Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

29 October 2014

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 29 OCTOBER 2014 COMMENCING AT 9.00AM IN THE BOARD ROOM EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1.	**Apologies for Absence** Chairman		v
2.	**Declarations of Interest** Chairman		v
3.	**Patient's Story** Director of Nursing and Midwifery		v
4.	**Chairman's Business** Chairman		v
5.	**Chief Executive's Report** Chief Executive		d
6. Strategy and Development			
6.1	**Half Year Review of Annual Plan 2014-15 Objectives and Outline of Process for Annual Plan 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 6 Finance Report Director of Finance		d
7.2	**Report of the Finance, Business Performance and Assurance Committee** • **24 October 2014 Committee** Chair of the Finance, Business Performance and Assurance Committee	To Follow	d

7. Performance and Improvement

7.3 **15 Steps Board Walkabout Update Report** d
Director of Nursing and Midwifery

7.4 **Annual Medical Appraisal for the Year 2013/14** d
Medical Director

8. Strategies and Annual Reports

8.1 **Infection Prevention and Control Annual Report 2013/14** d
Director of Nursing and Midwifery

8.2 **Research and Development Strategy 2014-2019** d
Medical Director

8.3 **Cerner Future Phases** d
Director of Infrastructure and Informatics

9. Governance

9.1 **External Assessment** d
- **Month 6 Monitor Compliance Report**

Director of Finance

9.2 **Board of Directors**

9.2.1 Minutes of the Previous Meeting d
- **24 September 2014**

9.2.2 Board Action Log d
Associate Director of Governance

10. Standing Items

10.1 **Any Other Business** v
Chairman

10.2 **Items for BAF/Risk Register** d
Chairman

10.3 **Date and Time of Next Meeting** v
Wednesday at 26 November 2014 at 9am

Board of Directors		
Agenda Item	5	
Title of Report	Chief Executive's Report	
Date of Meeting	29 October 2014	
Author	David Allison, Chief Executive	
Accountable Executive	David Allison, Chief Executive	
FOI status	Document may be disclosed in full	
BAF Reference	1, 2, 3, 5, 6, 10, 11, 12, 13	
Data Quality Rating	N/A	
Level of Assurance	Full	Board confirmation

1. External Activities

Commissioners

The recently published NHS England report into the CCG has indicated some changes to the way in which the CCG is organised and how it directs its priorities. The Trust welcomes these changes as a positive development which will build on the already improving relationship it is developing with the new senior team. There remains, however, much work to do to further push forward and develop a coherent strategic vision for health and social care in the Wirral which is affordable. The Trust is working hard with the CCG and other partners to develop the building blocks from which this vision can be delivered, but this process remains challenging and time consuming.

Against the key priority areas a number of big items and smaller, more rapidly implementable actions have been identified which the attached diagram illustrates *(appendix i)*. There is currently a paucity of detailed, implementable action plans and the outcomes or net benefits from schemes remain ill-defined at best. A Strategic Leaders Group meeting is currently arranged for 27 November 2014 to assess how greater strategic progress can be enabled.

Monitor

Our monthly update call took place with Monitor on 23 October 2014. We updated Monitor on our Month 6 financial position together with an outline of our plans for maintaining the rigour and focus on the savings plans that Atkins/FTI have brought to the Trust when they leave us at the end of October 2014. Updates provided also included the improving position with regards to meeting the A & E standards; the improving situation with regards to the CPE outbreak and an outline of the draft report received from CQC as described below.

CQC

As advised at the September Board Meeting the Care Quality Commission undertook its responsive inspection of Arrowe Park Hospital on 18th and 19th September 2014. The Trust has now received the draft report and is in the process of reviewing this for factual accuracy. The initial findings from the report have identified areas of moderate and minor compliance. The Trust has already undertaken action as a result of the inspection and a full action plan is being developed which will be submitted to the CQC in the next few weeks.

The full report will be published once finalised.

External Review

The FTI/Atkins assignment has progressed in accordance with their scope of work timeline resulting in a closing of the gap for 2014/15 and over performance of the full year impact, contributing to the 2015/16 challenge.

Significant work is currently progressing to identify the additional schemes necessary to address the 2015/16 CIP target.

Joint Advisory Group (JAG) Assessment

The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) operates within the Clinical Standards Department of the Royal College of Physicians and its core objectives are:

- To agree and set acceptable standards for competence in endoscopic procedures
- To quality assure endoscopy units
- To quality assure endoscopy training
- To quality assure endoscopy services

The JAG carried out its assessment on our endoscopy services on 22 October 2014 and the verbal feedback was that the assessment team would be recommending the Trust receives a pass. The assessment process still has to be quality assured, so the final result will not be known for a couple of weeks, however in the meantime the team have been thanked for their huge efforts.

2. Internal Activities

Infection Prevention & Control

We continue to perform well against the MRSA bacteraemia objective with no new cases identified during Quarter 2. However the C.difficile objective of no more than 24 cases remains a challenge as it is so close to the irreducible minimum. To date we have reported a total of 14 patients meeting the definition of hospital acquired, however post infection reviews have identified that 3 of these were not due to any ‘lapses in care’ and were potentially unavoidable, these are yet to be agreed by the local commissioner.

Carbapenemase Producing Enerobacteriaceae (CPE) is now our greatest Infection Prevention and Control challenge going forward locally and nationally. As a Trust, we do appear to be in the forefront in terms of delivering its CPE strategy, and with other Trusts now starting to experience CPE for themselves, they are being encouraged to follow suit

with the emphasis on prevention and early control. However we still have a great deal more to do as the national threat relating to antimicrobial resistance increases. This work is being addressed through a number of work streams to improve upon the key factors required to manage CPE:

- rapid detection
- effective isolation
- basics brilliantly

A proof of concept around rapid detection is currently being piloted and has so far demonstrated extremely positive outcomes both clinically and operationally. Its efficiency and efficacy has supported the interruption of the CPE outbreak.

Wirral Millennium Phase 2B

The Millennium journey started back in June 2010 when the first major department to go live was Emergency Department with the Wirral Millennium FirstNet application. Since then Millennium has become an integral part of our hospitals and we now rely on it in the same was as we rely on other utilities such as electricity and water. The system now runs all of our inpatient and outpatient administration, supports our theatres, makes images available through Picture Archiving and Communication System (PACS), allows some medical devices to connect to it and provides support for the laboratories and radiology.

Our organisation has been through four major go live events since 2010 with the last one being in June 2013. On the 15 November the Trust will go live with prescribing and medicines administration, nursing and AHP documentation and assessments and changes to the structure of the Millennium clinical notes.

The move from paper based inpatient assessments and documentation will be the biggest change yet to the way that our hospitals work and will put us on track to be a digital organisation by 2016. Most importantly it has the potential to improve the quality and safety of the care we can offer to our patients by making it transparent what tasks need to be completed for each patient and by increasing the time nurses and other health professionals can spend at the patient's bedside.

Advancing Quality Alliance AQUA

The Board attended a two day advanced Board Programme on Quality and Safety on the 13 and 14 October 2014. The programme is designed to develop the role of Boards in leading quality and safety and enable a greater insight into the oversight and governance of quality and safety through the deep exploration of patient safety.

The Board have developed a draft action plan as a result of the event which the Board will finalise and implement as part of its Development Programme.

Workforce

Sickness absence monthly rates are much improved with August 2014 having the lowest rate in three years and September the lowest for four years. Rolling 12 month rate remains above target. A number of priority actions discussed in full at the Quality & Safety Committee are being taken to address this.

The Appraisal rate at end Quarter 2 is 82.29%, below the KPI target of 88%. Divisional leads have been identified; action plans have been developed and are being enacted. Non-compliant staff have received letters requesting appraisal undertaken by 31/10/14.

Mandatory Training rates for Block A (3 yearly requirement); compliance has increased to highest ever level at 98.09%. Block B (18 month requirement), compliance is 75.32% and below KPI. HR&OD are working with divisions ensure bookings for non-compliant staff. It

was agreed at Q&S that Block B compliance would be reported for Q3 to allow the actions to improve compliance to be delivered.

The Trust has won the North West Macro Employer of the Year award for Apprenticeships and have now been entered into the national award. We have also been nominated as one of the top 100 UK employers for Apprenticeships.

NHS England introduced the Staff Friends and Family Test (Staff FFT) for all NHS Trusts from April 2014. The results have been received for Quarter 1. The results are as follows:

- 74% said they were Extremely Likely / Likely to recommend the Trust to friends and family if they needed care or treatment.

- 47% said they were Extremely Likely / Likely to recommend the Trust to friends and family as a place to work Actions to improve this score will be taken forward through a revised Staff Engagement Action plan and through the launch of a revised set of Values and Behaviours commencing with the 'PROUD' Awards.

The PROUD Awards 2014 took place on 30th September, hosted by Pauline Daniels, sponsored by Typhoo. The event was a positive celebration for our hard working and dedicated workforce. Approximately 450 staff attended and feedback indicated that the event was very well received.

Listening into Action (LiA)

Further to the success over the last 2 years through Listening into Action as a way of working at Wirral University Teaching Hospital and the many improvements that have been made, the Trust will now be working independently of Optimise Consultancy whilst remaining part of the national NHS LiA Network.

The plan for our 3rd year includes:

- Introduction of skills training for managers and key staff to enable them to apply the LiA improvement through staff engagement methodology

- We have established a network of LiA Champions based on those staff who have led LiA teams and schemes already to support others

- Our 3rd round of Big Conversations will be for managers and leaders in November and December of this year to focus on change through staff engagement

- Bringing together our staff engagement approaches and LiA into one comprehensive plan

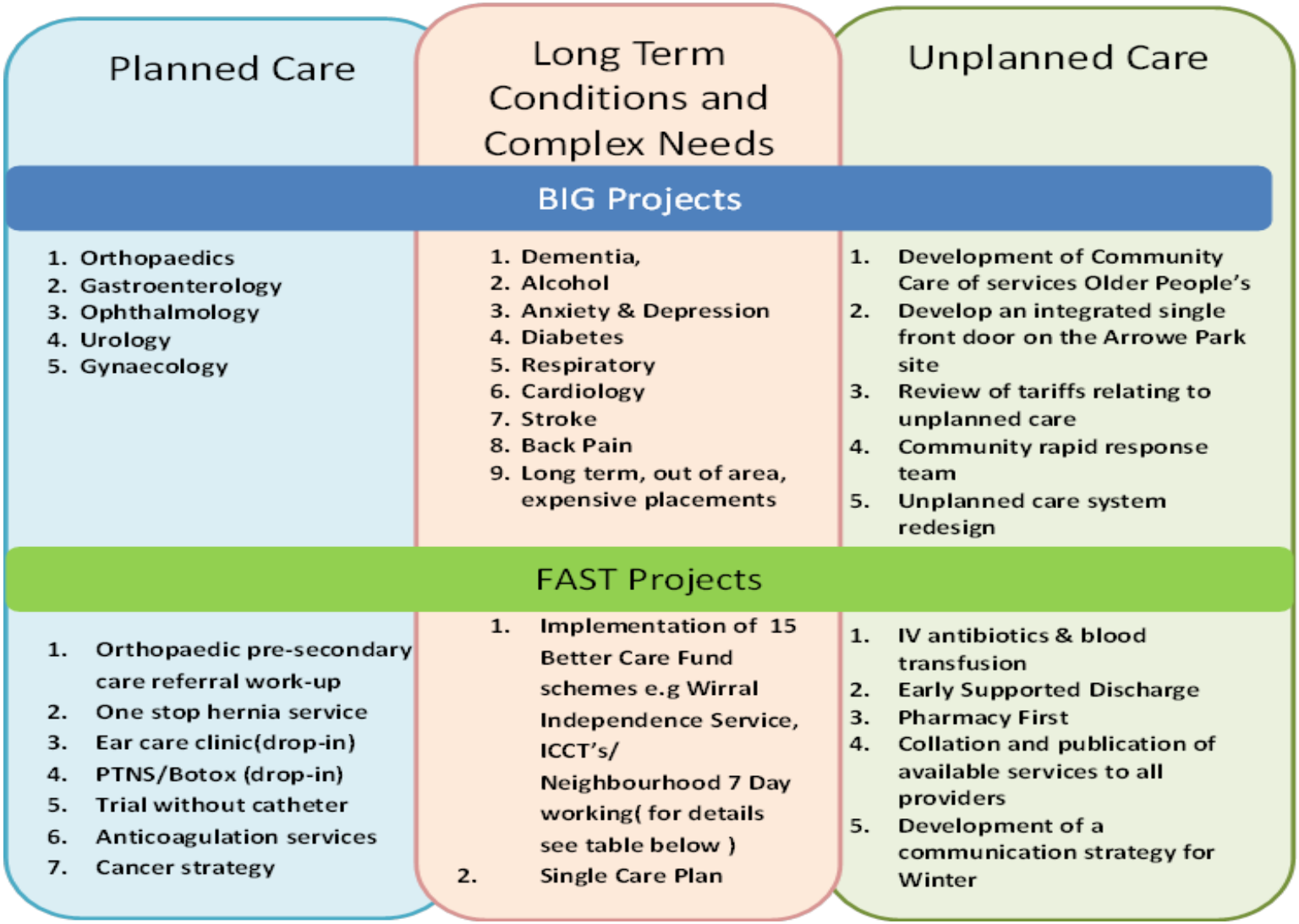
- Continuing to link LiA as a way of working into some of our Trust-wide and Divisional service priorities

In September 2014, a payslip leaflet was sent to all staff which provided an overview of what we have done to improve staff satisfaction and engagement in the Trust and what our LiA teams have done since the last round of CEO led Big Conversations. Currently we have 15 LiA teams in progress who, through the involvement of our staff, are creating improvements based on what staff said matters to them at the last round of Big Conversations as well as some of our Trust priorities. Examples include: CERNER IT system, pressure ulcer prevention, hospital readmissions, dementia care, health and wellbeing, social events, introduction of an employee of the month scheme and many more, as well as teams adopting this methodology to create improvements for themselves. These teams will feed back to the organisation on 5 December at the next LiA "Pass it On" Event. This is an

important event where we not only hear about the great things that the LiA teams have achieved but we also celebrate their success with them.

The national staff survey is currently in progress this quarter which will give us a further measure of how our staff are feeling and some of the areas where we can improve staff satisfaction and engagement supported by Listening into Action.

David Allison
Chief Executive
October 2014


Planned Care
Long Term Conditions and Complex Needs
Unplanned Care
BIG Projects
1. Orthopaedics
2. Gastroenterology
3. Ophthalmology
4. Urology
5. Gynaecology
1. Dementia,
2. Alcohol
3. Anxiety & Depression
4. Diabetes
5. Respiratory
6. Cardiology
7. Stroke
8. Back Pain
9. Long term, out of area, expensive placements
1. Development of Community Care of services Older People's
2. Develop an integrated single front door on the Arrowe Park site
3. Review of tariffs relating to unplanned care
4. Community rapid response team
5. Unplanned care system redesign
FAST Projects
1. Orthopaedic pre-secondary care referral work-up
2. One stop hernia service
3. Ear care clinic(drop-in)
4. PTNS/Botox (drop-in)
5. Trial without catheter
6. Anticoagulation services
7. Cancer strategy
1. Implementation of 15 Better Care Fund schemes e.g Wirral Independence Service, ICCT's/ Neighbourhood 7 Day working(for details see table below)
2. Single Care Plan
1. IV antibiotics & blood transfusion
2. Early Supported Discharge
3. Pharmacy First
4. Collation and publication of available services to all providers
5. Development of a communication strategy for Winter

Board of Directors		
Agenda Item	6.1	
Title of Report	Half Year Review of Annual Plan 2014-15 Objectives and Outline of Process for Annual Plan 2015-16	
Date of Meeting	29 October 2014	
Author	Jo Goodfellow, Associate Director of Strategy and Partnerships	
Accountable Executive	Anthony Hassall, Director of Strategic and Organisational Development	
FOI status	Document may be disclosed in full	
BAF Reference	1 - 14	
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated Bronze – qualitative data Performance against a number of targets is both externally validated (A&E, RTT). Others use quantitative and qualitative data to inform progress	
Level of Assurance	Incomplete	Board confirmation To note

1. Introduction

1.1 This paper provides a six month review of the Trust's annual objectives for 2014-15. Progress against these has been Red or Green rated, indicating whether they are on track for delivery or not. Where they are not on track, commentary has been provided to indicate remedial actions being taken in the remainder of the year to ensure delivery or at least mitigate any shortfall in delivery.

1.2 The paper also presents a summary of the timeline and arrangements that have been established to develop the organisation's objectives and plans for 2015-16, including the submission of the Monitor Annual plan. A detailed plan and commentary on preparations for the development of the 2015/16 plan will be presented to the Finance, Business and Performance Assurance Committee for review on 24 October 2014.

2. Summary and half year review of 2014-15 objectives

2.1 In January 2014, the Board approved a five year milestone plan for the delivery of the "Locally Focused, Regionally Significant" strategy which shaped the annual objectives for 2014-15. The plan included a baseline position established in 2013-14 and proposed a series of metrics which if delivered would show incremental improvement across the following five years. Annual objectives for 2014 – 15 are outlined in Appendix 1 of this paper.

2.2 As part of the planning process for 2014-15, these objectives were used to inform the development of Divisional and Corporate plans, and have since been integrated into the appraisal process to ensure the delivery of the objectives is tied into all departmental, team and individual objectives.

2.3 In July 2014, it was agreed that the Board Assurance Framework (BAF) would mirror the corporate strategic objectives and this would enable an on-going review of the objectives throughout the year.

2.4 At the end of September 2014, the Executive Team conducted a review of the delivery of objectives within the Annual Plan for 2014-15. These are included at appendix two and include a progress statement, a Red / Green rating and summary of actions to be taken in the final six months of the year to ensure delivery of the objective.

3. Construction of the Annual Plan for 2015-16

3.1 Monitor has indicated that in line with previous years, planning guidance for 2015-16 will be published in early December 2014. They have stated that an overarching objective of the planning round for 2015-16 will be to refresh the second year of the existing two year Operational Plans with a focus on making sure the plans are as realistic as possible. The expectation is that commissioners and providers will work closely together to develop the best possible set of plans for 2015-16.

3.2 Annual objectives for 2015 – 16 will be presented to the Board for agreement in December 2014 and will be presented in the context of performance against progress in 2014/15.

3.3 In line with the above and in response to the recommendations of reviews of the annual planning process undertaken in 2014/15, the Trust will commence consideration of its annual objectives and plan for 2015-16 from November 2014, in order that these can be communicated into the organisation in good time for operational plans to reflect and add detail to these objectives. An outline planning timetable is included at appendix 3.

4. Recommendations

4.1 The Board is asked to note the position in respect of delivery of objectives for 2014/15 and comment on and approve the outline process for development of the 2015/16 Annual Plan.

Annual objectives 2014-15

What will this mean (Our Strategic Objectives)	What will we do in 2014/5 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 Net promoter score of 65 or better Created a strong culture of empowered employees, delivering a Staff Engagement score of 3.59 or better, through implementation of our Nursing, Midwifery and a Customer service strategy
Leading on integrated shared pathways of care with primary, community and social care	Worked with partners in Wirral to reduced delayed transfers of care to no more than 4 per month and reduced readmissions to 7.5% 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 of our quality improvement strategy to reduce mortality to 85 (HSMR) Ensured that our harm free care score is no lower than 93% and no lower than 95% for 3 months
Ensuring our people are aligned with our vision	Re-launched our values and behaviours strategy and improved attendance rates to 96% and appraisal rates to 88%
Maximising innovation and enabling technologies	Implemented the next stage of our Cerner IT systems and delivered full electronic nursing documentation, piloted paper free outpatients and the ability to share documents with primary care (HIMMS level 5) To ensure patients are notified of opportunities to participate in suitable studies To participate in research to ensure the agreed recruitment goal is met for the Trust (400 patients)
Building on partnering for value	Delivered an increased market share to 77% of Wirral CCG referrals, through engagement with local GPs 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 cost improvement programme in full A Monitor Green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer.

Review of the Delivery of Objectives within the Annual Plan 2014-15

Annual Objective for 2014/15	Half Year Progress	RAG Rating	Action
Improved our patient experience to deliver a Friends and Family Net promoter score of 65 or better	Net promoter score 77 (September 2014)	Green	Improvements to the Friends and Family Test results are wide ranging across the services currently being measured including ED, Inpatient areas and Maternity. Many of the strategic aims of the nursing & midwifery strategy underpin improved performance on FFT including patient focused rounding and the introduction of flexible visiting. However, systemic changes across the organisation will help achieve sustained improvements in FFT including embedding values and behaviours, operational efficiency and improved staff satisfaction. It should be noted that NHS England has advised that the Net Promoter methodology will be replaced with a simplified achievement score. Guidance is awaited.
Created a strong culture of empowered employees, delivering a Staff Engagement score of 3.59 or better, through implementation of our Nursing, Midwifery and a Customer service strategy	3.64 (2013)	Green (based on 2013 results of Staff Survey) 2014 Staff Survey currently underway. Note though SFFT results show need for improvements	The staff engagement score is reported on an annual basis. The staff survey (2014) was issued during the first week of October 2014 and results of the survey are anticipated in January 2015 providing a score for the year end position. Results from the first quarter results of the Staff Friends and Family Test were mixed, with 90% of respondents saying that they would recommend the Trust as a place to receive treatment, but only 57.5% of respondents advising that they would recommend the Trust as a place to work. The results of this survey were considered at the Quality and Safety Committee. The Trust's Values and Behaviours have been refreshed and re-launched at the PROUD Awards in September. A revised Staff Engagement Plan incorporating Listening into Action will be considered by the Workforce and Communications Group before the end of 2014, following comprehensive redraft.
Worked with partners in Wirral to reduced delayed transfers of care to no more than 4 per month and reduced readmissions to 7.5% of total admissions, by developing a range of plans to deliver care closer to home	Delayed transfers of care. Average per month (April-September 2014) 4.8	Red	Delayed transfers of care include delays due to NHS and/or Social care. The average delayed transfers of care per month due to NHS alone are 2.7 (April-September 2014). Despite achieving this target, we know that this remains an organisational and system issue to tackle. Funding issues within social care do mean that delays remain in relation to these patients and the Urgent Care Action Plan has a series of measures in place to address performance in this area. The systems resilience plan, Better Care Fund action plan, and other unplanned care initiatives which support a reduction in delayed transfers of care are all documented in the Vision 2018 Unplanned Care Programme.

	Readmissions average 9.4% (April-August 2014)	Red	The Deputy Director of Operations is leading a patient flow initiative for the Trust which will contain workstreams which contribute to the reduction of delayed transfers of care. Readmissions include discharge spells subsequently readmitted non-electively within 30 days. Readmissions LIA event held in July 2014. Readmissions action plan in place which includes 1) identification of patients on their 2nd or subsequent admission to the Integrated care co-ordination teams (ICCT's) who will then review the patient's care plan if they are known to the team, or devise a care plan for new patients. 2) From 1st October 2014, a cross organisational MDT (Led by ADO Medicine/Acute) has been established to review the top 10 (non-elective) readmitted patients and put care plan in place. 3) Pathway for patients with Abdominal pain being developed by Surgical Division
Implementation of our quality improvement strategy to reduce mortality to 85 (HSMR)	April - June 2014 data is available HMSR 60 (51.8-68.8).	Green	Associate Medical Director (Risk) monitors actual deaths within the Trust and reports no cause for concern. Data for April-November is due in November 2014. HMSR is rebased each year. Target of 85% within the 2014-15 objectives is based on the achievement of an HMSR of 84.6 for 2013-14. It is anticipated the HMSR for 2014-15 will be rebased to 95 and the Trust will aim to reduce its HMSR to 85. Dr Foster is due to publish rebased figure in November 2014.
Ensured that our harm free care score is no lower than 93% and no lower than 95% for 3 months	Over 95% (April, May, June, August 2014). 94.3% (July 2014)	Green	Harm free care includes management of pressure ulcers, VTE, falls and catheter acquired UTI's. Ongoing action plans are in place to continue the delivery of this standard. This includes management of skin care based on NICE guidelines, ongoing assessment and appropriate prophylaxis for VTE. Falls from harm have increased in year and a group has been formed to review the Falls policy and ensure ward practice is in line with current guidance. Staff are directed to remove catheters as soon as it is clinically appropriate in the patient's journey. In all areas learning from RCA's is used to improve practice. A harm reduction collaborative has been established with Wirral Community Trust.
Re-launched our values and behaviours strategy and improved attendance rates to 96% and appraisal rates to 88%	Attendance rate (September 2014) 95.59%	Red	There are many factors which influence sickness absence rates it is therefore important to focus on those that are particularly significant locally. Analysis of data at WUTH and review of best practice in other Trusts has led to a focusing of action on the following areas. 1. Review of Policy – new policy to go live in January 2015, 2. Increase accuracy of data – ESR Manager self-serve to be rolled out to all areas by 31.3.15 3. Detailed review of all staff on long term sick – 73% of lost days are

			long term. HR, OH and divisional managers are focusing support to these staff. 4. Increase compliance with policy – Rolling program of Audit. 5. Celebration of high levels of attendance – 100% attendance certificates issued to individuals and departments, communications regarding high attenders. 6.Reduce Stress related absence – Stress is the most common reason for long term sickness, a stress working group has been established and an action plan is being implemented, 7. Increase wellness – Health and Wellbeing strategy has been developed and implemented.
	Appraisal rate (September 2014 82.29%)	Red	A number of actions are being undertaken to meet the 88% compliance rate by March 2015. These include: Letters re-issued to staff in purple and red (non-compliant) categories requesting appraisal is arranged with manager by 31/10/14. Monthly alert reporting for the Divisions will be continued. Policy KPI and updated action plan to go to Workforce and Communications Group December 2014 requesting increase in compliance target to 88% (policy currently states 85%) as best practice. Divisional leads identified to monitor action plans supported by HROD and also monitored at DMT's. Quality review of appraisals has taken place and made more robust around objectives and personal development plans.
Implemented the next stage of our Cerner IT systems and delivered full electronic nursing documentation, piloted paper free outpatients and the ability to share documents with primary care (HIMMS level 5)	HIMMS level 5 (September 2014)	Green	The Trust has performed an initial assessment with HIMMs which concluded that the Trust is almost at level 6 compliance but will not be able to satisfy all requirements until after 2B go-live.
National Institute for Research in Healthcare (NIRH) KPI target 100% Proportion of agreed recruitment goals being met.	230% achieved against target of 400 patients (September 2014)	Green	High level of compliance in the "Free Study" (genetics research) has been possible as it has involved family screening and lots of families have been willing to join the study – hence the performance in excess of 100%
Proportion of all studies achieving NHS permission to first patient, first visit within 30 days. Target 70%	67% (number of studies 3, Trust achieved 2)	Target to be reviewed	It has been found not be possible to recruit patients to all studies within 30 days of approval. Some studies have very low recruitment aims e.g. 2 patients per year. It is therefore highly unlikely we will recruit a patient within 30 days of approval. Research nurses are aware of the target and will raise awareness with principal researchers
Delivered an increased market share to 77% of Wirral CCG referrals, through engagement with local GPs	84.2% Definition: percentage share of GP referred new outpatient activity for Wirral CCG (Dr Foster).	Green	The Trust market share of Wirral GP referred new outpatient appointments was 84.2% (2013-14 84.1%). A Primary Care engagement plan has been implemented to maintain/improve the Trust's market share with Wirral and Neston/Willaston GP's. This has included visits to 16 practices by the

Developed a range of partnerships with NHS and non NHS providers to secure clinical sustainability, particularly in relation to our regionally significant services			Associate Medical Director and Associate Director for Strategy and Partnerships which have opened useful communication channels to discuss improvements that can be made to processes and communications to improve patient care. The GP newsletter, "In Practice" has been refreshed to provide more clinical focus following feedback from Primary care. A number of successful education events have been held in 2014 including a series of talks by specialist consultants to GP's at St Catherine's health centre, and study half days on specialty areas e.g. Neonatal care. Discussions have commenced with Director of IT to implement an electronic system to notify Primary care of their patient admissions and discharge plans (the latter linked to ICCT's and Ticket home initiative). Individual Divisions have a clear understanding of their market share of GP referrals following the strategic plans they have developed as part of the Annual planning process. They have used this information to target services e.g. clinics, in areas where they believe they can increase market share. The Trust has extended its work with the Countess of Chester Hospital to explore opportunities for collaboration in specialty areas where clinicians have indicated patient care and pathways could be improved through collaboration. The Trust is planning a joint workshop with CoCH and Betsi Cadwaladr Trust to identify opportunities to work in collaboration across the footprint of the three organisations. The Cardiology service has worked with Liverpool Heart and Chest Hospital to make a joint appointment to do PCI work (commences Nov 14) and investigate the opportunity to work in collaboration to establish a joint appointment for Electronic Physiology service. WUTH staff are working with partners from Wirral Health and Social care economy to implement Vision 2018, in particular the Integration of adult services and the establishment of Integrated Care Co-ordination Teams and the pathways between hospital and the ICCT's. The Women and Children's Division submitted a joint bid with Cheshire Wirral partnership to provide the 0-19 Health Child service on Wirral. The tender was won by WCT, although the collaboration work with CWP did help to develop and enhance relationships.

Full Compliance with our registration with the Care Quality Commission Registration	Green (quarter 1) Red (quarter 2)	Green Red	Quarter 1 green (with the exception of Infection Control which had a minor concern) Quarter 2 report Following the announced CQC visit on 18-19th September 2014, CQC have written to the Trust on 15th October 2014 enclosing their draft inspection report which has highlighted a number of areas for improvement, although no enforcement action. The Trust has been asked to respond with comments relating to factual inaccuracies by 29th October 2014. Upon receipt of the full and final report the Board will be provided with a full and detailed update.
A Monitor Continuity of Services rating of 2, meaning we have delivered our cost improvement programme	COS rating 2 (month 6)	Green/Red	Cos rating of 2 was achieved in month 6, although the cost improvement programme remains behind plan, with the overall financial plan behind target. Actions/Mitigations to maintain a COS rating of 2:- - Further work is ongoing to improve the income & expenditure through expenditure controls and further 10% reduction in spend in non-clinical areas. - Work is ongoing with external support to further identify and embed possible areas for cost improvement and transformation. - We have implemented the cash management actions to improve the cash position - We have secured the ITFF loan to support the capital programme and under pin forward look liquidity

A Monitor Green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer.	4 hour target Quarter 2 94.00%	Red	The following action plans are in place to ensure achievement of the 4 hour target - Organisational resilience action plan, Urgent care action plan and a Winter Plan Strategically the Better Care Fund plan (Health economy wide plan to reduce the number of non-elective admissions by 5% each year) has recognised the challenges faced by the health community in levering strategic change and has indicated a degree of transitional support which will be needed to transform the system.
	RTT (September 2014) Admitted 84.3% (planned fail) Non-admitted 94.1% (planned fail) Incompletes 93.8% (achieved)	Red (planned failure) Will return to compliance in December 2014	Following NHS England commissioned additional RTT activity to help the backlog of long waiting patients and improve RTT performance before the onset of winter; the Trust deliberately treated more long waiting patients in August 2014. Consequently our performance deteriorated meaning the Trust did not achieve the standards for admitted and non-admitted patients. The initiative has been extended to the end of November 2014.
	Cancer (achieved)	Green	Both Urology and Upper Gastro-intestinal surgery face ongoing challenges in meeting cancer targets. Urology has identified additional sessions to use the robot, additional MDT capacity, reviewed the patient pathway and have appointed an additional consultant to the Team. UGI patients are managed on a case by case basis due to the complexity of their pathway.

Appendix 3

Outline Plan for the Production of the 2015-16 Annual Plan

Date	Action
October 2014	Board paper on half year review of 2014/15 Annual Plan and process for 2015/16 Annual Plan Paper to Finance, Business Performance and Assurance Committee "Refreshing the Annual Planning and Budget setting Process"
November 2014	Annual plan task and finish group commences (until April 2015) Annual Plan Advisory Committee (Governors) commences meeting (until April 2015) 26.11.14. Executives review, refresh and agree milestones for strategic objectives and core objectives for 2014/15 Annual Plan
December 2014	Planning guidance for 2015-15 to be published by Monitor Tariff/grouper for 2015-16 issued and informs production of financial plan Briefing paper for Council of Governors on their involvement in Annual Plan including membership engagement Board agrees Annual Objectives for 2015/16
January 2015	Operational and Corporate teams review their plans based on learning in 14-15 and revise their operational plans for 2015-16. Executive Team consider high levels view of 2015-16 plans 13.1.15. Annual Plan Advisory Committee (APAC) 22.1.15. – Workshop with Council of Governors
February 2015	25.2.15. Board members receive detailed update and workshop on draft Monitor Annual Plan. Initial Board discussion to take place on risks within Corporate Governance Statement
March 2015	Operational and corporate annual plans submitted in line with agreement of annual objectives. 4.3.15. Council of Governors meeting to receive update on Annual Plan 25.3.15. Board agrees submission of Monitor Annual Plan and commentary on Corporate Governance Statement
April 2015	Annual Plan summary published and communicated to internal and external stakeholders

Board of Directors		
Agenda Item	7.1.1	
Title of Report	Integrated Dashboard and Exception Reports	
Date of Meeting	29 October 2014	
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 September 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 and Assurance, Audit, and Quality and 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 September are A&E 4-hour Standard, RTT 18 Weeks, Never Events, Infection Control, Attendance, Expenditure, CIP Performance, Non-core Spend and Advancing Quality. For the CQC metric, the Trust will be responding to Monitor following the recent CQC inspection, however no formal warnings have been notified and so this indicator is not flagged as Red.

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

4. Next steps

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

5. Conclusion

Performance across a range of metrics is provided for information.

6. Recommendations

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

WUTH Integrated Performance Dashboard - September 2014

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F Achievement Score Inpatients			JG	90.0%	September 2014
Patient Satisfaction - F&F Net Promoter Inpatients			JG	64.3	September 2014
Patient Satisfaction - F&F Net Promoter ED			JG	85.5	September 2014
Patient Satisfaction - F&F Net Promoter Maternity			JG	92.2	September 2014
Staff Satisfaction (engagement)			AH	3.64	2013
First Choice Locally & Regionally					
Market Share Wirral			AH	84.2%	April to June 2014
Demand Referral Rates			AH	3.2%	Fin Yr-on-Yr to Sept 14
Market Share Non-Wirral			AH	8.8%	April to June 2014

Organisational Risk Issues

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Key Performance Indicators					
A&E 4 Hour Standard			SG	94.0%	Q2 to September 2014
RTT 18 Weeks Standards			SG	1 tgt not met	September 2014
Cancer Waiting Time Standards			SG	All met	Q2 to September 2014
Strategic Objectives					
Delayed Transfers of Care			SG	3	12-mth ave to Sept 2014
Readmissions			EM	9.3%	September 2014
Harm Free Care			EM	97.0%	September 2014
HIMMs Level			MB	5	September 2014
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	2	September 2014
Complaints			JG	37.3	12-mth ave to Sept 2014
Infection Control			JG	0 MRSA; 4 C diff	September 2014
Productivity					
Bed Occupancy			SG	93.7%	September 2014
Theatre Utilisation			SG	65.4%	September 2014
DNA Rate			SG	8.9%	April to September 2014
Workforce					
Attendance			AH	95.2%	12-mth ave to Sept 2014
Qualified Nurse Vacancies			AH	2.8%	September 2014
Mandatory Training			AH	98.1%	September 2014
Appraisal			AH	82.3%	September 2014
Turnover			AH	9.3%	September 2014
Finance					
Contract Performance			AM	1.10%	To M6 September 2014
Expenditure Performance			AM	-1.60%	To M6 September 2014
CIP Performance			AM	-25.00%	To M6 September 2014
Capital Programme			AM	-10.70%	To M6 September 2014
Non-Core Spend			AM	8.30%	To M6 September 2014

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	3 areas below target	June 2014
Mortality: HSMR			EM	81.1 (low ci 76.4)	July 2013 to June 2014
Mortality: SHMI			EM	1.04 (low ci 0.89)	Jan to Dec 2013
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	To M6 September 2014
Monitor Risk Rating - Governance			SG	Not Green or Red	Q2 to September 2014
CQC			EM	0	September 2014
Local View					
Commissioning - Contract KPIs			SG	4	September 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 Achievement Inpatients	Friends & Family Survey - Achievement Score : Inpatients	>=85%	>=71% to < 85%	<71%
Patient Satisfaction - F&F Net Promoter Inpatients	Friends & Family Survey - Net Promoter Score : Inpatients	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter ED	Friends & Family Survey - Net Promoter Score : ED	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter Maternity	Friends & Family Survey - Net Promoter Score : Maternity	+86 to +100	+65 to +85	-100 to +64
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG elective hospital inpatient activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	All RTT standards met for the Trust as a whole	All met at Trust level	n/a	Not all met at Trust level
Cancer Waiting Time Standards	All Cancer Waiting Standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Strategic Objectives				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	>4 and <6	>= 7
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Harm Free Care	Compliance with Safety 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	<=7.5%	>7.5% to <9.0%	>=9.0%
Workforce				
Attendance	Rolling 12-month staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Non Core Pay Spend	% of total spend year to date	<5%	>=5.0% to 6.5%	>=6.6%
Qualified Nurse Vacancies	% vacant posts	<=2.5%	>2.5% to 5%	>5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Finance				
Contract Performance	Delivering both contracted volumes and values	>=3	2	1
Expenditure performance	Delivering planned levels of expenditure	>=3	2	1
CIP Performance	Delivering a recurrent CIP in-year & deliverable future proposals	>=3	2	1
Capital Programme	A sound investment programme mainatained & resourced appropriately	>=3	2	1

External Validation

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

WUTH Performance Dashboard Exception Report September 2014

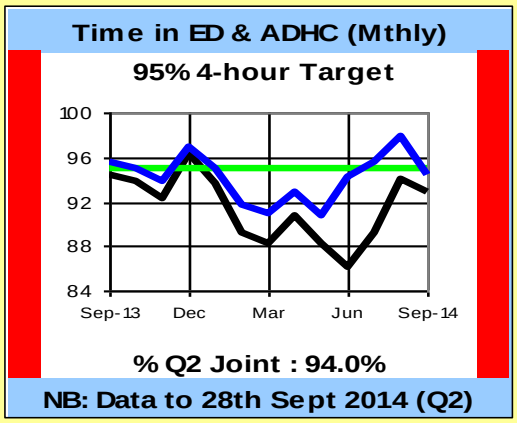
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	94.0%	Q2 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for September was 94.7%, including the All Day Health Centre at Arrowe Park site. WUTH's ED alone achieved 93.2%. This makes the joint position 94.0% for Q2, below national standard but in line with the revised trajectory shared with Monitor.

Historic data:



Proposed Actions:

A health economy urgent care recovery has been developed, building upon the initial findings of the Utilisation Management Team and the 'Perfect Day' initiative. This sets out a trajectory for performance against the target and is monitored weekly within the Trust, fortnightly with the CCG and monthly through the System Resilience Group. We continue to work with the Greater Manchester Central Support Unit who have advised that our ED processes are much improved and are now focusing their support on patient flow. The Trust Board supported a new staffing model for ED which is partially implemented and should be fully implemented by the end of November. This and other initiatives in the recovery plan are starting to have a positive impact on performance. A verbal update on progress will be provided at the meeting.

Assessing Improvement:

The difficulties with this standard are continuing. The continued collaboration of all stakeholders working together, both within the Trust and with external partners, is essential to deliver the necessary improvements.

Impact:

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

Expected date of performance delivery:

Quarter 3 in 2014/15

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — September 2014

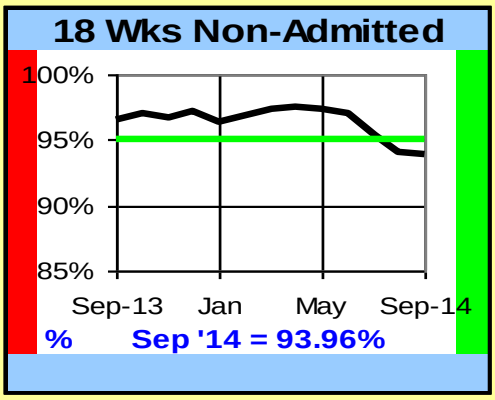
Indicator :
RTT 18 Weeks Standards

Rating	Target	Actual	Period
Red	All met at Trust level	1 target not met	Sept 2014

Issue:

The Trust did not achieve the RTT standard of 95% non-admitted patients to be treated within 18 weeks for the month of September. WUTH's performance was 93.96%. This failure was anticipated as WUTH, along with many other providers, is currently undertaking additional RTT activity at the request and with funding from NHS England. This is aimed at clearing backlogs of long waiting patients, and so it is acknowledged performance may deteriorate in this period. As a result financial penalties will not be applied for failing specialties for September. Monitor have not suspended the standards for this period, but have indicated their view of Trusts failing these standards will take into account this initiative. There has been a further tranche of additional non-admitted commissioned activity for October through December. It is a lower volume of activity, but the risk remains to the Trust-level achievement of the RTT target for this period.

Historic data:



Proposed Actions:

Continue to treat the additional RTT patients in line with the agreed NHS England plan through December.

Assessing Improvement:

There is weekly reporting to the DH/Monitor on RTT performance, plus weekly progress reports to Wirral CCG on the additional RTT activity. Internal performance management reports are long-established to track progress against all RTT standards at specialty level, and support delivery of the targets.

Impact:

Patients have an expectation, and a right under the NHS Constitution, to be treated within 18 weeks of referral. The standard is a hgh-profile target, underpinned by contractual penalties and Monitor's Risk Assessment Framework. Accessible services for patients are essential to ensure WUTH's ongoing viability.

Expected date of performance delivery:

From Q3 onwards

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — September 2014

Indicator :
Never Events : Incorrect sided implants

Rating	Target	Actual	Period
Red	Zero	2	Sept (reported)

Issue:

Summary of incidents:
Two separate occurrences reported of an incorrect-sided implant placed into the correct sided knee.

Historic data:

Proposed Actions:

RCAs commenced and underway. Standardised protocol introduced immediately for opening of prosthesis components.

Assessing Improvement:

The subsequent RCA action plans will be monitored until closure.

Impact:

The Trust has a target of no never events per year. The Trust reports each never event to StEIS, CCG, CQC and Monitor. The action plan will be monitored until closure by the CCG.

Expected date of performance delivery:

Expected period when turns 'Green' : April 2015

Executive approval:

Dr Evan Moore, Medical Director

WUTH Performance Dashboard Exception Report — September 2014

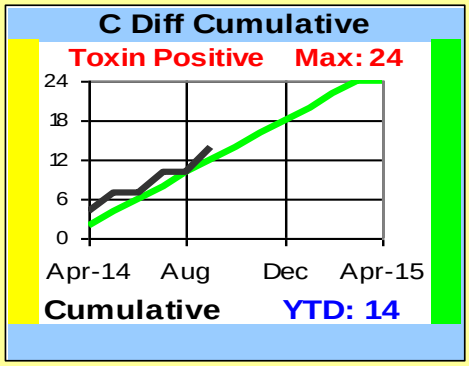
Indicator :
Infection Control

Rating	Target	Actual	Period
Red	Max 12 to Sept	14	April to Sept

Issue:

For infection control, the number of Clostridium Difficile cases was above trajectory at the end of Quarter 2, with 14 hospital cases against a maximum trajectory of 12. However following Post Infection Review, two of these cases in September are considered unavoidable by WUTH's Infection Control Team, and they are being discussed with Wirral CCG. If this view is supported by the CCG they would then not count against the trajectory, reducing the cumulative position for September down to 12. The maximum year-end trajectory is 24 cases.

Historic data:



Proposed Actions:

All cases have a Post Infection Review, with further discussion of appropriate cases with local commissioner.

Assessing Improvement:

Although close to an irreducable minimum, all hospital acquired cases are subject to Post Infection Review with lessons learned disseminated via the Infection Control Committee and across the Trust.

Impact:

The Trust has a maximum trajectory of 24 hospital acquired cases for 2014-15. The exceeding of this trajectory has the potential for Goverance concerns with Monitor and a financial impact with local commissioners.

Expected date of performance delivery:

From Q3 onwards

Executive approval:

Jill Galvani, Director of Nursing & Midwifery

WUTH Performance Dashboard Exception Report — August 2014

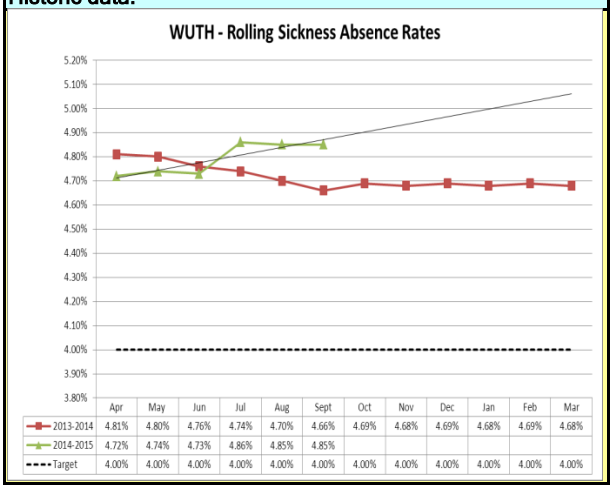
Indicator :
Attendance

Rating	Target	Actual	Period
Red	>= 96%	95.15%	Oct 13 - Sept 14

Issue:

Sickness Absence rolling 12 months was 4.85% at September 2014 and therefore above Trust target of 4% and higher than at the same point last yesr. However the month of September was only 4.41%. This represents the lowest September in four years. This follows the lowest August in 3 years. Continuation of this recent trend of low monthly perfomances will reduce the rolling figure.

Historic data:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-2014	4.81%	4.80%	4.76%	4.74%	4.70%	4.66%	4.69%	4.68%	4.69%	4.68%	4.69%	4.68%
2014-2015	4.72%	4.74%	4.73%	4.86%	4.85%	4.85%						
Target	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

Proposed Actions:

Rewrite of policy, Validate data, Review staff on long term sick, Audit policy compliance & corrective action, Health and Wellbeing Strategy, Sickness absence training, Detailed monthly reporting and associated drill down, Monthly workforce meetings (HR Managers and line managers), Individual action plans for poor attenders, Self-care scheme, Comprehensive Occupational Health Service, Flu vaccinations

Assessing Improvement:

Improvements will be monitored via monthly 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 permenent 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

September 2014

Indicator :

Expenditure

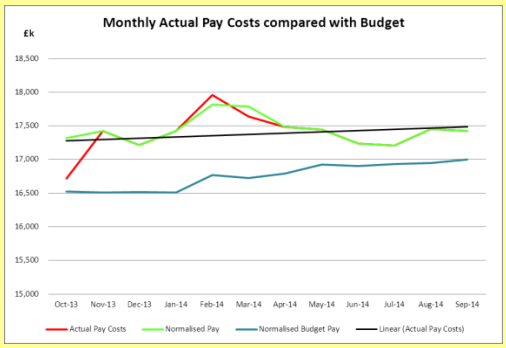
Rating	Target	Actual	Period
Red	On Plan	-1.6%	Sep-14

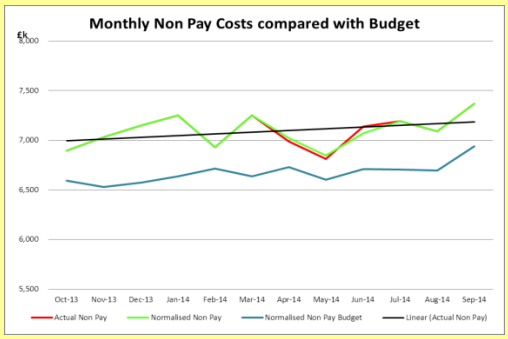
Issue:

The underlying operational expenditure is £850k overspent in month against plan, £424k on pay and £426k on non pay.

The overspending themes are CIP expenditure scheme slippage of £0.3m, costs of £0.2m due to the additional RTT patients, costs associated with delivering planned activity at premium rates of £0.2m, £0.2m of marginal cost impacts of delivering additional non elective activity and £0.1m on other expendtre categories, offset by other pay vacancies of £0.2m.
The total pay spend for September was £17.4m, which is broadly consistent woth August but at a higher level than June & July (£17.2m in each month.
Month on month non pay overspend costs have been relatively constant in the period and reflect the profiled plan.

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 conjunction with FTI, in closing the finnacial gap must continue through the current year and into the new financial year.
The Trust has been working with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change.

Assessing Improvement:

The divisional reviews will continue to assess performance on a monthly basis and any corrective turnaround plans will be implemented as necessary.
Transformational reviews including the Corporate review together with the generation/delivery of further ideas in conjunction with FTI are to improve /recover the financial position.

Impact:

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

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report September 2014

Indicator :
CIP

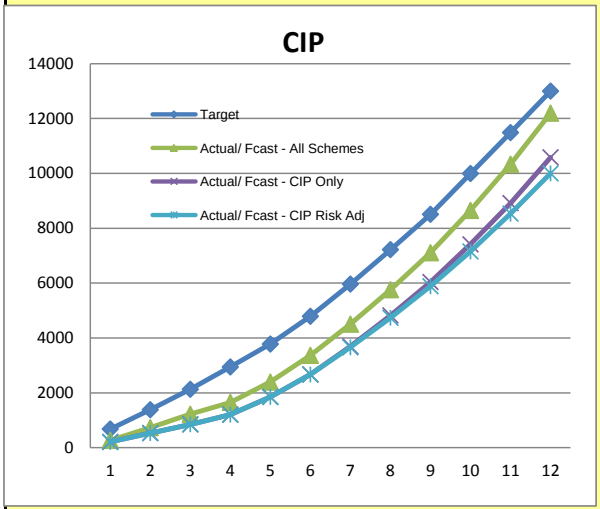
Rating	Target	Actual	Period
Red	On Plan	-25.0%	To Sept 2014

Issue:

Although the in year forecast has gone up to £10.5m (£10m adjusted for risk) between Month 5 and 6, due to the identification of additional schemes supported by FTI/Atkins and the 10% challenge offset primarily by the loss of assumed income from additional trauma beds, the gap remains at £3m.

Continued increases at this level will be a challenge as the external support ceases and the PMO resource is reduced due to leavers and long term sickness

Historic data:



Proposed Actions:

The Transformation Steering Group continue to meet on a weekly basis and work continues with the support of the external FTI team to develop additional schemes in both the identified priority and existing areas and there are further savings to be reflected. This level of effort and focus will need to be maintained by the organisation on an ongoing basis in order to mitigate against the risk of and deliver the existing CIP plans, identify new schemes to fill the gap and identify schemes for 2015/16.

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 both with the sub theme leaders, with the Divisions and with the Executive team.

Impact:

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

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report September 2014

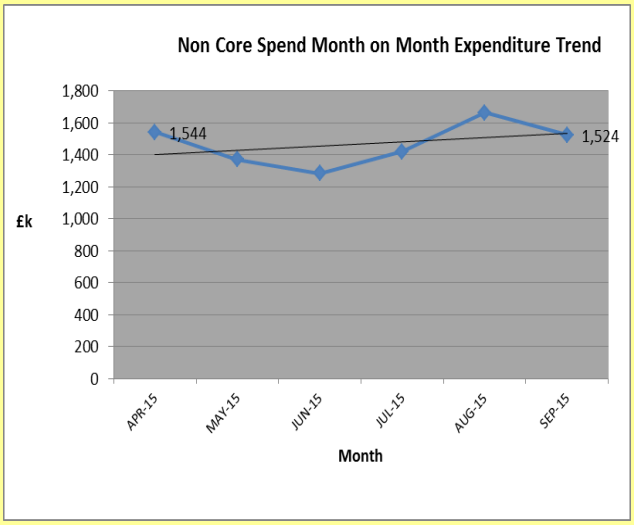
Indicator :
Non Core Pay Spend

Rating	Target	Actual	Period
Red	<5%	8.3%	To Sept 2014

Issue:

In September 2014 £1.5m has been spent on non core pay categories. This represents 8.3% of the total pay expenditure in September. There has been an impact on non core spend for the accelerated additional referral to treatment patients (RTT) of £259k last month and £195k this month. From a divisional perspective both the clinical divisions show relatively high spend with the Medicine and Acute division at a 12.7% level, Surgery/ Women & Childrens at 7.6% and the Clinical Support division is at 6.9%. All three Divisions are rated as red against the target of 5%. The operational issues requiring non core pay categoeies to be utilised are vacancy cover, sickness, staffing for the additional beds opened and the extra lists/activity to support the RTT patients which is offset by additional NHS clinical income. However The CPE and VRE costs linked with additional beds being opened that were high in August were minimal in September and RTT costs have reduced.

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 which have come down from 4.71% in April to 4.41% in Sepember 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 September 2014

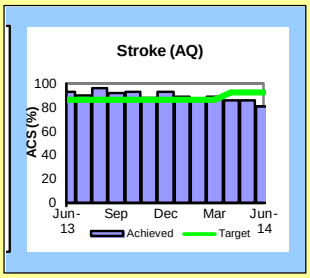
Indicator :
Advancing Quality

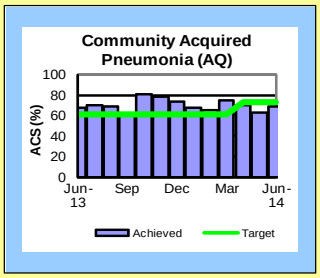
Rating	Target	Actual	Period
Red	All achieving	3 areas under target	June 2014

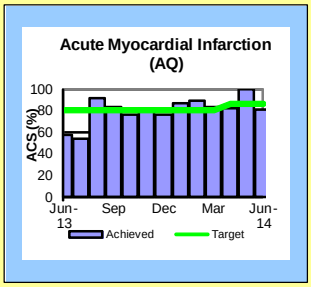
Issue:

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 June Stroke, CAP and Acute MI were below the required scores.Targets set are year-to-date (YTD).

Historic data:







Proposed Actions:

AMI - A problem has been identified and reported with the logic in the software to AQUA that inflated the score for trusts sending patients out for revascularisation. This led to a reduced achievement in June. The ongoing concern is timely referral to cardiac rehabilitation; visual alerts and education is in place to support this. YTD the appropriate care score is 88.2%. The reduced performance may continue as the issue was not identified until September. There is also now a gap in service for MINAP and AQ MI with proactive audit and prompting ceasing as the seconded auditor returned to the wards (Medical Division addressing). STROKE - the issue is getting the patients onto the unit within the prescribed timescales, due to the flow of patients and bed availability. YTD performance is 83.8%. PNEUMONIA - performance has improved slightly. YTD achievement is 65.7%, below target. Previously reported work is continuing to improve giving smoking cessation advice, and timely appropriate antibiotics. WIth reporting delays it is unlikely the impact will be seen before Christmas. In National Audit Week there was additional AQ promotion to staff.

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 6 Finance Report	
Date of Meeting	29 October 2014	
Author	Julie Clarke, Head of Financial Management	
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 6 is an in month deficit of £356k. Against this plan, an actual deficit of £368k was delivered, resulting in an adverse variance of £12k in month.

The cumulative position for the first 6 months shows a cumulative deficit of £5,148k against a planned deficit of £4,563k; this represents an adverse variance against plan of £585k. 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 6 months is recovered. Thus in months 7 to 12 it will be necessary for the Trust to deliver a surplus in order to achieve the plan.

In overall terms NHS Clinical income is above plan for September, which includes assumed increases in income from commissioners to support referral to treatment times and urgent care.

A clear message has been provided within the organisation that given the financial position it is required 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, in conjunction with FTI Consulting, in closing the financial gap

Cash Position & Continuity of Service Ratios (COS)

The cash position is £17.4m, £13.5m 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 first tranche of the loan
- Positive movements offset by delayed sale of Springview

The Continuity of Service rating has returned to a 2 in Month 6 in line with plan. The year-end forecast is forecast to be a 2 as the fall in EBITDA position is offset by the planned sale of Springview (the sale of which was originally scheduled for August). The liquidity position will also benefit from the drawdown of a loan from the ITFF to support the capital programme.

The headline financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 6 2014/15 (SEP)							Comparative 2013/14 Position (Month 6)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	24,978	25,525	547	147,982	149,757	1,775	146,970	145,513	(1,457)
Employee Expenses	(16,999)	(17,423)	(424)	(101,488)	(104,244)	(2,756)	(95,464)	(102,415)	(6,951)
All Other Operational Expenses	(6,941)	(7,367)	(426)	(40,384)	(42,593)	(2,209)	(36,563)	(39,825)	(3,262)
Reserves	(248)	15	263	(3,908)	(1,383)	2,525	(7,966)	(92)	7,874
EBITDA	790	750	(40)	2,202	1,537	(665)	6,977	3,181	(3,796)
Post EBITDA Items	(1,146)	(1,118)	28	(6,765)	(6,685)	80	(6,261)	(6,276)	(15)
Net Surplus/(Deficit)	(356)	(368)	(12)	(4,563)	(5,148)	(585)	716	(3,095)	(3,811)
EBITDA %	3.2%	2.9%	(0.2%)	1.5%	1.0%	(0.5%)	4.7%	2.2%	(2.6%)
CIP as % Op Expense	4.2%	3.9%	(0.2%)	3.3%	2.3%	(1.0%)	5.7%	1.7%	(4.0%)

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. The full requirement to month 6 identified a savings requirement of £4.8m.

As at month 6 schemes have delivered £2.7m, a shortfall of £2.1m against the year to date target of £4.8m and the latest CIP forecast is £10.6m compared with a £13m target. Please see table below for detail by Division/Executive theme leads.

£k	YTD Actual	YTD Budget	YTD Variance	Full Year Forecast Actual	Full Year Forecast Budget	Full Year Forecast Variance	Recurrent Forecast Actual	Recurrent Forecast Budget	Recurrent Forecast Variance
Exec Lead									
Sharon Gilligan	272	719	(447)	1,509	1,950	(441)	3,952	2,600	1,352
Jill Galvani	154	470	(316)	516	1,275	(759)	1,064	1,700	(636)
Alistair Mulvey	363	885	(521)	1,936	2,400	(464)	2,927	3,200	(273)
Mark Blakeman	486	1,050	(564)	2,101	2,850	(749)	3,843	3,800	43
Anthony Hassall	908	1,004	(97)	2,978	2,725	253	3,642	6,300	(2,658)
Evan Moore	486	663	(177)	1,544	1,800	(256)	2,542	2,400	142
TOTAL	**2,670**	**4,791**	**(2,122)**	**10,585**	**13,000**	**(2,415)**	**17,971**	**20,000**	**(2,029)**
Division									
Medicine & Acute	698	1,327	(628)	2,931	3,600	(669)	5,730	5,500	230
Surgery, W&C	1,034	1,327	(293)	3,001	3,600	(599)	3,069	5,500	(2,431)
Clinical Support - AF	179	774	(595)	810	2,100	(1,290)	2,307	3,200	(893)
Clinical Support - MW	123	553	(430)	830	1,500	(670)	2,002	2,300	(298)
Corporate Support	636	811	(175)	3,014	2,200	814	4,865	3,500	1,365
TOTAL	**2,670**	**4,791**	**(2,122)**	**10,585**	**13,000**	**(2,415)**	**17,971**	**20,000**	**(2,029)**
Adjustment for Risk	0	0	0	(584)	0	(584)	(2,502)	0	(2,502)
Risk Adjusted Total	**2,670**	**4,791**	**(2,122)**	**10,001**	**13,000**	**(2,999)**	**15,470**	**20,000**	**(4,530)**

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 6 months of the year translates into:

- A planned deficit of £4.6m, against which an actual deficit of £5.1m has been delivered (£0.6m adverse variance); and
- A COS rating of 2 in line with the planned COS rating of 2

The cash position is £17.4m, £13.5m 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 first tranche 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 deficit of £5.1m at Month 6 against a plan of £4.6m; 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 reported in the first 6 months is recovered.

Divisional Analysis

The following table shows the summary Divisional position (cumulative to Month 6). 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).

Divisional Analysis of Income & Expenditure Position

Detail	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Corporate £000	Central £000	Total £000
NHS Clinical Income						
Planned Income	56,525	66,295	7,363	431	3,482	134,095
Actual Income	58,532	64,862	7,945	365	3,843	135,546
Variance	2,007	(1,433)	582	(66)	361	1,451
Net Expenditure						
Planned Expenditure	39,244	37,023	35,482	16,236	3,908	131,893
Actual Expenditure	41,546	38,098	36,801	16,180	1,384	134,009
Variance	(2,302)	(1,075)	(1,319)	56	2,524	(2,116)
Variance EBITDA	(295)	(2,508)	(737)	(10)	2,885	(665)
Post EBITDA						
Planned Post EBITDA					6,765	6,765
Actual Post EBITDA					6,685	6,685
Variance	0	0	0	0	80	80
Total Variance to Plan	(295)	(2,508)	(737)	(10)	2,965	(585)

Pay Analysis

The most significant area of expenditure for the Trust in September, relates to pay. The total pay spend for September was £17.4m, this is comparable to the costs incurred in August although the preceding period incurred costs of £17.2m. 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	YTD £000
Budget	**16,789**	**16,922**	**16,901**	**16,933**	**16,944**	**16,999**	**101,488**
Pay Costs							
Permanent	15,950	16,081	15,944	15,776	15,785	15,897	95,433
Bank Staff	299	326	297	355	347	342	1,966
Agency Staff	318	357	311	379	537	449	2,351
Overtime	318	208	209	162	174	229	1,300
Locum	418	336	301	374	435	380	2,244
WLI (In Year)	180	138	170	164	171	125	948
Total	**17,484**	**17,444**	**17,234**	**17,210**	**17,449**	**17,422**	**104,243**
Variance	**(695)**	**(522)**	**(333)**	**(277)**	**(505)**	**(423)**	**(2,755)**
Pay Reserves	495	205	70	122	50	60	1002
Variance (after reserves)	**(200)**	**(317)**	**(263)**	**(155)**	**(455)**	**(363)**	**(1,753)**

4. Next Steps

The Trust has continued to work closely 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.

5. Conclusion

The in month position shows a deficit of £368k, against a plan of £356k, resulting in an adverse variance of £12k. The year to date position shows a deficit of £5,148k, which is £585k 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 5 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.

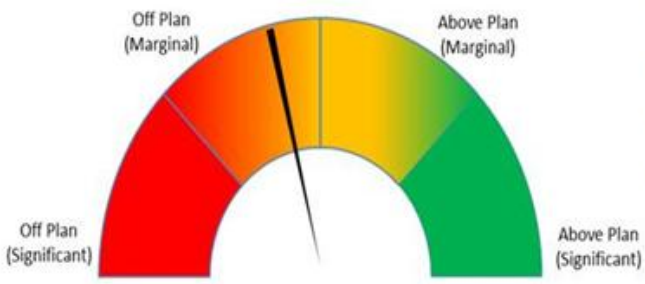
6. Recommendations

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

Alistair Mulvey
Director of Finance
October 2014

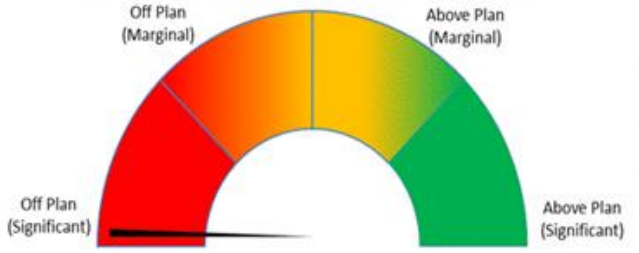
Attachment – Divisional Overview & Narratives

Divisional Overview (Month 6)



Medicine - Key issues

- ***Income over plan by £2.0m.***
- ***Expenditure exceeds budget by £2.3m .***
- ***Overall position £0.3m off plan.***

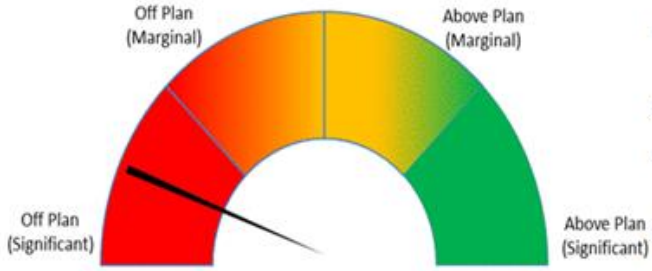


Surgery / W&C - Key issues

- ***Income behind plan by £1.4m.***
- ***Expenditure exceeds budget by £1.1m.***
- ***Overall position £2.5m off plan.***

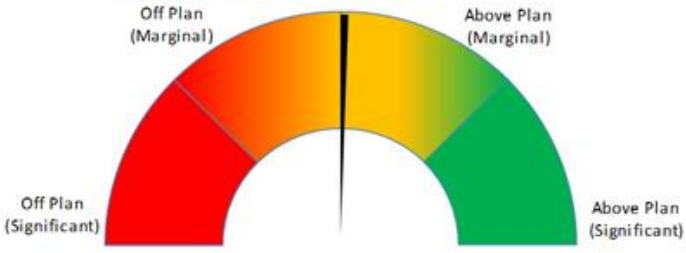
Diagnostics & Clinical Support - Key issues

- ***Income ahead of plan by £0.5m.***
- ***Expenditure over plan by £0.8m.***
- ***Overall position £0.3m off plan.***



Clinical Support - Key issues

- *Newly established Division includes Pathology, Hotel Services, Patient Flow and Cancer Pathway*
- *Income over plan by £0.1m—additional activity.*
- *Expenditure exceeds budget by £0.5m, driven by additional activity and CIP shortfall.*
- *Overall position £0.4m off plan.*



Corporate - Key issues

- ***Income below plan by £66k, relating largely to injury cost recovery.***
- ***Expenditure under spent by £57k in month.***
- ***Overall position £9k better than plan in month.***

Medicine & Acute I&E

Acute and Medical Care – The division reported an £330k surplus in month 6, the third successive month within which a surplus was reported albeit the cumulative position continues to reflect a deficit against plan of £295k year to date.

Income within the division is over achieving by c£2.0m, the main drivers of this include additional volumes of activity within planned care work streams both out-patients and in-patient care (£106k and £674k respectively relating to 764 out-patient and 1,260 in-patients) and increased volumes of patients from a non elective care perspective. Non elective activity has increased by 969 patients equating to £1,391k. The Division has generated this additional non elective activity within a reduced bed base of 40 funded beds. However, Emergency Department attendances are up against plan by 677, but due to penalties imposed relating to the 4-hour breaches, the net income position for ED is down against plan by £384k.

The costs of service delivery have exceeded the planned budget by £2.3m. The most significant element of pressure relates to staff costs, c£1.8m 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, £0.6m - the current level of overspending reduce to c£46k 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 substantive staff are appointed. The department has, in the last month appointed another substantive consultant which reduces the current consultant gap to two wte
- Gastro currently has overspending of c£448k as locum staff are required to fulfill vacant posts. It should be noted that the current over recovery of income within gastro is £351k and therefore 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 specialty activity assumptions increase significantly in the latter part of the financial year
- Nursing costs – nursing budgets are currently £735k overspending of this
- £188k relates to staffing of additional beds opened through the preceding 6 months as patient demand and infection control and prevention measures have impacted on the core bed stock
- £285k 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, and
- £262k 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 last two 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£371k which are driven by over 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 FTI 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£500k year to date pressure. All efforts continue to be focused on bridging the in year gap.

A detailed unmitigated outturn position based on current performance levels and run rates has been completed, which has the Division delivering a deficit of £1.2m, which has been reduced from a forecast earlier in the year of over £3m through additional income, investment in staffing and cost reduction schemes.

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

Surgery, Women's and Children's Division – The divisions overall financial position deteriorated in month 6 by £334k generating a cumulative year to date deficit of £2.5m. Within the overall deficit position expenditure variances are £1.07m year to date deterioration in month of £255k and income under performance is currently £1.4m of which £79k was in month. The key cumulative drivers of the overall year to date expenditure variance of £1.07m include:

- £176k to support additional bed capacity, of which £99k relates to the provision of the Trust CPE cohort ward;
- £276k relates to Non-PBR excluded devices and high cost drugs, which are pass through costs and attract additional income;
- £370k relates to Park Suite underperformance, 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;
- £413k of CIP underperformance and
- £153k Underspend on Theatres Prosthesis costs which is due to Income under performance.

The above costs, which reflect the cumulative position, were also incurred on a proportionate basis in month 6. Specifically in month 6 additional costs, covered by income, were incurred in the delivery of additional RTT activity, the direct costs of these attributable to Surgical Care were c£506k.

From an income perspective the division has a cumulative under performance of £1,433k of which £79k was in month 5.

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 £1,110k behind its elective plan. The division has also seen year to date under performance against neonatal activity of £262k. Favourable variances, most notably against RTT income and income streams associated with Wales go some way to mitigate these gross income pressures. The Division has seen an improvement in its outpatient activity in Month 6 relating to an over performance of £56k.

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.

The PBR orthopaedic plan was set this year based on available capacity to treat patients. Within the year there has been a significant casemix shift which means that higher volume, lower casemix cases are no longer being received into the Trust thus affecting the ability to deliver the plan.

To help mitigate the impact of this the Division approached Betsi Cadwaladr LHB to undertake cases to help with Welsh waiting time targets for both orthopaedics and ophthalmology to backfill the loss of English activity. These activities are now developing although there were some initial operational anomalies to overcome. Good working between the respective organisational teams have resolved these issues and it is hoped that this will support a longer term strategic alliance for future service delivery and it is forecast that the financial benefits of this service provision will flow into future periods and within September the Division has secured another 116 orthopaedic cases to be undertaken from Betsi.

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.

The current unmitigated outturn position for Surgery, Women & Children's is £3.9m based on the year to date position at Month 6 of £2.5m. Work is ongoing in the development of a turnaround plan within the Division to mitigate the financial position.

Diagnostics I&E

Diagnostics and Clinical Support - The newly established Division now includes Radiology, Theatres/Anaesthetics, Pain Services, Outpatients and Therapies. The overspend reported for the newly combined services @ month 6 is £345k year to date. **NB The cost of the pain service is included in this position but the income has still not been transferred which should improve the overall position**.

From an income perspective the Division is performing well and is £492k ahead of plan year to date. This is largely driven by direct access income from Radiology. Radiology has experienced an 18% increase in activity resulting in a £369k income over achievement with high demand continuing in areas such as Ultrasound. 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 adverse pay variance £103k year to date, Theatres are £238k overspent and Radiology £86k, however, encouragingly Outpatients is in surplus £92k and Therapies is also in surplus by £130k.

The Division is holding vacancies as it progresses its staffing restructure proposals in consultation with staff side colleagues in all areas. These savings partially off setting additional costs associated with the delivery of excess direct access activities.

Non pay budgets are £215k overspent year to date but this is offset by £110k in associated income. Theatres non pay overspend is £59k offset by £77k income and radiology non pay overspend is £150k but there is a shortfall on income of £20k. The bulk of these costs being variable costs associated with direct access volumes.

The division remains £627k behind its year to date CIP target. Specifically Theatres and Anaesthetics are £277k behind plan, Radiology £190k behind, Therapies £119k behind and Outpatients £41k behind. 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 FTI in exploring further opportunities to bridge any remaining gaps in CIP delivery.

A detailed forecast outrun based on current performance levels and run rates is being prepared and will be reported at month 6.

The full year unmitigated outturn position for Diagnostic & Clinical Support is forecast to be £1.2m adrift of budget with performance in the second half of the year expected to worsen by £0.6m; largely as a result of lower anticipated levels of Direct Access income, additional agency costs and the assumption that the currently high levels of vacancies will not continue. The forecast does not currently include any benefit from the proposed remedial plan to address CCG concerns over Direct Access waiting times – this could be c£0.1m.

Clinical Support I&E (Hotel Services, Patient Flow and Cancer Pathway)

Clinical Support – This sub division of the newly established Division includes Pathology, Hotel Services, Patient Flow and Cancer Pathway. The overspend reported for the newly combined services at Month 6 is £392k year to date.

From an income perspective the only area that generates Clinical Income is Pathology which is performing slightly ahead of plan by £90k year to date (activity is up 2.7%). This increase is largely driven by direct access income with Blood Sciences and Cellular Pathology being cumulatively ahead of plan whilst Microbiology income is slightly behind. Recent performance has dipped across Pathology leading to some caution around future volumes, however at this point we are projecting a small over performance for the remaining year. 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 a favourable pay variance £178k year to date with only Patient Flow showing a cumulative overspend owing in the main to sickness cover and pay protection. The Division continues to hold vacancies as it progresses its staffing restructure proposals in consultation with staff side colleagues in all areas.

Non pay budgets are £597k overspent year to date but this is offset by £349k in associated income. Pathology non pay overspend is £230k offset by £123k income, the bulk of lab costs are vary with both GP & Trust activity however Pathology is experiencing a significant cost pressure in the provision of blood products to the broader organisation (£119k year to date net of income recovery) – this area is being interrogated in more detail to ensure that all income is being fully recovered. Hotel Services non pay overspend is £326k offset by higher associated income of £170k, this area is the impact of accommodation guarantee (£98k adverse ytd),

The division remains £412k behind its year to date CIP target and this remains 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 FTI in exploring further opportunities to bridge any remaining gaps in CIP delivery.

The full year unmitigated outturn for Clinical Support (Pathology etc) is forecast to be £1.1m adrift of budget with performance in the second half of the year expected to worsen by £0.4m as a result of lower values expected for Pathology Direct Access income, additional agency costs and specific issues in respect of clinical supplies.

Board of Directors		
Agenda Item	7.3	
Title of Report	15 Steps Board Walkabouts Update Report	
Date of Meeting	29 October 2014	
Author	Michael Chantler, Head of Patient Experience	
Accountable Executive	Jill Galvani, Executive Director of Nursing & Midwifery	
FOI status	Document may be disclosed in full	
BAF Reference	1 & 2	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

A report was presented to the Board of Directors on 27/8/14 summarising the principle points arising from the 15 Steps Board Walkabouts which have been undertaken since October 2013. Following this review the Board asked for the Director of Nursing & Midwifery to present the paper, its conclusions and proposals the Council of Governors meeting on 23/9/14.

This updated report summarises the main points arising from the review by the Council of Governors as well as providing definitive next steps for the Board of Directors to approve.

2. Review by the Council of Governors

The original summary report detailed three proposals and these were discussed at the Council of Governors, these are summarised as follows:

- Reduction in the number of teams undertaking walkabouts from 8 to 4 to allow more flexibility for team members as scheduling 8 teams on a monthly basis has at times proved difficult

- The walkabouts, which have to date been announced to the wards/units move to being unannounced and are more reflective of the 24 hour nature of the services provided by the Trust

- Consideration is given to aligning the walkabouts to the revised CQC inspection methodology to provide the oganisation with assurance that standards of quality and safety are being delivered consistently. This would enable the teams to identify key lines of enquiry for progession and action in preparation for a CQC visit.

The Council of Governors reviewed these proposals and made the following points:

- The preference would be to keep the number of teams at 8 rather than reduce the number to 4

- Walkabouts remain announced as this gives the ward/unit an opportunity to highlight any areas of achievement or best practice

- Supportive of aligning the walkabouts to the new CQC inspection methodology

The Council of Governors also stated that they would like consideration to be given to a feedback mechanism resulting from the walkabouts beyond the immediate feedback given to managers following the visits. It was agreed to use the Walkabouts to enable Governors to see the Cerner system in practice.

The Board of Directors is asked to consider the points arising from the review undertaken by the Council of Governors and to approve the following:

- Retaining the number of teams at 8

- The walkabouts remain as announced but reflect the 24 hour/7 day nature of the service

- Aligining the walkabouts with the CQC inspection methodology to provide an additional level of assurance in the organisation

A feedback methodology will be developed to provide a summary report to each division on a quarterly basis through the Patient & Family Experience Group, with escalation to the Quality & Safety Committee of any issues that are considered necessary. In addition, a higher level report will be produced to the Board of Directors and the Council of Governors on a half yearly basis and this will include a summary of the actions taken as a result of the walkabout.

3. Next Steps

- The current methodology will be revised to align the walkabouts with the CQC inspection methodology whilst retaining the principle points of the 15 Steps. In practice this means that the walkabout team would consider key lines of enquiry using the patient focussed audit pro forma as a guide

- Scheduling for a new programme of walkabouts to be completed in November to start in December 2014

- Briefing sesssions to be undertaken with teams prior to the new programme of visits commencing

- A new reporting template will be designed to provide a divisional summary report on a quarterly basis. Divisions will be asked to summarise the actions taken as a result of the feedback and this will be incorporated into update reports for the Board of Directors and the Council of Governors

4. Recommendation

The Board of Directors is asked to review and approve the revised proposals.

Board of Directors		
Agenda Item	7.4	
Title of Report	Annual Medical Appraisal for the Year 2013/14	
Date of Meeting	29 October 2014	
Author	Dr Evan Moore, Medical Director	
Accountable Executive	Dr Debra King, Associate Medical Director for Appraisal & Revalidation	
FOI status	Document may be disclosed in full	
BAF Reference	4	
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

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

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

The Senior Medical Staff Appraisal Policy has been updated in 2014 and was ratified on 1 August 2014 with a review date of 1 August 2017.

Directorates are monitored for efficiency of the operational process.

There have been nine missed appraisals and one incomplete appraisal in the year April 2013/March 2014.

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

There were eight consultants undergoing formal remediation.

WUTH has received an overall rating of green from the Department of Health for its revalidation process. There still remains one amber area which refers to the need to update the policy "Procedure for handling concerns about the conduct, performance and health on medical and dental staff".

In 2013/14 sixty six doctors were revalidated and eight doctors had their revalidation deferred.

This is the fifth Board Report and the report refers to the appraisal year April 2013 / March 2014.

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

Financial implications will occur when remediation is implemented as a consequence of revalidation identifying concerns about medical staff.

The Responsible officer legislation came into force in January 2011 outlining the requirement for annual appraisal of doctors. Risks are around inability to remediate medical staff.

If doctors do not have satisfactory, quality assured appraisals they will be unable to retain their license to practice from the GMC and will be unable to work.

Wirral University Hospital Teaching NHS Foundation Trust

Annual Medical Appraisal
For the year 2013/14

Introduction/Background

1. Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

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

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

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

3. Appraisal is a positive process that gives doctors feedback on their past performance, charts their continuing progress and identifies their developmental needs. Its purpose is to improve performance and help to identify concerns about performance at an early stage and also to recognise factors which may lead to performance concerns. Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service and training. Successful annual appraisal will provide the foundation upon which the Responsible Officer will confirm a doctor's fitness to practice. Following a cycle of five successful annual appraisals the Responsible Officer will be able to recommend that a doctor is revalidated.

4. During the appraisal year 2013/14 66 doctors have been revalidated and 8 have had their revalidation deferred, (deferral rate 10.8%). All of the deferrals were due to lack of some element of supporting information. This reflects the current national picture where the GMC have reported 17.4% of doctors being deferred. The national deferral rate is 12.6% when trainees are excluded.

5. WUTH currently has an SLA in place to provide RO and appraisal services to Wirral Community Trust and Wirral Hospice St John's.

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

Management of Appraisal and Revalidation

7. Responsibility for Appraisal and Revalidation lies ultimately with the Medical Director as the Responsible Officer. The Associate Medical Director for Appraisal and Revalidation (AMD) and Clinical Lead for Appraisal (CL) are responsible for the successful performance of the process for all senior medical staff. The Appraisal and Revalidation Manager facilitates the process on a day to day basis.

8. At present, appraisals are undertaken by the AMD, CHDs, and CSL's and these managers are expected to appraise as part of their management duties. Due to the number of appraisals that need to be undertaken in the Trust, there are also non-managerial consultants who have taken on the role of appraiser and this group should have the appropriate time allocated for this process in their job plan, as referenced in the Trust's Consultant Job Planning Policy.

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

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

ACTIVITY LEVELS FOR APPRAISAL IN WIRRAL UNIVERSITY TEACHING HOSPITAL						
April 2013 - March 2014						
	Number of Senior Medical Staff for whom the trust has responsibility for appraisal and revalidation		Number of doctors who have had a completed appraisal as at 30.5.14		Number of doctors for whom a PDP has been agreed	
	Cons	SAS	Cons	SAS	Cons	SAS
A & E	7	5	6	5	6	5
Acute Med	8	1	8	1	8	1
Anaes	36	11	34	11	34	11
DME	13	3	13	3	13	3
Lab Med	17	1	16	1	16	1
Medicine	34	3	33	3	33	3
O & G	11	0	10	0	10	0
Ortho	16	1	15	1	15	1
Paeds.	18	4	18	4	18	4
Public Health	1	0	1	0	1	0
Radiology	20	1	19	1	19	1
Spec Surg	15	7	14	6	14	6
Surgery	21	3	21	3	21	3
Hospice	0	1	0	1	0	1
Wirral C Trust	0	3	0	3	0	3

EXCEPTIONS TO THE APPRAISAL PROCESS AT WIRRAL UNIVERSITY TEACHING HOSPITAL			
APRIL 2013 - March 2014			
Specialty	**Grade**	**Status**	**Reason**
Accident&Emergency	Consultant	Missed	Sickness absence
Anaesthesia	Consultant	Incomplete	Appraisal output not returned by appraiser within the given timescale
Anaesthesia	Consultant	Missed	Maternity Leave
Laboratory Medicine	Consultant	Missed	Appraisal output not returned by appraiser within the given timescale. Consultant has now retired.
Medicine	Consultant	Missed	Sickness absence
Obstetrics & Gynaecology	SAS	Missed	Maternity Leave
Orthopaedics	Consultant	Missed	MAF not completed by doctor within the given timescale
Radiology	Consultant	Missed	Maternity leave
Special Surgery	Consultant	Missed	MAF not completed by doctor within the given timescale
Special Surgery	SAS	Missed	Maternity leave

Missed appraisals are those which were due within the appraisal year but not performed.

Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the personal development plan or appraisal summary have not been signed off within two calendar months of the doctors appraisal month.

Quality Assurance

10. Quality assurance of the appraisal process is essential if it is to be effective.

11. The responsibility for quality assuring the process lies with the AMD and CL for Appraisal and Revalidation who have an overseeing role. Medical managers (MD,CHD, CSL) have responsibility to ensure that the process is fair and effective to meet the requirements of revalidation. The overall responsibility for the process lies with the Responsible Officer.

12. Quality assurance of the appraisers is undertaken as follows:

    - 360 feedback summary from doctors – annually
    - Feedback from Appraisal Manager observation – at least once in 5 years
    - Attendance record at Appraisal Support Group meetings (two meetings annually)
    - Every appraiser's summary is reviewed by the AMD/CL and RO and feedback is given as part of a sign off process
    - Feedback from AMD/CL on an ad hoc/ongoing basis
    - Formal feedback from AMD/CL annually to appraisers summarising the above data
    - This then forms the supporting information for the appraiser's appraisal so that developmental needs can be identified for their role

13. Quality assurance of the appraisal documentation is undertaken as follows:

    - The Appraisal Manager monitors the data in each doctor's Medical Appraisal Form (MAF) before appraisal and following return of the documentation

    - Each MAF is subject to quality assurance 'sign off', by CSL/CHD/AMD/CL/RO. Overall responsibility for the quality of the appraisal data of each doctor is taken by the AMD/CL, who have the ultimate sanction of not signing off the appraisal if data is not satisfactory

    - The following supporting information is required in each doctor's MAF:

        - **Clinical incident review and reflection** It is good practice that the clinical incident process is used and evidence of this seen. Case reflections are also encouraged. There should be some discussion about this at appraisal and this MUST be documented. All clinical incidents that a doctor has been involved in must be reviewed annually at appraisal

        - **Complaints** All complaints should be included and reflected on by the doctor

        - **Audit** Evidence of some involvement in audit

        - **CPD** All colleges recommend 50 hours per year. Doctors must provide a log of their CPD hours annually

        - **Mandatory Training** Needs to be recorded and up to date

        - **Data** Dr Foster and any other data must be included

        - **Job plan** Must be included

        - **Mersey Deanery Accreditation** This form is completed for first appraisal and then updated (with supporting information) if level as trainer is changed

        - **PDP** Previous years PDP must be discussed and also future PDP items agreed with the appraiser. The items can include Departmental and Trust objectives. The items MUST be SMART (Specific, Measurable, Achievable, Realistic and Time limited)

- **360 colleague/patient survey** Completed at least once in a 5 year cycle

- **Health and Probity** Annual review

- **Independent sector/Whole Practice Appraisal** Evidence from ALL sectors worked in must be provided so that practice can be confirmed to be similar to NHS practice

14. The operational process of the appraisal system is audited by the appraisal manager each year so that the directorates can be monitored in terms of their compliance (see table overleaf).

15. The Trust is responsible for the appraisal and revalidation of directly employed trainees (Locum Appointments for Service). These doctors participate in a Trust Annual Review of Clinical Performance (ARCP), which is a process in between the trainee doctors Annual Review of Competence Progression and the senior medical staff annual appraisal process. This is managed by the Director of Medical Workforce.

16. The ROs of visiting consultants and clinical assistants are requested to confirm that these doctors have had a satisfactory appraisal as part of the quality assurance process.

AUDIT OF TIMELINE OF PROCESSING APPRAISAL FOLDERS

Directorate	Folders sent out for completion by the Appraisal Team. Target: 6 weeks before appraisal date			Completed folders returned to the Appraisal Team for review prior to appraisal. Target 3 weeks.			Total % of folders returned to the Appraisal Team for review **before** appraisal meeting			Total % of folders returned from appraiser following appraisal Target 4 weeks.		
	2011/2012	2012/2013	2013/2014	2011/2012	2012/2013	2013/2014	2011/2012	2012/2013	2013/2014	2011/2012	2012/2013	2013/2014
A & E	100%	64%	92%	50%	18%	8%	75%	64%	75%	50%	55%	66%
Acute Med	100%	100%	100%	33%	40%	44%	100%	40%	88%	50%	40%	44%
Anaesthesia	100%	82%	100%	29%	33%	35%	93%	91%	88%	65%	74%	56%
Lab Medicine	100%	86%	94%	37%	36%	28%	100%	93%	100%	31%	71%	61%
Medicine	100%	80%	97%	38%	20%	41%	100%	91%	97%	48%	60%	51%
Spec Surgery	100%	90%	100%	48%	35%	18%	88%	85%	77%	38%	50%	68%
Surgery	100%	83%	100%	25%	21%	14%	95%	92%	93%	30%	42%	64%
DME	100%	67%	100%	33%	27%	38%	100%	93%	100%	16%	47%	25%
O & G	100%	78%	100%	12%	44%	9%	100%	100%	90%	50%	78%	82%
Paediatrics	100%	63%	95%	23%	26%	32%	95%	84%	100%	28%	68%	41%
Radiology	100%	63%	100%	60%	39%	5%	100%	89%	76%	53%	67%	48%
Orthopaedics	100%	80%	100%	33%	40%	29%	86%	93%	94%	0%	40%	35%
Hospice	-	100%	100%	-	0%	100%	-	100%	100%	-	100%	100%
Wirral C Trust	-	100%	100%	-	40%	33%	-	100%	100%	-	60%	100%

The numbers returning appraisal documentation in advance of the appraisal meeting is still consistently lower than we would wish. Return of the MAF's completed by appraisers within four weeks can also be improved, in five directorates this was less than 50%.

Development Needs

17. Appraisers

- All appraisers MUST attend the Trust's 1 day training course before appraising
- There were 45 trained appraisers in WUTH as at 31 March 2014
- Appraisers have considerable responsibility for the robustness of the process which ultimately leads to a senior doctor being recommended for revalidation. The Trust's Consultant Job Planning Policy now enables these doctors to be appropriately recognised for this role in terms of their time
- There will be a need to recruit new appraisers on an ongoing basis as numbers of senior staff increase as an appraiser should not perform more than 12 appraisals annually. There is also a turnover of appraisers as some step down. The AMD/CL monitor this with the Appraisal Manager and the CHD's/CSL's

18. Doctors

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

- Doctors can apply to attend the Trust 1 day course which runs at least three times annually and is updated continuously
- Their appraisers will provide necessary guidance. Appraisers are updated at the ASG meetings and by e-mail as necessary
- New consultants are encouraged to attend the appraisal course so they are aware of what is expected of them, and what they can expect from the process
- The AMD will give a lecture on Appraisal and Revalidation as part of the "New consultant development programme" which is being introduced in November 2014
- AMD updates as necessary at Medical Board meetings and by e-mail
- The Appraisal Manager and AMD/CL are available to provide guidance and advice on an ongoing basis

19. Responsible Officer

These officers need appropriate training and support. The RO training programme was developed by the Revalidation Support Team for the DH and has now been completed. The RO for WUTH has attended all the national training. The RO is now involved in the RO networks in the North Region in order to continue to be up to date and fit to practice in the role of a RO. The RO is appraised externally by NHS England (North). There are specific requirements for RO's to keep up to date and fit to practice including attending three out of four RO networks annually. The RO for WUTH is compliant with these requirements.

Performance Review, Support and Development of Appraisers

Training

20. Training of appraisers is a key component in the delivery of a successful appraisal process. Medical appraisers must be able to consistently facilitate and deliver high quality appraisals.

In order to meet the demands outlined above, the Trust has developed a one day training programme to train and support appraisers, and no appraiser is permitted to undertake a medical appraisal at the Trust without having first attended this course. Feedback on the course is always requested and to date this has been good, so much so that there is regular attendance from external consultants on these training days, and requests for the course to be held on the sites of other hospitals nationally.

Support and Development

21. The Appraiser Support Group is led by the AMD and meets at the beginning of the appraisal cycle to update members on new developments, and midway through the cycle to discuss issues and concerns.

    The AMD/CL are available outside these meetings for ongoing support of the appraisers, and the Appraisal Manager is also available to give advice on a day to day basis.

Performance Review

22. The AMD/CL have responsibility for the performance review of appraisers and this review will be informed from a number of sources:

    - Annual 360 feedback summary from doctors. All doctors are asked to complete a questionnaire following their appraisal about their appraiser and their skills in carrying out the meeting
    - The Appraisal Manager observes appraisers undertaking an appraisal once in every 5 year cycle (more often if necessary) and feedback is given at the end of the appraisal and then followed by a written record on a structured form
    - Attendance at the Appraiser Support Group is recorded
    - AMD/CL review of each appraisal summary by the appraiser for quality and completeness
    - All appraisers receive an annual performance review/report which includes the above data from the AMD/CL. They are asked to include this report in their own appraisal

Clinical Governance

23. Clinical Governance issues are detailed below:

    - Complaints are recorded on a database for medical staff and this summary is provided for appraisal so that the doctor can reflect on them at their appraisal
    - Clinical Incidents reported by and about a doctor are recorded on a database and this summary is provided for appraisal so that the doctor can reflect on them at their appraisal
    - Dr Foster data is provided. This data is not useful for all specialties in terms of accurately recording the performance of an individual. The data is more useful for surgical than medical specialties. Data cannot be provided for SAS doctors
    - Data by its nature will reflect the performance of a team rather than an individual and teams are constantly changing. There needs to be a method of retrieving data which is more useful and informs an individual on his/her performance. This is a national problem which is being discussed on an ongoing basis
    - Other data was to be included in the MAF including discharge letter quality, managing diagnostic test results, health record keeping standards and prescribing errors. This was collated corporately but met with problems in the last six months due to changes in IT capability. It is hoped that further development of useful data for inclusion as supporting information in the MAF will continue over the next twelve months
    - Each Department has a Consultant Clinical Governance lead who as part of their role should keep doctors updated on relevant national guidance and alerts

Responding to Concerns and Remediation

24. A Medical Staff Remediation Policy is now in place. This document includes advice on remediation and resources available locally and nationally which WUTH can access. It was identified that one of the resources required will be coaching and to this end a coaching strategy is now in place. Nine appropriate senior medical staff have been through a training programme aimed at developing their coaching skills. These doctors are now undertaking

coaching within the organization. Between November 2013 and March 2014, five doctors had been coached by the trained coaches. The coaching process is led by the AMD and managed by the Appraisal and Revalidation Manager. Coaching is a resource which is helping senior doctors to further develop their skills and the clinical service and there have been several self-referrals for coaching which is refreshing and commendable. Coaches are kept up to date and fit to practice as coaches as per the coaching strategy and this process is quality assured.

25. The numbers of staff who have gone through investigations or remediation processes in the period 1 April 2013 to 31 March 2014 are shown below:

Doctors	Type of concern	Type of Intervention
1	Competence	College report, supervision
1	Competence	College report, coaching
1	Conduct	Coaching, mentorship, OH
1	Conduct	Coaching
1	Conduct	Investigation – agreed outcome
1	Conduct	Excluded from Trust / GMC registration suspended, suspended, mentorship, OH
1	Health	Coaching, OH
1	Health	Coaching, mentorship, OH

Recruitment and engagement background checks

26. The Appraisal and Revalidation Manager ensures that there is RO to RO communication when WUTH employs a doctor. The doctor's current RO receives a request from WUTH's RO for information on past appraisals, previous concerns or GMC restrictions to practice etc. The doctor is fully informed about this process when WUTH employs them. This requires close working with HR Shared Services.

Access, Security and Confidentiality

27. The Appraisal Manager holds the master folder for each appraisal and access to folders is limited to the following people from the relevant Division on a 'need to know' basis:

- Chief Executive
- Medical Director
- Associate Medical Director (Appraisal & Revalidation)
- Clinical Head of Division
- Clinical Service Leads
- Consultant Appraiser
- Doctor
- Appraisal Manager

Conclusion and Next Steps

28. The conclusion and next steps are outlined below:

- A robust appraisal process has been in place at WUTH since 2001
- Appraisal has been implemented at WUTH, and with its quality assurance process WUTH is "fit for purpose" for the revalidation process
- The process for highlighting concerns in medical staff to the RO is described in the remediation policy. A full days training in this process was given in October 2013 and repeated in November 2013. CHDs, CSL's, appraisers, coaches and HR managers were invited to attend. The training was delivered by the AMD and the two Deputy HR Directors. This will contribute to embedding the policy in the organization which will be ongoing

- WUTH now has trained case investigators. There needs to be a managed process and case investigators need to be quality assured to ensure they remain up to date and fit to practice in this role. This has been passed to the HR/OD Department for consideration
- The WUTH policy "Procedure for Handling Concerns about Conduct, Performance and Health of Medical and Dental Staff" needs to be reviewed and updated. This process began in July 2014

Recommendations

29. The Board is asked to note the report and agree to receive the next report on the 2014/15 position in November 2015.

Dr Debra King
Associate Medical Director for Appraisal & Revalidation

Mrs Amanda Branson
Appraisal & Revalidation Manager
September 2014

Board of Directors		
Agenda Item	8.1	
Title of Report	Infection Prevention and Control Annual Report 2013/14	
Date of Meeting	29 October 2014	
Author	Andrea Ledgerton, Associate Director of Nursing Infection Prevention and Control David Harvey, Infection Control Doctor	
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery/Director of Infection Prevention and Control	
FOI status	Document may be disclosed in full	
BAF Reference	1, 2, 11 & 15	
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated	
Level of Assurance		Board confirmation

1. Executive Summary

This is the Infection Prevention and Control (IPC) annual report for 2013 – 2014. The purpose of the report is to provide an annual summary of the Trust's position and progress towards a zero tolerance approach to Healthcare Associated Infections (HCAI) and to alert the Board of Directors to any significant problematic Infection Prevention and Control issues within the organisation.

The report discusses progress toward the objectives to have zero avoidable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemias (Table 1) and to further reduce *Clostridium difficile (C.difficile)* (Graph 2) clearly demonstrating that 2013/14 has been one of the most challenging years for several years. The risk created by Carbapenemase Producing Enterobacteriaceae (CPE) threatens to overwhelm the current ways of working, potentially jeopardising the significant reduction in infection achieved over the last few years in relation to MRSA and *C.difficile.*

The significant challenges the Trust has had to face throughout the year relating to Multi Drug Resistant Organisms (MDROs), particularly CPE and VRE is described in detail within the report.

The report also includes summaries relating to some of the 'ad hoc' and reactive day to day issues that affect the IPC agenda.

Finally, further information is provided detailing the reassurances sought by the IPCT to ensure practices are of the highest standard to prevent colonisation and infection occurring ensuring that where these are not considered to be optimal, processes are in place to monitor the actions for improvement.

2. Background

The implementation of robust proactive IPC strategies have previously demonstrated a significant reduction in infection associated with MRSA bacteraemia and *C.difficile* and have supported the containment and management of the extremely difficult to control norovirus. Since identifying our first case of CPE in May 2011, the IPCT have promoted and directed a proactive strategy to manage and contain these extremely difficult to treat organisms with the focus on prevention to avoid colonisation in the first instance and ultimately clinical infection and increased mortality. These proactive strategies, introduced and supported by Public Health England (PHE) to manage and contain Multi drug Resistant Organisms (MDROS) {namely CPE and VRE} means that the challenge going forward to prevent a situation of uncontrollable transmission, whilst aiming for zero tolerance MRSA bacteraemia and a further reduction in *C.difficile* is tremendous. This is achievable with effective strategies and mitigating actions in place to prevent colonisation and subsequently clinical infection from occurring.

3. Key Issues

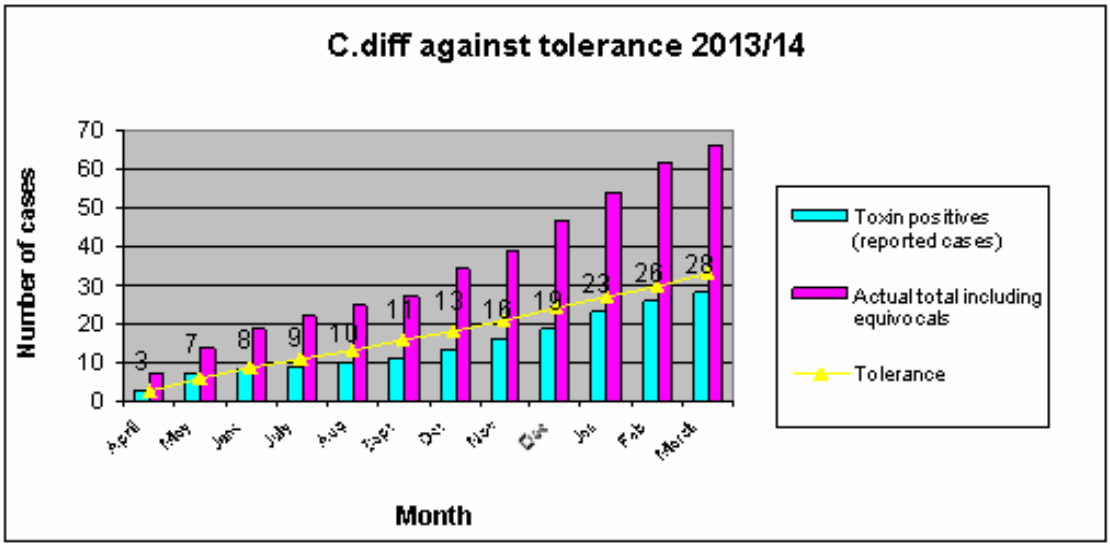
3.1 Meticillin Resistant *Staphylococcus aureus* (MRSA)

From April 2013 to end of March 2014 a Wirral Wide total of 4 MRSA bacteraemias was reported. Post Infection Reviews (PIRs) performed as per the new NHS England guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (from April 2014) resulted in the Commissioners assigning two of these to WUTH. The reviews identified both cases to be hospital attributed, however a full Root Cause Analysis identified one of these to have been unavoidable.

MRSA Bacteraemia Reports	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Pre 48 hours	9	11	8	9	3	1	2
Post 48 hours	12	10	8	5	1	2	2*
Contaminants	5	5	1	0	0	0	0
Cumulative Total	26	26	17	14	4	3	4

*1 post 48 hour unavoidable

3.2 Clostridium difficile

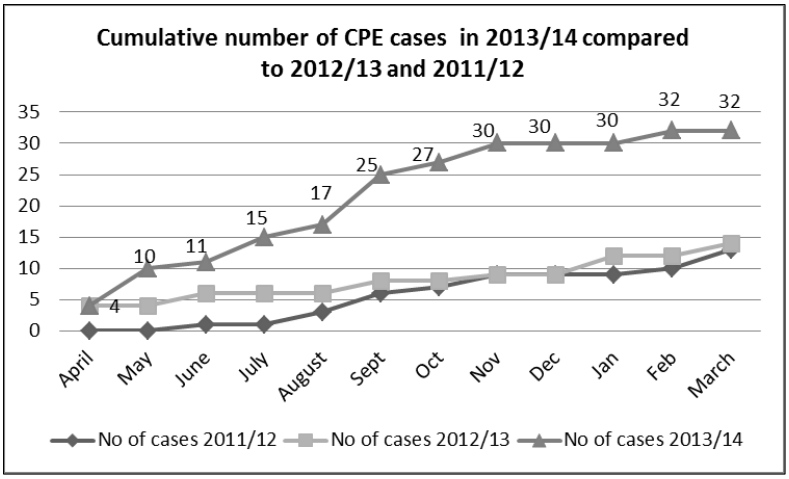


From April 2013 to end of March 2014, WUTH were working towards a *C.difficile* objective of no more than 33 toxin positive cases. (The presence of toxins in a stool sample indicates *C.difficile* infection). By the end of March we had reported 28 toxin positive cases, all of which were subject to a full investigation. Whilst we had achieved the objective, we were not able to demonstrate a reduction in the number of toxin positive cases having reported one less in 2012/13.

Also when comparing total number of *C.difficile* cases to include equivocals (toxin not detected and therefore may be colonised only) against the out turn for 2012/13 there has been a 30% increase (52 cases 2012/13, 66 cases 2013/14). This is most likely due to capacity pressures resulting in the temporary loss of the *C.difficile* cohort unit and interruption to the Hydrogen Peroxide Vaporisation (HPV) decontamination programme.

3.3 Multi Drug Resistant Organsims (MDROS) Carbapenemase Producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococci (VRE)

The predicted exponential increase in the number of patients becoming colonised with CPE and the growing national concern has resulted in the need to further optimise existing IPC measures by identifying more effective ways in which to manage these difficult to treat infections. The Trust has now experienced a number of outbreaks associated with CPE and VRE with successful interruption and with fewer clinical infections reported as control measures have become more embedded. However as these organisms become more endemic and resistance increases, such outbreaks will be more difficult to contain.



4. Next Steps

In response to the PHE review around the Trusts HCAI strategy and particularly in relation to CPE a Trust wide IPC strategy has been devised resulting in a number of work streams being set up to progress the actions required.

These actions progressed by the work streams will ensure that all aspects of the IPC agenda (e.g. to include C.diff and MRSA) are optimised and blended with the action plan to create a cohesive IPC strategy which will be launched in the New Year and will include:

- Re-energise 'board to ward' approach to IPC
- Prioritise containment of CPE
- Develop IT systems to support IPC as a priority
- Maintain the standard *C. difficile* strategy
- Maintain the standard MRSA strategy
- Maintain norovirus strategy
- Monitor VRE strategy
- Explore new ways of working

5. Conclusion

2013/14 has been one of the most challenging years for several years. The risk created by CPE should not be underestimated, and threatens to overwhelm the current ways of working. Whilst we are leading the way in progressing a CPE strategy, much more needs to be done, potentially beyond which the Trust can feasibly do. This is likely to have a knock on effect resulting in significant pressure to the other standard strategies for MRSA and *C.difficile* etc. High level engagement, particularly around CPE, is required to ensure we keep WUTH as safe as possible.

6. Recommendation

The recommendations aim to promote prevention with early control, as MDROs present a significant risk to patient safety, make it difficult to sustain the infection reductions already achieved, and greatly impact the day to day operations of the hospital.

Infection Prevention and Control
Annual Report
April 2013 to March 2014

1. Meticillin Resistant *Staphylococcus aureus* (MRSA)

1.1 From April 2013 to end of March 2014 a Wirral Wide total of 4 MRSA bacteraemias was reported. Post Infection Reviews (PIRs) performed as per the new NHS England guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (from April 2014) resulted in the Commissioners assigning two of these to WUTH. The reviews identified both cases to be hospital attributed, however a full Root Cause Analysis identified one of these to have been unavoidable.

MRSA Bacteraemia Reports	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Pre 48 hours	9	11	8	9	3	1	2
Post 48 hours	12	10	8	5	1	2	2 *
Contaminants	5	5	1	0	0	0	0
Cumulative Total	26	26	17	14	4	3	4

1.2 Root Cause analysis (RCA)

There were several omissions to practice which the RCA group agreed to have contributed towards the 2nd bacteraemia occurring. The most significant being a delay in recognizing a potential MRSA infection on admission, resulting in the inappropriate prescribing and management of the patient.

Lessons were also learned from the unavoidable bacteraemia, which whilst lapses in care did not on this occasion contribute towards the bacteraemia occurring, may have done so on another occasion.

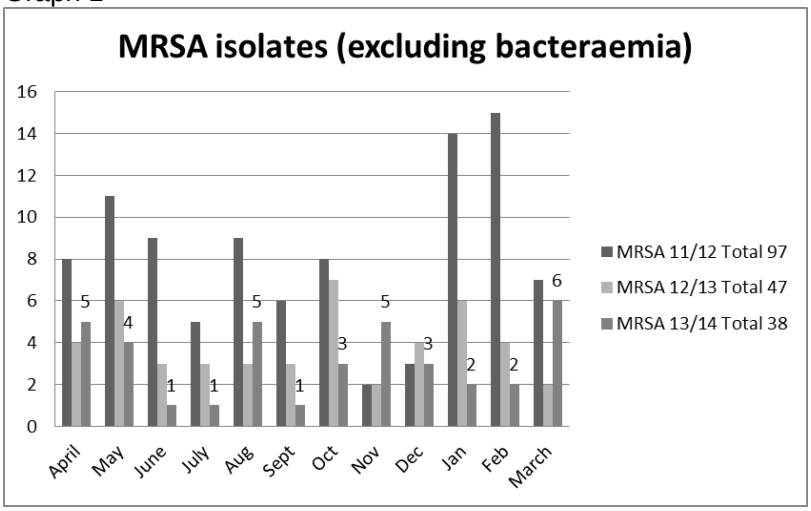
RCA findings were presented and shared at many forums including the Hospital Infection Control Group (HICG), Clinical Governance Group (CGG), Divisional IPC meetings and ward meetings.

1.3 All MRSA Isolates

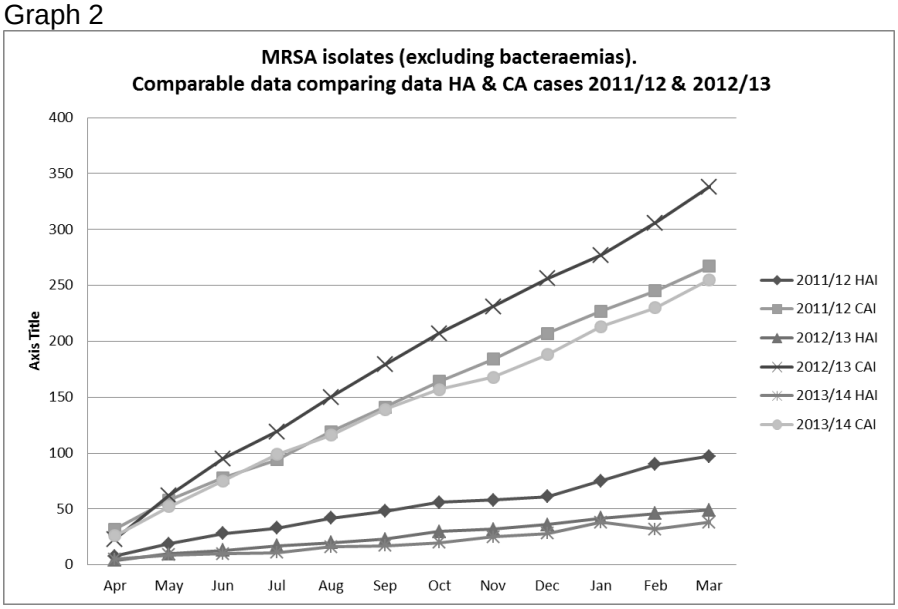
The MRSA bacteraemia prevention strategy directed by the IPCT focuses on the prevention of MRSA colonisation in the first instance. When patients are known to be colonised with MRSA, strict adherence to IPC practices to avoid colonisation becoming infection (a bacteraemia occurring) is promoted and monitored by the Infection Control Assistants.

The graphs below clearly demonstrate year on year reductions in the number of hospital attributed cases and since achieving a 50% reduction last year we have reduced the number of hospital attributed cases by a further 22%. This of course significantly reducing the risk of an MRSA bacteraemia occurring.

Graph 1



Graph 2



The number of cases identified on admission screening demonstrates that the reservoir of MRSA in the community will continue to serve to increase the reservoir of MRSA in the hospital and therefore prompt identification of positive cases through screening surveillance and appropriate management is essential and has continued.

The IPCT supported by the ward staff investigate all MRSA isolates believed to have been acquired whilst in hospital to identify how acquisition occurred and make recommendations to prevent further cases.

The most significant factor contributing to MRSA acquisition is the lack of side rooms to appropriately isolate patients with MRSA. Due to many competing pressures, particularly the emergence of MDROs, MRSA patients are frequently nursed in main bays presenting a risk of transmission. The increase in the number of Periods of Increased Incidence (PIIs) of MRSA is a reflection of this with 12 PIIs reported compared to 8 the previous year.

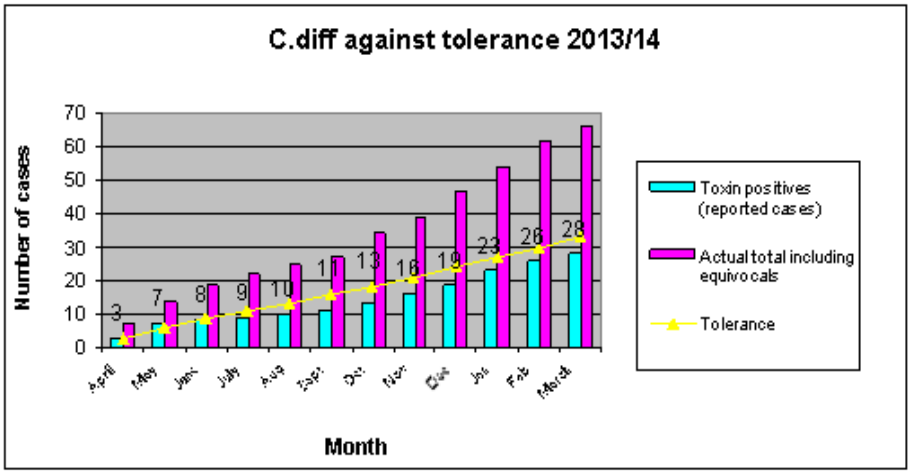
2. Clostridium difficile

2.1 Current *C.difficile* targets are based on all inpatients aged 2 years, or greater, from whom a positive result was obtained more than 72hrs after admission (defined as hospital acquired) and excludes GP specimens and pre 72hr specimens. From 1st April 2012, in line with National Guidance, WUTH have reported "toxin positive cases only" through the national mandatory reporting system. A positive sample in which toxins are also detected indicates C.difficile infection, however if C.difficile positive but toxin negative, this may be colonisation only and are referred to as equivocal. We do however report equivocal cases internally to ensure that if clinically significant the patients are managed appropriately, and to investigate whether transmission has occurred. Equally to ensure staff understood that these equivocal cases are still significant; and may result in further transmission.

2.2 From April 2013 to end of March 2014, WUTH were working towards a C.difficile objective of no more than 33 toxin positive cases. By the end of March we had reported 28 toxin positive cases, all of which were subject to a full investigation. Whilst we had achieved the objective, we were not able to demonstrate a reduction in the number of toxin positive cases having reported one less in 2012/13. When comparing total number of C.difficile cases (to include equivocals) against the out turn for 2012/13 there has been a 30% increase (52 cases 2012/13, 66 cases 2013/14).

2.3 During Quarter 4 2012/13 the HPV programme was suspended resulting in a higher number of cases being reported at the beginning of 2013/14. Once reinstated during Quarter 1, the number of cases decreased. With so few patients on the C.difficile cohort unit during September 2013, the unit was commandeered to support the bed pressures and in addition a further interruption to the HPV programme resulted in an increase in the number of cases. The mitigating actions to prevent C.difficile transmission were reinstated as soon as the operational pressures allowed for this.

Graph 3



2.4 During this period we unfortunately reported one death whereby C.difficile was believed to have been an attributable factor (Part 1 on the death certificate). This resulted in a full RCA with the findings and lessons learned presented at CGG, HICT and through the Divisional IPC Committees.

2.5 The RCA identified that it was unlikely that any changes in management would have altered the outcome in this case. There was a reasonable possibility that the patient was already colonised with C.difficile, however if the patient was not colonised on admission and had acquired C.difficile on the ward, the probability of this occurring could have been reduced by timely isolation of the index case and appropriate decontamination.

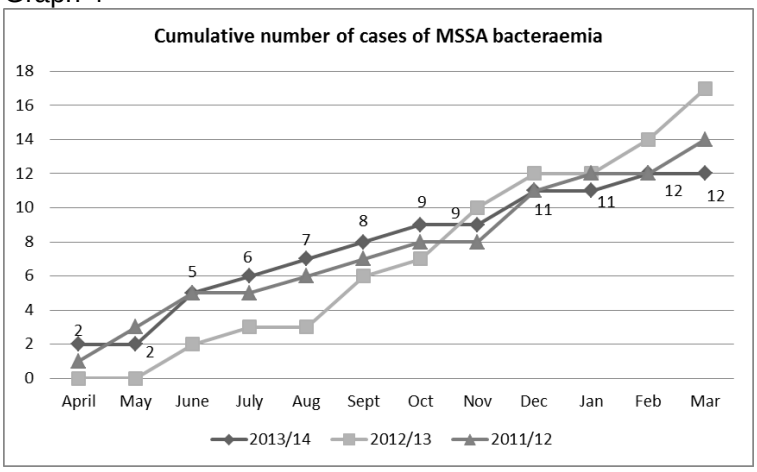
2.6 The index case was isolated once the positive result was reported rather than within 2 hours of symptoms of diarrhoea commencing, thus resulting in unnecessary prolonged exposure of C.difficile spores in the bay. In addition the unavailability of the C.difficile cohort unit at this time due to bed pressures also contributed to an increased bio burden of C.difficile spores in the ward environment.

2.7 We reported 3 deaths where C.difficile was entered as Part 2 on the death certificate and therefore believed to have been a contributory factor, however it was clearly documented on one of these death certificates that C.difficile associated infection had resolved at the time of death.

3. Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

3.1 WUTH reported 12 MSSA bacteraemias believed to have been (by surveillance definition) acquired whilst in hospital achieving a 29% reduction from the previous year. All 12 cases were investigated with the findings demonstrating a reduction in the number of intravascular related infections compared to the previous year. There is no local or national target set for MSSA.

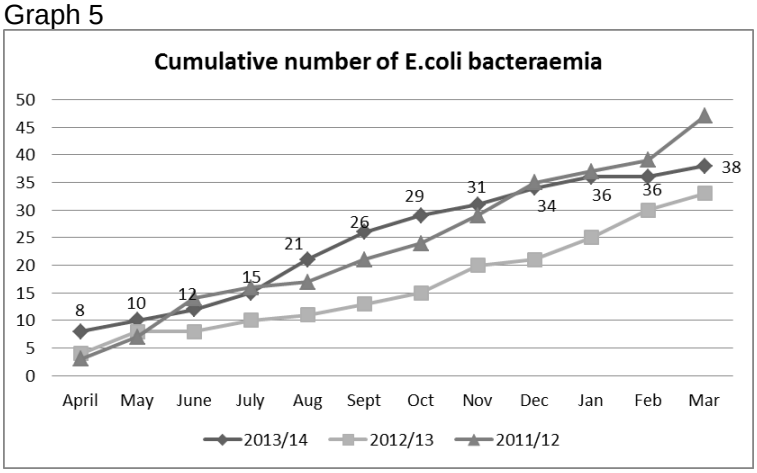
Graph 4



4. Escherichia Coli (E.coli) Bacteraemia

WUTH reported 38 cases believed to have been (by surveillance definition) acquired whilst in hospital. Investigations have highlighted that few of these may have been prevented, however emphasis has been placed on the clinical management of these patients and their association with medical devices (in particular urinary catheters), with an aim to reduce those that could be prevented. There is no local or national target set for E.coli bacteraemia.

Graph 5



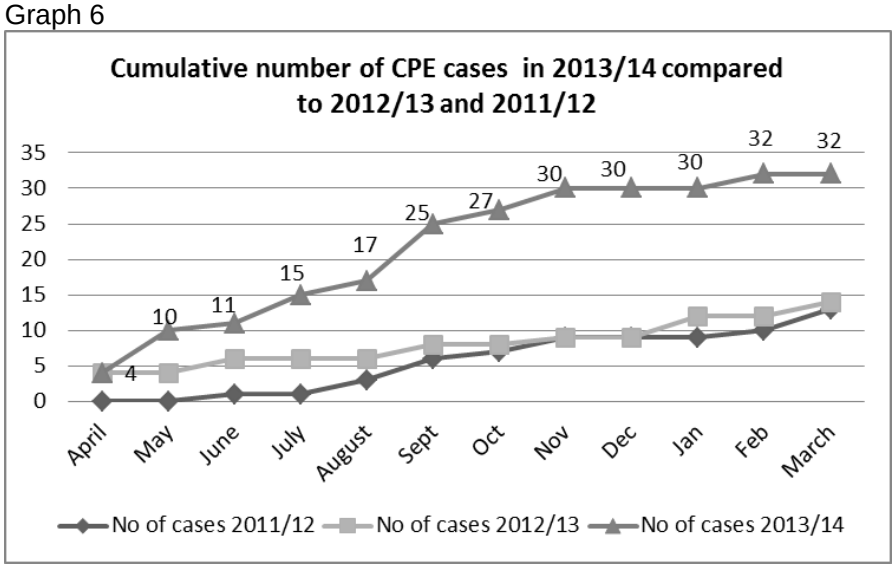
5. Carbapenemase Producing Enterobactericeae (CPE)

5.1 During 2013/14 the IPCT reported 32 cases of CPE of which 7 (22%) were identified in clinical samples. Of the clinical samples we reported 2 bacteraemias, one of which was believed to have been acquired whilst in hospital, with the other present on admission and potentially healthcare associated. Of the 32 patients a number of these were admitted to WUTH from other hospitals where potential exposure may have occurred.

5.2 Within the last year we have reported both the VIM and OXA-48 type with 72% of these being OXA-48 and therefore the predominant type. However we have also inherited the NDM and IMP types through global travel and from another hospital (respectively), with no subsequent transmission reported at WUTH.

5.3 The graph below demonstrates a 56% increase in the number of cases reported in 2013/14 compared with the last 2 years, clearly indicating an exponential increase in the number of cases, also experienced locally and is reflected in the literature globally. However it must be recognised that this increase is in the number of patients colonised with CPE, identified through a target surveillance screening strategy delivered to prevent transmission and ultimately clinical infection. The positive impact of this proactive approach may be demonstrated by the number of clinical infections reported. 28% (9/32) of clinical samples were identified to be positive in 2013/14 compared to 85% (8/13) and 50% (7/14) in 2011/12 and 2012/13 respectively.

Graph 6



5.4 In September 2013 an outbreak of OXA-48 was declared on ward 17. This was triggered by five confirmed cases within an 8-week period, preceded by 9 other cases over a 12-month period. Links to other hospital-wide cases became apparent on more detailed investigation. In this outbreak, positive cases exceeded the number of side rooms, therefore cohort nursing was attempted. This did not control further spread, resulting in ward closure. Likely contributory factors include environmental bio burden; colonisation pressure (i.e. long duration of stay, several patients concurrently colonised); ward facilities not conducive to modern IPC pressures (e.g. sluice design, side-room design, sink design and availability) and cleaning. The strict control measures subsequently implemented following ward closure included decanting existing known positive patients and exposed patients (all were considered to be high risk exposures) to an empty ward where the patients would remain until discharged home. Bay doors were installed to ward 17. The ward also received an HPV clean before it was re-opened. Since the discharge of the remaining positive and exposed patients on the decant ward, no further cases of CPE were identified on ward 17. However there have been sporadic cases elsewhere.

5.5 Whilst during any outbreak phase, IPC activity will be reactive in nature, the IPCT continued to promote the proactive strategy adopted to manage and prevent the spread of CPE. The team continued to monitor the epidemiology of CPE, gaining valuable insight into exposure of CPE to positivity and with this ensuring that heightened control measures were in place on wards where there was a risk of exposed patients converting to positive.

5.6 On 25th February 2014 and following invitation from the CEO, Public Health England performed a review of our HCAI strategy to provide further recommendation to support the management and containment of MDROs, particularly CPE. The review group provided verbal feedback on the day, identifying a number of good practice areas on infection prevention and control including the Trust having a dedicated and committed hospital infection prevention and control team and Director of Infection Prevention and Control; comprehensive and high quality local guidelines and procedures on HCAI; and overall good and evidence-based incident/outbreak management procedures in place.

5.7 Areas where a need for improvement was identified included:

- **Early recognition of colonised / infected cases** i.e. adequate laboratory capacity to undertake testing, improving analytical capacity and capability of Infection Prevention and Control (IPC) team, investing in molecular testing to allow early CPE detection

- **Early isolation of suspected / confirmed cases** and the potential to enhance isolation capacity as and when required i.e. have an isolation unit for CPE and Clostridium difficile

- **Ensuring effective treatment of cases and appropriate use of antibiotics** reinstating systematic and consistent multi-disciplinary antimicrobial stewardship ward rounds

- **Ensuring the profile of infection prevention and control is raised further across the Trust** i.e. improving all staff awareness on infection prevention and control; strengthen clinical/medical leadership role on the infection prevention and control agenda, explore ways of engaging and developing shared leadership between IPC team and senior medical staff, and develop Trust wide staff engagement strategy on infection prevention and control.

- **Ensuring Trust infrastructure supports and promotes infection prevention and control practice** i.e. upgrading hand wash facilities to the required standards, addressing lack of ensuite and good standard of hand hygiene facilities in side rooms, expediting macerator instalments, prioritising wards refurbishment work as per infection prevention and control needs, and improve IT support for IPC team.

Please Note: This report refers to the year 2013/14, but for completeness the Board are asked to note that the PHE review report was received in April 2014 and has been presented to the Hospital Infection Control Group, the Clinical Governance Group and the Executive Director Team. In addition, a detailed CPE update with next steps going forward post the PHE review has been presented to the Quality and Safety Committee.

6. Vancomycin Resistant Enterococci (VRE)

6.1 In April 2013 two clinical cases were identified on ward 11 within a 28 day period indicating a Period of Increased Incidence of Infection. Due to the nature and the risks associated with orthopaedic patients, immediate action to include ward closure was required to prevent the risk of transmission of VRE. Targeted surveillance screening was initiated on wards 10, 11 and 12 with 27 positive screens identified over a 2-month period, 50% of these believed to have been acquired during the current inpatient episode, this resulting in the closure of ward 10 also. There were no positive cases identified on ward 12.

6.2 Wards SAU, 36 and 25 were utilised during the initial outbreak phase to accommodate trauma patients. Several distinct strains were identified indicating that patient to patient transmission was unlikely but that there was an environmental bio burden of VRE, potentially introduced when patients on wards 10 and 11 had previously been affected by Norovirus. To remove this bio burden, full ward decontamination using HPV was recommended. As wards 10 and 11 eventually reduced the number of patients it was possible to utilise Parksuite for positive patients, to then allow wards 10 and 11 to be HPV cleaned and reopened, with the positive patients remaining on Park suite until they were discharged.

6.3 Whilst this interrupted the outbreak within the orthopaedic directorate, colonised cases had begun to appear in other areas, notably wards 30 (haematology), 17 (colo-rectal) and 34 (gastroenterology). During the period June – August 2013, a total of 15 VRE positive rectal screens were identified on ward 30, one of the positive patients unfortunately developing a VRE bacteraemia. Despite the ward having 100% side rooms, transmission occurred indicating that effective isolation was not being achieved, potentially due to the infrastructure of the ward and lack of effective ensuite facilities. Heightened measures and a strict admission criteria was introduced on ward 30 and careful allocation of haematology patients depending upon their VRE status coupled with cohort nursing appeared to support a reduction in the number of colonised cases being identified.

6.4 With more wards now affected generally, the outbreak management team approved the use of ward 26 as a cohort area for VRE positive and exposed patients, the concern being that there would be patients exposed during the outbreak period now being readmitted. In principle this should have been effective with fewer wards exposed to the risk of VRE resulting in fewer bay/ward closures. However, due to the clinical condition of some of the patients and their need for specialist nursing care (i.e. colo rectal), it was not possible to safely staff the cohort area and this resulted in fewer VRE patients being on the cohort ward than on the other wards. This resulted in full ward closure of ward 17, to allow it to be run down and HPV cleaned, again interrupting the outbreak.

6.5 VRE remains prevalent throughout the hospital with critical care, orthopaedic and haematology patients having the greater risk. Targeted screening surveillance is performed within these areas and monitored by the IPCT. The IPCT monitor and investigate all reported clinical cases in all other areas, and heightened measures to include screening within these areas will be triggered by 2 linked cases where transmission is suspected.

7. Pseudomonas

7.1 During 2011/12 the Trust had implemented the Pseudomonas aeruginosa guidance for Augmented Care Units. Augmented care areas being those in which medical/nursing procedures render the patients highly susceptible to invasive disease from environmental and opportunistic pathogens such as Pseudomonas e.g. neonatal, critical care, haematology, renal. The IPCT introduced a strategy, supported by PHE, to protect this high risk group of patients (with neonatal babies identified to be highest risk.)

7.2 Then in April/May 2013, a full RCA investigation was performed having reported 2 babies to be positive with Pseudomonas (colonisation) in their bloodstream on the neonatal unit during March 2013. The RCA identified:

- That there were many ways in which the 2 babies could have acquired pseudomonas.
- Water testing undertaken to investigate the potential link between source (tap water) and clinical isolate and subsequent typing results identified unique, unrelated strains of pseudomonas (i.e. baby 1, baby 2 and water samples had different strains). This suggested a potential source different to the tap water or alternatively a pseudomonas strain from the water that remained unidentified.
- Practices relating to use of tap water may have acted as a possible source of pseudomonas acquisition.
- It was not possible to ascertain the definitive source of the pseudomonas.
- Difficulties in reaching consensus regarding the optimal mitigation strategies and delays in finding practical working solutions led to a delay in implementation of the current risk assessment and mitigation strategy. Whilst this delay may have contributed to the pseudomonas acquisition, there was no evidence linking the perceived source and clinical isolate.
- Active surveillance at the time showed no other infants with pseudomonas colonisation.

7.3 A key message from the RCA is to be guided by experts within a particular field of expertise, and initiate recommendations at the earliest opportunity.

7.4 Since the above incident, during 2013/14 the IPCT have reported a total of 34 positive isolates across the augmented care areas. (12 of the 34 cases were identified through target screening surveillance on the neonatal unit, with no further clinical colonisation nor infection reported. The remaining 22 cases, whilst these were clinical samples from other areas, were not believed to be linked to a water source.

7.5 The IPCT continue to perform bi-monthly pseudomonas checks within the neonatal unit and monthly within all other augmented care areas. Whilst the team are reassured that mitigating actions are in place within the neonatal unit to avoid tap water from coming into contact with the most ‘at risk’ babies, there is a concern around cot spacing in the unit and the close proximity between babies. This has been raised as a risk onto the risk register and is going through the capital planning process for 2014/15.

8. Norovirus

8.1 It is difficult to quantify the costs of Norovirus outbreaks. There are direct costs associated with ward closure, staff sickness, lost bed days, potentially cancelled surgery due to bed closures, increased cleaning costs and PHE have estimated that it can cost the NHS in excess of £100 million per annum.

8.2 As part of the Norovirus strategy, the IPCT promoted that bay doors remain closed when Norovirus was known to be circulating either within the Trust or the Community. Where doors had not been closed prior to symptoms commencing, they were closed wherever possible on the onset of symptoms. In this instance, the IPCT would recommend full ward closure in order to assess the extent of any transmission. Providing that transmission was not evident, bays were opened provided that separate staff were available to provide care for the unaffected patients.

8.3 Between December 2013 and May 2014, 16 wards were either fully or partially closed due to Norovirus. Notably, ward 38 was affected on 3 different occasions. However, on each occasion only 1 bay was affected allowing the remainder of the ward to remain operational. Ward 21 was also affected on 3 separate occasions resulting in full ward closures as it was not always possible to close bay doors. Overall, the Trust was able to demonstrate that the Norovirus strategy had resulted in fewer affected patients and a reduced number of bed days lost compared to 2012/13 and 2011/12(*see table below).

8.4 The Norovirus epidemiology seen within WUTH this year was similar to the previous winter, with the majority of affected patients/cases admitted with 'other' diagnoses, but developing symptoms of viral gastroenteritis having been in hospital for a number of days. This suggests that the virus may have been introduced into the hospital by visitors or by staff. Whilst visiting was reduced to one visitor per patient on affected wards wherever possible, no areas in the Trust were closed to visitors.

Table 2

	No of wards fully or partially closed	No. of bed days lost	No. of patients affected	No. of staff affected
2011/12 (over 5 month outbreak)	37	1469	437	77
2012/13 (over 8 month outbreak)	38	1477	450	50
2013/14 (over a 6 month period)	16	395	162	24
* Please note that the 2012/13 outbreak was protracted potentially due to a new strain affecting more people				

8.5 The investment made to compartmentalise the wards has been a valuable asset to reduce transmission of Norovirus and maintaining patient safety and their outcomes. It has also served to reduce the disruption to services caused by norovirus outbreaks year on year, through partial closing of wards and earlier opening of affected bays.

9. Influenza

The Trust were once again well prepared during the approach to and throughout the flu season with all relevant guidance updated and available for staff to access on the hospital intranet.

9.1 The Occupational Health Department drove the 'flu' vaccination campaign, with 75.8% of WUTH staff known to be vaccinated by the end of January 2014. This was a significant improvement from the previous season when 57% of staff were vaccinated. This improvement resulted from a campaign to train key flu vaccinators throughout the Trust, and the recruitment of a Staff Nurse from the Nurse Bank whose sole responsibility was to deliver vaccinations throughout the Trust supported by the IPCNs

9.2 The IPCNs, with support from the Clinical Skills Team recommenced the programme to ensure that staff were suitably fit tested for FFP 3 Masks/respirators, identifying key trainers within each high risk area.

9.3 Between 22nd November 2013 and 15th March 2014 a total of 27 cases were confirmed to be influenza positive, all identified to be type 'A', with 9 patients requiring critical care management. The predominant strain remained H1N1 at WUTH, in line with National picture.

10. Measles

10.1 Following reports of an outbreak of measles in South Wales in March 2013, WUTH were well prepared for the admission of suspected cases through Accident and Emergency, and other high risk areas, having reviewed and adapted earlier devised algorithms, leaflets etc. in line with the latest PHE recommendations. However, there were no confirmed cases attending WUTH between April 2013 and March 2014.

11. Pertussis

11.1 In June 2012 the Joint Committee for Vaccination and Immunisation (JCVI) recommended that staff who had not received a Pertussis containing vaccine in the past 5 years and who worked with vulnerable groups (i.e. < 4 months of age) or who were pregnant, should be vaccinated against Pertussis. The HPA guidance was also amended to reflect this recommendation, and following an incident in March 2013 whereby two members of staff were clinically diagnosed with Pertussis, WUTH drove a campaign to promote uptake of this vaccination amongst its workforce.

11.2 The Trust experienced two incidents of Pertussis during 2013/14, the first of which occurred in July 2013 when a School Nurse employed by WUTH, (but working within the community), was diagnosed clinically. The second occurred in March 2014, when a child presented to WUTH on three occasions before admission and being diagnosed with Pertussis infection.

11.3 Incident meetings were held for both of these incidents, with the Consultant in Communicable Disease from HPE in attendance, and contacts were traced and notified of their exposure. Staff exposures were also traced and followed up through the Occupational Health Department with no subsequent cases identified.

12. Inspections

Patient Led Assessment of the Care Environment (PLACE)

12.1 The annual PLACE survey recognised the quality of food, privacy and dignity and the clean environment at both Arrowe Park and Clatterbridge Hospitals. The survey is assessed by the National Patient Safety Agency, awarding WUTH 'excellent' ratings for the clean environment in which care and treatment is provided for our patients.

National Standard of Cleanliness Scores

12.2 The Hotel Services Team performed monthly cleanliness inspections within all clinical areas with an average of 98% achieved during 2013/14.

13. Audits of Practice

Hand Hygiene

13.1 Weekly hand hygiene audits remain embedded into everyday practice with ward staff responsible for performing weekly hand hygiene audits within their own clinical areas. During 2013/14, a total of 27,630 staff were observed and audited against the World Health Organisation's '5 moments of hand hygiene' and 'bare below elbows'. 36 staff were found to be non-compliant indicating 99% compliance.

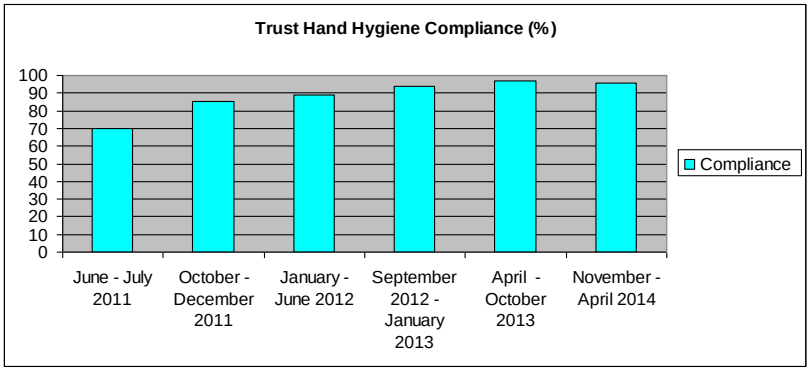
13.2 The IPCNs perform Quality Control hand hygiene audits over a 6 month period to assess the quality and validity of the results of the weekly ward audits.

13.3 During the months of November 2013 to April 2014, the IPCNs visited 39 clinical areas auditing a total of 646 staff. Of these staff 96% (616/646) demonstrated compliance with the '5 moments of hand hygiene' and 'bare below elbows' whilst 4% (29/646) failed to comply. Since the first quality control audit performed in June – July 2011, improvements have been observed year on year.

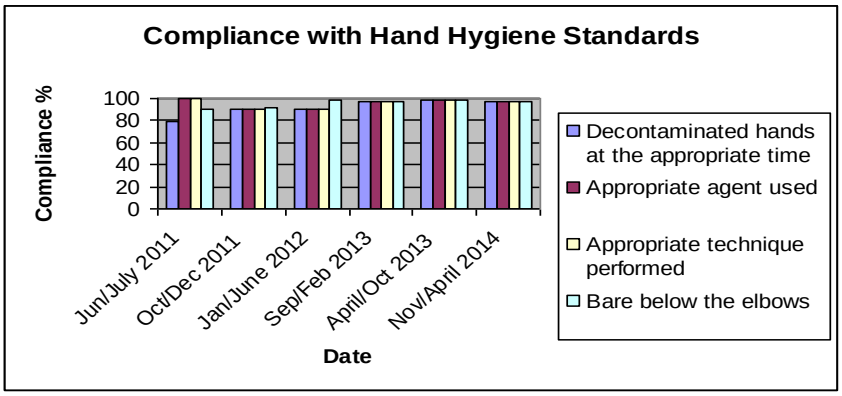
13.4 The 5 moments of hand hygiene are:

- Before patient contact
- Before aseptic technique
- After patient contact
- After bodily fluid exposure risk
- After contact with the patients environment

Graph 7- Results of the audit performed by the IPC



Graph 8 - Results from the audit performed by the IPCT



13.5 The quality control hand hygiene audit performed during November – April demonstrated poor compliance relating to:

- Missed opportunities before and after touching the patient
- Not all staff being bare below the elbow

13.6 However the IPCT regularly observe members of staff non-compliant with bare below the elbows on the ward corridors, however these staff did not meet the auditing criteria of the '5 moments of hand hygiene' and therefore were excluded from the audit. Additionally it is good practice and presents a positive public perception when staff use alcohol gel when entering and exiting a ward, however staff are regularly observed to be non-compliant with this and this lack of compliance will result in environmental contamination. Whilst the audit tool has been adapted to include these criteria, emphasis on hand decontamination at the point of care is the most important factor.

Infection Control Ward/Department Audits

13.7 Infection Prevention and Control Ward/Department audits are performed by the IPCNs annually using a locally adapted version of an audit tool promoted by the Infection Prevention Society (IPS). The tool covers elements of policy and practice including hand hygiene, clinical practices, observation of clinical procedures, isolation nursing precautions, MRSA and C.difficile guidelines, ward environment, care and decontamination of equipment, disinfectant and antiseptic use, waste disposal, sharps handling and disposal and linen handling and disposal. Audit results are communicated to senior staff including ward sisters and infection control leads to enable staff to address shortcomings.

13.8 All in-patient and outpatient areas were audited with 59 out of 64 (92%) areas achieving a green light status, 4 out of 64 (9%) received amber with 1 area (2%) in the red. All inpatient and outpatient area audits were discussed at IPC directorate assurance meetings with any issues that could not be addressed locally included on the IPC action assurance reports to HICG.

High Impact Interventions (HII)

13.9 Staff continue to monitor high impact interventions through peer assessment and print and display their own results on the VISWALL. The numbers of peer audits performed has decreased gradually since September 2013 as demands on the team have increased. However where data is being collected compliance with these care bundles is of a high standard and where compliance issues are identified these are escalated via Directorate IPC assurance reports. These include:

- Insertion and ongoing care of renal, central and peripheral lines
- Insertion and ongoing care of urinary catheters
- Ventilated patients
- Preventing surgical site infection
- C.difficile
- Decontamination of equipment

13.1.0. Only a small number of areas are unable to achieve full compliance with HII no. 8 relating to the cleaning of equipment, and this is largely due to these areas not having separate clean and dirty storage areas. This issue has been placed on the Trust risk register, and each Division has a responsibility to progress their actions to ensure that clean equipment is not stored within dirty utility areas.

Isolation audit

13.1.1. The purpose of the isolation audit performed in January 2014 was to identify whether patients with an infection or positive result were isolated according to policy and further more to identify whether staff were nursing patients adopting appropriate precautions (as per Standard Precautions and Isolation Policy). The audit also served to identify any improvement or decline from the previous year's audit. Issues identified include:

13.1.2. Not all patients (22%) requiring isolation (for IPC purposes) were isolated. This is an increase from the previous audit which identified that 15% of patients were not isolated. This was due to a number of reasons, including; lack of side room capacity for the demand within certain areas, inappropriate use of side rooms within certain areas and the lack of knowledge as to which patients require a side room based on risk assessment (low to high risk). In addition delivering same sex accommodation may impact upon being able to isolate effectively when a single room is indeed available. 39 patients required isolation due to infection were within Medical Specialties compared to 9 patients in Surgery. 19 of these patients were MRSA positive at the time of audit, of this number 6 (31%) were not isolated.

13.1.3. Targeted screening for MDRO's has led to a 100% increase in the number of patients alerted for VRE and CPE requiring a side room.

13.1.4. Another review of side rooms has been performed since and a business case is almost complete to be presented to the Executive Director Team to propose solutions to commission an interim isolation unit and then a permanent facility.

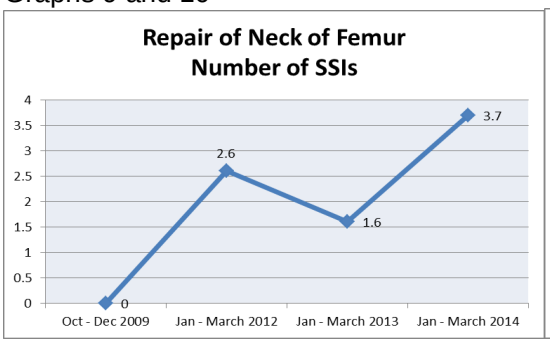
Antibiotic Safe Prescribing Indicator Audit

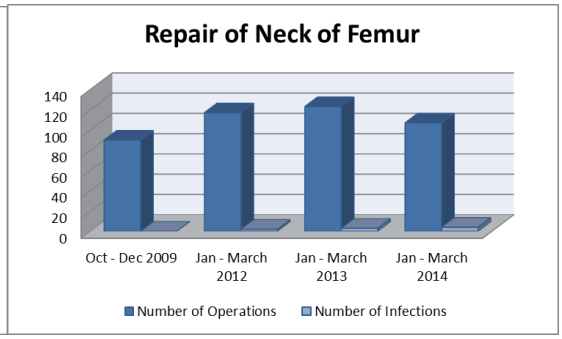
14. Antibiotic Safe Prescribing Indicator Audits were performed each month on every ward, identifying an overall average of 94% compliance with the Trust antibiotic formulary.

Surgical Site Surveillance

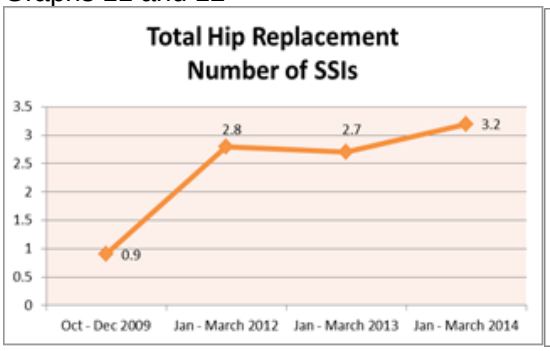
15. Mandatory orthopaedic surgical site infection (SSI) surveillance is undertaken to meet specified deadlines and this year a 3.2% infection rate was noted in 190 hip replacement procedures with a 3.7% (4 out of 107) rate reported for repair of neck of femurs. It is important to use trend data to identify consistently upward or downward trends in SSI incidence rates and whilst the 2014 data demonstrates an increase in the number of infections in both categories, the significance of comparing such data could be questioned when study populations and surveillance periods have varied and therefore care should be taken to interpret these rates. To perform ongoing surgical site surveillance would provide a more accurate and significant infection rate.

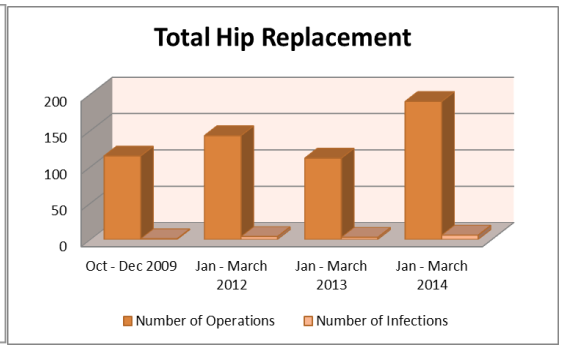
Graphs 9 and 10





Graphs 11 and 12





Catheter Associated Urinary Tract Infections

16. During September 2013 an audit was performed by the IPCT to identify a CAUTI rate which was compared with the baseline rate determined in a prevalence audit performed by the team in 2010. A 78% reduction was demonstrated with 2% of catheterised patients having an associated infection compared to the reduction 9% in 2010. The audit identified two cases of CAUTI, one pre 48 hour by surveillance definition indicating community acquisition and one post 48 hour indicating that this infection was acquired whilst in hospital.

16.1 The team have continued to reinforce best practice in relation to the management of urinary catheters and CAUTI prevention. This will also support the prevention of C.difficile, E.coli bacteraemias and MDROs.

Education and Shared Learning

17. Training and educational programmes were developed and delivered by the IPCT in accordance with national policies, service requirements and local need. Programmes were updated in response to learning from RCA investigations where a change in practice was required.

17.1 In addition to ad hoc training sessions and promotional campaigns, the IPCT have continued to deliver corporate induction for all groups of staff and provide mandatory infection control updates. The Mandatory and Essential Learning Team have expanded the methods of reaching the wider workforce and this has seen the introduction of a Blended Learning package for mandatory updates along with the production of a handbook to accompany the mandatory training presentation.

17.2 The team have delivered timely education sessions in preparation for the seasonal activity relating to both norovirus and influenza. The IPCT have also expanded their education sessions to include Trust wide MDRO teaching particularly in relation to CPE

17.3 The team continued to facilitated the NM6153 “Principles and Practice of Infection Prevention and Control” post graduate course through Chester University, twice yearly. It has also hosted twice yearly “Centre of Excellence” events to share with other organisations how we demonstrated significant Clostridium difficile reductions through a proactive decontamination strategy.

17.4 The IPCNs continued to produce quarterly newsletters which were circulated to all link staff, ward/deputy managers, matrons, lead nurses, IC medical leads, clinical service leads, clinical heads of division, clinical governance leads and directorate IPC Medical Leads informing them of the most recent infection control issues, lessons learnt through RCA, and progress towards C.difficile and MRSA targets. In addition the IPCNs have delivered drop in educational sessions and road shows for all staff to attend to develop their knowledge relating to many different Infection Control topics including what is most topical at the time.

17.5 The IPCT have also provided educational and information sessions for doctors from F1 to consultant level and sessions delivered to Medical Students at each year of their training. The Clinical Infection Control E learning Module remains accessible on the Trust intranet.

17.6 During October 2013 the IPCT promoted International Infection Prevention Control Week using the full week to raise awareness around the basic IPC principles to include:

- Hand Hygiene
- Cleaning
- Isolation
- Sharps Safety

17.7 The Infection Control Doctor and Associate Director of Nursing Infection Prevention and Control have presented poster and oral presentations at a number of National and International Conferences, workshops and symposiums to share learning from outbreaks

relating to MDROs and to support the National drive to act early in order to get ahead of the curve in dealing with these untreatable organisms.

18. Next Steps

18.1 In response to the PHE review around the Trusts HCAI strategy and particularly in relation to CPE a Trust wide IPC strategy has been devised resulting in a number of work streams being set up to progress the actions required relating to:

- Estates and Facilities
- Detect and Isolate
- Communication and Training
- IT, data and analysis
- Risk and Governance
- Antimicrobial stewardship
- Collaborative cross border working

18.2 These actions progressed by the work streams will ensure that all aspects of the IPC agenda (e.g. C.diff and MRSA) are optimised and blended with the action plan to create a cohesive IPC strategy which will be launched in the new year and will include:

18.3 Re-energise 'board to ward' approach to IPC, with board members revisiting their roles in terms of IPC being 'every one's responsibility'

18.4 Prioritise containment of CPE

a) early identification through defined risk groups and rapid testing
b) progress effective isolation solutions, permanent asap and interim urgently
c) build on the basics to perform them at a high level at all times
d) build collaborative relations with neighbouring organisations to progress a wider health economy approach to tackle CPE early
e) support and progress the work streams developed to tackle CPE
f) board level engagement with external authorities to ensure the magnitude of the task and solutions to overcome barriers are recognised and supported at the highest levels

18.5 Develop IT systems to support IPC as a priority

a) to allow IPC nurses to spend more time on the wards
b) to improve epidemiological analysis
c) To aid early identification of linked cases, and risk patients to allow earlier intervention. This should reduce outbreak frequency

18.6 Maintain the standard C. difficile strategy

a) basics brilliantly
b) early isolation of diarrhoeal cases, early testing of suspect cases, rapid transfer to a C.difficile cohort area
c) effective enhanced cleaning supported by HPV

18.7 Maintain the standard MRSA strategy

a) early identification of cases through screening

b) isolation
c) decolonisation supported by infection control assistants
d) continue with medical checklist to ensure early recognition of and treatment of infection

18.8 Maintain norovirus strategy - early action reduces number of cases and spread of other gut organisms

a) early detection
b) early bay closure
c) early ward closure if necessary - allows earlier return to normal ward running

18.9 Monitor VRE strategy:

A targeted strategy aimed at high risk areas is the pragmatic solution given other priorities, but monitoring of effectiveness with clinical infection as the main indicator is required

18.1.0. Promote preventative strategies where feasible, examples being:

a) Pertussis vaccination
b) Influenza vaccination
c) MMR vaccination

18.1.1. Explore new ways of working to:

a) optimise limited side-room resources,
b) reduce likelihood of unaffected patients being exposed to MDROs

e.g. rapid molecular testing at Arrowe Park Site

e.g. separate mixing of patients undergoing 'clean' elective work on general wards from urgent care patients

19. Conclusion

2013/14 has been one of the most challenging years for several years. The risk created by CPE should not be underestimated, and threatens to overwhelm the current ways of working. Whilst we are leading the way in progressing a CPE strategy, much more needs to be done, potentially beyond which the Trust can feasibly do. This is likely to have a knock on effect resulting in significant pressure to the other standard strategies for MRSA and C.difficile etc. High level engagement, particularly around CPE, is required to ensure we keep WUTH as safe as possible.

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Board of Directors		
Agenda Item	8.2	
Title of Report	Research and Development Strategy 2014-2019	
Date of Meeting	29 October 2014	
Author	Dr Charlotte Simpson, Specialty Registrar Public Health Dr Melanie Maxwell, Associate Medical Director	
Accountable Executive	Dr Evan Moore, Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	8	
Data Quality Rating	Bronze – qualitative data	
Level of Assurance	Full	Board confirmation

1. Executive Summary

Wirral University Teaching Hospital (WUTH) Research and Development Strategy is a five year plan that outlines the key priorities for research and development within the Trust until 2019.

2. Background

Participation in research brings many benefits for the NHS. Through advances made, quality of care and health outcomes are improved for our patients whilst the United Kingdom's position in the international science industry is strengthened and economic growth and investment promoted. Furthermore, research active NHS Trusts tend to have better patient outcomes and benefit from the competitive advantage gained through improved knowledge management and in particular, the ability to use and generate research knowledge.

There have been several recent changes to the research landscape, both regionally and nationally in relation to the National Institute for Health Research (NIHR) Clinical Research Network (CRN) and Collaborations for Leadership in Applied Health Research and Care (CLAHRC).

3. Key Issues

One of the Trust's current five-year strategic priorities is to maximize innovation and enabling technologies. Several objectives are included in the Strategy:

- **Culture -** Build a culture that promotes, supports and values research activity within the Trust
- **Capacity -** Develop capacity for research within the Trust
- **Patient engagement -** Maximise opportunities for our patients to take part in research
- **Research collaborations -** Maximise opportunities for research collaborations with external partners

4. Next Steps

The action plan as outlined in the document will be implemented.

5. Conclusion

The vision is that Wirral University Teaching Hospital (WUTH) will enhance innovation in clinical services by ensuring patients are given the chance to participate in research and continuously delivering evidence based care. The overall aim of the Research and Development Strategy is to increase and improve research and development activity within the Trust by embedding research and innovation into everyday practice.

6. Recommendations

The Board of Directors is invited to review the Strategy.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Research and Development Strategy 2014-2019

treating you well

Name and Designation of Strategy Author (s)	Charlotte Simpson, Public Health Specialty Registrar
Approved By (Committee/Group)	
Date Approved	
Links to Other Strategies, Policies, Procedures etc.	

Version History

Date	Ver	Author name and designation	Summary of Main Changes
05/01/05	1.0	Dr Sam Sartain, R&D Manager	(Original version)
12/11/08	1.1	Dr Rod Owen, R&D Manager	Re-align to NIHR Portfolio studies
30/05/12	2.0	Paula Brassey, Research Manager	
01/11/12	2.1	Paula Brassey, Research Manager	Amendment to recruitment aim for 2012/2013
07/02/14	3.0	Charlotte Simpson, Specialty Registrar Public Health	Development of new strategy

Contents

Research and Development Strategy 2014-2019: Overview

Vision: To enhance innovation in clinical services by ensuring patients are given the chance to participate in research and by continuously delivering evidence based care.

Aim: To increase and improve research and development activity within the Trust by embedding research and innovation into everyday practice.

Culture
Build a culture that promotes, supports and values research activity within the Trust.

- Consider as core business and part of everybody's job
- Have continuing executive support
- Increase research awareness
- Annual Research and Innovation Forum
- Quarterly Research Support Group Meetings
- Internal communications: e.g. monthly Start the Week research bulletin
- Quarterly Trust-Wide Clinical Governance Team report

Capacity
Develop capacity for research within the Trust

- Ensure completion of Good Clinical Practice training
- Include research roles and responsibilities into job descriptions
- Encourage career development
- Support staff in becoming committee members of NIHR research specialty groups
- Consider research within appraisals
- Explore possibility of appointing further Research Fellows
- Encourage shadowing of research nurses
- Explore nursing research secondments
- Encourage staff in developing small research and development projects

Patient engagement
Maximise opportunities for our patients to take part in research

- Increase awareness of research activity
- Maintain up-to-date Trust research internet pages
- Support campaigns and initiatives
- Maximise opportunities for NIHR - funded and commercial studies
- Improve NIHR target performance
- Increase awareness and capability of principal investigators to meet NIHR targets
- Increase number of patients recruited and time to recruitment target for current and future studies
- Explore research funding opportunities from non-NIHR sources and undertake more NIHR adopted and commercial studies
- Maintain current timescales of all studies receiving R&D approval within 30 days
- Increase number of studies in which the Trust acts as a Participant Identification Centre (PIC).

Research collaborations
Maximise opportunities for research collaborations with external partners

- Explore research partnerships within the community (e.g. with primary care, community care providers, local commissioners and academic units)
- Explore collaboration with the CLAHRC
- Develop formal nursing partnership with the Faculty of Health and Social Care, University of Chester (Practice Development and Research Partnership)
- Promotion of the Trust to external partners as a research capable organisation

1. Introduction

Wirral University Teaching Hospital (WUTH) Research and Development Strategy is a five year plan that outlines the key priorities for research and development within the Trust until 2019.

2. Background

Research aims to generate new knowledge using systematic and rigorous methods whilst development involves the local implementation of research findings in order to establish their effectiveness.

Participation in research brings many benefits for the NHS. Through advances made, quality of care and health outcomes are improved for our patients whilst the United Kingdom's position in the international science industry is strengthened and economic growth and investment promoted (Department of Health, 2011).

Furthermore, research active NHS Trusts tend to have better patient outcomes and benefit from the competitive advantage gained through improved knowledge management and in particular, the ability to use and generate research knowledge (NHS Confederation, 2010).

3. The Research Landscape

3.1 NHS England Research and Development Strategy

The NHS England draft Research and Development Strategy 2013-2018, identifies priorities for the promotion of research through:

- Visible leadership;
- Research into clinical interventions and innovations that have the greatest impact on outcomes;
- Supporting the NHS as a good place for both commercial and non-commercial research;
- Promoting health system policy research as a means of improving outcomes;
- The establishment of clear links with clinical leaders across all professions, with academia, industry, and with non-clinical researchers in health and social care;
- The development of clear governance structures (NHS England, 2013).

3.2 The National Institute for Health Research and Clinical Research Networks

The National Institute for Health Research (NIHR) is a nationally distributed organisation, funded through the Department of Health, concerned with maintaining a system in which the NHS supports those conducting research to meet the needs of patients and the public (National Institute for Health Research, 2014a).

The NIHR Clinical Research Network (CRN) consists of 15 local Clinical Research Networks across England, delivering research across 30 clinical specialties. These are managed within 6 divisions:

- Division 1: Cancer
- Division 2: Diabetes, stroke, cardiovascular disease, metabolic and endocrine disorders, renal disorders
- Division 3: Children, genetics, haematology, reproductive health and childbirth
- Division 4; Dementias and neurodegeneration (DeNDRoN), mental health, neurological disorders
- Division 5: Primary care, ageing, health services and delivery research, oral health and dentistry, public health, musculoskeletal disorders, dermatology
- Division 6: Anaesthesia/peri-operative management, critical care, injuries/emergencies, surgery, ENT, infectious diseases/microbiology, ophthalmology, respiratory disorders, gastroenterology, hepatology.

WUTH's local network (North West Coast) is hosted by The Royal Liverpool and Broadgreen University Hospitals NHS Trust. It is responsible for ensuring the effective delivery of research in the Trusts, primary care organisations and other qualified NHS providers throughout the North West Coast area.

3.3 Collaboration for Leadership in Applied Health Research and Care

Collaborations for Leadership in Applied Health Research and Care (CLAHRC) are partnerships between a university and surrounding NHS organisations in undertaking high-quality applied health research focused on improving patient outcomes (National Institute for Health Research, 2014b).

The North West collaboration, based at the University of Liverpool, has been awarded £9 million as well as a further investment of £12.5 million from NHS, local authority and university partners for 2014-2019.

Its themes are:

- Improving public health and reducing health inequalities
- Improving mental health
- Managing complex needs arising from long term conditions
- Delivering personalised health care

With research methodology themes including:

- Evidence synthesis and implementation
- Public and stakeholder management
- Knowledge exchange and implementation

4. Current Research Activity at WUTH

4.1 Research studies at WUTH

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is a research active organisation. Most research conducted at the Trust is NIHR funded with a small number of studies being non-NIHR (mainly student or consultant-led).

In 2013/14, 863 patients receiving NHS services provided or sub-contracted by the Trust were recruited to participate in research approved by a research ethics committee. This number is more than double last year's recruitment and demonstrates the Trust's continued commitment to research.

The Trust recruited participants to 44 National Institute for Health Research (NIHR) adopted studies; 41% of studies were Clinical Trials of Investigational Medicinal Products (CTIMPs; studies designed to test a new drug or to test a licensed drug in a different way). The research portfolio is clinically diverse with an increasing number of specialties able to offer research to suitable patients. This includes: cancer, cardiovascular, critical care, dermatology, elderly medicine, haematology, ophthalmology, paediatrics, reproductive health, respiratory, rheumatology, stroke and surgery.

4.2 Research support

Research within the Trust is supported by 6.6 WTE research nurses, 1.0 WTE research midwife and over 40 Trust clinicians and a small administrative team consisting of a Research Manager (1.0 WTE), a Research Coordinator (0.4 WTE) and a Data Coordinator (1.0 WTE).

Much of the research involves collaboration with key support services and the Research Department works closely with pharmacy, pathology and radiology to ensure that the Trust has the capacity and capability to set up and effectively run our studies.

For the last two years the Trust has achieved the national key performance indicator for granting NHS permission (R&D approval) to all new studies within the 30 day target.

4.3 Research funding

Funding is received from the CRN to cover the costs of working on National Institute for Health Research (NIHR) adopted studies e.g. research nurses, research administrative staff and key-service support departments' research-related activities. The Trust also receives income from industry-sponsored research; the majority of which goes directly to the speciality undertaking the research, though the Research Department does retain a proportion to cover costs and for capacity building.

4.4 Research priorities

One of the Trust's current five-year strategic priorities is to maximize innovation and enabling technologies.

Research has been identified as a strategic priority by several departments within the WUTH Five Year Clinical Strategy 2013-2015. Research-related aspirations and objectives, for example, have been identified by:

- Radiology
- Gastroenterology
- Palliative & End of Life Care
- Trauma and Orthopaedics
- Upper & Lower Gastrointestinal Surgery
- Urology
- Cancer
- Neonatal services
- Acute Paediatrics

In addition, innovative service redesign, development and innovative practice are prioritised across all divisions to improve patient care within the Clinical Strategy.

5. Our vision

Wirral University Teaching Hospital (WUTH) will enhance innovation in clinical services by ensuring patients are given the chance to participate in research and by continuously delivering evidence based care.

6. Aim

The overall aim will be to increase and improve research and development activity within the Trust by embedding research and innovation into everyday practice.

7. Strategic objectives

A) Build a culture that promotes, supports and values research activity within the Trust.

Research activity will be considered as core business within the Trust and will be seen as part of everybody's job whether clinical or non-clinical. There will be continuing executive support for research and development in the Trust.

An increased awareness of the value of research and development in the Trust will be promoted to staff via:

- An annual multidisciplinary Research and Innovation Forum aimed at employees who are research active or wish to be research active. The aim will be to support this with an open electronic forum where information can be posted and ideas shared. Its function will be:

    - To provide significant opportunities to share research and development best practice
    - To share knowledge of upcoming and current research opportunities and discuss ways to optimise current research projects

- To raise awareness of new developments in research arrangements, resources available, funding and governance locally and nationally in order to ensure that joint resources are used efficiently.

- A Research Support Group Meeting held quarterly to provide practical advice and assistance to clinicians and other researchers in setting up and supporting R&D projects. In particular, amongst specialties that currently have a small research portfolio, where research was identified as a priority within the Trust's Five Year Clinical Strategy or where these may be linked to the North West Coast's CLAHRC themes.

- Use of internal communications (e.g. monthly Start the Week research briefing) to raise the profile of local research and opportunities.

- A quarterly report presented to the Trust-Wide Clinical Governance Team reporting on research activity within the Trust.

Furthermore, it is well recognised that identifying best practice and implementing evidence-based recommendations (e.g. as outlined in NICE guidance) with respect to service delivery and individual patient care enhances the quality of our services and improves outcomes for our patients. Thus, a strong evidence-based decision-making culture within the Trust, aiming to put research into practice, will be fostered through continuing support for audit, evaluation and subsequent service improvement.

B) Develop capacity for research within the Trust

There is a need for more staff to be engaged in research and to ensure that relevant staff have the necessary knowledge, skills and confidence to carry out high-quality research. This will be promoted by:

- Supporting and ensuring the completion of Good Clinical Practice training by staff members involved in, or wanting to become involved in, research.

- Including research roles and responsibilities into job descriptions of newly appointed clinical staff where appropriate

- Encouraging career development of research talent e.g. by encouraging staff members to become committee members of NIHR research specialty groups and considering research activity within appraisals.

- Exploring the possibility of appointing further Research Fellows to the Trust.

- Encouraging nurse shadowing of research nurses

- Exploring the possibility of nursing research secondments.

- Encouraging participation of staff in developing small research and practice development projects (e.g. as part of PDRP (see below)).

C) Maximise opportunities for our patients to take part in research

The Trust will offer more opportunities for patients, and where appropriate their relatives, to become involved in research to ensure that more patients are engaged in research and that there is equity of access to opportunities.

Firstly, there is a need to ensure that the population served by WUTH is aware that it is a research active organisation. There will be achieved by:

- Ensuring the Trust research internet pages are accurate and up-to-date
- Supporting and participating in NIHR campaigns and initiatives which aim to encourage patient awareness and participation in research (e.g. the 'Ok to Ask' campaign')

Secondly, opportunities for income generation in relation to NIHR funded and commercial studies will be maximised by:

- Improving overall performance with respect to NIHR targets
- Increasing awareness and capability of principal investigators to meet NIHR targets
- Increasing number of patients recruited and improve time to recruitment target for current and future studies.
- Exploring research funding opportunities from non-NIHR sources and undertaking more NIHR adopted & commercial studies.
- Maintaining the current timescales of all studies receiving NHS permission (R&D approval) within 30 days of receipt of a valid complete application
- Increasing the number of studies which the Trust acts as a Participant Identification Centre (PIC), where the Trust approves and identifies potential participants for studies conducted elsewhere.

There will consequently be a robust process for ensuring that relevant staff members are aware of potential NIHR research studies that the Trust could potentially participate in and active support for participation where reasonable. In addition, there will be support for projects which are not defined as primary research but which aim to put research into practice.

B) Maximise opportunities for research collaborations with external partners

Collaboration with industry and academic partners can bring significant benefits for the Trust and its patients. These include sharing of resources, both financial and non-financial (e.g. skills, technologies), that ultimately enable more rapid translation of research ideas into innovative solutions in patient care.

Consequently, the following will be explored:

- Potential research partnerships within the community (such as with primary care, community care providers and local commissioners and academic units) with a long-term aim to promote the Wirral economy for research.

- Collaboration with the CLAHRC particularly where opportunities exist to address the North West Coast's CLAHRC themes.

In addition, a formal partnership will be developed with the Faculty of Health and Social Care, University of Chester. This will enhance opportunities for academic and nursing staff to collaborate with respect to audit, research and service evaluation. It will support Ward Sisters to gain academic credit for the work they are already leading on or have already completed. This Practice Development and Research Partnership (PDRP) will have the following objectives:

- To facilitate evidence-based practice development and critical reflection.
- To conduct practice relevant research and disseminate its findings (for example, through audit, publications, local intranets and practice networks and conference presentations).
- To facilitate staff development opportunities for all staff involved in the PDRP.
- To enhance the reputation of Wirral University Teaching Hospital and the University of Chester to underpin the aims of practice and clinical governance.
- To link projects with WUTH Nursing and Midwifery strategy 2013-2018

It is also important that WUTH is promoted to potential external partners as a research capable organisation. Key to this will be ensuring that the NIHR R&D Operational Capability Statement is reviewed, updated and disseminated to relevant external organisations annually and posted on the Trust website.

7. Governance

Research will be included in the remit of the Trust-Wide Clinical Governance Team escalating concerns as necessary to Clinical Governance Group. There is a need to ensure that high standards are maintained. In order to achieve this, the Trust will:

- Conduct an annual audit of Trust research governance arrangements and rectify any gaps and risks identified.
- Ensure all research is conducted in accordance with the Standards of Good Clinical Practice (GCP).

Attainment of strategic targets via key performance indicators will be monitored. The Research and Development Strategy will be subject to annual review.

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Research and Development Strategy 2014-2019: Action Plan

Actions	Lead	Short-term (December 2014)	Medium-term (April 2016)	Long-term (April 2018)
A) Develop a culture that supports and values research activity within the Trust				
Establish continuing executive support	MJM	X	X	X
Organise annual Research and Innovation Forum	PB/MJM/CS	X	X	X
Explore feasibility of having open electronic Research and Development Forum	CS	X		
Organise quarterly Research Support Group Meeting	PB	X	X	X
Production of monthly 'Start the Week' research bulletins	PB/ Communications Team	X	X	X
Production and presentation of quarterly Research Report to Trust-Wide Clinical Governance Group	PB	X	X	X
B) Maximise opportunities for our patients to take part in research				
Ensure WUTH Internet pages are accurate and up-to-date	PB	X	X	X
Ensure support for and involvement in NIHR patient campaigns	PB		X	X
Explore possibility of including research activity and performance as a component of consultant appraisals	MJM	X		
Ensure all relevant staff are aware of potential NIHR studies that the Trust could participate in	PB	X	X	X
Monitor and maintain timescales regarding receipt of NHS permissions	PB	X	X	X
Increase participation in research studies (including as PIC)	All		X	X
Increase recruitment to current and future studies	All	X	X	
Provide support for developing non-NIHR studies and development projects (including exploration of potential funding opportunities).	PB/MJM		X	X
C) Develop capacity for research within the Trust				
Organise Good Clinical Practice training to run alongside annual Research and Development Forum	PB	X		
Explore possibility of further research fellows with Health Education	MJM	X	X	

North West				
Explore possibility of research nurse shadowing/secondments	PB/MJM	X	X	
Encourage participation of staff in developing practice development projects	PDRP Steering Group	X	X	
D) Maximise opportunities to collaborate with partners				
Explore opportunities to develop community partnerships with respect to research and develop collaborative research projects	MJM/PB		X	X
Build upon existing relationships with the North West Coast CLAHRC to determine possibilities for research projects for regionally significant areas	MJM/PB		X	X
Formalise Practice Development and Research Partnership	TL/PDRP Steering Group	X	X	
Review, update and disseminate NIHR R&D Operational Capability Statement annually	PB	X	X	X
Additional				
Audit and gap analysis of Trust research governance arrangements	PB	X	X	X

Board of Directors		
Agenda Item	8.3	
Title of Report	Cerner Future Phases	
Date of Meeting	29 October 2014	
Author	Mark Blakeman, Director of Infrastructure and Informatics	
Accountable Executive	Mark Blakeman, Director of Infrastructure and Informatics	
FOI status	Supporting documentation includes FOI exempt information: • Pricing information of the individual Phases in commercially sensitive • Work with the Countess of Chester is at a draft stage and release could be prejudicial to any negotiations with their current or future suppliers • Cost savings regarding voice recognition are currently draft and need to be shared with staff side prior to disclosure Options appraisal is commercial and in confidence	
BAF Reference	7	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Incomplete	Board confirmation

Summary of Actions Required

The Board of Directors are asked to:

- Note the continued progress with the delivery of the Cerner programme
- Note revised costs of the programme taking into account the implications of the Trust's successful NHS England "Tech-fund" bid
- Note that a range of cash releasing benefits have now been identified from the Millennium programme and that these have been developed into PODs in line with the Trusts standard approach for managing cost improvements
- Note that further work is under way to explore the potential for further cash releasing benefits

- Agree the preferred option for presentation to the Trust board, in particular that:
    - Phases 2b and 2c should continue as planned
    - Progression to phase 3 remains part of the programme, but is subject to further review prior to the start of the phase
- Note the potential of future working with the Countess of Chester

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Cerner Future Phases

Version No: 1
Issue Date: October 2014

Contents

Available on Request (Subject to FOI Restrictions)

1 Introduction

This document provides:

- A brief update on current position, including continued progress with the delivery of the Cerner programme
- A reminder of the contents of the future phases
- An update of the financial impact of the programme, particularly in light of the amendments made following the Trust's successful NHS England "Tech-fund" bid
- A report on the currently identified cash releasing benefits of the solution and the work that is underway to explore the potential for further cash releasing benefits
- A review of the trusts commitment to each of the future phases
- an update on the work with the Countess of Chester

2 Current Position

In September, the Board of Directors received a paper that provided a reminder of the Cerner programme to date and an update on the progress with the latest implementation phase.

Progress with Phase 2b, due to go live on November 15th remains good, with no significant issues. Staff training has started and attendance to date has been good.

Subsequent to the September Board meeting, a small team of Executive and Non-Executive Directors met to review in more detail the contents, costs and benefits of the future phases of the programme. This paper is based on the outcome of that meeting.

3 Future Phases

As the Board will recall, the Cerner Millennium solution is being introduced into the Trust through a series of phases, including a new Phase 2c which was introduced following the successful "Tech-fund" bid to NHS England.

Appendix B provides a detailed view of the future Cerner Phases.

In summary:

- Phase 2b – to go live on the 15 November 2014 will be a key tipping point in the organisation. It provides the functionality to enable the vast majority of the Trust's electronic patient record, including virtually all nursing, AHP and medical documentation outside Theatres and ICU. In addition, this phase brings advanced nurse task and acuity management tools as well as the functionality to support clinical care pathways and real time analytics (to support improvements in sepsis management and readmission avoidance)

- Phase 2c – to be delivered during 2015 and 2016 through a series of projects that aim to digitise the hospital and link our medical devices and equipment directly with the Cerner solution. This will for example enable vital sign measurements to be automatically transmitted from bed side medical devices straight into the patients record, the automatic programming of infusion pumps reducing the potential for errors and saving nursing time and enable messages to be sent to clinicians mobile phones to warn them if their patients are deteriorating. In addition this phase will provide a full oncology management solution, including chemotherapy prescribing and a patient portal that will enable our patients to view their own record on line as well as book and amend appointment etc.

- Phase 3 planned for 2017/18 concludes the implementation, bringing a fully electronic ICU and theatres charting solution and a new pharmacy stock control system

Implementation of these three phases will ensure that the Trust has the highest level of digitisation possible and will provide a world class demonstration of the very best of what is possible with health care IT.

4 Financial Update (Including the Impact of the Successful "Tech-Fund" Bid)

Capital impact

The change in total capital costs associated with the Cerner Business Case (from its inception in 2008/09 to the project end date of 2019/20) is shown in Appendix D. In summary, the total capital expenditure over the life of the project has increased from £21.883m to £24.423m.

Within these total movements there have been significant changes between years as implementation plans and payments were moved to support the requirements in the bid for the £3.5m of PDC resource, partly offset by the deferral of the payment of the extension of the license fee. In total, the net impact is a £960k reduction in capital required to be provided by the Trust.

Revenue impact

The revenue impact of the Cerner project over its life to 2019/20 is £63.8m comprising £36.0m operational spend (staff costs, maintenance payments etc), with the balance of £27.8m being the "capital charges" which are the depreciation charge for the capital spend and the PDC payable on these assets. The total operational pressure over the remaining life of the project is an increase of £1.7m compared with the position at November 2013.

The changes in the total operational revenue costs over the life of the project (inception to 2019/20) are shown on Appendix E.

5 Benefits Management

Given the relative immaturity of the Trusts benefits management approach, to date the Trust has had to rely on estimates of benefits from Cerner's experience in the USA when making business case decisions. Whilst this experience is invaluable in making strategic decisions, it is much less helpful when trying to understand exactly how the Trust can translate these strategic capabilities into operational efficiencies.

Using money funded by the Tech-fund, The Trust has more recently engaged external expertise in the identification and management of benefits and has established a more formalised process that links international best practice to a Wirral specific benefits model.

From this work and supported by both the WHES team and FTI a series of PODs have been produced which identify the operation benefits of the system over the next 36 months. These PODs continue to be refined based on, on the ground measurement of current processes and an understanding of how the system will improve efficiency.

The financial benefits identified to date for each phase can be summarised as:

Phase	Key financial benefits currently identified	CIP Value Range Full year affect
2a	Whilst 2a has been live since last year, there are two remaining benefits that can be achieved; Reduction in laboratory reception staff due to bar coding of samples. Reduction in ward clerks due to reduced filing associated with electronic ordering and results reporting.	£85k - £450k p.a.
2b	The most significant financial benefit currently identified from the implementation of 2b is the termination of the PCIS contract. Other schemes include; Improved administration processes, such as outpatient kiosks, electronic patient booking in radiology and less reliance on the paper records, reducing the need for clerical staff. Improved clinical processes, such as reducing readmissions, better early identification of sepsis, easy access to primary care records for medicine reconciliation, hospital wide access to ECG results and electronic nursing documentation, enabling staff to spend more time with patients and reducing length of stay through more standardised and reliable processes.	£1.4m - £1.7m p.a.
Digital Dictation	The use of voice recognition, particularly in outpatients to reduce the volume of typing in the organisation.	£382k p.a.
2c	Implementation of computerised care pathways that guide clinicians through evidenced based clinical processes with an aim of reducing inappropriate demand on diagnostic services and reducing length of stay. Paperless A&E, reducing the need for clerical staff within the A&E department. Nursing acuity tool, helping to ensure that the Trust makes best use of its nursing resources and reducing the need for temporary staffing. Better bed management processes, reducing the need for clerical staff as well as improving patient flow.	£777k - £1.6m p.a.
3	Paperless ICU and Theatres, removes the final requirements for the paper record, releasing the remaining medical records staff. Integrated pharmacy and theatre stock control systems, improve stock management. Integration of ICU medical devices and removal of paper charts improve ICU efficiency.	£337k - £483k p.a.

Equally important are the quality and regulatory benefits, which are more difficult to accurately quantify from a financial point of view for example:

- Automatic alerting (2c) will alert the relevant clinician(s) via an email or text message if their patient is at risk of deteriorating based on their vital signs. This has been shown in other hospitals to improve outcomes for patients significantly, with hospitals showing for example a 15% reduction in mortality, cardiac arrest rates reduced by as much as 70% and a reduction of over 50% in unplanned transfers to ITU

- Powerchart Oncology (2c) introduces electronic prescribing for chemotherapy, in line with the requirement of the National Cancer Peer Review, but will also improve patient safety for patients with complex medicines as well as reduce the clerical processes for clinical staff associated with cancer tracking and staging

- Electronic barcoded medicines will reduce the potential drug administration errors

- Barcoded blood administration will improve the tracking of blood in the organisation and significantly reduce the time spent to trace the use of blood

6 Review of the Trusts Commitment to each of the Future Phases

Given the financial position within the Trust and the significant investment being made it is important that status of the future phases are regularly reviewed to ensure that they are expected to meet the Trust's short and long term goals.

Appendix C provides an options appraisal with regard to the future phases.

On the basis of the analysis:

- Phase 2c provides significant financial and quality benefits and has received financial support from the Tech-fund bid. Not proceeding with Phase 2c is economically unviable particularly as the trust would have to repay the NHS England Safer Hospitals funds, despite having already paid Cerner for the software licences. On this basis, the Board are asked to continue to support the implementation of Phase 2c

- There is the potential to reduce the implementation costs by not implementing Phase 3. Should the Trust decide not to proceed with Phase 3, the Trust would potentially save £1.25m capital in Cerner Deployment charges, plus £350k internal capital costs (floor walkers equipment etc). There could be a release of project management resources from within the Informatics department. This is estimated to be £265k pa. Overall Phase 3 has an expected return on investment of 4 years

  The Board of Directors will receive a recommendation from the October Finance Committee with regard to the future phases.

7. Update on the Work with the Countess of Chester

As part of the re negotiations, the potential to extend the Trusts solution to the Countess of Chester was included in the contract.

A team of 4 staff from the Countess of Chester will be joining us on our visit to the annual Cerner conference in November and three staff joined our trip to Denia in September to learn more about the systems and the way it could work for them to help inform their options appraisal.

8. Decisions Required

The Board of Directors are asked to:

- Note the continued progress with the delivery of the Cerner programme

- Note revised costs of the programme taking into account the implications of the Trust's successful NHS England "Tech-fund" bid

- Note that a range of cash releasing benefits have now been identified from the Millennium programme and that these have been developed into PODs in line with the Trusts standard approach for managing cost improvements

- Note that further work is under way to explore the potential for further cash releasing benefits
- Receive an update from the Finance Committee with regard to their recommendations associated with the future Phases
- Note the potential of future working with the Countess of Chester

Board of Directors		
Agenda Item	9.1	
Title of Report	Month 6 Monitor Compliance Report	
Date of Meeting	29 October 2014	
Author	Emma Pridgeon, Assistant Director of Finance – Corporate Financial Services John Halliday, Assistant Director of Information	
Accountable Executive	Alistair Mulvey, Director of Finance Sharon Gilligan, Director of Operations	
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

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 2 2014/15 is described below, with further financial detail attached in Appendices 1-4.

As the Trust is on monthly monitoring it also submits monthly financial information and a more summarised commentary for the month.

The Board is asked to recommend to the Board that they self-certify the statements that accompany the year end monitoring returns that are detailed in Appendix 5.

The Board 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 2 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 2 position was 94.0% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site.

On the 17th September 2014 the Wirral Health and Social Care Community approved the 4 hour A & E Standard recovery plan. The plan contains the revised trajectory for improvement for this site for the months up until March 2015. The trajectory for Quarter 2 was 94% which the Trust achieved.
The Trust has also approved and implemented a revised model of staffing in the A & E department to provide greater resilience and capacity at known peak times.

The Referral to Treatment (RTT) standards were not achieved at Trust level for Quarter 2 for admitted and non-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 2 performance accordingly. Monitor has not relaxed their Risk Assessment Framework targets, but again is aware of this planned action. The target for patients not yet treated (Incompletes) was achieved at Quarter 2, and shows an improved position reflecting the additional activity.

For infection control, the number of Clostridium Difficile cases was above trajectory at the end of Quarter 2, with 14 hospital cases against a maximum trajectory of 12. However two of the cases in September are considered unavoidable by WUTH's Infection Control Team, and they are being discussed with Wirral CCG. If this view is supported by the CCG they would then not count against the trajectory, reducing the cumulative position for September down to equal the trajectory of 12. The maximum year-end trajectory is 24 cases. Failure in Quarter 3 would trigger a potential governance concern. The actions taken so far and the forecast in-year position are being reviewed to support the achievement of the year-end trajectory.

CQC Standards

The Trust has just undergone a responsive inspection at Arrowe Park Hospital focusing and is currently awaiting the formal feedback report. The verbal report indicates some areas of minor and moderate non-compliance which are currently being actioned.

Compliance Rating

WUTH will not be Green for Quarter 2 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 and potentially the underperformance against the c difficile trajectory. 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 cannot confirm the finance governance statement that "The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months".

Quarter 2 2014/15 Financial Commentary for Monitor

The following commentary covers the key reasons for the Quarter 2 variations against the 2014/15 plan.

The financial position of the Trust shows a year to date deficit of over £5.1m against the planned deficit of just under £4.6m, therefore an adverse variance of £0.6m.

NHS Clinical Revenue

To Quarter 2 there is a gain of £1.4m against planned levels, a gain of £1.1m in the quarter.

Key variances to Quarter 2 are as follows:

Point of Delivery	Cumulative variance to plan £m	Variance In Q2	Commentary
Elective	(0.3)	(0.2)	On a cumulative basis the majority of the variance is caused by an underperformance in Surgical specialties of £1.0m, partly offset by an over performance in Medicine of £0.1m and through patients treated on the RTT pathway by additional North Wales activity, totaling £0.6m. In the quarter the £0.2m adverse variance is caused by Surgical under performance (particularly in Trauma and Orthopaedics) of £0.8m, largely offset by income from accelerated RTT and North Wales of £0.6m.
Non elective	1.7	0.9	Over performance to date in the Medicine & Acute Division continues across specialties at £1.4m and also in the new combined Surgery and Women & Children's Division by £0.1m. There is a £0.3m reduction for activity over and above the non elective block which is offset by the readmission cap and other income risk adjustments. In the quarter the key area of over performance was in the Medicine and Acute Care division of £1.0m.
Day Case	0.6	0.0	On a cumulative basis there has been an over-performance in Gastroenterology of £0.3m, Cardiology of £0.1m, Clinical Haematology £0.2m, Vascular of £0.3m and Oral Surgery £0.1m. In addition £0.3m has been generated through RTT work and from activity from North Wales. These are offset by underperformances in Opthalmology (£0.2m), Trauma and Orthopaedics (£0.3m), Upper GI (£0.1m) and Gynecology (£0.2m). In the quarter there have been gains on Medicine and income from accelerated RTT and North Wales, these have been offset by under performances in Surgery and Women & Children's.

Outpatients	(0.1)	0.1	To date Outpatient procedures are cumulatively £0.1m over plan, within this there are a number of under and over performances. Outpatient Attendances (both first and follow up) are continuing to underperform across most specialties with a total value of £0.5m. The key areas of concern are Gynecology and Paediatrics. Included in this total is a reduction of £0.3m for the outpatient follow up cap, which represents approximately 3,975 attendances which the Trust is not paid for, discussions continue with the CCG on patient pathway changes to abate these penalties. The balance of the variance is due to additional RTT and North Wales activity of under £0.4m. In the quarter Outpatient procedures showed a recovery of £40k (where the under performance in Breast Surgery was more than offset by the gain in Gynaecology). First and follow ups under performed by £0.3m, of which £0.2m reflects the follow up cap. In the quarter £0.3m was received for accelerated RTT/North Wales work.
A&E	0.3	0.5	This area continues to over perform due to increased activity by circa. £50k, but is offset by a penalty for activity that has breached the 4 hour wait threshold of £0.3m. It also includes Urgent Care funding from Wirral CCG of £0.6m. This trend continued in quarter, plus the Trust reflected the Urgent Care income of £0.6m from Wirral CCG.
Other – tariff	(0.2)	(0.0)	The year to date underperformance is mainly due to Unbundled Diagnostic Imaging of £0.2m.
Other non tariff	(0.6)	(0.2)	In year there are over and under performances in a number of Non PbR areas, in particular over performance in Direct Access Radiology £369k, Pathology £79k, and Device Exclusions £267k. Offset by an under recovery on AMD (£166k), AUD (£71k), HRG exclusions (£123k), Critical Care (NNU) (£261k), High Cost Drugs (£275k), Vascular Transition (£90k), Audiology (£71k), High Cost Bloods (£37k) and Back Pain clinics (£18k) CQUIN is reported at breakeven. These over/under recoveries continued in the quarter generating the £0.2m adverse variance.
Total	**1.4**	**1.1**	

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 £1.2m increase in NHS Clinical income due to Income Generation schemes across a range of points of delivery (with a net value of £0.9m). This is slightly 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 disputes, contract monitoring meeting 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 1; however it should be noted some of the specific targets are only payable upon the achievement of the CQUIN in all quarters.

Other Income and Operating Expenditure

These net costs are above plan at Quarter 2 by just under £2.1m, an adverse movement of £1.5m in Quarter 2.

The key elements are:

Reason for variance	Cumulative variance to plan £m	Variance in Q2	Commentary
CIP delivery	(1.6)	(0.7)	At the outset of the year, it was recognized that not all the recurring and cash CIP schemes would be implemented and delivered from the start of the year, as noted in more detail below. The consequence of this is that cash slippage for the year against the CIP and cost avoidance plan for divisional expenditure and income (net of costs of delivery) is £1.6m, across most cost categories. The rate of slippage has fallen slightly in Quarter 2.
Reserve release	2.5	0.8	As at Quarter 2 the Trust has released £2.5m of reserves. The rate of reserves applied in Quarter 2 is half that applied in Quarter 1 and represents the proportional amount available to the end of the year.
Emergency care	(0.6)	(0.2)	The Trust has invested in emergency care from reserves in 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	(0.4)	(0.2)	Costs have fallen in comparison to previous months. The cost of additional beds originally increased in the quarter due to Infection Control requirements but has recently fallen so is similar to Quarter 1.
Premium costs	(1.1)	(0.7)	Planned and unplanned activity at premium prices. The cost of premium activity has increased in quarter 2 due to the pressure of funding vacancies, especially in Surgery.

Additional activity	(0.8)	(0.7)	There has been over spend of £0.8m 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. This work has taken place in Quarter 2 causing the increased variance.
Non PBR offset	0.1	(0.1)	There has been an underspend of over £0.1m on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions).
Other	(0.2)	0.3	There has been a year to date overspend of £0.2m on "other" expenditure/loss of income such as specialling, sickness and maternity cover, loss of private patient income etc., offset by vacancies. This pressure has fallen considerably in Quarter 2 due to an increased level of vacancies (only some of which are offset by the premium costs above) and non pay savings in some areas.
Total	**(2.1)**	**(1.5)**	

In summary, expenditure adverse variances have increased due to the costs of meeting the RTT and Welsh activity. As a result lower levels of reserves have been able to be applied.

Overall the Trust has benefitted from the contribution from the accelerated RTT and North Wales activity (£0.6m) and the Urgent Care funding (£0.4m) from Wirral CCG.

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 2 (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)	867	3,924	1,035	3,756	**4,791**
Year to date Actual	909	2,459	1,179	2,188	**3,368**
Year to date Variance	42	(1,465)	144	(1,567)	**(1,423)**

External consultants FTI/Atkins came into the Trust in July and will continue to provide support until the end of October albeit on a receding scale. Throughout that period FTI/Atkins have provided support in the form of additional capacity to work up and unlock barriers to delivery on all priority work streams as well as provide additional analytical support. They have provided assurance that the Trust is working on the right priority areas for CIP delivery and have lead Executive level discussions on unlocking barriers and increasing the pace of delivery.

The processes and procedures of the Transformation Steering Group, previously set up by the Trust, have been strengthened and improved to bring Executive level focus of CIP planning, pace and delivery as well as a more robust monthly risk assessment.

A full review of the PMO has been carried out and that is now being turned into an action plan supported by a Communication plan to further strengthen and improve how PMO resources are deployed and used in the future.

Regular updates have been given to the Board and a recommendation has been made to appoint a Turnaround Director and next steps on this will be presented to the October Board meeting.

EBITDA

The favourable NHS Clinical Income variance and the operational adverse variance therefore give an unfavourable Quarter 2 EBITDA variance of £0.7m.

Post EBITDA Items

There is a minor favourable variance to the post EBITDA budget at month 6 of £0.1m due to the underspend on the capital programme against plan generating an overall adverse bottom line variance of £0.6m at Quarter 2.

Forecast

A paragraph will be added on the forecast position including in year out turn, in year CIP shortfall and the recurrent impact once this has been agreed at F,P&BAC.

Statement of Position (Balance Sheet)

The actual Total Assets Employed and Total Taxpayers Equity equal £147.2m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are below budget. Significant early receipts from debtors and internal cash actions have more than offset the invoices raised for additional work and other over performances.

- There is a £2.4m debtor for the planned sale of Springview which has not yet taken place. This is now expected in November 2014.

- 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) for month 6 was £5.9m against a plan of £7.9m. This variance of £2.0m is due to the decision to lease equipment that was due for purchase at £0.6m and slippage on the Cerner and IT projects of £1.4m, (of which £1.0m is offset by delays on PDC drawdown) and other smaller variances.

- The Trust submitted a reforecast of its capital spend at quarter 1. The forecast to Quarter 2 was £6.6m, therefore there is a £0.6m variance. This is due largely to a £0.3m timing difference on Cerner equipment spend and a slight delay on the A&E modifications project.

- Borrowings – the Trust has drawn down the first 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 cash balance at the end of month 6 was £17.4m, being £13.5m above the planned £3.9m. 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 tranche 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 is continuing to implement the internal actions identified from the external review by KPMG. This has had a significant impact on the average daily cash balance, although not all actions cause month end cash levels to increase. On average at month end creditor balances would increase cash by £2m and debtors by £0.5m. Further opportunities are still being explored. Of the £13.5m variance at Quarter 2, c,£7.0m is deemed to be permanent (through the loan, cash actions and maternity payment) and the remainder temporary.

The Trust has embedded the twice monthly 13 week cash forecasting model and discusses the outputs and forecasts with operational colleagues. The Trust is also exploring further improvements and developments of the model with KPMG.

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 November.

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. £3.1m of this was drawn down in September with a further £2.6m and £1.8m due in November and February respectively.

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 first tranche of the loan within the ITFF.

The Trust recognises that without the loan its COS rating at Quarter 2 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 recognizes that it has benefitted in the quarter from the contributions from the accelerated RTT and Urgent Care income and that this contribution will fall in Quarter 3. As a result of this contribution the Trust has been able to apply lower reserves in Quarter 2 which reflect a proportionate level of the amount remaining for the year. In addition the CIP requirements in the second half of the year are challenging but have received validation and further robustness from the work with FTI/Atkins.

Alistair Mulvey
Director of Finance
October 2014

INCOME STATEMENT

September Reporting - Income Statement

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15		
	FT Plan	**Actual**	**Variance**
	September 2014 Year to Date £m	September 2014 Year to Date £m	September 201 Year to Date £m
Operating			
NHS Clinical Revenue			
Elective revenue, long stay:			
Tariff revenue	£12.202	£11.899	£(0.303)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£37.312	£39.061	£1.749
Planned same day (day case):			
Tariff revenue	£13.868	£14.404	£0.536
Outpatients:			
Tariff revenue	£17.868	£17.792	£(0.076)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£5.000	£5.321	£0.321
Other NHS Activity:			
Direct access & Op, all services (Tariff revenue)	£1.435	£1.279	£(0.156)
Maternity Pathway (Tariff revenue)	£3.078	£3.083	£0.005
CQUIN revenue (Non-Tariff revenue)	£2.578	£2.578	£0.000
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£2.207	£2.620	£0.413
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£5.938	£5.895	£(0.043)
High cost drugs revenue from commissioners (Non-Tariff revenue)	£4.418	£4.174	£(0.244)
Other drugs revenue (all types all bands including Chemotherapy) (Non-Tariff revenue)	£1.221	£1.330	£0.109
Other (Non-Tariff revenue)	£26.659	£25.771	£(0.888)
Total	**£133.783**	**£135.207**	**£1.424**
Non Mandatory / non protected revenue			
Private Patient revenue	£0.787	£0.433	£(0.354)
Other Non Mandatory / non protected clinical revenue	£0.732	£0.505	£(0.227)
Total	**£1.519**	**£0.938**	**£(0.581)**
Other operating income			
Research and Development income	£0.163	£0.300	£0.137
Education and Training income	£4.616	£4.745	£0.129
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	£0.602	£0.669	£0.067
Catering Income	£0.988	£1.007	£0.019
Revenue from non-patient services to other bodies	£3.812	£4.300	£0.488
Misc. Other Operating Income	£2.667	£2.750	£0.083
Total	**£12.848**	**£13.771**	**£0.923**
Total Operating Income	**£148.150**	**£149.916**	**£1.766**
Operating Expenses			
Employee Benefits Expenses	£(103.780)	£(100.958)	£2.822
Employee Benefits Expenses - agency and contract staff	£0.000	£(4.568)	£(4.568)
Drug Costs	£(10.503)	£(9.988)	£0.515
Clinical Supplies and Services	£(15.104)	£(15.739)	£(0.635)
Non Clinical Supplies and Services	£(2.535)	£(2.857)	£(0.322)
Consultancy expense	£0.000	£(0.072)	£(0.072)
Movement of Impairment of receivables	£0.000	£0.229	£0.229
Misc other Operating expenses	£(14.026)	£(14.425)	£(0.399)
Total operating expenses	**£(145.948)**	**£(148.378)**	**£(2.430)**
EBITDA	**£2.202**	**£1.538**	**£(0.664)**
Non operating income and expense			
Interest income	£0.148	£0.109	£(0.039)
Interest expense on Non commercial borrowings	£(0.117)	£(0.116)	£0.001
Interest expense on finance leases	£(0.036)	£(0.037)	£(0.001)
Depreciation and amortisation - owned assets	£(4.106)	£(4.033)	£0.073
Depreciation and amortisation - donated assets	£(0.144)	£(0.097)	£0.047
Depreciation and amortisation - finance leases	£(0.144)	£(0.145)	£(0.001)
Other Finance Costs - Unwinding Discount	£(0.026)	£(0.026)	£0.000
PDC dividend expense	£(2.339)	£(2.340)	£(0.001)
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)	**£(4.562)**	**£(5.147)**	**£(0.585)**
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	**£(4.562)**	**£(5.147)**	**£(0.585)**

BALANCE SHEET

September Reporting - Balance Sheet

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan September 2014 £m	Actual September 2014 £m	Variance September 2014 £m
Non current assets			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£12.062	£12.350	£0.288
Property, Plant and Equipmen - Donated or granted	£2.276	£2.284	£0.008
Property, Plant and Equipment - Purchased or constructe	£158.454	£156.526	£(1.928)
NHS Trade Receivables, Non-Current	£0.000	£0.000	£0.000
Other non current receivables	£2.134	£2.111	£(0.023)
Impairment of Receivables for Bad & doubtful debts	£(0.405)	£(0.259)	£0.146
Total non current assets	**£174.521**	**£173.012**	**£(1.509)**
Current Assets			
Inventories	£4.446	£4.224	£(0.222)
NHS Trade Receivables	£7.383	£5.475	£(1.908)
Non-NHS Trade Receivables	£1.167	£1.351	£0.184
Other Receivables	£1.400	£1.570	£0.170
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)	£(0.276)	£(0.209)
Accrued Income	£1.319	£1.255	£(0.064)
Prepayments	£3.425	£3.299	£(0.126)
Cash and cash equivalents	£3.925	£17.438	£13.513
Total Current Assets	**£22.998**	**£36.771**	**£13.773**
Current liabilities			
Current loans	£(0.265)	£(0.573)	£(0.308)
Deferred income	£(2.225)	£(3.746)	£(1.521)
Provisions, current	£(0.707)	£(0.754)	£(0.047)
Trade Creditors	£(8.447)	£(16.143)	£(7.696)
Taxation payable	£(3.917)	£(3.882)	£0.035
Other Creditors	£(2.894)	£(2.436)	£0.458
Capital Creditors	£(1.048)	£(1.453)	£(0.405)
Accruals	£(8.098)	£(9.958)	£(1.860)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.343)	£(0.344)	£(0.001)
Interest payable on non commercial loans	£0.000	£(0.006)	£(0.006)
PDC creditor	£0.000	£0.000	£0.000
Total Current Liabilities	**£(28.844)**	**£(40.195)**	**£(11.351)**
Net Current Assets / (Liabilities)	**£(5.846)**	**£(3.424)**	**£2.422**
Liabilities, non current			
Loans, non current, non commercial	£(5.041)	£(7.819)	£(2.778)
Deferred income, non current	£(11.799)	£(11.799)	£0.000
Provisions for Liabilities and Charges	£(2.590)	£(2.542)	£0.048
Finance leases, non current	£(0.269)	£(0.270)	£(0.001)
	£(19.699)	**£(22.430)**	**£(2.731)**
Total Assets Employed	**£148.976**	**£147.158**	**£(1.818)**
Taxpayers equity			
Public Dividend Capital	£72.385	£71.366	£(1.019)
Retained earnings	£29.765	£28.738	£(1.027)
Revaluation reserve	£46.826	£47.054	£0.228
Total Taxpayers Equity	**£148.976**	**£147.158**	**£(1.818)**

CASH FLOW

September Reporting - Cashflow

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan Year to Date September 2014 £m	FY 14/15 Actual Year to Date September 2014 £m	FY 14/15 Variance Year to Date September 201 £m
Surplus/(deficit) after tax	**£(4.562)**	**£(5.147)**	**£(0.585)**
Finance income/charges	£0.005	£0.070	£0.065
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	£4.394	£4.275	£(0.119)
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	£2.339	£2.340	£0.001
Other increases/(decreases) to reconcile to profit/(loss) from operations	£0.000	£0.000	£0.000
Non-cash flows in operating surplus/(deficit), Total	**£6.738**	**£6.685**	**£(0.053)**
Movement in Working Capital			
Inventories	£0.000	£(0.088)	£(0.088)
NHS Trade receivables	£1.261	£4.058	£2.797
Non NHS Trade receivables	£(0.185)	£(0.311)	£(0.126)
Other receivables	£(0.088)	£0.298	£0.386
Assets held for sale	£0.000	£(2.435)	£(2.435)
Accrued income	£(0.136)	£0.008	£0.144
Prepayments	£(1.845)	£(1.447)	£0.398
Deferred income	£(0.383)	£0.966	£1.349
Provisions for Liabilities and Charges	£(0.008)	£(0.031)	£(0.023)
Tax payable	£(0.001)	£0.006	£0.007
Trade Payables	£(1.106)	£3.953	£5.059
Other Payables	£(0.249)	£(0.324)	£(0.075)
Payment on Account	£0.000	£0.000	£0.000
Accruals	£(0.541)	£1.811	£2.352
	£(3.281)	**£6.464**	**£9.745**
Net cash inflow / (outflow) from operating activities	**£(1.105)**	**£8.002**	**£9.107**
Investing activities			
Property - new land, buildings or dwellings	£(1.633)	£(0.812)	£0.821
Property - maintenance expenditure	£(0.300)	£(0.768)	£(0.468)
Plant and equipment - Information Technology	£(1.841)	£(0.061)	£1.780
Plant and equipment - Other	£(0.664)	£(0.452)	£0.212
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(3.393)	£(3.788)	£(0.395)
Increase/(decrease) in Capital Creditors	£(0.552)	£0.091	£0.643
	£(8.383)	**£(5.790)**	**£2.593**
Net cash inflow / (outflow) before financing	**£(9.488)**	**£2.212**	**£11.700**
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	£(0.036)	£(0.037)	£(0.001)
Capital element of finance lease rental payments	£(0.162)	£(0.162)	£0.000
Interest (Paid) / Received on cash and cash equivalents	£0.148	£0.107	£(0.041)
Drawdown of non commercial loans	£0.000	£3.087	£3.087
Repayment of non commercial loans	£(0.133)	£(0.133)	£0.000
Non current receivables	£2.400	£2.421	£0.021
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	**£(6.227)**	**£7.404**	**£13.631**
Opening cash and cash equivalents	£10.152	£10.034	£(0.118)
Net cash (outflow) / inflow	£(6.227)	£7.404	£13.631
Closing cash and cash equivalents	**£3.925**	**£17.438**	**£13.513**

CONTINUITY OF SERVICE (COS) RATING

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

Key Ratios / Risk Rating 2014/15

Based on September 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)	-12.23	**2**	-12.69	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	0.59	**1**	0.84	**1**
		Weighted average risk rating		**1.50**		**1.50**
		Overall Risk Rating		**2**		**2**

Appendix 5a

GOVERNANCE STATEMENTS FOR Q2 – 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 31st October 2014

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

2. Recommendation

It is recommended that the Board:

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

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

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

GOVERNANCE STATEMENTS FOR Q2 – 2014/15

Worksheet "Governance Statement"

Click to go to index

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

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

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

For governance, that:

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

Otherwise:

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

Consolidated subsidiaries:

NEW	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	29th October 2014	Date: 29th October 2014

0

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

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

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

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

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

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

B: 1. The Trust identified the A & E access target as a key risk in its Annual Planning process and although performance for the last 3 quarters has been below the standard there has been a systematic level of improvement. Q4 performance was 92.7%; Q1 was 91.1% and Q2 was 94% as expected. The monthly trajectory outlined in the approved Health Economy Wide Plan is designed to bring the Trust up to the required standard in Q3 but is predicated on the actions in the plan being progressed. 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 Q2 for admitted and non-admitted patients. NHS England and local commissioners accepted this likely consequence. Further additional activity has now been commissioned for Q3, with the potential for a similar consequence. 3. The internal forecast for Clostridium Difficile cases across 2014-15 is being reviewed to ensure all efforts are made to stay within the annual maximum trajectory. 4. The Trust is now in receipt of the draft 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 Trust is checking the report for factual accuracy and is developing an action plan although many of the areas have since been addressed.

C:

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

24th SEPTEMBER 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
Jeff Kozer	Non-Executive Director
Sharon Gilligan	Director of Operations
Apologies:	
Andrea Hodgson	Non-Executive Director
In attendance:	
Carole Self	Associate Director of Governance (minutes)
Mark Blakeman	Director of Infrastructure & Informatics
Terry Whalley	Project Director
Governors:	John Karran, Public Governor
Members of the Public:	None

Reference	Minute	Action
BM 14-15/080	**Apologies for Absence** Apologies were noted as above.	
BM 14-15/081	**Declarations of Interest** None	
BM 14-15/082	**Patient's Story** The Director of Nursing and Midwifery provided the Board with an overview of 2 patients who had made complaints as a result of multiple cancellations. The Board noted that these complaints had been reviewed in detail by the Clinical Commissioning Group, the outcome being that more work was required on the communication of cancelled operations. The communication would set out the expectations for patients and ensure that they were aware that operations would only proceed if it was safe to do so.	

Reference	Minute	Action
BM 14-15/083	**Chairman's Business** The Chairman updated the Board on recent consultant appointments, these being: Dr Turab Ali, Mr Raman, Dr Latha Rajan and Dr Denise Langhor. The Board was informed of the outcome of the recent Governor Elections as follows: Brenda Kerr – Neston, Little Neston, Parkgate, Riverside, Burton, Willaston and Thornton Derek Hampson – Liscard and Seacombe Steve Evans – Bromborough and Eastham Paul Harris – New Brighton and Wallasey The Chairman was pleased to announce that The Trust had won the Macro Employer of the Year in the North West Division of the National Apprenticeship Awards at Liverpool Town Hall on 12 September 2014 and had also been shortlisted for a HSJ Award for staff engagement.	
BM 14-15/084	**Chief Executive's Report** The Chief Executive provided an overview of the key highlights in the Chief Executive's Report. The Board was advised that although the revised Better Care Fund Proposals aligned more closely with the Trust's own view, these were not sufficiently developed at this stage to allow the Trust to refresh its own activity assumptions particularly given the current increases in emergency admissions. The Chief Executive advised that the feedback from the Department of Health to the commissioners was that there was more collaboration and dialogue then had been evidenced previously. The Chief Executive provided the Board with an update on the monthly monitoring calls with the Regulator which included confirmation that the financial situation continued to be kept under constant review and the feedback was that the Trust was doing all that it could. The Board was advised that the approved Urgent Care Recovery Plan and the monthly trajectory for achievement of the 4 hour A & E standard had also been shared with Monitor who were keen to see that the Health and Social Care Economy were working together collaboratively. The Board was updated on the recent responsive inspection undertaken by the Care Quality Commission (CQC). This included some of the verbal feedback received from CQC whereby they complimented the Trust on its open and honest approach; the helpfulness of staff; overall governance and process; the recognition and management of risk with evidence of improvements and the recognition of issues from the ward to the Board. Some concerns were noted by CQC in relation to escalation areas; movement of nurses to staff additional areas; basic nursing on a couple of wards and record keeping especially around nutrition.	

Reference	Minute	Action
	The Director of Nursing and Midwifery confirmed that the Trust had already progressed investigations on the areas of concern with the view that these would be shared with CQC ahead of receiving the written feedback in a few weeks. The Chief Executive provided an update on the use of external support confirming that Atkins/FTI had brought an additional level of rigour and pace in the organisation in progressing the savings plans. The Trust had recognised that additional work was still required and therefore had agreed to impose a further 10% savings target for each Executive Director against all non-clinical areas. These plans were being progressed with the expectation that these would be implemented from 1st October 2014. The Chief Executive confirmed that the next steps were to feed the proposals through the PMO office in order that the necessary impact assessments could be carried out. The Board sought clarity on the accountability at Executive level for the savings plans and their delivery as well as clarification as to why the accountability had not been implemented earlier in the year, The Board was advised that the 10% saving requirement was the full year effect thereby requiring 5% for the remainder of 2014/15. The Director of Finance confirmed that many of the schemes in principle would be non-recurrent to allow for a fuller assessment as part of the budget setting process. The Board was asked to formally endorse the additional 10% savings from the budget, recognising that this is over and above the cost improvement plans. The Board approved the proposal. The Board debated the risks associated with the additional costs of treating extra patients over winter and whether this would be funded by the commissioners. The Chief Executive confirmed that the Trust was on a block contract and therefore was not currently funded for additional demand although some funding for winter pressures had been forthcoming. The Board requested that the Chief Executive put these concerns in writing recommended that the Trust and the Commissioners share the risk.	**DA**
BM 14-15/085	**Response to the consultation document issued by Clatterbridge Centre for Oncology NHS Foundation Trust on their proposed relocation of services to central Liverpool** The Director of Strategic and Organisational Development presented the Trust's response to the consultation document and confirmed that this included the views of clinicians. The Board was informed that the impact of the proposals had been considered with operational and corporate teams to ensure that the response took into account what this would mean for patient care and experience. The Board was asked to note the paper and approve the responses. The Board approved the responses with the slight amendment to the response to question 9 which should refer to question 3 and not 2.	

Reference	Minute	Action
BM14-15/087	**Cerner Progress Update** The Director of Infrastructure and Informatics presented the Cerner Paper which provided an update on the Cerner Programme. In particular the paper described the current position and the work underway to enable the Board to compare the costs and benefits of the future phases. The Board was advised that a more detailed paper would be presented in October 2014 and the intention was for a sub group of Non-Executive colleagues to be constituted which would review the detail. Concerns were raised in relation to the workload anticipated from the November implementation programme and the timing of this. The Board was advised that the timing was necessary due to the changes required in pharmacy and the switch off of PCIS. The Board sought to understand whether there was any interest from other organisations which would benefit the Trust. The Board was advised that there was interest however any progression on this would be subject to the usual commercial processes. The Director of Infrastructure and Informatics outlined the purpose of the Safer Hospitals Tech Fund Bid of £250K for temporary business change, further details of which would be provided in the October paper. The Board agreed that a sub group would be useful ahead of the October Board meeting and that Mr Hollick, Mr Kozer and Ms Maddaford would join this group. The Director of Nursing and Midwifery proposed that the Board Walkabouts in the future could be used to observe the changes pre and post Cerner implementation and assess levels of understanding and engagement.	**JG**
BM 14-15/088	**Integrated Performance Report** **Integrated Dashboard and Exception Reports** The Director of Infrastructure and Informatics presented the integrated performance report highlighting the current position against the A & E 4 hour standard and the Referral to Treatment RTT standard which the Trust planned to fail in order to undertake the NHS England initiative to reduce long waits. The Board was advised that the root cause analysis on the previously reported Never Event was now in place. The Board was also advised of 2 further Never Events in orthopaedics which were currently being reviewed and would be formally reported to the Quality and Safety Committee and then to the Board. An overview of areas where performance required improvement was provided, this included finance, Advancing Quality and Attendance rates.	

Reference	Minute	Action
BM 14-15/089	**Finance Report** The Director of Finance presented the Finance Report which provided an overview of the Trust's high level financial performance to the end of Month 5. The planned income and expenditure position for Month 5 showed an in month deficit of £1,148k, the plan being based on the expectation that the income profile for August would be amongst the lowest of the year due to a combination of annual leave and the expectation that patients may choose not to have their elective care provided in the summer period. Against the plan, the Trust delivered an actual deficit of £1,288k, resulting in an adverse variance of £140k per month. The Board was advised that the cumulative position for the first 5 months showed a deficit of £4,779k against a planned deficit of £4,207k which represented an adverse variance against plan of £572k. The Director of Finance reported an improvement in the cash position against the plan of £6.7M tof £14.7M. The Board was advised that the Cost Improvement Programme CIP as at month 5 was £3.8M against which £2.4M had been achieved, the shortfall of £1.4M representing the cumulative impact of the schemes which were yet to be identified and therefore manifest as an overspending within the I & E position. The Director of Finance confirmed that the current I & E performance and the deterioration in the liquidity position due to the delay in the sale of Springview had resulted in a Continuity of Service CoS rating of 1 in Month 5 against a plan of 2. The Board was assured that the plan was to return to a CoS rating of 2 in September having now drawn down the loan from ITFF. The Board noted the inclusion of financial performance and analysis at a divisional level. The Board reviewed the use of flexible labour and determined that a narrative was required in future if bank and flexible labour was used in the reporting period. The Board reviewed the key highlights from each Division and re-emphasised that the Trust needed to move to service line reporting as soon as possible. The Board requested that the reports concentrate on the variance against plan in future as opposed to the actual costs. The Director of Finance advised that the format of the reports would change in October for presentation at Finance, Business Performance and Assurance Committee. Following the discussions the Board concluded that further work was required on the analysis of pay spend to ensure that the drivers of the expenditure were included in future reports as the permanent staffing costs were not reducing as required in the CIP plan. The Board agreed to undertake a further strategic review of the future bed requirements at the November meeting.	**AM** **AM**

Reference	Minute	Action
BM 14-15/090	**Emergency Department Staffing Report** The Medical Director presented the Emergency Department Staffing Report which had previously been discussed at the Board Development Day in August. The paper outlined the Medical and Acute Specialties Divisional proposal to amend and invest in medical staffing, advanced nurse practitioners and emergency nurse practitioners within the Emergency Department to reflect the increases in patient acuity, age and demand. The Board formally approved the proposal.	
BM 14-15/091	**Report of the Audit Committee** **4th September 2014** Mrs Bond presented the Chair of Audit Committee report highlighting the Limited Assurance report received on Decontamination. Mrs Bond informed the Board of the issues with the current software and provided assurance that interim solutions were being utilised although a risk still existed. The Board was advised that the Committee had a challenge on the Board Assurance Framework in relation to the scoring/rating of risks within the framework. Mrs Bond confirmed that the Committee had agreed to hold a further workshop on the development of the BAF ahead of the December meeting which would be used to inform the Board on the future development of the framework.	
BM 14-15/092	**Report of the Quality and Safety Committee** **10th September 2014** Dr Quinn provided the Board with an overview of the work of the Quality and Safety Committee highlighting areas of good practice and improvement and areas that were of concern. Areas of concern included the opening of beds at short notice; the results of the friends and family test for staff and some of the trends being seen in the CIP quality impact assessment. The nurse staffing report was highlighted which had been reviewed and showed a maintained position for July.	
BM 14-15/093	**Risk Management Policy and Strategy** The Medical Director presented the Risk Management Policy and Strategy for review by the Board following changes made to reflect the current processes for managing risks and incidents in the Trust. The Board reviewed the policy and highlighted areas that required amendments due to the changes in organisational and governance structure. The changes related to the duties and responsibilities of individuals and Committees.	**EM**

Reference	Minute	Action
	The Board asked that the Policy and Strategy be amended to reflect the current positon as approved by the Board in July 2014. Subject to these minor amendments the Board approved the Risk Management Policy and Strategy.	
BM 14-15/094	**External Assessment** **Month 5 Monitor Compliance Report** The Director of Finance presented the Month 5 Monitor Compliance Report to the Board confirming that this had been formally approved by the Chief Executive and the Chairman ahead of the submission to Monitor. The Board reviewed the key points in the report namely the financial governance review; the A & E position and the Continuity of Services CoS rating of 1 as expected. The Board was advised of the new team in place at Monitor and the desire to build relationships quickly to ensure a consistent understanding of the Trust was maintained.	
BM 14-15/095	**External Assessment** **Q1 Letter from Monitor 2014/15** The Board noted the Q1 Letter from Monitor 2014/15. The Chief Executive advised the Board of the recent publication which highlighted the fact that the Foundation Trust sector was largely in deficit and were also failing A & E collectively. The Chief Executive agreed to circulate the publication.	**DA**
BM 14-15/096	**Board of Directors** **Minutes of the meeting dated 29th July 2014** The minutes of the meeting held on the 30th July 2014 were agreed as a correct record of the meeting subject to the inclusion of Jill Galvani, Director of Nursing and Midwifery and Jeff Kozer, Non-Executive being recorded as present. **Board Action Log** The Board reviewed the action log and concluded that this provided an up to date view of progress.	
BM 14-15/097	**Any Other Business** None	
BM 14-15/098	**Items for BAF/Risk Register** The Board reviewed the risk numbered 2611 in relation to highly virulent bacterial infections, this having been escalated in line with the Risk Management Policy and Strategy.	

Reference	Minute	Action
	The Medical Director of Director of Nursing and Midwifery highlighted the key actions being undertaken to mitigate the risk and provided some background to the scoring methodology.	
BM 14-15/099	**Date and Time of Next Meeting** Wednesday 29th October 2014 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 – 29 October 2014

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
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		Nov 14	
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG		Oct 14	
Sept - 14	BM 14-15/089	Narrative to be included in future finance reports when flexible labour is used	AM		Oct 14	
Sept - 14	BM 14-15/089	Further strategic review of future bed requirements to be undertaken at Board	AM		Nov 14	
Sept - 14	BM 14-15/093	Include changes to organisational and governance structure in the Risk Management Policy and Strategy	EM	**Risk Team advised to make the changes**	Oct 14	
Sept - 14	BM 14-15/095	Circulate the Monitor publication on the Foundation Trust Sector Performance	DA	**Completed**	Oct 14	

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 30.07.14						
July-14	BM 14-15/061	Update on complaints handling	JG		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		Nov 14	
July - 14	BM 14-15/073	Provide a progress update on compliance with Health and Safety Legislation	AH		Nov 14	
July - 14	BM 14-15/073	Explore the possibility of the internal auditors undertaking a governance review on health and safety	AH		Nov 14	
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	**To be included in Board Nursing Staffing update in November 2014**	Oct 14	
APR 14-5	BM 14-15/017	Provide proposed financial reporting areas, and related data, for the Board to focus on for 2014/15	MB / AM	To be completed in September 2014 CEO, DoF and John Halliday met with CB to discuss areas of additional information to add insight to BoD discussions. Additionally DoF has met with GH to reframe report-ing through to FPaBAC and subsequently BoD with aim being revisions to October cycle of meetings	July 14	