Board of Directors Meeting

28 January 2015

**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 28 JANUARY 2015
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL**

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Patient Story** Director of Nursing and Midwifery	v
4.	**Chairman's Business** Chairman	v
5.	**Chief Executive's Report** Chief Executive	d
6. Strategy and Development		
6.1	**Annual Plan – Update and Agreement of Annual Objectives 2015/16** Director of Strategic and Organisational Development	d
7. Performance and Improvement		
7.1	**Integrated Performance Report**	
	7.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics	d
	7.1.2 Month 9 Finance Report Director of Finance	d
7.2	**Report of the Finance, Business Performance & Assurance Committee** • **23 January 2015** Chair of the Finance, Business Performance & Assurance Committee	d
7.3	**Report of the Quality and Safety Committee** • **14 January 2015** Chair of the Quality and Safety Committee	d
7.4	**Report of the Audit Committee** • **4 December 2014** Chair of the Audit Committee	d

7.5	**Progressing Towards Safer Nurse Staffing : Update on the Establishment Review of Nursing, Midwifery and Healthcare Support Worker Staffing: November to December 2014Nurse Staffing Report** Director of Nursing and Midwifery	d
7.6	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: October, November and December 2014** Director of Nursing and Midwifery	d
7.7	**Demand and Capacity Modelling** Director of Infrastructure and Informatics	p
7.8	**CQC Final Report and Action Plan Update** Medical Director	d

8. Governance

8.1	**External Assessment**	
	• **Monitor Quarterly Return**	d
	• **Monitor Q2 Feedback Letter**	d
	Director of Finance	
8.2	**Corporate Governance Review** Associate Director of Governance	d
8.3	**Fit and Proper Persons Test** Associate Director of Governance	d
8.4	**Board of Directors**	
	8.4.1 Minutes of the Previous Meeting	d
	• **26 November 2014**	
	8.4.2 Board Action Log Associate Director of Governance	d

9. Standing Items

9.1	**Items for BAF/Risk Register** Chairman	v
9.2	**Any Other Business** Chairman	v
9.3	**Date and Time of Next Meeting** **Wednesday 25 February 2015 at 9am**	v

Board of Directors		
Agenda Item	5	
Title of Report	Chief Executive's Report	
Date of Meeting	28 January 2015	
Author	David Allison – Chief Executive	
Accountable Executive	David Allison – Chief Executive	
FOI status	Document may be disclosed in full	
BAF Reference	1,3,4,5,6,7	
Data Quality Rating	NA	
Level of Assurance	Full	**Board confirmation**

1. External Activities

Five Year Forward View – New Models of Care
NHS England has now published its planning guidance for 2015/16 and this is summarised in the Annual Plan update report which is on the agenda for this meeting. Also included in this guidance was a call for organisations within health and social care communities to express interest in becoming 'vanguard' pilots for new models of care. I am pleased to report that with the support of the Strategic Leaders Group which oversees Vision 2018, the Trust has led engagement with a number of key stakeholders on shaping an application to be a vanguard site. A full update is provided in Part 2 of the meeting.

GP Engagement

At the Board meeting in November, Non executives asked for an update on the engagement work we have been undertaking with GPs. A short update is provided on the range of work we have been progressing in appendix i.

Monitor

The Trust hosted a visit for Monitor in December 2014, the content and outcomes of which can be seen in appendix ii.

The Trust found the visit very helpful and provided it with the opportunity to showcase some of the good work in the Trust.

The next monitoring call is planned for the 9 February 2015 when the Trust will discuss the outcomes of Q3 and agree next steps.

Victoria Central Health Centre

Given the Trust's financial challenges, it has been reviewing the costs associated with providing outpatient clinics at Victoria Central Health Centre in Wallasey. As most of our clinical space at this location is rented through Wirral Community NHS Trust, talks at reducing costs with our landlord and Wirral Clinical Commissioning Group are ongoing.

A verbal update will be provided at the Board Meeting.

External Review

Working with the Recovery Director and Turnaround Advisor the Trust has made significant progress in developing the necessary structures and processes to ensure enhanced CIP delivery in 2015/16.

Each workstream now has the key leads identified and in the three key areas of LoS, Theatres and Outpatients detailed workstream plans are now in draft format.

The sustainable model of delivery is developing and the PMO element of this work has now been fully defined. Clinical engagement will be a key focus over the weeks to come.

2. External Activities

Infection Prevention & Control

At the end of December The Trust reported a total of 18 toxin positive C.difficile cases, of which 3 were unavoidable and a further 3 whilst still under review were potentially unavoidable. Therefore there are potentially 12 avoidable cases to report. The Trust has had a further 4 cases reported up until the 21st January which are currently being reviewed. The target for the Trust is 24 cases per year.

We have reported 2 MRSA bacteraemia (1 November, 1 December) with a total of 3 since April 2014. Root Cause Analyses have been performed identifying these to have been avoidable, with a common theme being lack of side room facilities to isolate patients with MRSA.

Rapid detection of CPE continues to be successful and the Trust is now looking at making this a more permanent intervention. An interim solution for the isolation of patients identified with a positive CPE infection is currently being reviewed and a weekly outbreak meeting has been established to ensure an overview is maintained.

The options for future permanent isolation facilities have been reviewed by the Executive Team who support the proposed approach but requires further detail in terms of the impact on the capital programme.

During December, flu activity increased within the Trust to reflect the National picture. The flu plan adopted over previous years has been initiated to ensure transmission is prevented.

The processes to ensure preparedness for Ebola continue to be adapted to take into account directions from Public Health England as the picture for Ebola evolves.

A&E Update

The Trust, like most other Trusts, has seen increased pressure from urgent and emergency admissions over the past few weeks which has placed a massive strain on our staff and necessitated the opening of additional unplanned escalation areas. Whilst ED attendances have remained fairly constant, which may reflect the success of some of the health economy schemes and also the communication strategy which the Trust has led on involving local and national media, the number of admissions has increased.

The Trust would expect around 80 ambulance conveyances per day but in January received some of the highest number of ambulance arrivals in the region; over 140 on some days. The number of trauma standby calls has increased and the new resuscitation area, which has doubled in capacity to 8, has been full on numerous occasions. The number of admissions has increased from an average of 83 per day in quarter 3 to 98 per day on average up to 14 January 2015.

Clearly this pressure has been reflected in compliance with the 4-hour target and it is unlikely that the Trust will be able to recover in this quarter. Monitor has been appraised of the situation and a reforecast will be submitted at the end of January once agreed with the health economy.

A number of Trusts nationally declared a major incident and although it has been close on a number of occasions it is testament to the hard work and commitment of our staff, many of whom have gone ‘that extra mile’, that we managed to avoid doing so with the support of our health economy partners.

Wirral Millenium Phase 2B

Whilst there are a small number of issues to be resolved, the adoption and use of the new Millenium functionality that went live in November remains excellent. On this basis, the Informatics team have re engaged with HIMMS to arrange a level 6 assessment. This assessment will also include an early assessment of the gaps and actions required to achieve a level 7 award. Planning is also underway for the remainder of the Cerner phases.

Workforce

HR&OD continue to support Divisions in a large number of difficult organisational change schemes. The Human Resources team is very much at the centre in proactively supporting managers in leading these change programmes. An LiA has recently been held with local Trade Union Representatives highlighting the challenges ahead and re-affirming the importance of the partnerships agreement framework.

Attendance rates remain a concern with December 2014 showing a particularly poor attendance rate. The Trust is not unique in this matter and the Trust's benchmarking position against peer organisations has been improving. A number of priority actions discussed in full at the Quality & Safety Committee are being taken to address attendance levels. These include the implementation of the refreshed Health & Wellbeing plan; a new Attendance Capability Policy and a recognition programme to reward good attendance.

The Appraisal rate for our workforce remains strong when comparing to peer organisations (December 2014 being 82.97%) although this is below the KPI target of 88% it is an increase on the November figure of 82.60%. Furthermore the Trust can be confident that our workforce is receiving all necessary Mandatory Training as compliance rates remain high (December 2014 being 97.37%) which is above the 95% compliance target.

The annual flu vaccination campaign has been taking place and I am pleased to report that we vaccinated 75% of our front line workforce more than 6 weeks earlier than this time last year. This work programme continues despite achieving the externally determined 75% staff flu vaccination target.

The Trust received a positive report following the recent Deanery visit on 14 November 2014 and formal feedback is expected by the end of February 2015. The Trust received 94% in their LQAF accreditation following the Library evidence submission at the end of August 2014 and the development visit on the 8 October 2014.

Listening into Action

We continue to embed Listening into Action as a way of working with a roll out plan now commenced for all wards to host their own LiA events led by the ward sister and a lead consultant. This aims to improve ward performance, staff satisfaction and engagement and patient experience. We held another successful "Pass it On" event in December 2014 where our 4th wave of LiA teams feedback to the organisation on the improvements they have made which included: IT Enabled Healthcare – Maternity; Hospital Readmissions; World Class Dementia Care; Pressure Ulcers; Health and Wellbeing; Learner Engagement; HROD and Trainee Doctors

We have held our latest round of LiA Big Conversations with managers this year following which further actions will be identified along with additional LiA teams to take this work forward. The last conversation was on 21 January 2015.

We have developed an Integrated Culture and Engagement Plan which brings together a range of work including Listening into Action, Staff Satisfaction, Cultural Barometer, Staff Friends and Family Test and the actions associated with driving improvement in these areas. This plan underpins the

delivery of the Workforce and Organisational Development Strategy 2015-18 and will be monitored by the LiA Sponsor group and assured by the Workforce and Communications Group.

David Allison
Chief Executive

January 2015

Update on the Primary care Engagement Strategy- January 2015

1. Background

1.1 A Primary Care engagement strategy for the Trust was developed in November 2013 in recognition that our local GP Practices are our core customer base. The Strategy identified that it is essential that the organisation is engaged with local General Practitioners (GP's) and their practice staff, to inspire high levels of confidence and satisfaction with the service they receive from the Trust.

1.2 The Primary Care engagement strategy identified a number of workstreams through which the organisation would engage with Primary care including engagement opportunities with GP's. Core to this strategy were visits to individual GP practices.

1.3 This paper provides an update on the workstreams within the strategy and the actions which are being implemented. The Strategy and Partnerships Team have actively involved the clinical divisions and relevant corporate departments in delivery of the workstreams in order to provide the best quality services to GP Practices.

2. Workstream update

2.1.Business development information

This data, which is drawn from Dr Foster Marketing Manager Tool, provides analysis of the Trust's market share by GP practice and clinical subspecialty. It enables each Division to review its market share by service line, understand the key competitors in the market place and develop strategies as part of its Annual Plan to retain or increase market share.
The Trust is able to report its overall market share, which is one of its strategic objectives.
An analysis of Wirral and West Cheshire GP referred New Outpatient attendances between September 2012 - August 2013 and September 2013 - August 2014 can be seen in the table below

Wirral CCG	WUTH % market share (OP New)	Comment
September 2012 to August 2013	83.6	Growth in WUTH market share. Virgin market share reduced from 7.1% to 6.5%. Spire from 4.6 to 4.1%
September 2013 to August 2014	84.7	
West Cheshire CCG	**WUTH % market share (OP New)**	
September 2012 to August 2013	8.2	Reduction in WUTH market share which equates to 69 referrals. CoCH market share increased from 80.2% to 83.3%. Up by 12,000 attends of which 10,000 accounted for by diagnostic imaging believed to be due to a change in the data they submit.
September 2013 to August 2014	6.7	

The Strategy and Partnerships Team is working with the Divisions to develop a 2015-16 CIP scheme to repatriate Wirral Market share in a number of specialties.

2.2. GP Practice visits

A programme of visits to individual practices in the Wirral and Neston areas was planned to enable informal face to face meetings with GP's, Practice nurses and Practice Managers to share information and seek views on how primary and secondary care could work together to further improve patient pathways. Ten visits were carried out in the latter part of 2014 and a programme of visits to remaining practices in 2015 is currently being scheduled. The visits are attended by the Associate Director of Strategy and Partnerships and the Associate Medical Director, Strategy and Partnerships. If the preparatory practice profile indicates a low market share, the relevant CSL is also invited to attend the meeting. In 2014, Mr Glynn Thomas, CSL for Trauma and Orthopaedics joined meetings at 3 Practices.

A summary of key themes which arose from the visits and actions taken are described in the table below

Theme	Action
Use of IT to enhance flow of patient related information and communication. This includes outpatient and inpatient discharge letters, ED summaries, referrals, admission and death notifications. GP's stressed that information should be accurate, timely, complete and clearly state what the GP is required to do. It was agreed that Primary Care communications to secondary care should also reflect these standards. Each GP practice must activate the HIE data sharing agreement (giving WUTH clinicians access to GP records) within the system and this has only occurred at 5 practices.	Meetings have been held with Mr O'Sullivan and Sheila Stewart to describe issues raised. They advised that a joint Primary/Secondary Care group should agree the content and design of reports and communications created on the Cerner system. Associate Director of S+P has approached Wirral CCG to establish a task and finish group comprised of primary and secondary clinicians and support managers to design systems/processes to enable information flow. Meeting has been requested with Bennett Quinn, Lead GP for data sharing and the CCG to agree a solution. Information will be sent to Practices through the HUB. Informatics Team are working with practices to establish this system. 3 practices go live in January 2015. Plan is in place for remaining practices.
Improving care pathways-GPs are keen to revise care pathways so that they are able to manage patients in the community with advice from senior clinicians at the Trust. GP's are willing to manage patients who may have an unplanned care need. They would like access to senior clinical advice, and send these patients for a planned outpatient appointment if required. GP's would like to be more involved in the discharge plans for their patients.	Associate Medical Director for S+P meeting with CHD's/CSL's to agree communication channels for GP's to contact specialties. The method will vary according to the specialty and degree of urgency. The Acute Physician of the Day is now available to GP's via bleep. When Emergency Surgeons commence in post (interviews 3.2.15.) they will adopt similar system. Agreement with Julie Tunney (and subsequently her replacement) to involve GP's in the Ticket Home project.
Getting to know consultant colleagues-GP's want to know which consultants are working at the Trust and their areas of interest. They like to be able to discuss clinical care with consultants.	'In Practice' quarterly communication to GP's now provides information on Consultants who have joined the Trust. The Communications and Marketing Team are continuing to populate consultant profiles on the Trust's website.
Excess waiting times for direct access x-ray service.	This was immediately raised with the CHD in Diagnostics who personally contacted GP's over specific cases. The CHD and ADO for Diagnostics and clinical support have developed and implemented an action plan to reduce waiting times to within the KPI and this issue is now resolved.

2.3. Booking service

Monthly meetings are now held between the WUTH Booking service manager and GP practice managers to update on service developments and discuss operational issues which require action. Any issues raised with the Strategy and Partnerships Team about booking services are immediately

	conveyed to the Booking service manager who acts upon an appropriate solution. For example, if there are no available appointments within 6 weeks on Choose and Book patients are put onto an active list whilst additional capacity is sought from the Division and then this data is reported to OMT on a monthly basis so actions to provide sufficient clinic capacity can be monitored. **2.4. QIPP groups/workstreams** The role of QIPP groups has been discussed with the CCG in light of the Vision 2018 structure. "Fast Five" work streams have been linked to existing QIPP groups wherever possible. Following the revised structure at Wirral CCG we are awaiting clarification of the future of QIPP groups. **2.5. Education opportunities** This area requires a flexible approach due to the availability of Primary care staff to attend events in light of demand for patient care. Half day seminars were held by Women's and Children's Division in 2014 for Primary care clinicians. They were well attended and well received and provide a model for future seminars which will focus on a clinical theme. A series of one hour presentations were delivered by WUTH consultants (from all Divisions) to a group of GP's at St Catherine's Health Park over Summer 2014. We are awaiting clarification of GP lead for CCG wide education following restructure at the CCG. AMD for S+P will work with this individual to agree dates/events for joint education sessions in 2015. **2.6. General communication** The Strategy and Partnerships Team identified that there was no standard route for providing regular updates to GP's which GP's and Practices understood was a recognised source. The team raised this issue with the CCG which contributed to the establishment of a weekly primary care briefing delivered from a central point at the CCG. The Trust now uses this route to communicate Wirral wide information to Practices and GP's Feedback from GP's indicated that the Trust quarterly GP newsletter "In Practice" was not sufficiently GP focussed or providing coverage of clinical developments and consultant profiles. The Associate Director of Strategy and Partnerships worked with the Media Relations Team and Clinical Divisions to refresh the content of the newsletter which has been welcomed by Primary Care. Practice managers and GP's have expressed frustration that there was not an informal point of contact at the Trust if they wished to raise an issue. The Strategy and Partnerships Team has provided this point of contact and promoted this to Practices during visits or contact calls. This service has enabled GP's and Practice managers to call or e mail in an ad hoc manner. It has been used appropriately to raise issues which are dealt with in a timely manner and ensure they are referred to the correct individual to respond to their enquiry. It is also enabled Practice Managers who require a secondary care opinion on service redesign to approach the Strategy and Partnerships Team to share ideas which prepares the ground well as the Trust explores development of the PACS model described in the Five Year Forward View, for example support on application to the PM's Challenge Fund. The Strategy and Partnerships Team have also been asked to attend GP practice patient groups where they have been able to listen and respond to patient concerns and ideas and discuss the strategic plans of the Trust in response to demographic changes, National initiatives and local commissioning intentions.
3.	**Next Steps** Primary care engagement will remain an iterative process during 2015 as the Strategy and Partnerships team continue to build upon the Primary Care relationships that were established in 2014. The organisation must exploit the opportunities which the 2b phase of Cerner Millennium has enabled and the Associate Medical Director for Strategy and Partnerships will drive CSL's to agree routes of communication which GP's can use to discuss clinical care options with GP's A task and finish group with GP and commissioning partners will focus on realising these opportunities. The Trust is keen to develop the PACS model described in the Five Year Forward View and plans to engage local GP's in discussions on the local benefits of employing this model.

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8 January 2015

Mr Michael Carr
Chair
Wirral University Teaching Hospital NHS FT
Arrowe Park Hospital
Arrowe Park Road
Upton
CH49 5PE

Dear Michael

Wirral University Teaching Hospital NHS Foundation Trust ("the Trust") – Letter following Monitor's visit to the Trust on 15 December 2014

1. I am writing to you following our visit to the Trust on 15 December 2014 where we met with a number of Board members ("the meeting").
2. The meeting follows a number of conversations held with the Trust as part of our annual, monthly and quarterly monitoring processes, and our concerns over the financial governance and sustainability of the Trust; and over performance against the 4 hour A&E target.
3. The purpose of the meeting was to further understand:

   3.1. the strategic risks to the long term sustainability of the Trust's services and the Trust's progress in implementing actions to reduce exposure to these risks;
   3.2. how the Board has gained assurance over the deliverability of the Trust's financial plan for 2014/15, in particular the Trust's ability to return to the planned outturn position in year; and
   3.3. the Trust's ability to return to compliance with the 4 hour A&E target on a sustainable basis.

4. The remainder of this letter sets out the key matters discussed at the meeting and Monitor's remaining concerns and expectations of the Trust.

5. **Long term sustainability and Trust strategy**

   5.1. The Trust has enlisted external assistance to develop its strategy; using FTI to undertake extensive work over the CIP plans for 2014/15 and 2015/16 and appointing Terry Watson to the role of Transformation Director to continue to drive the strategy forward.

   5.2. The Trust explained that the five year strategy remains broadly as submitted during our Annual Planning Review (APR) in July 2014; however the Board noted that the strategy was developed in the absence of a firm CCG plan. We remain concerned by the potential misalignment between the Trust and CCG strategies, particularly

with regards to intentions surrounding the Better Care Fund, and we will explore this further during the Q3 monitoring process.

5.3. We expect the 2015/16 APR plan to be aligned and agreed with the Trust's key strategic partners, including the CCG, and will require assurance that this is the case. We are pleased to note that the Trust continues to strengthen its strategic relationships with other providers, such as Countess of Chester and Betsi Cadwaladr.

5.4. The Trust described the implementation of Cerner technology throughout the hospital, with the ultimate aim of the Trust becoming paperless in the future. The Trust reported that the Cerner system aims to improve clinical quality by analysing clinical and performance data to drive improvements and by releasing staff time previously spent completing administrative tasks. We were pleased to be shown the Cerner system in operation at the Trust, and saw a positive level of staff engagement in the technology programme.

6. **Financial Governance**

6.1. The KPMG financial governance report highlighted a number of areas for development which the Board stated it is taking action on. We expect the Trust to continue to deliver the required actions at pace.

6.2. At Month 8 the Trust is behind plan, reporting a deficit of £4.736m against a planned deficit of £4.061m. The Trust assured Monitor at the meeting that it still believed the position would return to plan by the year end; however we continue to have some concerns about the feasibility of this. At Q3 we will seek to understand how the Board has assured itself that a return to plan is realistic, particularly given the challenging back-loaded 2014/15 CIP target.

6.3. Performance against the CIP programme has been behind plan throughout the year and we have concerns that the full-year CIP target will not be achieved. The Trust explained that the pace of delivery is forecast to increase in the final quarter – we will continue to monitor this closely through our monthly discussions with the Chief Executive and Finance Director, and expect the Board to fully consider mitigations that will reduce the impact of non-achievement of CIP on the financial position.

7. **Operational Performance**

7.1. We acknowledge that A&E performance is challenging for all providers at present and are pleased that the Trust has been working with partners across the local health economy to develop and implement the Wirral Health and Social Care Community Urgent Care Recovery plan.

7.2. Performance against the target remains a challenge and Monitor will continue, where appropriate, to raise relevant local health economy issues with the North Tripartite. We expect the Trust to continue to drive the initiatives described to us in the meeting, such as discharge to assess and ambulatory care; and to raise wider LHE issues at SRG meetings.

We were pleased to have been shown around the Trust's Emergency Department and Assessment Units and would like to thank the Board and the staff for taking the time to provide a tour of the facilities

8. **Next Steps**

8.1. The Trust continues to report a Continuity of Service Risk Rating of 2 and we will continue monthly financial monitoring. We may require additional assurances from the Board as to how the financial position will be improved.

8.2. As previously discussed, we made the decision not to open an investigation into the Trust at Q2; however we will reassess this position, using the Risk Assessment Framework, at Q3. If the Trust is unable to demonstrate an improvement in the Trust's financial position (as outlined to us), or if further financial governance concerns arise, we may also consider the need for an investigation outside of the quarterly monitoring cycle.

8.3. If you have any queries in relation to the above, please contact me on 020 3747 0352 or tania.openshaw@monitor.gov.uk or Gill Gibson in the first instance on 020 3747 0608 or gill.gibson@monitor.gov.uk.

Yours Sincerely,

Tania Openshaw

Senior Regional Manager

cc. David Allison, Chief Executive

Board of Directors		
Agenda Item	6.1	
Title of Report	Annual Plan – Update and Agreement of Annual Objectives 2015/16	
Date of Meeting	28 January 2015	
Author	Anthony Hassall, Director of Strategic and Organisational Development	
Accountable Executive	Anthony Hassall, Director of Strategic and Organisational Development	
FOI status	Document may be disclosed in full	
BAF Reference	All items of the BAF are relevant	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	**Board confirmation** For approval

Locally Focused; Regionally Significant – Strategic milestones, Annual Objectives for 2015/16 and development of Annual Operational Plan

1. Introduction

1.1 As part of Board discussions following the agreement of the Locally Focused; Regionally Significant strategy to 2018, it was agreed that each strategic objective should have specific, measurable targets associated with them, to ensure that the Board had a clear line of sight that the Trust was moving in an incremental way towards the delivery of these objectives. These were agreed in January 2014.

1.2 In December 2014 both NHS England and Monitor have published significant guidance on the production of Operational Plans for 2015/16.

1.3 It is a core requirement of all high performing organisations to have robust and responsive arrangements in place to generate and monitor delivery of an Annual Plan and local supporting business plans which link to the overall strategic objectives and vision of an organisation.

1.4 This paper will present Annual Objectives for 2015/16 for agreement, which are based on year two of the annual objective trajectory agreed in January 2014 and summarise the requirements and process for the development of the WUTH Operational Annual Plans for submission to Monitor by April 10 2015.

2. Locally Focused; Regionally Significant – Annual Objectives 2015/16 and exception reporting

2.1 In January 2014, the Board agreed a set of strategic objectives and associated annual milestones. These formed the basis of the 2014/15 organisational 'Plan on a Page' and the foundations of the 2014/15 Annual Operational Plan. Progress against these was reviewed in November 2014 as part of a 6 monthly review.

2.2 At the six monthly review a number of objectives were noted as being 'off track' for delivery. Since then, 'Recovery Plans' for metrics associated with attendance, appraisal, readmissions and research studies have been produced and reviewed by the relevant Executive Director.

2.3 In December 2014, the Board received in draft proposed objectives for 2015/16 which had been iterated both on the back of the changes to some data collection and reporting and in year performance issues.

2.4 The 'Plan on a Page' for 2015/16 is presented at **Appendix 1** for approval. Draft objectives have already been circulated in the organisation and on the basis of these objectives are being used to develop Divisional Plans in operational areas.

2.5 Divisional plans will be reviewed at quarterly Strategic Review meetings in January 2015 and are being monitored through the Annual Plan Task and Finish Group which is meeting fortnightly from January 2015 (after having been already meeting three-weekly in November and December 2014.
a) Approve the Annual Objectives for 2015/16
b) Note the publication of NHS E and Monitor guidance on the production of the Operational Plans for submission in April 2015

3. Development of Operational Plans – Monitor requirements

3.1 NHS England and Monitor have now published their guidance on the development of Annual Plans for 2015/16, proposing a significantly different process than in previous years. As summary of the guidance is available at **Appendix 2**.

3.2 In summary, Trusts will have to submit a refreshed Operational Plan for 2015/16 based on assumptions made for that year in 2014/15. In a change from previous years and reflecting wider pressures on the system, a high level draft plan will need to be submitted to Monitor on 27 February 2015 (to be approved at the Board meeting on 25 February 2015 and a final Operational Plan on 10 April 2015 (to be approved at a special Board meeting convened for 8 April 2015). The Operational Plan will need to include a clear link to the Strategic Plan submitted in June 2014 but also address quality priorities, management of operational requirements and financial forecasts.

3.3 Monitor is asking foundation trust boards to make a number of declarations alongside their operational plans.

- **Sustainability.** Monitor expect boards to be able to refresh the declaration of sustainability made in the 2014/15 strategic plans based on the 2015/16 strategic context and expected progress against the strategic agenda over the next two years.
- **Resilience.** Based on the analysis undertaken we would expect boards to be able make a judgement on quality, operational and financial resilience over the next two years, as asserted in the 'Continuity of Services condition 7: Availability of Resources' and 'Interim/planned term support requirements' declarations.

3.4 The Board should note that plans are expected to include demonstration of a high degree of engagement with local health economy partners.

3.5 The Executive Team have agreed an approach to the completion of the Annual Operational Plan to be driven by the Annual Plan Task and Finish Group.

3.6 In order to ensure appropriate engagement from the Governors, an Annual Plan Advisory Committee of a small group of Governors has been established and has already started to meet monthly to consider Governor and Member input into the development of the Annual Operational Plan.

4. Conclusion

4.1 2015/16 is the second year of the delivery of the 'Locally Focused; Regionally Significant' strategy and objectives for this year are presented for approval.

4.2 NHS England and Monitor have now produced their guidance on the development of the plans for 2015/16. Executives have agreed a process for the Operational Plan and regular updates will be brought to the Board Sub Committee structure and to the Board.

5. Recommendations

7.1 The Board is asked to:
a) Approve the Annual Objectives for 2015/16
b) Note the publication of NHS E and Monitor guidance on the production of the Operational Plans for submission in April 2015

Anthony Hassall
Director of Strategic and Organisational Development

January 2015

Appendix 1: WUTH Annual Plan and Corporate Objectives 2015/16

Our Goal

Vision – Locally Focused – Regionally Significant
"We will be the First Choice Healthcare partner to the communities we serve, supporting patients' needs from the home to the provision of regional specialist services"

"Over the next 5 years we will work together to transform our organisation, building on our considerable clinical capabilities, to place our patients and our other customers at the heart of everything we do. We will focus on exceptional customer service which will be delivered through integrated, seamless, continuous pathways of care enabled by innovation and leading edge technology."

What will this mean (Our Strategic Objectives)	What will we do in 2015/6 to move towards this (Our Annual Objectives)
To be the top NHS Hospital Trust in the north west for patient, customer and staff satisfaction	Improved our patient experience to deliver a Friends and Family recommended score of 95% or better Created a strong culture of empowered employees, delivering a Staff Engagement score of 3.59 or better.
Leading on integrated shared pathways of care with primary, community and social care	Worked with partners in Wirral to reduced number of medically fit patients to no more than an average of 40 on the list and reduced readmissions to 7.7% of total admissions, by developing a range of plans to deliver care closer to home
Delivering consistently high quality secondary care services, enhanced through the provision of regional specialist services	Implementation o f our quality improvement strategy to reduce mortality to 80 (HSMR) Ensured that our harm free care score is no lower 95% for each month of the year
Ensuring our people are aligned with our vision	Continued the implementation of our values and behaviours strategy - PROUD - and improved attendance rates to 96.3% and appraisal rates to 91%
Maximising innovation and enabling technologies	Further roll out our Wirral Cerner IT systems including clinical documentation, voice recognition, advanced clinical analytics, such as SEPSIS, readmission alerting and the extension of electronic prescribing beyond the inpatient setting.(HIMMS level 7) To ensure 100% of our research studies achieve their agreed recruitment goals To ensure that 80% of our research studies achieve NHS permission to first patient in their first visit within 30 days
Building on partnering for value	Delivered an increased market share to 86% of Wirral CCG referrals, through engagement with local GPs Continued to developed a range of partnerships with NHS and non NHS providers to secure clinical sustainability, particularly in relation to our regionally significant services
Supported by financial, commercial and operational excellence	Full Compliance with our registration with the Care Quality Commission Registration A Monitor Continuity of Services rating of 2, meaning we have delivered our financial plan A Monitor Green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer.

Appendix 2 – Summary of NHS England and Monitor Guidance on Annual Planning 2015/16

NHS England Annual Planning Guidance – based on the 'Five Year Forward View'

- Over the next year NHS E will co-design a programme of support with a small number of selected areas and organisations that have already made good progress and which are on the cusp of being able to introduce the new care models set out in the *Forward View*. Their goal is to make rapid progress in developing new models of promoting health and wellbeing and providing care that can then be replicated much more easily in future years. Achieving this goal involves structured partnership rather than a top-down, compliance-based approach. So they are extending an open invitation to local and national partner organisations **to put themselves forward by the end of January 2015** to work alongside NHS E in creating and implementing these new prototypes.
- For this planning round NHS organisations are asked to refresh their operational plans for 2015/16 only, based on the common planning assumptions for NHS commissioners and providers agreed by NHS England, Monitor and the TDA andon their local joint health and wellbeing strategies.
- NHS E expect **aligned, realistic activity and financial assumptions between NHS commissioners and providers**, right across the country.
- NHS E will take action to become the first country to **implement at scale a national evidence-based diabetes prevention programme**, based on proven UK and international models, and linked where appropriate to the NHS Health Check.
- All NHS employers should take significant additional actions in 2015/16 to improve the physical and mental health and wellbeing of their staff - for example by providing support to help them keep to a healthy weight, active travel schemes and **ensuring NICE guidance on promoting healthy workplaces** is implemented
- NHS E will work with the Royal College of Midwives and others to develop plans so that, from 2016/17, **tariff-based NHS funding will support the choices women make rather than constrain them and, as a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services**
- NHS E expects NHS employers to lead the way as progressive employers. The introduction from **April 2015 of the first NHS workforce race equality standard** in the NHS contract is a major step to ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve. All NHS employers and their boards must examine themselves against this standard.
- Working with a small initial cohort of sites, NHS E will start by prototyping four different types of care models outlined in the *Forward View*:
    - an ambitious vision of what change they want to achieve to the model of care, in order to meet clear identified needs and preferences of their local population;
    - a record of already having made tangible progress towards new ways of working in 2014;
    - a credible plan to make move at serious pace and make rapid change in 2015;
    - funded local investment in transformation that is already agreed;
    - effective managerial and clinical leadership, and the capacity and capability to succeed;
    - strong, diverse and active delivery partners, such as voluntary and community sector organisations;
    - positive local relationships, for example the support of local commissioners and communities.
- Local organisations or areas wishing to become first cohort sites are asked to **express their interest by Monday 2 February** to the new care models team (england.fiveyearview@nhs.net).
- Next year NHS E will invite UK and international innovators to bid to **develop a small number of test-bed sites to sit alongside and enable new models of care**. These

innovators will work in collaboration—for example, Academic Health Science Networks/Centres in partnership with statutory, voluntary and private sector organisations. They will focus on deploying and evaluating the impact of different technologies and innovations working in combination.

- A **local health economy will have the option, during the year, of coming together as one and inviting in the national bodies for a joined-up conversation about their emerging local system-wide plan.**
- **Commissioners and providers should prioritise the major strategic and operational task of how they will be implementing the urgent and emergency care review**. This will be reinforced in 2015/16 by incentives in both the CCG quality premium and the CQUIN framework for providers.
- **NHS England will complete a review of maternity services** – including perinatal mental health - by autumn 2015
- NHS England has identified tackling **sepsis and acute kidney injury** as two specific clinical priorities for improving patient safety in 2015/16**.** Sepsis and acute kidney infection will therefore form the basis of new national indicators for the 2015/16 commissioning for quality and innovation (CQUIN) incentive framework.
- All **providers of acute care should agree service delivery and improvement plans (SDIPs**) with commissioners, setting out how they will make further progress in 2015/16 to implement at least five of the ten clinical standards for seven day services
- Learning from the experiences of 2014/15, NHS England, Monitor and the TDA will, as part of plan assessment and assurance, require **CCGs and providers to make realistic and aligned assumptions about the likely activity levels for both elective and emergency care**, including diagnostics, necessary to meet demand and delivering waiting times standards. This includes having realistic ambitions for activity diversion initiatives, using past and current performance as a relevant guide alongside future plans. Unless and until it is clear that demand has reduced, NHS E strongly advise system resilience groups not to switch off additional winter capacity for urgent and emergency care.
- Commissioners and providers will need to consider the underlying activity pressures specific to them and to their local health economy and type of provision. This should reflect local demographic pressures (nationally, ONS population projections imply roughly 1.3% activity growth per year due to a growing population and changing age mix) while also considering non-demographic trends (for example, new treatments). At a national level, we might expect the overall activity growth pressure, before application of any demand management reduction, to be around 3% per year.
- Commissioners must confirm the level of activity they wish to commission from providers in the 2015/16 standard contract, whilst providers must clearly understand the level of capacity that they have in order to meet demand in a safe and sustainable way.
- There will also be a **new national CQUIN theme on improving urgent and emergency care** across local health communities, commissioners will select indicators locally from a menu of options;
- NHS England, the TDA and Monitor consider it to be a major failing of a health economy where parties do not manage to reach agreement prior to the start of the financial year, and we therefore expect that robust, good value contracts are signed between commissioners and all major providers by **11 March 2015.**

Monitor Planning Guidance 2015/16

- The 'Five Year Forward View' highlighted that major system changes are required to protect high-quality, sustainable care for patients now and into the future. In this context, Monitor has **two main expectations** of foundation trusts:
    - To address any performance issues engaging appropriately with health system partners. This means meeting operational and financial requirements and having the flexibility and capacity to overcome unexpected short-term difficulties along the way. For ease, we refer to this as **'resilience'**.
    - To put together, deliver and evolve a credible strategy for achieving the required performance levels into the long term. We refer to this as **'sustainability'**.
- Monitor require a **one year operational plan only**, sitting within the context of your overarching strategy:
    - High-level **draft plan** by midday on **27 February 2015**. (3 pages) This major change is a response to the current level of risk in the sector, and the need for early foresight of the potential risks and challenges ahead.
    - **Final detailed plan** by midday on **10 April 2015**. (20 pages)
- In order to encourage the alignment of foundation trusts' plans with those of commissioners we now require foundation trusts to take part in a weekly contract tracker[10]. **Beginning 29 January 2015**, this process will involve Monitor collecting weekly updates from foundation trusts (every Thursday) on the status of their contracts, in order to track their progress and highlight risks of misalignment.
- **20 pages - Establishing strategic context – max. 3 pages; Progress against delivery of the strategy – max. 5 pages; Quality priorities – max. 2 pages; Operational requirements – max. 3 pages; Financial forecasts – max. 7 pages**
- Monitor is asking foundation trust boards to make a number of declarations alongside their operational plans. The narrative should clearly support the declarations and trusts may wish to explicitly reference this:
    - **Sustainability.** Monitor expect boards to be able to refresh the declaration of sustainability made in the 2014/15 strategic plans based on the 2015/16 strategic context and expected progress against the strategic agenda over the next two years.

Resilience. Based on the analysis undertaken we would expect boards to be able make a judgement on quality, operational and financial resilience over the next two years, as asserted in the 'Continuity of Services condition 7: Availability of Resources' and 'Interim/planned term support requirements' declarations

Board of Directors		
Agenda Item	7.1.1	
Title of Report	Integrated Dashboard and Exception Reports	
Date of Meeting	28 January 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 Reference	Risks 1 to 9 and 11 to 14	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	**Board confirmation**

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 December 2014.

2. Background

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

- should focus the Board's attention on the issues they should be focused on, particularly those issues reserved for the Board;
- should enable the Board to monitor the delivery of external regulatory requirements as well as the Trust's longer term strategic goals and importantly to gain assurance that the right conditions are in place to continue to do so;
- should recognise and support the delegation to the Finance Business Performance & Assurance, Audit, and Quality & Safety Committees;
- sets out clear performance targets and where performance fails to meet the required level has a standardised format for providing further information.

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

3. Key Issues

Individual metrics highlighted as Red for December are Friends & Family, A&E 4-Never Events, Infection Control, Attendance, Expenditure, CIP Performance, Non-core Spend, Advancing Quality and CQC concerns. To avoid duplication, exception reports are included in the dashboard for those metrics not covered by separate reports or updates to the Board from the relevant associated Committee.

In the patient satisfaction section the Net Promoter methodology has been replaced nationally with a simpler “Recommend” and “Not recommend” scoring process. The two metrics currently shown on the Dashboard relate to the Trust-wide position across all areas. Consideration may be given whether it is more illustrative in future months to show the rates per patient activity area as per the previous approach.

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

Monitor has confirmed that under the Risk Assessment Framework for 2014-15 the Governance status for WUTH is currently considered to be neither Green nor Red, with some issues identified and described accordingly.

4. Next Steps

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

5. Conclusion

Performance across a range of metrics is provided for information

6. Recommendation

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

WUTH Integrated Performance Dashboard - December 2014

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F "Recommend" Rate			JG	91.0%	December 2014
Patient Satisfaction - F&F "Not Recommend" Rate			JG	3.0%	December 2014
Staff Satisfaction (engagement)			AH	3.64	2013
First Choice Locally & Regionally					
Market Share Wirral			AH	84.6%	April to Aug 2014
Demand Referral Rates			AH	6.6%	Fin Yr-on-Yr to Dec 14
Market Share Non-Wirral			AH	8.6%	April to Aug 2014

Organisational Risk Issues

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Key Performance Indicators					
A&E 4 Hour Standard			SG	92.2%	Q3
RTT 18 Weeks Standards			SG	All met	December 2014
Cancer Waiting Time Standards			SG	All met	Q3 to December 2014
Strategic Objectives					
Delayed Transfers of Care			SG	4	12-mth ave to Nov 2014
Readmissions			EM	8.9%	October 2014
Harm Free Care			EM	95.0%	December 2014
HIMMs Level			MB	5	December 2014
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	1	December 2014
Complaints			JG	36.3	12-mth ave to Nov 2014
Infection Control			JG	1 MRSA; 0 C diff	December 2014
Productivity					
Bed Occupancy			SG	91.5%	December 2014
Theatre Utilisation			SG	67.4%	December 2014
DNA Rate			SG	8.8%	April to December 2014
Workforce					
Attendance			AH	95.1%	12-mth ave to Dec 2014
Qualified Nurse Vacancies			AH	4.9%	December 2014
Mandatory Training			AH	97.4%	December 2014
Appraisal			AH	83.0%	December 2014
Turnover			AH	10.0%	December 2014
Finance					
Contract Performance			AM	1.2%	To M9 December 2014
Expenditure Performance			AM	-1.9%	To M9 December 2014
CIP Performance			AM	-24.3%	To M9 December 2014
Capital Programme			AM	-11.6%	To M9 December 2014
Non-Core Spend			AM	8.6%	To M9 December 2014

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	3 areas below target	October 2014
Mortality: HSMR			EM	87.7 (low ci 80.08)	April to Aug 2014
Mortality: SHMI			EM	1.04 (low ci 0.89)	Jan to Dec 2013
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	To M9 December 2014
Monitor Risk Rating - Governance			SG	Not Green or Red	To M9 December 2014
CQC			EM	5	December 2014
Local View					
Commissioning - Contract KPIs			SG	4	December 2014
Commissioning - CQUINS			EM	tbc	tbc
Education			AH	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F "Recommend" Rate	Patient Satisfaction - Friends & Family "Recommend" Rate for Trust	>=95%	n/a	<95%
Patient Satisfaction - F&F "Not Recommend" Rate	Patient Satisfaction - Friends & Family "Not Recommend" Rate for Trust	<=2%	n/a	>2%
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG GP Referred New OP Activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

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

A Healthy Organisation

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

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

External Validation

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

WUTH Performance Dashboard Exception Report December 2014

Indicator :
Friends & Family - Recommend / Not Recommend

Rating	Target	Actual	Period
Red	>95% and <2%	91.0% and 3.0%	Dec 2014

Issue:

The national measures of the Friends and Family Test have changed form the previous Net Promoter score to more simple 'Recommend' and 'Not Recommend' measures. The performance thresholds have been set at a minimum 95% for Recommend, and less than 2% for Not Recommend. For December the performance was 91.0% for Recommend, and 3.0% for Not Recommend - so both measures did not achieve the standards.

Historic data:

Proposed Actions:

Performance was discussed at the Q&S Committee on the 14th January, and at the DIvisional Performance reviews on 20th January. Divisions are targettting actions on wards & units that are underperforming. A key element for some areas will be to increase the response rates, which in itself willl result in improved performance

Assessing Improvement:

Performance is monitored via regular reporting at department and ward level to Clinical Governance Group and at the monthly Divisional Performance Reviews, with Q&S Committee also receiving updates.

Impact:

Key measures of patient satisfaction with our clinical services. The metrics provide internal focus on areas for improvement, and are an external view available in the public domain on the perceived quality of WUTH services.

Expected date of performance delivery:

Ongoing

Director approval:

Jill Galvani, Direictor of Nursing and Midwifery

WUTH Performance Dashboard Exception Report — **December 2014**

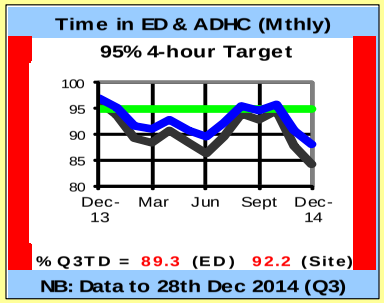
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	92.2%	Q3 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for December was 87.99%, including the All Day Health Centre at Arrowe Park site. For WUTH alone perfoprmance was 84.14%. The full Q3 position was confirmed at 92.24% and so below the 95% threshold target.

Historic data:



Proposed Actions:

The start of Quarter 4 has seen a significant increase in the non-elective pressures felt by the Trust. In January the hospital had the highest number of non-elective medical admissions ever and the UK has seen the worst weekly Emergency Department (ED) performance since the commencement of weekly reporting. Following effective communication strategies there been a reduction of inappropriate ED attendances. Whilst positive, this makes it more difficult to achieve the target as the patients who are attending generally require more time and attention.

The acuity of the patients presenting at the ED has increased significantly, placing immense pressure within ED and on patient flow. This is also present in ambulance conveyances with Wirral receiving some of the highest number of ambulance attendances within the region. Expected average ambulance arrivals are circa 80 per day, in January the hospital saw days where ambulance presentations have been over 140 patients directly to the ED.

The Acute Medicine department have been over the last 4 months adapting the way they provide consultant level review. From December every patient, both ED and GP admissions are now seen by an acute physician before admission to the main hospital. WUTH is one of the few Trusts that provide such an enhanced timely senior medical review. The Trust has seen a month on month increase in the number of patients discharged directly from Acute Medicine; December 2014 saw 60% of patients discharged by our Acute Medicine Team.

The schemes in place across the economy have assisted in mitigating the impact of the significant spikes in admissions and acuity. However, further work is required around the implementation of Discharge to Assess as the number of medically fit patients in the hospital regularly exceeds 50 and although lower than many other hospitals it is still higher than the 20-30 assumed in the winter plan. This has been raised at the System Resilience Group and is an acknowledged major area of focus for the group.

Assessing Improvement:

The current performance is 84.22% and discussions are ongoing with the health economy to agree a reforecast position for the quarter, but given the extremely poor start to the quarter and the various infection issues which adversely affect patient flow it is unlikely that the Trust will achieve this target in Q4. Monitor has been appraised of the situation.

Impact:

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

Expected date of performance delivery:

Quarter 1 in 2015/16

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report December 2014

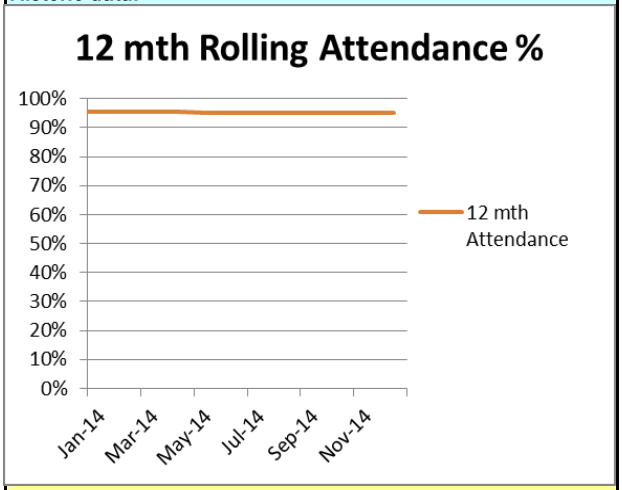
Indicator :
Attendance

Rating	Target	Actual	Period
Red	>= 96%	95.10%	Jan 14 - Dec 14

Issue:

Attendance (12 months rolling) was 95.10% at December 2014 and therefore below the Trust target of 96%. Urgent actions as detailed below are taking place to address this. The majority of sickness days lost are long term anfd there is a focus on this. The new Attendance Capability policy goes live on 19th January 2015 and has additional measures aimed at reducing long term absence.

Historic data:



Proposed Actions:

Sickness absence training to be delivered to 300+ managers in January 2015. New policy to go live, Validate data, Review staff on long term sick, Audit policy compliance, Health and Wellbeing Strategy, Detailed Monthly reporting and drill down, Monthly workforce meetings (HR Managers and line managers), Individual action plans for poor attenders, Self-care scheme, Comprehensive Occupational Health Service.

Assessing Improvement:

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

Impact:

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

Expected date of performance delivery:

Q1 of 2015/16

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report — **December 2014**

Indicator :
Expenditure

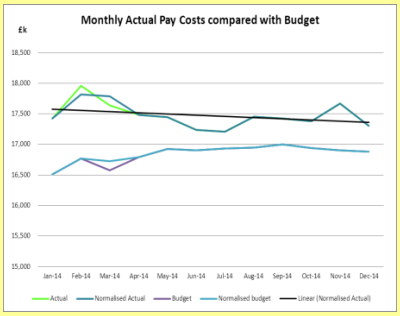
Rating	Target	Actual	Period
Red	On Plan	-1.9%	To M9

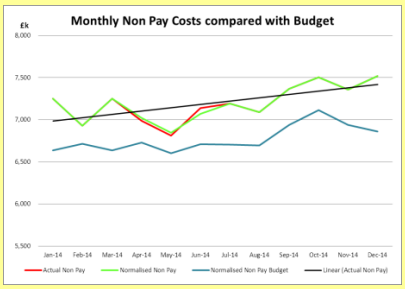
Issue:

The underlying operational expenditure is £1085k overspent in month against plan, £423k on pay and £662k on non pay. There has been no improvement this month on the underlying operational performance and in fact a deterioration driven by further operational issues which include the opening of unplanned capacity (Trust CPE cohort ward and Ward 25) to manage non-elective demand together with the impact of bed pressures on elective capacity. The pressure on medical beds is driven by increased GP referrals, acuity of patients and delayed discharges and has been mitigated by increasing the bed base supported by non recurrent urgent care monies . In addition sickness rates for December were high further impacting on pay costs as well as premium costs incurred to deliver planned activity.

The total pay spend for December was £17.3m, which is broadly consistent with previous months and shows a decreasing trendline, although June /July were lower and November exceptionally spiked due to catch up of RTT costs which were offset in NHS clinical income/some planned Cerner implementation costs and pay arrears for the clinical excellence awards. Overall the actual pay costs is continuing to run at a relatively constant £0.4m/0.5m gap to plan.
The total non pay spend is £7.5m in December compared with £7.3m last month and shows some exceptional items relating to Cerner implementation costs.

Historic data:





Proposed Actions:

Divisional performance reviews both with the Director of Finance and the Executive team are continuing to monitor financial performance. A clear message has been provided within the organisation, emphasising the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs. The following actions are to be applied across the organisation:
-There is a cessation of all non-essential expenditure;
- Where possible necessary expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
- the generation and delivery of further ideas in closing the financial gap must continue through the current year and into the new financial year.
The Trust has appointed a Turnaround Director, supplemented by additional resource from FTI to assist in improving the financial performance.

Assessing Improvement:

The divisional reviews continue to assess performance on a monthly basis and any mitigation plans are constantly considered.
A Turnaround Director has been appointed supplemented by additional resource from FTI to identify and implement the generation/delivery of further ideas to improve /recover the financial position and achieve financial sustainability.

Impact:

Overspending against the expenditure financial plans will put at risk the financial sustainability of the Trust for 2014/15 and beyond and have a significant impact on liquidity.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report December 2014

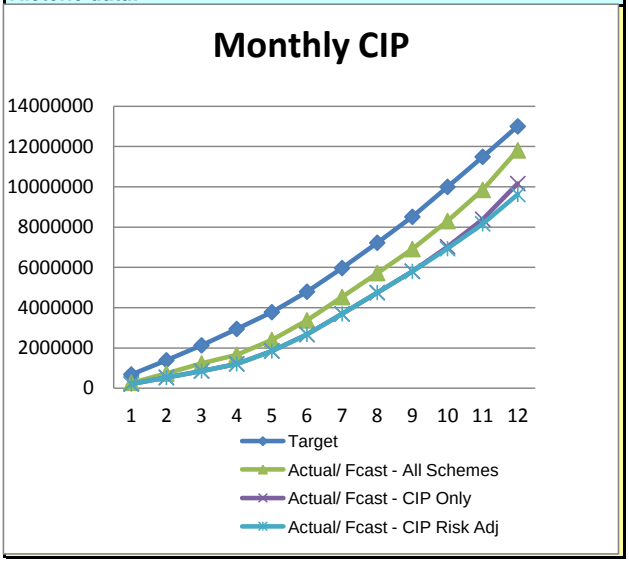
Indicator :
CIP

Rating	Target	Actual	Period
Red	On Plan	-24.30%	To M9

Issue:

As at month 9 44.6% of the in year CIP Target has been delivered with a further 33.5% forecast to be delivered in the next 3 months, leaving a remaining gap of £2.8m. The step up required to achieve the forecast plans and the requirement to find schemes to fill the gap remains a challenge. Work continues to find new recurrent schemes to close the 2014/15 gap as well as identify non recurrent savings wherever possible. However the lead time needed for savings to be realised means that most schemes currently being worked on will not deliver savings until 2015/16.

Historic data:



Proposed Actions:

The Transformation Steering Group continue to meet on a weekly basis and the Trust has now appointed both a full time and a part time temporary turnaround advisor to the Board. Work streams for 2015/16 have been revised and a process is currently ongoing to appoint workstream leads. The larger more complex workstream will have full time dedicated posts focused on comprehensive planning and delivery of transformational change. All will have a workstream sponsor and a designated clinical lead. A revised and strengthened PMO structure will also be in place with dedicated PMO managers that will provide business intelligence to the organisation and have a purely governance focus.

Assessing Improvement:

The Transformation Steering Group will continue to monitor progress of the 2014/15 delivery and further development of the plans on a regular basis. This will be strengthened by the revised structure for both the PMO and the work streams with more dedicated and focused resource together with greater clinical engagement.

Impact:

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

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report **December 2014**

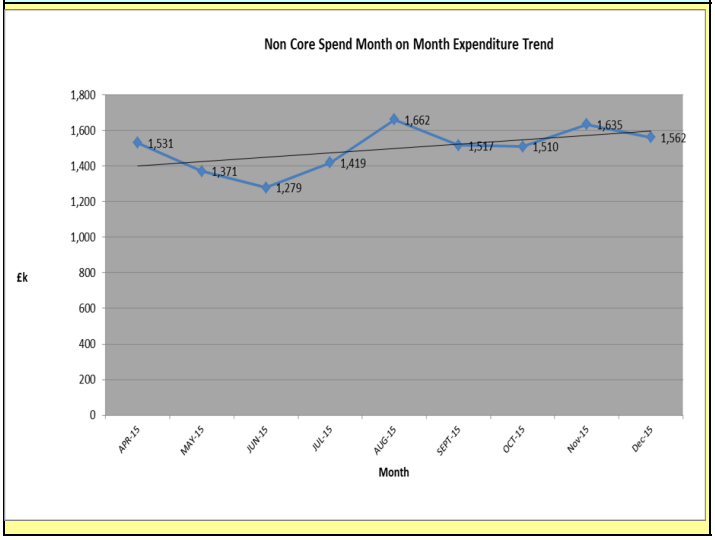
Indicator :
Non Core Pay Spend

Rating	Target	Actual	Period
Red	<5%	8.6%	To M9

Issue:

In December 2014 £1.5m has been spent on non core pay categories. This represents 8.6% of the total pay expenditure in December. From a divisional perspective both the clinical divisions show relatively high spend with the Medicine and Acute division at 12.6% and Surgery/ Women & Childrens at 8.1%. This has been steady over the last four months excluding the spike last month which included catch ups in RTT which is offset in income. Clinical Support division is at 6.3%. All three Divisions are rated as red against the target of 5%.
The operational issues requiring non core pay categoeies to be utilised are locum spend ED for target support, vacancy cover/recruitment issues, sickness cover and staffing the additional beds for the unplanned capacity.

Historic data:



Proposed Actions:

The Workforce Strategy is focused on primarily using core pay spend however from a financial perspective the use of bank has a limited financial impact and allows staffing flexibility.
Continuation of tight control of Non-Core spend will continue in 2014/15 particularly around the impact of premium rates.
Targeted actions are in place to reduce sickness absence and for vacancy control to be managed effectively. WLI rates (change from procedure rates to sessional rates) have been implemented for 2014/15.

Assessing Improvement:

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

Impact:

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

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report December 2014

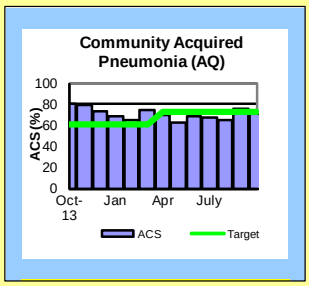
Indicator :
Advancing Quality

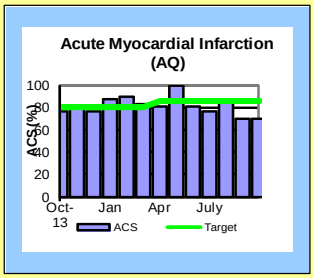
Rating	Target	Actual	Period
Red	All achieving	3 areas under target	October 2014

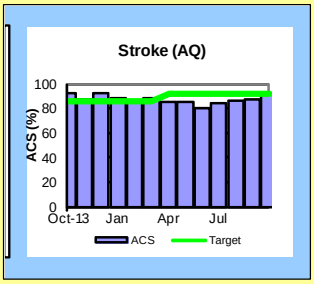
Issue:

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

Historic data:







Proposed Actions:

AMI - There was no resource to cover data capture for AMI over Sept and Oct; this has now been rectified. The expectation is that November data will reflect the work undertaken to improve rehabilitation referrals and smoking cessation advice. The new auditor is trying to support real-time data collection; however as they are learning how to complete the MINAP audit tool this is challenging. It is still possible to achieve the end of year target for this focus group. YTD performance 80.9%

CAP there was significant improvement in the October figures with 83.1% receiving appropriate care; this has been above the target for the last 2 months. Additional campaigns were run in November and early indications are performance has improved again. YTD performance 68.3% and provided similar improvements occur over the next five months the target can be reached.

STROKE whilst the monthly attainment was 91.9%, the YTD remains substantially below target at 85.8%. The key measure is access to a stroke unit bed and therefore is highly dependent on the flow of patients within the hospital. We are unlikely to meet the target set as this would require almost perfect care for the next 5 months.

Assessing Improvement:

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

Impact:

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

Expected date of performance delivery:

Improvement ongoing through 2014-15

Executive approval:

Evan Moore, Medical Director

Board of Directors		
Agenda Item	7.1.2	
Title of Report	Month 9 Finance Report	
Date of Meeting	28 January 2015	
Author	Jim Davies, Deputy Director of Finance	
Accountable Executive	Alistair Mulvey, Director of Finance	
FOI status	Document may be disclosed in full	
BAF Reference	13	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	**Board confirmation**

1. Executive Summary

Income and Expenditure Position
The planned income and expenditure position for Month 9 is an in month deficit of £187k. Against this plan, an actual deficit of £479k was delivered, resulting in an adverse variance of £292k in month.

The cumulative position for the first 9 months shows a cumulative deficit of £5,215k against a planned deficit of £4,248k; this represents an adverse variance against plan of £967k. This now means that in order for the Trust to operate within its plan for the year – which is a deficit of £4.2m, it will be necessary for there to be no further deterioration in the position for the remaining months of the year; and furthermore that the adverse variance reported in the first 9 months is recovered. Thus in months 10 to 12, which were planned to breakeven across the three month period, it will be necessary for the Trust to deliver a surplus of circa £1m in order to achieve the full year planned position.

In overall terms NHS Clinical income is above plan for December, which includes non-recurrent increases in income from commissioners to support urgent care / system resilience, together with associated costs to support delivery.

A clear message, through the Chief Executive Forum, has been provided – which outlines the importance of delivering the best possible year end outturn position, and that this will require that there is no further deterioration to the cumulative position; and further that the position is improved to bring it back as close as

possible to the planned position. Key messages delivered within the organisation outline the need that;

- There is a cessation of all non-essential expenditure;
- Where possible necessary expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
- The generation and delivery of further ideas to close the financial gap this year and into the new financial year

Delivery of the above remains challenging with the pressures seen not only within WUTH but across the country through December and into January with increasing pressures on urgent care services within both A & E and in-patient beds.

Cash Position & Continuity of Service Ratios (COS)
The cash position is £15.0m, £11.7m better than plan, this is largely due to:

- Increase in net of trade creditors and trade debtors, including specific cash management actions;
- Payments received early (ahead of terms);
- Capital spend below plan;
- Draw down of loan;
- Positive movements offset by delayed sale of Springview and adverse income & expenditure position.

The overall Continuity of Service rating at month 9 is a 2, which is in line with the planned COS rating. However the metrics which underpin the overall rating have been weakened by the adverse income & expenditure performance. The year-end CoS continues to be forecast to be a 2.

The headline financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 9 2014/15 (DEC)							Comparative 2013/14 Position (Month 9)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	24,964	25,100	136	223,756	226,811	3,055	222,831	222,226	(605)
Employee Expenses	(16,878)	(17,301)	(423)	(152,211)	(156,596)	(4,385)	(144,412)	(153,769)	(9,357)
All Other Operational Expenses	(6,859)	(7,521)	(662)	(61,296)	(64,975)	(3,679)	(56,256)	(60,898)	(4,642)
Reserves	(256)	244	500	(4,258)	(583)	3,675	(10,318)	(626)	9,692
EBITDA	971	522	(449)	5,991	4,657	(1,334)	11,845	6,933	(4,912)
Post EBITDA Items	(1,158)	(1,001)	157	(10,239)	(9,872)	367	(9,485)	(9,483)	2
Net Surplus/(Deficit)	(187)	(479)	(292)	(4,248)	(5,215)	(967)	2,360	(2,550)	(4,910)
EBITDA %	3.9%	2.1%	(1.8%)	2.7%	2.1%	(0.6%)	5.3%	3.1%	(2.2%)
CIP as % Op Expense	5.4%	4.3%	(1.1%)	3.9%	2.6%	(1.3%)	5.7%	2.6%	(3.1%)

Cost Improvement Programme (CIP)

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

As at month 9 schemes have delivered £5.8m of the full year forecast, leaving £4.3m to be delivered in the remaining 3 months, a total of £10.2m in year. There are however a number of risks associated with this not least the fact that of the remaining £4.3m, £1.1m relates to schemes which have not yet started, the risk rating process takes account of this and any other risks resulting in a net risk adjusted forecast of £9.6m

Month 9 CIP Position

	YTD			Full Year Forecast			Recurrent Forecast		
£k	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Exec Lead									
Sharon Gilligan	626	1,276	(650)	1,444	1,950	(506)	3,946	2,600	1,346
Jill Galvani	318	834	(517)	549	1,275	(726)	1,183	1,700	(517)
Alistair Mulvey	831	1,571	(740)	1,447	2,400	(953)	2,271	3,200	(929)
Mark Blakeman	1,103	1,865	(762)	2,164	2,850	(686)	3,721	3,800	(79)
Anthony Hassall	1,951	1,783	167	2,866	2,725	141	3,196	6,300	(3,104)
Evan Moore	975	1,178	(203)	1,687	1,800	(113)	2,756	2,400	356
TOTAL	**5,804**	**8,508**	**(2,704)**	**10,159**	**13,000**	**(2,841)**	**17,073**	**20,000**	**(2,927)**
Division									
Medicine & Acute	1,487	2,356	(869)	2,747	3,600	(853)	5,419	5,500	(81)
Surgery, W&C	2,382	3,040	(658)	3,720	4,700	(980)	4,801	7,200	(2,399)
Clinical Support - AF	118	704	(585)	246	1,000	(754)	610	1,500	(890)
Clinical Support - MW	323	946	(624)	786	1,500	(714)	1,817	2,300	(483)
Corporate Support	1,494	1,462	31	2,659	2,200	459	4,425	3,500	925
TOTAL	**5,804**	**8,508**	**(2,704)**	**10,159**	**13,000**	**(2,841)**	**17,073**	**20,000**	**(2,927)**

2. Background

The Trust began the year with a deficit plan of £4.2m, which provided a risk rating of 2. The position for the first 9 months of the year translates into;

- a planned deficit of £4.2m, against which an actual deficit of £5.2m has been delivered (£1.0m adverse variance); and
- A COS rating of 2 in line with the planned COS rating of 2, although the metrics which underpin the overall rating have been weakened by the adverse income & expenditure performance.

The cash position is £15.0m, £11.7m better than plan; this is largely due to early settlement of debtors, delays in the payment of creditors, slippage in the capital programme, specific actions taken to improve cash management and the draw down of the loan. The positive variance in cash balances is offset in part by the poor income and expenditure position, and the delay in the sale of Springview.

3. Key Issues

The Trust has a cumulative deficit of £5.2m at Month 9 against a plan of £4.2m; this position is not sustainable going forward. The Trust has continued to work closely in order to assist in improving the financial performance and in embedding deeper transformational change.

For the Trust to achieve its plan for the year it will be necessary for there to be no further deterioration in the position for the remaining months of the year; and furthermore that the adverse variance of £1m reported in the first 9 months is recovered in the final three months of the financial year.

Divisional Analysis

The following table shows the summary Divisional position (cumulative to Month 9). The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail (attached to this document).

Detail	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Corporate £000	Central £000	Total £000
NHS Clinical Income						
Planned Income	85,875	100,310	11,090	650	4,442	202,367
Actual Income	88,899	98,529	11,917	580	4,896	204,821
Variance	3,024	(1,782)	827	(70)	454	2,454
Net Expenditure						
Planned Expenditure	59,243	71,880	27,143	24,905	13,205	196,376
Actual Expenditure	62,417	74,860	28,035	24,873	9,979	200,164
Variance	(3,174)	(2,980)	(892)	32	3,226	(3,788)
Variance EBITDA	(150)	(4,762)	(65)	(38)	3,680	(1,334)
Post EBITDA						
Planned Post EBITDA					10,239	10,239
Actual Post EBITDA					9,872	9,872
Variance	0	0	0	0	367	367
Total Variance to Plan	(150)	(4,762)	(65)	(38)	4,047	(967)

Pay Analysis

The most significant area of expenditure for the Trust, relates to pay. The total pay spend for December was £17.3m, which is lower than the position for November and the average for the year – but still higher than the budgeted level of spend. The following figure provides further detail of the monthly and cumulative position in the year to date, and also splits expenditure between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	April £000	May £000	June £000	July £000	August £000	September £000	October £000	November £000	December £000	YTD £000
Budget	**16,789**	**16,922**	**16,901**	**16,933**	**16,944**	**16,999**	**16,943**	**16,902**	**16,878**	**152,211**
Pay Costs										
Permanent	15,950	16,081	15,944	15,776	15,785	15,897	15,870	16,034	15,740	143,077
Bank Staff	299	326	297	355	347	342	330	350	305	2,951
Agency Staff	318	357	311	379	537	449	504	590	474	3,919
Overtime	318	208	209	162	174	229	195	203	281	1,979
Locum	418	336	301	374	435	380	339	344	381	3,308
WLI (In Year)	180	138	170	164	171	125	143	149	120	1,360
Total	**17,484**	**17,444**	**17,234**	**17,210**	**17,449**	**17,422**	**17,381**	**17,670**	**17,301**	**156,596**
Variance	**(695)**	**(522)**	**(333)**	**(277)**	**(505)**	**(423)**	**(438)**	**(768)**	**(423)**	**(4,385)**

4. Next Steps

The Trust has continued to work closely with external support partners in order to assist in improving the financial performance and in embedding deeper transformational change. The financial performances of the divisions are being closely monitored through the monthly performance review process. A clear message has been provided within the organisation, emphasing the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs. Discussions with commissioners to agree year end contractual positions to minimize income risk are well advanced and progress, albeit slower than anticipated, is being made on the sale of Springview to ensure that this is concluded in the current financial year in line with plan.

5. Conclusion

The in month position shows a deficit of £479k, against a planned deficit of £187k, resulting in an adverse variance of £292k. The year to date position shows a deficit of £5,215k, which is £967k worse than planned. In order for the Trust to operate within its plan it will be necessary that the position does not deteriorate any further in the remaining months of the year; and furthermore that the Trust recovers the adverse performance for the first 9 months of the year in the remaining three months of the year. A clear message has been provided within the organisation as to the importance of delivering against activity plans, and in controlling and minimising costs and actions with external partners, commissioners and other providers, are in place to deliver an outturn position aligned to plan although in achieving this c£1m of risk continues to exist within forecasts.

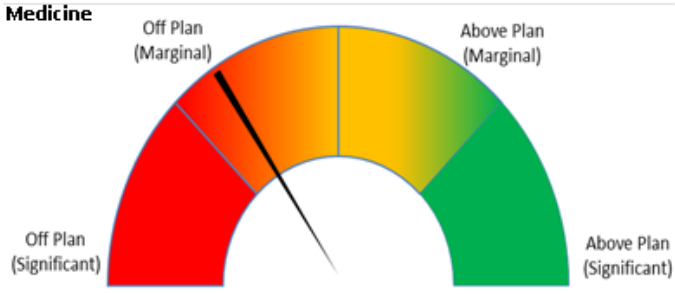
6. Recommendations

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

Alistair Mulvey
Director of Finance
January 2015

Divisional Overview (Month 9)

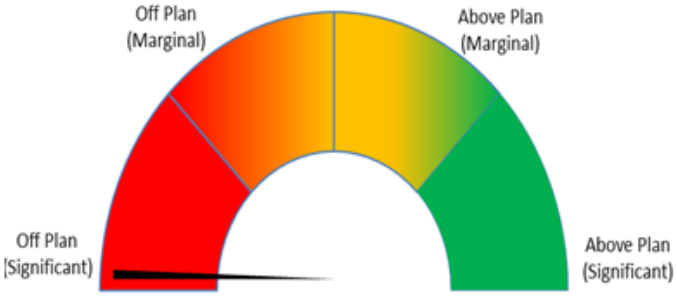
Medicine



Medicine - Key issues

- ***Clinical Income over plan by £3.0m.***
- ***Net Expenditure exceeds budget by £3.2m .***
- ***Overall position is £0.2m off plan.***

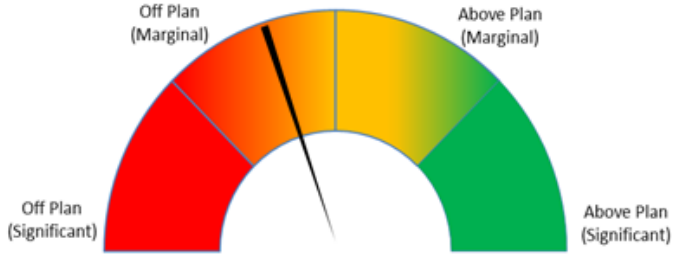
Surgery / W&C



Surgery / W&C - Key issues

- ***Clinical Income behind plan by £1.8m.***
- ***Net Expenditure exceeds budget by £3.0m.***
- ***Overall position £4.8m off plan.***

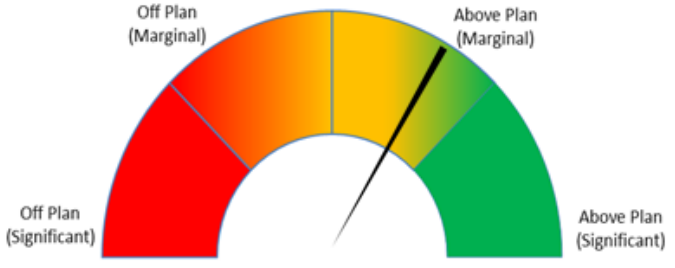
Clinical Support



Clinical Support - Key issues

- ***Clinical Income over plan by £0.8m—additional activity.***
- ***Net Expenditure exceeds budget by £0.9m.***
- ***Overall position £0.1m off plan.***

Corporate



Corporate - Key issues

- ***Divisional income below plan by £0.3m.***
- ***Expenditure under spent by £0.3m .***
- ***Overall position on plan.***

To note: Corporate dial above excludes Hotel Services.

Medicine & Acute I&E

The division reported a £1k deficit in month 9, and has resulted in the cumulative position having a deficit against plan of £150k. A concern for the forthcoming months is the level of acuity of patients attending A&E and the increase in referrals from GP's which has had a resulting pressure on beds. The acuity of patients within the Divisional beds has also created pressure on Social Services and this has also contributed to the pressures on beds as Medical fit patients are staying longer than is required.

Clinical Income within the division is over achieving by c£3.0m, the main drivers of this include additional volumes of activity within planned care work streams both out-patients and in-patient care (£280k and £772k respectively relating to 930 out-patient and 1,747 in-patients) and increased volumes of patients from a non elective care perspective. Non elective activity (net of re-admissions) has over performed against plan by 1,261 patients equating to £1,985k. The Division in December has increased its bed base due to the increased level of admissions. However, Emergency Department attendances are up against plan by 156, but due to penalties imposed relating to the 4-hour breaches, the net income position for ED is down against plan by £737k. The Division has had the benefit of non recurrent Urgent Care/Winter monies of £1.3m.

The costs of service delivery have exceeded the planned budget by £3.2m. The most significant element of pressure relates to staff costs, c£2.7m with the balance being slippage against CIP plans and over spending against clinical supplies.

From a pay perspective, the cumulative deficit relates to :-

- ED staffing, £0.7m - the current level of overspending has reduced per month as expected rather than the previous £100k per month. The excess costs which will persist relate to the use of temporary / locum staff whilst awaiting substantive staff to be appointed. The department has, in the last month appointed another substantive consultant which reduces the current consultant gap to two wtes.
- Gastro currently has overspending of c£0.7m as locum staff are required to fulfill vacant posts. It should be noted that the current over recovery of income within gastro is c£0.3m and therefore partially off sets these costs. Recruitment processes are underway to fill posts substantively. However, the over-recovery of income is not expected to continue as the speciality planned activity assumptions increase significantly in the latter part of the financial year and there will be additional gaps due to Nurse Endoscopists having recently left.
- Nursing costs – nursing budgets are currently £1.3m overspending, key areas of this are:-
  - £0.6m relates to staffing of additional beds opened and for the recent months additional bed pressure spend is offset by the additional income received via Urgent Care/Winter monies.
  - £0.3m relates to staff sickness cover. Sickness levels were at 5.6% at their height in 14/15 and through a programme of work have been reduced to under 4% in September
  - £0.4m relates to the provision of additional staff for Specialing of patients as a function of their acuity needs. A revised process of agreement for the use of additional staff has been implemented and seen favourable financial results in the recent months although is likely to remain a pressure moving forwards.

Pressures through non pay subjective lines include variable costs associated with clinical supplies of c£0.6m which are in the main driven by over performance for activity and therefore covered by income secured. To ensure controls and best practice processes for ordering goods is in place the divisional teams are working closely with procurement colleagues.

The division continues to work closely with the PMO and the Turnaround team to maximize delivery of CIP. Whilst the division is confident that it will achieve its target on a recurrent basis, in year the division is facing a c£869k year to date pressure, which includes slippage on income schemes not being realised. All efforts continue to be focused on bridging the in year gap.

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

The divisions overall financial position deteriorated in month 9 by £417k generating a cumulative year to date deficit of £4.76m. Within the overall deficit position expenditure variances are £2.98m year to date deterioration in month of £384k and income under performance is currently £1.78m of which £33k was in month. Theatres & Anaesthetics has transferred back to the Division and represents £132k of the in-month deficit and £1,277k of the cumulative deficit.

The key cumulative drivers of the overall year to date expenditure variance of £2.98m include:

- £268k to support additional bed capacity, of which £108k relates to the provision of the Trust CPE cohort ward and £160k due to the additional unfunded Ward (25) that has been open.
- £450k relates to Non-PBR excluded devices and high cost drugs, which are pass through costs and attract additional income;
- £723k relates to Park Suite underperformance and operational overspends, against which there is strategic agreement to identify a different PP provision, this will be supplemented with in year price changes where available. Agreement was reached at the beginning of the year that whilst this service sat within the Surgical division any associated pressure would be centrally managed;
- £685k of CIP underperformance and
- £692k expenditure to deliver the additional RTT work which is funded by NHS England.

The above costs, which reflect the cumulative position, were also incurred on a proportionate basis in month 9.

From an income perspective the division has a cumulative under performance of £1,782k of which £33k was in month 9.

Whilst there are variations in income across several points of delivery and specialties the key feature within the division both cumulatively and in month relates to Orthopaedic activity. Year to date Orthopaedics is £1,533k behind its elective plan which includes £189k in Month 9. However, there has been additional work done from Wales in T&O which offset this under performance equating to £288k. The division has also seen year to date under performance against neonatal activity of £282k. Favourable variances, most notably against RTT income and income streams associated with Wales go some way to mitigate these gross income pressures.

The division continues to scrutinise the detail of the orthopaedic position from both a retrospective and prospective perspective increasingly focusing on a daily and weekly basis on the volume of operations booked to ensure slots are filled and resource utilisation maximised and available capacity used for alternative services where appropriate.

Whilst the overall divisional position remains significantly challenging the focus has been and continues to be on:-

- Minimising costs where possible with engagement and support with the PMO and more recently FTI who are specifically supporting changes within theatre use and utilisation;
- Exploring, with success, new markets for the provision of services, specifically within north Wales and potential collaboration with Chester;
- Delivering additional RTT volumes where possible to underpin loss of core income; and
- Ensuring prospective systems are in place for the booking of patients to allow the divisional management teams can support the maximisation of use of clinics and available in-patient resources

Clinical Support

The newly combined Division includes Radiology, Pathology, Outpatients, Therapies, Patient Flow and Cancer. The Division reported a slight overspend of £65k year to date at month 9 with an adverse movement of £139k in month, (although £41k better than forecast).

Year to date Therapies remains under spent by £131k, Outpatients £97k, Cancer £15k, and Patient Flow by £13k, Radiology is slightly overspent by £16k and pathology £511k.

From an income perspective the Division is performing well and is £827k ahead of plan YTD, this is largely driven by Radiology with unbudgeted unbundled imaging income of £176k ytd and direct access income ahead of plan by £560k - Radiology DA has experienced a 20% increase in activity with high demand continuing in areas such as Ultrasound and Plain Film. Both AHPs & Pathology are performing slightly ahead of plan (YTD £23k and £69k respectively); again this is largely driven by direct access performance but there is some volatility in demand in these areas leading to some caution around future volumes. Whilst these income gains generate a contribution there is an affordability risk across the economy if these levels of diagnostic demand continue.

The Division is reporting an overall underspend on pay of £376k YTD with only Radiology and Patient Flow showing a cumulative over spend. Outpatients and Therapies are underspent £140k and £204k respectively. The Division is holding vacancies as it progresses its staffing restructure proposals in consultation with staff side colleagues in all areas. These savings partially offsetting additional costs associated with the delivery of excess direct access activities.

Non pay budgets are £854k overspent year to date but this is offset by £472k in associated income. Pathology non pay overspend is £453k offset by £172k income, the bulk of lab costs vary with both GP & Trust activity however Pathology is experiencing a significant cost pressure in the provision of blood products to the broader organisation (£132k year to date net of income recovery) and historic over performance against the Roche MSC. Radiology non pay overspend is £297k and income offset of £3k - the bulk of these costs being variable costs associated with direct access volumes. Outpatients non pay costs are below budget owing to the new Patient Reminder Service contract.

The Division remains £885k behind its year to date CIP target. Specifically Radiology is £276k behind, Therapies £205k, Outpatients £76k and Labs £331k behind plan. This is the biggest risk to delivering a balanced budget. Every service is actively in consultation/implementation to introduce new structures which will reduce cost. The division is working closely with PMO in exploring further opportunities to bridge any remaining gaps in CIP delivery.

Board of Directors		
Agenda Item	7.2	
Title of Report	Report of the Finance Business Performance and Assurance Committee – 23.01.15	
Date of Meeting	28 January 2015	
Author	Graham Hollick, Chair of Audit Committee	
Accountable Executive	Alistair Mulvey, Director of Finance	
Corporate Objective Ref as outlined in the BAF	5A, 7B,7C	
Level of Assurance		**Board Confirmation**
Gaps with mitigating actions		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

Chair's Business

The Committee agreed to include a further meeting in its cycle of business for 2015/16 to allow for further discussion and agreement associated with the Annual Planning Cycle. The additional meeting will take place in February and will take the number of meetings to 7.

Board Assurance Framework Review (BAF)

The Committee approved proposals to improve the review of the Board Assurance Framework this included the following:

- An amendment to the description of levels of assurance to either positive or gap(s), with the addition that all gap(s) would be supported with the mitigating action.
- A revised template for reports to include a stronger link to the BAF; the level of assurance as described above; the purpose of the paper ie Approval, Discussion or Note and the inclusion of the requirement for an Equality Impact Assessment.
- The proposal for reporting of gaps in control or assurance; the review of existing risks and identification of new risks together with standardised Committee and Board reporting.

The Committee reviewed the risks and the objectives associated with Finance and Cerner and agreed with the assurance that the statements provided and the associated actions to reduce the risks further.

Monitor Compliance Report Quarter 3 2014/15

The Committee reviewed the narrative in the paper which provided the basis for the statements. Particular attention was placed on the issues with regards to the performance against the A & E 4

hour standard; the Referral to Treatment planned failure; the impact of the CQC report following the responsive inspection and the CoS rating of 2. All of which, subject to minor amendments to some of the narrative around acuity levels, resulted in the Committee recommending to the Board that they could not confirm compliance against the financial and governance statements.

The Committee reviewed the statement in relation to the out-turn deficit in the context of the proposed out-turn forecast from the Wirral Commissioners and agreed with the recommendation of the range between £4.2M and £5.2M although it recognised the risk that still existed with this.

Month 8 and Month 9 2014/15

The Committee noted both reports

Financial Position

The latest financial position was outlined as follows:

- In month deficit of £479k against a plan of £187k resulting in a variance of £292k.
- The cumulative position for the first 9 months showed a deficit of £5,215k against a planned deficit of £4,248k resulting in an adverse variance of £967k.
- Continued delivery of a Cos rating of 2 although this has been weakened
- Cash position still above plan at £11.7M

The ongoing pressures on pay, sickness levels, use of flexible labour due to the number of beds open were highlighted as likely to have a negative impact in January in the order of £200K .

The capital programme was confirmed as on track, avoiding the need for a reforecast as at the end of Q3. The Committee determined the following levels of assurance:

- Income and Expenditure – No Assurance
- Cost Improvement Programme – Limited Assurance
- CoS Rating – Full Assurance
- Cash position – Full Assurance

Progress update in relation to Service Level Agreements (SLAs)

The Committee reviewed the streamlined approach being adopted towards contracting and service level agreements which would lead to a reduction in numbers held and endorsed the approach being taken to encourage Divisions to continue to develop SLAs in relation to the work they are leading on.

Performance Management Framework for Procurement

The Committee reviewed performance against the core metrics for procurement as at the end of Q3. 4 of the 7 core areas were rated as Green and on track. 2 areas were rated as red; these were in relation to impact on patient care and spend control. The rationale for the first area was in relation to availability of equipment in a very small number of cases which was identified as an internal logistical problem and the second had limitations for achievement and had therefore been raised nationally by Heads of Procurement. The Amber area was work in progress against the NHS standards of Procurement.

The Committee was advised that the feedback from the latest North West Procurement Event had highlighted the Trust as progressing well in a lot of areas.

2014/15 Cost and Service Improvement update

The Committee was updated on the continuing work with the Turnaround team and the latest position with regards to the savings plan which was £5.8M against a plan of £8.5M at month 9. The Committee reviewed the reasons for the variance from plan which was associated in part with

the HR processes and the need to consult and engage with staff and the difficulties with the closure of a ward in light of the current continued demand.

The Director of Finance confirmed that the majority of savings schemes were in place and largely on track.

Performance Report

Key areas of concern discussed were the continued challenge with meeting the Cancer targets; the planned failure associated with RTT targets and the request from commissioners to send some of our patients to the independent sector which had now been actioned and the performance against the A & E 4 hour standard which continues to be reforecast on a monthly basis due to the demand and acuity levels being presented by patients.

Graham Hollick
Finance Business Performance and Assurance Committee Chair

Board of Directors		
Agenda Item	7.3	
Title of Report	Report of the Quality and Safety Committee – 14 January 2015	
Date of Meeting	28 January 2015	
Author	Dr Jean Quinn, Chair of the Quality and Safety Committee	
Accountable Executive	Dr Evan Moore, Medical Director	
Corporate Objective Ref as outlined in the BAF	1A, 1B, 2A, 3A, 3B, 4A, 7 A, 7C	
Level of Assurance		**Board Confirmation**
Gaps with mitigating actions		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

This report provides a summary of the work of the Quality and Safety Committee which met on the 14th January 2015.

Patient Story

The patient story highlighted the impact on patient experience and care as a result of the rise in demand over the winter period. The story also raised concerns with assisting patients with eating and drinking; accuracy in record keeping and treating patients with dignity and respect.

The Committee agreed that the issues raised were replicated through many of the reports presented for review at the meeting.

The Committee was provided with an update on the nursing recruitment situation including the outcome from the recent recruitment day which successfully recruited 28 nurses together with the further investment in nursing planned which would be outlined in the January Board paper.

Board Assurance Framework Review (BAF)

The Committee approved proposals to improve the review of the Board Assurance Framework this included the following:

- An amendment to the description of levels of assurance to either positive or gap(s), with the addition that all gap(s) would be supported with the mitigating action.
- A revised template for reports to include a stronger link to the BAF; the level of assurance as described above; the purpose of the paper ie Approval, Discussion or Note and the inclusion of the requirement for an Equality Impact Assessment.

- The proposal for reporting of gaps in control or assurance; the review of existing risks and identification of new risks together with standardised Committee and Board reporting.

Complaint, Litigation, Incidents, PALS & Patient Experience (CLIPPE) Q2 2014-15 Summary Report

The Committee noted the developments to the report as a result of work undertaken with internal audit. Key areas for discussion included the action plan to address concerns on Ward 10 following an increase in complaints and the feedback from the CQC inspection. The Committee noted improvement in the patient satisfaction feedback on this ward since the actions had been progressed. Although the Trust was meeting its infection control targets for C difficile concerns were raised at the rising levels due to additional beds being open in response to the demand which was to be addressed with the Commissioners. Incorrect disposal of needle-sticks/sharps was highlighted as a concern and was to be addressed through a series of engagement and communication programmes.

Workforce Dashboard

The Committee noted improvements in mandatory training rates and appraisal rates however was concerned with the under achievement of targets for attendance and sickness absence. The Committee debated the reasons for the under achievement which included the significant incidences of flu. Difficulty with bank fill rates was debated and the actions taken to address this which included the decision to pay bank shifts on a fortnightly basis, as opposed to monthly, and at the mid-point of a Band 5 instead of base. The actions were in response to feedback from staff and do appear to be having an impact. The arrangement is a pilot until the end of March 2015 in order that the impact of the initiative on quality and safety as well as financially can be established.

Clinical Quality Dashboard

The Committee was advised of the slight change in HSMR as a result of the rebasing exercise although still lower than the national average.

Improvements were noted in pneumonia, pressure ulcers, a reduction in serious incidents and eating and drinking. Areas of concern were in relation to sustainability of the MEWS scores in all areas, re-admission rates which were not benefitting from the impact as yet by the health economy initiatives implemented recently and the results from the inpatients friends and family test which showed the Trust as an outlier. The Committee concluded that many of the actions arising from the responsive inspection by the CQC would address the areas of concern.

New Risks 15+

The Committee reviewed all the risks as presented which included those in relation to the implementation of Cerner, the shortage of physios and therapists and the CQC inspection. The actions to address each of these risks were reviewed and accepted by the Committee.

Never Events

The Committee reviewed the factors impacting on the number of Never Events being reported. The Committee reviewed in full the one Never Event formally reported together with a further Never Event which had recently occurred. The Committee reviewed the action being taken which included a change in theatre leadership; the commissioning of an External Review of the WHO checklist and the requirement for human factors training. Although the Committee concurred with the approach being taken, members agreed that in view of the numbers being reported that this would be raised to the Board via this report.

CQC Compliance and Assurance Report

The Committee received an update on the latest CQC Intelligent Monitoring Report (December 2014) which placed the Trust in the lowest category of risk at 6. The Committee reviewed the updated action plan developed in response to the inspection by CQC in September 2014. The Committee noted the huge progress being made with the action plan and requested that key performance indicators also be included for supervision and perceptorship. The Committee

received an update on the preparation for the full inspection to be undertaken by CQC before the end of December 2015 which included the undertaking of mock inspections using real time information due to commence shortly. Further work was still required to understand why staff felt the need to report concerns to the CQC rather than use the Trust's own internal processes.

Quality Impact of Cost Improvement

The Committee noted the increase in serious incidents reported on STEIS as a result of a change in the reporting methodology; the bed occupancy level which was above the recommended level and the Referral to Treatment RTT performance which was showing the impact of the planned NHS England waiting list initiative.

The Committee agreed to focus attention on leavers in specific staff groups as part of their review of the workforce dashboard at the next meeting. The concern was whether current levels were directly or indirectly related to the Cost Improvement Programme. The Committee was concerned that the financial situation was causing the Trust to make some difficult decisions.

Director of Nursing and Midwifery Q2 Performance Report

The Committee was advised that Patient Focussed Audit results had been impacted by the lack of nurse staffing. Ward 22 was highlighted as having the largest decline in the reporting period the result being a change in nurse leadership. Concerns in patients having 2-4 hourly observations and MEWS 3 as part of the MEWS Compliance Audit were reported together with the actions to improve this which included a deep dive.

The Committee was assured that all patients now had water by their bed and that MUST compliance was being undertaken.

The patient focussed audit results for Ward 21 were discussed at length as the results of the audit which were 100%, the patient satisfaction results which were 100% did not triangulate with the findings of the CQC. A review of the audit was being undertaken to ensure all the appropriate areas were being reviewed.

Annual Plan Update

The Committee received a verbal update on progress of the development of the Annual Plan specifically the items related to quality and safety.

Recommendations to the Board of Directors

The Committee agreed to re-emphasise the impact of the number of beds open coupled with the acuity levels of patients on the Trust's ability to deliver good quality safe care.

Dr Jean Quinn
Quality and Safety Committee Chair

Board of Directors		
Agenda Item	7.4	
Title of Report	Report of the Audit Committee – 4 December 2014	
Date of Meeting	28 January 2015	
Author	Cathy Bond, Chair of Audit Committee	
Accountable Executive	Alistair Mulvey, Director of Finance	
Corporate Objective Ref as outlined in the BAF	All	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

Clinical Audit

The Committee reviewed the Trusts clinical audit process. We received reports and presentations on the Clinical Audit Policy, the current Clinical Audit Plan, the process of review through Clinical Governance and the Quality and Safety Committee and the latest Internal Audit report which reviewed the Clinical Audit process in the Trust.

Audit Committee sought to establish that a sound system of Clinical Audit existed and was supported within the Trust; that this was managed and reviewed within the governance structure of the Trust and that there was evidence of changes to practice as a result of Clinical Audit results. Further, the Audit Committee sought evidence that there was independent review of Clinical Audit and that recommended changes to the process were agreed and action taken to implement the recommendations.

The Audit Committee concluded that an adequate process for Clinical Audit exists within the Trust, there are appropriate systems of review, that change in practice was evidenced through the Advancing Quality programme although it was recognized that the learning was more variable in other areas with further work required to capture this. It was also noted that the Clinical Audit Plan was driven largely by mandatory external requirements and the advancing quality programme leaving little scope for locally determined areas of specific interest. There was some concern that the Audit plan had some delays on the start date, but noted that this was reviewed by Quality and safety. The Committee reviewed the mitigating actions to overcome the concerns associated with limited resources to undertake this work, this included the use of information technology and undertaking sampling on a smaller scale to achieve assurance.

Internal Audit

Limited Assurance was received on the IM & T Core Legacy Infrastructure and the Cerner data quality Reviews. The Committee received confirmation that the Core Legacy Infrastructure review was commissioned to enable the Trust to ascertain what the organisation would receive from the Cheshire and Merseyside Commissioning Support Unit when the service transfer takes place this year. Assurance that contingency planning was in place during this interim period was provided. The limited assurance rating for Cerner data quality related to system migration as part of Cerner Phase 2a in June 2013, no further migration has been or is expected to be undertaken under the current contract with Cerner and therefore although this is a high risk, the likelihood is nil.

The Committee requested that Internal Audit incorporate in all future reports, those high level recommendations and the responses to these including any delays.

The Committee requested that the work being undertaken on the standing orders, standing financial instructions and scheme of delegation be completed ahead of the February meeting of the Audit Committee in order that the Committee could recommend their approval at the February Board Meeting.

External Audit

The Committee reviewed the draft External Audit Plan which was largely unchanged with the exception of the requirements in relation to ISA 700. An overview of the risk mapping process which had been undertaken with finance was provided which had helped to inform the plan. The Committee reviewed the Audit Fee for the coming year in line with the provisions of the contract. Finalisation of the Audit Plan, the fee and the tendering process for when the contract ends will be reviewed in February 2015.

Raising Concerns Policy (Whistleblowing)

The Committee reviewed the revisions to the recently ratified policy with members placing particular focus on the communication of this in light of the recent CQC report. The Committee discussed the options for providing feedback to staff who raise concerns anonymously and requested that this form part of a formal process to ensure that the Trust could demonstrate it acted upon concerns irrespective of whether the whistleblowers' identify was available or not. The Committee requested that the outcomes of this process be formally reported to the Board in the future.

Monitor Licence – Compliance Review

The Committee noted the report which highlighted the issues associated with the achievement of the A & E 4 hour performance standard, the action taken as a result of the CQC Responsive Inspection and the latest position with regards to the financial turnaround plan. The new requirements for the Fit and Proper Persons Test together with the Trust's response was also highlighted.

Board Assurance Framework (BAF)

The Associate Director of Governance presented the revised Board Assurance Framework following the workshop held with MIAA in November 2014. The main changes were in relation to risk descriptors, risk scoring, controls, assurances and the key actions. The Committee confirmed that the revised BAF provided a greater degree of assurance. The following additional changes were also agreed:

- The date to be included on the BAF which would aid Committees with reviewing the timelines presented
- The residual risk score to be included on the Audit Committee cover report which currently highlights the top five risks

- Risks in relation to information governance to be considered in the future
- Ensure that the risk management process is aligned with the workings of the BAF in the future
- Determine which strategic items in the BAF were reserved for the Board in the control structure

Risk Process Dashboard – Incidents and Risks

The Committee reviewed the high-level summary of incidents and risks since the last reporting period. Improvements in reporting within 5 working days were noted. Assurance was sought from the Medical Director and the Associate Director of Risk on the reporting of serious incidents; the reason for out of date risks by Division including confirmation as to how long these were overdue and the impact of incidents raised on the development of the clinical audit plan.

Anti-Fraud Update

A review of the current investigations and referrals to date was undertaken which included the difficulties outlined with securing or recovering payments from patients from abroad. The Committee requested that the Director of Strategic and Organisational Development review the communication of responsibility and accountability of Managers for processing salary changes in a timely way to prevent salary overpayments.

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Review of the Terms of Reference

The Committee reviewed their terms of reference, and made minor amendments to the frequency of meetings and the requirement for external audit in relation to ISA 700. The terms of reference are presented with this report for Board approval.

Quarterly Financial Assurance/Losses and Special Payments/Waivers and Use of the Seal

The Committee received assurance on the process for recovering debts however they sought to further understand the process for addressing the salary overpayments

Cathy Bond
Audit Committee Chair

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Audit Committee

Terms of Reference

Authors Name & Title: Carole Self, Associate Director of Governance	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: Audit Committee Terms of Reference	
To be read in conjunction with the following documents:	
Document for public display? No	

Unique Identifier:	**Review Date: 1st December 2015**	
Issue Status: Draft	**Issue No: 1.0**	**Issue Date:**
Authorised by: Board of Directors	**Authorisation Date:**	
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Archive: Document Control	**Date added to Archive:**	
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1. Constitution

In line with the requirements of the NHS Codes of Conduct & Accountability, the Board hereby resolves to establish the Audit Committee as a Committee of the Board. The Committee is a Non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Authority

In order to facilitate the achievement of good governance, the Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of advisers with relevant experience and expertise if it considers this necessary.

3. Objectives

The role of the Committee will be to take a wide responsibility for the overarching scrutiny for the Trust's risk and assurance structures and processes which affect all aspects of the Trust's business.

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 Governance, Risk Management and Internal Control:

3.1.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. This includes reviewing the effectiveness of the organisation's committee structure.

3.1.2 To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.1.3 To review the adequacy of underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.1.4 To review the adequacy of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

3.1.5 To review the adequacy of policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

3.1.6 To review the integrity of the statutory financial statements of the Trust and any formal announcements relating to the Trust's financial performance, reviewing statutory financial reports and judgements contained therein.

3.1.7 To review the adequacy of annual plans / reports from the Local Counter Fraud Specialist and the Local Security Management Specialist.

3.2 Internal Audit:

3.2.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit charter, strategy, audit operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work, management's response and progress on the implementation of recommendations;
- ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring adequate independent assurances are provided; and
- annual review of the effectiveness of internal audit.

3.2.3 The Committee will be involved by the Director of Finance in the selection process of the Internal Auditor.

3.2.4 The Director of Audit will have a right of access to the Chair of the Audit Committee.

3.3 External Audit:

3.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

3.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

3.3.3 To assess the external auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

3.3.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

3.3.5 To review external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.6 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

3.3.7 To undertake a review of the requirements of ISA 700.

3.4 Counter Fraud:

3.4.1 To satisfy itself that the organisation has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work.

3.5 Other Assurance Functions:

3.5.1 The Audit Committee shall review the findings of other assurance functions, both internal and external to the organisation, and consider any governance implications.

3.5.2 These will include, but will not be limited to, any reviews by Department of Health arms length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

3.5.3 In addition, the Committee will link closely with the other Board Committees and be informed particularly by the work of the Risk Management Group through the review of the risk dashboard.

3.5.4 The Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function, this incomes a review of the audit plan and its effectiveness.

3.5.5 The Committee will review on an annual basis the Trust's whistleblowing arrangements.

3.6 Annual Accounts Review:

3.6.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. At this time the Committee will also receive the Annual Report which summarises the outcome of the external audit. This review will cover but is not limited to:

- The rigour with which the Auditor has undertaken the audit;
- the meaning and significance of the figures, notes and significant changes;
- areas where judgment has been exercised;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements;
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved; and
- letter of representation.

3.6.2 To annually review the accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.6.3 To review the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

3.6.4 The Committee will also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.7 Governance:

3.7.1 To review on behalf of the Board of Directors the operation of, and proposed changes to the Governance manual including standing financial instructions, scheme of delegation, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

3.7.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.8 Other:

3.8.1 To review performance indicators relevant to the remit of the Audit Committee.

3.8.2 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

3.8.3 To ensure the effective use of the Board Assurance Framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as the CQC's Quality Risk Profile (QRP) and reports and assurances sought

from Directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

3.8.4 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

3.8.5 To review the work of all other Board Assurance Committees in connection with the Audit Committee's assurance function.

4. Equality and Diversity

The Committee will ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the Committee's work.

In addition the Committee will have regard for the NHS Constitution in delivering its objectives.

5. Membership

The Committee will be appointed by the Board from amongst the Non-executive Directors of the Trust (excluding the Chairman) and will consist of three members, one of whom shall have recent and relevant financial experience. The composition of the Committee should be given in the Trust's Annual Report.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Director of Finance (Executive Lead)
- Associate Director of Governance

Other senior managers will attend when they have papers to present or when the Committee is discussing areas of risk or operation that are the responsibility of that Director / officer.

The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Attendance is also anticipated from Internal and External Auditors and the Local Counter Fraud Specialist.

The Associate Director of Governance will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chairman and committee members.

7. Quorum and Frequency

A quorum shall be two members.

Meetings shall be held as required but not less than four times per year.

The Internal or External Auditors may request additional meetings if they consider such a meeting necessary and shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

8. Reporting

The minutes of all meetings shall be formally recorded by the Committee Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work, demonstrating interrogation and scrutiny of both clinical and non-clinical governance, risk management, internal control, internal audit, external audit and other assurance functions.

The Chair of the Audit Committee shall provide a regular report to the Council of Governors.

The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities.

There are no groups reporting to this Committee.

9. Conduct of Committee Meetings

The terms of reference of shall be reviewed annually by the Audit Committee with recommendations made to the Board of Directors for any amendments.

The agenda and supporting papers will be sent out four 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

Board of Directors		
Agenda Item	7.5	
Title of Report	Progressing Towards Safer Nurse Staffing : Update on the Establishment Review of Nursing, Midwifery and Healthcare Support Worker Staffing: November to December 2014	
Date of Meeting	28 January 2015	
Author	Jill Galvani, Director of Nursing and Midwifery Andrea Hughes, Interim Deputy Chief Nurse Gaynor Westray, Former Associate Director of Nursing (Surgery Women's & Children) & Deputy Chief Nurse Julie Tunney, Former Associate Director of Nursing (Medicine & Acute) Naomi Holder, Associate Director of Nursing (Surgery Women & Childrens) Martin Townsend, Associate Director of Nursing (Medicine & Acute) Debbie Edwards, Head of Midwifery	
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FOI status	Document may be disclosed in full	
BAF Reference	Aligned with WUTH Strategic Objectives: To be the top hospital in the North West for patient, customer & staff satisfaction; Delivering consistent high quality secondary care services; Ensuring our people are aligned with our vision; Maximising innovation & enabling technologies; Supported by financial, commercial & operational excellence (Compliance with Care Quality Commission (CQC) Registration & Fundamental Standards) & Monitor governance rating. Board Assurance Framework:1A; 1B; 2A; 3A; 3B; 4A; 5A; 7A; 7C.	
Data Quality Rating	Gold, Silver & Bronze	
Level of Assurance	Gaps in assurance	Board confirmation

1. Executive Summary

This report provides the Board of Directors with an update on the Trust's progress towards Safer Nurse Staffing. The paper includes a comprehensive update for the Board of Directors on the work that has been undertaken during 2014 to describe and determine Nursing and Midwifery staffing levels in the Trust at January 2015 in preparation for budget setting and submission of the Annual Plan to Monitor. The report builds on previous reports to the Board of Directors, and its' subcommittees since January 2013. Data on nursing outcomes and improvements in quality of care following previous investment in nurse staffing are presented and the impact is analysed.

It is acknowledged that there has been previous investment into nursing as below:

Year	Investment
2012/13	£704,000
2013/14 (Oct 2013)	£677,000
2014/15 (May 2014)	£1,000,000

The senior nursing team has rebased the nursing requirement for adult in-patient wards based on the acuity audit completed in April 2014. It is the intention of the senior nursing team to review this again, in line with National Institute of Clinical Care Excellence (NICE) in February 2015. This is following the next planned acuity audit which will be conducted on the 26th January 2015; the audit will run parallel with the Cerner pilot of the Clairvia programme which is an in-built acuity tool. This will enable the team to understand if there is any further deficit in establishment following the proposed investment into the uplift against the outcomes of the acuity audit. The data can then also be compared to test the accuracy and validity of the electronic programme and if successful will then be a reliable tool to elicit real time staffing level requirements.

The Midwifery Staffing Review, referred to as Birthrate Plus®, was completed in December 2014. This review needs to be validated by Director of Nursing & Midwifery and Deputy Director of Nursing and is not included in the paper. The review of Emergency Department (ED) nursing (separate to Advanced Nurse Practitioners and Emergency Nurse Practitioners as these roles support the Medical Staffing model in ED) is included. The Baseline Emergency Staffing Tool (BEST) was completed in November 2014.

The methodology for the staffing reviews are described and the findings presented for each Ward or area to enable the Board of Directors to prepare for potential further investment in 2015/16 and the impact of this in terms of grade of staff and skill mix.

Demonstrating sufficient staffing is one of the six essential standards that must be met to comply with Care Quality Commission (CQC) regulation. Appropriate staffing levels are a core requirement in the new CQC inspection regime and the Board of Directors can expect that the CQC will be looking for compliance with all the actions outlined in their regulations as part of this. Monitor will act where the CQC identifies any deficiencies in staffing levels.

The Responsive Inspection of the Trust by the Care Quality Commission on 18 and 19 September 2014 resulted in a ‘minor’ breach compliance for safe staffing. However, 4 further breaches were direct failures in nursing regulation, some of which have been a feature of previous reports to the Board of Directors and its’ sub-groups. The paper draws out the relationship between appropriate nurse staffing levels and the impact on nursing outcomes and therefore safety and mortality.

To progress towards safer nurse staffing it is proposed this is supported in a phased approach. The Trust currently has headroom of 16.7% (20% uplift) for nursing, one of the lowest in England; the Royal College of Nursing recommend 25%. The proposed requirement for investment to progress to 20% headroom in 2015/16 is provided as part of the Board of Director’s commitment to progress to safer nurse staffing levels.

Headroom - Relates to the percentage of non-effective working days (absences) that are included in each establishment for each individual.

Uplift - the required increased staffing to cover the non-effective days to ensure the shifts are covered.

The three phases for nursing investment are described below:

- **Phase 1 (2015/16)** Investment into nursing and midwifery to adjust uplift from 20% to 25%, therefore an increase in headroom from 16.7% to 20% in all adult in-patient wards, Neonates, Maternity and Emergency Department. It is proposed that this investment takes place in 2015/16 as Phases 2 and 3 are completed and validated to inform the requirements for subsequent years.

- **Phase 2 (2016/17)** Investment into Neonates, Maternity and Emergency Department following outcome and validation of BEST (ED), Birthrate Plus® and BAPM (British Association of Perinatal Medicine) guidance.

- **Phase 3 (2016/17)** Investment into Wards following outcome and validation of acuity audit (plus Clairvia) scheduled for 26 January 2015, in conjunction with reviews in line with NICE guidance

Phase 1 would require the investment of £1,064,478 (see table 1) to adjust the uplift. An improvement in the current uplift will have a positive impact on the reduction in use of temporary staff including bank and agency staff to cover annual leave, sickness, study leave and maternity leave. This in itself will improve the continuity in nursing care and expected patient outcomes and experience. The current Month 9 position for nursing overspends for the Divisions of Surgery, Women & Childrens' and Medicine and Acute are reported as £1,807,554. This will however also include the staffing of the additional beds that are currently open.

Table 1

Nursing/Midwifery Area with uplift @ 25% to give headroom of 20%	RN/MW WTE	£	CSW/MSW	£	Total
Medicine & Acute Uplift (excluding Wards 21,22,24 already @25% funded) Band 5 RN	7.57	264,906			264,906
Band 2 CSW			6.07	140,795	140,795
Emergency Department Band 7, 6, 5	3.05	121,182			121,182
Emergency Department Band 2 CSW	0	0	0.59	15,432	15,432
Total for Medicine & Acute, including Emergency Department					**542,315**
Surgical Wards uplift Band 5 RN	7.34	256,871			256,871
Band 2 CSW			4.19	97,237	97,237
Neonates Band 5 RN	2.13	74,638			74,638
Neonates Band 2 CSW			0.04	889	889
Maternity Band 5 MW	2.41	84,350			84,350
Maternity Band 2 MSW			0.35	8,178	8,178
Total for Maternity					92,528
Total Surgery, Women and Childrens					**522,163**
Total Medical & Acute & Surgical & Emergency Department (excluding maternity)					**1,064,478**

2. Background Context

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. The National Quality Board issued guidance in November 2013: 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. The National Quality Board (NQB) for England considers that nursing staff capacity and capability are the main determinants of the quality of care experienced by patients. This is further supported in recent research by Aiken and Rafferty et al (2014) which found an increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7%.

Following the publication of the Francis report in February 2013, there has been focused work in the nursing and midwifery community to promote openness and honesty about nurse staffing levels and nurse sensitive outcomes. Patients and the public have a right to know how the hospitals they are paying for are being run and therefore the Government has made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' (2014) to make this information more publically available. Contained within this document were ten expectations. These were presented to the Board in November 2014 and are attached at Appendix 1.

Table 2 below provides an overview for the Board of Directors on the progress towards safer staffing levels in the Trust since the Director of Nursing & Midwifery commenced in post in March 2013.

Table 2

Date	Action Taken	Nursing Investment Required	Nursing Investment supported
2012/13	Investment into Care of the Elderly (DME) wards to increase nurse: patient ratio from 1:15 to 1:10; Establishment of the Essential Care Team for short term, unplanned capacity; opening of a new Ward (26); Further investment into DME wards & Ward 34; neonatal nursing review.	Approval in January 2013 for £704K investment in 2012/13 and into 2014.	2012/13 £704,000
February & March 2013	Francis Report published New Director of Nursing & Midwifery appointed Commenced review of nurse staffing levels in April 2013.		
August 2013	Full staffing review paper presented at Workforce & Communications Group	£2.7M Required for Ward 14 & Medical Specialties and to increase headroom; to prioritise areas for investment.	

October 2013	Medical Specialties staffing review paper presented at Finance, Performance & Business Committee	£677K Required for 3 DME wards & approved (Wards 21, 22 & 24 to increase to 3 Registered Nurses (RNs at night).	£677,000
November 2013	Publication of 'Hard Truths: The journey to Putting Patients First'	The 10 Expectations of the BoD presented to Quality & Safety (Q&S) Meeting	
December 2013	Full staffing review paper presented to Executive Directors Team	£3.531M Required for remaining wards and to achieve headroom.	
December 2013	Full staffing review paper presented at Finance, Performance and Business Committee	Update provided; £3.531M to be phased.	
February 2014	Full staffing review paper presented at Finance, Performance and Business Committee	£1.526M Required for priority areas of concern: Wards 23, 30, 26, 33 & HAC*, 36, 36 @ CBH (M2), 10, 14, ESAU**	
2014/2015	Budget allocation agreed in May 2014.	£1M agreed prioritised to Wards 23, 30, 33 & HAC, 36, 10, 14 & partial SAU. Ward 26 not included as there was a plan to close the Ward in Autumn of 2014.	£1,000,000
May 2014	Residual minus impact of ward closures	£2.531M Required to meet remaining wards & headroom less the impact of ward closures (Ward 26, Medical Day Ward).	
May 2014	Review – NHS England North under way	Commissioned in January 2014 to externally review WUTH Nurse Staffing levels completion expected in next 2 months. This work did not progress as there was no capacity from NHS England.	
May 2014	WUTH AUKUH Acuity audit completed; results analysed and utilised to inform the 2015/16 nurse staffing requirements	Residual investment requirement estimated to be circa £2M, minus planned Ward Closures but prior to NICE Guidance being published.	
May 2014	Report to BoD on their accountability & responsibility for nursing, midwifery & care staffing capacity & capability: meeting the NQB's Expectation 1	Recommendations accepted were: 1. Receive the report to meet Expectation 1; 2. That as Wards close, reconfigure the 3 Ward areas that were unable to meet minimum safe staffing levels – Wards did not close therefore reconfiguration was not possible;	

		3. That the DoN&M worked in partnership with DoF & DoS, P & OD to establish the financial & workforce impact of 22.4% headroom; 4. A further Benchmark review in August/September to respond to future NICE Guidance; the Trust Acuity & Dependency review; the Birthrate Plus review & BEST review in ED; 5. Consider any recommendations from NHS Review (this did not take place).	
June 2014	The May BoD Report was presented to the Clinical Governance Committee for information		
June 2014	Monthly staffing report to Quality & Safety Committee on ward nurse fill rate	Reports provided on each month performance to Q&S or BoD.	
July 2014	National Institute for Clinical Care Excellence published guidance on Adult In-Patient Nurse Staffing levels	Key aspects of the guidance were to focus on acuity & dependency of patients (not included to date as focus on improvements in nurse:bed ratio & RN:Patient ratio; ward layout and additional activities such as ward attenders/clinics based on wards. 'Red flags' including falls, incidents, failure to take breaks introduced in guidance – to be progressed in February 2015.	
September 2014	Responsive CQC Inspection undertaken in response to patient & staff concerns	Preliminary findings indicated minor compliance failing in nurse staffing compliance; minor & moderate failings in staff being moved; failings in fundamental care standards: breaches in nursing regulations.	
November 2014	6 Monthly report on Nurse Staffing presented to BoD; second 6 monthly update on nurse staffing data to the end of the second quarter 2014/15.	It was acknowledged that during this period there was an unprecedented increase in the reporting of incidents relating to infection control, specifically CPE. Increasing the bed base in the Trust whether as a result of activity pressures or infection control has a direct impact on the role of the Ward Sister/Charge Nurse and Matron and the ability of the	

		Trust to monitor and improve standards of nursing care for compliance that cannot be sustained without additional improvement schemes. Every effort is being made to ensure: improved isolation facilities for infected patients and bed capacity, patient throughput including discharge & transfer and demand analysis are aligned.	
November 2014	The outcomes of the nurse staffing review and recommended option were reported at divisional level in the monthly divisional performance reviews with Executives on 25th November 2014.	Staffing reviews undertaken using NICE Guidance & ratified by Divisional Accountants for inclusion in draft list of priorities for 2015/16	
November 2014	Baseline Emergency Staffing Review: (last undertaken in Sept 2012)		
November 2014	'Safer Staffing: A Guide to Care Contact Time' CNO, NHS England published on 26.11.14	Presented for discussion at Strategic Nursing & Midwifery Team meeting on 19 Dec 2014.	
December 2014	Birthrate Plus® Midwifery Services Workforce Planning & Decision Making draft report 08.12.14	Presented to DoN&M, Head of Midwifery & Operational Manager.	
December 2014	Overview of nurse staffing requirements in terms of finance & workforce presented to Executive Director Team meeting.	Further work required to check finance; enhance quality outcome data; include Cost-improvement data; review of Bank & Agency nurse expenditure.	
December 2014	Draft CQC report received and returned by 12 December with action plan.	Action plan includes the 2014/15 review of nurse staffing levels; ward sister performance & accountability & education & development of ward sisters.	
January 2015	Draft NICE Guidance for ED nurse staffing published for consultation.	Work required to assess Trust's position against this.	
26 Jan 2015	Commence Repeat nursing acuity & dependency audit alongside 'red flags' (NICE Guidance) and Cerner programme Clairvia	Commence mock CQC Inspections of Ward areas in preparation for full CQC Inspection 2015.	

*****HAC: Heart Assessment Unit; **ESAU: Surgical Assessment Unit

3. Nursing Performance Measures

This section provides an overview of nursing outcomes since the Board of Directors have invested in nurse staffing numbers.

Table 3 Quarterly Nursing Performance

Measurement	TARGET	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2014/15
Hospital Acquired Grade 2 Pressure Ulcer		128	82	67	101	66	84	
Hospital Acquired Grade 3 + 4 Pressure Ulcer		6	1		1			
Braden: Pressure Ulcer Risk Assessment Compliance	86%	84%	87%	82%	83%	88%	85%	No data
Assistance with Eating	86%	73%	68%	60%	72%	75%	70%	75%
Assistance with Drinking	86%	67%	74%	64%	81%	92%	82%	84%
Falls		318	236	248	222	208	233	
Infection Control MRSA	0	0	2	0	0	1	0	(3)
Infection Control CDIF	24(2014/15)	8	3	8	9	7	7	4
MUST	90%	83%	91%	89%	84%	94%	89%	No data
Water Jugs in reach	86%	99%	97%	99%	99%	100%	99%	No data
MEWS 12 hourly	90%	97%	84%	49%	90%	95%	96%	No data
MEWS 2-4 hourly	90%	66%	52%	37%	50%	52%	62%	No data
MEWS 4-6 hourly	90%	78%	70%	79%	87%	61%	83%	No data
MEWS if the score is 3	90%	91%	80%	78%	88%	36%	54%	No data
MEWS if the score is 7<	90%	100%	100%	100%	100%	100%	100%	No data
Staff FFT - How likely are you to recommend the Trust to friends and family if they needed care or treatment						74%	69%	No data
Staff FFT - How likely are you to recommend the Trust to family and friends as a place to work						47%	51%	No data
(Average score) FFT in patients Monthly reporting	66 Net Score	64	59	69	67	73	68	New Method
Attendance/sickness	<4%	4.35%	4.45%	5.02%	4.99%	4.85%	4.56%	5.20%
(Average) Staffing fill rate	95%					97%	97%	98%
Staffing clinical incidents		No data	No data	No data	No data	No data	43	52
Average no. bed moves		1.7	1.9	1.9	2	2.2	2.2	2.1

Measurement	TARGET	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2014/15
Additional beds		No data	No data	No data	No data	19	26	42
Staffing cause for concerns		12	26	23	18	16	27	35
PALS Staffing level		1	1	3	1	3	3	1
PALS Nursing Care		184	205	175	149	155	181	170
PALS Nurse staff attitude		21	21	26	19	22	20	14
Complaints Staffing levels		3	2	1	3	5	6	2
Complaints Nursing Care		87	87	95	93	67	69	53
Complaints Nursing Staff attitude		22	18	22	20	13	17	16

As a result of previous investment in nursing, there is demonstrable improvement in pressure ulcer prevention, particularly Grades 3 and 4 (no Grade 4 pressure ulcers in 2014/15). There has been a reduction in complaints and concerns raised regarding nursing care and nursing staff attitude.

However, in key areas that support the Trust's strategy to reduce mortality there is no significant change in compliance with Braden and MUST assessment; it has been challenging to secure improvement in feedback from patients regarding assistance with eating and drinking and of particular concern are the scores for MEWS response where there is a challenge in attaining and sustaining an acceptable performance. The Cerner system will enable data capture for audit but nurses must assess their patients and then respond to the findings.

The revised Patient Focused Nursing and Midwifery Care Audits have been in place for over a year since implementation in November 2013. The results provide a level of assurance about performance and care delivered at ward level and enable early identification of areas of concern for escalation and action.

Table 4 Patient Focused Audit Results

		Quarter 1 2014/15	
Ward/ Unit		**%**	**Overall indicator sample**
Derm Ward	Green	97	32
Ward 12		89	36
Ward 32 & CCU		88	43
Ward 31		87	39
Ward 30		86	43
54		86	37
Park Suite	Red	85	34
SAU		83	36
M1		82	33
Maternity		81	21
OPAU		80	45
MAAU		78	37
Ward 23		78	41
Ward 14 (20)		78	40
Ward 21		77	44
Ward 17		77	39
Ward 18		75	44
Medical Day Ward		74	35
FAAU		73	37
Ward 22		71	45
Ward 38		71	45
Ward 36 APH		70	46
CRC		69	40
Ward 33 & HAC		69	42
Ward 26		68	41
EDRU		67	34
Ward 24		67	42
Ward 11		67	43
Ward 10		65	43
36 CBH		62	42
Childrens	Red	59	34
Critical Care		Not audited	

		Quarter 2 2014/15	
Ward/ Unit		**%**	**Overall indicator sample**
Ward 21	Green	100	45
Ward 12		91	35
M1		91	34
Ward 23		88	41
Derm Ward		88	32
Ward 30		86	42
Ward 10		86	44
Childrens	Red	85	27
CRC		83	41
Maternity		81	21
OPAU		80	45
SAU		79	34
Ward 38		77	44
54		77	35
Ward 11		76	38
Ward 14 (20)		76	42
Park Suite		74	39
Ward 32 & CCU		73	44
Ward 18		73	41
MAAU		72	43
36 CBH		71	41
FAAU		69	39
Ward 24		68	44
Ward 17		68	41
Ward 33 & HAC		67	43
Ward 26		67	46
Ward 36 APH		64	45
Critical Care		56	34
Ward 22		51	43
EDRU		Not audited	
Ward 31		**Closed**	
Medical Day Ward		Not audited	

The performance for Quarters 1 and 2 in 2014/15 show how few wards attain 86% on what are basic requirements with the majority of wards unable to progress out of 75% and over. Tables 3 and 4 show some improvement but overall a static position for nursing outcomes. If further investment is supported in nursing then performance management of outcomes will be important and is included in the CQC action plan.

4. Methodology used to determine Ward Nurse Staffing levels 2015/16

The department of Health and NHS England had asked NICE to develop evidence based guidelines on safe staffing, with a particular focus on nursing staff. This request followed the publication of the following reviews and reports:

- Francis report on Mid Staffordshire (Francis 2013)
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (Keogh 2013)
- Cavendish review, an independent enquiry into healthcare assistants and support workers in the NHS and social care setting (Cavendish 2013)
- Berwick report on improving the safety of patients in England (Berwick 2013)
  The need for guidelines on safe staffing, including nursing staff, was also highlighted in the subsequent policy document and responses:
- How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing and care staffing capacity and capability (National quality Board 2013)
- Hard truths. The journey to putting patients first (Department of Health 2013)
  NICE recommends that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. NICE also states that when agreeing the ward nursing staff establishment it should be sufficient to provide planned nursing staff requirements at all times. This includes capacity to deal with planned and predictable variations in nursing staff available, such as: annual, maternity and study leave, sickness, fluctuations in patients' nursing needs and evidence of improved patient outcomes. Others aspects to be considered are:

  Patient factors – including patient acuity and dependency, end of life care, increased risk of clinical deterioration and deprivation of liberty.
  Ward factors – including expected patient turnover during a 24 hour period, ward size and layout (number of side rooms). The challenges in transforming quality of care on Ward 14 (previously Urology) provide an excellent example of how the environment has an impact on nursing; since moving to Ward 20 nursing outcomes are improved, nursing staff report being in control of patient care and this is reflected in an improvement in attendance rates, patient complaints have reduced and Friends & Family Test scores have improved.

  Nursing staff factors – including nursing activities other than direct patient care for example; communication with Multi-disciplinary team, relatives, professional clinical supervision, mentoring of student nurses and nursing staff, board rounds, access to documentation and IT for record keeping.

5. Safer Nursing Tool: Association of UK University Hospitals (AUKUH) Acuity/Dependency; Proposals to phase investment in nurse and midwifery staffing

Wirral University Teaching Hospital (WUTH) uses the 'Association of UK University Hospitals' (AUKUH) acuity / dependency tool. This is a validated tool and is one of the listed recommend tools within NICE guidance. The tool requires patients to be reviewed over a 20 day period including weekends. The review involves assessing each patient's acuity against 5 different levels of care. The tool then determines the amount of nursing hours required to care for these patients and is then calculated into an overall average. During the 20 day period staffing levels are also monitored to compare actual staffing during the time of the review. The AUKUH data is then compared with actual staffing and what the funded establishment should be to identify any variances. WUTH has been using this tool on a six monthly basis since 2012 and therefore has created a robust data set to identify changes in acuity and then analyse reasons for this. The next audit will be conducted on the 26th January 2015 to run parallel with the Cerner pilot of the Clairvia programme which is an in-built acuity tool. The data can then be compared to test the accuracy and validity of this electronic programme and if successful will then be a reliable tool to elicit real time staffing level requirements.

Following NICE guidance, data generated from the use of the 'Safer Nursing Tool' determines the nursing requirements of the Wards' patient population. This is a significant move for the Trust, where preliminary work focused on attaining an above nurse to bed ratio of 1 or more (using evidence from Keith Hurst's 2008 work) and subsequently Royal College of Nursing minimum recommendations based on nursing outcomes evidence of 1:8 (days) and 1:10 (nights). This is why the staffing requirements and associated costs are at variance from previous staffing reviews and presentations to the Board of Directors.

Following the review process in October/November, further work was undertaken with colleagues in finance to translate the staffing establishment figures into cost calculations.
The three phases for proposed nursing and midwifery investment are described:

- **Phase 1 (2015/16)** During 2015/16, propose investment into nursing to adjust uplift from 20% to 25%, therefore an increase in headroom from 16.7% to 20%.

- **Phase 2 (2016/17)** Investment into Neonates, Maternity and Emergency Department following outcome and validation, BEST, Birthrate Plus® and BAPM guidance concluding in 2015/16 in preparation for 2016/17 annual plan.

- **Phase 3 (2016/17)** Investment into Wards following outcome and validation of acuity audit (plus Clairvia) scheduled for 26 January 2015, in conjunction with reviews in line with NICE guidance to be considered with Phase 2 for prioritisation.

6. Cost Improvement Programme 2013/2015

Throughout 2014 a nursing efficiency work stream was commenced to focus on the identification and delivery of schemes to achieve a recurring cost saving of £1.5million. This has mainly focussed on non-ward based nursing including Main Outpatients, Clinical Nurse Specialists, Maternity Services, Matrons, Critical Care, Safeguarding and Infection Prevention and Control.

The current 2014-15 Month 9 forecast is as follows:

2014-15 YTD Position £ 311,876
2014-15 Forecast £ 529,768
Recurrent Forecast £1,032,839

Plans are progressing for 2015/16 which will focus on ward based nursing, reduction in bank/agency spend as well as further opportunities in non-ward based nursing.

The proposed investment in nursing and midwifery should also be set against the current nursing 2014/15 overspend:

Table 5

Division	Month 9 financial position (nursing)
Medicine and Acute	£1,250,000
Surgery, Women & Childrens'	£557,554 (including midwifery)
Total	£1,807,554

7. Recruitment and Retention of Nurses and Midwives

The Trust has a successful track record of recruitment of established nurses and midwives and new graduates. Following the Francis report and the subsequent publications during

2013, the majority of NHS Trusts have been increasing registered nurse staffing levels. Set against workforce plans that have proposed reductions in nurse training commissions, plans to increase registered nurse staffing levels are challenging and many Trusts have decided to recruit internationally. This section provides the Board of Directors with information about the activities in place to attract, recruit and retain registered nurses to the Trust.

7.1 Return to Practice (RTP)

The Trust has approached all universities on the North West placement circuit to confirm that we are actively seeking students to undertake RTP placements. The RTP programme is for all Nurses who have been away from practice for more than 3 years, have been on part one of the NMC register and now wish to return. Students will study at the University of their Choice for 15 weeks part time and undertake clinical placement with the Trust. Time spent in the clinical area is based on each student's needs, but is a minimum of 100 hours. They will be supported by qualified mentor. Upon successful completion of the programme WUTH proposes that we offer each nurse a 6 month part time contract which will enable the practitioner to complete Preceptorship and agree a future career plan. The Trust aims to recruit 5 RTP students during 2015 and offer fixed term contracts upon completion.

7.2 Assistant practitioners

Assistant practitioners are at level 4 of the NHS Career Framework and at Band 4 Agenda for Change. They are trained but not on Part One of the Nursing Midwifery Council (NMC) Register therefore are not registered nurses. They may work in a broad range of areas, primarily but not exclusively, with patient contact. The Trust Assistant Practitioners (APs) are working across the Trust in a variety of specialties. Surgery: SEAL Unit, SAU, Theatres, Eye clinic, Dermatology**;** Orthopaedics : Fracture Clinic, Wards; Medicine: General Wards, Endoscopy, Dialysis; Outpatients Department; Neonatal Unit; Women's Services: Delivery Suite, Antenatal clinic, and postnatal ward, Gynaecology Ward (still trainees).

Assistant Practitioners working in these areas are functioning at a high level and in most of these areas have filled Band 5 roles adequately. They possess excellent and advanced clinical skills. Within their own specialised areas, Assistant Practitioners take charge of a caseload of patients. They have all completed a 2 year Foundation degree which includes work based competencies - both generic and specialty-specific. Training is funded by Health Education England at rate of £228 pro rata month backfill money for each trainee. It is recognised that over the next 5 years there will be a RGN workforce shortfall and the Trust needs to identify alternative safe workforce solutions. Nursing will undertake a scoping exercise to identify additional areas where assistant practitioners can reduce the demand for Band 5 registered nurses and support the 'Grow Your Own initiative'. This means that there is an opportunity to reduce the financial impact of progressing towards safer nurse staffing levels by substituting some Band 5 posts for Band 4 posts. Alongside this is a caution that the CQC may not recognise Band 4 practitioners and therefore there is a need to influence the Inspection regimes and compliance requirements accordingly.

7.3 Nurse vacancies, recruitment and retention strategies, including the Use of Bank and Agency staff

A patients' right to be cared for by appropriately qualified and experienced staff in safe environments is enshrined within the National Health Service (NHS) Constitution, and the NHS Act 1999 makes explicit the board's corporate accountability for quality. Nurses' responsibilities regarding safe staffing are also stipulated by the Nursing and Midwifery Council (NMC), covering every RN in the UK. Recurrent shortages of staff impact on the stress and wellbeing of staff leading to higher sickness and greater dependency on bank, reducing continuity of care and impacting on substantive workload. In addition, staffing establishments should take account of the need to allow nurses and care staff to have time to undertake continuous professional development and fulfil mentorship and supervisory roles.

The Trust workforce plan has been submitted; newly qualified registrants were recruited in advance of qualifying in September 2014 to ensure a supply of Registered Nurses. Similarly in the January 2015 recruitment event a further 26 candidates were recruited into existing vacancies. The recent Health Education England document: "Nursing Return To Practice" (2014) reports that there is an urgent need to increase the availability of RNs to meet the demand, and that increasing commissioned nurse education will not yield an increase until 2017. The emphasis is therefore for the Trust to make better use of current RNs either working on a part time basis, whose registration has lapsed, or out of practice RNs who are employed in non-clinical focused work and by providing a nurturing, flexible environment to enhance the retention of newly qualified and those considering retirement.

In addition to this plans are in place to pursue overseas nurse recruitment if this is required. Prior to commencement of overseas recruitment into the Trust, Senior Nurses have agreed the following:

- Rolling programme of Monthly Trust wide recruitment for Registered Nurses
- To review and reduce the use of flexi bank where this is possible as part of the Nursing Workforce Cost Improvement Plans (CIP)
- To deliver Version 10 of E-roster and deliver associated CIP
- Actively recruit newly qualified students
- Develop a recruitment event
- Return to Practice uptake aim of 7 – 8 per year
- Deliver the Preceptorship Programme
- Develop Aspiring Nurse Leaders
- Participate in the Virtual Recruitment opportunity provided by the Nursing Times
- Utilise Cerner Millennium as a recruitment strategy

The Trust recruits to its core PROUD values, and the beliefs of the Chief Nursing Officer's document "Compassion in Practice" (DoH 2012) and the 6Cs: Care, Compassion, Competence, Communication, Courage and Commitment. RNs and CSWs have to demonstrate their ability to deliver care to these standards in the recruitment and selection process. This approach aims to ensure that the Trust has the right workforce, with the right skills, with the right values, to support effective team working and deliver excellent patient care and experience.

The Director of Nursing has previously reported that during the months of August and September 2014 there have been serious concerns with regard to the provision of minimum staffing levels and 95% fill rate of registered nurses. Although challenging, minimum staffing levels were achieved in August, and there were occasions during September where the minimum staffing levels were not met, despite intense effort. This pattern continued into October, November and December and is reported separately.

There are currently 37 RN vacancies across the Trust including winter recruitment of 11 RNs. Recruitment to ward establishments must be timely to avoid overuse of the Flexibank. The Flexibank function has not reliably provided Registered Nurses as requested, and a detailed analysis of requests to the Flexibank versus fill rates is under way, along with recent recruitment into the Flexibank to ensure availability of staff. Once the revised staffing establishment is recruited to however, there should be a corresponding substantial reduction in the cost attributed to bank and agency staffing. The additional benefit of substantive teams will improve consistency and continuity in patient care and improvements in patient experience.

8. Potential benefits realisation of Cerner

The NQB (2013) recommends that staff working within structured teams are able to practice effectively through the supporting infrastructure of the organisation such as the use of IT, deployment of ward clerks, housekeepers and supportive line management. There are early

indications that the realisation of the benefits of Cerner, once fully established, may find efficiencies in the nursing support establishment numbers, for example Ward Clerks. However this has yet to be robustly evidenced. The benefit of this may mean the development of a new nursing support role to take on some of the duties currently delivered by the nursing team which are not directly patient and family facing, thereby freeing up nursing time which will be used in face to face patient care. This, in addition to the potential increase in direct patient contact time which Cerner may produce needs further clarification and scrutiny to evidence how this may be translated into nursing efficiencies.

There may also be benefits associated with the proposed implementation of Clairvia which has a built-in acuity functionality to provide real time and proactive forecasting. This is planned to commence in pilot from 26th January 2015. The Acuity/Dependency Tool AUKUH (Association of UK University Hospitals) will be re-run in paper format to compare and validate acuity data, therefore, future six monthly nurse staffing reports required by NICE and the NQB will be based on automated, objective data. Further assurance is potentially available from the Clairvia system as this will have the ability to provide evidence on the Trust / Ward resources available on any given day in the past.

The current Nurse Roster system does not allow upload of data relating to staff fill rates. Version 10 of E-Roster will not only enable uploading of data but will also provide the potential for real time information on the nurse staffing resource available and its utilisation. Resources to implement the new system in February 2015 are currently being reviewed.

9. Next Steps

This paper proposes an increase to the uplift in nursing and midwifery to reduce the dependency on temporary staffing in 2015/16. There is further analysis to be done in 2015 on the Birthrate Plus® findings pending NICE guidance on midwifery staffing, and on Emergency Department Nursing Staffing following BEST and the publication of draft NICE guidance on ED nurse staffing. A further review of patient acuity and dependency commences on 26 January alongside the Cerner product Clairvia. Further work will be undertaken in the development of the nursing quality dashboards to triangulate at Trust wide level the relationship between quality of care, nurse establishment and nursing fill rates. This work will link with, and support, the continued development of ward performance dashboards (CQC action plan), to provide comprehensive information and analysis of the patient experience, quality of care and safety in a timely and proactive way.

Recruitment to the current 37 RN staffing vacancies (including the 11 associated with winter planning) is underway with a comprehensive recruit plan. Agency nurses have been employed and trained in Cerner to cover some of the gaps, particularly on Ward 26.

A retrospective trend analysis and cost implication of agency and flexibank is being undertaken as part of the Cost Improvement workstreams to provide a baseline of activity and cost which can then be offset against the costs involved with re-setting the nursing establishment. Divisions are reviewing the Month 9 and end of year out-turn overspend on nursing and midwifery to align this with the potential for investment to offset temporary staffing costs.

The realisation of the benefits associated with Cerner in terms of releasing time to care needs further clarification and scrutiny to evidence how this may be translated into nursing efficiencies during 2015 and beyond.

10. Conclusion and Recommendations

The investment in nurse staffing and recruitment at this scale will require the development and delivery of a prioritised, risk assessed, implementation and recruitment plan phased over several months. The final timescale and approach of which will need to be considered in line with the availability qualified nurses and our internal recruitment processes,

consideration of the recruitment and training of Band 4 Assistant Practitioners, consideration of overseas recruitment, and the aligning the funding streams with the budget setting process.

The opportunity to “sense check” the progress and outcomes will be provided when the next six monthly acuity and establishment takes place. This will be linked to the robust data provided by Clairvia and will provide assurance to the Board of Directors of the pace, appropriateness and improved patient outcomes which will be required to justify the continued investment and attainment of CQC Compliance.

The Board of Directors is asked to receive this report, and discuss the progress being made to ensure compliance with the national guidance relating to nursing and midwifery staffing levels, and the development of a robust methodology in determining the correct levels and skill mix of staff.

The Board of Directors is requested to consider the outcome of the nurse staffing review and the preliminary estimates to invest in nursing and midwifery staffing as Annual Planning progresses during January and February 2015 and to approve Phase 1 investment of £1,064,478 as part of 2015/16 annual planning exercise which will have a positive impact to the requirements of Phase 2 and 3.

Appendix 1

Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility

Expectation 1

The Board of Directors has responsibility for the quality of care provided to patients and as a key determinant of quality takes full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

Expectation 2

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.

Expectation 3

Evidence based tools are used to inform nursing, midwifery and care staffing and capability.

Expectation 4

Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

Expectation 5

A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.

Expectation 6

Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Expectation 7

Boards receive monthly updates on Board workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

Expectation 8

NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.

Expectation 9

Providers of NHS services take an active role in securing staff in line with their workforce requirements.

Expectation 10

Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

Board of Directors		
Agenda Item	7.6	
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: October, November and December 2014	
Date of Meeting	28 January 2015	
Author	Andrea Hughes - Interim Deputy Chief Nurse	
Accountable Executive	Jill Galvani - Director of Nursing and Midwifery	
BAF Reference	Risks 1, 2, 4, 5, 11, 12 & 14 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.	
Level of Assurance		**Board Confirmation**
Concerned		
Data Quality Rating	Silver	
FOI status	Document may be disclosed in full	

1. Executive Summary

This paper provides the nurse staffing data for October, November and December 2014. Data was prepared to determine performance against the Trust's own targets of 90% and 95% of shifts that met the planned requirement. No target fill rate has been set nationally; therefore the Trust applies these percentages as a test, given that 100% is optimum.

There have been serious concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period. Although challenging, minimum staffing levels of 90% were achieved in October, however there were several occasions during November and December where the 90% staffing levels were not met, despite intense effort. Table 1 shows the overarching performance of an increasing pattern in the numbers of areas reporting less than 95% and 90% fill rate of staff to establishment. The table also highlights that the majority of wards failing to meet the % fill rates are due to a lack of registered staff, and that where possible, non-registered staff back fill registered staffing numbers to increase the overall fill rate.

Table 1 Percentage and number of all wards reporting less than 95% and 90% average fill rate per month, rounded up/down to nearest total

Month	% (number) of all wards reporting less than 95% average fill rate for all staff, day and night	% (number) of all Wards reporting less than 95% average fill rate for registered Staff, day or night	% (number) of all wards with less than 90% fill rate for all Staff, day and night	% (number) of all Wards reporting less than 90% fill rate for registered Staff, day and night
October	52% (19)	40% (14)	6% (2)	3% (1)
November	57% (20)	57% (20)	17% (6)	17% (6)
December	57% (20)	54% (18)	28% (10)	23% (8)

Following the publication of the Francis report in February 2013, there has been focused work in the nursing and midwifery community to promote openness and honesty about nurse staffing levels and nurse sensitive outcomes. Patients and the public have a right to know how the hospitals they are paying for are being run, and therefore the Government has made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' to make this information more publically available.

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. The Divisions of Surgery and Medicine and Acute have a daily staffing meeting to determine whether or not planned staffing requirements are met and to take action where there may be a shortfall. The outcomes of these meetings are recorded and contribute to the monthly staffing report. There is further work required to enhance assurance on processes following receipt of the draft report on Nurse Staffing by Mersey Internal Assessment and Audit (MIAA) and this will be completed during February 2015

2. Background

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. The National Quality Board issued guidance in November 2013: 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This document informs this paper and is augmented with the July 2014 publication of the National Institute for Care and Healthcare Excellence (NICE) guidance: Safe Staffing for Nursing in Adult In Patient Wards in Acute Hospitals.

3. Key Issues:

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the Hard Truths milestones set out in the guidance published on 31 March 2014.

- Information regarding the nurses, midwives and care staff are displayed for each shift compared to what was planned. A Board is available at the entrance to each in-patient area.

- A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month is to be presented to the Board regularly – this is the report for October – December 2014. The report will be published on the Trust's website and will be linked to the relevant hospital webpage on NHS Choices.

- A separate report to the Board, "Progressing towards Safer Nurse Staffing" provides assurance and outcome of the ongoing work to ensure safe staffing levels are provided on each ward across the Trust, by the process of the staffing review undertaken on each inpatient adult ward across the Trust during October 2014.

From the period October – end December 2014 the majority of Wards achieved 90% of planned staffing levels (see attachment 1) however, the effect of increasing numbers of patients with higher patient dependency (acuity) is that more than the minimum staffing levels are essential to provide the level of care which these patients need. Close nurse management of the movement of nurses to support patient acuity is on–going and continues to be challenging. Outstanding vacancies and sickness continue to be the main rationale for reduced staffing levels. These are being addressed by the corporate recruitment strategy, and the implementation of the new Attendance Capability policy which went live on 19th January 2015.

3.1 October staffing report

The data provided for October 2014 (attachment1) demonstrates staffing of at least a 90% fill rate, levels were achieved across divisions. However based on a 95% fill rate the data indicates that 12 (35%) of wards declared a shortfall in staffing levels of registered nurses, and 4 Wards declared a shortfall in Care support workers (CSW) on day shifts. Fill rates on night shifts indicate a slightly better picture with 5 wards declaring a shortfall in staffing levels for registered nurses and only 1 for CSWs.

When compared with the August and September data there are 4 Wards with continuing reporting of less than 95% fill rate in Day shifts they are: Wards 12,17,21,22. In September 2014 the CQC carried out an inspection which included Wards 21 and 22 and highlighted areas for improvement including; Staffing, Respecting and Involving people who use services and Care and welfare of service users. An action plan has been put in place and implemented and is closely monitored at Senior Nursing and Midwifery team meetings and the Quality and Safety Group.

Please note: Ward 25 which was open during October as contingency beds, is not included in the October data, it has been agreed that it will be included in future reports. Staff are taken from wards to staff additional areas, including ward 25 and the medical day ward

3.2 November 2014 staffing report

The data provided for November 2014 shown in attachment 1, indicates deterioration in the average fill rate at both 90% and 95% In contrast to the October figures, 6 wards indicated less than 90% fill rates during day shifts for Registered Nurses. The Data shows an increase of a further 8 wards on October figures with 20 wards (57%) declaring a less than 95% average fill rate for registered nurses on day shifts and 8 showing a less than 95% for CSWs. Night shifts show a slightly improved picture.

Neonatal have the lowest reported day shift Registered nurse fill rates within the Trust. The Trust hosts a level 3 Neonatal Unit (NNU). The NNU is part of the Cheshire and Mersey Regional Neonatal Network. During November 2014 there were occasions where the NNU has not provided staffing levels to BAPM (British Association for Perinatal Medicine) guidelines for safe nurse staffing. However, there is a clear understanding of the reasons why this is in the wider context of the Cheshire & Mersey Neonatal Network. The Surgical, Women's & Children Division is implementing a number of measures to ensure the NNU is fully supported.

3.3 December 2014 Staffing Report

December 2014 data (attachment 1), indicates a slight improvement in the number of wards indicating a less than 95% fill rate for Registered nurses on day shifts, however the overall achievement of 95% fill rate remains at 57%. The figures show a deterioration of the fill rate for CSWs with 12 Wards (34%) indicating less than 95% fill rate for those staff grades. At the 90% fill rate level there is a deterioration, as 8 wards indicate red for day shift registered nurses, and 6 for CSWs. Wards with the lowest fill rate for Registered nurses are: 26, 30 MAAU and MSSW. There has also been an increase in unfilled bank shifts, which have contributed to the lower fill rates predominately in women's services.

4. Opening and closing of wards.

Attachment 2 illustrates the fluctuating position in terms of additional beds during this period; the planned additional capacity for winter is shown on the attachment against ward 25, MDW and ward 26. There is also some additional unplanned contingency against ward 27 and ward 14 but this is generally balanced out with closures elsewhere. The overall impact of providing nurse staffing to

an average of 42 additional beds per week open during December, with a high of 71 extra beds during the week commencing 29th December is evident in the December fill rate. December saw an increase both in the demand for capacity and in the acuity of patients.

During the period commencing 6th October to End December 2014 there were an average of 40 additional beds open each week within the Trust. Attachment 2 indicates the detail of where the beds were open and closed within the Trust. The relocation of staff to provide nursing care for patients in these additional beds takes away resources from wards which are already under significant pressures.

Increasing the bed base in the Trust whether as a result of activity pressures or infection control has a direct impact on the role of the Ward Sister/Charge Nurse and Matron and the ability of the Trust to monitor and improve standards of nursing care for compliance that cannot be sustained without additional improvement schemes. Every effort is being made to ensure improved isolation facilities for infected patients and bed capacity and demand analysis are aligned.

There are a series of schemes that are in place to improve the environment of nursing care and the impact on nurse staffing challenges such as:

- Ticket Home Initiative
- Nurse-led and criteria-led discharge
- Discharge to assess and Early supported discharge
- Board Rounds and 8am Ward Rounds
- Check & Act
- Embed the Frailty Unit
- New model for the Emergency Department Review Unit
- Improved Care Pathways
- Matrons providing leadership to Wards for patient care and patient flow.

During November and December 2014, Ward Sisters and Charge Nurses have been required to work some shifts clinically to ensure minimum staffing levels are achieved. Given the scope of the Ward Sister/Charge Nurse role it is essential that they are supernumerary / supervisory to enable them to monitor and improve nursing care standards. Similarly, the Matron role is to oversee nursing care standards, to hold the Ward Sisters and Charge Nurses to account, and to actively support improvements in nursing care. Matrons are currently required to work clinically and to support bed management. This detracts greatly in terms of their ability to continue to implement improvement schemes, Matrons are required to focus on care standards and delivery of discharge schemes to reduce the length of stay as key strategies to avoid opening additional bed.

5. Action taken / Next steps

The Trust workforce plan has been submitted; newly qualified registrants were recruited in advance of qualifying in September 2014 to ensure a supply of Registered Nurses. Preparations are under way to repeat this exercise for nurses due to qualify in March 2015. The recent Health Education England document “Nursing Return To Practice” (2014) reports that there is an urgent need to increase the availability of RNs to meet the demand, and that increasing commissioned nurse education will not yield an increase until 2017.

Plans are in place to pursue overseas nurse recruitment if this is required. Prior to commencement of overseas recruitment into the Trust, Senior Nurses have agreed and commenced the following;

- The commencement of a Rolling programme of Monthly Trust wide recruitment for Registered Nurses from January 2015, with 26 recruited at the first event in January,
- Actively recruit newly qualified students,
- Return to Practice uptake aim of 7 – 8 per year by end 2015,
- To continue to review the use of flexi bank, which should see an associated reduction in use once newly appointed nurses are in practice
- To deliver version 10 of E-roster To deliver E-roster by Mid- February wich brings the the benefit of having a 3 month rolling view of nurse staffing thereby enabling the identification

of potential staffing shortfalls and taking mitigating action. There will always be some need to respond to variance in patient acuity, infection control and unexpected capacity demand,
- Deliver the Preceptorship Programme,
- Develop Aspiring Nurse Leaders,
- Utilise Cerner Millennium as a recruitment strategy.

6. Conclusion

There have been serious concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period. Although challenging, minimum staffing levels of 90% were achieved in October, however, there were several occasions during November and December where the 90% staffing levels were not met, despite intense effort. The Trust did not meet the 95% staffing level across all Wards during October, November or December.

Nurse and midwifery staffing requirements are reviewed on a daily basis and shift by shift if this is necessary.

The impact of cohort nursing to control CPE, influenza and patient acuity and increased demands in capacity, have proved to be significant challenges to the nursing management teams during this period.

Whilst Nursing has responded to the organisational pressures there has been a negative impact on the nurse leadership team's ability to fulfil core roles of supervision and monitoring of standards as exemplified in the draft CQC Responsive Review undertaken in September 2014.

7. **Recommendations**

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

December 2014
Table 3

Ward name	Day		Night	
	Average fill rate - registered nurses/mid	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid	Average fill rate - care staff (%)
10	95.2%	94.7%	98.4%	98.4%
11	93.5%	88.8%	94.4%	95.2%
12	94.9%	92.6%	100.0%	90.3%
14/20	92.1%	98.0%	94.6%	96.8%
17	91.8%	87.7%	93.5%	96.8%
18	95.4%	97.0%	95.1%	96.8%
21	94.6%	98.9%	97.6%	100.0%
22	97.5%	98.7%	99.1%	100.0%
23	89.0%	95.5%	97.2%	100.0%
24 & Isolation	98.9%	97.2%	96.0%	99.2%
OPAU	91.9%	98.1%	91.4%	100.0%
30	86.4%	93.5%	100.0%	98.9%
32 & CCU	96.3%	95.1%	100.0%	100.0%
33 / HAC	96.0%	97.2%	93.5%	98.9%
36	87.2%	92.0%	97.8%	100.0%
38	97.4%	98.5%	99.2%	100.0%
26	86.5%	89.0%	90.4%	100.0%
MAAU	87.2%	88.1%	98.3%	98.9%
MSSW	87.4%	90.5%	99.3%	98.9%
EDRU	100.0%	100.0%	100.0%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	97.0%	100.0%	100.0%	101.8%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	100.0%	98.4%	
M1	93.0%	93.1%	100.0%	103.5%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	89.9%	89.6%	93.8%	98.3%
53	80.6%	73.7%	88.7%	96.6%
Neonatal	90.8%		95.0%	
Children's	97.8%	96.6%	94.8%	96.8%
CRC	97.1%	98.9%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	96.4%	100.0%	100.0%
25	93.4%	96.4%	100.0%	100.8%

Nov-14
Table 2

95%

Ward name	Day		Night	
	Average fill rate - registered nurses/midwi	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwi	Average fill rate - care staff (%)
10	94.8%	94.5%	100.0%	96.8%
11	89.1%	86.8%	100.0%	96.8%
12	93.4%	91.3%	100.0%	95.0%
14/20	89.6%	88.6%	96.8%	98.4%
17	96.2%	96.3%	96.8%	98.4%
18	91.5%	97.5%	98.9%	98.4%
21	93.9%	98.5%	95.6%	98.9%
22	92.3%	98.6%	99.1%	100.0%
23	90.8%	98.9%	100.0%	100.0%
24 & Isolation	93.9%	96.2%	96.0%	99.2%
OPAU	90.5%	95.5%	91.7%	96.8%
30	86.9%	95.9%	99.3%	100.0%
32 & CCU	95.8%	98.8%	100.0%	100.0%
33 / HAC	94.1%	95.0%	100.0%	100.0%
36	89.9%	99.0%	98.9%	100.0%
38	98.7%	99.3%	96.1%	100.0%
26	98.7%	99.4%	100.0%	100.0%
MAAU	92.7%	94.2%	97.1%	98.9%
FAAU	90.4%	91.7%	99.6%	99.3%
EDRU	100.0%	96.5%	97.9%	100.0%
Parksuite	99.3%	100.0%	100.0%	
SAU	100.0%	100.0%	100.0%	100.0%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	99.2%	98.4%	
M1	90.8%	93.4%	100.0%	90.3%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	95.7%	96.7%	99.3%	96.7%
53	94.4%	92.5%	100.0%	93.5%
Neonatal	71.1%		72.8%	
Children's	92.5%	95.0%	96.4%	100.0%
CRC	100.0%	98.8%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	99.4%	100.0%	100.0%
25	81.90%	98.20%	100.00%	100.00%

Oct-14
Table 1

Ward name	Day		Night	
	Average fill rate - registered nurses	Average fill rate - care staff (%)	Average fill rate - registered nurses/	Average fill rate - care staff (%)
10	93.9%	97.3%	98.4%	100.0%
11	96.1%	94.0%	99.2%	98.4%
12	94.2%	98.6%	96.6%	96.8%
14/20	92.9%	96.6%	98.9%	100.0%
17	92.0%	96.6%	97.2%	100.0%
18	92.6%	99.5%	98.9%	100.0%
21	92.9%	100.0%	92.4%	100.0%
22	92.6%	98.1%	99.1%	99.3%
23	92.2%	99.5%	98.9%	98.4%
24 & Isolation	98.4%	99.6%	96.0%	99.2%
OPAU	94.7%	97.6%	85.5%	104.8%
30	93.9%	98.5%	100.0%	99.5%
32 & CCU	97.7%	98.8%	100.0%	98.9%
33 / HAC	96.5%	97.4%	97.8%	100.0%
36	92.9%	97.3%	97.8%	98.9%
38	97.6%	97.5%	92.8%	98.9%
26	98.3%	99.7%	100.0%	100.0%
MAAU	95.1%	92.2%	91.1%	98.9%
FAAU	95.4%	91.1%	96.7%	100.0%
EDRU	98.7%	100.0%	97.8%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	96.0%	96.5%	97.8%	88.8%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	100.0%	100.0%	
M1	98.3%	98.6%	100.0%	96.5%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	96.1%	98.3%	99.6%	100.0%
53	96.0%	91.9%	99.2%	96.9%
Neonatal	98.6%		98.9%	
Childrens	94.3%	96.6%	93.8%	100.0%
CRC	100.0%	100.0%	98.2%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	100.0%	100.0%	100.0%

December 2014

Ward name	Day		Night	
	Average fill rate - registered nurses/mid	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid	Average fill rate - care staff (%)
10	95.2%	94.7%	98.4%	98.4%
11	93.5%	88.8%	94.4%	95.2%
12	94.9%	92.6%	100.0%	90.3%
14/20	92.1%	98.0%	94.6%	96.8%
17	91.8%	87.7%	93.5%	96.8%
18	95.4%	97.0%	95.1%	96.8%
21	94.6%	98.9%	97.6%	100.0%
22	97.5%	98.7%	99.1%	100.0%
23	89.0%	95.5%	97.2%	100.0%
24 & Isolation	98.9%	97.2%	96.0%	99.2%
OPAU	91.9%	98.1%	91.4%	100.0%
30	86.4%	93.5%	100.0%	98.9%
32 & CCU	96.3%	95.1%	100.0%	100.0%
33 / HAC	96.0%	97.2%	93.5%	98.9%
36	87.2%	92.0%	97.8%	100.0%
38	97.4%	98.5%	99.2%	100.0%
26	86.5%	89.0%	90.4%	100.0%
MAAU	87.2%	88.1%	98.3%	98.9%
MSSW	87.4%	90.5%	99.3%	98.9%
EDRU	100.0%	100.0%	100.0%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	97.0%	100.0%	100.0%	101.8%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	100.0%	98.4%	
M1	93.0%	93.1%	100.0%	103.5%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	89.9%	89.6%	93.8%	98.3%
53	80.6%	73.7%	88.7%	96.6%
Neonatal	90.8%		95.0%	
Children's	97.8%	96.6%	94.8%	96.8%
CRC	97.1%	98.9%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	96.4%	100.0%	100.0%
25	93.4%	96.4%	100.0%	100.8%

Nov-14 **90%**

Ward name	Day		Night	
	Average fill rate - registered nurses/midwi	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwi	Average fill rate - care staff (%)
10	94.8%	94.5%	100.0%	96.8%
11	89.1%	86.8%	100.0%	96.8%
12	93.4%	91.3%	100.0%	95.0%
14/20	89.6%	88.6%	96.8%	98.4%
17	96.2%	96.3%	96.8%	98.4%
18	91.5%	97.5%	98.9%	98.4%
21	93.9%	98.5%	95.6%	98.9%
22	92.3%	98.6%	99.1%	100.0%
23	90.8%	98.9%	100.0%	100.0%
24 & Isolation	93.9%	96.2%	96.0%	99.2%
OPAU	90.5%	95.5%	91.7%	96.8%
30	86.9%	95.9%	99.3%	100.0%
32 & CCU	95.8%	98.8%	100.0%	100.0%
33 / HAC	94.1%	95.0%	100.0%	100.0%
36	89.9%	99.0%	98.9%	100.0%
38	98.7%	99.3%	96.1%	100.0%
26	98.7%	99.4%	100.0%	100.0%
MAAU	92.7%	94.2%	97.1%	98.9%
FAAU	90.4%	91.7%	99.6%	99.3%
EDRU	100.0%	96.5%	97.9%	100.0%
Parksuite	99.3%	100.0%	100.0%	
SAU	100.0%	100.0%	100.0%	100.0%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	99.2%	98.4%	
M1	90.8%	93.4%	100.0%	90.3%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	95.7%	96.7%	99.3%	96.7%
53	94.4%	92.5%	100.0%	93.5%
Neonatal	71.1%		72.8%	
Children's	92.5%	95.0%	96.4%	100.0%
CRC	100.0%	98.8%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	99.4%	100.0%	100.0%
25	81.90%	98.20%	100.00%	100.00%

Oct-14

Ward name	Day		Night	
	Average fill rate - registered nurses	Average fill rate - care staff (%)	Average fill rate - registered nurses/	Average fill rate - care staff (%)
10	93.9%	97.3%	98.4%	100.0%
11	96.1%	94.0%	99.2%	98.4%
12	94.2%	98.6%	96.6%	96.8%
14/20	92.9%	96.6%	98.9%	100.0%
17	92.0%	96.6%	97.2%	100.0%
18	92.6%	99.5%	98.9%	100.0%
21	92.9%	100.0%	92.4%	100.0%
22	92.6%	98.1%	99.1%	99.3%
23	92.2%	99.5%	98.9%	98.4%
24 & Isolation	98.4%	99.6%	96.0%	99.2%
OPAU	94.7%	97.6%	85.5%	104.8%
30	93.9%	98.5%	100.0%	99.5%
32 & CCU	97.7%	98.8%	100.0%	98.9%
33 / HAC	96.5%	97.4%	97.8%	100.0%
36	92.9%	97.3%	97.8%	98.9%
38	97.6%	97.5%	92.8%	98.9%
26	98.3%	99.7%	100.0%	100.0%
MAAU	95.1%	92.2%	91.1%	98.9%
FAAU	95.4%	91.1%	96.7%	100.0%
EDRU	98.7%	100.0%	97.8%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	96.0%	96.5%	97.8%	88.8%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	100.0%	100.0%	100.0%	
M1	98.3%	98.6%	100.0%	96.5%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	96.1%	98.3%	99.6%	100.0%
53	96.0%	91.9%	99.2%	96.9%
Neonatal	98.6%		98.9%	
Childrens	94.3%	96.6%	93.8%	100.0%
CRC	100.0%	100.0%	98.2%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	100.0%	100.0%	100.0%

Number of Beds opened and closed during October – December 2014

	6/10	13/10	20/10	27/10	3/11	10/11	17/11	24/11	1/12	8/12	15/12	22/12	29/12
10	-								5 closed	4 closed			
12								6 closed					
20						4 closed							*5 closed*
sau	6	4	4						3	4			4
54											1		
21	*13 closed*	*9 closed*					*1 closed*	12closed					
22												*4 closed*	*14 closed*
23	1		2 closed						1	*3 closed*			
26		*29 ward closed*	14 contingency										
25	22	22	22	17	20	21	22	21	22	12	19	12	12
27								15				10	13
30										3 (on 14)	1		
ccu											2	2	1
Edru	2	2								1			
M2												*3 closed*	*8 closed*
mdw	10	10	10	10	10	10	10	10	10	10	10	10	10
14		26 cpe cohort	22pts not extra	12 pts Not extra	7 not extra	14							36
Total number closed Beds	13	40	31	0	0	4	1	18	5	7	0	7	22
Add. Beds	29	64	58	29	30	31	32	46	36	33	33	34	71
Balance	**+26**	**+24**	**+27**	**+29**	**+30**	**+27**	**+31**	**+28**	**+31**	**+26**	**+33**	**+27**	**+49**

Board of Directors		
Agenda Item	7.8	
Title of Report	CQC Final Report and Action Plan Update	
Date of Meeting	28 January 2015	
Author	Joe Roberts – Head of Assurance	
Accountable Executive	Dr Evan Moore – Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	12	
Data Quality Rating	Bronze – qualitative data	
Level of Assurance	Full	**Board confirmation**

1. **Executive Summary**
   This is an updated version of the action plan which was produced in response to the most recent Care Quality Commission inspection.

2. **Background**
   The Trust was inspected by CQC in September 2014. The inspectors visited A&E, and wards 1, 20, 21, 22 and 33, all at Arrowe Park. The inspection was in response to concerns that had been raised directly with CQC by patients, carers and staff. The subsequent inspection report stated that CQC had 'moderate concerns' about two standards – records and care and welfare of patients – and 'minor concerns' about three more (assessing and monitoring the quality of services, respecting and involving patients, and staffing).

   We developed an action plan which was approved by the Board in November and submitted to CQC in December. Subsequently to the plan being approved by the Board but prior to submission to CQC, some extra actions were added to the plan in early December at the request of the Director of Nursing and Midwifery. These mainly related to improving the nutritional needs assessment process, and to developing a new performance management and learning framework for Ward Sisters.

   The attached document is an updated version of the plan, which now shows the status of the actions in mid-January 2015.

3. Key Issues

Good progress is being made with implementing the plan. One action – reviewing the Discharge Policy – has been rescheduled from the end of December 2014 to the end of March 2015. This is because the changes required are broader than was originally considered necessary and it will be necessary to consult with our colleagues in the community about changes to the process, rather than simply updating the policy to reflect the changes made as a result of replacing paper documentation with Cerner Millennium.

4. Next Steps

We will continue to proceed with implementing this plan and we envisage that outstanding and ongoing actions will be completed in accordance with their deadlines.

5. Conclusion

Progress is satisfactory at this time and we do not have concerns about the completion of the remaining actions.

6. Recommendation

The Board is asked to note the progress which has been made and to support the remaining actions.

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Arrowe Park Hospital

Arrowe Park Hospital, Arrowe Park Road, Wirral, CH49 5PE

Tel: 01516785111

Date of Inspections: 19 September 2014
18 September 2014

Date of Publication: November 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Wirral University Teaching Hospital NHS Foundation Trust
Overview of the service	Arrowe Park Hospital is situated in the Upton area of Birkenhead, on the Wirral peninsula. It is one location of Wirral University Teaching Hospital NHS Foundation Trust and is one of the biggest and busiest acute trusts in the North West, serving patients across the Wirral peninsula and surrounding areas. They provide a full range of 'acute' health services for adults and children, an Accident & Emergency (A&E) unit and a Maternity Unit.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Long term conditions services Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 September 2014 and 19 September 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We conducted this inspection in response to a number of concerns that were reported to us relating to poor patient care and unsafe discharges. Specific concerns were raised that Ward 1 (surgical day case unit) was being used for patients being transferred from Accident and Emergency (A&E) and related to unsuitable bathing facilities for a mixed sex unit. We raised these concerns with senior hospital management alongside concerns around shortfalls in nutritional action plans for patients and requested an investigation into the care of a patient as a result. We found the system in place for monitoring the care practices for patients was inadequate which puts patients at risk of not having their needs met.

We visited six wards and departments in the hospital, spoke to patients and staff of different grades and reviewed case notes. We observed inconsistencies in the care being delivered in each area we inspected. All the nurses and support workers we observed talked to patients in a kind and professional manner.

We visited the following wards:
Accident and emergency (A & E)
Wards 21 and 22– Care of the Elderly Wards
Ward 1 –Surgical Day Case Unit
Ward 20 – Urology Ward
Ward 33 – Heart Assessment Centre, Cardiology and Renal Ward

On the above wards and departments we spoke with care support workers, staff nurses, ward managers, the deputy associate director of nursing for medicine and the matrons for surgery. In addition we spoke with the director of nursing and midwifery, the associate director of operations for medicines and acute specialties, associate director of operations for surgery and the head of human resources.

We identified some concerns regarding staff providing safe and appropriate care.

We found that the trust needed to take more action to ensure the records made by staff were accurate and promoted the wellbeing and safety of patients because records were incomplete on the care of the elderly wards.

We found the trust had some established quality governance systems in place from ward to board level. We did not have confidence that quality assurance and monitoring processes were sufficiently robust to effectively assess and monitor the quality of service that people received. Areas of ongoing work that required further improvement include the board assurance framework and the risk register.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 28 November 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

Patient's privacy, dignity and independence were not always respected.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Before our inspection we had received some concerning information in relation to poor patient care and during this inspection we saw instances where patients' dignity was not fully respected.

We looked at the trust's nursing strategy 2013-2018. The strategy set out the framework for delivering care and aims to ensure nurses, midwives and nursing assistants were clear on what was expected of them and how they would be monitored. This included a set of nursing and midwifery care standards in relation to privacy and dignity, clinical care, nutrition, hygiene, comfort, safety and communication. Each standard had a set of actions to define what they meant. For example, the privacy and dignity standard stated: "Patients will have clean, appropriate nightwear and bed linen at all times and patients will receive gold standard framework end of life care and will be cared for with compassion when they are at the end of their lives."

We were told that nurses, midwives and nursing assistants were involved in the development of the strategy and each member of staff had received a copy to sign and read. The document included a statement which said: "I confirm that I will uphold the values and behaviours described in the nursing and midwifery strategy to deliver exceptional patient care, every patient, every time".

We heard staff speaking with patients in a respectful way. We saw that family contact was encouraged and where necessary this was outside of the ward visiting hours. Visitors were observed coming and going throughout the day, except at lunch time as the ward managers told us they tried to keep this time 'protected' to ensure the environment was calm.

On wards 21 and 22 (care of the elderly) we observed some of the patients did not look

well cared for with little attention spent on their hair, facial hair and finger nails. We observed that some patients were wearing non matching hospital pyjamas with missing buttons, which were poorly fitting and exposed continence products. We spoke with a staff member who told us they: "Had too many patients to care for and [they] had been unable to carry out all personal care". Another staff member said: "I was going to go back and shave the men as necessary". This showed that care was not always person centred and delivered in line with patients' individual needs.

Although we found patients' privacy and dignity was mainly respected when carrying out personal care, we saw one example of when a patient's privacy and dignity could have been better promoted by using the curtains around the patient's bed as the patient was receiving end of life care.

Limited information was obtained from some of the patients we spoke with due to their communication difficulties or dementia care needs, however we spoke with six visiting relatives. One relative told us: "One day [my relative's] catheter bag was on the floor and sometimes the straps are not attached. It's a worry and it's not good."

During our inspection we visited ward 1 (day surgery unit). The trust told us that during extremely busy periods (escalation periods) this ward would sometimes be opened as an inpatient ward for short periods. We noted that the environment on ward 1 was not tailored towards maintaining patients' privacy and dignity. The ward was a mixed sex ward, however on discussion with staff it emerged that there was only one shower room on the ward that was adjacent to the male patient bay areas. The bay areas did not have appropriate storage facilities such as patient lockers which meant patients could not store their personal effects safely.

We looked at the trust's escalation policy which defined the processes to be followed to manage patient safety, flow and capacity. It defined the roles and responsibilities of staff in the event of escalation and includes a checklist for the opening of escalation areas to ensure they are fit for use. The policy also contained standard operating procedures for surgical specialities in the event that Ward 1 needed to be converted to an inpatient area. One of the requirements that must be in place to enable patients to be admitted to Ward 1 was "Admitted patients must be transferred to a bed with a patient locker, table and chair." This meant the ward had not been opened in line with the trust's policy as no patient lockers were available. The policy did not mention the lack of single sex shower facilities and how this should be managed.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During the inspection we highlighted some concerns relating to patient care on wards 21 and 22, both care of the elderly wards. We found examples where patients were not having their care needs met in a timely way and concerns regarding the staff providing safe and appropriate care. We identified issues in relation to poor communication between relatives and professionals. We also had concerns that a patient was not being regularly reviewed to ensure their care remained appropriate.

We observed a patient who had bed rails in situ. The patient's records showed a bed rails assessment had been completed, however the assessment did not recommend the use of bed rails as the patient could potentially try to climb over the rails. The bed rails in use were without any protection and we noted the patient was moving around in the bed. We were concerned this may lead to the patient sustaining an injury and asked if padded rail covers (also called "bumpers") were available. However, the nurse told us: "We haven't had bumpers for years". The inspector highlighted a bruise on the patient's leg to the staff, which staff were unaware of. We looked at the body map for this patient and there was no record of bruising recorded. This meant that without the appropriate detailed risk assessment and protective covers in place this patient was at further risk of harming themselves.

For frail elderly patients we observed some patients required additional one to one support to ensure their safety and care was monitored. An early warning score system was in place to monitor patients' conditions. Early warning scores are sets of observations that alert nurses and doctors to a possible deterioration in the patient's condition and allow prompt action to be taken to prevent further illness or complications. We had concerns that shortfalls in monitoring and safety checks of patients led to them not always being comfortable and having their essential needs met. We saw from completed observation charts on the day of the inspection that nurses had not completed all required observations. This meant there was a risk that doctors would not be alerted in a timely way to changes in a patient's condition and patients were at risk of not always receiving appropriate care and treatment.

We spoke with the ward manager about the usual arrangements over lunch and how they supported vulnerable patients. We were told there was usually a lunch time coordinator but due to two clinical support workers absence on the day of this visit, this had affected their usual organisation. We saw that patients were provided with a choice of suitable, nutritious food and drink.

The trust used the 'Red Tray' system to identify patients who needed additional support with their meals. We were told that patients on the red tray system would be supported to prepare for their meal, in addition these patients would be allocated a care support worker or nurse to provide one to one to support and encouragement when meals and drinks were served. This meant nutritional intake could be monitored and changes made as necessary. We saw that information about dietary needs including thickened fluids to prevent choking, pureed diet or if 'nil by mouth' was displayed above the bed of each patient. This was to inform housekeeping staff who served drinks and snacks and remind nursing staff and visitors so that patients were not accidently put at risk. This meant that a system was in place to communicate dietary need so that health and wellbeing was promoted.

However we had concerns that patients were not always in receipt of sufficient amounts of food and fluids. During our inspection we spoke with six relatives of patients. Comments from relatives included: "When we arrived here I was told, the care is terrible, you shouldn't keep your relative here", and "The weight has dropped off my husband since he came here. I have to sit by him as much as possible to assure myself he is getting some of the attention he needs." Another patient's relative told us, "It is evident to my eyes, the weight they have lost".

We selected four care records at random and found they contained a malnutrition universal screening tool (MUST). This is used to identify if patients were at risk of not eating or drinking sufficient amounts. Where patients had been identified as being at risk, we found they had been referred to a dietician. However, we also found that all four patients had lost significant amounts of weight during their stay in hospital. The ward manager told us patients for whom they were concerned would be highlighted on the ward's white board and on the patients' individual records. On ward 21 we found, the board had not been completed. We were told this was due to the ward having only moved back the previous night following re decoration. We were unable to confirm whether patients had been supported to have sufficient amounts of food and drink because food and fluid intake charts had not been fully completed. We asked the trust to look into these patients' needs during our inspection and we were provided with an action plan to address the shortfalls.

The atmosphere in the A & E department and some of the wards we inspected was calm and relaxed. Patients told us they were happy with the care they received and did not have any concerns relating to staffing levels or staff competence. They told us they would contact the trust's Patient Advice and Liaison Service (PALS) if they had any concerns about their care and treatment.

We spoke with six patients and their relatives on Wards 21 and 22. We received some mixed views about the care received. One patient told us they had been on the ward for two weeks and they had no concerns relating to their care. They told us they had no concerns relating to staff and that the nurses responded promptly when called. The patient was aware of how to contact PALS (patient advisory liaison service) if they had any concerns. Another patient's relative told us how they had raised a complaint regarding the

care of their relative. However, the relative had been invited to attend a case conference to discuss their relative's care and discharge arrangements.

We had some concerns around the management of patients being discharged back into the community. One patient's relative was distressed about the plans and communication around their relative's proposed discharge into a care home; they did not feel they were being supported with the arrangements and that staff did not appreciate how 'traumatic this was for them after 63 years of marriage'. Although the relative visited regularly they did not feel they had been kept informed about what was happening and when.

We discussed patients awaiting discharge with a doctor, they told us there were nine patients who were medically fit for discharge on Ward 22 but they were delayed leaving the ward due to lack of social care arrangements. This put additional pressure on the hospital in terms of patient flow and placed vulnerable patients at the potential risk of hospital acquired infections which could create additional medical and social concerns.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet patients needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with staff on all the wards and departments we inspected due to concerns raised with us prior to the inspection of a bullying culture that was allegedly present in the trust. Staff we spoke with had no concerns regarding bullying and we found no evidence to support this concern. However staff told us they had little opportunity to take their breaks and morale for staff on some of the wards was generally low.

In addition concerns were raised regarding staffing levels and the skill mix of staff. One area of concern highlighted was when inpatient beds were used on Ward 1.

The planned and actual staffing levels were displayed on a notice board in each ward we inspected. This showed the expected and the actual staffing levels for registered nurses and care support workers. We saw the wards were generally staffed in line with their expected levels on the days of this inspection. We were told by ward managers existing staff were able to work overtime and bank and agency were used to provide additional cover during periods of staff sickness or leave.

Comments from staff we spoke with on the care of the elderly wards included: We are "too busy" and 'I've been too busy to spend time with patients to encourage fluids this morning as I've had 15 patients to support" and "I am leaving the ward because I go home feeling dissatisfied about the quality of care I can give these frail patients. I have not had the training and support I should have received".

On one care of the elderly ward we observed two patients who were in need of immediate attention from staff on more than one occasion. We had serious concerns about the deployment of staff on the ward as we were unable to locate staff to meet these patient's needs in a timely way. We alerted staff to a patient's nasal oxygen not being effective due its position, a patient who was causing themselves harm due to their bed rails and for a patient whose condition was deteriorating. Due to the nature of these concerns these patients required close observation and staff were not available in the bay to observe and meet or respond to the patients' needs in a timely way.

Senior staff confirmed that ward 1 was frequently used as an inpatient ward to relieve bed pressures across the hospital, including patients from both medical and surgical specialties. We looked at a sample of bed occupancy figures. This showed from the 2 September to 17 September 2014 the ward had 26 medical patients occupying beds on this surgical ward. We discussed our concerns with senior management for surgery who told us the majority of patients only stayed overnight while they were awaiting beds in a more appropriate ward and additional staff were made available to provide care for patients. The associate director of nursing for surgery confirmed that the hospital had cancelled elective surgery to reduce the number of day case patients when the ward had been used for inpatients.

The trust's escalation policy checklist stated to ensure ward 1 was appropriately staffed there must be a "minimum 1 registered nurse per shift to be deployed from substantive post within medicine."

The associate director of nursing for surgery told us that as part of the escalation process only patients with low acuity should be identified to stay on ward 1. Acuity refers to the level or intensity of nursing care a patient requires. Staff from other wards should then be sourced to provide specialist (e.g. medical or surgical) support for patients staying overnight. However, the ward staff we spoke with told us that the patients were not always accompanied by appropriately trained staff and staff on ward 1 were required to care for these patients.

Staff talked about the skill mix of staff and how at times they were moved to other wards where they did not always feel they were as effective as they could be. We saw nurses were moved on a regular basis from one ward to another. Staff told us this was 'frustrating' and did not always leave their ward with the continuity of staff or with staff who knew the patients'.

In A & E we did not highlight any concerns with the levels of nursing staff on the day of the inspection. The A & E department appeared to be appropriately staffed with an appropriate skills mix. The environment appeared calm and staff were able manage the flow of patients appropriately. The A & E department was managed by an A & E coordinator, whose role included preparing staffing rotas and monitoring patient flow. The coordinator was supported by a team of nurses and clinical support workers. We spoke with nursing staff who told us the number of nursing staff and the skills mix within A & E was appropriate unless there were issues with sickness or leave.

Concerns were raised that when staff were off sick or on leave the staffing was 'stretched'. Some concerns were raised in relation to the need for changes in the skill mix. One nurse told us there were not enough band 6 nurses on each shift (due to sickness and leave) and this had an impact on their workload. However, staff confirmed that they were able to cope with the extra work to ensure patient safety was not impacted. They told us they regularly missed their breaks because they were busy.

We had received some information of concern relating to the use of additional beds within ward 14(Urology). This ward was closed at the time of our inspection. The matron for urology, general and special surgery told us the urology ward had moved to ward 20 from ward 14 during July 2014. We did not highlight any concerns with the levels of nursing staff or skills mix on the day of the inspection. Ward 20 was a 29-bedded ward that was staffed appropriately and there was no physical capacity on this ward to increase the number of patient beds.

During our inspection we received information of concern that Ward 33 regularly had nursing staff transferred to support shortages on other wards which would leave nursing staff on night duty with a high number of patients to support. From the records we reviewed, we found that this was correct. There were instances when nurses from the ward were moved to support shortages on other wards and backfill did not always occur. This meant there were occasions when two nurses were responsible for 29 patients. This meant there were times when the hospital was not adhering to the trust's target staffing levels of 1:10 at night.

The ward manager for ward 33 told us the majority of nurses were experienced and not newly qualified nurses. The ward manager told us the skills mix of the staff on the ward was not always appropriate for the types of patients on the ward. For example, there were no renal specialty trained nurses on the ward on the day of our inspection (due to leave or sickness).

The ward manager told us all the nursing staff had undergone basic induction training in renal care so patients were not at risk. They told us that they planned to train all the nursing staff in cardiology and renal specialties in the future so they could be better utilized. There were no specific timelines for when this would take place.

The ward manager confirmed that one nurse was frequently taken off the ward during the night shift to support escalation beds elsewhere in the hospital. We spoke with two nurses (band 5), who told us it was difficult to provide suitable care for high dependency (dialysis and cardiology) patients with only two nurses on the night shift. They told us they often had to miss their breaks due to the increased workload. They also told us they felt the workload was better managed when there were three nurses on the ward during the night shift.

We looked at the trust's workforce and organisational development strategy 2013-2016 to support us in making a decision if the trust had an appropriate risk assessment and escalation in place for staffing. The strategy aimed to ensure the trust had "the right people, at the right time, with the right knowledge and skills and the right approach". The strategy set out objectives such as "Improve the capacity of the organisation to maximise the deployment of its workforce in order that the trust can meet/respond to organisational challenges and deliver safe and reliable services". In response to staff sickness there had been a drive in "wellbeing" interventions in hotspot areas such as a self-care course, a stress working group and a flu vaccination campaign.

We saw that a board report containing planned and actual staffing on a shift by shift basis at ward level for the previous month was presented monthly. The minutes for the Quality and Safety committee (10 September 2014) showed the July 2014 report and outlined the operational challenges faced. The report identified that July was a key holiday period and access to bank nursing staff had been a challenge, this had led to a reliance on overtime and agency nurses. Data showed that at times, the older people's assessment unit, ward 33 and HAC, neonatal unit and ward 38 had not met the trust's 90% staffing fulfilment target for registered nurses on nights. The reasons given for these shortages were: outstanding vacancies, additional beds open at the beginning of the month, short notice sickness and staff relocated to contingency areas .However, the report also stated that despite these difficulties the data for June and July showed that Royal College of Nursing and other professional guidance of 1:8 (days) and 1:10 (nights) had been met.

During the inspection the trust provided us with details of staffing on ward 1 and the number of instances it had been used as an inpatient ward. From 1 September to the 17

September, the ward had been used as an inpatient facility on 11 occasions. Staff to patient ratios were within recommended levels (1:8 during the day and 1:10 at night) with the exception of Thursday 9 September when the ratio of nurses to patients at night was 1:14. In terms of skill mix, at least one of the nurses per shift was from a substantive post usually within medicine and an agency has then been used to back fill. It is not clear from this report whether there was a mix of surgical and medicine nursing staff. There is a comment at the end of the report which states "When staff were moved from wards this relates to inpatient wards so ward 1 would be staffed by our own hospital trust nurses to ensure appropriate clinical skill set."

We reviewed records from 26 August to 19 September 2014 which showed the trust had a system in place for reviewing staffing levels on a daily basis. These reports showed that staffing shortages were being covered and every effort was made to ensure appropriate skill mix by ensuring agency staff were supported by permanent staff. However, there was limited flexibility to cope with additional sickness absence or opening of escalation wards.

One email sent on 31 August 2014 from the deputy associate director of operations, medicine and acute division states: "It has been a challenging weekend for staffing and bed availability particularly Saturday which has involved considerable time and effort to manage. The impact upon flow has been kept to a minimum but could have had significant effect on performance." Another email sent by one of the matrons from medicine and acute specialities on 6 September states "There have been the usual difficulties in trying to ensure all areas adequately staffed. Again a number of staff and bank staff are sick or did not attend which caused added pressure." On 7 September the staff planning email showed that a registered nurse night shift was not covered on two wards and patient acuity was not covered on one ward (ward 33). This confirmed there were constant challenges to meeting adequate staffing arrangements.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

Good evidence was seen of analysis, learning and assessing risks to quality. However, there were some shortfalls in the quality governance systems in place at ward level. As a result we found systems in place did not always identify and manage risks accordingly.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

A review of the majority of risk and governance systems in place was undertaken via document review and interviews with staff. In addition we reviewed how systems were implemented at ward level.

The trust described its comprehensive process for managing alerts, such as Central Alert System broadcasts in its 'Actioning Safety Alerts Policy'. Monitoring reports for alerts were also provided and reviewed. In addition to the central alert system broadcasts, the trust also monitored internal alerts as a mechanism to share key safety issues arising from internal investigations or findings.

There was a Clinical Audit Policy and Procedure in place which described the process for developing the annual clinical audit plan against agreed priorities and how to register and undertake a clinical audit. A quarterly report was produced to monitor progress against the annual plan, including completion of reports and associated action plan. This process appeared to be well embedded. We could see evidence of audits being presented locally at 'Good Practice Days' held bi-monthly in the medicine and acute specialties division and being discussed in service level governance meeting minutes.

Where audit findings identified non-compliance, evidence was seen of risk assessment and inclusion on the risk register.

An internal audit was undertaken during 2013/14 by an external audit and consultancy provider. The audit concluded there was 'significant assurance' around the clinical audit processes. We saw evidence that some of the actions agreed following this audit had been completed during our inspection. However during our inspection we found there were issues with the quality of care provided on some wards. These issues had not been identified as part of the trust's "nursing audit" process. This meant the systems in place had not identified some of the risks to inappropriate care and treatment at ward level.

The trust's Concerns and Complaints Handling Policy described the processes available for staff when a concern or complaint was raised. This ranged from resolving issues at ward and department level to the formal complaints process. The trust had made some significant improvements in complaints over the last 12 months. These improvements included increasing the proportion of complaints that were responded to within agreed timescales. .

The trust also planned to introduce a 'Complaints Scrutiny Team' with the first meeting scheduled for December 2014. The aim of the group will be to review eight to ten randomly selected complaints to consider the quality of the responses and if appropriate identify learning as a result of each complaint.

The executive director team received a monthly complaints summary to track progress and learning from complaints. The trust had 10 referrals made to the Parliamentary and Health Services Ombudsman during 2013/14. Of these 10, no complaints were fully upheld and two were partially upheld.

There were comprehensive governance structures in place throughout the trust. The board of directors received assurance from the quality and safety committee for the majority of quality governance issues. Reporting into this committee was the patient and family experience group, clinical governance group, workforce and communications group and the risk management group.

In addition to the formal board committee structure there was a monthly trust-wide clinical governance team meeting to keep on track of operational governance issues. All divisions also had a clinical governance meeting and service level meetings. We were also provided with divisional exception reports and evidence of learning being shared at ward and department meetings. The structure appeared to work well with good evidence of issues, risks and learning being communicated in all directions.

We saw evidence of analysis and learning from incidents at all levels of the organisation via meeting minutes.The quarterly 'serious incident trend' report also monitored compliance with incident management. This was particularly poor with regards to the incident report being received within two working days for serious incidents. Compliance with the time to complete the investigation was variable and, similar to complaints, was more likely to go over agreed timeframes in the acute care and medical specialties division. This division had more serious incidents than the other divisions with 21 of the 42 in the quarter one report being from this division.

We reviewed a selection of serious incidents from all divisions. It was not clear from the report template that root cause analysis tools and techniques were used. We saw there was no formal section for care or service delivery problems. We saw evidence of learning from serious incidents.

The trust had a positive patient safety incident reporting culture. However, during the inspection staff told us about staffing level problems that they were not reporting as incidents despite telling us staffing was an issue on a regular basis. This meant the trust could not be assured that analysis of incident reports provided an accurate picture of issues within the hospital.

The trust undertook a review of its systems and processes in relation to all NICE guidance issued from January 2012 to December 2013. The monitoring systems in place reported

that the trust was 'unassured' about compliance with 75% of guidance. The trust had recently changed its process to accept other forms of evidence from the divisions to confirm assurance. From 79 pieces of guidance that were recorded as 'non-compliant' or 'not assured', only three had not had a risk assessment completed for inclusion on the risk register.

Following our inspection the trust told us that when guidance is published, the lead for each piece of guidance must complete an initial response form. This meant that initially most guidance would be un-assured. Therefore whilst the report was correct in that 75% of the guidance in the report was unassured when disseminated after publication, only 24% of the guidance remained unassured at the time the report was written in February 2014. The trust hoped that its new streamlined processes, with clear responsibilities, will improve compliance and help support service improvement through the NICE Quality Standards.

The trust had a Quality Improvement Strategy 2013-16. This document had measurable outcomes and was monitored annually. A progress report in June 2014 showed progress in most areas but acknowledged that not all milestones had been met.

For example, the priorities for 'patient experience', 'Improve care for patients with dementia' and 'ensure patients are supported with eating and drinking based on their individual needs' were both areas highlighted by the inspection team as being concerns in the ward areas.

As part of the inspection we reviewed the risk register including high level risks scoring 15 and above and the Board Assurance Framework. The Board Assurance Framework was aligned to the strategic objectives, with clear risk descriptions, appropriate controls and sources of potential assurance identified. However, the Board Assurance Framework did not include any risk scores, which could make it difficult for the board to understand the level of risk it was carrying, where it was aiming to be by the end of the financial year and tracking progress along the way. We were told that this had been identified and the trust planned to review the Board Assurance Framework and look at risk scoring and ranking.

The risk register reflected the risks that staff told us about during the course of the inspection along with potential risks we identified through document review. Overall the risk descriptions described the condition, cause and consequence although the quality was variable. On discussion with the associate director of risk it was agreed that the risk ratings were not always consistent or appropriate to the actual risk presented. The associate director of risk had introduced a training programme to educate staff about forthcoming changes in risk management. We were provided with the risk assessments to accompany this risk register and found them to hold far more detailed information than the risk register itself. Some of the actions completed on the risk register had dates of 2010. There was no indication on the risk register of the dates when the risks were identified, which made it difficult determine whether risks were being managed in a timely way.

There appeared to be a strong risk culture within the trust with the risk register used appropriately for risks to quality through non compliance with NICE, clinical audit findings, external reports, internal audit findings and quality impact assessments for cost improvement programmes. Annual reports were also undertaken for key governance areas, such as risk management, clinical audit, complaints, and incidents to identify further areas for improvement for well-embedded systems and processes.

We saw information displayed on the wards that demonstrated performance data and

analysis of audits and incidents. Ward level data was then reported on in the 'safety thermometer' and ward 'dashboards'. Evidence was seen of quarterly ward health and safety inspections having taken place and discussed at ward meetings.

Overall we found that the trust had systems in place to monitor and assess quality and safety. However some of these systems were not fully embedded and were not always effective in identifying and managing the risks at ward level.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not adequately protected from the risks of unsafe or inappropriate care and treatment due to inadequate care records.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

This outcome was added because we found additional issues during the inspection with the accuracy of record keeping within the medical, care of the elderly wards. We also found shortfalls in the completion of records for checking of resuscitation equipment and drug fridges.

We looked at the nursing documentation for six patients during this inspection. We found that when patients were admitted to hospital their needs were assessed and nursing documentation was completed. Assessments reflected individual patients' needs and included general and specific assessments such as risk of falls, pressure ulcers, bed rail use, modified early warning score (MEWS) and nutrition. Where risks were identified a specific plan of care was documented. Assessments seen included those undertaken by nursing, medical and other allied healthcare professional staff.

Our review of the documentation and risk assessments showed there were some shortfalls. For example, we had concerns about the accuracy of a bed rails risk assessment for one patient. The assessment showed bed rails were not recommended as the patient may have attempted to get out of bed or may lead to increased confusion. However, we found bed rails were in use for this patient and the rationale for using bed rails had not been recorded as required.

We looked at the nutrition and dietetics forms for three patients. These showed patients had been seen by a dietician, following referral due to their weight loss. The dietician's actions plans included comments such as: "commence food charts", "encourage high protein diets with milky drinks", "request strict food records please", "unable to locate food record charts", "provide snack between meals and a pint of full fat milk daily".

Where the dietician had reviewed patients, their reports stated: "Not meeting the fluid recommendation a patient required". Another report stated: "Unable to locate food record charts. Please monitor plan. Strict food records", "Fluid intake remains poor" and "Currently not meeting fluid recommendation". On checking food intake records we found

them to be unavailable or incomplete. This meant there was a risk that patients were not receiving appropriate food and drink because records did not accurately reflect nutritional intake.

We could not find evidence in the records that patients were checked regularly in line with trust policy to make sure they were clean, comfortable, had access to fluids and a call bell to hand. These quality and safety checks would ensure patients were comfortable and had their essential needs met. We looked at the MEWS (Modified early warning scores) chart for a patient who was visibly unwell. This showed there had been no recording of the patient's observations since "12:10" the previous day. It was not clear from the record whether this was 12:10 am or pm.

Staff used a checklist for the discharge of patients from the wards. Patients on the care of the elderly wards were discharged directly from the wards, whereas other patients awaiting discharge were transferred to a discharge lounge. We looked at the records for two patients who had been discharged during the inspection or were in the process of being discharged (one on ward 33 and one on ward 21). The checklists had not been completed.

We spoke with two patients on ward 1 who were due for discharge, they told us they hadn't been spoken with about their discharge plans. However records completed by the staff stated discussions had been held. The staff we spoke with told us they had a verbal discussion with patients so they had all the relevant information they needed. This showed that patients were not always provided with a clear written record of their discharge plan.

We spoke with a social worker on a care of the elderly ward. We looked at the assessment information they had been provided with in order to make a judgement on the patient's current abilities. We had concerns about the lack of detailed information provided on the assessment and the lack of a summary for this patient in relation to their rehabilitation, mobility and required level of supervision. The social worker had raised their concerns with the ward manager.

We saw there were booklets called 'This Is Me' for patients with dementia or their families to complete. This was a tool used for caring for people with dementia to inform staff about their needs, preferences, likes, dislikes and interests to enable individualised care and support. We found that some had not been completed at all. One staff member told us: 'Clearly it's not possible, if no relatives visit'. We were concerned that there was no other detailed personal record of the patient's likes or dislikes readily available to inform the staff. This meant patients were at risk of receiving inappropriate care due to a lack of proper information about them and their needs.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Nursing care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Patients' rights to privacy and dignity were not always respected and upheld. Regulation 17 (1) (a) and (2) (a), Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The care and welfare of patients at the trust were not always being met, or met in a timely way. Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met:

This section is primarily information for the provider

	The trust did not always have sufficient members of suitably qualified persons on duty to meet patients needs and patients needs were not always met in a timely way. Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Systems in place did not always effectively identify and manage risks relating to the health, welfare and safety of service users. Regulation 10 (1) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not adequately protected from the risks of unsafe or inappropriate care and treatment due to inadequate care records. Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 28 November 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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ACTION PLAN IN RESPONSE TO CQC INSPECTION, SEPTEMBER 2014

Issue	Action	Responsible Person Name/Designation	Due Date	Status
Outcome 1 – Respecting and Involving people who use services				
Patients' Appearance and Hygiene On two wards patients were observed to look 'not well cared for' with little attention spent on their hair, facial hair and fingernails, and some were wearing pyjamas that did not match.	Relaunch process of Patient Focused (intentional) rounding within Medical and Acute Specialties, and roll out in other clinical areas	Associate Directors of Nursing	End Dec 2014	*Complete* – November 2014
	Recruit Patient Focused Rounding champions	Associate Directors of Nursing	End Dec 2014	*Complete* – December 2014
	Revise Matron Ward Round checklist to include whether patient focused rounding has been done	Director of Nursing and Midwifery	End Sept 2014	*Complete* - September 2014
	Purchase new supply of single-colour pyjamas following review of nightwear	Laundry Manager	End Dec 2014	*Complete* – December 2014
Dignity at the end of life CQC observed one instance where a patient was at the end of life and their dignity was not maintained by drawing the curtains around their bed.	Conduct an RCA investigation into the incident that was observed by CQC where a patient was not recognised as being at the end of life	Matron within Medical Specialties	End Dec 2014	*Complete*– following review of the details of the case it was considered more appropriate to investigate the matter through the Human Resources process
	Review leadership arrangements of the ward where this was observed	Associate Director of Nursing – Acute and Medical Specialties	End Sept 2014	*Complete* - September 2014 Following this inspection there has been a change of leadership on the ward, with the previous sister moving to a different role.
Ward 1 – Same Sex Accommodation The ward is a mixed sex ward but there is only one shower area, which is adjacent to the male patient bays. Our Escalation Policy does not mention the issue of same sex shower facilities.	Cease to use Ward 1 as an escalation area by removing it from the Escalation Policy	Director of Nursing and Midwifery	October 2014	*Complete* - October 2014
Ward 1 – Lack of Lockers Ward 1 did not have appropriate storage facilities, e.g. patient lockers, for patients to store their personal belongings securely.	As ward 1 will no longer be used as an escalation area, this is no longer an issue as lockers are not provided for day case patients.	Director of Nursing and Midwifery	October 2014	*Complete* - October 2014

Outcome 4 – Care and welfare of service users				
Availability of 'bumpers' A patient was found to be in a bed with rails and to have suffered a bruise. No padded rail covers had been used and staff said that the hospital did not have any of these or use them.	Procure bumpers and provide two to each ward	Specialist Matron for Dementia Care	End Dec 2014	*Partially complete* – these have been ordered from our supplier, but we are waiting for them to be delivered.
Medical Early Warning Scores CQC noticed that in some cases not all observations had been completed, with the risk that doctors might not be alerted promptly to a deterioration in the patient's condition.	Implement red card alert system	Ward Sister within Acute & Medical Specialties division	End Dec 2014	*Complete* – this has progressed further. In addition to the red card placed at the end of the bed, the Cerner Millennium system now has an electronic flag for the frequency of vital signs observation
	Ensure staff on the wards where this was found, are aware of the exemption policy	Ward Sisters	End Sept 2014	*Complete* – September 2014
	Monitor compliance through revised Matron's Ward Round	Matrons	End Sept 2014	*Complete* - October 2014
	Use laminated action cards by patient's bedside as a visual prompt of when MEWS next needs to be completed	All nursing staff	End Sept 2014	*Complete* – see comments above regarding red card system
	Investigate how the new Cerner Millennium electronic patient records system can be adapted to alert staff that observations need to be completed	Associate Director of Nursing – Surgery and Women's and Children's	End Jan 2015	*Complete* – this has already taken place and the system now flags when observations are needed.
Patients at risk of malnutrition CQC selected a random sample of four patients to review their nutrition plans. All four patients had lost significant amounts of weight in hospital. Food and fluid intake charts had not been completed so it was unclear whether they had received enough food.	Revise food chart and fluid chart to show weekly nutrition rather than daily, and to show dietetics plan on the chart rather than in the casenotes	Ward Sister within Acute & Medical Specialties Division	End Oct 2014	*Complete* - October 2014
	Implement paper version of new charts across the Trust following approval by the Nutrition Steering Group	Deputy Chief Nurse	End Jan 2015	*Partially complete* – these charts are now in use in several clinical areas; the Deputy Chief Nurse is to meet with the Nutritional Steering Group later in the month to agree their wider usage
	Design and implement electronic versions of charts through Cerner Millennium patient information system	Deputy Chief Nurse	End April 2015	*Pending* – not yet due
	Monitor the above as part of the revised Matrons' Ward Round checklist	Matrons	End Sept 2014	*Complete* - October 2014

	Review process for MUST nutritional screening with a view to making the process more personalised around the patient's specific needs, in discussion with dieticians and the Nutritional Steering Group	Deputy Chief Nurse	End Jan 2015	*Pending* - the Deputy Chief Nurse is to meet with the Nutritional Steering Group later in the month
Discharge Some relatives told the inspectors that they had been dissatisfied by the level of communication regarding a patient's discharge to a care home. Nine patients on ward 22 were medically fit for discharge but remained in hospital because there were no social care arrangements in place.	Revise Discharge Policy to provide greater consistency across the hospital and reflect the implementation of Millennium	Nicky Martin (Matron)	End Dec 2014	*Ongoing* - Following the implementation of Cerner, and feedback from key stakeholders, a thorough review of the policy needs to be undertaken. The date has been revised to **31st March**. The new Deputy Chief Nurse, who has just taken up her post, will lead this working group.
	Hold 'Check and Act' meetings consisting of divisional leadership triumvirates and ward sisters to review the cases of individual patients who present a problem regarding discharge	Associate Directors of Nursing and Clinical Heads of Division	Already occurring	*Complete* - September 2014
	Implement 'Ticket Home' project within clinical divisions	Associate Directors of Nursing	Already occurring	*Ongoing* – 'Ticket Home' is in place in several wards. The Deputy Associate Director of Nursing for Clinical Support is developing a process to monitor its implementation and has produced an action plan.
	Improve patient flow within the hospital by streamlining bed management in surgery with medicine, moving across to bed management team	Deputy Director of Operations	Nov 2014	*Complete* - November 2014
Outcome 13 - Staffing				
Ward 33 – Night-time staffing levels CQC observed from staff rotas that there were occasions when the target staffing level of one nurse to ten patients at night was not being met.	Plan on a daily basis through divisional staffing meeting to retain the third registered nurse on the ward	Associate Director of Nursing – Acute & Medical Specialties	End Sept 2014	*Complete* - September 2014 Reviewed at the staffing meeting daily
General issues regarding staffing levels Several wards had not met the 90% fulfilment target for registered nurses on night shifts for reasons including: outstanding vacancies; short notice sickness; additional beds being opened; and staff being transferred to contingency areas. Current staffing levels allow only	Target areas with high levels of sickness absence in certain areas of Medical Specialties by requesting additional support from the Absence Management Team and monitoring adherence with the Attendance Capability Policy through regular 1:1s with Matrons and Ward Sisters	Deputy Assistant Director of Nursing – Medicine	End Sept 2014	*Complete* - September 2014

limited flexibility to respond to these situations. CQC observed that some wards were moved very frequently between wards, meaning that there was a lack of continuity in patients' care.	Undertake establishment review of current ward nurse staffing levels against NICE guidance to inform budget setting for 2015/16 financial year	Director of Nursing and Midwifery	End Nov 2014	*Complete* - November 2014
	Present findings of first stage of the review to Executive Director Team meeting	Associate Directors of Nursing, Associate Directors of Operations	End Dec 2014	*Complete* – this was presented to the Divisional Review Meeting on 16th December.
	Undertake second acuity audit	Associate Directors of Nursing	End March 2015	*Pending* – not yet due
Outcome 14 – Supporting staff				
Leadership Visibility The topic of nursing leadership was not explicitly covered by the inspection report, but we consider that more visible leadership at ward level may help to identify some of the problems which CQC observed and ensure that they are dealt with promptly.	Meet with ward sisters and matrons to define clear expectations for individuals in those roles, and how they will be held to account	Associate Directors of Nursing	End Sept 2014	*Complete* - September 2014
	Arrange for Band 7 sisters to be rostered for two clinical shifts per week, and for Matrons to be rostered for one clinical shift per week	Associate Directors of Nursing	Dec 2014	*Complete* - September 2014
	Ensure attendance by sisters and staff nurses from each area at the leadership event to be held on 1st October	Associate Directors of Nursing	Oct 2014	*Complete* - October 2014
	Scope, design and implement a system of performance management for Ward Sisters and Charge Nurses	Deputy Chief Nurse	End Mar 2015	*Pending* – not yet due
Supervision and Preceptorship Although this was not referenced in the inspection report, the Inspectors did speak to some new nurses who had not been able to access preceptorship.	Clinical Facilitators to complete spot check on records of twelve preceptees across the Trust	Practice Education Facilitators	End Sept 2014	*Complete* – October 2014 Two audit reports have been produced based on the results of this exercise
	Matrons to provide assurance over preceptorship arrangements in their own areas of responsibility – specifically that there are mentors for all staff who require preceptorship and that they meet regularly with their preceptors	Matrons	End Dec 2014	*Complete*– this information is now held on a database by the Practice Education Facilitators. Q & S Committee 14.01.15 requested that KPIs be developed and reviewed in the future
Education and Development for Ward Sisters The education and development of ward managers and charge nurses is a known factor in determining the quality of nursing, and all Ward Sisters are on a programme to achieve their first degree.	Review progress of ward sisters towards achieving first degree (BA / BSC) every six months through Practice Development and Research Partnership with Chester University	Deputy Chief Nurse	End May 2015	*Partially complete* –a baseline audit of training received by Ward Sisters is being undertaken to identify gaps and Sisters will be required to be booked on the appropriate courses.

Outcome 16 – Assessing and monitoring the quality of services				
Patient Focused Audit The report commented that some of the issues which CQC had observed had not been identified by the Patient Focused Audit which is carried out monthly by Corporate Nursing and that *"this meant the systems in place had not identified some of the risks to inappropriate care and treatment at ward level".*	Review content of, and approach to, Patient Focused Audit, which will also need to be revised in any case to reflect the implementation of Cerner Millennium	Director of Nursing and Midwifery, supported by Corporate Nursing Audit Team	End Dec 2014	*Ongoing* – we have developed an expanded ward dashboard which includes information from other sources besides the quarterly audit. Corporate Nursing are currently in discussion with IT regarding developing automated reports which will reflect the new way of working under the Cerner Millennium system.
	Revise content of Matron ward rounds to focus more specifically on issues of concern	Director of Nursing and Midwifery	End Sept 2014	*Complete* - September 2014
	Develop a programme of mock inspections against the new CQC Fundamental Standards, based on the Lead Nurse Gemba walks which were done in 2012/13	Head of Assurance	End Dec 2014	*Complete* – checklist has been developed and pilot phase of mock inspections scheduled to commence during week commencing 19th January.
	Improve response rate for Friends and Family Test in the wards which were visited by engaging with Consultants, making more use of promotional materials, and publishing achievement charts to compare results from different areas. This provides an extra source of assurance and a 'reality check' against which to compare our own audit results.	Deputy Assistant Director of Nursing - Medicine	End Dec 2014	*Complete* – from late December we have been distributing green 'exit cards' on discharge from inpatient wards and assessment areas to patients who have not completed a questionnaire during their stay, and there are bins near the exits to the building where these can be placed.
Root Cause Analysis Reports CQC reviewed a sample of RCA reports. It was not clear from the reports whether root cause analysis tools and techniques were used, and there was no formal section in the report template for care and service delivery problems.	Review NPSA Level 1 and 2 template to include care and service delivery problems and a reference to the tools used	Risk Manager	End Dec 2014	*Complete* – October 2014
Board Assurance Framework The Assurance Framework did not include risk scores and did not correlate with the risk register, making it difficult for the Board to understand the level of risk which the Trust was making and how this had changed	The two Assurance Committees (Quality and Safety and Finance, Business Performance and Assurance) to review the BAF in terms of the generic natures of the risks, controls and assurances and also how they should be risk-scored	Associate Director of Governance	Oct 2014	*Complete* - October 2014

over time.	Meet with Internal Audit to agree revised methodology for the Assurance Framework	Associate Director of Governance	End Dec 2014	*Complete* – November 2014
	Present revised Assurance Framework to Audit Committee for approval	Associate Director of Governance	End Dec 2014	*Complete* – 4th December 2014
Risk Ratings CQC considered that the risk ratings of entries on the risk register were not always appropriate to the severity of the risk presented.	The risk score of all risks on the risk register have been reviewed and agreed by the appropriate group as per the Trust Governance Structure. However it has previously been highlighted that the Trust does not currently use a residual risk score when actions are completed to mitigate the risk, therefore this will be reviewed in line with the full policy and process review of the Risk Management Strategy	Risk Manager	End March 2015	*Pending* – not yet due
Outcome 21 - Records				
Record-keeping by nursing staff The inspectors found shortcomings and gaps in the following areas: - Bed rails assessments - Food and fluid intake charts - Discharge checklists - Information to be used by social workers regarding patients' rehabilitation, mobility and required level of supervision	Revise Matron Ward Round checklist – includes completion of documentation for DNAR, falls assessment, bedrails assessment and MUST	Director of Nursing and Midwifery, ADN Surgery & Women's and Children's	End Dec 2014	*Complete* – October 2014
	Develop a daily ward routine, including a checklist for the Ward Sister / shift co-ordinator to complete	ADN Surgery & Women's & Children's, supported by Matrons	End Sept 2014	*Complete* - September 2014
Discharge Plans CQC found that patients were not always provided with a clear written record of their discharge plan, with only verbal discussions taking place, and not being recorded.	See actions relating to discharge for outcome 4 above			
'This is Me' booklets for dementia patients The inspectors noted that for some dementia patients, these booklets, which document their needs, preferences, interests and likes and dislikes, had not been completed. This put the patients at risk of receiving inappropriate care.	Monitor whether 'This is Me' booklets have been given out and completed as part of the quarterly Dementia Carers and Relatives' Audit and escalate any areas of concern to ward sister or Matrons as appropriate	Specialist Matron for Dementia Care	End Dec 2014	*Ongoing* - The carer's audit continues and the last quarterly audit was done in December. The results of the audit continue to be disappointing. A number of actions are planned or underway, such as the launch of the Dementia Strategy in February and providing on-line training. We are monitoring dementia care as one of our Quality Account priorities for 2014/15.

Board of Directors		
Agenda Item	8.1	
Title of Report:	Monitor Quarterly Return	
Date of Meeting:	28 January 2015	
Author:	Emma Pridgeon, Assistant Director of Finance – Corporate Financial Services John Halliday, Assistant Director of Information	
Accountable Executive :	Alistair Mulvey, Director of Finance Sharon Gilligan, Director of Operations	
FOI status	Document may be disclosed in full	
BAF Reference	13 & 14	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	**Board Confirmation**

1. EXECUTIVE SUMMARY

Foundation Trusts are required to submit a report to Monitor on a quarterly basis using templates provided, covering targets and indicators, governance and finance. The basis of the report for Quarter 3 2014/15 is described below. The key financial statements are included in the Appendices 1-4.

As the Trust is on monthly monitoring it also submits monthly financial information and a more summarised commentary for the month. The reports for months 8–9 are included on the agenda and have been circulated to FBPAC upon submission to Monitor each month.

The Board are asked to review and recommend the quarterly submission, cognizant of the feedback from the FBPAC which reviewed the submission at its meeting on 23rd January 2015. The Board of Directors are also asked to note that subsequent to the distribution of FPBAC papers a proposed year end financial contractual settlement has been proposed by the CCG and good progress has been made to conclude the sale of Springview in the final quarter of the financial year.

The Board of Directors is asked to approve the compliance report which will be submitted to Monitor.

2. BACKGROUND

Governance Targets & Indicators

Under Monitor's Risk Assessment Framework, each indicator has an equal weighting of 1 point for each standard not achieved. The overall Governance ratings are Green for no concerns (i.e. all targets met). Beyond this, the failure against targets raises Governance concerns at Monitor, with no RAG rating being assigned until such time as formal regulatory action is taken and a Red rating applied.

WUTH will not be considered Green for Quarter 3 and issues of note with the Risk Assessment Framework standards are detailed below.

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the final Quarter 3 position was 92.24% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. Therefore the Trust, like many others, failed this performance target.

The start of Quarter 4 has seen a significant increase in the non-elective pressures felt by the Trust. In January the hospital has seen the highest number of non-elective medical admissions ever and the UK has seen the worst weekly ED performance since the commencement of weekly reporting.

It is encouraging to note that the communication agenda the Trust has led on with the BBC and Sky News appears to have been effective as the Trust has seen a reduction of inappropriate Emergency Department attendances. Whilst this is positive it makes it more difficult to achieve the target as the patients who are attending generally require more time and attention.

The absolute numbers of ED presentations hasn't increased although the acuity of the patients presenting at the Emergency Department has increased significantly, which is placing immense pressure within the emergency department and on patient flow.

The acuity has also been seen from the ambulance conveyance perspective with Wirral receiving some of the highest number of ambulance attendances within the region. Average ambulance arrivals that the Trust would expect are circa 80 conveyances per day, in January the hospital saw days where ambulance presentations have been over 140 patients directly to the ED.

As expected with such high numbers of ambulance arrivals, admissions specifically to medicine have increased significantly since late December. Average admissions for quarter 3 were 83 patients per day, this has increased in quarter 4 (up to 14th January) to 98 patients per day.

The Acute Medicine department have been over the last 4 months adapting the way they provide consultant level review. From December every patient, both ED and GP admissions are now seen by an acute physician before admission to the main hospital, WUTH is one of the few Trusts that provide such an enhanced timely senior medical review. The Trust has seen a month on month increase in the number of patients discharged directly from Acute Medicine; December 2014 has seen 60% of patients discharged by our Acute Medicine Team.

The schemes the economy has put in place have assisted in mitigating the impact of these significant spikes in admission and acuity. However, further work is required around the implementation of Discharge to Assess as the number of medically fit patients in the hospital regularly exceeds 50 and although this is lower than many other hospitals it is still higher

than the 20-30 assumed in the winter plan. This has been raised at the System Resilience Group and it is acknowledged that this needs to be a major area of focus for the group. To help address the fact that the additional beds agreed were not available in the community the CCG funded a limited number of beds at Spire Murrayfield for 2 weeks to help acute pressure.

This increase in demand has resulted in the opening of additional escalation beds which the teams are trying to reduce. The Trust has on a number of days managed patient flow in a command and control basis to ensure optimum flow and patient safety and has been very close to declaring a major incident in recent weeks.

The current performance is 83.58% and discussions are ongoing with the health economy to agree a reforecast position for the quarter, but given the extremely poor start to the quarter and the various infection issues which adversely affect patient flow it is unlikely that the Trust will achieve this target in Q4. Monitor has been appraised of the situation.

The Referral to Treatment (RTT) standard was not achieved at Trust level for Quarter 3 for admitted patients. This was a direct result of treating additional long-waiter patients, activity that was commissioned by NHS England across the country. NHS England and local commissioners have acknowledged this would be the likely impact and so will assess Quarter 3 performance accordingly. Monitor has not relaxed their Risk Assessment Framework targets, but again is aware of this planned action. The targets for non-admitted patients treated, and for patients not yet treated (Incompletes), were achieved at Quarter 3.

CQC Standards

The Trust has received the formal report from the CQC on the responsive inspection at Arrowe Park Hospital in September 2014. An action plan was formulated immediately following the verbal report, and the remedial actions are well underway.

Compliance Rating

WUTH will not be Green for Quarter 3 under Monitor's Risk Assessment Framework. Governance concerns may be raised by Monitor over the repeated failure to achieve the A&E 4-hours standard. The Trust has engaged with Monitor on a regular basis in terms of its plans for improvement in A & E performance.

Governance Information

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

Finance Declaration

The Trust has submitted a 2 year operational plan showing a deficit for 2014/15 and 2015/16 and a resulting COS rating over this period of 2. Therefore the Board is unable to confirm the finance governance statement that "The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months".

Quarter 3 2014/15 Financial Commentary for Monitor

The following commentary covers the key reasons for the Quarter 3 variations against the 2014/15 plan.

The financial position of the Trust shows a year to date deficit of £5.2m against the planned deficit of £4.2m, therefore an adverse variance of £1.0m. Whilst the Trust remains away from plan year to date actions to move back to plan in the final quarter including securing a fixed contractual settlement with the localities CCG for the year end and further progress on the planned sale of a Trust asset (Springview) for c£0.8m above plan provide opportunities to deliver against the in year plan. Despite these two favourable movement a pressure of c£1m continues to exist largely in relation to CIP delivery in year which may make the achievement of the planned deficit difficult giving a deficit range of between the planned position of £4.2m and £5.2m at year end. Within these positions a Continuity of Service rating of 2 will be achieved.

NHS Clinical Revenue

To Quarter 3 there is a gain of £2.5m against planned levels, a gain of £1m in the quarter.

Key variances to Quarter 3 are as follows:

Point of Delivery	Variance in Q3	Cumulative variance to plan £m	Commentary
Elective	0.1	(0.1)	Cumulatively the variance is driven by an underperformance in Surgical specialties of (£1.3m), partly offset by an over performance in Medicine of £0.2m and additional non recurrent monies of £0.7m, made available nationally for RTT; Organisations were not aware of this during the planning period. Also the Trust has undertaken additional activity for North Wales of c£0.4m, secured in year to support the achievement of Welsh access targets; this was unknown during the initial planning submission timelines. During the quarter the over recovery reflects an over performance in Medicine of £0.2m. This was partly offset by Surgery / Women & Children's under performance of (£0.5) (particularly in Trauma and Orthopedics (£0.3)). This was offset by income from the accelerated RTT and North Wales of £0.4m.
Non elective	0.4	2.1	Over performance in the Medicine & Acute Division continues across specialties by £2m, whilst Surgery and Women & Children's Division is slightly under performing by £0.1m. Within the position there is a reduction of £0.7m for activity exceeding the non elective block; this is offset by the readmission cap and other income risk adjustments. In the quarter the areas of over performance were Medicine and Acute Care division of £0.6m, partly offset by the increase in the penalty for activity

			exceeding the non elective block (£0.2m).
Day Case	(0.1)	0.4	On a cumulative basis there has been an over-performance in Gastroenterology of £0.3m, Cardiology of £0.1m, Clinical Hematology £0.2m and Vascular of £0.5m. In addition, £0.6m has been generated through RTT and North Wales additional activity. This is offset by underperformances in Ophthalmology (£0.4m), Trauma and Orthopedics (£0.5m), Upper GI (£0.1m) and Gynecology (£0.3m). In the quarter there has been an under performance across all specialties, offset in part by RTT and North Wales.
Outpatients	0.0	(0.0)	Cumulative outpatient procedures are showing a breakeven position. Outpatient first attendances are under performing by (£0.1m), predominantly in Women's and Children's. Outpatient follow-up attendances also continue to perform below plan across most specialties with a total value of (£0.3m). The key areas being Gynecology and Pediatrics. Included within this position is a penalty of £0.4m for outpatient follow up caps. The balance of the variance is due to additional RTT and North Wales activity of £0.4m. In the quarter Outpatient procedures showed an under recovery of £50k, (the over performance in Cardiology and Gynecology, is offset by the under performance in Ophthalmology ENT and Breast Surgery). First and follow ups over performed marginally, within this is a penalty of (£0.1m) for the follow up cap. In the quarter £0.1m was received for accelerated RTT/North Wales work.
A&E	0.6	1.0	Although activity in this area continues to over perform, a reduced level of acuity and the application of the penalty for activity that has breached the 4 hour wait threshold of £0.5m, has resulted in the cumulative position showing an under recovery of (£0.3m). However non-recurrent Urgent Care/Winter funding of £1.3m released in year at a national level, has supported the position. This trend continued during the quarter, the favourable variance reflects an additional £0.7m for Urgent Care/System Resilience income from Wirral CCG.
Other – tariff	(0.0)	(0.2)	The year to date position reflects the continuing underperformance in Unbundled Diagnostic Imaging of £0.2m. The quarterly breakeven position reflects mainly Diagnostic Imaging activity generated via RTT and North Wales, mitigating the under performance against plan.

Other non tariff	(0.0)	(0.7)	Over and under performances in a number of Non PbR areas, in particular over performance in Direct Access Radiology £0.6m, Adult Critical Care £0.3m, Device Exclusions £0.4m. These are more than offset by an under recovery on AMD (£0.2m), Renal Block (£0.5m), Critical Care (NNU) (£0.3m), High Cost Drugs (£0.3m), Audiology (£0.2m), and Rehab (£0.5m). CQUIN is reported at breakeven and is planned at 90%. These over/under recoveries continued in the quarter resulting in a net breakeven position.
Total	**1.0**	**2.5**	

Overall income has increased due to the Urgent Care funding and in the activity from accelerated RTT and North Wales.

Included in the above figures is a £2.5m increase in NHS Clinical income due to Income Generation schemes across a range of points of delivery (with a net value of £1.7m). This is ahead of planned levels.

Contractual Status

The Trust has signed all contracts with Commissioners with the exception of North Wales, the reason for this is additional activity over and above contracted levels is currently being discussed. There are no areas of dispute, contract monitoring meetings with the host CCG (responsible for commissioning approximately 80% of the Trusts clinical income) are held on a monthly basis. Meetings with NHSE, the second largest commissioner, are held on a quarterly basis.

The Trust achieved all its CQUINs targets at the end of quarter 3, however it should be noted some of the specific targets are only payable upon the achievement of the CQUIN in all quarters.

The Trust has negotiated a year end position with its main commissioner which will reduce risk associated with this key component of the Trusts income.

Other Income and Operating Expenditure

These net costs are above plan at Quarter 3 by £3.8m, a movement of £1.7m in Quarter 3.

The key elements are:

Reason for variance	Variance in Q3	Cumulative variance to plan £m	Commentary
CIP delivery	(0.5)	(2.1)	Cash slippage for the year against the CIP and cost avoidance plan for divisional expenditure and income (net of costs of delivery) is £2.1m, across most cost categories. The rate of slippage has fallen in Q3 despite the higher level of CIP to be achieved due to its profile.
Reserve release	1.1	3.7	As at Quarter 3 the Trust has released £3.7m of reserves.

			The rate of reserves applied in Quarter 3 is slightly lower than the proportional amount for the first half of the year.
Emergency care	(0.1)	(0.8)	The Trust has invested in emergency care from reserves from Quarter 2 therefore this variance is expected to be lower for the rest of the year and has fallen in recent months.
Unplanned beds / capacity	(0.2)	(0.6)	Costs have remained relatively static in comparison to previous months due to general winter activity pressures and infection control requirements earlier in the year.
Premium costs	(0.6)	(1.8)	Planned and unplanned activity at premium prices. The cost of premium activity has remained high in quarter 3 due to the pressure of funding vacancies, especially in Radiology, Theatres and Gastroenterology.
Additional activity	(1.0)	(1.7)	There has been over spend of £1.7m which has been directly offset by an increase in NHS clinical income, most notably the income for the RTT (18 to 16 weeks) scheme and the additional Welsh activity and Urgent Care. More of this work and cost pressure has taken place in Quarter 3 causing the increased variance.
Non PBR offset	(0.1)	(0.1)	There has been an underspend of £0.1m in the quarter on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions).
Other	(0.3)	(0.4)	There has been a year to date overspend of £0.4m on "other" expenditure/loss of income such as specialling, sickness and maternity cover, loss of private patient income etc., offset by vacancies. This has increased by under £0.3m in the quarter. Vacancies have been offset by some divisional non pay overspends, an increase in the bad debt provision and RTA debt write-offs.
Total	**(1.7)**	**(3.8)**	

Achievement of the 2014/15 Cost Improvement Programme

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

The CIP position at Quarter 3 (including cost avoidance and non recurrent schemes) can be summarised as follows :

	BY SCHEME TYPE		BY COST		TOTAL
	Income Generation (net of cost of delivery) £m	**CIP (including cost avoidance)** £m	**NHS Clinical Income** £m	**Divisional Budgets** £m	£m
Year to date Budget (including unidentified at time of plan)	1,584	6,924	2,038	6,470	**8,508**
Year to date Actual	1,701	5,208	2,516	4,393	**6,909**
Year to date Variance	117	(1,716)	478	(2,077)	**(1,599)**

Work of the Turnaround Director and PMO Team

The CIP work streams for 2015/16 have been identified and work stream leads are currently being finalised including clinical leads and workstream sponsors. Detailed comprehensive plans to support each the workstream are currently being worked outlining all savings opportunities, including current plans and additional opportunities. Dedicated project managers will shortly be in post for the larger more transformation projects. The Turnaround Director is currently meeting all workstream leads to agree work stream templates, quality impact assessment templates and role descriptions as well as outlining the new process going forward.

The PMO is also undergoing a restructure to give it sole focus on governance and assurance and separate out the delivery aspects of project management to the workstream leads.

The Turnaround Director will be taking a timetable for completing the turnaround plan, with key milestones, to the next Transformation Steering Group and then present this to the Board at the March meeting.

EBITDA

The favourable NHS Clinical Income variance and the operational adverse variance therefore give an unfavourable Quarter 3 EBITDA variance of £1.3m, a deterioration of £0.6m in the quarter.

Post EBITDA Items

There is a favourable variance to the post EBITDA budget at month 9 of £0.4m due to the underspend on the capital programme and a fall in PDC payable (due to lower average daily cash balances) generating an overall adverse bottom line variance of £1.0m at Quarter 3.

Full Year 2014/15 Outturn

The Trust anticipates generating a full year outturn deficit of in the range of £4.2m to £5.2m, the potential variance relating to the continued pressures associated with in year CIP delivery. Within this range the Trust will deliver a Continuity of Services rating of 2 as planned.

Statement of Position (Balance Sheet)

The actual Total Assets Employed and Total Taxpayers Equity equal £147.1m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are slightly above plan.
- There is a £2.4m debtor for the planned sale of Springview which has not yet taken place. This is now expected in February 2015.
- Trade creditors and accruals are significantly higher than planned due to delays in the receipt and agreement of charges received, creditors for contract underperformance (due to the difference between the planned and contracted income and under performance against the contract) and the internal cash management changes.
- Deferred income is higher than planned largely due to the receipt of the "maternity prepayment" monies.
- Capital spend (on accruals basis) to month 9 was £9.2m against a plan of £11.2m. This variance of £2.0m is due to the decision to lease equipment that was due for purchase at £0.6m, slippage on the Cerner and IT projects of £1.2m, (of which £1.0m is offset by delays on PDC drawdown), slippage on the progression of the car park conversion scheme of £0.3m, and other smaller variances.
- The Trust submitted a reforecast of its capital spend at quarter 1. The forecast to Quarter 3 was £10.4m, therefore there is a £1.2m variance (12%). This is due largely to a £0.7m timing difference on Cerner and IT spend and slippage on the car park modification scheme of £0.3m.
- Borrowings – the Trust has drawn down the second tranche of the loan with the ITFF (see following section).
- There is a variance of £1.0m for the PDC not drawn down against the Cerner spend above. This is part of a £3.5m allocation in 2014/15 which is still due to be spent this year and was built into the Trust's reforecast. The remaining balance will be drawn down in month 10.
- The cash balance at the end of month 9 was £15.0m, being £11.7m above the planned £3.3m. As noted above, this is due to the significant increase in creditors and accruals, slippage on capital payments, the maternity deferred income, and the draw down of the first two tranches of the loan. Within these variances are also those improvements derived from the internal cash management work undertaken which impact the month end cash position. These increases have been partly been offset by the delays in the receipt from the sale of Springview and the bottom line position.

Cash and Liquidity measures

The Trust has substantially implemented the internal actions identified from the external review by KPMG, although the area is under continual review. This has had a significant impact on the average daily cash balance, although not all actions cause month end cash levels to increase. On average at month end creditor balances would increase cash by £2m-£2.5m and debtors by £0.5m. Of the £11.7m variance at Quarter 3, £11m-£12m is deemed to be permanent (through the loan, cash actions and maternity payment) and the remainder temporary.

The Trust had planned to sell one of its buildings ("Springview") to Cheshire and Wirral Partnership Trust in August 2014. This sale has slipped and therefore this will impact on the liquidity (and cash balances) of the Trust in the short term. The sale is expected to go ahead, at a greater value than that included in the plan, but the sale is now not expected until February 2015.

The Trust has arranged a £7.5m loan with the Independent Trust Financing Facility (ITFF) repayable at 1.96% over 10 years. The loan is against the 2014/15 capital programme. £5.7m has been drawn down to date with a further £1.8m due in February 2015.

Continuity of Service Rating (COS) & Certification

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

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

The Trust had a lower opening liquidity position than planned and the fall in this year's EBITDA levels has reduced liquidity further. In addition the sale of Springview has not yet taken place as planned. However, this has been offset by slippage in the capital programme and the draw down of the majority of the loan within the ITFF.

The Trust recognises that without the loan its COS rating at Quarter 3 would be a 1 due to the delay of the sale of Springview.

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

Validation Errors

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

Executive Team membership

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

3. CONCLUSION

The Trust continues to face a challenging financial year. It recognises that it has benefitted in the year from the contributions from the accelerated RTT and Urgent Care income and that this contribution will not be sustainable. The Trust anticipates generating a full year outturn deficit within the range of £4.2m to £5.2m with focus for the final quarter being on achievement at the lower end of this range based on increased surety of year end income and greater confidence that the transaction for the sale of Springview will be concluded in advance of the year end.

Alistair Mulvey
Director of Finance
January 2015

APPENDIX 1
INCOME STATEMENT

December Reporting - Income Statement

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan December 2014 Year to Date £m	Actual December 2014 Year to Date £m	Variance December 2014 Year to Date £m
Operating			
NHS Clinical Revenue			
Elective revenue, long stay:			
Tariff revenue	£18.385	£18.242	£(0.143)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£56.939	£59.061	£2.122
Planned same day (day case):			
Tariff revenue	£21.103	£21.517	£0.414
Outpatients:			
Tariff revenue	£27.038	£27.023	£(0.015)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£7.376	£8.386	£1.010
Other NHS Activity:			
Direct access & Op, all services (Tariff revenue)	£2.161	£2.908	£0.747
Maternity Pathway (Tariff revenue)	£4.624	£3.666	£(0.958)
CQUIN revenue (Non-Tariff revenue)	£3.866	£3.867	£0.001
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£3.327	£4.029	£0.702
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£8.806	£9.140	£0.334
High cost drugs revenue from commissioners (Non-Tariff revenue)	£6.626	£6.396	£(0.230)
Other drugs revenue (all types all bands including Chemotherapy) (Non-Tariff revenue)	£1.832	£1.999	£0.167
Other (Non-Tariff revenue)	£40.282	£38.587	£(1.695)
Total	**£202.367**	**£204.821**	**£2.454**
Non Mandatory / non protected revenue			
Private Patient revenue	£1.180	£0.609	£(0.571)
Other Non Mandatory / non protected clinical revenue	£1.098	£0.692	£(0.406)
Total	**£2.278**	**£1.301**	**£(0.977)**
Other operating income			
Research and Development income	£0.244	£0.398	£0.154
Education and Training income	£6.925	£7.040	£0.115
Donations & Grants received of PPE & intangible assets	£0.000	£0.000	£0.000
Donations & Grants received of cash to buy PPE & intangible assets	£0.000	£0.000	£0.000
Parking Income	£0.911	£0.992	£0.081
Catering Income	£1.499	£1.468	£(0.031)
Revenue from non-patient services to other bodies	£5.758	£6.434	£0.676
Misc. Other Operating Income	£4.023	£4.600	£0.577
Total	**£19.360**	**£20.932**	**£1.572**
Total Operating Income	**£224.005**	**£227.054**	**£3.049**
Operating Expenses			
Employee Benefits Expenses	£(154.754)	£(150.320)	£4.434
Employee Benefits Expenses - agency and contract staff	£0.000	£(7.228)	£(7.228)
Drug Costs	£(15.701)	£(15.151)	£0.550
Clinical Supplies and Services	£(22.629)	£(23.927)	£(1.298)
Non Clinical Supplies and Services	£(3.804)	£(4.186)	£(0.382)
Consultancy expense	£0.000	£(0.447)	£(0.447)
Movement of Impairment of receivables	£0.000	£0.106	£0.106
Misc other Operating expenses	£(21.127)	£(21.245)	£(0.118)
Total operating expenses	**£(218.015)**	**£(222.398)**	**£(4.383)**
EBITDA	**£5.990**	**£4.656**	**£(1.334)**
Non operating income and expense			
Interest income	£0.222	£0.144	£(0.078)
Interest expense on Non commercial borrowings	£(0.174)	£(0.196)	£(0.022)
Interest expense on finance leases	£(0.054)	£(0.056)	£(0.002)
Depreciation and amortisation - owned assets	£(6.252)	£(6.022)	£0.230
Depreciation and amortisation - donated assets	£(0.216)	£(0.145)	£0.071
Depreciation and amortisation - finance leases	£(0.216)	£(0.217)	£(0.001)
Other Finance Costs - Unwinding Discount	£(0.039)	£(0.028)	£0.011
PDC dividend expense	£(3.509)	£(3.351)	£0.158
Loss on asset disposal	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - purchased / constructed assets	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - donated / granted assets	£0.000	£0.000	£0.000
Net Surplus / (Deficit)	**£(4.248)**	**£(5.215)**	**£(0.967)**
Comprehensive income and expense			
Revaluation gains /(losses) of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Revaluation gains / (losses) of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Fair Value gains / (losses) straight to reserves	£0.000	£0.000	£0.000
Other recognised gains and losses	£0.000	£0.000	£0.000
Total comprehensive income and expense	**£(4.248)**	**£(5.215)**	**£(0.967)**

APPENDIX 2
BALANCE SHEET

December Reporting - Balance Sheet

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan December 2014 £m	Actual December 2014 £m	Variance December 2014 £m
Non current assets			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£12.888	£13.562	£0.674
Property, Plant and Equipmen - Donated or granted	£2.276	£2.236	£(0.040)
Property, Plant and Equipment - Purchased or constructe	£158.741	£156.581	£(2.160)
NHS Trade Receivables, Non-Current	£0.000	£0.000	£0.000
Other non current receivables	£2.134	£2.067	£(0.067)
Impairment of Receivables for Bad & doubtful debts	£(0.405)	£(0.314)	£0.091
Total non current assets	**£175.634**	**£174.132**	**£(1.502)**
Current Assets			
Inventories	£4.446	£4.256	£(0.190)
NHS Trade Receivables	£6.797	£6.210	£(0.587)
Non-NHS Trade Receivables	£1.273	£2.085	£0.812
Other Receivables	£1.556	£1.812	£0.256
Assets Held for Sale	£0.000	£2.435	£2.435
PDC Receivables	£0.000	£0.000	£0.000
Impairment of Receivables for Bad & doubtful debts	£(0.067)	£(0.344)	£(0.277)
Accrued Income	£1.320	£1.358	£0.038
Prepayments	£3.539	£2.810	£(0.729)
Cash and cash equivalents	£3.312	£14.985	£11.673
Total Current Assets	**£22.176**	**£35.607**	**£13.431**
Current liabilities			
Current loans	£(0.265)	£(0.837)	£(0.572)
Deferred income	£(2.101)	£(3.712)	£(1.611)
Provisions, current	£(0.669)	£(0.755)	£(0.086)
Trade Creditors	£(7.575)	£(12.846)	£(5.271)
Taxation payable	£(3.917)	£(3.820)	£0.097
Other Creditors	£(2.926)	£(2.836)	£0.090
Capital Creditors	£(1.010)	£(1.237)	£(0.227)
Accruals	£(8.091)	£(9.753)	£(1.662)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.353)	£(0.353)	£0.000
Interest payable on non commercial loans	£(0.057)	£(0.086)	£(0.029)
PDC creditor	£(1.170)	£(1.011)	£0.159
Total Current Liabilities	**£(29.034)**	**£(38.146)**	**£(9.112)**
Net Current Assets / (Liabilities)	**£(6.858)**	**£(2.539)**	**£4.319**
Liabilities, non current			
Loans, non current, non commercial	£(5.041)	£(10.186)	£(5.145)
Deferred income, non current	£(11.676)	£(11.676)	£0.000
Provisions for Liabilities and Charges	£(2.590)	£(2.462)	£0.128
Finance leases, non current	£(0.179)	£(0.179)	£0.000
	£(19.486)	**£(24.503)**	**£(5.017)**
Total Assets Employed	**£149.290**	**£147.090**	**£(2.200)**
Taxpayers equity			
Public Dividend Capital	£72.385	£71.366	£(1.019)
Retained earnings	£30.079	£28.670	£(1.409)
Revaluation reserve	£46.826	£47.054	£0.228
Total Taxpayers Equity	**£149.290**	**£147.090**	**£(2.200)**

APPENDIX 3
CASH FLOW

December Reporting - Cashflow

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan Year to Date December 2014 £m	Actual Year to Date December 2014 £m	Variance Year to Date December 2014 £m
Surplus/(deficit) after tax	**£(4.248)**	**£(5.215)**	**£(0.967)**
Finance income/charges	£0.006	£0.136	£0.130
Donations & Grants received of PPE & intangible assets (not cash)	£0.000	£0.000	£0.000
Other operating non-cash movements	£0.000	£0.000	£0.000
Depreciation and amortisation, total	£6.684	£6.384	£(0.300)
Impairment losses/(reversals)	£0.000	£0.000	£0.000
Gain/(loss) on disposal of property plant and equipment	£0.000	£0.000	£0.000
PDC dividend expense	£3.509	£3.351	£(0.158)
Other increases/(decreases) to reconcile to profit/(loss) from operations	£0.000	£0.000	£0.000
Non-cash flows in operating surplus/(deficit), Total	**£10.199**	**£9.871**	**£(0.328)**
Movement in Working Capital			
Inventories	£0.000	£(0.120)	£(0.120)
NHS Trade receivables	£1.846	£3.323	£1.477
Non NHS Trade receivables	£(0.290)	£(0.977)	£(0.687)
Other receivables	£(0.244)	£0.056	£0.300
Assets held for sale	£0.000	£(2.435)	£(2.435)
Accrued income	£(0.137)	£(0.095)	£0.042
Prepayments	£(1.959)	£(0.959)	£1.000
Deferred income	£(0.631)	£0.810	£1.441
Provisions for Liabilities and Charges	£(0.046)	£(0.113)	£(0.067)
Tax payable	£(0.001)	£(0.056)	£(0.055)
Trade Payables	£(1.979)	£0.656	£2.635
Other Payables	£(0.216)	£0.076	£0.292
Payment on Account	£0.000	£0.000	£0.000
Accruals	£(0.547)	£1.610	£2.157
	£(4.204)	**£1.776**	**£5.980**
Net cash inflow / (outflow) from operating activities	**£1.747**	**£6.432**	**£4.685**
Investing activities			
Property - new land, buildings or dwellings	£(2.200)	£(0.881)	£1.319
Property - maintenance expenditure	£(0.600)	£(1.497)	£(0.897)
Plant and equipment - Information Technology	£(2.116)	£(0.306)	£1.810
Plant and equipment - Other	£(1.589)	£(1.134)	£0.455
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(4.728)	£(5.391)	£(0.663)
Increase/(decrease) in Capital Creditors	£(0.590)	£(0.125)	£0.465
	£(11.823)	**£(9.334)**	**£2.489**
Net cash inflow / (outflow) before financing	**£(10.076)**	**£(2.902)**	**£7.174**
Financing activities			
Public Dividend Capital received	£3.500	£2.481	£(1.019)
Public Dividend Capital paid	£(2.339)	£(2.455)	£(0.116)
Interest (Paid) on non commercial loans	£(0.117)	£(0.117)	£0.000
Interest element of finance lease rental payments	£(0.054)	£(0.056)	£(0.002)
Capital element of finance lease rental payments	£(0.243)	£(0.244)	£(0.001)
Interest (Paid) / Received on cash and cash equivalents	£0.222	£0.141	£(0.081)
Drawdown of non commercial loans	£0.000	£5.716	£5.716
Repayment of non commercial loans	£(0.133)	£(0.133)	£0.000
Non current receivables	£2.400	£2.520	£0.120
Other Non current receivables	£0.000	£0.000	£0.000
Other cash flows from financing activities	£0.000	£0.000	£0.000
Net increase / (decrease) in cash and cash equivalents	**£(6.840)**	**£4.951**	**£11.791**
Opening cash and cash equivalents	£10.152	£10.034	£(0.118)
Net cash (outflow) / inflow	£(6.840)	£4.951	£11.791
Closing cash and cash equivalents	**£3.312**	**£14.985**	**£11.673**

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

Key Ratios / Risk Rating 2014/15

Based on December 2014 Reported Performance

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

Wirral Hospital Position

Financial Criteria	**Weight %age**	**Metric to be scored**	**2014/15 ratings - Actual**		**2014/15 ratings - Plan**	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-11.21	**2**	-14.00	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	1.20	**1**	1.50	**2**
		Weighted average risk rating		**1.50**		**2.00**
		Overall Risk Rating		**2**		**2**

APPENDIX 5a
GOVERNANCE STATEMENTS FOR Q3 – 2014/15

1. Introduction

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

The quarterly submission must be made to Monitor by 4 p.m. on 30th January 2015.

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

2. Recommendation

It is recommended that the Board:

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

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

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

APPENDIX 5b

GOVERNANCE STATEMENTS FOR Q3 – 2014/15

In Year Governance Statement from the Board of Wirral University Teaching Hospital

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

		Board Response
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed
	Otherwise:	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	Confirmed
NEW	**Consolidated subsidiaries:** Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	David Allison	**Name**	Alistair Mulvey
Capacity	Chief Executive	**Capacity**	Director of Finance
Date		**Date**	

0

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

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

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

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

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

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

B: 1. The Trust identified the A & E access target as a key risk in its Annual Planning process. Performance improved in Q2 to the anticipated 94%, however extreme pressure on emergency services and beds in Q3 resulted in performance of 92.2%. The Health Economy Wide Plan is still being fully implemented in conjunction with local health and social care partners and in addition there have been a range of emergency initiatives including additional inpatient capacity, mutual aid for nursing workforce and internal declaration of major incident setting on a number of days in the quarter. 2. As anticipated, the delivery of additional targeted long-waiting elective activity commissioned nationally by NHS England has resulted in the 18 week Referral to Treatment standards not being achieved in Q3 for admitted patients. NHS England and local commissioners accepted this likely consequence. Further additional activity has now been commissioned for Q4, with the potential for a similar consequence. 3. The Trust is now in receipt of the formal CQC Report following the responsive inspection undertaken on 18 and 19 September 2014. The report identified 5 areas of minor and moderate non-compliance. The action plan developed immediately in response is now being implemented in all areas.

C:

5 December 2014

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

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Making the health sector work for patients

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Dear David

Q2 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q2 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 2
- Governance risk rating - Under Review

These ratings will be published on Monitor's website later in December.

The Trust has failed to meet the A&E 4 hour wait target in Q2, which is the third consecutive quarter that has been breached. In addition, there are on-going financial planning and delivery concerns (following the Monitor investigation carried out in Q2 2013/14) with some of the resulting Trust actions yet to evidence sustainable improvement. As a result of both of these, the Trust has triggered consideration under the Risk Assessment Framework for further regulatory action.

As previously communicated to you, the Trust's governance risk rating has been amended to "Under Review – Monitor is requesting further information following multiple breaches of the A&E target and a continuity of services risk rating of 2, before deciding next steps". This reflects our on-going discussions with the Trust to understand the actions being taken to address A&E 4 hour wait target, the financial performance and financial governance arrangements.

The Trust also failed to achieve the 18 weeks Referral to Treatment (admitted and non-admitted) targets for Q2, which the Trust later informed Monitor was a planned breach to clear backlog.

Monitor uses the above performance indicators (amongst others) to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the Trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account as

appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We will monitor A&E performance against the monthly trajectory for recovery (as per the projection table submitted on 18 September 2014) and consider what, if any, further regulatory action may be appropriate if this is not delivered.

We will continue to review the financial position of the Trust on an ongoing basis as part of the monthly monitoring arrangements already in place, and review the Trust's progress against the action plan resulting from the external KPMG review of Financial Governance at the Trust (completed September 2014).

We will also be visiting the Trust on Monday 15 December 2014, along with the Regional Director – North, Paul Chandler, to meet with the Board to gain further understanding of the Trust's A&E 4 hour wait performance and the financial delivery challenges.

The Trust's governance risk rating will remain Under Review until we have concluded our considerations for further regulatory action, at which point we will write to you again.

A report on the FT sector aggregate performance from Q2 2014/15 is now available on our website[3] which I hope you will find of interest.

We have also issued a press release[4] setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

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

Yours sincerely

T Openshaw

Tania Openshaw
Senior Regional Manager

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

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

Corporate Governance Review	
Agenda Item	8.2
Title of Report	Corporate Governance Review
Date of Meeting	28th January 2015
Author	Carole Ann Self, Associate Director of Governance
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	*Note for Report Writers - Ensure the mitigating action is included where gaps in assurance have been identified or alternatively where the gaps will be monitored*
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion and Approval
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No – no impact on service users or staff

1. Introduction and Background

The Trust approved the revision to the Governance, Assurance and Performance Management Structure in July 2014 in response to internal reviews and external reviews from McKinsey and KPMG from 2012 to 2014. A further review of Financial Governance and reporting was undertaken in June 2014 for which an update has been provided to Board members separately.

The Board agreed at the time of approval that the Associate Director of Governance would evaluate and report on the effectiveness of the changes in January 2015 and make further recommendations as necessary.

The Board also agreed as part of its Development Session in December 2014 to include those elements that were highlighted as corporate governance to be included in this review.

2. Key Issues

The key issues from the KPMG external review on financial governance and planning undertaken in February 2014 highlighted the following themes which were considered by the Board in July 2014:

- Reassurance Vs Assurance
- Speed of decision making
- The frequency of Board and Assurance Committee Meetings
- Membership and attendance at Assurance Committees
- A complexity and blurring in the decision, approval and assurance
- processes resulting in timelines being difficult to achieve and the focus of meetings not aligned to the terms of reference
- The capacity required to service the structure was felt to be onerous and not adding value to the achievement of the Trust's objectives
- The relationship between the Finance, Business Performance and Assurance Committee and the Board of Directors
- Reflection of discussion in the minutes

3. Review of the Governance and Assurance Proposals approved in July 2014

3.1 The Board

The Agreement in July 2014

The Board agreed to meet 10 times per year on a monthly basis with the exception of August and December and to undertake Board Development 6 times per year immediately following a public Board meeting as per the Board Agenda Cycle. The increase in frequency was designed to improve the speed and influence of Board decision making and re-establish the primary of the Board.

The Review in January 2015

The Board has met on a monthly basis, has undertaken development sessions as per the agenda cycle including in the months of August and December. The evaluation of each of the meetings for September, October and November indicated that the agenda and level of discussion at each meeting was appropriate, provided good triangulation of information and evidenced good systems for escalating issues to the Board.

The length of each Board Meeting continues to be the focus of review as the workload of the Board increases. In order to assist with this, the Board has asked that authors avoid unnecessarily lengthy reports, be clear about the actions/recommendations required and that there is greater alignment with the Board Assurance Framework specifically referencing the impact. This will not only assist with agenda planning but all the discussion and decision making process.

The Associate Director of Governance presented proposals to the Operational Management team, Quality and Safety Committee and the Finance Business Performance and Assurance Committee in order to address the above issues. The draft report template has been designed to draw out the BAF references more clearly, asking report writers to be clear about whether reports provide positive assurance or highlight gaps in assurance. For each gap in assurance, the author is required to provide recommendations as to the mitigating action. Authors are also asked to indicate the purpose of their report ie Approval, Discussion or Note. The final addition to the template relates to the inclusion of the Equality Impact Assessment which was recommended for inclusion as part of the Board discussion in November 2014.

The Board also highlighted the following areas as a result of a review of Board effectiveness in December 2014:

- Greater strategic focus with dedicated time for regular surveillance of the external landscape
- Greater understanding of the Trust's risk profile and the Board's appetite for risk
- Greater line of sight on our regulatory compliance particularly with regard to CQC

The Associate Director of Governance will review the Board cycle ahead of the start of the new financial year to take into account the need for a greater level of discussion on the above topics.

3.2 The Finance, Business Performance and Assurance Committee and the Quality and Safety Committee

The Agreement in July 2014 – Finance Business Performance and Assurance Committee

The Board agreed that the terms of reference for this Committee should reflect the focus on assurance and not on operational performance, the membership should be streamlined to limit the number of Non-Executives and Executives to ensure a greater degree of objectivity and scrutiny is undertaken at the Board. The number of groups reporting into the Committee should be reduced from 8 to 4 and the Committee should only meet 6 times per year to discharge its responsibilities.

A further recommendation was for the Associate Director of Governance to attend every meeting and record the minutes to ensure that these reflect the full level of discussion and decision making being undertaken.

The Agreement in July 2014 – Quality and Safety Committee

The Board agreed that the terms of reference for the Quality and Safety Committee remained largely unchanged with the exception of the membership which was

streamlined as outlined above, and a reduction in the number of meetings to 6 per year.

The Review in January 2015 - Finance Business Performance and Assurance Committee

The Committee diligently focusses on assurance rather than operational issues although there is sometimes a tension between who is assuring who. There needs to be a recognition that Non-Executives have a role to play in providing assurance to the Board along with the Executives for the work they undertake at Committee level.

The reduction in the number of groups has not directly impacted on the work of the Committee although there has been little written or verbal feedback to allow the Committee to make an informed judgement on this. The Associate Director of Governance has recommended in a series of proposals to the Operational Management Team, Quality and Safety and the Finance Business and Assurance Committee that the groups reporting into Committees should do so through the minutes with the addition that each section of the minutes has the level of assurance recorded as either positive or gap(s). This will ensure that each Committee is drawn to any gap(s) and therefore the associated action to mitigate this.

The Committee meets in line with the revised cycle but has recognized that a further meeting in February of each year would be beneficial in order to allow another forum for greater discussion on the annual planning requirements. The cycle of business for the Committee is under review and will form the basis of discussion at the meeting in January 2015.

The Committee largely discharges its authority in line with the terms of reference with the exception of the review of reporting groups as outlined above and the 6 month post approval of business cases although there is a recognition that this is likely to be a timing issue associated with this short review.

The Associate Director of Governance attends all the meetings and provides the minutes and action log in line with expectations.

The Review in January 2015 – Quality and Safety Committee

The Committee has largely discharged its duties with regards to its terms of reference although with the removal of the quality and risk profile nationally the Committee has had to begin to develop a new process for reporting compliance. Currently the Clinical Governance Group receives a monthly status report which highlights areas of concern and the associated action to address this and the Risk Management Group which meets quarterly receives a RAG rated compliance report against the essential standards however the Quality and Safety and the Board still feel that their line of sight on this could be further improved. It is recommended in line with the new fundamental standards this is considered further.

The review of the work of groups supporting Quality and Safety is through the receipt of the minutes of the meetings which do attract a level of discussion. The enhanced reporting as outlined above would help to direct the Committee to key items in the future.

The review of compliance with the NHS constitution is not formally undertaken at Quality and Safety as per its terms of references so in line with discussions with the Chair this will need to be factored into the Committee cycle of business for the coming financial year.

The membership of the group does not currently include the Associate Director of Risk who is operationally responsible for risk, incidents and CQC compliance. The recommendation therefore would be to include this post in the membership in the future.

The Associate Director of Governance attends all the meetings and provides the minutes and action log in line with expectations.

The Review in January 2015 – Recommendations relevant to both Assurance Committees

The streamlined membership has had mixed reviews with feedback from some Executives and Non-Executives that there is a lack of sufficient information in the Chair's report to the Board to provide those Board members, not in attendance, with the necessary background to gain assurance.

Upon reviewing the original recommendation from KPMG and listening to concerns from both the Chief Executive, the Chairman and a couple of Non-Executives, the recommendation is to open up attendance to both the Finance Business Performance and Assurance Committee and the Quality and Safety Committee to all Board Members in order that they may attend as they wish. The emphasis on providing assurance to the Board will still be discharged from the membership of each Committee through the Chair's Report.

To support the assurance at Board level a further recommendation is for the Chair of the Committee reports to clearly describe whether the Committee determined the level of assurance as positive or identified where there were gap(s), this is likely to be aggregated at a report level as opposed to individual items. Any gap(s) reported should be supported with an appropriate action or confirmation of where this will be monitored.

3.3 Audit Committee

The Agreement in July 2014

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

The Review in January 2015

The Associate Director of Governance undertook a review of the cycle of business for the Committee against HFMA guidance and made a recommendation to formalise the review of clinical audit and whistleblowing which has been accepted.

The Committee also reviewed the Board Assurance Framework against the HFMA guidance and in conjunction with the Trust's internal auditors have made a variety of revisions since approval in July 2014 which are outlined below.

4. Review of Performance Management Proposals approved in July 2014

The Agreement in July 2014

The Executive Directors Team identified 3 principal mechanisms in order to discharge their responsibilities; these were the Operational Management Team, the Transformation Steering Group and the Divisional Performance Reviews. The membership of the Operational Management Team was fundamentally changed to include all Executive Directors as well as clinical leaders from Divisions along with Associate Directors.

The Review in January 2015

The feedback from the Operational Management Team has been very positive in terms of providing a forum for gaining cross divisional buy in to business cases, changes in practice or initiatives. Both clinical and managerial leaders present and inform the debate resulting in collective agreements and mutual understanding.

The Transformation Steering Group has been subject to change as a result of the engagement of external advisors. Further work is underway to combine the work of the Productivity Group with this Group to avoid the duplication that now appears to exist. A full review of the terms of reference of both groups will need to be undertaken and approved by the Finance Business Performance and Assurance Committee to ensure the appropriate levels of delegation remain in place.

The Divisional Performance Reviews remain largely unchanged although work is progressing on revising the performance management framework to ensure correct levels of accountability and autonomy are achieved.

5. The Board Assurance Framework (BAF)

The Agreement in July 2014

The Board agreed for the revised BAF to include the Trust's strategic objectives as detailed in the strategic plan; the key measures required to achieve each strategic objective together with the principal risk(s). Examples of positive assurance or gaps in assurance would also be articulated. The Board agreed to undertake an annual review of the BAF delegating regular monitoring to the Quality and Safety and Finance Business Performance and Assurance Committees. The Board agreed that the BAF would be regularly reviewed to ensure that it continues to provide the assurance required.

The review in January 2015

The Associate Director of Governance continues to review the BAF against HFMA guidance and more importantly against the requirements of the organization.

The review has resulted in the following revisions:

- The introduction of risk scoring including the consequence and likelihood – this enables reviewers to better understand the impact on the Trust's ability to achieve its objectives; it assists with the organization's understanding of its overall risk profile

- Risks in the BAF included as part of the Risk Management System – this ensures a greater alignment between risk and the BAF and allows for single system reporting in the future

- Review of risk descriptors by the Associate Director of Governance and Executives – this ensures risks are not just opposites of the strategic objective rather that they articulate clearly the cause and effect of potential or real risks which in turn assists the Trust with identifying the most appropriate actions to mitigate the these.

- Controls linked to the approved Governance, Assurance and Performance Management Structure – this allows the Trust to review whether the structure put in place assists with the overall internal control and helps identify gaps early which in turn can then be rectified.

- Assurances are specific and time-bound – the Associate Director of Governance and Executives have been establishing the most appropriate elements of assurance for each strategic objective to assist with the review at Committees

- Gaps in assurances/control – the Associate Director of Governance will highlight where these occur at each Committee Meeting in order that the Committee can consider whether the actions identified provide them with assurance that these will be addressed.

- Key Actions to include timescales – this ensures that Committees can make a judgment about the level of the risk and the timeliness of the action being taken

- Residual Risk Ratings including consequence and likelihood scores – this allows Committees to determine whether the actions outlined are likely to impact on the level of risk in the short, medium or long term.

- The Audit Committee at their December meeting also requested the following:

    - The date to be included on the BAF which would aid Committees with reviewing the timelines presented
    - The residual risk score to be included on the Audit Committee cover report which currently highlights the top five risks
    - Risks in relation to information governance to be considered in the future
    - Ensure that the risk management process is aligned with the workings of the BAF in the future
    - Determine which strategic items in the BAF were reserved for the Board in the control structure

The Associate Director is currently in the process of implementing all the revisions identified and continues to report on progress at each Committee meeting.

6. Next Steps

The template for reports will be amended to take account of the key changes outlined in this report and communicated throughout the organisation. The

Associate Director of Governance will provide support to report writers to assist with the quality of papers and articulation of assurance levels.

7. Recommendations

The Board is asked to approve the following:

- The revised template for Board and Committee Reports
- The revised approach to Chair of Committee Reports
- The review of the Board cycle to take into account for a greater level of discussion on strategy, regulatory compliance and risk
- The open attendance to Assurance Committees for all Board members
- The additional meeting for the Finance Business Performance and Assurance Committee in February of each year
- Membership of the Quality and Safety Committee be extended to the Associate Director of Risk
- A revised approach being adopted to reporting of CQC compliance at Quality and Safety and Board

Board of Directors		
Agenda Item	8.3	
Title of Report:	Fit and Proper Persons Test	
Date of Meeting:	28 January 2015	
Author:	James Mawrey - Director of Workforce Carole Self - Associate Director of Governance	
Accountable Executive:	Anthony Hassall - Director of Strategic & Organisational Development	
FOI status:	Document may be disclosed in full	
BAF Reference:	7D	
Data Quality Rating	Bronze - qualitative data	
Level of Assurance	Immediate Action	**Approval Required**

Executive Summary

This report provides details of how the Trust will implement the requirements of the Care Quality Commission's Fit and proper person requirement for Directors which came into place on the 27th November 2014.

A Fit and Proper Persons test is not novel. As a Foundation Trust we are required to ensure that Governors and Directors meet Monitor's Fit and Proper Persons Test as part of our licence. However, the Monitor test is less demanding than the test under this regulation. As such it is important that all elements of this Test are adhered to and the actions set out in this paper are implemented.

Background

1. The details of this regulation (Regulation 5) are set out in the link below. http://www.cqc.org.uk/content/fit-and-proper-persons-requirement-and-duty-candour-nhs-bodies

2. Appendix A then demonstrates the suggested measures that will be taken to ensure compliance with this regulation.

3. The Board will note that the new regulations present an opportunity for the Trust to further evidence that it has robust recruitment and employment processes in place when making Board level appointments.

Key Issues and Next Steps

1. The Trust will implement all elements of the Fit and Proper Persons test for all Directors. This will formally be undertaken for the first Director to be appointed following the

implementation of Regulation 5 on the 27th November. This will be the newly appointed Non-Executive Director.

2. The Associate Director of Governance will undertake the same process for all current Executive and Non-Executive Directors. This measure will then be repeated as part of the Remuneration and Appointments Committee review of Executive Appraisals and the Nominations Committee review of Non-Executives Appraisals. The reason for undertaking this measure for current Executive and Non-Executive Directors is that the Regulation states: "The provider must regularly review the fitness of directors to ensure that they remain fit for the role they are in. The provider must determine how often to review fitness based on the assessed risk to business delivery and/or to the people using the service posed by the individual and/or role."

3. The process for undertaking F&PP checks on Directors can, in the most part, be achieved through a series of checks:

   - Enhanced DBS including Adult and Child Barring list
   - Check of Professional registers
   - Application form
   - Occupational Health check
   - Check of the insolvency register companies' house for barred directors

4. The one element not covered by these checks is 5(3)(d) of Regulation 5 which requires the organisation to ensure that: "the individual has not been responsible for, been privy to, contributed to or facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity." The process to undertake this additional check is set out by the CQC that they believe are relevant for providers to use as part of their Fit and Proper Persons Registration due diligence:

   - Any provider whose registration had been suspended or cancelled due to failings in care in the last five years or longer if the information is available because of previous registration with CQC predecessor bodies.
   - Public inquiry reports about the provider.
   - Information where we are notified about any relevant individuals who have been disqualified from a professional regulatory body. This information would be shared with the individual and the provider in accordance with the Data Protection Act.
   - Serious case reviews relevant to the provider.
   - Homicide investigations for mental health trusts.
   - Criminal prosecutions against providers.
   - Ombudsmen reports relating to providers

Conclusion

As indicated within this paper the Fit and Proper Persons test is not novel. The enhanced rigour is both endorsed and welcomed by the organisation and as such it is proposed that the Trust adheres to all of the actions set out in this paper.

Recommendation

1. Note the introduction of the Fit and Proper Persons effective from 27th November 2014
2. Note the actions required to support implementation

AppendixA - Fit and Proper Person Test - Complying with the Regulations

	Standard	Assurance Process	Evidence
	At Appointment		
1.	Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. (Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professional.)	Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including: ▪ two references, one of which must be most recent employer; ▪ qualification and professional registration checks; ▪ right to work checks; ▪ proof of identity checks; ▪ occupational health clearance; ▪ DBS checks (where appropriate); ▪ search of insolvency and bankruptcy register; ▪ search of disqualified directors register.	References; Outcome of other pre-employment checks; DBS checks where appropriate; Register search results; List of referees and sources of assurance for FOIA purposes.
2.	Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	Report and debate at the nominations and Remuneration and Appointments committees. Report and recommendation at the council of governors (for NEDs) or the board of directors (for EDs) for foundation trusts, reports to the board for NHS trusts. Decisions and reasons for decisions recorded in minutes. External advice sought as necessary.	Record that due process was followed for FOIA purposes.
3.	Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those	Requirements included within the job description for all relevant posts.	Person specification Recruitment policy and

	Standard	Assurance Process	Evidence
	individuals that meet the required specification, including any requirements to be registered with a professional regulator.	Checked as part of the pre-employment checks and references on qualifications.	procedure
4.	The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept. *N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to NED appointments.*	Employment checks include a candidate's qualifications and employment references. Recruitment processes include qualitative assessment and values-based questions. Decisions and reasons for decisions recorded in minutes.	Recruitment policy and procedure Values-based questions Minutes of council of governors. Minutes of board of directors.
5.	In addition to 4, above, a provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	Discussions and recommendations by the nominations committee(s). Discussion and decision at board of directors or council of governors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.	Minutes of committee, board and or council meetings. NED appraisal framework NED competence framework Notes of ED appraisals
6.	When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.	Self-declaration subject to clearance by occupational health as part of the pre-employment process. NHS Employment Check Standards Board/council of governors decision	Occupational Health clearance

	Standard	Assurance Process	Evidence
7.	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	Self declaration of adjustments required. NHS Employment Check Standards Board/council of governors decision	Minutes of board meeting/council of governors meeting
8.	The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. ('Regulated activity' means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Schedule 1 covers the provision of: • personal care; accommodation for persons who require nursing or personal care; accommodation for persons who require treatment for substance misuse; treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Act; surgical procedures; diagnostic and screening procedures; management of supply of blood and blood derived products etc.; transport services, triage and medical advice provided remotely; maternity and midwifery services; termination of pregnancies; services in slimming clinics; nursing care; family planning services. 'Responsible for, contributed to or facilitated' means	Consequences of false or inaccurate or incomplete information included in recruitment packs. Checks set out in 1. Above i.e. Employment checks in accordance with NHS Employers pre-employment check standards including: ▪ self-declarations of fitness including explanation of past conduct/character issues where appropriate by candidates; ▪ two references, one of which must be most recent employer; ▪ qualification and professional registration checks; ▪ right to work checks; ▪ proof of identity checks; ▪ occupational health clearance; ▪ DBS checks (where appropriate); ▪ search of insolvency and bankruptcy register; ▪ search of disqualified directors register. Included in reference requests.	NED Recruitment Information pack Reference Request for ED/NED

	Standard	Assurance Process	Evidence
	that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement. 'Privy to' means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed. 'Serious misconduct or mismanagement' means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.") *N.B. This provision applies equally to executives and NEDs.*		
9.	The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. *N.B. The CQC accepts that providers will use reasonable endeavours in this instance.* The existence of a compromise agreement does not indemnify the new employer and providers will need to ensure that their Core HR policies address their approach to compromise agreements.	Consequences of false, inaccurate or incomplete information included in recruitment packs. Core HR policies for appointments and remuneration Checks set out in Section 1 above. Included in reference requests.	NED and ED Recruitment Information packs Core HR policies Reference Request for ED/NED
10.	Only individuals who will be acting in a role that falls	DBS checks are undertaken only for those posts	DBS policy

	Standard	Assurance Process	Evidence
	within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). *N.B. The CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.*	which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken.	DBS checks for eligible post-holders
11.	As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant DBS list.	Eligibility for DBS checks will be assessed for each vacancy arising.	DBS policy
12.	The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	Assessment of continued fitness to be undertaken each year as part of appraisal process. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process. Board/Council of Governors reviews checks and agrees the outcome.	Continual to be assessed as part of appraisal process Register checks if necessary Board/council minutes record that process has been followed.
13.	If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.	Core HR policies provides for such investigations. Revised contracts allow for termination in the event of non-compliance with regulations and other requirements. Contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement.	Core HR polices Contracts of employment (for EDs and director-equivalents) Service agreements or equivalent (for NEDs)
14.	The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken;	Core HR policies include the necessary provisions. Action taken and recorded as required	Core HR polices

	Standard	Assurance Process	Evidence
	the provider must demonstrate due diligence in all actions.		
15.	Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.	Core HR Policies	Managerial action taken to backfill posts as necessary.
16.	The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.	Core HR Policies	Referrals made to other agencies if necessary.

In the table above, unless the contrary is stated or the context otherwise requires, "ED" means executive directors and director equivalents.

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

26 NOVEMBER 2014

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

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

Apologies

Jeff Kozer Non-Executive Director

In attendance

Carole Self	Associate Director of Governance (minutes)
Mark Blakeman	Director of Infrastructure & Informatics
Terry Whalley	Project Director

Governors

None

Members of the Public

None

Reference	Minute	Action
BM 14-15/128	**Apologies for Absence** Apologies were noted as above.	
BM 14-15/129	**Declarations of Interest** Ms Maddaford declared an interest in relation to the item on the Countess of Chester in the Chief Executive's report and the work being undertaken by that Trust with the University of Chester. Ms Maddaford confirmed that she was a Member of Council for the University of Chester.	
BM 14-15/130	**Patient's Story** The Director of Nursing and Midwifery recited a patient story with the consent of the family. The patient story was a complaint which highlighted that on the three occasions which involved admissions, all within a short period of time, the Trust had not given the right level of care to a vulnerable patient with dementia, and had not communicated well with the	

Reference	Minute	Action
	family. Following a full investigation a number of recommendations have been put in place and shared with the family as well as the rest of the medical and nursing staff.	
BM 14-15/131	**Chairman's Business** The Chairman congratulated the Chief Executive, the Executive Directors and all the staff involved in the achievement of the recent HSJ award for staff engagement. The Board was pleased with the national recognition this award provided and keen that this achievement was shared throughout the organisation The Board was advised of 4 recent consultant appointments, these being Mr Snehal Patel – Consultant in Urology Dr Senthil Kumar Muthu - Consultant in Anaesthesia Dr Omar Noorullan – Consultant Gastroenterologist Dr Bharathi Chinnathurai – Consultant Gastroenterologist The Chairman confirmed that the formal JAG accreditation had now been received, which followed the update received at the last Board Meeting. The Chairman formally notified the Board that two pieces of legislation were due to come into effect through the Care Quality Commission, the first was in relation to duty of candour and the second the fit and proper persons test ,both come into force on the 27th November 2014. The Board was advised that the next Council of Governors Meeting would take place on the 10th December; the Board Development Day was due to take place on the 17th December with the next public Board Meeting taking place on 28th January 2014.	
BM 14-15/132	**Chief Executive's Report** The Chief Executive presented the report and the Board noted the contents therein.	
BM 14-15/133	**Vision 2018 Board Update** The Chief Executive presented the Vision 2018 Board update which highlighted the need for the health economy to articulate the programme of care for the future. The Board was advised that all Chief Executives within the local health economy were well aware of the challenges and were keen to share a common understanding which was now articulated in the document and which was being shared with their respective Boards. The Board was reminded of the case for change in order to achieve the savings of circa £150M and for the need for this to be rapid and transformational if it hoped to address the financial gap.	

Reference	Minute	Action
	The Board revisited the main 3 priorities and the large scale items which needed to be addressed through this programme. The Chief Executive advised the Board of a key meeting due to be held on the 27th November which was the opportunity for all Chief Executives to present their plan on a page. He suggested that this would highlight the disconnect in the health economy and therefore provide an opportunity to address this going forward. The Chief Executive commented that the paper did not cover the substance required to progress the Vision due to a lack of capacity and capability which was disappointing and needed to be addressed. The positive feedback provided on the development of the integrated geographical teams was noted together with the need to build upon this. The Board considered that Cerner should be instrumental for population based management in the future and proposed that this should be raised at the meeting on the 27th November together with the need to share risks across the health economy in the future. The Chief Executive referenced the message from David Flory which was that it was no longer acceptable for all the risk to be pushed to one part of the system it needed to be shared by the whole and therefore that it was not acceptable for this Trust to be in deficit and the rest of the health economy to be in surplus. The Board debated the extent of the challenge, and whether a narrower perspective would be more achievable in terms of focussing on one of the priorities, citing unplanned care as an example. It was felt better to await the outcome of the 3 day workshop planned for the 9-11 December on unplanned care before considering the matter further. The Board raised concerns that the vision 2018 programme would become lost in the 15/16 contract negotiations without proper care and consideration, and that the Better Care Fund was still not transparent. The Director of Strategic and Organisational Development was asked to what extent the key issues from the paper had been factored into the strategic plan. He confirmed that the strategic plan articulated the key risks and forewarned the Board that the Trust would have to make a judgement in the plan for 2015/16 on the Better Care Fund and the degree of candour to be expressed about the projections.	
BM 14-15/134	**Integrated Performance Report** **Integrated Dashboard and Exception Reports** The Director of Infrastructure and Informatics presented the integrated performance dashboard and highlighted the key areas of performance which required improvement. The Director of Operations confirmed that the performance for October	

Reference	Minute	Action
	2014 against the 4 hour A & E standard was 95.8%, highlighting that the Trust was the only one in the region to achieve this. She outlined the current position as at Week 9 following two weeks that were below performance, this being 93.57% which would mean that the Trust would not achieve 95% in November although it was still possible to achieve 95% for the quarter albeit significantly challenging. The Director of Operations confirmed that A & E attendances had been fairly static compared with the previous quarter although these did peak in week 7. The Board was advised that whilst admissions from A & E had decreased due to increased screening, GP admissions had increased 25% on the same time last year. The Director of Operations confirmed that this information had been shared with the CCG in order that referral patterns could be investigated. Finally the number of ambulance attendances was reported, again this showed a peak in week 7 where a 27% increase was seen resulting in the Trust needing to open further bed capacity which had since been closed. The Board was advised that the health economy response to the situation was excellent. Therapists came in from the community to enable patients to be discharged and daily teleconferences took place on site including over the weekend. The overriding conclusion was that the urgent care recovery plan identified the right things to do and it was a case of keep doing these. The Chief Executive advised the Board that Monitor had noted that this Trust was the only Trust in the North West to be Green on A & E performance at the last Quality Summit although the last 3 weeks had been a problem nationally. The Board congratulated the team for the work undertaken during this period and was pleased to note the way in which the economy had responded although it was keen that an understanding of why the peaks occurred in the first place was established in order to prevent future situations of this nature. The Board sought further assurance that the level of engagement from the health economy varied from routine management of performance to crisis management in these situations. The Board reviewed the exceptions report and asked that the status delivery be revised to avoid using the narrative “ongoing” in the future although it recognised the difficulty in reporting longstanding issues. The Board noted the rise in sickness absence levels and was concerned as the Trust approached the difficult winter period. The Director of Strategic and Organisational Development confirmed that the actual in-month performance was better than at the same time last year although he still recognised that it was an issue. The Board asked whether the level of exceptions raised this month was of concern as this had risen slightly from previous months. The Chief Executive advised that the level of focus on bed occupancy levels and the financial situation was hugely improved and that the month on month	

Reference	Minute	Action
	improvement in attendance levels was encouraging.	
BM 14-15/135	**Finance Report** The Director of Finance presented the Month 7 position and highlighted the following: The planned income and expenditure position for Month 7 showed a surplus of £494K against a plan of £586K. The cumulative position for the 7 months showed a deficit of £4,652K against a planned deficit of £3,976K which represented an adverse variance against plan of £676K. The capital programme was reported as slightly behind plan. Cash was reported as strong although the sale of Springview was still to be concluded. The Director of Finance highlighted the good performance in the Division of Medicine and Acute who had delivered a small surplus for the fourth consecutive month. As a result of the good performance the Division had been given autonomy to recruit to established posts without the need for these to be approved by the Vacancy Panel. The Board was advised that the Cost Improvement Programme was still forecasting £10.5M against the target of £13M and the work with Atkins/FTI continued to make progress. The Board discussed the risks that had materialised as a result of the huge demands for urgent care which had led to the cancellation of elective activity and were assured that discussions were ongoing with the CCG to seek to address this.	
BM 14-15/136	**Report of the Quality and Safety Committee 12 November 2014** Dr Quinn presented the report and highlighted to the Board the increased number of items the Committee noted as receiving partial assurance. Dr Quinn advised that Patient reported delays and delays in discharge were much higher in the surgical division than in other parts of the hospital. She expressed concern that the demands being put on the hospital felt as though they were having an impact on quality as evidenced through the clinical dashboard. The Board debated the reliability of the Winter Plan in view of the bed escalation that had occurred over the last 2 weeks. The Director of Nursing and Midwifery outlined the impact that the increased demand had on the Trust and how this had been managed much better during this latest period of extremely high demand which allowed the Trust to return to a steady state much earlier. The Director of Infrastructure and Informatics confirmed that this was showing in the reductions in length of stay. The Board sought assurance that beds were not being blocked with	

Reference	Minute	Action
	patients who were medically fit to be discharged so they could understand the overall risk to patient safety as a result of the increase in demand. The Director of Nursing and Midwifery confirmed that the Trust was looking after patients who could be cared for elsewhere but that the Trust was working with the Local Authority to arrange appropriate packages of care. The Medical Director highlighted the risk associated with not being able to fill nurse bank shifts by up to 25% in some cases which ultimately impacted on the quality of care the Trust provides. The Board asked that the integrated winter plan and contingency planning be discussed and agreed at the next Strategic System wide Resilience Group. The Board asked that the winter plan reflects activity scenarios in the bridging the gap paper in light of recent events. Dr Quinn advised that the new workforce dashboard stimulated a lot of discussion as Committee members found this very helpful.	**SG** **AM/SG**
BM 14-15/137	**Complaints Handling Update** The Director of Nursing and Midwifery presented the Complaints Handling Update and highlighted the following points: • The sustained improvement on the response rates • The reduction in the number of complaints comparable to the previous year as a result of the early handling initiatives • The Health service ombudsman had investigated more complaints generally which has had an impact on this Trust although the feedback on these had been good. • The Patients Relations Team and the PALs and Complaints Team would come together from next year. • The establishment of a patients' complaints scrutiny team to be led by a Non-Executive Director. Ms Maddaford confirmed that she would undertake this role. The Board noted the progress made and thanked the Director of Nursing and Midwifery for the report.	
BM 14-15/138	**Francis Report: Hard Truths Commitment: Publishing of Staffing Data** The Director of Nursing and Midwifery presented the progress report and highlighted the following points: • The registered nurse to patient ratios and the work progressing to improve this along with the evidence to support the NICE guidance in this area. • The initiatives to reduce length of stay and how these were being implemented through clinical partnership working. • The impact of CPE on nurse staffing levels and the positive impact being realised from the rapid testing solution.	

Reference	Minute	Action
	• Progress against the expectations from the Francis Report The Director of Nursing and Midwifery confirmed that nurses were being used as efficiently as possible and that she did expect nurses to raise concerns so these could be addressed. The Board was appraised of the current position with regards to nurse recruitment which included the shortage nationally and the options being explored to ensure that the appropriate nursing ratio for the acuity of patients presenting was secured. The Director of Nursing and Midwifery confirmed that the Trust was using its current workforce differently citing the use of clinical nurse specialists for clinical practice as required. The Board was advised of the use of Cerner in the future as an incentive to recruitment. The Director of Nursing and Midwifery summarised the paper by confirming that nursing in the Trust was resilient and as such was doing the best to maintain quality and safety The Board thanked the Director of Nursing and Midwifery for the excellent report and noted that further recommendations around the nursing establishment might be brought forward in due course. The Board asked for information on nursing in outpatients to be included in future and how these were being utilised during periods of high demand.	**JG**
BM 14-15/139	**CQC Report and Action Plan** The Medical Director presented the action plan as a consequence of the responsive inspection by the Care Quality Commission in September together with the preparation plans for a full CQC inspection. The Board was advised that the first of the plans set out what had been done to date and what still needed to be done to return to compliance. The second plan provided the Trust with the opportunity to build upon the feedback from the September inspection and was currently therefore a work in progress. The Medical Director highlighted the third strand of work required which was in relation to the culture of the organisation and the need to build upon the work done to date. The Medical Director highlighted the benefits of “real time” information which was being provided by Cerner and the need to build upon this for the future. The Board sought assurance as to where the Action Plans would be monitored. The Medical Director confirmed that these would be driven through the Clinical Governance Group reporting formally to the Quality and Safety Committee.	

Reference	Minute	Action
BM 14-15/140	**Emergency Planning Review** The Director of Nursing and Midwifery presented the Emergency Planning Review and highlighted the improvements required to move the Trust from substantial to full assurance by the end of the calendar year. The Board noted the report.	
BM 14-15/141	**Equality and Diversity Annual Report** The Director of Nursing and Midwifery presented the Annual Equality and Diversity Report highlighting the improvements required in relation to the inclusion of equality impact assessments in Board papers and the preparations being undertaken in readiness for the overall assessment. The Board noted the increase costs associated with translation services and explored the possible reasons for this. Mandatory training on equality and diversity for all staff was debated, which included the need for a refresher session for Board members, which was planned. The Board also noted the workforce data presented and the implications this may have on the culture of the organisation to be discussed in the private part of the Board. The Board noted the report.	
BM 14-15/142	**External Assessment** **Month 7 Monitor Compliance Report** The Director of Finance presented the Month 7 Monitor Compliance report which had been submitted to the regulator in line with the previously agreed approval route.	
BM 14-15/143	**CQC Report Revised Statement of Purpose** The Medical Director presented the revised Statement of Purpose for approval. The Board debated the impact of potential changes on the statement and how these would be revised in the future. The Board approved the revised Statement of Purpose subject to a small amendment on page 129 amending the number of Executives from six to five to reflect the current position.	
BM 14-15/144	**Health and Safety Legislation Compliance Report** The Director of Strategic and Organisational Developed presented the Compliance Report and outlined the governance review process which now supported this statutory area of work.	

Reference	Minute	Action
	The Board noted the improvements made in compliance since the last update which now left 3 areas of non-compliance outstanding which were being progressed. The Board was advised that Health and safety audits were now in place which were in line with best practice guidance and the compliance with flu vaccination rates which was at 68.3% which put the Trust at the forefront nationally. The Board was asked to note the progress in the report and consider future reporting at Board level. The Board agreed to continue to receive the report on a quarterly basis until full compliance was achieved. The Board raised concerns on the delays recorded in obtaining a further asbestos survey due to the lack of capital monies. The Board requested that this action be progressed with urgency in view of the statutory nature of the risk.	**AM/AH**
BM 14-15/145	**Risk Scoring 20+** The Medical Director presented the 20+ risk in the Womens and Childrens unit in relation to emergency access. He confirmed that the risk was being mitigated in the short term by manual opening and in the longer term that capital funding would be required undertake the work**.**	
BM 14-15/146	**Board of Directors** **Minutes of the meeting dated 29 October 2014** The minutes of the meeting held on 29 October 2014 were agreed as a correct record of the meeting**.** **Board Action Log** The Board reviewed the action log and concluded that this provided an up to date view of progress.	
BM 14-15/147	**Items for BAF/Risk Register** None	
BM 14-15/148	**Any Other Business** None	
BM 14-15/149	**Date and Time of Next Meeting** Wednesday 28 January 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 – 28 January 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 26.11.14						
Nov - 14	BM14-15/136	Integrated winter plan and contingency planning to be discussed at the next Strategic system wide resilience group	SG	**Completed**	Jan 15	
Nov 14	BM14-15/136	Ensure winter plan reflects activity scenarios in the bridging the gap paper in light of recent events	AM/SG	**Completed**	Jan 15	
Nov 14	BM/14-15/138	Include how outpatient nurses were being utilised during period of high demand in the next nurse staffing paper	JG		Jan 15	
Nov 14	BM14-15/144	Progress the commissioning of an asbestos survey urgently	AM/AH	**Undertaken – to commence Jan 15**	Dec 14	
Date of Meeting 29.10.14						
Oct - 14	BM14-15/113	CEO to discuss with CoCH concerns in relation to CPE and impact on vascular elective work	DA	**Completed**	Nov 14	
Oct - 14	BM14-15/114	Report against a trajectory of improvement in the future in relation to the Annual Plan	AH	**Ongoing**	Jan 15	
Oct - 14	BM14-15/117	Review of Finance, Business Performance and Assurance papers against the Chair's Report to ensure assurance is provided to members not in attendance	All		Jan 15	**To be included as part of Governance Review by Associate Director of Governance**

Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM			
Date of Meeting 24.09.14						
Sept - 14	BM 14–15/084	CEO to write to commissioners raising concerns around levels of demand that currently exceed significantly the block contract and ask that the risk be shared	DA	**Completed**	Nov 14	**To be raised at Senior leadership forum 27.11.14**
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG		Oct 14	**To be included as part of programme from Dec 2014**
Sept - 14	BM 14-15/089	Further strategic review of future bed requirements to be undertaken at Board	AM	**Remove**	Nov 14	**This action will be addressed through the review of nurse staffing and the annual planning process**
Date of Meeting 30.07.14						
July - 14	BM 14-15/061	Update on complaints handling	JG	**Completed**	Nov 14	
July - 14	BM 14-15/063	Algorithm to be produced that took into account changes in contractual income and mapped through to the impact on activity and productivity	AM/SG	**Remove**	Nov 14	**This action will be addressed through the review of nurse staffing and the annual planning process**
July - 14	BM 14-15/073	Provide a progress update on compliance with Health and Safety Legislation	AH	**Completed**	Nov 14	
July - 14	BM 14-15/073	Explore the possibility of the internal auditors undertaking a governance review on health and safety	AH	**Completed**	Nov 14	

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting: 28.05.14						
May 14-	BM 14-15/039	Undertake a review of headroom percentages for nurse staffing once NICE guidelines were published.	JG	**Completed**	Oct 14	**To be included in Board Nursing Staffing update in November 2014**