s are escalated to the Director of Operations and are added to the Divisional Risk Register. The Cancer Services Manager works with the relevant Directorate/Associate Directorate Managers in order to manage themes and/or trends and effectively address capacity and resource issues.
Patients who are treated on day 55-62 of a (corresponding) cancer pathway are classed as 'near misses' and are also subject to pathway analysis every three months by the Information Governance Team.

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6 Roles and Responsibilities

Executive Lead for Cancer

There is an Executive Lead for Cancer who has overall responsibility for the delivery of the Cancer Waiting Times (CWT) Targets.

Lead Cancer Clinician

The Lead Cancer Clinician is a named, designated clinical lead who has overall responsibility for ensuring that high standards of cancer clinical care are delivered across the organisation in a timely manner, leading the development of the cancer strategy with director, managerial and clinical support.

Lead Cancer Nurse

The Lead Cancer Nurse has responsibility for supporting the delivery of CWT. This role also includes development of the cancer nursing strategy and a lead role in coordinating peer review.

With professional line management links to the Deputy Director of Nursing and Associate Director of nursing (Clinical Support Division), the Lead Cancer Nurse supports Divisional Matrons with professional line management of Cancer Specialist Nurses throughout the organisation. The Lead Cancer Nurse further supports the Cancer Services Manager and Directorate/Divisional Management Teams in monitoring and achieving attainment of patient cancer pathways in a highly professional, responsive and consistent manner.

Clinical Nurse Specialists

Clinical Nurse Specialists (CNSs) are dedicated to a particular area of nursing; caring for patients suffering from long-term conditions and diseases such as cancer. The cancer CNS will use their own knowledge of cancer and treatment to meet the needs of the patient and are responsible for co-ordinating individual patient care plans. By acting as the patient's 'key worker' they will manage each individual case by working with members of the multidisciplinary team, to provide the best possible holistic care. Their roles will also include education, user involvement and service improvement.

Cancer Services Manager

The Cancer Services Manager will ensure that all MDT Coordinators are aware of this policy and have received adequate training in order to be able to follow the processes and guidelines that ensure effective tracking and data collection.

The Cancer Services Manager will also ensure that the MDT Coordinators are sufficiently supported in order to carry out their role effectively. The Cancer Services Manager is responsible for ensuring that cancer performance and associated management is discussed in the correct Trust forums and that effective communication and escalation processes work smoothly and effectively.

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The Cancer Services Manager is also required to ensure that themes, trends and breach analysis are shared in order to be able to predict future performance and work with the Directorates and Divisions to adequately and comprehensively address any identified issues or areas of concern.

The Cancer Services Manager will ensure that initiatives such as national and regional cancer related campaigns are communicated effectively to all Cancer MDTs and Divisional Management Teams in order that effective planning and preparation can be planned for in advance in terms of capacity and resource planning e.g. increase in clinical referrals and activity, including associated diagnostic requirements.

Cancer Services Data Manager

The Cancer Services Data Manager is responsible for ensuring that data pertaining to cancer waiting times is accurate, validated and uploaded to Open Exeter within the correct timescales.

Cancer Services MDT Coordinators

The Cancer Services MDT Coordinators are responsible for keeping an accurate patient record on SCR and monitoring the patient's progress on the pathway. They are responsible for escalating any issues which cause the patient to deviate from their timed pathway.

Cancer Steering Group

The Cancer Steering Group meet on a bi-monthly basis. The meeting is chaired by the Cancer Lead Clinician and is attended by the Lead Cancer Nurse, Cancer Services Manager, Cancer Services Team Leader, Divisional Management Teams, Cancer MDT Leads, Macmillan Cancer Information Manager and representatives from diagnostics and other cancer support services.

Directorate and Divisional Managers/Management Teams

The Directorate and Divisional Managers/Management Teams have a responsibility to ensure that adequate capacity and resource is available for all patients added to all waiting lists to enable the Trust to achieve the required local and national cancer standards.

The Directorate and Divisional Management Teams also have a responsibility to ensure that their respective clinical teams have robust processes and procedures in place in order to enable cancer patients to be added to (corresponding) waiting lists and receive diagnostic tests/investigations and reports in a timely and consistent manner.

Macmillan Cancer Information Manager

Based within the hospital, the Macmillan Cancer Information Manager is responsible for the provision and management of a highly efficient, integrated and accessible Macmillan Cancer Information Service that provides discreet and invaluable assistance and support to patients and their families/carers, health and social care professionals, trust-wide hospital departments and in addition, liaises with voluntary sector agencies.

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Trust-Wide Clinicians

Clinicians must be fully informed and engaged in the cancer performance and management process and must ensure that they are aware of the patient's target date for treatment. They are responsible for ensuring that it is clearly documented when a patient has chosen to delay their treatment so that adjustments can be made where appropriate with documented evidence to support it. They should be engaged with the management teams in assessing capacity and resolving issues that may cause breaches in their specialty.

General Practitioners (GP)/General Dental Practitioners (GDP)

GPs/GDPs have a responsibility to ensure that the patient referrals they make are timely, accurate and appropriate, following recommended NICE guidelines and that the referral contains all required/relevant information in order to adequately inform the receiving Consultant team.

They should be responsive to feedback from acute care colleagues as to the appropriateness of their referrals. They also have a responsibility to inform the patient that they are being referred on an urgent/suspected cancer pathway and what the patient can expect to happen next.

Choose and Book (C&B)

Choose & Book staff have a responsibility to ensure that all patient referrals are correctly entered onto the Wirral Millennium system so that the patients can be tracked and managed effectively and appropriately.

7 Training and Resources

The Cancer Services Management Team will ensure that there is adequate and appropriate staffing and resource in the MDT Coordinator Team.

Full training will be given to new members of staff and all relevant mandatory training, local induction and associated documentation will be supplied.

Achievement of relevant education and training should be monitored throughout the year and should form part of the annual staff appraisal process.

8 Associated Documents and References

Trust Wide Policy 058 - Wirral Patient Access Policy (2011)

Improving Outcomes: A Strategy for Cancer (DH, 2011)

Cancer Waiting Times (CWTs) - A Guide (Version 8.0) DH 2011

NHS England - Everyone Counts: Planning for Patients (2013/14)

DRAFT

Cheshire and Merseyside Clinical Networks - Policy for 62 day cancer waiting time; breach reallocation for inter-provider transfers (2015)

NHS Interim Management and Support - Delivering Cancer Waiting Times; A Good Practice Guide (2015)

NHS England - Improving and Sustaining Cancer Performance (2015)

Cheshire & Merseyside Strategic Clinical Networks - Going Further on Cancer Waiting Times; Eight Key Priorities for 2015/16

9 Monitoring and Audit

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
Cancer Access Targets	PTL/weekly performance pack	Cancer Services Manager/ Divisional Performance Management Group: Surgery, Womens & Childrens and Medical & Acute Specialties Division	Weekly	Cancer Services Manager/ Divisional Performance Management Group: Surgery, Womens & Childrens and Medical & Acute Specialties Division	Cancer Services Manager/ Divisional Performance Management Group: Surgery, Womens & Childrens and Medical & Acute Specialties Division	Cancer Services Manager/ Divisional Performance Management Group: Surgery, Womens & Childrens and Medical & Acute Specialties Division
Cancer Operational Policy	Review against guidance	Cancer Services Manager	Annually	Cancer Services Manager	Cancer Services Manager	Cancer Services Manager

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Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Alison Quinn	20th October 2015	Initial impact assessment completed. Full assessment not required
Expert Committee/ Policy Reader	Trust Operational Management Team Trust Cancer Steering Group	20th October 2015	Checked for workforce / development, medicines, finance or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Development	Trust Cancer Services Team Trust Operational Management Team Trust Cancer Steering Group Trust-wide Cancer MDTs Divisional Cancer Performance Management Teams		
Trust Staff Consultation via Intranet	To be completed by the Assurance Team		

Date notice posted in the News Bulletin.	To be completed by the Assurance Team	Date notice posted on the intranet	To be completed by the Assurance Team

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc.)	**By Whom will this be Delivered?**
Consultation period via Trust Intranet Publication of ratified Policy on Trust Intranet site Raising Awareness Event - Trust Cancer Steering Group and Divisional Cancer Performance Management Meetings Distribution of Policy to all Trust Cancer MDTs Raising Awareness Event - Ward Sisters/Charge Nurses/Matrons Meetings	Trust Assurance Team Trust Lead Cancer Clinician Trust Lead Cancer Nurse Trust Cancer Services Manager/Cancer Data Manager

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
07/09/15	1	Alison Quinn, Deputy Associate Director of Nursing Lynsey Gorman, Cancer Services Manager Evelyn Rogansky, Cancer Services Data Manager	New Policy

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Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Attainment of Trust Cancer Waiting Time Targets	85%	Weekly data collection and analysis/monthly reporting	Operational Management Team	Monthly	Director of Operations

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Directorate/Divisional Management Teams	Operational Management Team	Monthly

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BOARD OF DIRECTORS	
Agenda Item	8.3
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: October 2015
Date of Meeting	25 November 2015
Author	Gaynor Westray, Deputy Chief Nurse Jill Galvani, Director of Nursing and Midwifery
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 (Risks 2799 & 2798); 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 (Risks 2837 & 2611); 3b: Ensure that our harm free care score is no lower than 93% & no lower than 95% for 3 months (Risks 2799, 2837 & 2798); 7a: Full compliance with our registration CQC (Risks 2798 & new risk scored at 15). The risk of further severe enforcement action should the Trust not respond appropriately to the requirement notice regarding nurse staffing.
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Revalidation for Registered Nurses and Midwives is mandated from 1 April 2016; there is a potential risk that nurses may miss this deadline and therefore are unable to work as Registered nurses or midwives. This risk is on the risk register and there are plans in place to mitigate the potential impact. Positive: No additional wards have been open since May 2015 Successful recruitment to ward 25 (isolation ward) and ward 27 (first planned additional ward) The Trust's recruitment plan is having a positive impact on staffing levels and the Trust's fill rates with overall 98% for October 2015.
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 report provides the Board of Directors with information on the details of the actual hours of Registered nurses/midwives and Clinical Support staff's time on ward day shifts and night shifts versus planned staffing levels for October 2015.

As a Trust there has been a systematic approach to staffing wards safely over the past three years; the total investment agreed by the Board of Directors commencing 2012/2013 has been circa £3.45M. This has supported the response to the guidance issued by the National Quality Board and by the National Institute for Health and Care Excellence (NICE 2014), embracing transparency about the planned versus actual staffing levels, and focusing on how to make services as safe as possible within available resources.

Further guidance circulated by Jane Cummings, Chief Nursing Officer, NHS England, in May 2014 clarified that the Board of Directors will be advised of those wards where staffing capacity and capability materially falls short of the plan, the reasons for the gap, the impact and actions being taken to address it. This can be presented as an exception report, providing the Trust website publishes ward by ward data on actual versus planned numbers of staff by registered nurse / midwife / care staff and day duty / night duty. These data are presented in this paper.

2 Recruitment Strategy

The recruitment and retention strategy within the Trust is continuing to report a positive position. During October 2015, the Trust successfully appointed a further 12 Registered Nurses, 7 being experienced and the remainder 5 due to qualify in March 2016.

In October the Trust welcomed 9 registered nurses from Poland; they have now completed the 'Welcome to Wirral programme' and start their placements on 16th November. Further overseas recruitment has resulted in 15 registered nurses being recruited from Spain and Portugal and they are due to join the Trust 23 November 2015 with a start date for their placements being 7th December.

The next corporate recruitment event is 25th November 2015, with 13 registered nurses applying; corporate recruitment will continue each month.

The electronic staff record (ESR) report demonstrated that at the end of October 2015 the total number of RN vacancies at Band 5 ward nurse posts is reported as 36.76 WTE (vacancy rate of 5.59%) This figure has increased since last month (12.51 WTE), but remains low when compared to peer organisations. NHS England reports most Trusts being at over 10% nursing vacancies.

Table 1 below provides a monthly breakdown of numbers of Band 5 Registered Nurses. This movement in position is as a result of internal recruitment into trainee Advanced Nurse Practitioners to support the medical workforce and internal promotion.

Table 1

Division	Area		May	June	July	August	September	October
All Inpatient Ward Areas	All Areas	Establishment	626.36	626.36	626.11	666.55	666.55	657.90
		Actual Numbers	595.49	595.19	591.78	628.62	654.04	621.14
		Vacancies	30.87	31.17	34.33	37.93	12.51	36.76
		Vacancies %	4.93%	4.98%	5.48%	5.69%	1.88%	5.59%

3 NHS Professionals

The Trust successfully transferred to NHS Professionals as a temporary staff provider on 2 November 2015. Regular meetings are established at operational level to oversee day to day transactions and at Director level group to oversee and scrutinise the governance arrangements. Initial feedback is positive with an increase in the fill rate and structure around the requesting facility; with the system set up to prevent any CSW / Nursing and Midwifery shifts going to agency. These shifts have been locked and only the ADoN for the Division or deputy can unlock. This will support the Trust to achieve the 3% cap on agency expenditure set by Monitor.

4 Monthly Safe Staffing Report

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 Trust's obligation to publish staffing levels on hospital wards.

The report (appendix 1) 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. The information for average staff fill rates is triangulated with key quality indicators and sickness at ward level.

Trust Indicators:

Green Fill rate of 95% and above
Amber Fill rate of 81-94%
Red Fill rate 80% and below

These parameters provide information for the Board of Directors on how the Trust is progressing towards safe staffing. The overall fill rate for October is maintained at 98%. The table below shows compliance for fill rate for both RN and CSW shifts, both for day and night shifts for the month of October 2015.

Day Shift	**Green**	**Amber**	**Red**
Number of wards compliant with RN fill rate	30	5	0
Number of wards compliant with CSW fill rate	31	3	0
Night Shift			
Number of wards compliant with RN fill rate	33	2	0
Number of wards compliant with CSW fill rate	31	2	0

For the 35 clinical inpatient areas, the optimal number of hours of nursing or midwifery staff time required for day shifts and night shifts has been calculated for the month and the actual fill rate has been recorded. Overall the actual fill rate for in-patient areas has improved with the following to report:

Day shift A reported increase in the number of wards with 100% fill rate
RN shifts 9 clinical inpatient areas reported a 100% compliance with RN fill rate
CSW shifts 18 clinical inpatient areas reported a 100% compliance with CSW fill rate

Of the remaining areas:

The lowest fill rate for RN reported for adult in-patient was 92.2% for ward 54 (Gynaecology)
The lowest fill rate for CSW reported was 89.1% for the maternity ward

Night shift A reported increase in number of wards with 100% fill rate
RN shifts 19 clinical inpatient areas reported a 100% compliance with RN fill rate
CSW shifts 22 clinical inpatient areas reported a 100% compliance with CSW fill rate

Of the remaining areas:

The lowest fill rate for RN reported was 95.9% for Medical Short Stay Ward (MSSW)
The lowest fill rate for CSW reported was 89.9% for ward 53 (Maternity), an improvement on September position of 87.1%.

It is to be noted that the maternity fill rate reported in the September report as being 87.1% has improved in October to 100% following the review of rosters and closer management of staff allocations. This has also been supported by the reduction in sickness levels.

5 NMC Revalidation

The Chief Nursing Officer for England confirmed on 30 October 2015 that she is “content for revalidation to proceed from April 2016.” The Trust has put all measures in place to prepare staff for revalidation; although it must be stressed the responsibility for revalidation rests with individual registrants.

NMC Revalidation has been risk assessed and added to Trust Risk Register (initial score 12 reduced to 8 following mitigation).

6 Next steps

- Review staffing levels at ward level following outcomes of acuity audits currently taking place.
- Validation of roster templates against budgeted establishment underway
- Continue with the programme of Monthly Trust wide recruitment for Registered Nurses, including overseas recruitment.
- Continue to update the Board of Directors on a monthly basis.
- Undertake the planned audit of revalidation readiness during Quarter 3 for those nurses and midwives due to re-register in Quarter 1 of 2016/17.
- Conclude the Phase 2 work on midwifery staffing and skill mix for 2016/17

7 Conclusion

The impact of the recruitment strategy is being realised in October 2015 and data has been presented to demonstrate this. There is evidence to support improvement in nurse and midwifery attendance, in-patient and staff Friends and Family scores and the overall Trust nurse staffing fill rates. All mitigating actions are in place to ensure that safe and appropriate nurse staffing levels are in place, including preparation of out-patient nurses to support in-patient areas when appropriate.

The source of this data is the electronic staff record (ESR). The information has been validated through Human Resources and Organisation Development (HR&OD), Finance and Corporate Nursing.

8 Recommendations

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

Wirral University Teaching Hospital NHS Foundation Trust

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Monthly Safe Staffing Report - October 2015

			Days – RNs				Days – CSW's				Nights – RNs				Nights – CSW's				Quality indicators						
Specialty	Ward	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence	RN Vacancies (WTE)	CSW Vacancies (WTE)
Orthopaedics	10	28	1725	1718.7	6.3	99.6%	1230	1230	0	100.0%	1080	1080	0	100.0%	690	690	0	100.0%	0	0	0	0	3.18	5	0
Orthopaedics	11	25	1725	1718.75	6.25	99.6%	1230	1180	50	95.9%	1080	1080	0	100.0%	690	646	44	93.6%	0	2	0	0	5	0	0
Orthopaedics	12	16	1173	1173	0	100.0%	1035	1028.75	6.25	99.4%	690	677.5	12.5	98.2%	345	356.25	-11.25	103.3%	0	0	0	0	2.76	0	0
DME	16 / OPAU	23	2342.5	2294	48.5	97.9%	1550	1500.45	49.55	96.8%	1069.5	1069.5	0	100.0%	713	713	0	100.0%	1	0	0	0	4.34	2	0
Colorectal	17	30	1875	1793.7	81.3	95.7%	1230	1180	50	95.9%	1080	1045.4	34.6	96.8%	690	695.7	-5.7	100.8%	0	0	0	0	5.67	4	0
General Surgery	18	29	1725	1718.75	6.25	99.6%	1230	1230	0	100.0%	1230	1230	0	100.0%	690	690	0	100.0%	0	1	1	0	3.95	0	0
Urology	20	30	1725	1718.75	6.25	99.6%	1263.25	1263.25	0	100.0%	1230	1230	44	100.0%	690	690	0	100.0%	0	0	0	0	5.38	0	0
DME	21	31	1572	1519	53	96.6%	1530	1530	0	100.0%	1215	1171	44	96.4%	1035	1035	0	100.0%	1	0	1	0	2.15	1	0
DME	22	30	1722.5	1716.25	6.25	99.6%	1356.25	1356.25	0	100.0%	1263.25	1251.25	12	99.1%	713	713	0	100.0%	0	1	0	0	5.51	1	0
Stroke	23	26	2110	2001.4	108.6	94.9%	1162.5	1162.5	0	100.0%	1069.5	1069.5	0	100.0%	713	725	-12	101.7%	0	0	0	0	0	2	0
DME	24 & Isolation	38	2098.52	2026.67	71.85	96.6%	1619.73	1619.73	0	100.0%	1426	1407	19	98.7%	1426	1426	0	100.0%	1	1	1	0	11.64	2	0
General Medicine	26	29	2110	1999.6	110.4	94.8%	1937.5	1931.35	6.15	99.7%	1069.5	1069.5	0	100.0%	1069.5	1069.5	0	100.0%	0	2	0	0	0	3	0
Haematology	30	22	1722.5	1676.5	46	97.3%	1162.5	1138.5	24	97.9%	906.75	894.75	12	98.7%	1069.5	1069.5	0	100.0%	0	0	0	0	1.09	0	0
Cardiology	32 & CCU	31	3078.75	3001	77.75	97.5%	1550	1520.5	29.5	98.1%	1426	1414	12	99.2%	1069.5	1082	-12.5	101.2%	0	0	0	0	7.13	1	0
Cardiology	33 & HAC	29	1722.5	1687.1	35.4	97.9%	1162.5	1162.5	0	100.0%	1069.5	1069.5	24	100.0%	1069.5	1045.5	24	97.8%	0	0	1	0	5.13	3	0
Gastro	36	32	2253.75	2157.3	96.45	95.7%	1550	1512.45	37.55	97.6%	1069.5	1045.5	24	97.8%	1069.5	1057.5	12	98.9%	0	0	1	0	5.6	1	0
Respiratory	38/37	45	2497.5	2484.5	13	99.5%	1743.75	1707.75	36	97.9%	1426	1426	0	100.0%	1069.5	1057.5	12	98.9%	0	0	0	0	0.1	3	0
Maternity	53	38	1598.5	1550.5	48	97.0%	744	663	81	89.1%	1426	1426	0	100.0%	356.5	320.5	36	89.9%	0	0	0	0	9.69	0	0
Gynaecology	54	16	885.5	816.5	69	92.2%	713	713	0	100.0%	713	648.5	17.3	91.0%	0	0	0	-	0	0	0	0	5.96	0	0
General Medicine	AMU	24	1955	1943.5	11.5	99.4%	1426	1414.5	11.5	99.2%	1069.5	1052.2	17.3	98.4%	1069.5	1045.5	24	97.8%	0	0	0	0	4.69	2	0
General Medicine	MSSW	21	2311.5	2161.75	149.75	93.5%	1782.5	1632.75	149.75	91.6%	1635.25	1568.95	6.3	95.9%	1635.25	1568.95	66.3	95.9%	0	0	0	0	4.69	2	0
Emergency	EDRU	10	885.5	885.5	0	100.0%	356.5	356.5	0	100.0%	550.25	543.95	6.3	98.9%	356.5	356.5	0	100.0%	0	0	0	0	10.52	0	0
	Parksuite	8	840	840	0	100.0%	345	345	0	100.0%	690	690	6.3	100.0%	0	0	0	-	0	0	0	0	8.84	2	0
Surgical Assessment	ESAU	12	1185	1174	11	99.1%	690	679	11	98.4%	1035	1028.7	6.3	99.4%	690	690	0	100.0%	0	0	0	0	4.63	1	0
Critical Care	ITU	11	4822.5	4822.5	0	100.0%	212.5	212.5	0	100.0%	4278	4278	0	100.0%	0	0	0	-	0	2	0	0	3.66	3	0
Critical Care	HDU	6	1722.5	1722.5	0	100.0%	387.5	387.5	0	100.0%	1426	1426	0	100.0%	356.5	356.5	0	100.0%	0	1	0	0	3.66	3	0
Maternity	Delivery Suite	10	3381	3321	60	98.2%	690	690	0	100.0%	3208.5	3148.5	390	98.1%	690	690	0	100.0%	0	2	0	0	2.85	0	0
Neo Natal	Neonatal	24	3381	3082	299	91.2%	0	0	0	-	3208.5	2818.5	390	87.8%	0	0	0	-	0	0	0	0	4.1	0	0
Children's	Children's	27	2186	1892	294	86.6%	356.5	332.5	24	93.3%	1782.5	1771	11.5	99.4%	356.5	356.5	0	100.0%	0	0	0	0	6.92	1	0
Orthopaedics	M1	20	1530	1530	0	100.0%	1035	1035	0	100.0%	690	690	0	100.0%	345	345	0	100.0%	0	0	0	0	2.08	0	1
General Surgery	M2	26	345	345	0	100.0%	345	345	0	100.0%	138	138	0	100.0%	138	138	0	100.0%	0	0	0	0	0	0	0
DME	CRC	20	1328.75	1311	17.75	98.7%	1550	1527	23	98.5%	713	713	0	100.0%	906.75	900.5	6.25	99.3%	0	0	0	0	2.08	2	0
Neuro & Rehabilitation	Ward 36 CBH	20	1335	1293.55	41.45	96.9%	968.75	962.45	6.3	99.3%	713	713	0	100.0%	356.5	356.5	0	100.0%	0	0	0	0	3.45	2	0
Dermatology	Dermatology	12	602.25	602.25	0	100.0%	143.75	143.75	0	100.0%	264.5	264.5	0	100.0%	264.5	264.5	0	100.0%	0	0	0	0	0.86		
Geriatric Medicine	14	30	750	750	0	100.0%	750	750	0	100.0%	690	690	0	100.0%	690	690	0	100.0%	0	1	0	0		6	0
Totals		829	64223.52	62448.52	1775		36038.98	35443.43	595.55		43631.5	42839.2	792.3		23023.5	22840.4	183.1								

Overall Staffing Hour totals (Rounded to the nearest hour)	Fill Rate	98%	Total Planned Hours	166917.5	Total Actual Hours	163571.55	Varaiance	3345.95

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.

Vacancy data is an actual figure from divsions at the time of this report

Board of Directors	
Agenda Item	9.1
Title of Report	Report of the Finance Business Performance & Assurance Committee 20 November 2015
Date of Meeting	25 November 2015
Author	Graham Hollick, Chair of Finance Business Performance and Assurance Committee
Accountable Executive	David Allison, Chief Executive
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

Amendment to the Winter Plan 2015/16

The Committee reviewed a revision to the Winter Plan which would result in the Commissioner now utilizing the winter monies planned for the second winter ward in the hospital on a collaborative approach in the community. The approach would provide the additional winter capacity, 28 beds, that the Trust requires whilst at the same time improving patient flow. As the proposal was innovative, albeit it has been adopted in other areas, the Committee sought assurances on the approach being deployed by the Commissioner as to the quality and safety of patients. The Committee supported the proposal on the condition that the 2nd winter ward in the hospital would not be opened.

Chairman's Business

The Committee was pleased to note that the Trust's Spell adjusted index score of 91, following the recent release of the reference cost material, was well below that of other NHS bodies. The score is a measure of the Trust's efficiency based on its management of costs.

M7 Financial Position

The Committee reviewed in detail the cumulative year to date deficit position at M7 which was reported as £8.8M against the plan of £8.4m. The Committee noted that the Trust was continuing to forecast achievement of the full year plan although it was recognised that the second half of the year would be challenging with delivery of two thirds of the CIP over the autumn and winter months.

The cash position was reported as £9.3M above plan. The Capital programme was confirmed as on track. The Continuity of Services Rating was reported at 2 as per the plan.

The Committee reviewed performance against the new agency cap for nursing staff of 3% for this Trust. For the first month of reporting, this being October, the Trust reported a figure of 1.9%. The implementation of the NHSP contract would hopefully mitigate any breach of this figure over the winter period.

The surgical plan was confirmed as largely on track although the risk of industrial action by Junior Doctors would impact significantly on the Trust's financial position and its ability to achieve the referral to treatment time target in December.

The Committee reviewed other key areas of risk associated with the affordability of the plan and the impact on the health economy as a whole as well as the risk of penalties and CQUIN payments. The Committee was assured that the Trust was taking all the necessary action to mitigate these risks as much as possible.

Cash Management and Reporting Update

The Committee reviewed the Trust's Cash Management processes which included the checks and balances deployed going forward together with a range of sensitivity analyses. The Committee reviewed the forecast of cash to the end of the year without the need for distressed funding together with the upsides and downsides to be considered. Overall the approach was considered to be prudent. The Board would now formally agree at its meeting on 25th November 2015 the response to Monitor in respect of any distressed funding requirement in 2015/16.

2016/17 Annual Plan

The Committee reviewed the approach to budget setting to be undertaken in 2016/17 this included the tolerances and assumptions to be considered and the relationship with the financial improvement plan. The impact of key assumptions was outlined as was the commissioner intentions for 2016/17. The Committee was pleased that the plan had begun in good time however concerns over many of the

uncertainties were raised. The Committee concluded that the plan should progress as described with rigour applied to all the areas which were within the Trust's control. The Committee reviewed the impact of significant changes to the tariff based on historical experience.

Progress Report on the Recovery Plan 2015-16

The Committee reviewed progress of the CIP programme at M7. The programme had an adverse variance of 200K between M6 and M7 as a result of slippage of the delivery of CIP schemes in month and the consequence of a CIP requirement that increased exponentially in Q3 and Q4. After applying the CIP contingency however, the variance improved by £100K year to date and by £500K in year. Progress against the additional £3.2M CIP challenge was reported which included the identification of £1M of new schemes.

Areas of concern remain the same, these being predominantly coding and patient flow. The change in the mean price spell was reported to have had a positive impact on the coding workstream as was hoped would be the outcomes from the work with Maxwell Stanley. The amendment to the winter plan was highlighted as a key factor to improve the patient flow workstream hence the urgency with progressing with this work. The Committee debated the difficulties with making whole time equivalent reductions in administrative and clerical posts as part of the IT enabled workstream without the ability to quantify the efficiency benefit from the implementation of technology with ease.

The Committee reviewed the suite of KPIs and concluded that these needed further clarification and streamlining to ensure a clear understanding of the impact of key drivers was provided.

Performance Report

Key points from the performance report included:

- Achievement of all cancer targets.
- Achievement of all RTT targets although this was reported as very difficult and the risk of achievement of the December target was highlighted in light of the industrial action being taken by Junior Doctors. The impact of community paediatrics on the Trust's ability to achieve the RTT target as a whole was debated in detail with further discussions due to take place with Commissioners on 24th November 2015 to enable a short, medium and longer term solution to be identified.
- C difficile remains a concern although the action plan was deemed to be successful as the Trust had not had any reportable avoidable cases since its implementation
- A & E 4 hour standard – the outcome of the work of the Systems Resiliance Group and the recent escalation meeting with health economy partners was deemed to be key to achieving improved patient flow. The improvements to streamlining of patients at the "front door" was noted with the focus now being on discharge before noon, discharges at weekend and the work of the integrated discharge team to improve the discharge of medically fit patients.

Board Assurance Framework

The committee reviewed the amended risk in relation to community paediatrics and agreed to consider the position again following the meeting with Commissioners in this regard on 24th November 2015. Key risks to be raised with the Board of Directors were the risk to RTT time targets in December as well as the financial impact as a result of the industrial action by Junior Doctors. The risk of opening up a 2nd winter ward should the capacity identified in the community not be successful. The Committee agreed to highlight to the Board that the amendment to the winter plan had only been approved on the condition that a 2nd winter ward would not be opened in the hospital.

Graham Hollick
Chair of Finance Business Performance and Assurance Committee

Board of Directors	
Agenda Item	9.2
Title of Report	Report of the Quality & Safety Committee 11 November 2015
Date of Meeting	25 November 2015
Author	Dr Jean Quinn, Chair of the Quality and Safety Committee
Accountable Executive	Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1,3,4,5,6,7 1a,1b,3a,3b,4a,5b,6b,7a,7c,7d 1445,1908,1909,2328,2485,2611,2678
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
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

This report provides a summary of the work of the Quality and Safety Committee which met on the 11th November 2015

Board Assurance Framework (BAF)

The Committee's agenda reflected the gaps in assurance/control on the BAF which enabled a full review against each area. The Committee agreed that a further review of the risk and assurances in relation to the End of Life Care was required by the Medical Director and Director of Nursing and Midwifery as well as some amendments to the risk in relation to partnership governance and sustainability in order to provide greater oversight in this area.

The Terms of Reference

The Committee reviewed its terms and reference and recommend these, as attached, to the Board of Directors for approval.

Workforce and OD Dashboard

Good performance was reported in the attendance rate although for October this had rose slightly above 96%. Nurse vacancies rates remained low with continued focus on recruitment; the overall increase in staff during September was above the number of leavers. The NHSP fill rate for the first week was reported at 68.9% against a target of 85% which was reported as encouraging.

Clinical Quality Dashboard

Good progress reported for SHMI and HSMR data; MEWS data continues to improve as does the Friends and Family Test results.

Areas for improvement/focus were in relation to medication errors which are due to reported upon in January 2016; harms from falls which are being addressed through training; pressure ulcers which increased in September and again is the focus of training and support.

Actual Harm from serious incidents

The Committee reviewed in detail 4 serious incidents which had resulted in death to ensure that the learning had been implemented in each of these.

Director of Nursing and Midwifery Performance Report Q1 2015-16

Good performance continues with MEWS assessments; improvement with nutrition and hydration performance was reported as was patient experience as demonstrated by the Friends and Family Test results. Areas for improvement were the patient focussed nursing and midwifery audits which showed some wards below the threshold of 86%, mitigating action to improve this included changes in leadership on 5 wards.

Winter Plan 2015/16

A further update was provided on the preparations for winter 2015/16, this included the opening of the first winter ward and the recruitment for the second. The proposals to try and secure further beds in the community by working innovatively with a Care Home although this was subject to funding agreements, further details of which will be reported upon.

A & E Triage Improvement Plan

The Committee reviewed the improvement plan, focussing particularly on electronic triage paperwork which was designed to prevent blockages in A & E. Assurances were provided that patients in triage were monitored hourly to ensure patients were safe at all times. The Committee requested details of the findings of the full impact assessment undertaken together with quarterly progress reports in the future.

Quality Improvement Strategy

Improvements year on year were reported in numerous areas with the exceptions being patients being assisted with eating; readmission rates and the advancing quality targets in relation to stroke and AMI. The Committee approved some targets to ensure these were aligned to the Quality Account.

Annual Reports

The Committee reviewed and noted the following Annual and Bi-Annual Reports

- Claims Annual Report
- Accountable Officer for Controlled Drugs Annual Report
- Organ Donation Bi-Annual Report

Community Paediatrics

The Committee received an overview of the service, full details of the current concerns with regards to waiting times together with a discussion on the next steps. The Committee reviewed how the risks to patients waiting could be mitigated further in the short term as well as longer term solutions. The Committee agreed to escalate the matter for further discussion at the Board of Directors as part of its private agenda.

Review of Clinical Governance Group Minutes

The Committee noted concerns with compliance with the WHO checklist following a recent audit. The reasons for this were debated together with the action to address this. Although the audits are normally conducted on a bi-annual basis, a further review is now planned for December 2015.

Dr Jean Quinn
Chair of Quality and Safety Committee

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee

Terms of Reference

Authors Name & Title: Medical Director	
Scope: Trust Wide	Classification: Terms of Reference
Replaces: N/A	
To be read in conjunction with the following documents: Board Assurance Framework Standing Financial Instructions	
Document for public display? Yes	

Unique Identifier:	Review Date: November 2016	
Issue Status: Approved	Issue No: 3.0	Issue Date: November15
Authorised by: Board of Directors	Authorisation Date: November 15	
After this document is withdrawn from use it must be kept in an archive for 10 years		
Archive: Document Control	Date added to Archive:	
Officer responsible for archive: Document Control Administrator		

1 Constitution

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

2 Authority

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

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

3 Objectives

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

3.1 Risk

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

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

3.1.3 To receive and monitor relevant areas of the CQC's Intelligent Monitoring report (as determined by the Executive Team)

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

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

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

3.2 Clinical Effectiveness and Safety

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

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

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

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

3.2.5 To seek assurance that there is ongoing compliance with CQC Fundamental Standards of Care and that all actions plans arising from CQC inspections are monitored and progressed promptly.

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

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

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

3.3 Patient Experience

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

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

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

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

3.4 Workforce

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

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

3.5 Staff Satisfaction and Engagement

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

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

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

3.6 Governance

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

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

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

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

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

3.6.6 To receive an annual divisional assurance report.

3.6.7 To receive and recommend the Annual Quality Account.

3.6.8 To undertake deep dives as appropriate.

4 Equality and Diversity

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

5 Integration

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

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

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

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

The Committee will identify areas of duplication and ensure that reports are received by exceptions from those groups reporting to it.

6 Membership

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors (one of whom shall be Vice Chair of the Committee – each member shall be a member of either the Audit Committee or the Finance, Performance Assurance Committee)
- Medical Director(Nominated Deputy - Associate Medical Director)
- Director of Nursing & Midwifery (Nominated Deputy – Deputy Chief Nurse)
- Director of Workforce
- Chief Operating Officer (upon appointment)
- Associate Director of Risk
- Director of Operations
- Nominated Governor
- Nominated Patient Representative (suggestion Healthwatch)

7 Attendance

- *Director of Governanc/Corporate Secretary*

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

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

8 Quorum and Frequency

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

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

9 Reporting

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

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

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

10 Conduct of Committee Meetings

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

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

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

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

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

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

28 OCTOBER 2015

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Sharon Gilligan	Director of Operations
Andrea Hodgson	Non-Executive Director
Gareth Lawrence	Deputy Director of Finance
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director

Apologies

Jill Galvani	Director of Nursing and Midwifery
Graham Hollick	Non-Executive Director

In attendance

Carole Self	Director of Governance/Corporate Secretary
Jon Scott	Senior Advisor to the Chief Executive
Mark Blakeman	Director of Informatics and Infrastructure
Mark Taylor	Recovery Adviser
Gaynor Westray	Deputy Chief Nurse

Reference	Minute	Action
BM 15-16/157	**Apologies for Absence** Noted as above	
BM 15-16/158	**Declarations of Interest** None	
BM 15-16/159	**Patient Story** This was delayed until November due to technical difficulties.	
BM 15-16/160	**Chairman's Business** The Chairman advised the Board that the Remuneration and Appointments Committee had met on 30th September 2015 to agree the following: • The interim arrangements for the Director of Finance until the substantive post was appointed to. The Committee agreed that the Deputy Director of Finance would act into this position in the interim supported on a part time basis by an experienced Director of Finance. • The recruitment plan for the Director of Finance	

Reference	Minute	Action
	• The recruitment plan for the Chief Operating Officer The Chairman updated the Board on the following dates for their diaries: • Joint Board/Governor Workshop – 3 November commencing at 2:00pm • Board Meeting – 25 November 2015 commencing at 9:00am • Council of Governors Meeting – Wednesday 9 December commencing at 2:00pm	
BM 15-16/161	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas for discussion: • Rates of C difficile were reported at above trajectory with a total of 27 avoidable cases recorded against an annual target of 29. The Board was advised that this had been raised as a governance concern and hence formally reported to Monitor. A full analysis against best practice and current processes was being undertaken in order that an updated action plan could be implemented with a view to maintaining and improving the situation. The Board debated the reasons for the increases in case of C difficile which were in the main associated with the high bed occupancy rates and the physical constraints of the hospital. The actions to improve the situation included the 6 week HPV programme; the opening of the new isolation ward; the review of infection prevention and control in a holistic way on a weekly basis to ensure optimum use of available beds and greater rigour to be applied to early isolation. As well as the impact of quality of care the Board sought to understand the financial impact of exceeding the annual target and thus requested an update on this for the next meeting. • A second never event was reported during the reporting period April to October 2015. An overview of the event was provided and the Board sought and received assurance that the patient involved suffered no harm. The Board was also advised that the patient was advised straight away of the incident and the action being taken to prevent this happening again. A full root cause analysis was being undertaken. • The wider system challenges in A & E were reportedly having an impact on patient flow and performance overall. The Board agreed to review the causes and actions being taken as part of the Performance Report update. • The implication of not achieving the required levels of NMC revalidation were debated with assurance being provided by the Deputy Chief Nurse on the programme of action and the support and coaching put in place for nurses to prepare their nurse portfolio. The Board agreed to review this on a monthly basis as part of the nurse staffing paper. The Chief Executive summarised the report by confirming that the hospital was in a challenged position at present hence the focus on ensuring that the right patients were in the right beds and reducing the number of outliers. The Board was advised of the increases in elderly length of stay of 3 days since the introduction of the Care Act from 1st April which had effectively cancelled out the benefits of the length of stay work. It was	**GW/GL**

Reference	Minute	Action
	made clear that the Trust was not alone in experiencing these delays. A series of recommendations to resolve this were being considered by the Systems Resilience Group SRG with outcomes being sought immediately. The Board supported the action being taken and the endeavours to keep staff morale high as the feedback from the Unions was still positive and the Trust was eager for this not to diminish.	
BM 15-16/162	**Annual Plan – Mid-Year Review** The Chief Executive presented the Annual Plan- Mid Year Review and highlighted the following areas that required improvement: • Working with partners to develop care closer to home and reduce delayed transfers – The Board agreed that the measure needed to be reviewed as it was no longer meaningful. • Readmissions – The work to reduce the financial penalties was recognised however the ambition of reducing readmissions to 7% was felt to be unachievable. The Board agreed to review the measure and focus on measuring and reducing avoidable readmissions in the future. • HSMR – The Board noted the huge work undertaken in this area, however as a result of constant rebasing it was no longer sure of the credibility of the 85% target. The rate of change nationally for the Trust was faster than its comparators yet the Trust was recording this as requires improvement. In view of this it was agreed to re-look at the measure. • Appraisal rates – The Board agreed that improvements were required in this area • CQC compliance - The Board agreed with the current rating and the work being undertaken to improve this • Monitor rating – The Board agreed with the current rating and the work being undertaken to improve this. • Cos Ratings – The Board agreed that the current rating should be recorded as 2 and not 1 as shown in the report.	**MC**
BM 15-16/163	**Integrated Performance Report** The Director of Infrastructure and Informatics presented the Integrated performance dashboard highlighting the good performance in the areas of meeting our vision and a health organisation. The challenges were highlighted in the areas of operational excellence and external validation, with financial recovery to be discussed as part of the finance report. Key areas of focus, not already discussed, included: • **A & E 4 hour standard** – Mr Scott reported concerns about the achievement of the Q3 target, albeit still mathematically possible to achieve he confirmed that it would not be easy. Mr Scott advised the Board of a series of actions to improve the situation even if this fell short of the target. He confirmed that the SRG had accepted that the assessment delays were causing the problem with these equating to over 30 beds being unavailable. He updated the Board on the Emergency Care Improvement Event recently undertaken and the	

Reference	Minute	Action
	plans to re-run the "perfect week" in January as well as the system wide "perfect weekend". Further plans included the opening of the first winter ward next week; the continued work with doctors to improve engagement in change and the proposals being considered for a step down facility as well as the second winter ward. The Board sought to understand the level of impact the launch of the NHS 111 service had had on the Trust's attendance levels which were felt to be significant. The Board discussed progress on the "single front door" concept designed to stream patients much more effectively as well at GPs at triage. Continued monitoring through the Senior Management Team together with a detailed analysis of what actions worked and which did not was proposed. • **Advancing Quality indicators** – a case note audit is being completed for every hip and knee replacement which fails compliance; this is as a result of compliance falling from 100% to 90%. The disappointing performance for Sepsis was raised with improvements expected following the electronic alerts and the Sepsis event held in September. • **Surgical Activity** – reported 95 cases down against the plan. Orthopaedics, oral surgery, ENT and ophthalmology remain the specialties causing most risk to activity levels although the risk is increasing in gynaecology. Risk to referral to treatment times RTT was reported in pain management and community paediatrics. The Board sought to understand how the pressures in A & E were impacting on the surgical plan. The Director of Operations confirmed that if Ward 1 was used this would have a significant impact with the exception of orthopaedic work which was currently protected as this presented the most risk to the Trust. The Board was advised that the concerns with surgical activity did not confine themselves to the risk of delivery of the financial plan but also to cancer targets as the majority of patients were either clinically urgent or on a cancer pathway. The Board was advised that despite concerns, the surgical plan had been achieved in September, was on track to achieve for October and work was progressing well for November. The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance. The consistent reporting of consultant unavailability was a cause for concern which the Board agreed to discuss as part of the development agenda. • **RTT** – Concerns were expressed with the achievement of the RTT target with two areas causing the most concern these being pain management and community paediatrics. The Director of Operations advised the Board that the Trust was currently 1% lower in the month than expected with a number of factors affecting this which included sickness and vacancies in the validation team resulting in a greater number of un-validated records. Actions to improve performance were highlighted as outsourcing some of the pain management work to Spire; validation of the community paediatrics list to reduce the "do not attend" DNA rates and a review of the validation team. The Board sought to understand if there was any further action it could take which would improve the situation. The Director of Operations advised that additional work being undertaken by consultants and the additional locum would improve performance in community paediatrics. The	**MB/SG**

Reference	Minute	Action
	Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has to ensure this does not happen again.	**MB/SG**
BM 15-16/164	**Month 6 Finance Report** The Deputy Director of Finance reported that the cumulative deficit as at the end of September was £8.173M which was an £244k adverse variance to the plan of £7.928M. The in- month performance was broadly on plan with a marginal £87K deterioration. Positive performance was reported in terms of the delivery of surgical activity against the plan. The cash position was reported as strong, this being £13.2M against a plan of £8.6M. The CoS rating of 2 remained in line with plans. The Board was alerted to the spend on non-core pay categories in September which in the main were associated with medical and nurse agency spend. The Board was reminded of the plans implemented to reduce this which should lead to reductions in the future. The latest forecast outturn position for CIP had reduced to circa £9.8M which was £1.2M below initial plans with the in-month deterioration in the forecast arising primarily within the Patient Flow workstream. Planned reductions in patient length of stay had not transpired due to the increased complexity of patients seen and process changes as outlined earlier in the meeting. The Board agreed to discuss and review this in greater details as part of the full review of the recovery plan in the private part of the agenda. It was agreed that the position with regards to the need for distressed funding would be concluded in the private part of the agenda with the Board recognising the need to undertake the full cash analysis review first.	
BM 15-16/165	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: September 2015** The Deputy Chief Nurse presented the report showing the staffing data for September and highlighted the success in the overseas recruitment strategy following the investment by the Board. The accommodation initiative was proving to be popular for Polish nurses. The Board was also advised of the local recruitment event taking place which involved 16 nurses being interviewed. The key points of the report included the 98% fill rate with no areas reported as RED with the areas recorded as AMBER were the focus of a review. The new E-Roster system and the use of NHSP from November was expected to improve staffing levels and ensure compliance. The use of agency staff was prioritised for weekends. The Deputy Chief Nurse outlined the next steps as follows: • Explore further the use of AHP within the ward team staffing levels • Review staffing levels at ward level taking into account acuity and	

Reference	Minute	Action
	dependency, as well as local factors • Continue with the programme of monthly trust wide recruitment for registered nurses including overseas recruitment • Continue to focus on the management of long and short term sickness • Provide training for the E-Roster leads to ensure that the Trust maximises the functionalities of the system • Establish a mechanism to assure data quality for nurse staffing • Undertake the planned audit of revalidation readiness during Quarter 3 for those nurses and midwives due to re-register in Quarter 1 of 2016/17 The Board asked that the monthly safe staffing appendix be reviewed as although there was a lot of information it was not convinced of its value. The Board raised concerns with the sickness rates reported in some areas. The Deputy Chief Nurse confirmed that this was currently being reviewed with key leads. The Board thanked the Deputy Chief Nurse for the report and agreed that it would look with interest at the report from the CQC when received in view of the communication on nurse staffing from external agencies.	**GW**
BM 15-16/166	**External Assurance - Quarterly Monitor Report** The Deputy Director of Finance presented the Quarterly Monitor report highlighting the key reasons for the Quarter 2 variations against the 2015/16 plan. The recommendations in relation to the Governance Statements from the Finance Business Performance and Assurance Committee were tabled for review and agreement. The Board noted the recommendation to change the response from "Confirmed" to "Not Confirmed" in relation to the exception reporting in the quarter as a result of the C difficile performance. The Board agreed to approve the statement with the slight addition to include the additional discharge pressures. The Board resolved to discuss the application for distressed funding and the timing of this in the private part of the meeting, the outcome of which will be reported to Monitor accordingly.	**CS**
BM 15-16/167	**Report of the Finance Business Performance and Assurance Committee 23 October 2015** Mrs Hodgson presented the report from the Finance Business Performance and Assurance Committee and highlighted the discussions undertaken on performance to date, the impact on the cost improvement plans, the cash position and the future requirements for distressed funding. The impact of the early contract payments and the increased visibility of cash forecasting was discussed at length as part of the cash requirement	

Reference	Minute	Action
	review.	
BM 15-16/168	**Research Annual Report** The Medical Director presented the Research Annual report in line with reporting requirements and confirmed that this addressed national research targets and the Trust's ability to meet these targets. He confirmed that during 2014/15 the Trust continued to exceed two national KPIs and improved significantly in another. The Board sought to understand how it could make more of the good work in this area through the local media and asked the Medical Director to progress this. Further discussion followed on the benefits of research for the organisation in terms of training and particularly how this could be used to focus on specialities which were regionally significant. The limited resource was highlighted as a barrier to progressing this work and the Board requested that the use of charitable funds be considered.	 **EM** **EM**
BM 15-16/169	**Board of Directors** The Minutes of the Board of Directors Meetings held on 30 September 2015 were confirmed as an accurate record. **Board Action Log** The Board action log was updated as recorded	
BM 15-16/170	**Items for BAF/Risk Register** None	
BM 15-16/171	**Any Other Business** None	
BM 15-16/172	**Date and Time of Next Meeting** Wednesday 25 November 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 – November 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 28.10.15						
	BM15-16/161	The Board sought to understand the financial impact of exceeding the C difficile annual target and thus requested an update on this for the next meeting.	GW/GL		November 2015	
	BM 15-16/162	Changes to the Annual plan to be made as follows: Review the delayed transfer measure to ensure meaningful Review the readmissions measure to focus on reducing and avoidable readmissions Review the target for HSMR Review the current and forecast CoS rating to 2	MC		November 2015	
	BM 15-16/163	Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance.	MB/SG		November 2015	

	BM 15-16/163	RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has.	MB/SG		November 2015	
	BM 15-16/165	The Board asked that the monthly safe staffing appendix be reviewed to ensure this added value	GW		November 2015	
	BM 15-16/166	The Board agreed to approve the Monitor Governance statement with the slight addition to include the additional discharge pressures.	CS	**Completed**	November 2015	
	BM 15-16/168	The Board sought to understand how it could make more of the good work in the Research area through the local media and asked the Medical Director to progress this.	EM		November 2015	
	BM 15-16/168	Progress how charitable funds could be used to address the limited research resource going forward.	EM		November 2015	
Date of Meeting 30.09.15						
Sept 15	BM 15-16/131	Key messages from the new models of care programme to be discussed at the October Board meeting.	DA	**Completed**	October 2015	
Sept 15	BM 15-16/131	Members requested that a high level programme summary be circulated together with the anticipated benefits of the New Models of Care programme.	DA		October 2015	

Sept 15	BM 15-16/132	The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review.	MB		October 2015	
Sept 15	BM 15-16/132	The Board requested that the Chief Executive reach a clear position with the CCG as soon as possible with regards to Community Paediatrics.	DA	**Further update to be provided at the November meeting**	October 2015	
Date of Meeting 29.04.15						
Apr 15	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**Ongoing – included on agenda for July 15**	May 15	
Apr 15	BM 15-16/016	Consider adjusting the nurse staffing ratio targets when contingency wards used	JG	**Consider as part of the winter planning process**	June 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	**Well-led Governance Review Tender being developed**	December 15	
Date of Meeting 29.10.14						
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM	**The research team are considering this recommendation - completed**		