Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

27th September 2017

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 27th SEPTEMBER 2017
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	**Chairman's Business** Chairman	v
4	**Chief Executive's Report** Chief Executive	d
5. Quality and Safety		
5.1	**Patient's Story/Learning** Interim Director of Nursing and Midwifery	v
5.2	**Hard Truths Commitment- Nurse Staffing Report** Interim Director of Nursing and Midwifery	d
5.3	**Acuity and Depending Nurse Staffing Review** Interim Director of Nursing and Midwifery	d
5.4	**Report of Quality & Safety Committee** Chair of Quality & Safety Committee	d
5.5	**Mortality Review Process** Medical Director	d
6. Performance and Improvement		
6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	6.1.2 Month 5 Finance Report Director of Finance	d
7. Governance		
7.1	**NHSE EPRR Core Standards 2017 18** Chief Operating Officer	d
7.2	**Report of Finance Business Performance and Assurance Committee** Chair of Finance and Business Performance Assurance Committee	d
7.3	**Equality and Diversity Update** Interim Director of Nursing and Midwifery	d

7.4	**Annual Review of Modern Slavery Act** Director of Corporate Affairs	d
7.5	**Chair of the Audit Committee Report** Chair of the Audit Committee	d
7.6	**Annual Review of Board Assurance Framework** Director of Corporate Affairs	d
7.7	**NHSI Quarterly Monitoring Report** Director of Finance	d
7.8	**Board of Directors**	
	7.8.1 Minutes of the Previous Meeting – 26th July 2017	
	7.8.2 Board Action Log Director of Corporate Affairs	

8. Standing Items

8.1	**Items for BAF/Risk Register** Chairman	v
8.2	**Items to be considered by Assurance Committees** Chairman	v
8.3	**Any Other Business** Chairman	v
8.4	**Date and Time of Next Meeting** Wednesday 25th October 2017	v

Board of Directors	
Agenda Item	4
Title of Report	Chief Executive's Report
Date of Meeting	27th September 2017
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides an overview of work undertaken and important announcements over the reporting period.

Internal

- **Improving Patient Flow**

I recently received the initial 6 week diagnostic report from Ernst Young, the detail of which will be presented to the board today. It was assuring to note that their assessment aligns with our own diagnosis and informatively advises on the key workstreams and improvements most expected to show a key change in our delivery against the 4 hour standard.

Communication of the detail is being shared with operational and clinical teams and changes to the way in which we perform huddles within the Emergency Department and Bed Management meetings have already been made which is receiving widespread support.

- **Interim Director of Nursing**

I was pleased to welcome Denise Price, Interim Director of Nursing who will be working with our nursing colleagues whilst Gaynor Westray, our Director of Nursing and Midwifery is absent from work for personal Medical reasons.

External

- **Global Digital Exemplar Programme – "Fast Followers"**

The Secretary of State for Health Jeremy Hunt has announced the second wave of NHS digital pioneers, or 'fast followers' at this year's NHS Innovation Expo in Manchester on 12th September 2017.

The Trust was pleased to confirm that the Countess of Chester Hospital NHS Foundation Trust will be its digital 'fast follower'. This approval signals a great example of true partnership working, giving us the opportunity to work better together to make the most of digital technology and the positive impact this can have on quality safe patient care.

Strategy

Merseyside Sustainability and Transformation Plan STP it has become clear that there is a genuine desire to refresh and refocus the STP and to deliver some real change across the patch. It has been confirmed that Mel Pickup has been appointed as the Senior Responsible Officer for Cheshire and Merseyside C + M STP.

It appears certain that STPs are here to stay for the foreseeable future, and that there is no appetite from the Centre for the footprint of Cheshire and Merseyside to change; in other areas STPs are merging and certainly not getting smaller.

There is also an emerging desire from NHS England NHSE and NHS Improvement NHSI for the STP to become the local 'system manager' – progressively taking on many of the functions currently undertaken by local NHSE/I offices - in a way that many feel has been missing since the demise of the old health authorities. This approach could prove helpful to building momentum, as long as there is no attempt at mass centralisation at the expense of more locally appropriate solutions and that Place-based Service provision is the major building block of our local system.

To deliver this, we need to be clear about what is done where and by whom, how we can deliver change at speed and how the system of C+M is managed. We are nearly halfway through the year and we now need to make some rapid progress across C+M by year-end. Andrew is planning a stakeholder event in late October/early November when we can do a little refining of our narrative and approach if necessary and also be clear about what we are going to deliver and by when.

It is recognised that the term STP is rather toxic in some areas but nationally we will still be called an STP and the terms ACS/ACO/PACS/MCP will still be banded about without strict definition. Within C+M it is proposed we start using the term 'NHS Cheshire and Merseyside' for the STP, and 'Place-based Care' as a generic term for integrated/accountable approaches locally.

NHSI have written to all Trusts outlining their plans to see a move to 29 pathology networks, based on benchmarking data which shows a significant efficiency gain could be achieved by consolidation. We are placed into 'North 4' along with Aintree, Countess of Chester, Royal Liverpool & Broadgreen, Southport & Ormskirk, St Helens & Knowsley and Warrington & Halton Hospitals.

Following the launch of our Wirral & West Cheshire Alliance, we have established a Clinical Services Collaboration formed from Medical Directors, Directors of Nursing and senior Medical and Nursing colleagues from both WUTH and Countess of Chester. This will provide the clinical leadership to our acute care collaboration as we consider the merit of any work we might do together that will enable both trusts to continue to provide local access to high quality hospital care. Our initial priorities include Urology, Haematology, Women's & Children's, Renal, Pathology and Radiology.

Commissioning colleagues continue with their work to draft a green paper for consultation on their commissioning intentions for 2018/19. Colleagues from Providers and Commissioners will be attending a couple of focused workshops on 6th and 19th October aimed at ensuring we have a shared understanding of our collective current financial position, what we might learn from the Capped Expenditure Programme, commissioning intentions and developing our forward plan for Place based care.

Celebrating Success

- **PROUD Awards**

When we meet on Wednesday 27th September 2017 the annual PROUD awards will have taken place at the Floral Pavilion in New Brighton . I will look forward to providing members with the highlights from the evening.

- **Freedom to Speak up Guardians**

The Trust received news last week that our Freedom to Speak up Guardians have been shortlisted in the HSJ Awards 2017 in the category of Staff Engagement. Our Freedom to Speak up Guardians are making such a huge difference to our colleagues and it is fantastic that they have been recognised for a national award. This will now go to a judging panel and the winner will be announced at the HSJ Awards on Wednesday, 22nd November.

David Allison
Chief Executive
September 2017

BOARD OF DIRECTORS	
Agenda Item	5.2
Title of Report	Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Update Report (April – September) including bi-monthly staffing report for July and August 2017.
Date of Meeting	27 September 2017
Author	Clare Pratt, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head Workforce Transformation
Accountable Executive	Denise Price, Interim Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk Reference: 1, 2 and 3
Level of Assurance	**Positive** • The Trust continues to meet the requirements of The "Hard Truths Commitment" • A range of mechanisms have been utilised to ensure a safe nurse staffing establishment is in place, along with the recent staffing acuity and dependency review. • Introduction of Specialty reporting of staffing fill rates and Care Hours Per patient Day (CHPPD) allows for easier comparison of staffing data • Associate Director of Nursing (ADN) provides assurance and oversight that mitigating actions are taken, to address staffing shortfalls **Gaps** • There has been an increase in staff reported incidents relating to staffing levels, mostly in respect of staff moves.
Purpose of the Paper	For information and discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	N/A

1. Executive Summary

This paper provides the 6 monthly update on progress within the Trust to meet the requirements of 'Hard Truths: The Journey to Putting Patients First; Expectations, Accountability and Responsibility'.

The report also provides the Board of Directors with information on Registered Nurse / Midwives and Clinical Support Workers staffing data specifically for July to August 2017, including vacancy rates and staffing related incidents. The report also includes the details of the Trust's monthly submission of Care Hours per Patient Day (CHPPD).

Key points of note:

- The Trust continues to meet the requirements of The "Hard Truths Commitment";
- A range of mechanisms have been utilised to ensure a safe nurse staffing establishment is in place, with a dependency and acuity review completed across a third of the inpatient areas during April/May 2017;
- There are emerging concerns in relation to staff moves and the potential impact on leaver figures. A deep dive exercise involving HR and Corporate Nursing is planned. to understand and act on any emerging themes.
- The Trust has robust mechanisms to continue to report its Safe Staffing Data openly across the Trust and to report this locally and nationally. Informal discussions regards safe staffing levels happen continually through the week, in response to operational demands, between Ward Managers, Matrons and the ADN's.
- Alongside robust recruitment strategies, we need a clear focus on retention of staff through the use of meaningful pre-exit interviews.
- Divisions have been proactive in piloting new workforce solutions. These must be evaluated and rolled out as part of a Trust wide Workforce Strategy.
- There is a continued trend towards an increasing nursing vacancy rates. The Trust must ensure that it is fully engaged with regional work led by the Cheshire and Mersey Director of Nursing forum, in respect of wider recruitment campaigns and workforce development, of which overseas recruitment is part.

2. Background

The National Quality Board issued guidance in November 2013, 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This report details the progress and emerging risks in meeting these requirements.

Expectation	Progress
Recommendation 1 The Board of Directors has responsibility for the quality of care provided to patients and as a key determinant of quality takes full and collective responsibility for nursing, midwifery and care staffing capacity and capability	• The Director of Nursing and Midwifery is provided with information on staffing capacity and capability on a monthly basis by the Associate Directors of Nursing. This information is collated and presented to the Board of Directors on a bi-monthly basis.

Recommendation 2 Processes are in place to enable staffing establishments to be met on a shift-to-shift basis	• The Trust continues to work on a minimum requirement of 1 Registered Nurse (RN) to 8 patients during the day and 1 RN to 11 patients at night as per funded establishments; • The nurse staffing escalation guide has been circulated to all ward sisters / charge nurses and hospital clinical coordinators. This provides guidance and supports decision making if concerns are raised with regard to staffing; • Daily staffing meetings are held, (chaired by the ADNs) to determine whether or not planned staffing requirements are met. These meetings are attended by Ward Sisters and Matrons and a cross organisational review and realignment of staff takes place for the following 24 hrs. or the weekend period; • Staffing plan with agreed potential moves is prepared for out of hour's periods; • Close workings with NHS Professionals (NHSP) to ensure improvement in fill rates for temporary staffing is ongoing; • The Trust is currently exploring the implementation of an IT interface between NHSP and eroster which will allow for contemporaneous review of staffing and NHSP fill rates.
Recommendation 3 Evidence based tools are used to inform nursing, midwifery and care staffing and capability	• A Dependency and Acuity (Patient Dependency / Acuity Specialty Specific Tool TM) audit was undertaken in all inpatient areas over a consecutive 21 day period during April/May 2017 and the Board of Directors has received this as an adjacent report; • The Emergency Department staffing is reviewed in line with the 'British Emergency Department Staffing Tool' Assessment (BEST) and draft NICE guidance for Emergency Department Nurse staffing published in January 2015. A review was planned to take place in Quarter 1 2017 however the tool has not yet been released. This has been placed on the Divisional Risk Register and will be completed in Quarter 3 when release of the Tool is anticipated; • Critical Care Unit adheres to Cheshire and Merseyside Critical Care Network (CMCCN) service specification guidance. The Critical Care Network specification meeting has recently taken place, where several staffing and activity parameters were benchmarked. The Trust currently uses, and is compliant with, RCN Guidance on staffing; • Neonatal Unit utilise British Association of Perinatal Medicine (BAPM) standards to inform staffing levels. BAPM levels continue to be monitored on a shift basis. This remains a challenge, particularly as there has been demand for the unit to be over occupied on a regular basis. Staffing is supported through additional hours, bank and agency where possible. There is on-going work to review the possibility of integrating the maternity unit transitional care team with the neonatal team to increase flexibility of the workforce and also progress the functionality of transitional care. This will be assessed as part of a transition plan/proposal.

Recommendation 4 Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns	• At the monthly Strategic Nursing and Midwifery Team meeting, the Director of Nursing and Midwifery, Deputy Director of Nursing and the Associate Directors of Nursing review the staffing incidents report for the previous month and feedback actions taken within the Divisions; • Three incidents of whistleblowing regarding safe staffing have been reported to the CQC in Q1 and Q2. All have been investigated and assurance given regarding safe staffing levels and practices; • Freedom to Speak Up Staff Guardian numbers have been increased to allow for greater visibility across the wards and department. Key themes that have been noted in Q1 and Q2 are in relation to staff moves and low morale caused by poor communication in relation to these moves. This may be contributing to the trend in increased number of leavers in recent months, to be determined through work around pre-exit interviews.
Recommendation 5 A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	• Nurse staffing levels are set and monitored through the Clinical Divisions and Senior Nursing Team. Information on safe staffing is made available to the Board of Directors and an annual review programme has been commenced.
Recommendation 6 Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	• The Trust has a robust process for recording and reporting Care Hours per Patient Day (CHPPD). The Board of Directors receives a bi-monthly report containing key themes from a comparison of data of CHPPD across all wards and specialties as well as regional and national comparison data. This information demonstrates that WUTH staffing is in line with peer organisations; • An upward trend in incident reporting in relation to safe staffing levels has been noted. Analysis of reported incidents indicates that the majority of reports relate to staff moves rather than patient related “red flag” (patients not receiving the fundamentals of care) events. The Nurse Sensitive Indicators do not demonstrate any increase in patient harms during the report time frame; • In 2014 Ward Managers were afforded Supervisory status and as such are not included in funded establishment. A recent audit demonstrated that no Ward Managers have maintained supervisory status for 100% of shifts with the majority only achieving supervisory status between 20%-50% of the time. This has impacted on their ability to fulfill their leadership and quality assurance role; • Matrons are increasingly involved in managing operational patient flow on a daily basis.

Recommendation 7 Boards receive monthly updates on workforce information and staffing capacity. Capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review	• Monthly safe staffing data is collected and reported each month on the Trust internet; • Monthly staffing reports include information on vacancies and number of occurrences of patient harm during the month; • The Board of Directors receives formal bi-monthly reports • Monthly workforce information presented as part of integrated Board Dashboard.
Recommendation 8 NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift	• Daily nurse staffing data is displayed outside each ward. This process is audited via Matron audits and Care Quality Inspections (CQI) to ensure compliance; • Monthly staffing data is displayed on ward viswalls.
Recommendation 9 Providers of NHS services take an active role in securing staff in line with their workforce requirements	• The workforce forward plan is completed annually with full stakeholder involvement; • The Workforce and Organisational Strategy is performance managed on a quarterly basis through workforce and communications group – Board Level support; • Recruitment strategies are in place. Nurse vacancy rate is 8% compared to a National average of 15%; • A review of Retention Strategies is required to ensure they are fit for purpose; • WUTH is working with local Higher Education Institutes (HEIs) to secure future clinical workforce requirements through participation in the Nursing Associate Pilot, apprentice pathways, hybrid Care Support Worker/Therapist apprentice and pharmacy technician presence to support safe medicines administration.
Recommendation 10 Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract	• A copy of this six monthly staffing report is presented to the Wirral Clinical Commissioning Quality and Risk meeting for information and progress

3. Recruitment Strategy

A key priority for the Trust is to ensure appropriate nurse staffing levels are established and maintained. The previous investments in nurse staffing, as well as a robust recruitment plan, has ensured that the Trust has had a stable nursing and midwifery workforce. In view of the national issues surrounding nurse recruitment, the organisation has endeavoured to be more creative around supporting nurse's personal development at ward level through the facilitation of planned rotational posts.

There has been a pilot programme developed for pharmacy technicians to be trained to safely administer medications to patients, this will allow the ward nurse to deliver safe, high quality care. This pilot was developed in view of the increased incidents surrounding medication administration and, following evaluation will be rolled out across other areas.

Nationally nurse vacancy rates have almost doubled in just three years from 6% in 2013 to 11.1% in 2016; and nearly a quarter of NHS trusts have a vacancy rate for registered nurses of over 15%, compared to a 2.7% vacancy rate across all job sectors. In addition NHS training bursaries have stopped, nurses are now required to apply for a £9,000 per annum student loan to cover their tuition fees, which has resulted in applications by students in England to nursing and midwifery courses at British universities falling by 23%. Evidence is growing nationally of direct recruitment of students to Trust employment, for the term of the 3 year programme and a period beyond. This helps offset the longer term attrition rates of student nurses and the overall bank/agency bill over a 3 year foot print.

The total Trust vacancy rate for the registered nursing and midwifery workforce continues to rise, July 2017 - 6.97 % (106.68 WTE) which increased in August 2017 to 8.01 % (122.51 WTE). Our vacancy rate remains significantly better than the national average of 15% however additional strategies are needed to improve the vacancy rate and leaver rate, the latter outstripping the pace of recruitment. To mitigate the above HR/OD have restructured their team to ensure dedicated time and expertise available to develop and implementation of comprehensive workforce plan.

As reported in previous months the majority of vacancies occur in the Medical and Acute Division, data for Band 5 posts identified a vacancy rate of 12.5% in July 2017 and 14% in August 2017 which equates to 84 WTE and 95 WTE vacancies respectively (drawn from the Trust's electronic staff records).

Medicine and Acute Division continue to look at innovative ways to review the ward establishment and implement a variety of support roles across Band 3 and 4. They have recently implemented a rotational post for Critical and High Dependency areas and are currently considering a similar rotational post between ED and Acute Assessment Areas.

3.1 Nursing Associates

The 6 trainee Nursing Associates (Jan 17 cohort) are progressing through their 2 year programme.

The Nursing and Midwifery Council has informed us this month that legislation to enable the regulation of this new nursing associate role will be delayed until November 2017. The next cohort is planned for January 2018 and the divisions are discussing how many trainee posts they can support.

.A project plan had been agreed that facilitates monthly recruitment events locally, across all nursing and midwifery groups.

3.2 EU Recruitment Programme

The Trust has commenced phase 2 of its International recruitment programme with Placement Group, there is evidence that 69% of UK Trusts are actively recruiting for nurses overseas.

Brexit and the Internal English Language test (IELTS) requirements have led to a 96% drop in EU nursing applications to the NMC and this has had an impact on the Trust's ability to secure this group of staff.

The table below highlights current EU recruitment activity;

Recruitment Events 2017	Offered Posts at WUTH	Placement Areas	Commenced in Post	Comments
10-12 May	10	Priority Medicine	2 - started in August ward 11 & 25	Meeting with Placement Group 8/9/17 to improve the timeline from recruitment to starting.
5-6th July	9		Planned October	

			2017	
20th July	6		Awaiting confirmation.	
Sept TBC				A/w confirmation from agency following meeting 8/9/17

4. Temporary Staffing

The 2016/17 annual review of the NHSP contract/service provision has demonstrated a productive and collaborative partnership with key highlights relating to the nursing workforce of;

- External agency decreased by 15%
- Bank fill rate increased by 11%
- Nursing and Midwifery represent the highest number of new starters on NHSP

National and regional benchmarking identified WUTH having the lowest nursing agency usage rate at 4.4% against a national average of 20.8% fill rate.

5. Care Hours Per Patient Day (CHPPD)

Since May 2016 the Trust has collected and reported Care Hours per Patient Day (CHPPD). Use of CHPPD hours to support the review of staffing levels.

As **CHPPD is based on a comparison of the actual staffing levels and ward activity** this is recognised as being a better reflection of staffing levels. It must be acknowledged that this data is still in its infancy, but provides a crude insight and general comparison.

The table below details the CHPPD for each ward March to August 2017 against their overall staffing fill rate. The tables have been categorised into Directorate specialties to help provide some specialty comparisons although it should be acknowledged that there are also sub specialties within these such as Ward 23 which is a specialist stroke service.

Data has been reviewed to provide **an "Average Range"** for each individual specialty. **This is calculated using the staffing establishment, any associated fill rate and the care hours required per patient day, during the previous 6 months, to calculate an average range for comparison. This is set nationally.**

Orthopaedics	CHPPD information	Indicators	March	April	May	June	July	August
Ward 10	Average: **6.6** Range 5.9-6.7	CHPPD	5.9	6.6	6.5	7.3	6.6	6.7
		Fill Rate	90%	93%	92%	94%	95%	91%
Ward 11	Average: **9** Range 8.4-9.7	CHPPD	9.4	9.7	9.3	8.9	8.4	8.4
		Fill Rate	99%	119%	113%	114%	101%	104%
Ward 12	Average: **8.9** Range 8 - 9.7	CHPPD	8	8.7	8.9	8.7	9.7	9.2
		Fill Rate	89%	81%	# 77%	# 79%	78%	101%
M2 Ortho (Previously M1)	Average: **11.4** Range 9.9 -12.5	CHPPD	11	11.2	12.3	11.4	12.5	9.9
		Fill Rate	82%	# 71%	83%	# 78%	81%	77%

M2 Orthopaedics has recently been reconfigured from Ward M1. Safe staffing was in place for the elective activity during August and CHPPD remains higher than the other orthopedic wards.

Acute Care	CHPPD information	Indicators	March	April	May	June	July	August
MSSW	Average: 6.4 Range 6.2-6.9	CHPPD	6.9	6.4	6.4	6.4	6.2	6.2
		Fill Rate	90%	85%	88%	85%	87%	84%
AMU	Average: 9.9 Range 9.3 -10.5	CHPPD	10.5	9.9	9.7	10.1	9.3	9.6
		Fill Rate	105%	100%	99%	101%	97%	103%
EDRU	Average: 9 Range 8.6-9.9	CHPPD	9.2	8.9	8.6	8.9	8.6	9.9
		Fill Rate	100%	105%	100%	103%	98%	103%
ITU	Average: 28 Range 26.8 -29.6	CHPPD	28.3	28.5	29.6	28.1	29.5	26.8
		Fill Rate	# 73%	# 64%	#66%	81%	81%	60%
HDU	Average: **22.3** Range 20.9-24.3	CHPPD	24.3	21.1	22.6	22.7	22.6	20.9
		Fill Rate	95%	91%	94%	91%	89%	87%

Although staffing fill rate for ITU is in red safe staffing for the acuity level of the patients was in place. The Associate Director Nursing (ADN) for Acute and Medical specialties has completed a full review and assurance is provided with details in this report within the staffing incident section.

Women's & Childrens	CHPPD information	Indicators	March	April	May	June	July	August
Children's	Average: 12.3 Range 10-17.2	CHPPD	10	11.4	10.9	11.4	13.1	17.2
		Fill Rate	103%	107%	105%	108%	98%	96%
Maternity	Average: 6.7 Range 5.2-10.9	CHPPD	10.9	6.8	5.2	5.2	5.4	6.6
		Fill Rate	98%	93%	98.50%	96%	93%	100%
Delivery Suite	Average: **34.7** Range 31.6-37.7	CHPPD	37.7	36.6	32	34.6	35.7	31.6
		Fill Rate	102%	101%	98%	99%	97%	95%
Ward 54	Average: 6.5 Range 4.7 - 7.5	CHPPD	4.7	7.5	6.9	7	6.6	6.3
		Fill Rate	97%	92%	89%	84%	94%	88%
Neonatal	Average: **13.3** Range 12 - 15.4	CHPPD	14.4	12.5	11.6	15.4	13.7	12
		Fill Rate	96%	99%	84%	82%	94%	96%

Surgical	CHPPD information	Indicators	March	April	May	June	July	August
Ward 17	Average: **6.1** Range 5.7 - 6.9	CHPPD	5.9	5.9	6.9	6	5.9	5.7
		Fill Rate	107%	106%	106%	96%	97%	91%
Ward 18	Average: 6.2 Range 5.8 -8	CHPPD	5.9	5.8	5.8	6.1	8	5.6
		Fill Rate	95%	94%	93%	94%	96%	93%
Ward 20	Average: 5.8 Range 5.4 - 7.1	CHPPD	5.7	5.6	5.7	7.1	5.4	5.5
		Fill Rate	98%	99%	99%	98%	95%	99%
ESAU	Average:12 Range 10.3-12.6	CHPPD	12.6	12.5	11.9	12.4	12.5	10.3
		Fill Rate	97%	99%	98%	97%	97%	95%
M2 Surgical	Average: 19.8 Range 8.4 - 31.8	CHPPD	16.1	21.2	23	18.4	8.4	31.8
		Fill Rate	95%	94%	100%	100%	100%	60%
Dermatology	Average: 9.3 Range -7.9-11.1	CHPPD	8.7	11.1	9.2	9.3	9.4	7.9
		Fill Rate	100%	100%	93%	100%	71%	83%

M2 Surgical has formed part of the M1 / M2 reconfiguration. M2 is now occupied by an M2 Orthopedic ward and M2 surgical, despite the drop in planned to actual staffing rates, safe staffing was in place.

DME / Rehab	CHPPD information	Indicators	March	April	May	June	July	August
Ward 21	Average: 6.1 Range 5.8 - 6.4	CHPPD	6.1	6.4	6.2	6.3	6.3	5.8
		Fill Rate	105%	104%	105%	107%	107%	99%
Ward 22	Average: 5.8 Range 5.6 - 6.3	CHPPD	5.6	5.6	6.3	5.6	5.6	6
		Fill Rate	99%	98%	99%	98%	99%	93%
Ward 23	Average: **7** Range 6.5 - 7.3	CHPPD	6.8	7.2	7.3	7.2	6.8	6.5
		Fill Rate	99%	105%	108%	103%	105%	100%
Ward 27 (Ward 24)	Average: 5.9 Range 5.5 - 6.2	CHPPD	5.8	5.9	5.5	6.2	6.1	6.1
		Fill Rate	91%	96%	92%	96%	102%	102%
M1 Rehab / M1MO (Previously M2 Rehab)	Average: **5.6** Range 5.2 - 6	CHPPD	5.7	4.9	5.3	5.1	5.2	7.9
		Fill Rate	97%	92%	93%	99%	104%	83%
CRC	Average: **6.2** Range 5.9 - 6.6	CHPPD	6.6	6.1	5.9	6	6.7	6
		Fill Rate	113%	98%	99%	99%	110%	97%

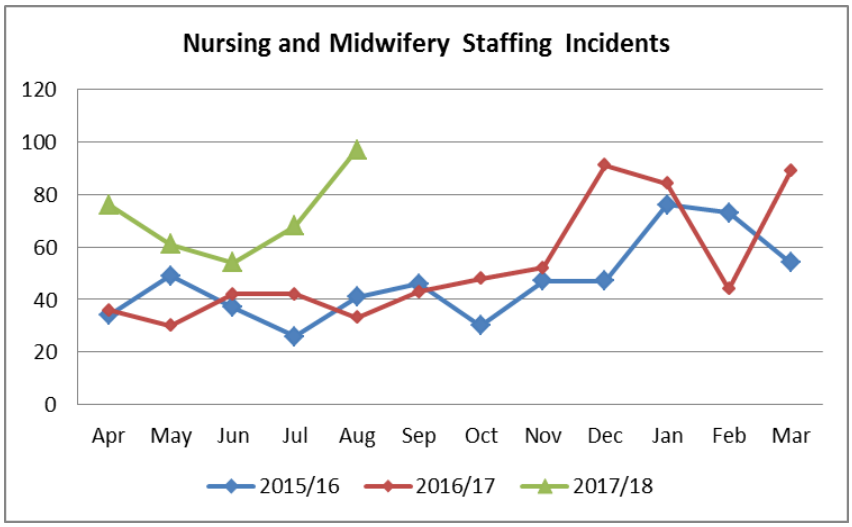
Medicine	CHPPD information	Indicators	March	April	May	June	July	August
Ward 26	Average: **6.3** Range 5.8 - 7.4	CHPPD	6.6	6.2	5.8	7.4	6.1	5.9
		Fill Rate	108%	96%	94%	103%	101%	97%
Ward 30	Average: 6.5 Range 6.2 - 6.6	CHPPD	6.6	6.3	6.5	6.8	6.2	6.4
		Fill Rate	97%	92%	97%	92%	88%	92%
Ward 32	Average: 6 Range 5.9 - 6.4	CHPPD	5.9	6	6	5.9	6.4	5.7
		Fill Rate	97%	95%	94%	94%	101%	91%
CCU	Average: **12.7** Range 12.1 - 13.9	CHPPD	12.6	12.1	13.9	13	12.1	12.7
		Fill Rate	95%	91%	92%	97%	95%	95%
Ward 33	Average: 6**.3** Range 5.8 - 6.9	CHPPD	6.2	6.9	5.8	7.5	5.5	5.6
		Fill Rate	92%	97%	90%	94%	88%	87%
Ward 36	Average: **5.8** Range 5.5 - 6.7	CHPPD	5.7	5.5	5.7	5.7	5.7	6.7
		Fill Rate	95%	91%	94%	94%	93%	93%
LAU (Previously Ward 37)	Average:5.7 Range 5.3 - 6.1	CHPPD	6.1	6.1	5.4	5.4	5.3	5.6
		Fill Rate	100%	101%	99%	100%	109%	87%
Ward 38	Average: **5.4** Range 5 - 5.9	CHPPD	5.4	5.5	5.9	5.6	5	5.1
		Fill Rate	103%	101%	105%	104%	91%	88%
Ward 25	Average: 9 Range7.5 - 11.4	CHPPD	10.4	9.1	9.4	9.4	9	8.1
		Fill Rate	110%	107%	111%	109%	144%	73%
Ward 24 (IPC)	Average : 6.1 Range 5.6 -6.9	CHPPD	5.6	5.8	5.6	6.3	6.9	6.2
		Fill Rate	101%	93%	93%	100%	90%	81%

Ward 25 noted a decrease in planned to actual staffing rates but the CHPPD remains within acceptable limits indicating that Safe Staffing is in place.

The Corporate Nursing and Midwifery Team will continue to work with NHS England to identify the best possible organisations to benchmark against over the coming months.

6. Reported Staffing Incidents

WUTH is proud to have a positive culture of incident reporting and whilst there has been an increase in the number of staffing incidents reported these did not result in any patient harms. The line graph below indicates a significant increase in reported incidents during July and August, following analysis of the incidents it has been concluded that there are duplicates within the system ie several members of staff submitting an incident form relating to the same incident. This has been raised with the Risk Management Department who are exploring ways within the system to try and capture this so that an accurate number of incidents can be reported.



A monthly analysis report of all Nursing and Midwifery incidents is provided for review and monitoring of themes and actions to the Senior Nursing Team. A review of these incidents indicate that many are based on staff's perception of staff shortages and on investigation by the senior nursing team, staffing levels were safe or mitigating actions had been put in place.

It is also acknowledged that the Trust has increased the bed base during Q1 and Q2 requiring additional staffing and this has had a significant impact on staff morale as it has been necessary to move staff more frequently to ensure safe staffing across all wards. Whenever possible staff have been moved for blocks of time to allow for continuity of care and to help develop good team working. Each escalation area has been managed by a dedicated Ward Sister and Manager to ensure a strong focus on leadership and team working is in place.

Increased reporting of incidents relating to safe staffing was noted in two areas:

6.1 Critical Care

Analysis has highlighted Critical Care as an area during August with a significant frequency of reported incidents with a total of 14 incidents. The majority of incidents reported for Critical Care were in relation to staff being relocated to support other areas. A full review from the ADNs for Medicine and Acute Division has provided assurance that safe staffing levels were in place at all times with the following rationale;

- The unit had a higher than average number of level 1 patients in the unit during this period, these patients required normal ward care rather than a higher level of care.
- No Patient was refused admission to critical care due to nurse staffing.
- The incident reporting has increased due to staff being moved to other areas in the division to support, no patient or staff member came to harm due to this movement.
- Staffing on the unit does not include 5 supernumerary nurses who are coming to the end of a 6 week preceptorship programme.

6.2 Ward 25

Ward 25 has for 3 consecutive months being one of the highest areas with increased staffing incident reporting. During July 2017 this was significantly impacted by duplicate incident reporting. Analysis of the incidents relate to a variety of different incident themes including increased patient acuity, staff moves and the impact that providing 1:1 support for Deprivation of Liberty assessed patients had on the ward. There were no patient harms as a result of these incidents.

The ADN Acute and Medical Specialties has completed a full review and is assured that safe staffing was in place. Ward 25 has the ability to flex its bed base and as a specialised infection prevention and control area can have empty beds which following risk assessment can result in staff being relocated to support other areas. The ward has recently recruited to their vacancies.

7. Conclusion and Recommendations

Whilst progress has been made to meet the recommendations of 'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility there are some emerging concerns in relation to Ward Managers and Matrons ability to provide Leadership and Support to junior staff members due to the competing demand around patient flow and workforce flexibility.

In benchmarking the Trust performance for Care Hours per Patient Day (CHPPD) with other acute hospitals via the model hospital portal, allows us to further assure ourselves that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low.

The Trust will continue with monthly Trust wide recruitment for registered nurses in conjunction with other initiatives outlined in this report. A full acuity and dependency review has been completed.

8. Recommendation

The Board of Directors are asked to receive this report.

BOARD OF DIRECTORS	
Agenda Item	5.3
Title of Report	Wirral University Nurse and Midwifery Staffing Review – Interim report.
Date of Meeting	27 September 2017
Author	Clare Pratt, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Julie Reid, Associate Director Nursing (ADN) for Medicine and Acute Division Naomi Holder, ADN for Surgical Division Debbie Edwards, Head of Midwifery/Lead Nurse for W & C
Accountable Executive	Denise Price, Interim Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Risk Reference 1,2 and 3
Level of Assurance **Positive** **Gap(s)**	This is the first establishment/staffing review undertaken across the in-patient areas. The review used a recognised mix of acuity/dependency tools and professional judgement, to determine the level of staffing in each area. **Positives** • In 8/21 wards the ADNs are able to provide assurance that the current funded establishment is set at a satisfactory level or that they have been able to mitigate against any variance in funded: actual establishment. • Divisions have deployed solutions to ensure improved continuity, safe patient care and to reduce reliance on an decreasing RN workforce **Gaps** • In 7/21 wards the ADNs have recommended a further review of staffing take place • In 5/21 wards, substantial reconfiguration of services have recently or are shortly to take place and will require a further review • Further work is required to understand the "over establishment" on some wards as indicated.
Purpose of the Paper **Discussion** **Approval** **To Note**	Approval
Reviewed by Executive Committee	None
Data Quality Rating	Silver – quantitative data that has not been externally validated

FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	N/A

1. Executive Summary

The NHS has pledged a commitment to ensuring that health care providers have a safe and effective Nursing Staffing establishment in place.

Guidance issued by Jane Cummings, Chief Nursing Officer for England, in conjunction with the National Quality Board "How to ensure the right people with the right skills, are in the right place at the right time", sets out clear expectations of commissioners and providers. Expectation 3 recommends Trusts use evidence-based tools to inform nursing, midwifery and care staffing capacity and capability. There is no single ratio or formula in place to provide a definitive answer regarding the number of staff required, the guidance advises using a combination of evidence based tools and professional judgement. Attempts to introduce a nationally agreed staffing formula have yet to be agreed in England.

Staffing reviews are normally undertaken annually at a minimum. During the spring 2017, Nurse and Midwifery Staffing reviews were commenced to be completed in 2 phases, the phasing reflecting the operational demands on senior nurses versus time to undertake the reviews. It is proposed that the Phase 2 staffing reviews and findings are presented to the Clinical Governance Group (CGG) and the Quality and Safety Committee during the late autumn and on an annual basis thereafter.

Phase 1 - This report gives an overview of the findings of the Inpatient Nurse Staffing review undertaken in April and May 2017, including Maternity (incorporating OPD), Neonatal, Paediatrics whom have specialist guidance and tools in place and have been included as a separate section within the detailed report.

Phase 2 – The remaining areas to include specialist areas such as Assessment Areas (ESAU, AMU, MSSW) Critical Care, OPD and the Emergency Department, will be reviewed and reported to the CGG at the end of Q3.

Key points of note:

- The staffing review outlines our current staffing models over and above the care hours for patient day, using evidence based tools and professional judgment;
- Comparing the care hours per patient day data and the reviews to date, we have assurance that our staffing levels are safe, acknowledging some areas are over establishment;
- These reviews are complimented, by the weekly informal staffing reviews undertaken by the Associate Directors Nursing (ADN) and Matrons, to ensure wards & areas are staffed safely;
- Areas with significant vacancies, such as Elderly Medicine have deployed solutions to ensure improved continuity, safe patient care and reduced reliance on agency staffing, continuity of care often a feature in patient complaints;
- Reviews should be undertaken annually at a minimum or as the function of areas change. Where concerns are raised through the reviews, these can be repeated quarterly;
- Reviews should be undertaken annually at a minimum or as the function of areas change. Where concerns are raised through the reviews, these can be repeated quarterly;

- Further work is required to understand the "over establishment" on some wards as indicated.

2. Background

The Board of Directors receives monthly data (provided in a bi-monthly report) in relation to the percentage of shifts on each ward where planned and actual staffing levels have been achieved. It also includes a review of Care Hours per Patient Day and compares this data with our National and Regional Peers. Whilst this report provides assurance that on a day to day basis the actual staffing reflects the planned staffing levels it does not provide assurance that the planned staffing levels (or establishment) are set at an appropriate level to meet the needs of our patients.

3. Methodology

3.1 Acuity and Dependency Tool

Since 2010, the Trust has used the Shelford Safe Staffing Acuity Tool to provide evidence based insight into staffing levels to help inform professional judgement. These acuity audits were undertaken by the Corporate Nursing Team and results presented at Board level. Since the introduction of evidence based nurse staffing tools, different variations of tools which reflect the complex variety of specialties, patient case mix, environmental ward layouts, an aging population and changes in medical and surgical interventions have been developed.

A review was undertaken across the impatient areas using the Acuity (SNCT Shelford) tool and a Dependency tool (Patient Dependency / Acuity Specialty Specific Tool TM) over a consecutive 21 day period during April/May 2017. The reviews were completed at the same time of day each day to allow for a full 24 hours review. Both tools are in the recommended list of evidence based nurse staffing tools. The Dependency tool also incorporates both specialism and/or ward layout factors within its calculations. Reviews were completed by the Ward Sister/Charge Nurse to help promote an understanding and ownership of the process. Matrons contributed by overseeing the collection and validation of results and the data was checked by the Corporate Nursing team to ensure data quality and reduce variations. A full resource pack was supplied with support from Corporate Nursing and each tool has a clear list of criteria guidance to support the auditor in allocating an acuity and dependency level.

Acuity is allocated into the following levels;

Level 0 Patient requires hospitalization, needs met by provision of normal ward care.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.
Level 2 May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit.
Level 3 Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Dependency is categorised into the following levels;

Level 1 independent
Level 2 between dependence and independence
Level 3 dependent
Level 4 highly dependent

The report reflects the agreed staffing establishment which is compared to the recommended staffing levels derived from the Acuity and Dependency reviews. With the completion of phase 2, it is anticipated that all the data will be triangulated with the Nurse Sensitive Indicators. Work to produce an IT solution that ensures these staffing reviews inform the developing integrated quality dashboard, is underway.

3.2 Professional Judgement

While evidenced based tools are used, the staffing reviews also require significant professional judgment both in terms of determining the acuity and dependency of individual patients and determining the essential external factors. The expert nursing assessment includes these local external factors such as patient cohort, ward environmental issues, flux in demand and seasonal variation, to determine how many staff of each grade are required per shift per day, reflecting patient need.

The Associate Directors Nursing (ADN) for each divisional area has reviewed the information, alongside Nurse; patient ratios and skill mix split to provide assurance that the staffing is safe or to recommend adjustments to individual ward staffing/further review.

3.3 Capable workforce

It is not only important to consider the capacity of the workforce when considering safe staffing but also to be mindful of the capability of the workforce. Time available for staff development and support, levels of staff experience and skill mix split all contribute to the overall efficiency of the team.

Ward leadership - In 2014 Ward Managers were afforded Supervisory status and as such are not included in funded establishment. As a result many corporate functions (eg recruitment and ESR) were transferred to their role. The impact of RN shortages has necessitated most ward managers relinquishing some of their supervisory status to work clinical shifts. A recent audit demonstrated that no Ward Managers have maintained supervisory status for 100% of shifts with the majority only achieving supervisory status between 20%-50% of the time. This has impacted on their ability to fulfill their leadership and quality assurance role, to release staff for training and appraisals and to access the CPD that they require. This issue is further compounded by the requirement for Matrons to become increasingly involved in managing operational patient flow on a daily basis. This will be reviewed as part of the work around divisional structures.

Staff Turnover – A review of the Registered Nurse (RN) turnover data from Sept 2016 - Aug 2017 demonstrates a shortfall in Leavers Turnover Rate (LTR) as displayed on the table below. The highest percentage of leavers falls in the Band 5 category (who makes up the majority of the Nursing workforce) with over 100WTE leaving the Trust in the last year. We have reported an increase in our vacancy rate from 6.97% in July to 8.01% in August.

	Headcount	FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Payscale								
Band 5	930.00	799.84	104	87.47	130	107.89	13.98	13.49
Band 6	436.50	379.41	18	12.68	24	20.96	5.50	5.52
Band 7	206.50	187.05	8	5.65	21	18.59	10.17	9.94

Work has commenced a deep dive exercise between HR and Corporate Nursing, to understand the reasons for nurses leaving the Trust, to include our retention strategies.

The organisation has a comprehensive preceptorship programme in place which is well evaluated by new starters and, unlike many other organisations; we see limited

attrition rates in this group. Once this preceptorship period is over however, there is limited support for band 5 staff as they progress throughout their career or move between wards.

A review of our in-house nursing development and clinical support is required alongside the role of the Clinical Skills Team, to ensure our nursing workforce is equipped with the right skills, feels supported in the workplace and looks for career development within the Trust, not external to it.

National shortfall of RNs – despite robust recruitment strategies being implemented within the Trust, the national shortage of RNs has led to difficulty in recruiting registrants and the Divisions have had to explore alternative workforce models to address this issue. In some areas a review of the Registered Nurse; Care Support Worker (CSW) has been undertaken and several wards now have a funded establishment that falls below the previously RCN recommended 65:35 split.

Further work is required to ensure that the Trust is using the broadest possible methods of recruitment to meet the current workforce requirements. Whilst several Workforce strategies have been put in place in the last 12 months to support RN vacancies (including Nursing Associate Pilot, apprentice pathways, hybrid CSW / Therapist apprentice and pharmacy technician presence to support safe medicines administration), many of these schemes are in their infancy and their impact requires further evaluation.

Following concerns being raised nationally regards the inappropriate use of the "Nursing" title, an immediate scan across the divisions provides assurance that the "Nursing" title is used only in registered roles, but a more thorough review will be undertaken as part of the new divisional structures.

4. Assurance and Key Issues/Gaps in Funded Establishment (Full breakdown given in Appendix 1)

4.1 Medicine and Acute and Surgical Divisions

Following the review of inpatient staffing the ADNs for the Medical and Acute and the Surgical Division have concluded that:-

- In 8/21 wards the ADNs are able to provide assurance that the current funded establishment is set at a satisfactory level or that they have been able to mitigate against any variance in funded: actual establishment.

- In 7/21 wards the ADNs have recommended a further review of staffing take place, given varying levels of over establishment. These reviews will be completed in conjunction with Ward Sisters, Matrons, Divisional Leads and Finance Department during the next 3 months.

- In 5/21 wards substantial re-configurment of services have recently or are shortly to take place. As such these areas will require a further review in 6 months to ensure that the newly established staffing establishment is correct.

- In 1/21 ward the information presented was incomplete and is being repeated.

4.2 Women's and Children's Division

The Lead Nurse for Women's and Children's Division has used several different sources of information – both local and national network guidance and her Professional Judgement, to review the staffing within the Division and has concluded that:

- In 4/4 areas the Lead Nurse is able to provide assurance that the current funded establishment is set at a satisfactory level or that they have been able to mitigate against any variance in funded: actual establishment.

New specialist guidance for pediatrics is due in October 2017 and will support a staffing review of the Children's ward following this release.

5. Conclusion

The results of this review are intended to provide assurance to the Board that there is a robust and comprehensive process in place to review and adjust Nurse/Midwifery staffing levels to ensure safe staffing is in place. Further work is required as part of the Integrated Quality Dashboard development, to ensure staffing data is reported alongside quality & safety measures.

Additional focus needs to be placed on ensuring that staff feel supported and developed and that targeted retention strategies are effective for key staff groups, between Bands 5-7.

Whilst it can be demonstrated that appropriate Nursing Establishments are in place in several areas it is acknowledged that the review will need to be repeated in some areas as limited assurance can be given that the Nursing Workforce is being used as effectively as it could be.

Where wards appear to be over established for example 20 and OPAU staff will be moved from these areas to support safe staffing in under established areas or where we currently rely on temporary staffing. These moves will be subject to ongoing review by the ADNs to ensure that Workforce or Nurse Sensitive indicators are not negatively impacted.

The Methodology recommends that no large scale staffing changes should be made as a result of a single review and for that reason it is proposed that this comprehensive review is completed on an annual basis. When wards are reconfigured a full staffing review should be completed at that time to ensure that safe staffing is in place to meet changing needs.

The Trust is committed to ensuring that it has the correct nursing and midwifery workforce in place and over the past 18 months has implemented a number of initiatives to ensure safe staffing meets increasing challenges and demands. The effectiveness of implementing revised workforce models will be evaluated over the coming year.

6. Recommendations

The Board are asked to note this report and the on-going work to complete all staffing reviews across in-patient areas.

Orthopaedics	Staffing Review Outcome
Ward 10	The Current Establishment requires further review aligned to re-configurement of bed base.
Ward 11	The Current Establishment requires further review aligned to re-configurement of bed base.
Ward 12	The Current Establishment requires further review aligned to re-configurement of bed base.

Surgical	Staffing Review Outcome
Ward 17	Current Establishment Correct
Ward 18	Current Establishment Correct
Ward 20	The Current Establishment requires future review
M2 Surgical	Ward Reconfiguration : Review required in 6 months

DME / Rehab	Staffing Review Outcome
Ward 21	Establishment requires further review as data collection was not completed for this
Ward 22	Current Establishment Correct
Ward 23	Further review of the Establishment will be required as requested by the CSL.
Ward 27 (Ward 24)	The Current Establishment requires future review
M1 Rehab / M1MO (Previously M2 Rehab)	Ward Reconfiguration : Review required in 6 months
CRC	Current Establishment Correct
OPAU	The Current Establishment requires future review

Medicine	Staffing Review Outcome
Ward 26	Current Establishment Correct
Ward 30	Current Establishment Correct
Ward 32	The Current Establishment requires future review
CCU	

Ward 33	Ward Reconfiguration : Review required in 6 months
Ward 36	Current Establishment Correct
LAU (Previously Ward 37)	Ward Reconfiguration : Review required in 6 months
Ward 38	Ward Reconfiguration : Review required in 6 months
Ward 25	The Current Establishment requires future review
Ward 24 (IPC)	The Current Establishment requires future review

Women's & Children's	Staffing Review Outcome
Children's	New Paediatric tool available in October 2017: Current Establishment correct
Maternity	Current Establishment Correct
Delivery Suite	Current Establishment Correct
Ward 54	Current Establishment Correct

Board of Directors	
Agenda Item	5.4
Title of Report	Report of the Quality & Safety Committee – 13 September 2017
Date of Meeting	27 September 2017
Author	Cathy Maddaford, Chair of the Quality and Safety Committee
Accountable Executive	Denise Price Interim Director of Nursing and Midwifery Dr Susan Gilby, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1, 2, 4, 5, 7 1a, 1b, 2a, 2b, 2c, 4a, 5a, 5b, 5c, 7a, 7b, 7c, 7d 1, 2, 3, 16, 17, 19
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
Review by Assurance Committee	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 13 September 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The key changes to the BAF made during the reporting period are outlined below:

- **Risk 4 (Improving Clinical Outcomes)** – the risk descriptor had been revised entirely to redirect focus to the consistent delivery of evidence based practice 7 days per week. As a consequence, the risk score has been reduced to reflect current performance.
- **Risk 12 (C.diff)** – the risk score had been increased to reflect the recent upward trend of avoidable cases of C.diff. although still on trajectory. The Committee received a specific report

on infection control as requested at a previous meeting. The report highlighted issues with basic hand hygiene compliance; decision making processes and compliance with the HPV programme. Mitigating actions had been put in place and the Trust had liaised with the Central Manchester IPC team to review and advise on policy as well as providing assistance in this area.

- **Risk 19 (Clinical Engagement)** - the risk score has reduced as over the last few months as there has been a sustained improvement in developing effective controls to support Medical Engagement alongside the development of a more robust assurance process.

The Committee reviewed the emerging risks as outlined in the Senior Management Team meetings of 4 and 25 August 2017, the content of the BAF has been updated as follows:

- **Risk 1 (Quality and Safety)** – the risk narrative has been updated to reflect that clinical handover remains a risk, as identified by the CQC, following serious incident review and audit of electronic handover which indicated non-compliance. Further work is to take place to streamline the e-handover process and regular audits are to be conducted to monitor compliance and identify non-compliance trends which require further action.
- **Risk 2 (Patient Experience)** – the risk template has been updated to reflect the issues raised in respect of responding to complaints outside of acceptable timescales (this includes the number of complaints which have exceeded the internal response standard). The Trust is to identify resource to progress overdue complaints
- **Risk 3 (Staff Engagement)** – the risk template has been updated to reflect the high nursing vacancy rate with particular reference to the challenges experienced in the Medicine and Acute Division and the action being taken to address this..

The Committee was pleased with the work that had been undertaken on the BAF to reduce the overall size of the document without losing the key emphasis on assurance & emerging risks. The Committee noted that further work was planned on the risk descriptors and in particular those associated with strategy. The Committee reviewed the one new risk raised by the Senior Management Team for quality and safety as outlined below:

Risk 3099 (risk score 15) related to the ongoing necessity to fund additional therapy resource, following funding discontinuation from 31 March 2017, for escalation area Ward 33 which has remained open longer than initially planned. The Committee was pleased that the Physiotherapy posts were recruited to on Monday 4 September and that the Occupational Therapy posts were being interviewed on Tuesday 13 September, and the Division was confident they would recruit to the posts.

Director of Nursing and Midwifery Performance Report

The Committee noted sustained performance in the safety thermometer metrics compared to other Hospital Trusts; the recommend rates for Inpatients and Maternity services which were above the national average and the reduction in hospital acquired Grade 2 ulcer prevalence.

The Committee was disappointed to note the rise in falls that had led to serious harm in Q1, this being 5, particularly as these were a result of falls from beds and trolleys which was unusual. Urgent action and learning had been put in place to address this. The Friends and Family Test figures for the Emergency Department although consistent for the year 2017/18 were well below previous years and likely to be as a result of the unprecedented demand on this service. The Committee reviewed the work being undertaken to improve compliance with nutrition MUST assessments.

The work being undertaken to improve medicines management was reviewed and in particular the pilot project undertaken in Q1 on missed doses which showed significant improvement in 3 of the 4 pilot wards.

The Committee agreed to receive performance updates in this area as part of the integrated quality dashboard in the future as this afforded them a greater degree of triangulation.

Workforce & OD Dashboard

The Committee reviewed the Workforce & OD Dashboard which highlighted the following key points:

- A sickness rate of 4.48% for year to date, which was just above the Trust target of 4% for the first time in 5 months. Work is progressing with senior managers in the areas where there are the highest sickness levels.
- Nursing and Midwifery workforce vacancy rates were reported as 6.97% which remains low compared to other organisations however a particular concern is the division of Medicine & Acute where the vacancy rate for Band 5 in inpatient areas is nearing 11%. In response a Nurse Recruitment Plan has been developed and work continues to support Nursing managers in the successful recruitment of staff.
- The appraisal compliance rate for July 2017 had decreased to 83.78%, which remained below the Trust target of 88%
- Mandatory training compliance was reported at 91.59% (Block A) and 88.11% (Block B) for July 2017 which was below the Trust targets of 95%.

The HR indicators triangulated with the staff engagement results which showed a dip in the pulse check from 3.78 to 3.76 and was of concern. The Committee sought to understand whether the interventions to improve these were the right interventions and was advised that these were also being reviewed as part of the action plan.

The Committee again agreed to receive further updates as part of the integrated quality dashboard.

Alcohol Related Liver Disease ARLD

The Community received a presentation from Change Grow Live, the leading charity providing free treatment and support in this area together with support from Public Health.

Following the presentation the Medical Director and Interim Director of Nursing and Midwifery agreed to meet with the organisation to consider how they were working on prevention rather than just intervention and in particular working with families.

Quality Governance Improvement Roadmap

The Committee reviewed the work undertaken to date following the quality governance review. Five key programmes of work were reviewed, these being:

- Integrating systems and quality governance assurance
- Sustainability and developing capability
- Patient safety
- Quality improvement and surveillance
- Engaging stakeholders

The Committee noted and was pleased that the area most advanced was patient safety with the introduction of weekly safety summits and safety bites and the establishment of the new serious incident review process. Work was also underway on the new integrated quality governance structure to support this work, as was the work to refresh the electronic risk system – Safeguard. The Committee sought and received assurance that the work to engage with stakeholders was moving from an information given forum to true engagement with the development of engagement panels.

Ophthalmology Service Review Update

Following the review by the Royal Collage of Ophthalmologists on 27 and 28 April, the Trust was presented with a series of actions that the reviewers felt would improve the service. As a result of this the Division had developed an action plan which still required work to ensure the Trust was focusing on the key areas to improve the key findings of compliance with policy; standard operating procedures; patient identification; team working; relationships and culture. The action plan focused

heavily on issues with the estate and the impact on patient experience which needed to be prioritised. The Committee was pleased that the Trust had engaged external support to work with the team on developing the appropriate culture.

Never Events Reporting and feedback

The Committee reviewed the never events for 2016/17; the action taken and the learning as a result of these. The Committee also noted the introduction of the safety summits provided the forum for real time learning in the organisation. The Committee was advised of a Never Event which had recently been reported. A patient undergoing a laparotomy had been found to have a retained drain. Further enquiries had confirmed that the drain was left in situ during an LSCS in 2013. The consultant no longer works at the Trust. The Trust has begun its root cause analysis.

Integrated quality dashboard

The Committee welcomed the new integrated quality dashboard, many aspects of which had been discussed as part of the original agenda. Key concerns not already discussed were compliance with the VTE assessments. The Committee was updated on the actions being taken to address this which were being monitored through the newly established. The Committee supported the inclusion of many of the workforce and nursing metrics in the future to aid with decision making.

Health and Safety Report

The Committee noted the outcome of the HSE scheduled inspection of the radiology services on the 30 June 2017. Two verbal recommendations were made relating to quality assurance processes for the mobile C arm and updating the local rules to clarify the process should an unauthorized person access a room whilst x-ray equipment is in use. The Committee was pleased that the HSE had commented on the good quality of risk assessment and that no material breaches of legislation were found.

The number of staff clinical incidents reported during the quarter had increased with a good proportion associated with staff moves although the Trust had reviewed each one and concluded that there was no risk to patients. The Committee noted the decrease in sharps clinical incidents compared to the same quarter last year although raised concerns with the increase in the number of slips, trips and falls. The Committee noted however that there were no incidents related to defects to our external walkways due to preventative action being taken.

The Committee agreed to include key compliance indicators in the integrated quality dashboard in the future although it acknowledged that the Board still would receive the annual report as part of its statutory duties.

Mortality Review Process

The Committee reviewed the draft policy in response to the “National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care” which was published in March 2017. The Committee recommended the policy for approval by the Board in September and acknowledged that as from quarter 3 the Clinical Governance Group and the Board would receive and monitor the mortality dashboard.

CQC Compliance and Assurance Report

The Committee reviewed the outcomes of the 5 areas inspected and reported upon during this period. Three areas were rated as good and two as requires improvement. Ward 22 which was rated as requires improvement had previously been rated as inadequate. Again the Committee will use the integrated quality dashboard in the future to monitor compliance with the five domains in the CQC assessment framework.

Emergency Plans

The Committee reviewed and approved the following plans in line with the annual review process in line with NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework:

Pandemic Influenza Plan
Severe Weather Plan
Evacuation Plan

The Board is asked to note this work.

Legal Services Annual Report

The Committee was pleased to note the reduction in the values of clinical and non-clinical claims during the last year which was the third successive year that this had happened. The Committee was made aware of a high value maternity claim however that would impact on claim values in 2017/18.

The Committee was pleased that the learning from inquests and in particular where there was neglect contributed or a regulation 28 preventing future deaths notice issued would now form part of the learning outlined in the safety summit structure. The Committee was alerted to the fact that only 36% of new clinical claims had been reported internally before the claim arose which was the focus of attention for the Trust noting that early identification and investigation helps the Trust to settle a claim where appropriate quickly or defend a claim more robustly.

The Committee was advised that the annual report and quarterly divisional reports would be reviewed to ensure that this enacts the appropriate learning.

Accountable Officer Controlled Drugs Annual Report

The Committee reviewed the Accountable Officer Controlled Drugs Annual Report and noted the extent of the work undertaken during the year. Key issues highlighted were associated with implementation of Trust procedure relating to the management of CDs at a ward level. The Trust supported the recommendations in the report to improve compliance in the coming year.

Assurance Reporting

The Committee received Chair's reports from the following Working Executive Committees:

- Clinical Governance Group- the Group raised the risk of VTE assessment as part of it's report.
- Patient and Family Experience Group,
- Workforce and Communication Group.

Issues for escalation to the Board of Directors

The Committee agreed to escalate to the Board the slight deterioration in the staff engagement score; compliance with all aspects of VTE assessments; infection prevention and control and the increase in falls resulting in serious harm. The Committee's review of the integrated quality dashboard at its next meeting will focus on these items in particular and the work that has been undertaken in the reporting period to mitigate these risks.

Cathy Maddaford
Chair of Quality and Safety Committee

Board	
Agenda Item	5.5
Title of Report	Mortality Review Process
Date of Meeting	27 September 2017
Author	Dr M E Lipton, Deputy Medical Director
Accountable Executive	Dr Susan Gilby, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk 4
Level of Assurance • **Positive** • **Gap(s)**	• The Mortality Review Policy presented to Hospital Board in September 2017 • The mortality dashboard of avoidable deaths will be ready for Q3 presented in January 2018 • Structured Judgmental Review training will start in November 2017 • Primary mortality review is 39% since April 2017, however the % level is not mandated by the National Quality Board's documentation, the aim is eventually to review all deaths.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **No**	N/A

1. Executive Summary

In 2016, the CQC published '*Learning, candour and accountability – a review of the way NHS trusts review and investigate the deaths of patients in England*', It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

In March 2017, the National Quality Board, NQB, published *'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care'*; this report is in response to the CQC document and describes the process all hospitals should now follow.

2. Background

The Trust is on course to meet the requirements of the NQB to have the designated mortality policy running to produce an avoidable deaths dashboard in Q3 for Jan 2018.

- The Mortality Review Policy is being presented to the Board in September 2017
- The mortality dashboard of avoidable deaths will be ready for Q3 presented in January 2018
- Structured Judgmental Review training will start in November 2017

3. Key Issues/Gaps in Assurance

Primary mortality review is 39% since April 2017, however the % level is not mandated by the National Quality Board's documentation, although the Trusts aim is eventually to review all deaths.

4 Recommendations:

To note the report and approve the Mortality Review Policy

5 Appendices:

A: Mortality Review Policy – Appendix 1

MORTALITY REVIEW POLICY

Version: 1.2

Name and Designation of Policy Author(s)	Dr Mark Lipton, Deputy Medical Director
Ratified By (Committee / Group)	Clinical Governance Group
Date Ratified	
Date Published	
Review Date	
Target Audience	All staff involved in the screening or review of inpatient deaths
Other Associated Strategies, Policies, Procedures, etc	041 - Risk Management Strategy & Policy 041a - Incident Reporting & Management Policy & Procedure 057 - Safeguarding Children Policy & Procedure

CONTENTS

Content **Page**

1 Introduction

In 2016, the CQC published '*Learning, candour and accountability – a review of the way NHS trusts review and investigate the deaths of patients in England*', It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

In March 2017, the National Quality Board published *'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care'*; this report is in response to the CQC document and describes the process all hospitals should now follow.

Within Wirral University Teaching Hospital, (WUTH), we have reduced our mortality to significantly below average since 2014/15. Hospital Standardised Mortality Ratio, (HSMR), is below 100 indicating a level of mortality less than would be expected with our population adjusted for demographics, deprivation and co-morbidities. Summary Hospital-level Mortality Indicator, (SHMI), which lags behind HSMR is also routinely below 100. This success has been due to a mortality review process in place for many years with programs including Advancing Quality, Improving care of the deteriorating patient (implementing the Modified Early Warning Score policy), Improving end of life care and clinical handover/reducing delayed care and Listening into action.

2 Purpose

This policy replaces the Mortality Review Framework and meets the requirements of National Quality Board. The policy also sets out additional responses the Trust has under taken.

The policy will ensure the Trust learns from the deaths of patients where there are problems in care delivered at the Trust. The process will be managed using robust, governance processes.

The aim is eventually for every death within the hospital will be subjected to a primary review, this may then be followed by a more detailed local review using an evidence-based national audit tool recommended by the National Quality Board.

The actions taken will improve the learning from deaths and the care given to our patients. This should reduce avoidable deaths, ensuring the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) stay within acceptable limits.

At the time the relatives receive the death certificate, within the bereavement pack, we will enquire whether the relatives were happy with the standard of care received by the deceased. We will take the necessary steps, in consultation with the relatives, to answer any concerns and improve the care we provide.

Also the junior doctors completing the death certificate will be asked to notify of any concerns they have with the care given to the deceased which will result in appropriate action.

3 Scope

This framework applies to any staff involved in reviewing mortality within the Trust.

The policy does not replace the requirements for full investigation of unexpected deaths or deaths following harm to patients in our care as described in the Incident Reporting Policy (041a).

4 Review Process

The evidence-based national audit tool which will be utilised to review the majority of deaths is the "Structured Judgemental Review" as developed by the Royal College of Physicians, mortality review programme: https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

1. The following groups will be subject of a structured judgement review (SJR):

    a. deaths where the bereaved or staff raise significant concerns about the care
    b. deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate , concerns from audit , CQC concerns, outlier alerts)
    c. deaths where the patient was not expected to die-for example, in elective procedures
    d. deaths where the patient has severe mental health needs, this will be done in conjunction with Cheshire and Wirral Partnership
    e. deaths where learning will inform the provider's quality improvement work
    f. deaths where the doctor completing the death certificate believes a review should occur
    g. a sample of deaths within 30 days of discharge, including those expected to die
    h. deaths of any patient from Wales (in line with contractual obligations)
    i. within Women's services not undergoing external/ peer review
    j. within Paediatric services not undergoing external /peer review

2. All deaths of patients with learning disability will be reviewed by the Learning Disabilities Mortality Review, (LeDeR), methodology

3 All Infant and child (under 18) deaths will be reviewed in accordance with Working Together to Safeguard Children

4 All perinatal and maternal deaths will be reviewed by the perinatal mortality review tool once available. The deaths are also reviewed by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, (MBRRACE-UK).These deaths may meet the definition of a Serious Incident and will be investigated accordingly.

5 SJRs will be undertaken by staff who have been trained (national training program will begin in 2017)

6 SJRs will be completed by clinicians independent of the case; however, if specialist knowledge is required and the treating clinician is the only source of expertise they can be part of the reviewing team.

7 Any death thought categorised as “very poor care” must be reported as a serious incident in line with the Trust’s incident reporting policy (Policy 041a).

8 Findings from this process will be shared across the hospital through governance mechanisms, such as speciality meetings using a monthly bulletin and special alerts where necessary.

9 Where a specific theme is identified an action plan will be developed at the appropriate organisational level – speciality, divisional or corporate; agreed with the Mortality Review Steering Group.

10 In addition, a bimonthly report to the Clinical Governance Group, documenting the HSMR and SHMI (when available), any diagnoses or procedures with raised relative risks or CUSUM triggers as determined by the latest Dr Foster™ data available. And crude death trends will also be provided. Triggers identified will be managed in line with the Mortality Outliers and Alert Standard Operating Process (SOP) (Appendix 1).

11 From Q3 2017 onwards, the Trust will publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings utilising learning from deaths dashboard (Appendix 2).

12 Summary information will be published in the Quality Account from June 2018 onwards.

13 The primary review process will be organised corporately. The review will be undertaken by a senior doctor and/or nurse who is independent of the patient’s care during their final admission. The primary review will be completed within 2-6 weeks of death.

14 An agreed audit form will be used to provide consistency (Appendix 3).

15 Eventually all inpatient deaths will have a primary review unless:
   a. they are subject to external or internal enquiry
   b. they are identified as requiring a SJR as designated above
   c. the patient refused access to their information prior to their death outside of direct patient care

16 Any death where there is concern will be referred for a structured judgement review. However, if the care given is considered very poor, it will be reported in line with the incident policy and investigated through the risk management process to avoid further delay.

5 Definitions

Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality. This helps compare an NHS Trust’s actual number of deaths to its expected or predicted number of deaths. HSMR is a statistical number that enables the comparison of mortality

rates between hospitals. This prediction takes account of factors such as the age and sex of patients, their primary diagnosis and complicating factors. Standardisation of mortality rates allows comparison between different hospitals, serving different communities.

If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below reduced expected mortality. However the standard deviation must be noted to obtain significance for higher or lower mortality.

SHMI

The 'Summary Hospital-level Mortality Indicator (SHMI)' is another mortality measure. SHMI looks at factors such as the patient's age, method of admission and underlying medical conditions. The SHMI is a ratio of the observed deaths over a period of time divided by the expected number given the characteristics of patients treated by that Trust.

The data used to calculate the SHMI includes all deaths in hospital, and occurring within 30 days after discharge from hospital. The SHMI only attributes a death to the hospital which last treated the patient prior to death.

6 Duties / Responsibilities

6.1 Medical Director

The Medical Director has overall responsibility for providing assurance to the Board that this policy is being delivered and lessons learnt from any suboptimal practices identified and actions are taken to improve care defects identified. Such actions will be reviewed and monitored by the Mortality Review Steering Group

6.2 Mortality Review Lead Clinician (Deputy Medical Director)

The post holder is responsible for ensuring this process works at an operational level. They will manage the screening process, ensure reports are provided in a timely way and lessons learnt are disseminated across the Trust. They are responsible for updating this policy and process. They will chair the Mortality Review Steering Group.

6.3 Clinical Reviewers

Clinical reviewers will undertake the primary review and if trained SJR reviews. Those completing SJR reviews, will be expert by experience and training (once available). The SJRs will be reviewed by the Mortality Review Steering Group.

6.4 Mortality Review Steering Group

Members will be defined in the Terms of Reference. They are responsible for ensuring the review process works at a local level including the dissemination of findings. They will review the SJRs and identify, review and monitor what actions are needed and ensure they are taken within Divisions/Departments in line with any improvements identified.

7 References

Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239.

Keogh B: Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. July 2013 NHSE

Mortality Governance Guide; Dec 2015 NHSE

Whittington J, Simmonds T, Jacobsen D. *Reducing Hospital Mortality Rates (Part 2).* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2005. (Available on www.IHI.org)

Appendix 1 – Mortality Outliers and Alert Standard Operating Process (SOP)

This Standard Operating Procedure (SOP) describes the actions that will be taken when there is a raised mortality alert. The alert may be through internal monitoring or from an external source, such as CQC.

Background:

The most recent UK studies estimate avoidable mortality to be between 3-8% (average 5.6%) with a further 11% where suboptimal care may have contributed to death. (Hogan H, Black N et al. Preventable Incidents Survival and Mortality studies PRISM 1 and 2, 2012).

When an alert occurs the Trust needs to be assured patients within the alerted Healthcare Resource Group, (HRG), diagnosis or procedure are receiving safe, effective care and that every effort is being made to reduce avoidable mortality.

From month to month, the HSMR varies and the conditional Relative Risks associated with it. When these are above expected this will present in Dr Foster as a red box meaning "significantly worse than the benchmark" and or have a red bell where the CUSUM trigger has been alerted. CUSUM is a cumulative mortality measure over time. To stop the CUSUM triggering month on month once alerted, the measure is halved. If there is a further trigger within a year, CQC will be alerted and issue an outlier alert.

Therefore there are opportunities to investigate these triggers in advance of any external scrutiny.

For some diagnoses and procedure all deaths will have been audited as part of the established review process and therefore Divisions should be able to provide assurance rapidly. However, where there is a sampling method in place (Medicine and DME), a selective audit may be required.

Standard work to respond to HSMR outlier report

1. The Clinical Lead will ensure there is a bimonthly mortality report produced for Clinical Governance Group (CGG). This will include the cumulative position for the year and highlight any changes in "red boxes" or CUSUM alerts since the previous report by condition or procedure, with some preliminary analysis for discussion.

2. CGG identifies what additional assurance is required; in most cases this will be associated with one CUSUM trigger.

3. If assurance is already available, a report will be generated by the Division for review by CGG the following month with the action plan. The agreed action plan will be monitored by Mortality Review Steering Group, escalating as required.

4. For internal reviews, where additional information is required the Divisional Mortality Lead will ensure this is undertaken within the following six weeks using the structure judgement review (SJR) tool. It must include deaths from within the assessment period. Review sample size will vary but are likely to be all cases available from the assessment period or a minimum of 30 cases. The investigational report will outline any specific actions required within two months of notification, for review at CGG.

5. For external reviews, where the investigation is in response to a CQC alert the timescales will need to reflect the requirements of the notice; the response will be undertaken by the relevant Division, using the SJR tool and coordinated by the Mortality Review Lead Clinician. The Medical Director will endorse the final report if timescales prohibit discussion at CGG. The agreed action plan will be monitored by Mortality Review Steering Group, with a briefing to CGG quarterly.

6. Any risk to patient safety identified must be escalated in line with Trust escalation policy.

Appendix 2 - LEARNING FROM DEATHS DASHBOARD

nqb-learning-from-deaths-dashboard (2).x

Appendix 3 – Primary Mortality Review Audit Form

primary mortality review audit form.doc

Consultation, Communication and Implementation

Consultation Required	
Other Stakeholders / Groups Consulted as Part of Development	Mortality Review Steering Group, Clinical Governance Group. Trust wide consultation Quality and Safety Committee Patient Experience (via the Head of Patient Experience) Trust Governors (via the Membership Manager)

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
Divisional awareness raising DMDs to discuss within job planning	Members of MRSG DMDs

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
	1	Dr Mark Lipton, Deputy Medical Director	New Policy to replace Mortality Review Framework

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Trust Board quarterly reports as open agenda item	4 pa	Trust Board agenda	MRSG	Quarterly	Divisional Leads
Dr Foster analysis reports to CCG	5 pa	CCG agenda	MRSG	Bimonthly	Associate Medical Director
Outlier investigations managed in line with SOP	Ad hoc	Report to CCG	MRSG	Ad hoc	Associate Medical Director
Annual audit report on policy report	1pa from June 2018	Report to CCG	MRSG		

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Mortality Review Clinical Lead	Clinical Governance Group	Annual

Board of Directors	
Agenda Item	6.1
Title of Report	Integrated Performance Dashboard
Date of Meeting	27th September 2017
Author	Anthony Middleton, Director of Ops / Deputy COO John Halliday, Assistant Director of Information
Accountable Executive	Janelle Holmes Chief Operating Officer
FOI status	Document may be disclosed in full
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 All Strategic Objectives (1 through 7) All Key Measures (1A through 7D) All Principal Risks
Level of Assurance • **Positive** • **Gap(s)**	 Partial with gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	 Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	 No

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of August 2017.

2. Summary of Performance Issues

The key national priorities are A&E and 62 Cancer performance, although other key targets by exception are covered in this narrative.

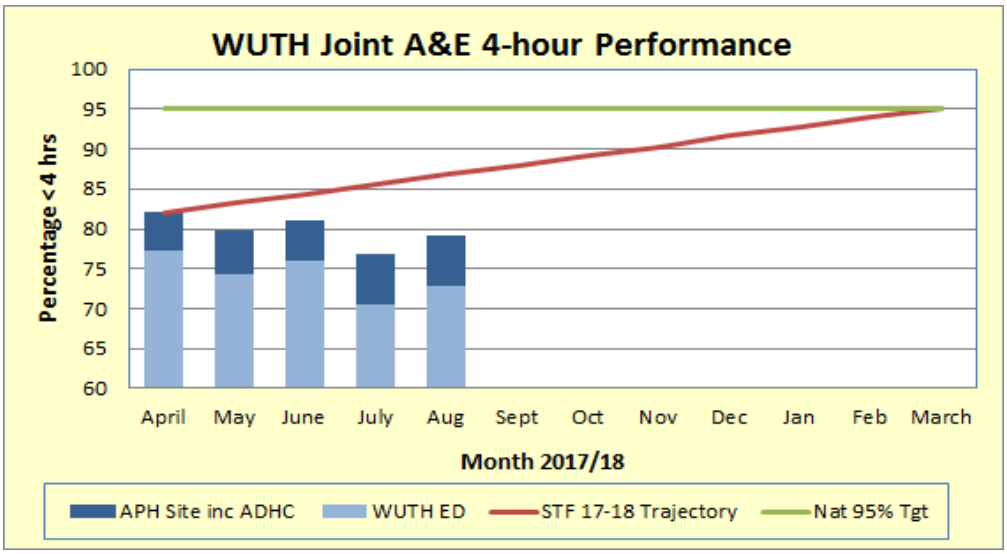
3. Detailed Explanation of Performance and Actions

a. A&E 4 Hour Target

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of August was 79.26% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 72.88%.

This is a slight improvement from July but below the trajectory the health economy has agreed with regulators on the path to deliver 95% by March 2018 and fares poorly in comparison with surrounding Trusts and nationally. Planned system wide improvements are beginning to show a tangible benefit and a marked improvement is now being seen during September.

The Trust has been working with other economy partners and has submitted its winter plan to regulators to demonstrate how performance will be maintained throughout this period of higher demand, and what contingent measures would be taken should demand outstrip expectations.

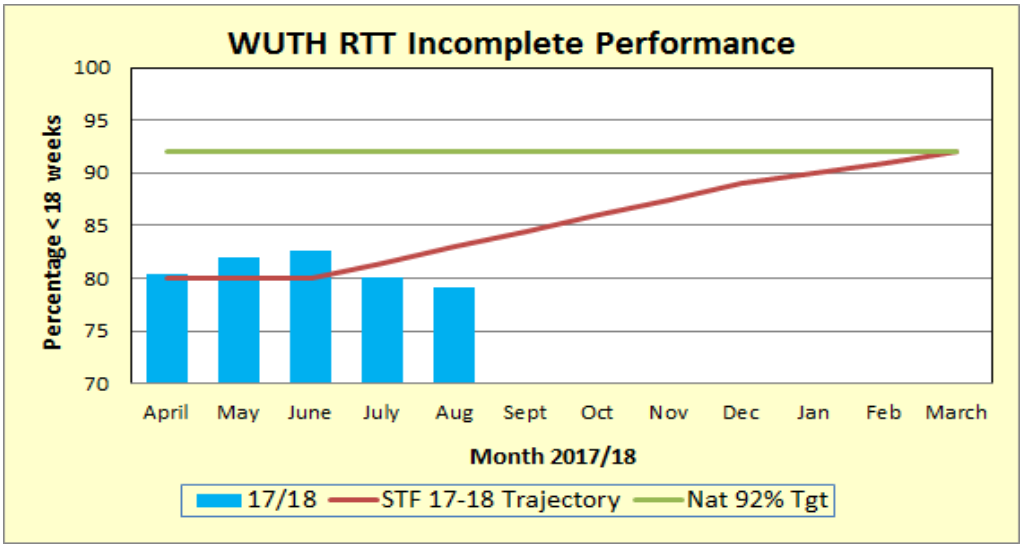


18 Weeks Referral To Treatment (RTT)

The focus of RTT is solely on the Incomplete standard, with the threshold set at a minimum 92% of patients waiting to be at 18 weeks or less. The Trust is judged externally by the total waiting across all specialties, though financial penalties are calculated under the contract for individual specialties that do not achieve.

The position for the end of August was 79.07%. This is below the national standard of a minimum 92%, and a slight deterioration on the previous month's position. The primary reasons are the completion of the data cleansing exercise and slippage on the use of the independent sector to assist with reducing the backlog.

The use of IS has now commenced as well as internal working which is showing an upturn in performance during September.



b. Diagnostic Six Weeks Wait

Although a supportive measure for RTT, the standard that patients should wait less than six weeks for a diagnostic test is a key performance metric in its own right. Waiting times against a subset of 15 diagnostic investigations are measured at the end of every month.

The Trust has experienced high degrees of demand for some diagnostic procedures and has developed capacity solutions to match, but this has seen the target missed by a small margin for the past two months, with August's position at 98.72%. It is expected that this will be rectified during September.

c. Cancer

The management of individual patient pathways and validation of waiting times is continuing, and as a result the Trust is maintaining a strong record of delivery against all cancer standards in aggregate. Where individual tumour pathways are experiencing high demand management teams are taking actions to address. All standards are expected to be met for Q2.

The 62-day standard continues to be the most difficult to achieve, and this is reflected in performance at a national level. This particular standard also has an explicit line in STF trajectories, with the expectation the 85% standard will be achieved each month. Cancer waiting time performance is only finalised many weeks after month-end due to the time required to confirm diagnosis and share patient pathways between providers.

d. Infection Control

The Trust has a trajectory of a maximum 29 toxin-positive avoidable cases for 2017/18. There were 6 avoidable hospital acquired cases in August, which brings the cumulative total to 14 and so 5 cases above the trajectory at this point in the year.

The Hospital Infection Control Team are reviewing the post infections to identify the issues, however there is an early indication that there is a need to reinforce the application of basic hygiene standards as well as continuing our HPV programme.

4. Recommendation

The Board of Directors are asked to:

Note the Trust's current performance to the end of August 2017.

WUTH Integrated Performance Dashboard - Report on August for Sept 2017 BoD

Area	Indicator / BAF	June	July	Aug	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	99%	99%	97%		*>=95%*	Aug 2017	GW
	Patient - F&F "Not Recommend" Rate	0%	0%	0%		*<=2%*	Aug 2017	GW
	Staff Satisfaction (engagement)	3.78	3.78	3.78		*>=3.69*	Q4 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	82.5%	82.8%	83.2%		*>= 85%*	March to May 2017	AM
	Demand Referral Rates	-28.5%	-25.2%	-19.1%		*>= 3% YoY variance*	Fin Yr-on-Yr to Aug 2017	AM
	Market Share Non-Wirral	6.0%	6.7%	6.3%		*>=8%*	March to May 2017	AM
	Strategic Objectives							
	Harm Free Care	97%	97%	97%		*>= 95%*	Aug 2017	GW
	HIMMs Level	5	5	5		*5*	Aug 2017	PC
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	81.14%	76.94%	79.26%		*>=95%*	Aug 2017	AM
	RTT 18 Weeks Incomplete Position	82.67%	80.15%	79.07%		*>=92%*	Aug 2017	AM
	Diagnostics 6 Week Standard	99.25%	98.76%	98.72%		*>=99%*	Aug 2017	AM
	Cancer Waiting Time Standards	Concern 1 standard	On track for the quarter	On track for the quarter		*All met at Trust level*	Q2 to Aug 2017	AM
	Infection Control (c Diff cumulative YTD)	0 MRSA; 7 C diff	0 MRSA; 8 C diff	0 MRSA; 14 C diff		*0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory*	Aug 2017	GW
	Productivity							
	Delayed Transfers of Care - % of beddays	6.43%	3.26%	4.74%		*< 3.5% of occupied beddays*	Aug 2017	AM
	Medically Optimised Inpatients	206	183	231		*New metric - tbc*	Aug 2017	AM
	Bed Occupancy	90.5%	91.7%	90.2%		*<=85%*	Aug 2017	AM
	Bed Occupancy Medicine	94.9%	96.0%	94.7%		*<=85%*	Aug 2017	AM
	Theatre Utilisation	88.6%	86.0%	89.0%		*>=85%*	Aug 2017	AM
	Outpatient DNA Rate	8.3%	8.2%	8.1%		*<=6.5%*	Aug 2017	AM
	Outpatient Utilisation	79.9%	79.5%	78.3%		*>90%*	Aug 2017	AM
	Length of Stay - Non Elective Medicine	5.5	5.4	6.2		*<= 5.0*	Aug 2017	AM
	Length of Stay - Non-elective Trust	5.2	4.7	5.7		*<=4.2*	Aug 2017	AM
	Contract Performance (activity)	2.7%	1.6%	0.7%		*0% or greater*	Aug 2017	AM
	Finance							
	Contract Performance (finance)	-1.6%	-2.2%	-3.3%		*On Plan or Above YTD*	Aug 2017	DJ
	Expenditure Performance	0.4%	-0.4%	-1.4%		*On Plan or Below YTD*	Aug 2017	DJ
	CIP Performance	-48.1%	-54.0%	-40.2%		*On Plan or Above*	Aug 2017	DJ
	Capital Programme	25.3%	37.0%	29.9%		*On Plan*	Aug 2017	DJ
	Non-Core Spend	9.7%	10.0%	10.3%		*<5%*	Aug 2017	DJ
	Cash Position	55.0%	224.0%	56.0%		*On plan or above YTD*	Aug 2017	DJ
	Cash - liquidity days	-17.2	-13.8	-17.4		*> 0 days*	Aug 2017	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	1	0	0		*0 per month*	Aug 2017	SG
	Complaints	30	28	27		*<30 per month*	Aug 2017	GW
	Workforce							
	Attendance	95.59%	95.52%	95.48%		*>= 96%*	Aug 2017	JM
	Qualified Nurse Vacancies	6.46%	6.97%	8.01%		*<=6.5%*	Aug 2017	GW
	Mandatory Training	91.41%	91.59%	92.23%		*>= 95%*	Aug 2017	JM
	Appraisal	82.01%	83.78%	83.83%		*>= 85%*	Aug 2017	JM
	Turnover	10.88%	10.65%	10.65%		*<10%*	Aug 2017	JM
	Agency Spend	24.7%	17.4%	12.3%		*On plan*	Aug 2017	GW
	Agency Cap	186	185	159		*0*	Aug 2017	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	2	2		*All areas above target*	Aug 2017	SG
	Mortality: HSMR	89.5	92.9	91.8		*Lower CI < 0.90*	June 2016 to May 2017	SG
	Mortality: SHMI	0.97	0.97	0.97		*Lower CI < 90*	Jan 2016 to Dec 2016	SG
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	3	3	3		*1 or 2 (NHSI amended Oct 2016)*	Aug 2017	DJ
	CQC	Amber	Amber	Amber		*Overall CQC rating Requires Improvement*	Aug 2017	SG
	Local View							
	Commissioning - Contract KPIs	9	9	9		*<=2*	Aug 2017	AM

Quarter	2
Period	01/07/2017 - 30/09/2017

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

Quarter 2 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	2	0	2	5	3	8	60.00%	75.00%
	Lung	0	0.5	0.5	4	3.5	7.5	100.00%	93.33%
	Other	0	0	0	2	1	3	100.00%	100.00%
Med & Surg	Upper GI	0.5	0.5	1	3.5	4	7.5	85.71%	86.67%
Surgery	Breast	1	1	2	29.5	14	43.5	96.61%	95.40%
	Colorectal	5	2	7	17	8	25	70.59%	72.00%
	Head & Neck	1.5	1	2.5	2.5	2.5	5	40.00%	50.00%
	Skin	1	0	1	54	29	83	98.15%	98.80%
	Urology	10.5	7	17.5	37	20	57	71.62%	69.30%
Women's	Gynaecology	0	1	1	9.5	4.5	14	100.00%	92.86%
	Total	**21.5**	**13**	**34.5**	**164**	**89.5**	**253.5**	86.89%	86.39%

Quarter 2 - July

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	1	0	1	100.00%	N/A
	Lung	0	0	0	2.5	0	2.5	100.00%	N/A
	Other	0	0	0	1	0	1	100.00%	N/A
Med & Surg	Upper GI	0.5	0	0.5	0.5	0	0.5	0.00%	N/A
Surgery	Breast	1	0	1	16.5	0	16.5	93.94%	N/A
	Colorectal	2	0	2	7	0	7	71.43%	N/A
	Head & Neck	1	0	1	1.5	0	1.5	33.33%	N/A
	Skin	0	0	0	31.5	0	31.5	100.00%	N/A
	Urology	6.5	0	6.5	16	0	16	59.38%	N/A
Women's	Gynaecology	0	0	0	5.5	0	5.5	100.00%	N/A
	Total	**11**	**0**	**11**	**83**	**0**	**83**	86.75%	N/A

Quarter 2 - August

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	2	0	2	4	0	4	50.00%	50.00%
	Lung	0	0	0	1.5	0.5	2	100.00%	100.00%
	Other	0	0	0	1	0	1	100.00%	100.00%
Med & Surg	Upper GI	0	0	0	3	0	3	100.00%	100.00%
Surgery	Breast	0	0	0	13	0	13	100.00%	100.00%
	Colorectal	3	0	3	10	0	10	70.00%	70.00%
	Head & Neck	0.5	0	0.5	1	0.5	1.5	50.00%	66.67%
	Skin	1	0	1	21.5	3	24.5	95.35%	95.92%
	Urology	4	1	5	21	3	24	80.95%	79.17%
Women's	Gynaecology	0	0.5	0.5	4	0.5	4.5	100.00%	88.89%
	Total	**10.5**	**1.5**	**12**	**80**	**7.5**	**87.5**	86.88%	86.29%

Quarter 2 - September

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	0	3	3	N/A	100.00%
	Lung	0	0.5	0.5	0	3	3	N/A	83.33%
	Other	0	0	0	0	1	1	N/A	100.00%
Med & Surg	Upper GI	0	0.5	0.5	0	4	4	N/A	87.50%
Surgery	Breast	0	1	1	0	14	14	N/A	92.86%
	Colorectal	0	2	2	0	8	8	N/A	75.00%
	Head & Neck	0	1	1	0	2	2	N/A	50.00%
	Skin	0	0	0	1	26	27	100.00%	100.00%
	Urology	0	6	6	0	17	17	N/A	64.71%
Women's	Gynaecology	0	0.5	0.5	0	4	4	N/A	87.50%
	Total	**0**	**11.5**	**11.5**	**1**	**82**	**83**	100.00%	86.14%

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 5 Finance Report
Date of Meeting	27 September 2017
Author	Gareth Lawrence, Deputy Director of Finance
Accountable Executive	David Jago, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: CIP performance below plan with consequent non delivery of STF funding.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the month 5 financial performance of the Trust for the 2017/18 financial year.

The Trust submitted a revised plan to NHS Improvement (NHSI) which agreed delivery of an operational deficit of £0.426m in line with the control total issued and agreed at Board in March 2017. Within this plan is the requirement to deliver a Cost Improvement Programme (CIP) of £15m and a requirement to deliver additional initiatives identified and agreed at Board in March to deliver further savings/initiatives of £6.6m (residual risk of £5m) profiled to the latter part of the financial year with a key element of this reliant on working with a formally appointed SEP.

At the end of August 2017 the Trust has delivered an overall deficit of £10.9m which is £3.4m adverse performance to the plan excluding Sustainability and Transformation Funding (STF). As a result of the non-achievement of the financial plan the Trust has not been able to access £1.2m of the STF with a further £0.2m withheld for the A&E performance in Q1.

The Trust disappointingly is reporting a £1.6m adverse variance to the CIP plan. The Trust continues to review all transformational schemes via the Transformational Steering Group (TSG) in order to support sustainable delivery of the savings target. This level of performance at the end of M5 as previously highlighted is of concern and continues to be a key risk going forwards to delivery of the overall financial plan if the pace of identification and execution of CIP schemes does not increase significantly in the coming months.

The cash balance position at the end of August was £3.9m which is £1.4m above plan. This primarily reflects the closing 16/17 cash position being higher than plan and the additional cash received to support the Global Digital Exemplar (GDE) programme, offset by movements in working capital and EBITDA performance.

The year-end NHSI forecast remains in line with plan this month but it is at significant risk if the pace of change in respect of identification and execution of CIP does not significantly increase, operational costs incurred in future months are not in line with levels catered for in the financial plan and it is agreed to release the risk reserve by commissioning colleagues. The Board of Directors attention is brought to the NHSI Forecast Protocol whereby any variation to the financial plan can only be completed at the end of Q2 and Q3 reporting. The Trust has undertaken a review of recovery actions which will be presented to the Board within a separate paper.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As in previous months, the agency spend rating is preventing the overall UoR Rating from dropping to 4.

Table 1 Income and Expenditure Performance

Year ending 31 March 2018 Position as at 31 August 2017	Current Month			YTD		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Clinical income	25,171	23,323	(1,848)	125,019	121,178	(3,842)
Non-NHS clinical income	131	211	80	655	1,058	403
Other income	2,445	2,524	79	12,225	12,214	(11)
Total operating income	**27,747**	**26,059**	**(1,688)**	**137,899**	**134,449**	**(3,450)**
Pay	(18,190)	(19,659)	(1,469)	(91,744)	(96,623)	(4,879)
Other expenditure	(9,124)	(9,115)	9	(46,032)	(43,124)	2,908
Total operating expenditure before depreciation and impairments	**(27,314)**	**(28,775)**	**(1,461)**	**(137,776)**	**(139,747)**	**(1,971)**
EBITDA	**433**	**(2,716)**	**(3,149)**	**123**	**(5,297)**	**(5,420)**
Depreciation and net impairment	(693)	(542)	151	(3,413)	(2,682)	731
OPERATING SURPLUS / (DEFICIT)	**(260)**	**(3,258)**	**(2,998)**	**(3,290)**	**(7,979)**	**(4,689)**
Net finance costs and gains / (losses) on disposal	(359)	(363)	(4)	(1,782)	(1,795)	(12)
ACTUAL SURPLUS / (DEFICIT)	**(619)**	**(3,621)**	**(3,002)**	**(5,072)**	**(9,774)**	**(4,702)**
Reverse net impairment	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	**(619)**	**(3,621)**	**(3,002)**	**(5,072)**	**(9,774)**	**(4,702)**
Reverse capital donations/grants I&E impact	12	13	1	59	7	(52)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	**(607)**	**(3,608)**	**(3,000)**	**(5,013)**	**(9,766)**	**(4,754)**
AFPD excluding STF	**(1,200)**	**(3,608)**	**(2,407)**	**(7,529)**	**(10,898)**	**(3,369)**

The variance on AFPD measures the Trust's perfomance against its control total.

The table above details the current performance of the Trust in relation to the plan submitted to NHSI in March 2017. The detailed Income and Expenditure account can be viewed in Appendix 1.

PbR activity is currently above plan by £1.3m YTD as a result of over performance in Elective/Day case, Non Elective and A&E activity; during August PbR activity fell below plan as a result of reduced clinical capacity in excess of a lower profiled plan. The YTD PbR performance has been offset with under performance in Non-PbR, (£1.1m) relating to a difference in the treatment of penalties within the main CCG contract offer (offset within expenditure), a further (£1.4m) relates to non achievement of STF monies. Although Non PbR is broadly on plan, there are a number of areas within this category which are below plan, namely adult critical care, neonatal and rehabilitation services. Non PbR excluded drugs is currently below plan by (£2.5m), this is offset within expenditure.

As a result of the increased levels of NEL activity the Trust has currently been penalised by £0.6m greater than planned for in respect of the NEL marginal rate. The Trust is currently discussing the use of this resource with the CCG in order to secure investment back into the Trust to help support the increased levels of activity.

Due to the Trust signing up to the Control Total issued by NHS Improvement, the Trust has avoided financial sanctions of c£4.9m YTD due to A&E and RTT adverse performance to targets. The Trust has had £1.4m withheld from the STF at the end of M5 as a result of not achieving the A&E trajectory and not achieving the financial control total.

Operational expenditure is currently materially above plan this month as a result of non-delivery of CIP (£1.6m) and operational overspends in pay and clinical supplies across the Trust. In month position includes a one off £0.3m charge to I&E in respect of historic VAT recovery following a recent HMRC compliance audit. Non-recurrent initiatives were applied in Q1 to mitigate pace of CIP delivery and operational run rate pressures alongside the utilisation of the CQUIN risk reserve that was included within the Trust plans.

The Trust continues to experience high levels of non-core spend, 11.5% of the pay bill being expended this way in August as demonstrated in the table below:

Table 2 Core and Non-Core Expenditure Analysis

	15/16 Average £000's	16/17 Average £000's	17/18 Average £000's	Apr £000's	May £000's	Jun £000's	Jul £000's	Aug £000's	YTD £000's
Plan				18,241	18,506	18,455	18,190	18,352	91,744
Pay Costs									
Substantive	**16,047**	**16,944**	**17,334**	**17,340**	**17,366**	**17,346**	**17,213**	**17,405**	**86,670**
Bank Staff	299	**336**	410	**377**	**374**	406	418	474	2,049
Agency Staff	723	**591**	585	**424**	**515**	568	696	724	2,927
Overtime	290	**255**	290	**339**	**266**	280	272	292	1,449
Medical Bank/Locum	357	**462**	545	**486**	**506**	558	546	629	2,725
WLI (In Year)	95	**103**	161	**166**	**164**	152	186	135	803
Non Substantive Total	**1,764**	**1,748**	**1,990**	**1,791**	**1,825**	**1,964**	**2,118**	**2,254**	**9,952**
Total Pay	17,811	18,692	19,324	19,131	19,191	19,310	19,331	19,659	96,622
Variance				(890)	(685)	(855)	(1,141)	(1,307)	(4,878)
Non-Core %	9.9%	9.4%	10.3%	9.4%	9.5%	10.2%	11.0%	11.5%	10.3%

The Trust will continue to review the operational pay spend via F&PG and FBPAC with a renewed focus on actions required to reduce the pay run rate currently being experienced. The Trust agency YTD spend in M5 was £2.9m compared to the "ceiling" of £3.3m issued by NHSI. While this is a positive position agency has increased in month again and will continue to be closely managed given the premium adverse impact of agency costs on the financial plan. The agency underspend is ensuring that the Trust is currently delivering a UoR Rating of 3.

As a result of the adverse performance in expenditure and CIP delivery the position includes as previously reported to the Board of Directors as a mitigation action the release of £1.2m from the CQUIN risk reserve that was built into the financial plan. This remains a risk to the Trust as this funding stream has not yet been released by the CCG. The Trust continues to be in discussions with NHSI so that they can authorise the transfer of the funds with high level discussions taking place between NHSE and NHSI.

Non recurrent support of £1.3m has also been released within the YTD position at the end of August after reviewing year end accruals. However, in Month 5 this has been mitigated by a non-recurrent pressure of (£0.3m) as a consequence of review of VAT recovery. This overall non recurrent support is not be available in future months to support any continuance of the current higher than planned expenditure run rate of the Trust.

The impact of the associated risks and non-recurrent adjustments to the current YTD position and the underlying position are demonstrated in the table overleaf.

Table 3 Underlying Deficit

	YTD Plan £k	YTD Actual £k	YTD Variance £k
Adjusted financial performance surplus / (deficit) (AFPD)	**(5,072)**	**(9,774)**	**(4,701)**
AFPD excluding STF	(7,588)	(10,905)	**(3,316)**
AFPD excluding Non-Recurrent Support	(7,588)	(11,905)	**(4,316)**
AFPD excluding CQUIN Risk	(7,588)	(13,105)	**(5,516)**
AFPD Underlying Position (exc STF & CQUIN Risk)	**(7,588)**	**(13,105)**	**(5,516)**

Cost Improvement Programme (CIP)

The CIP for 2017/18 is £15m (4.5%) that is split as a target both divisionally and workstream led. As at the end of the Month 5 the Trust is behind the YTD target of £4.2m by £1.6m.

Table 4 set out below details the month 4 position for CIP.

Table 4 CIP Performance

Summary as at Month 5	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£4,233k		£15,000k		
Fully Developed TSG approved schemes	£2,823k		£8,996k		
Overperformance/ (Gap) v NHSi Plan	-£1,410k	-33.3%	-£6,004k	-40.0%	
Latest Forecast performance on TSG approved schemes	£2,597k		£8,976k		
Over/ (Under)performance compared to TSG approved schemes	-£226k	-8.0%	-£20k	-0.2%	
Latest Forecast including mitigation	£2,597k		£8,976k		
Performance Variance (Latest Forecast to NHSi Plan)	-£1,636k	-38.7%	-£6,024k	-40.2%	
Latest Forecast adjusted for risk	£2,597k		£6,674k		
Performance Variance (Latest Forecast to NHSi Plan)	-£1,636k	-38.7%	-£8,326k	-55.5%	

The above table excludes the identified "stretch" initiatives required to deliver the agreed control total.

The table below further analyses CIP performance by Division.

Table 5 Divisional CIP analysis

Divisional Summary	YTD			In Year			FYE		
	Target	Actual	Variance to NHSi Plan	Target	Forecast	Variance to NHSi Plan	Target	Forecast	Variance to NHSi Plan
Division	£k	£k	£k	£k	£k	£k	£k	£k	£k
Medicine and Acute	1,185	312	(873)	4,200	1,201	(2,999)	4,200	1,157	(3,043)
Surgery	996	793	(203)	3,530	2,937	(593)	3,530	2,040	(1,490)
Women and Children	415	187	(228)	1,470	602	(868)	1,470	534	(936)
Diagnostics and Clinical Support	677	268	(409)	2,435	1,148	(1,287)	2,435	1,449	(986)
Corporate	959	783	(177)	3,365	2,478	(887)	3,365	1,509	(1,856)
Central			0		610	610		1,500	1,500
TBC		254	254		0	0		0	0
TOTAL FULLY DEVELOPED PRE ADJUSTMENT FOR RISK	**4,233**	**2,597**	**(1,636)**	**15,000**	**8,976**	**(6,024)**	**15,000**	**8,190**	**(6,810)**
Adjustment for Risk					(2,302)	(2,302)		(2,207)	(2,207)
TOTAL FULLY DEVELOPED AFTER RISK	**4,233**	**2,597**	**(1,636)**	**15,000**	**6,674**	**(8,326)**	**15,000**	**5,983**	**(9,017)**

The year to date position as at the end of August is £2.6m, £1.6m short of the NHSi Plan requirement. £1.4m of this variance is as a result of the unidentified gap against the NHSi Plan requirement with a further £0.2m underperformance on developed schemes.

The in-year forecast for fully developed schemes at the end of August is £9m, an increase of £0.3m over the previous month reported figures. This has been delivered through the approval of £0.3mk of new schemes at TSG.
The adjustment for risk calculation is applied based upon the programme delivery RAG rating, as follows:

Red schemes	90% benefit reduction assumed
Amber schemes	50% benefit reduction assumed
Green schemes	10% benefit reduction assumed

Considerable work has been undertaken with the divisional and programme leads to develop the plans in progress and opportunities schemes for approval at TSG. Work will continue to assess the remaining schemes within these categories, with a view to obtain approval at TSG and have a clear understanding of the unidentified gap in order to take the appropriate action. It is of note that the lead time in terms of benefits realisation associated with many of the transformational and STP programmes will necessitate an increased focus on tactical in year schemes which may include income gains by delivering additional activity, tariff optimisation and negotiation in order to meet the required target for cost improvement. This work, together with the control of the underlying position is being progressed through the Trust recovery plan, and at the time of writing the benefits of this to the CIP position are not yet known and a verbal up-date will be provided.

Statement of Financial Position (SOFP), cash position and Use of Resources (UoR) Rating

The Trust's Balance Sheet is detailed at Appendix 2 – *Statement of Financial Position (SOFP).* Capital variances to plan (£2.7m) are primarily due to actual brought-forward balances for 2017/18 exceeding those in plan, and depreciation savings, offset by a year-to-date capital underspend. Depreciation savings have been delivered by extending the asset life of the Cerner EPR system. While this has had a benefit to the Income & Expenditure position, it increases the risk of the Trust funding its capital programme without additional external support.

GDE capital funding received to date (£3.9m) must be spent within the current financial year, and expenditure to date has been negligible. Aside from GDE, capital expenditure is £0.4m behind plan for the year to date, as a result of slippage to some capital projects.

August's working capital variances to plan continue to be within acceptable tolerances, and are due to controlled variations in the working capital cycle. In month 5, movements and variances in borrowings are attributable to finance lease balances rather than treasury activity, as no further support funding was drawn down.

The August cash position was £3.9m, which is £1.4m above plan. This variance is primarily due to 2016/17 closing cash exceeding planning assumptions (£3.6m), the cash effects of capital slippage (£0.9m), and the PDC drawdown associated with GDE (£3.9m), offset by the adverse effects of the operational trading deficit and working capital movements (£7.0m). Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As previously noted, the agency spend rating is preventing the overall UoR Rating dropping to 4.

Conclusion

The Trust is currently reporting adverse to plan performance of £3.3m at the end of August and as a consequence of this has not received the STF payments of £1.2m for this period. The non-achievement of the A&E target in Q1 meant that £0.2m of STF was withheld for that period therefore delivering a YTD adverse variance of c£4.8m. The underlying deficit position of the Trust at the end of M5 as set out in table 3 is of concern but reflective of the underlying deficit position reported previously to the Board of Directors with the Trust entering the current financial year with an underlying deficit at circa £23.0m. Overall

operational financial plan performance has not improved in M5 and non-recurrent support has not been available to mitigate the position. It is imperative that the expenditure run rate and specifically the pay run rate is robustly managed back in line with plan in order to support both the delivery of the CIP and overall financial plan. In line with the NHSI Forecast Protocol a review of financial recovery actions will be undertaken and reported separately to the Board.

Despite below plan operational performance the cash position remains positive with a continued focus on delivering cash preservation initiatives and robust management of working capital, in addition to a draw-down of GDE PDC funding in advance of expenditure.

Recommendations

The Board of Directors are asked to discuss and note the contents of this report.

David Jago
Director of Finance
September 2017

Appendix 1
Income & Expenditure

Income and expenditure statement (SoCI)

Wirral University Teaching Hospital NHS Foundation Trust

Year ending 31 March 2018 Position as at 31 August 2017	YTD Plan £k	YTD Actual £k	YTD Variance £k	Year-end forecast Board-approved Plan £k	Year-end forecast Actual £k	Year-end forecast Variance £k
NHS clinical income						
Elective	9,223	9,655	432	22,534	23,816	1,282
Daycase	10,936	10,880	(56)	26,899	28,430	1,531
Elective excess bed days	433	300	(133)	1,063	908	(155)
Non-elective	37,469	39,297	1,828	90,511	95,975	5,464
Non-elective excess bed days	906	919	13	2,191	2,099	(92)
A&E	5,200	5,383	183	12,453	12,635	182
Outpatient	13,959	13,471	(488)	34,148	33,432	(716)
Diagnostic imaging	1,011	977	(34)	2,472	2,414	(58)
Maternity	2,357	2,210	(147)	5,622	5,271	(351)
Non PbR	29,005	27,401	(1,604)	69,801	66,293	(3,507)
HCD	8,535	6,013	(2,522)	20,485	14,496	(5,990)
CQUINs	3,369	3,399	30	6,398	6,398	0
Other income	100	142	42	240	45	(195)
STF	2,516	1,131	(1,385)	8,875	1,131	(7,744)
Total clinical income	**125,019**	**121,178**	**(3,842)**	**303,692**	**293,343**	**(10,349)**
Non-NHS clinical income						
CRU / RTA / ICR income	270	205	(65)	647	491	(155)
Other income	385	853	468	919	1,990	1,071
Total non-NHS clinical income	**655**	**1,058**	**403**	**1,566**	**2,482**	**916**
Other income						
Education & training	4,075	4,093	18	9,780	9,675	(105)
R&D	170	169	(1)	408	405	(3)
Non-patient services to other bodies	3,865	4,388	523	9,277	9,788	512
Other income	4,115	3,563	(552)	14,824	8,764	(6,060)
Total other income	**12,225**	**12,214**	**(11)**	**34,288**	**28,632**	**(5,656)**
Total operating income	**137,899**	**134,449**	**(3,450)**	**339,546**	**324,457**	**(15,089)**
Pay costs	(91,744)	(96,623)	(4,879)	(221,376)	(232,970)	(11,594)
Drug costs	(11,280)	(9,889)	1,391	(29,220)	(23,709)	5,511
Clinical supplies	(13,000)	(14,638)	(1,638)	(30,933)	(34,868)	(3,935)
Other costs	(21,752)	(18,597)	3,155	(45,893)	(45,359)	533
Depreciation and net impairment	(3,413)	(2,682)	731	(8,353)	(6,672)	1,681
Total operating costs	**(141,189)**	**(142,428)**	**(1,239)**	**(335,775)**	**(343,578)**	**(7,804)**
Operating surplus / (deficit)	**(3,290)**	**(7,979)**	**(4,689)**	**3,771**	**(19,122)**	**(22,892)**
Operating surplus / (deficit) %	**-2.39%**	**-5.93%**		**1.11%**	**-5.89%**	
Net finance costs and gains / (losses) on disposal	(1,782)	(1,795)	(12)	(4,340)	(4,478)	(137)
Actual surplus / (deficit) per annual accounts	**(5,072)**	**(9,774)**	**(4,702)**	**(569)**	**(23,599)**	**(23,030)**
Reverse net impairment	0	0	0	0	0	0
Surplus / (deficit) before impairments and transfers	**(5,072)**	**(9,774)**	**(4,702)**	**(569)**	**(23,599)**	**(23,030)**
Reverse capital donations/grants I&E impact	59	7	(52)	142	101	(41)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
Adjusted financial performance surplus / (deficit) (AFPD)	**(5,013)**	**(9,766)**	**(4,754)**	**(427)**	**(23,498)**	**(23,071)**
AFPD excluding STF	**(7,529)**	**(10,898)**	**(3,369)**	**(9,302)**	**(24,629)**	**(15,327)**

The variance on AFPD measures the Trust's perfomance against its control total.

Appendix 2
Statement of Financial Position (SOFP)

Actual as at 01.04.17 £k		Actual as at 31.07.17 £k	Actual as at 31.08.17 £k	Variance (monthly) £k	Plan as at 31.08.17 £k	Actual as at 31.08.17 £k	Variance (to plan) £k	Forecast 31.03.18 £k	Plan 31.03.18 £k
	Non-current assets								
145,789	Property, plant and equipment	145,240	145,036	(204)	142,986	145,036	2,050	148,507	145,166
12,216	Intangibles	11,945	11,878	(67)	11,236	11,878	642	16,211	10,080
950	Trade and other non-current receivables	898	898	0	1,612	898	(714)	896	1,612
158,955		**158,083**	**157,812**	**(271)**	**155,834**	**157,812**	**1,978**	**165,614**	**156,858**
	Current assets								
3,881	Inventories	3,870	3,590	(280)	4,051	3,590	(461)	3,590	4,051
16,389	Trade and other receivables	21,100	21,028	(72)	20,694	21,028	334	15,448	20,760
0	Assets held for sale	0	0	0	0	0	0	0	0
5,390	Cash and cash equivalents	6,491	3,909	(2,582)	2,513	3,909	1,396	2,257	2,257
25,660		**31,461**	**28,527**	**(2,934)**	**27,258**	**28,527**	**1,269**	**21,295**	**27,068**
184,615	**Total assets**	**189,544**	**186,339**	**(3,205)**	**183,092**	**186,339**	**3,247**	**186,909**	**183,926**
	Current liabilities								
(31,059)	Trade and other payables	(35,295)	(35,951)	(656)	(33,387)	(35,951)	(2,564)	(34,473)	(32,172)
(3,341)	Other liabilities	(3,350)	(3,159)	191	(3,944)	(3,159)	785	(2,783)	(3,696)
(1,015)	Borrowings	(1,073)	(1,073)	0	(1,015)	(1,073)	(58)	(1,073)	(1,014)
(668)	Provisions	(668)	(652)	16	(664)	(652)	12	(668)	(664)
(36,083)		**(40,386)**	**(40,835)**	**(449)**	**(39,010)**	**(40,835)**	**(1,825)**	**(38,997)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(8,925)**	**(12,308)**	**(3,383)**	**(11,752)**	**(12,308)**	**(556)**	**(17,702)**	**(10,478)**
148,532	**Total assets less current liabilities**	**149,158**	**145,504**	**(3,654)**	**144,082**	**145,504**	**1,422**	**147,911**	**146,380**
	Non-current liabilities								
(9,154)	Other liabilities	(9,040)	(9,012)	28	(9,012)	(9,012)	0	(8,813)	(8,812)
(26,708)	Borrowings	(29,774)	(29,769)	5	(29,542)	(29,769)	(227)	(45,218)	(27,627)
(2,221)	Provisions	(2,158)	(2,158)	0	(2,061)	(2,158)	(97)	(2,048)	(1,969)
(38,083)		**(40,972)**	**(40,939)**	**33**	**(40,615)**	**(40,939)**	**(324)**	**(56,078)**	**(38,408)**
110,449	**Total assets employed**	**108,186**	**104,565**	**(3,621)**	**103,467**	**104,565**	**1,098**	**91,837**	**107,972**
	Financed by								
	Taxpayers' equity								
72,525	Public dividend capital	76,416	76,416	0	72,525	76,416	3,891	77,511	72,525
4,575	Income and expenditure reserve	(1,579)	(5,200)	(3,621)	(1,726)	(5,200)	(3,474)	(19,024)	2,779
33,349	Revaluation reserve	33,349	33,349	0	32,668	33,349	681	33,350	32,668
110,449	**Total taxpayers' equity**	**108,186**	**104,565**	**(3,621)**	**103,467**	**104,565**	**1,098**	**91,837**	**107,972**

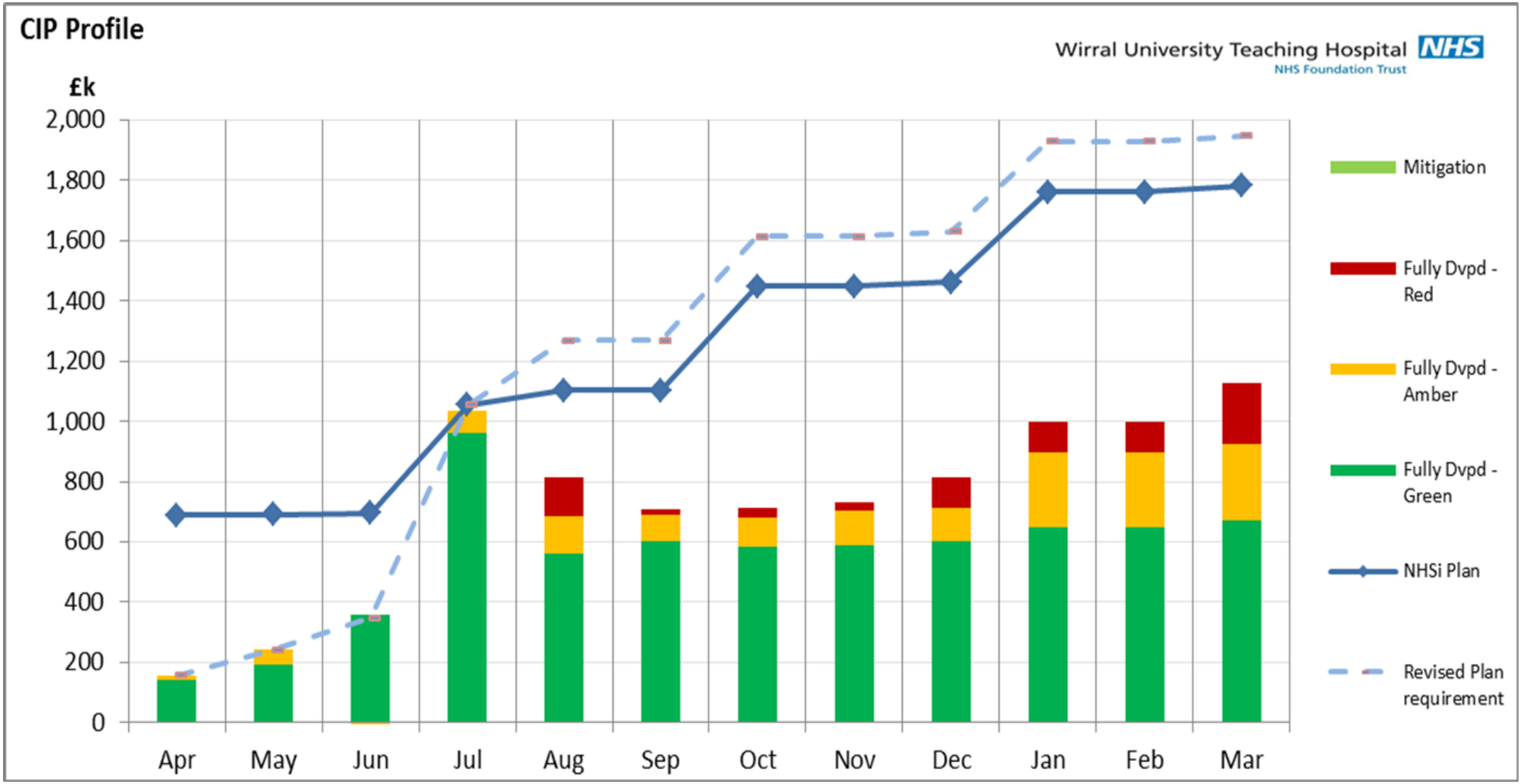
Appendix 3
Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£k	£k	£k	£k	£k	£k	£k	£k
Opening cash	**6,491**	**2,003**	**4,488**	**5,390**	**1,752**	**3,638**	**5,390**	**1,752**
Operating activities								
Surplus / (deficit)	*(3,621)*	*(705)*	*(2,916)*	*(9,774)*	*(5,072)*	*(4,702)*	*(23,599)*	*(568)*
Net interest accrued	*85*	*80*	*5*	*406*	*384*	*23*	*1,145*	*982*
PDC dividend expense	*277*	*277*	*(0)*	*1,385*	*1,386*	*(1)*	*3,324*	*3,326*
Unwinding of discount	*1*	*3*	*(2)*	*3*	*15*	*(12)*	*8*	*35*
(Gain) / loss on disposal	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Operating surplus / (deficit)	(3,258)	(345)	(2,913)	(7,981)	(3,288)	(4,693)	(19,123)	3,775
Depreciation and amortisation	542	693	(151)	2,682	3,413	(731)	6,672	8,353
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(0)	0	(0)	(60)	0	(60)	(60)	0
Changes in working capital	493	430	63	(999)	452	(1,451)	2,244	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	2	7	(4)	12	34	(22)	21	82
Purchase of non-current (capital) assets [1]	(355)	(275)	(80)	(1,848)	(2,684)	836	(11,644)	(7,964)
Sales of non-current (capital) assets	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	17	0	17	17	0
Financing activities								
Public dividend capital received	0	0	0	3,891	0	3,891	4,986	0
ITFF loan principal drawdown	0	0	0	0	0	0	0	0
Support funding [2] principal drawdown	0	0	0	5,000	5,000	0	21,500	9,600
ITFF loan principal repaid	0	0	0	0	0	0	(1,015)	(1,014)
Support funding [2] principal repaid	0	0	0	(2,166)	(2,166)	0	(2,166)	(7,666)
Interest paid	0	0	0	1	0	1	(1,170)	(1,064)
PDC dividend paid	0	0	0	0	0	0	(3,324)	(3,326)
Capital element of finance lease rental payments	(5)	0	(5)	(25)	0	(25)	(59)	0
Interest element of finance lease rental payments	(1)	0	(1)	(5)	0	(5)	(12)	0
Total net cash inflow / (outflow)	**(2,582)**	**510**	**(3,092)**	**(1,481)**	**761**	**(2,242)**	**(3,133)**	**505**
Closing cash	**3,909**	**2,513**	**1,396**	**3,909**	**2,513**	**1,396**	**2,257**	**2,257**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

[2] Support funding currently comprises a working capital facility, issued by DH and administered by NHSI.

Appendix 4
CIP Profile



BOARD OF DIRECTORS	
Agenda Item	7.1
Title of Report	NHS England Emergency Preparedness, Resilience & Response (EPRR) Core Standards 2017/18
Date of Meeting	27th September 2017
Author	Helen Nelson Head of Emergency Preparedness
Accountable Executive	Anthony Middleton Director of Operations & Performance/Deputy Chief Operating Officer/Accountable Emergency Officer
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	7D Compliance with regulatory requirements
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	To Note
Reviewed by Assurance Committee	
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1. Executive Summary

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

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet and are included in the NHS

standard contract and, through this, the NHS Commissioning Board Emergency Planning Framework (2013). The director level accountable emergency officer and/or governing body in each organisation are responsible for making sure these standards are met.

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

2. Background

The 2017/18 EPRR Assurance Process is based on the revised Core Standards. To comply with the national requirements NHS England requested that each organisation:

- Undertake a self-assessment against the revised core standards identifying the level of compliance for each standard (red, amber, green)
- Submit an action plan addressing any areas of improvement required
- Complete the statement of compliance identifying the organisation's overall level of compliance - full, substantial, partial or non-compliance
- Present the above outcomes to the Board of Directors or through appropriate governance arrangements where the Board has delegated their responsibility for EPRR

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

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

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	**Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.**
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

3. Key Issues/Gaps in Assurance

The Trust has completed the required self-assessment against the 64 core standards (including CBRNE applicable to Acute Trusts and has concluded that there are no Red areas of concern, 1 Amber area requiring further improvement with the remainder green.

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

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

The area identified as requiring improvement to achieve compliance is (Improvement Plan attached):

- *Documented training program for HAZMAT/CBRN to be in place in the Emergency Department*

Each year NHS England initiates a 'deep dive' into a specific area of EPRR. This year's is Governance. The action required can be seen in the attached 'Improvement Plan'; however the deep dive does not form part of the Core Standards compliance.

4. Next Steps

- The Board Report, Statement of Compliance and the Improvement Plan will be submitted to the Clinical Commissioning Group and Local Health Resilience Partnership
- The Improvement Plan will be submitted to the Quality & Safety Department for inclusion on the Trust Risk Register and monitored in line with the Risk Management Strategy & Policy

Conclusion

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

5. Recommendations

The Board of Directors is asked to note the content of this report.

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Wirral University Teaching Hospital has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	**Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.**
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
63	0	1	62
Acute providers: **63**** Specialist providers: **51**** Community providers: **50**** Mental health providers:**48**** CCGs: **38**			

Also includes **HAZMAT/CBRN standards** applicable to providers: **Standards:** Acutes **13** / Specialist, Community, Mental health **7
Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Anthony Middleton Director of Performance & Operation / Accountable Emergency Officer

27/09/2017
Date of Board of Directors' meeting

11/09/17
Date signed

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Organisation: Wirral University Teaching Hospital

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
CC11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	• Identify activities and functions are critical • What is an acceptable level of service in the event of different types of emergency for all your services • Identifying in risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	BIA templates to be introduced to the Clinical Divisions for their completion	Complete
CC45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	• There is a named role responsible for ensuring these checks take place	2 CBRN Leads to Undertake CBRN Train the Trainers Course	Complete
CC49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and	2 CBRN Leads to Undertake CBRN Train the Trainers Course	Complete

		control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material:		

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	Training programme to be developed.	Training to be delivered to all ED staff in 2 sessions. An early morning session on erecting the 'tent'. A second session will cover the theory and practical.	31/01/18

Responses to the governance deep dive standards

	Core standard	Self assessment RAG	Action to be taken	Lead	Timescale
2017 Deep Dive					
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.		N/a		
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.		N/a		
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.		N/a		
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function		N/a		
DD5	**The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group**		N/a		
DD6	**The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings**		Discuss and agree future attendance at LHRP with the AEO	Helen Nelson	30/09/2017

Board of Directors	
Agenda Item	7.2
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 8th September 2017
Date of Meeting	27th September 2017
Author	Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee (FBPAC), which met on the 08 September 2017. Key focus areas are those, which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The Committee noted the key changes to the Board Assurance Framework (BAF) during the reporting period, including:

- **Risk 4 (Improving Clinical Outcomes)** – the risk descriptor had been revised entirely to redirect focus to the consistent delivery of evidence based practice 7 days per week. As a consequence, the risk score has been reduced to reflect current performance.
- **Risk 12 (C.diff)** – the risk score has been increased to reflect the recent upward trend of avoidable cases of C.diff.
- **Risk 19 (Clinical Engagement)** - the risk score has been reduced as over the last few months there has been a sustained improvement in developing effective controls to support Medical Engagement alongside the development of a more robust assurance process.

The following emerging risks were identified at the Senior Management Team meetings which took place on the 4 and 25 August 2017, the content of the BAF has been updated as follows:

- **Risk 1 (Quality and Safety)** – the risk narrative has been updated to reflect that clinical handover remains a risk, as identified by the CQC, following serious incident review and audit of electronic handover which indicated non-compliance. Further work is to take place to streamline the e-handover process and regular audits are to be conducted to monitor compliance and identify non-compliance trends which require further action.
- **Risk 2 (Patient Experience)** – the risk template has been updated to reflect the issues raised in respect of responding to complaints outside of acceptable timescales (this includes the number of complaints which have exceeded the internal response standard). The Trust is to identify resource to progress overdue complaints
- **Risk 3 (Staff Engagement)** – the risk template has been updated to reflect the high nursing vacancy rate with particular reference to the challenges experienced in the Medicine and Acute Division.

The Committee noted the work undertaken to review and update the content of the BAF to ensure that the information presented remains concise whilst retaining the key data required to provide assurance of the Trust's progress in working to minimise risks to its strategic objectives and key measures. Significant progress had been made in respect of this review and it was visible within the presented BAF, however there remains further work to be conducted to complete the full review. The review is to include a significant update to the content of the strategic risks 13 (STP C&M), 14 (LDSP W&C) and 15 (Health Wirral) to be conducted by the Director of Strategy and Sustainability.

1. Risks at 15+

There were no risks scored at 15+ reported to the Committee this month.

At the July 2017 meeting the Committee approved Risk 3089 (risk score 15) which pertained to the Trust inability to satisfy its statutory obligations if transfusion data stored in the Triple G computer system could not be accessed. The Committee noted that work around has been identified, which was subsequently approved by the laboratory and saw the extraction, storage and back up of data from the Triple G system with access to the data granted to transfusion senior staff. The data extraction had been completed to the satisfaction of the department and the risk and its score were now being reviewed by the transfusion senior staff. The Committee requested confirmation that this work was now fully completed.

The Committee agreed to receive an update on the estates position in the Trust noting that no formal report had been received for the last 2 months.

M4 Financial Position

The Committee reviewed M4 financial position, which reported an actual year to date deficit of £6.15m which resulted in the Trust not achieving the financial control total this month and the respective sustainability and transformation (STF) payment of £0.6M. This was in addition to the £0.2M that was not received in Q1 as a result of not achieving the A & E trajectory. The overall position excluding the STF was still a £1m deterioration to the plan in M4. The Committee was advised that failure to deliver the financial plan would result in the loss of all STF funding going forwards.

The Committee was advised that the forecast underlying deficit (at circa £23.0m) for 2017/18 remained relatively unchanged. The Committee examined the key attributes associated with the deterioration in the monthly position which in the main were a slight increase in the agency run rate in July and the loss of STF funding of £800K. Members noted that whilst NHS clinical Pbr income continued to deliver above plan by £1.8M, Non Pbr income was £3.2M below plan. Of the £3.2M Pbr under-performance (£1.9M) relates to lower pass through High Cost Drugs that was set within the plan – this underperformance is offset by a corresponding underspend within drug expenditure. Operating expenditure was reported £0.4M above plan year to date however there were significant risks with this including the non-delivery of the cost improvement plan of £1.5M, additional costs incurred due to operational pressures whilst experiencing full capacity, pressures in the emergency department and further staffing pressure costs in relation to the use of non-core staff to cover medical gaps and nursing vacancies. The Committee was pleased to note that the Trust had written to the CCG with regards to the marginal rate emergency tariff as this was not being applied and therefore having an impact on financial performance.

The Committee was concerned that the increase in pay costs coincided with an upward trend in agency spend and sought and received assurance on the level of Executive challenge. The Committee also sought to understand why the CIP plan was off track although it acknowledged the £2m of schemes that had been approved over the last couple of weeks. The high risk schemes associated with estates and procurement were outlined which would now have to be sufficiently mitigated. The Committee accepted that many of the transformational schemes required a significant degree of resource to bring these to fruition and were subject to delay as a result of restrictions of capital or potential TUPE arrangements.

The Committee was advised that the Trust cash position was £6.5M exceeding the plan by £4.5M.

The Use of Resources (UoR) rating was reported at level 3, which was in line with the Trust plan.

In-depth Transformation Project Review (Patient Flow)

The Committee commissioned an in-depth review of patient flow as part of its work programme. The Committee was advised that the project had £4.2M of savings associated with it however this was predicated on closing 2/3 wards and with the current operational pressures the converse was happening. The Committee reviewed the key enablers supporting the project, the governance and how the Ernst Young diagnostic work and the rapid improvement programme supported achievement of the desired outcomes. The Committee reviewed the progress of implementation of SAFER as a key driver to supporting effective patient flow and was disappointed that when reviewed this was not compliant in all areas although action was being taken to address this. The Committee sought to understand how the Trust was working with partners to improve patient flow and was advised that this now appeared to be having more traction. The Committee was pleased that the Medical Director was the lead for SAFER to ensure that this was clinically led.

Financial Recovery Plan

The Committee reviewed the work being undertaken to develop a financial recovery plan and sought to establish that financial recovery focused on a forward view as well as a backward view. The Committee noted that the Board would receive the draft plan in September 2017.

Budget Setting

The Committee reviewed the strategic budget setting methodology which had been refreshed although was a continuation of the plan developed in year 1. The Committee was advised that the guidance on timescales for submission was still awaited.

Control Total

The Committee was reminded that the control total for 2017/18 was £0.4M deficit and the plan for 2018/19 was £7.4M deficit without STF funding. The Committee was advised that NHSI had put forward a revised control total for 2018/19 of £5.1M deficit despite the work undertaken by the Trust to commit to an already ambitious target. The Committee was reminded that the current plan

had a number of significant challenges in it not least the cost improvement plan of £15M. The Committee having extensively reviewed its position when the original submission was made could not accept the revision on the basis that the original plan was significantly challenging and that there was an absence of clarity on key assumptions such as the tariff deflator. The Committee agreed, with the support of the Chairman, to confirm to NHSI that it could not, because of the reasons outlined here, accept the revised total noting the risks with not accepting a control total, this being access to STF funding which afforded the Trust protection from a range of penalties.

Data quality and informatics programme review

The Committee received an update on the work to establish a system of kite marks for data which gave a view of 7 different dimensions of data quality. The Committee agreed that a much more pragmatic approach needed to be adopted as the cost and resource implications of this work was extensive. The Committee agreed to implement the kite mark in a sample set of areas in agreement with proposed owners to assess the viability of the process.

The Committee also received an update on the IT work programme which included the work in the hospital, with Healthy Wirral economy and with the Countess of Chester. The Committee noted the absence of the alignment of technology in the patient flow project review although this was underpinning this. The Committee agreed that the benefits realisation of this work needed to be much more visible.

Performance Report for Period Ending 31 July 2017

The Committee was pleased to note that performance for August had improved from the July position although acknowledging that this was well below the expected standard. Further improvements had been seen in September following the interventions outlined in the review of patient flow and in line with the planned improvements.

The Committee noted that the health economy winter plan had now been submitted although further iterations were likely following regulatory review. The Committee agreed that the full winter plan would be reviewed by the Board in September.

Although the Committee was pleased that the cleansing work on the referral to treatment time patient list had been completed, it was concerned with the reliance on the independent sector to reduce the backlog although formal processes were not in place to achieve this.

Some issues in echo-cardiology were outlined in relation to 6 week diagnostics although work was being undertaken to improve the position.

The Committee noted that 1 case of avoidable C difficile was reported in July which was in line with the trajectory.

No issues in cancer performance were reported although the reliance on dermatology for overall performance at an aggregate level was noted.

Procurement Performance Report

The Committee noted that 8 out of the 14 key areas were performing well with further work to do in the others. This work was seen to support work with buyers in terms of the Trust's ability to negotiate. The Committee agreed that future reviews would be undertaken at Finance and Performance Group although exception reporting would still be provided.

Workforce Report

The Committee received the report having discussed the agency spend as part of the financial performance supported the move to future reports in dashboard form in line with the recommendations from the Integrated governance review.

Sub-Group Terms of Reference

The Committee approved the revised terms of reference for the Finance and Performance Group and the new Strategy and Sustainability Planning Group.

NHS Improvement – Monthly Return

The Committee noted the content of the NHSI Month 4 financial commentary, which detailed the financial position at the end of July 2017 and cumulatively against the 2017/18 plan.

Assurance Reporting

The Committee received Chair's reports from the following Working Executive Committees:

- Finance and Performance Group.
- Digital Wirral Programme Board.
- Information, Information Governance and Coding Group.
- The Strategy and Sustainability Planning Group

Escalation to the Board/Inclusion on the Board Assurance Framework

The Committee agreed to escalate to the Board the risks associated with accepting and rejecting the revised control total and the risks associated with transformation change.

The Committee agreed to strength the alignment in the Board Assurance Framework of IT and Patient Flow.

Andrea Hodgson
Chair of Finance, Business Performance and Assurance Committee

Board of Directors	
Agenda Item	7.3
Title of Report	Equality, Diversity and Human Rights, EDS2 Inclusive Leadership and WRES Summary Report
Date of Meeting	27th September 2017
Author	Alison Quinn, Associate Director of Nursing (ADN) - Clinical Support & Diagnostics Division, Head of Patient Experience Johanna Ashworth-Jones, Senior Analyst Adriana Roscoe, Deputy Head of Human Resources
Accountable Executive	Denise Price, Interim Director of Nursing & Midwifery Gaynor Westray, Director of Nursing & Midwifery James Mawrey, Director of Workforce (providing interim support)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	To be the top NHS Trust in the North West for patient and staff satisfaction Risk 3 and 3
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken •	Not Applicable

1. Executive Summary

1. The Trust Board received the Equality, Diversity and Human Rights Annual Report in April, 2017. At this meeting the Board requested a further update on the progress that was required under the 'Inclusive Leadership' domain. This paper is intended to provide this update.

2. The paper also provides a link to the Workforce Race Equality Standard (WRES) for 2017. This can be viewed on the internet via the following link http://www.wuth.nhs.uk/patients-and-visitors/about-us/equality-and-diversity as the Trust is required to place this important document in the public domain.

3. The Trust Board is asked to note the details of the paper and comment on whether any further assurance is required.

2. Background

The Board will recall that the Equality, Diversity and Human Rights Annual Report noted that the Trust is required to undertaken an annual self-assessment, the ratings of which are then externally verified against the Equality Delivery System 2 (EDS 2). This was launched by NHS England in November 2011 to help NHS organisations respond to the specific duties of the public sector equality duty. At the heart of the EDS is a set of 4 clear goals that encompass 18 outcomes. The outcomes cover the issues of most concern to patients, stakeholders, communities, NHS staff and Trust Boards in relation to the nine 'protected characteristics' (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation).

Using these outcomes, performance is analysed and graded by working with local patients, community groups, staff and voluntary organisations. The goals are grouped as follows:

- Better health outcomes
- Improved patient access and experience
- Representative and supported workforce
- Inclusive leadership

For each outcome, there are 4 grades or 'criteria' as identified below:

EDS2 GRADING OF OUTCOMES		
	Undeveloped	staff members or people from all protected groups fare poorly compared staff members or people overall
	Developing	staff members or people from only some protected groups fare as well as staff members or people overall
	Achieving	staff members or people from most protected groups fare as well as staff members or people overall
	Excelling	staff members or people from all protected groups fare as well as staff members or people overall

At the last Board meeting, further information was requested on what further steps needed to be taken by the Trust with regard to the 'Inclusive Leadership' goal (noting that as at April, 2017 this was considered as 'developing' for all three indicators within this goal). These are:

- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

- Papers that come before the Board and other major Committees must identify equality-related impacts including risks, and say how these risks are to be managed
- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

The Associate Director of Nursing (who is currently overseeing this portfolio) has undertaken a peer review assessment in relation to the Inclusive Leadership goal to identify the areas that would support the Trust in moving from 'developing' to 'achieving' in this area. This was determined by seeking information from regional colleagues via e-mail correspondence and during attendance at the North West Equality & Diversity Leads Forum.

From this assessment, it was noted that the primary action was to enable senior staff to achieve the knowledge and skills required to be able to demonstrate and embed a positive equality, diversity and human rights culture throughout the organisation. This can be facilitated via education & leadership training, specifically by attendance at 'Level 2' enhanced Equality, Diversity and Human Rights (EDHR) sessions, targeted at Senior Managers and Board members.

Additional measures that will support the Trust in moving to 'achieving' include:

1. **Attainment of the Navajo Chartermark**. A number of the Trusts in the Merseyside & Cheshire and Liverpool region have received (or are seeking to achieve) attainment of this as it demonstrates a Trust's inclusive approach towards lesbian, gay, bisexual, transgender and intersex (LGBTI) people. The chartermark assessment takes into account an organisation's cultural practices and policies, how it educates, trains and recruits, and how it engages with its staff.

2. **Publication of the Workforce Race Equality Standard (WRES**). The purpose of this is to improve the experience of Black and Minority Ethnic (BME) staff within the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relation processes. It also applies to BME people who want to work in the NHS, helping to foster an environment in the Trust whereby all staff feel engaged, valued and supported which, in turn, will contribute towards high quality patient care and improved health outcomes.

3. **The Workforce Disability Equality Standard (WDES)**. From April, 2018 the Trust is required to publish a WDES. As with the WRES, the WDES will identify support mechanisms for our staff with this protected characteristic, promoting an environment whereby all staff feel engaged, safe, valued and supported.

3. Key Issues/Gaps in Assurance

1. A training needs analysis (TNA) has been undertaken and has concluded that all senior managers up to and including Board member level should undertake enhanced Level 2 Equality, Diversity and Human Rights training. An implementation training programme (and associated resource) has been agreed by members of the Executive Team and compliance has been set at 95%. It is anticipated that the Trust will reach compliance by June 2019 and performance of this will be monitored via the Workforce & Communication Group from January 2018 onwards.

2. The Trust has committed to embarking on attainment of the 'Navajo Chartermark', with achievement normally taking organisations of this size between 18 months and two years. Discussions have taken place with the Navajo North West Lead and this programme will commence in December 2017.

3. The key findings from our Workforce Race Quality Standard (WRES) analysis for 2017 show that:

    - The percentage of BME staff employed at WUTH increased by 8.2% in the 12 months up to 31 March 2017.

    - The percentage of BME staff employed at WUTH (6.7%) is greater than the population of Wirral as a whole (3.2%).

    - BME staff make up a significantly high percentage of our very senior medical grades (33% of consultants and 54% of career grade doctors).

    - Although the proportion of BME staff in our non-clinical grades is relatively low, the proportion of BME staff in band 8 is higher than in lower bands.

    - BME staff are less likely to be disciplined than non-BME staff.

    - BME staff are more likely to access non mandatory training and CPD than non-BME staff.

    - Our latest staff survey results show that:-

        - BME staff are significantly less likely to experience harassment, bullying or abuse from patients, relatives or the public than non-BME staff

        - BME staff are less likely to experience harassment, bullying or abuse from colleagues than non-BME staff

        - Fewer BME than non-BME staff believe the Trust offers equal opportunities for career progression

        - BME staff are less likely than non-BME staff to have personally experienced discrimination at work from managers/teal leaders or other colleagues

    - There are no voting BME board members

4. The Workforce & Communication Group will oversee the requirement to publish a Workforce Disability Equality Standard (WDES) from April, 2018.

5. Whilst the broader Equality, Diversity and Human Rights Action Plan is not included within this paper, members are asked to note that the Workforce & Communication Group will receive a bi-annual report on delivery against the action plan in October, 2017.

4. Concluding Comments and next Steps

The Inclusive Leadership domain is currently graded as 'developing'.

Having moved from an 'undeveloped' Inclusive Leadership EDS2 rating in 2015/16, to one of 'developing' in 2016/17, this demonstrates the Trust's commitment towards continuous improvement in attaining a rating of 'achieving' by 2017/18. With a focused and concerted effort, the Trust is capable of achieving a rating of 'excelling' within the next two/three years.

The Workforce Race Equality Standard will be placed on the Trust internet site.

A full six month progress report outlining the trust's legislative, contractual and NHSE requirements will be received by the Workforce and Communications Group with sign off by the Quality & Safety Committee (via the Workforce Chairs report). The achievement of the indicators within the EDHR action plan will provide evidence relating to all four goals within the EDS2.

5. Recommendations

The Trust Board is asked to note the details of the paper and comment on whether any further assurance is required.

Glossary of terms

BME	Black and Minority Ethnic
EDHR	Equality, Diversity and Human Rights
EDS	Equality Delivery System
EDS2	Equality Delivery System 2
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
TNA	Training Needs Analysis
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Board of Directors	
Agenda Item	7.4
Title of Report	Annual Review of Modern Slavery Act
Date of Meeting	27th September 2017
Author	Carole Ann Self, Director of Corporate Affairs
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk 18
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

Executive Summary

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

Summary of the Act

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains. Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial

year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors.

There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money.

Assurance

The Trust will be required to review and /or prepare a similar statement on an annual basis.

Recommendations

The Board is asked to review the Annual Statement as attached and approve this for inclusion on the Trust's website.

Modern Slavery and Human Trafficking Act 2015 Annual Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are being taken to prevent slavery and human trafficking.

Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our 5,500-strong workforce serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint. We operate across two main sites these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebbington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

The Trust acknowledges responsibility under the Modern Slavery Act and will ensure transparency within the organisation. The Trust has well established and robust recruitment and vetting procedures however at this time it cannot provide assurances that suppliers operate to the same high ethical standards and code of conduct .

In August 2016 the Trust wrote to all suppliers requesting them to affirm their compliance with the legislation. This will now be undertaken on an annual basis. Additional provisions will be built into the Trust's procurement and tendering processes to ensure Suppliers are compliant with the requirement of the Act. Where frameworks are used to satisfy the Trust's requirement for goods, works or services Procurement will work with the framework providers to ensure that similar provisions prevail.

The Trust's Procurement team (Buyers) are all members of the Chartered Institute of Purchasing and Supply (CIPS) and uphold the CIPS code of professional and ethical conduct and practice. This high level approach will be strengthened in supply chain categories identified as being more likely to employ forced labour (agricultural, construction, food processing, hospitality industries and in factories).

The Trust will continue to follow good practice, ensuring all reasonable steps are taken to prevent slavery and human trafficking within its supply chain and will monitor and review its approach via the Trusts Procurement Strategy."

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Board of Directors	
Agenda Item	7.5
Title of Report	Chair of Audit Committee Report
Date of Meeting	27th September 2017
Author	Graham Hollick, Chair of the Audit Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

This report provides a summary of the work of the Audit Committee which met on the 15 September 2017. Key focus areas are those, which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The Committee received the updated Board Assurance Framework (BAF) and considered how the Trust had reviewed the risks within it during the reporting period. The Committee noted that 6 changes in risk score took place since its last review and noted the emerging risks highlighted through the Board or the Senior Management Team. The Committee was assured that the BAF had been reviewed at each of the appropriate committees and that action had been taken as a result of this.

The Committee welcomed the incorporation of risks above 15+ as part of the reporting process as this aligned the risks in the electronic risk management system Safeguard with those in the BAF.

The Committee was provided with an overview as to how the BAF had formed part of a training programme for Divisions and Corporate Services teams supplemented with risk management training.

The Committee was pleased with the revisions made to the BAF which afforded the Trust with a much more streamlined overview of each risk. The Committee also noted that further work was being undertaken on the risk descriptors in particular in relation to strategy.

The Committee agreed that the methodology for updating, review and escalation of the risks in the BAF provided adequate assurance.

Legal Update

The Committee received a legal update which included the following:

- The recent publication of the Use of Resources Assessment
- The recent publication in relation to the Well Led Assessment
- The consultation currently underway on the Single Oversight Framework

The main topic of discussion focussed on the Use of Resources Assessment which commenced in September 2017. The full guidance is attached at **Appendix 1.** The Committee was advised that the CQC would publish the UoR rating in line with existing CQC ratings these being Outstanding, Good, Requires Improvement and Inadequate. The key metrics for the assessment were reviewed and assurance sought that the Trust could capture this data. The Committee noted that the Board was due to receive an overview of the Model Hospital presentation in September which includes the key metrics for this assessment. The Committee was advised that the UoR assessment would be combined with quality from early 2018 following further consultation. The Committee recommended that the UoR assessment form part of the Internal Audit Programme in the future.

The Well Led Assessment was published in June 2017 by NHSI and replaced the Well-Led Framework for Governance Reviews: Guidance for NHS Foundation Trusts (April 2015). The guidance retains a strong focus on integrated quality, operational and financial governance and includes much more explicit Key Lines of Enquiry KLOEs. The Interim Director of Governance in preparation for the next CQC inspection will be working with the Board and Senior Managers with a view to establishing our baseline assessment against the KLOEs.

The Committee noted the consultation on the changes to the Single Oversight Framework which closed on the 18th September 2017. The draft version takes into account the UoR assessment. Essentially the key changes are to the format and presentation of the document and some small changes to the information and metrics NHSI uses to assess Providers' performance under each theme and the indicators that trigger consideration of a potential support need.

Performance will only be linked to STF trajectories for A & E standards, meaning that for all other indicators this will be the constitutional standard and a new metric for dementia is planned. The updated version of the Single Oversight Framework is due to be launched in October 2017. The final version of the Single Oversight Framework will be presented to the Board in October 2017.

Compliance with Licence Review

The Committee reviewed compliance with key areas of the Provider Licence and as per previous discussions agreed to align part of the review with the annual declaration made by the Board each year. There were no new risks to bring to the Board's attention.

Standards of Business Conduct

The Committee reviewed compliance against the revised Standards of Business Conduct Policy which the Trust monitors through the Senior Management Team. Although the Committee noted a significant improvement in the number of declarations made and how the Trust was monitoring this, there was still more work to do. The Committee noted the requirement to publish declarations in line with the new national guidance on the Trust website.

The Committee noted the increased number of Freedom of Information Requests in this arena and also reviewed the work of MIAA internal Auditors in this regard. The Committee was made aware

of incidences where secondary employment/conflicts had not been declared which were being followed up.

Financial Assurance Report

The Committee reviewed the Financial Assurance Report and in particular:

- The losses and special payments recorded up to 31 July 2017
- The current debtors position – over 6 months old and over £5k and overseas patients
- Capital – completed projects with spend +/- 10% of plan
- Single tender actions

The Committee sought an understanding of the latest position with regards to One to One Midwives and the work being undertaken with NHSI in this regard. There were no other issues raised by Committee members.

NEP ISAE 3402 Report

The Committee reviewed the most recent International Standard for Assurance Engagements ISAE 3402 Type II auditor report on the Trust's financial system. The report offered the Committee assurance regarding the design and operation of controls within the Trust's financial system. These controls mitigate risks to the Trust of error or fraud.

There were a number of relatively minor (low risk) exceptions listed in the report which the Trust had responded to. There was one exception which was identified as more significant. The exception pertained to a period during which NEP's subcontractor (Capita IBS) held a single user account with the ability to amend clients' ESR (payroll) data. The service auditors' opinion as a result of this was "qualified". Measures have been put in place to address the identified exceptions

With regards to the more significant exception the Committee took assurance that the Trust had taken the necessary action to mitigate this risk.

Internal Audit

The Committee received and reviewed the following Internal Audit Reports:

- Water Safety – significant assurance
- Bank and agency staffing – significant assurance
- Mandatory training – significant assurance
- CQC Improvement Action Plan – significant assurance
- HR/ESR payroll – significant assurance

Anti-Fraud Progress Report

The Committee reviewed the progress of the Anti-Fraud work plan as well as the progress made to address fraud referrals.

The Committee was updated as to how NHS Protect benchmarks organisations for this work.

External Audit

The Committee received a report on progress from the External Auditors noting that this is early in the audit cycle.

Graham Hollick
Audit Committee Chair

Use of Resources: assessment framework

August 2017

support collaborate challenge improve inspire

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

Introduction

1. As public-sector organisations, NHS trusts and NHS foundation trusts (here together referred to as trusts) are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

2. NHS Improvement's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of *Operational productivity and performance in English NHS acute hospitals*. They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, our approach will focus on acute non-specialist services, due to the availability and quality of data in this area. As we develop metrics for specialist acute, ambulance, mental health and community services, we will include them in this framework before introducing Use of Resources assessments to providers of these services.

3. The principles that underpin the Use of Resources assessment are that it should:

   - lead to a focus on better quality, sustainable care and outcomes for patients
   - be proportionate, minimising regulatory burden, and draw on existing data collections where possible
   - be clear to trusts what information we will look for and what 'good' looks like – all data will be made available to all trusts through the Model Hospital[1]
   - promote good practice to aid continuous innovation and improvement

[1] https://model.nhs.uk/

- help us to identify trusts' support needs through the Single Oversight Framework, as well as being a useful improvement tool for organisations.

4. The framework mirrors the structure of the joint Well-Led framework and CQC's inspection approach, where key lines of enquiry (KLOEs), prompts and metrics are used for a balanced assessment of a trust.

5. NHS Improvement will introduce Use of Resources assessments alongside CQC's new inspection approach from autumn 2017. In autumn 2017 CQC and NHS Improvement will also consult on how Use of Resources ratings should best be combined with other ratings to yield an overall trust-level rating, to be introduced from 2018.

Use of Resources: the assessment

6. Use of Resources assessments are based on a number of KLOEs, which are the lens through which trust performance should be seen (see Figure 1). The KLOEs correspond to the main areas of productivity – clinical services; people (including doctors, nurses and allied health professionals – AHPs); clinical support services (including pharmacy and pathology services); corporate services, procurement, estates and facilities; and finance. Data relating to all these areas can be found on the Model Hospital.

Figure 1: Overview of key lines of enquiry

Use of resources area	Key lines of enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

7. The starting point for Use of Resources assessments will be an analysis of trust performance against a small number of initial metrics, local intelligence gathered during NHS Improvement's day-to-day interactions with the trust, as well as any other relevant evidence, such as specific data and analysis drawn from the work of the Operational Productivity directorate within NHS Improvement and made available to trusts through the Model Hospital.

8. This analysis will be followed by a qualitative assessment carried out during a one-day site visit to the trust and using the KLOEs and prompts to help probe trust performance in a consistent and comparable manner. NHS Improvement's assessment team, made up of approximately five senior staff, will obtain input from the leadership team with responsibility in the areas of clinical and operational services, workforce and finances. We are likely to meet the trust's chair, chief executive officer, medical director, nursing director, finance director, human resources director, chief operating officer, head of procurement, head of estates and chief pharmacist.

9. All relevant evidence will be collated into a brief report and used to reach a proposed rating of outstanding, good, requires improvement or inadequate in accordance with CQC practice. NHS Improvement will use the Use of Resources draft report and proposed rating to identify potential support needs at trusts.

10. NHS Improvement will also submit the draft Use of Resources assessment report and proposed rating to CQC, which will consider it as part of the process of preparing and finalising its trust-level inspection reports. CQC will consider NHS Improvement's report and recommendations in determining the trust's final Use of Resource rating and will publish the final report and rating alongside the trust-level inspection report and the current Quality rating.

Use of Resources: the evidence

11. The Use of Resources assessment centres on delivery and performance at trust level currently and looking back over the previous 12 months. We recognise that trusts do not work in isolation and are working with, and affected by, their local health and care economies. CQC will assess the way trusts are working in their local systems through the updated Well-Led framework.[2] The Use of Resources assessment focuses on how effectively trusts are using their resources in the context of the funds available to them.

12. NHS Improvement will draw on a wide range of evidence that will include a basket of initial metrics, additional data or information collected by us and shared by the trust, local intelligence from our day-to-day interactions with the trust, and evidence gathered during a qualitative assessment (see Figure 2).

Figure 2: Evidence for Use of Resources assessments

Initial metrics	• How is the trust performing on each initial metric? • Is the trust an outlier on any of the initial metrics?
Additional evidence	• Is the trust an outlier on any of the wider set of metrics (eg Model Hospital, Getting It Right First Time (GIRFT), data supplied by the trust)? • Is there any data or information, shared with us by the trust, which is used internally to assess productivity?
Local intelligence	• Are there any areas of finance and productivity not covered by the metrics where the trust's performance is notable? Are there any areas of unrealised efficiencies? • What do we know about the trust's performance more generally, eg cost improvement programmes, private finance initiatives, local health and care economy context?
Qualitative assessment	• Please see key lines of enquiry and prompts

[2] https://improvement.nhs.uk/resources/well-led-framework/

Initial metrics

13. The initial metrics are the starting point for the Use of Resources assessment (see Figure 3). They include productivity metrics drawn from the work of the Operational Productivity directorate in NHS Improvement and cover clinical services; people (workforce); clinical support services; and corporate services, procurement, estates and facilities. All such metrics are available to trusts through the Model Hospital. The initial metrics under the finance KLOE contain the Finance and Use of Resources theme metrics currently in NHS Improvement's Single Oversight Framework.

14. For all metrics we consider in assessing trusts' use of resources, we will ask the following general questions:

    - How does performance compare with the national average and the trust's peer group?
    - Has the measure improved or deteriorated in the last 12 months?
    - Is there a reason or relevant context for the trust's performance?
    - Has the trust implemented any activities or interventions to improve performance as appropriate in the given area? Have these been effective?

15. The metrics will be used as the basis for engagement with trusts to understand the drivers for performance in these areas, and no single metric (and indeed no single piece of evidence throughout the assessment) will determine a trust's Use of Resources rating. (See Appendix A for further details about the rationale for inclusion of the initial metrics.)

16. All the initial metrics will be made available through the Model Hospital. However, it is important to note that not all of the metrics available on the Model Hospital are included in the initial metrics for this assessment. Other metrics on the Model Hospital are intended to give a broader, more granular view of productivity to support trusts to drive their own improvement, alongside the assessment process. Where new robust, high quality metrics become available, we will consider whether they provide broader insight into the productivity of trusts and should become part of the initial metrics.

17. A number of metrics, including 'cost per test', have only been recently developed and are currently being refined. This will be taken into

consideration when performing the assessments. We are also working to develop productivity metrics for specialist, mental health, community and ambulance trusts. The Use of Resources assessment will be adapted and introduced for non-acute trusts as and when these metrics are available.

Figure 3: KLOE themes and initial metrics

Use of resources area	Initial metrics
Clinical services	Pre-procedure non-elective bed days Pre-procedure elective bed days Emergency readmissions (30 days) Did not attend (DNA) rate
People	Staff retention rate Sickness absence rate Pay cost per weighted activity unit (WAU) Doctors cost per WAU Nurses cost per WAU Allied health professionals cost per WAU (community adjusted)
Clinical support services	Top 10 medicines – percentage delivery of savings target Overall cost per test
Corporate services, procurement, estates and facilities	Non-pay cost per WAU Finance cost per £100 million turnover Human resources cost per £100 million turnover Procurement Process Efficiency and Price Performance Score Estates cost per square metre
Finance	Capital service capacity Liquidity (days) Income and expenditure margin Distance from financial plan Agency spend

Additional evidence and local intelligence

18. Additional evidence and local intelligence gathered during day-to-day interactions with trusts will give NHS Improvement a broader and more rounded view of trust performance, helping us understand the context in which the trust operates. This may include any other relevant and useful data, such

as information from the Getting It Right First Time (GIRFT) specialty programmes or other data contained on the Model Hospital, such as proportion of consultants with an active job plan, pharmacy staff cost per WAU, medicines cost per WAU, percentage of transactions on e-catalogue, and estates and facilities cost per WAU. It will help identify areas of good performance, unrealised efficiencies and areas for improvement that may have been missed by examining the initial metrics alone.

19. In a similar way to CQC's inspection process and as part of CQC's provider information return, trusts will be asked to provide brief, high-level commentary against each KLOE ahead of each assessment. Trusts will also be asked to review NHS Improvement's analysis of the initial metrics and share more recent data that they think might be helpful to inform the assessment. NHS Improvement will review all submissions to inform our understanding of the trust's performance and identify areas that would benefit from particular focus at the on-site assessment. Some additional evidence may occasionally be requested after the on-site assessment to support qualitative evidence collected on the day.

Qualitative assessment

20. The aim of the prompts (see Figure 4) is to get a better understanding of trust performance, contextual information and improvement action undertaken by the trust. NHS Improvement will rely on these during the site visit, but will not be bound by them. Assessment teams are likely to ask additional questions and will not necessarily use all the prompts during the assessment.

Figure 4: Prompts for key lines of enquiry

KLOE	Prompts
Clinical services: How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?	• How far are delayed transfers of care that are within the trust's control leading to a lack of bed capacity and/or cancellations of elective operations? • Is the trust improving clinical productivity (elective and non-elective) by doing what could reasonably be expected of it in co-ordinating services across the local health and care economy? • What percentage of elective and non-elective cases are admitted on the day of surgery for each specialty? • Has the trust engaged with the GIRFT programme? What improvements have been made as a result?
People: How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?	• How is the trust tackling excessive pay bill growth, where relevant? • Is the trust operating within the agency ceiling? • How well is the trust reducing its reliance on temporary staff, in particular agency nurses and medical locums? • Are there significant gaps in current staff rotas? What has the trust been doing to address these? • Is the trust making effective use of e-rostering or similar job management software systems for doctors, nurses, midwives, AHPs, healthcare assistants and other clinicians? How many weeks in advance are the trust's rosters signed off? • Is there an appropriate skill mix for the work being carried out (clinical and otherwise)? • Are new and innovative workforce models and/or new roles being investigated? Is the trust making effective use of AHPs to improve flow? • Is the trust an outlier in terms of sickness absence and/or staff turnover? • What proportion of consultants has a current job plan? How is job plan data captured?

Clinical support services: How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?	• Is the trust collaborating with other service providers to deliver non-urgent pathology and imaging services? • Is the trust an outlier in terms of medicines spend? • Is the trust using technology in innovative ways to improve operational productivity? For example, patients receive telephone or virtual follow-up appointments after elective treatment.
Corporate services, procurement, estates and facilities: How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?	• What is the trust doing to consolidate its corporate service functions? Which functions are being consolidated and how? • Is the trust an outlier in terms of procurement costs? • Is the trust looking for and implementing appropriate efficiencies in its procurement processes? • What is the value of the trust's backlog maintenance (as cost per square metre) and how effectively is it managed? • How efficiently is the trust using its estate and is it maximising the opportunity to release value from NHS estate that is no longer required to deliver health and care services?
Finance: How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?	• Did the trust deliver, and is it on target to deliver, its control total and annual financial plan for the previous and current financial years respectively? • What is the trust's underlying financial position? • How far does the trust rely on non-recurrent cost improvement programmes (CIPs) to achieve financial targets? • What is the trust's track record of delivering CIP schemes? • Is the trust able to adequately service its debt obligations? • Is the trust maintaining positive cash reserves? • Is the trust taking all appropriate opportunities to maximise its income? • How does the trust use costing data across its service lines? • To what extent does the trust rely on management consultants or other external support services?

Ratings characteristics

21. The ratings characteristics (see below) describe what outstanding, good, requires improvement and inadequate use of resources look like. This framework, when applied using judgement and taking into account good practice and recognised guidelines, will guide NHS Improvement and CQC when assessing trusts' use of resources and determining ratings.

22. The characteristics set out the kinds of factors that will be taken into account in making the overall assessment. Ratings will reflect all the available evidence and the specific circumstances of the trust. A trust will not have to demonstrate all the attributes in a ratings characteristic to have it applied to them nor will a characteristic be applied purely because the majority of the attributes are considered to be present. Where a trust is in special measures for financial reasons, the trust rating will be no better than 'requires improvement'.

Outstanding

The trust is achieving excellent use of resources, enabling it to provide high quality, efficient and sustainable care for patients.

The trust takes a proactive, and often innovative, approach to managing its financial and non-financial resources, which supports the delivery of high quality, sustainable care and achieves excellent use of its resources.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of care or rehabilitation, for example a discharge to assess model, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Clinical productivity improvements are achieved by, for instance, appropriately co-ordinating services across the local health and care economy and in line with good practice identified through the GIRFT programme.

The organisation actively involves patients in scheduling elective care, leading to low DNA rates. Effective capacity and demand planning, and patient-centred care pathways support low levels of emergency readmissions and pre-procedure non-

elective and elective bed days.

There is effective control over staff costs with expenditure on staffing not exceeding initial staffing budget, low pay bill growth and low pay cost per weighted activity unit (WAU). The trust is operating below or at its agency cap and has low staff turnover and sickness levels. Innovative and efficient staffing models and roles are used to deliver high quality and sustainable care, including by ensuring there is an appropriate skill mix for the work being undertaken.

The organisation makes extensive use of job planning to effectively organise and deploy its entire workforce, including consultants, nurses and AHPs, to maximise productivity.

The trust can demonstrate the use of technology in innovative ways to improve productivity, for example through telephone and virtual follow-up appointments, real-time monitoring and reporting of operational data, medical staff job planning through e-rostering and electronic shift booking systems, e-prescribing, electronic catalogues for procurement and electronic payments.

The trust has implemented efficiencies across the majority of its procurement and back office functions, pharmacy, and pathology services through collaborative arrangements, including consolidation wherever possible, and leads transformation initiatives in these areas.

The trust's estates management, human resources and finance functions are cost effective, which is reflected in, for example, low estates and facilities running costs and a well-managed property maintenance backlog.

Financial resources are used as efficiently and effectively as possible to provide the best possible value (that is, quality and cost) to patients and taxpayers, as demonstrated by the trust's income and expenditure position.

The trust is in surplus and has an excellent track record of managing spending within available resources and in line with plans. It delivered its financial plan in the previous financial year and is on track to deliver its financial plan and meet its control total in the current financial year.

The trust has an ambitious cost improvement programme (CIP), which is currently delivering against plan, and delivered its planned savings in the previous financial year. CIPs have been driven by recurrent efficiency schemes, including those of a transformational nature.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support[3] in the last 12 months.

Good

The trust is achieving good use of resources, enabling it to provide high quality and sustainable care for patients.

The trust is actively managing resources to meet its financial obligations on a sustainable basis to deliver high quality care and good use of resources. There is evidence of a systematic approach to identifying and realising efficiency opportunities.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Some clinical productivity improvements have been achieved by, for instance, engaging with good practice identified by the GIRFT programme.

There is some evidence of effective communication with patients in respect of scheduling care, which is manifested in the trust's DNA rates. There is evidence of pathway development and/or capacity planning at service-line level leading to reduced emergency readmission rates and pre-procedure non-elective and elective bed days.

Staff costs are generally well controlled, demonstrated by expenditure on staffing not exceeding initial staffing budget and by the trust's pay bill growth, pay cost per WAU and staff turnover and sickness levels. The trust is operating at or around its agency cap. There are some examples of staffing innovation replacing traditional models of care delivery (for example, use of nursing associates).

The organisation makes good use of job planning to organise and deploy much of

[3] As defined in Secretary of State's Guidance under section 42A of the National Health Service Act 2006.

its workforce effectively, in particular doctors and nurses.

The trust uses technology in some areas to improve productivity and effectiveness, for example by good utilisation of digital systems, medical staff job planning and e-rostering systems.

The trust continues to look for and has implemented some efficiencies across its procurement and back office functions, pharmacy and pathology services, including consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions are fairly cost effective, which is reflected in, for example, its estates and facilities running costs and an effectively managed property maintenance backlog.

The trust is in surplus and broadly on track to deliver its planned financial position in the current year. Or the trust is in deficit, but the planned position shows a marked improvement on the previous year and the trust is meeting its control total.

The trust is able to demonstrate delivery against a CIP which is forecast to deliver the planned level of improvement at the end of the year and has delivered planned savings in the previous financial year.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected in its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support.

Requires improvement

The trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care. The approach to identifying and realising efficiency opportunities is not embedded across the organisation.

A material number of patients are not receiving care in the best clinical setting and the trust is not doing enough to address delayed transfers of care for patients out of acute hospital settings. Suboptimal discharge planning and a lack of collaborative

working are resulting in relatively high rates of emergency readmissions.

Some clinical improvements have been made; however, these have been inconsistently implemented and have not sufficiently taken into account the sustainability of the trust's service lines.

Staff costs are not effectively controlled within budget, as evidenced by the trust's pay bill growth, pay cost per WAU, distance from the trust's agency cap, and staff turnover and sickness levels. The trust consistently struggles to fill gaps in rotas, and has not maximised the benefits of innovative workforce models and new roles (for example, use of nursing associates).

The trust's use of technology to improve productivity is elementary, for example failing to maximise the benefits of job planning, e-rostering systems or basic electronic catalogues for procurement.

The trust is still at early stages of considering the implementation of efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions could be more cost effective, which is reflected, for example, in its estates and facilities running costs and inconsistent management of its property maintenance backlog.

The trust is in deficit and is delivering a financial plan that does not improve on the previous year's position or meet its control total.

The trust did not realise its cost improvement programme for the previous financial year. Its current cost improvement programme is behind plan, and there is significant risk it will not be achieved by the end of the year.

The trust is not able to consistently meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is unable to maintain positive cash balances without the need for interim support or is expecting to require this support in its current plans.

Inadequate

The trust is not making adequate use of its resources, putting at risk its ability to provide high quality, efficient and sustainable care for patients.

The trust is not managing its resources in a way that supports the delivery of high quality care or demonstrates adequate use of resources is being achieved. There are significant and wide-ranging unmet efficiency opportunities.

The trust is unable to control its staff costs, including, for instance, unwarranted pay bill growth that is significantly higher than comparable peers, high pay cost per WAU, and agency costs that are more than 50% above the trust's agency cap. The trust's workforce is not being used effectively, demonstrated by substantial or frequent staff shortages, high turnover and staff sickness rates and ineffective job planning.

The trust's estates management, human resources and finance functions are inefficient, demonstrated by, for example, high estates and facilities running costs. There is no effective programme in place to repair and maintain the trust's estate.

The trust is not utilising its existing digital systems effectively and is doing little to use technology to improve efficiency; for example, there is no use of basic electronic catalogues for procurement and no payments are made electronically.

The trust has undertaken little or no work to implement efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

Plans for patient discharge or transfers are incomplete or significantly delayed, and as such patients are not moved into settings that are more appropriate for the delivery of their care or rehabilitation, or are not being cared for in the best clinical setting. Poor discharge planning and a lack of collaborative working are resulting in unacceptably high rates of emergency readmissions.

Few clinical improvements have been made, often implemented inconsistently and having little or no impact on the sustainability of the trust's service lines.

The trust is in deficit and its financial plan does not improve on the previous year's position or meet its control total. Or the trust is in deficit and off track to deliver its financial plan and is not expecting to recover within the financial year.

The trust's CIP is materially behind plan and it is not able to recover the position.

The trust is not able to meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is unable to maintain positive cash balances without the need for interim support.

Appendix A: Use of Resources metrics and rationale

Area	Initial metrics	Rationale
Clinical services	Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
	Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. Better performers will have a lower rate of readmission.
	Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
People	Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
	Sickness absence	High levels of sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.

	Pay cost per weighted activity unit (WAU, a unit of clinical output)	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
	Doctors cost per WAU	This is a doctor-specific version of the above pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	Nurses cost per WAU	This is a nurse-specific version of the above pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
	AHP cost per WAU	This is an AHP-specific version of the above pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Clinical support services	Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. A low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
	Top 10 medicines	As part of the top 10 medicines project, trusts are set trust-specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines (complex medicines that are clinically comparable to the branded product), the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Corporate services, procurement, estates and facilities	Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.

	HR cost per £100 million turnover	This metric shows the annual cost of the HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
	Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score for five individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
	Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance	Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
	Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
	Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
	Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
	Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.

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BOARD OF DIRECTORS	
Agenda Item	7.6
Title of Report	Annual Review of the Board Assurance Framework
Date of Meeting	27 September 2017
Author	Carole Ann Self, Director of Corporate Affairs
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	Bronze – qualitative data
FOI status	Entire document is exempt under FOI
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

This report reviews the process for review and update of the Board Assurance Framework which was established in its current state in September 2016.

Members will recall that the Trust had taken the decision to revise the framework for a variety of reasons as outlined below:

- The key measures which underpin the revised strategic objectives for 2016/17 and now 2017/18 were extensive and did not lend themselves to being incorporated into the existing BAF format.

- The Board had requested that the learning from the risk appetite session be incorporated into the BAF.
- The introduction of Sustainability and Transformation Trajectories from NHSI and the need to monitor progress against these without losing sight of NHS constitutional standards.
- The number of risks that had emerged as a result of the agreement of a financial envelope with the Commissioner associated with managing demand and referral levels.
- The feedback from the Well led Governance Review in relation to providing an "at a glance" view of the trajectory of risk scoring and tolerance for each and the need to clearly articulate how risks are assigned to relevant Committees
- The need to manage the size of the BAF in an ever challenging landscape
- The new single oversight framework and the appetite from the Board to frame risks around themes

The BAF took into account all these considerations without losing the strengths of the original BAF in terms of all Board Members being able to articulate clearly what the key risks facing the organization were and our ability to manage them.

2. Methodology for review of the BAF

The Board is required to undertake an annual review of the BAF to ensure that the methodology for review provides the Board with the assurance it requires. This report outlines how the BAF has been reviewed over the last 12 months. The current iteration of the BAF is provided at **Appendix 1** with an overview of the Trust's risks at **Appendix 2.**

Each of the Board's Assurance Committees has undertaken a review of the BAF at each of its meetings during the last 12 months. Each of the 20 risks identified by the Board are assigned to each of these Committees. The Audit Committee at each of its meetings over the last 12 months has reviewed how the Finance Business Performance and Assurance Committee and the Quality and Safety Committee has reviewed the BAF including changes to risk scores; emerging risks and those risks above 15+ were being managed. The Board receives an update on the BAF at each of its public meetings via the Assurance Committee Chairs Report.

The content of each of the risks in the BAF has changed extensively during the year to reflect the mitigating action and assurance for each of these. The latest iteration of the BAF seeks to outline each risk on one page to ensure that the key focus for action and assurance is drawn out. The Trust acknowledges that there is still more work to do to ensure that the description of the risk adequately reflects the ever changing NHS context.

The changing risk score over the last 12 months is clearly articulated in the form of a graph in the detailed analysis of each risk.

The BAF is a "live" document and is used extensively throughout the Trust and much more recently in the Senior Management Team meetings SMT and with Governors. The SMT identify emerging risks for Board members to be aware of together with the action that is being taken to address these. It also reviews all risks above 10+ and escalates any above 15+ to the appropriate Assurance Committee, with any above 20+ being referred directly to the Board. These risks haven't necessarily impacted on the overall strategic objectives of the Trust but early oversight and action have led to successful mitigation and risk reduction in every case.

3. Risk Appetite

The Board determined in September 2016 that it would develop a risk appetite statement and following extensive consultation the Board agreed its risk appetite statement as attached at **Appendix 3** and this has been widely shared throughout the organisation and has been used to develop tolerable risk scores in the BAF.

4. Learning and development of an open and transparent culture

The Trust has rolled out training and awareness on the use of the BAF with all Divisional and Corporate Service Leadership teams alongside risk management training. The BAF is available on the Trust's intranet for all staff to access and is updated on a monthly basis. This has created a greater understanding of risk and the importance of mitigation or escalation as appropriate.

Sharing the BAF throughout the organisation supports the Trust's desire to develop a much more open and transparent culture.

Because the BAF is so extensively used throughout the organisation, if a risk materialises that the Trust was unaware of, this prompts learning to understand how the Trust can ensure that this does not happen again and provides a useful signal in terms of good integrated governance.

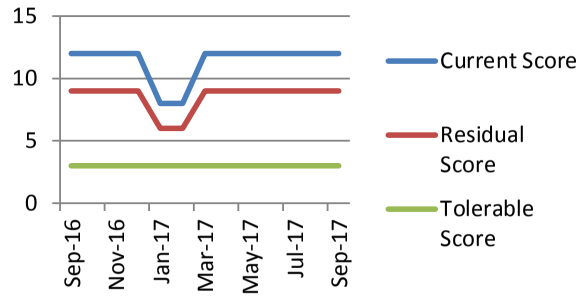
5. Recommendations

The Board is asked to consider whether the BAF has enabled the Trust to have oversight of its key risks and the actions being taken to mitigate these and whether any further improvements are required.

Quality of Care

Strategic Objective:			**To be**: the top NHS Trust in the North West for patient and staff satisfaction **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	2a – Continue to deliver our quality strategy and build on the recommendations of our September 2015 CQC inspection	
				Linked Risks/ collaboration opportunities		
Risk ID:	1	**Risk:**	**Quality and Safety:** The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	**Board Lead:**	Medical Director	**Date last reviewed:** August 2017
				Audit Committee Position	MIAA Quality Spot checks – significant assurance report received in December 16 MIAA Safeguarding – significant assurance report – May 16 MIAA Safe Staffing (nursing) – limited assurance – Feb 17 MIAA Mandatory Training audit – significant assurance – July 17	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 3 = 12
Residual Risk Score:	3 x 3 = 9
Tolerable Risk Score:	1 x 3 = 3
Direction of Travel:	⟷



Controls: (How are we managing this risk?)

- Quality and Safety Committee commissions "deep dive" reports
- Weekly safety summits followed by a review of serious incidents (real time learning)
- Weekly Safety Bites bulletin
- Review of Integrated quality dashboard & identification of key action required
- Using CQC Insight to prioritise intervention
- Harm care reviews in place for long waiters

Assurances (How do we know if the things we are doing are having an impact?)

- Audits and Patient Feedback indicate improvements in End of Life Care
- Maternity cultural review – positive patient and staff feedback through FFT
- Safety thermometer targets compliant – July 17
- Reduction in VTE pressure ulcers – 33%
- HSMR and SHMI data better than national expectations
- Increased awareness of MCA/Dols –Audit June 17

Key Performance Indicators

Cross reference to integrated quality dashboard August 17

Gaps/rationale for current risk score/emerging risks

1. Trustwide safety culture – concerns with Never Events
2. Safe staffing – Nursing in Medicine & Acute and Junior Medical Staff Trustwide
3. Medicines storage audit (clinical areas) – 78% compliant – July 17
4. Clinical handover flagged as a risk by CQC following serious incident review/audit of electronic handover indicates non-compliance – July 17
5. Protecting Vulnerable People training behind trajectory although increasing
6. Access to good quality data that aids decision making
7. Current compliance against all CQC fundamental standards

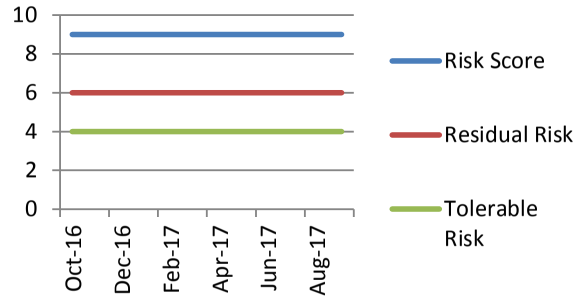
Mitigating actions: (What further mitigating action could be take?)

1. Introduction of safety summits and OD interventions - ongoing
2. Nurse recruitment campaigns & development of hybrid roles and development of workforce plan to address shortages – Sept 17
3. Meds Storage - 6 areas that have been non-compliant for 2 months to complete weekly checks
4. Closer monitoring of audit compliance with electronic handover – Aug 17
5. Trajectory of improvement in place for MCA/Dols training – Sept 17
6. Draft Integrated Quality Dashboard in development – Sept 17
7. CQC inspection preparation group in place, updates to Q & S

Quality of Care

Strategic Objective:			**To be:** the top NHS Trust in the North West for patient and staff satisfaction **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver an FFT recommend score of above 95% and a non-recommend score of below 2% 1b – Deliver a year on year reduction in the number of complaints and a year on year improvement in response times 2b – Deliver the Harm Free Care programme and ensure that the Trust Harm Free Care score is no lower than 95% 2c – Deliver a Hospital Mortality Rate that is better than expected 7c – Look to improve our Research and Development Metrics	
				Linked Risks/ collaboration opportunities	Risk 9 - 4 hour A & E Standard Risk 10 - RTT	
Risk ID:	2	**Risk:**	**Patient Experience:** The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	**Board Lead:**	Director of Nursing and Midwifery	**Date last reviewed:** August 2017
				Audit Committee Position	MIAA previous Limited Assurance report on water safety – High risk recommendations completed Mar 17.	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 3 = 9
Residual Risk Score:	2 x 3 = 6
Tolerable Risk Score:	2 x 2 = 4
Direction of Travel:	⟷



Controls: (What are we currently doing about the risk?)

- Monthly Integrated Quality Dashboard
- Revised QIA process for all CIP schemes with post implementation review

Assurances (How do we know if the things we are doing are having an impact?)

- Positive QIA process review undertaken by CCG – August 17
- Safety thermometer targets compliant – July 17
- HSMR and SHMI data better than national expectations
- Bereavement survey – 92.6% recommend rate March 17 from 57% in 2014
- Complaints reducing compared to 2016/17

Key Performance Indicators

Cross reference to integrated quality dashboard August 17

Gaps/rationale for current risk score/emerging risks

1. Complaints response times show levels outside of acceptable timescales
2. FFT scores in ED and outpatients deteriorating
3. PLACE survey – food scores lower than expected following CIP initiative although Trust responded by making further changes
4. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year

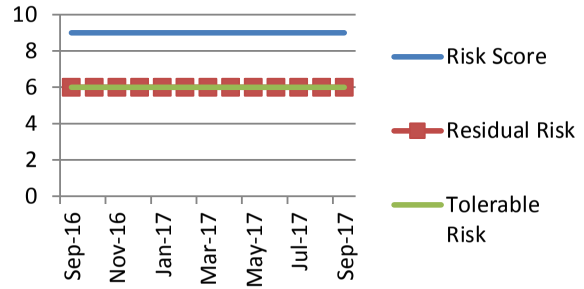
Mitigating actions: (What more should we do?)

1. Short term resource being identified to respond to longstanding complaints
2. Actions as per Nursing Performance Paper Sept 17
3. Action already taken to mitigate the risk
4. Learning from Inquests paper along with recommendations presented to Q & S – Sept 17

Quality of Care

Strategic Objective:			**To be:** the top NHS Trust in the north west for patient and staff satisfaction **To ensure:** our people are aligned with our vision	**Key Measures:**	1c - Deliver a year on year improvement in our staff satisfaction survey score 5a – Continue the on-going delivery of the Workforce and OD Strategy to deliver (i) healthy organisational culture (ii) sustainable and capable workforce (iii) effective leaders and managers 5b – Work to deliver absence rates below 4%, appraisal rates of 88% and continued improvement in our NHS Staff Survey 5c – Increase the number of staff attending LiA events by 20%	
				Linked Risks/ collaboration opportunities		
Risk ID:	3	**Risk:**	**Staff Engagement:** There is a risk that the challenging NHS environment impacts on staff engagement.	**Board Lead:**	Director of Workforce	**Date last reviewed:** August 2017
				Audit Committee Position	MIAA – payroll/human resources – significant assurance – Sept 16 MIAA – mandatory training – significant assurance – July 17	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 3 = 9
Residual Risk Score:	2 x 3 = 6
Tolerable Risk Score:	2 x 3 = 6
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Workforce & Organisational Development Strategy is monitored via Workforce & Communication Group and reported to the Quality & Safety Committee
- The Workforce & Organisational Development metrics are reported from Divisional up to Trust level (Assurance being at Quality & Safety Committee)
- The Trust has developed a Staff Engagement Plan which is being monitored at Divisional and Trust level. Reportable to Workforce & Communication Group

Assurances (How do we know if the things we are doing are having an impact?)

- Traditional delivery against Workforce metrics targets (e.g. attendance, appraisal, staff satisfaction, mandatory training)

Key Performance Indicators

See Integrated Quality Governance Dashboard

Gaps/rationale for current risk score/emerging risks

1. Workforce metrics benchmark well but below Trust target
2. Staff FFT Recommend the Trust as a place to work – 57% Q1 17/18 deteriorating
3. Staff FFT Overall staff engagement score per NHS staff survey – 3.76
4. Increasing nursing vacancy rate, particularly within Medicine and Acute

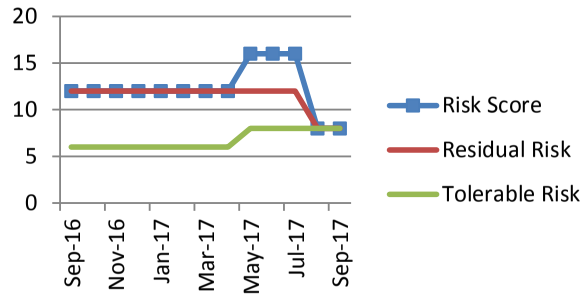
Mitigating actions: (What further mitigating action could be taken?)

1. Action plan being progressed at Directorate level to improve performance of key Workforce metrics with enabling support from HR&OD.
2. The Trust has commenced a range of Organisational Development activities to support in developing the cultures required
3. LIA huddles completed in all departments by mid Sept. We Said We did feedback in advance of national staff survey.
4. The Trust has taken a strong promotion of key work programmes such as Freedom to Speak Up Guardians.
5. Divisional recruitment action plans in place to assist in recruitment to nursing posts

Quality of Care

Strategic Objective:			**To be:** the top NHS Trust in the north west for patient and staff satisfaction **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver a FFT recommendation score of above 95% and a non-recommendation score of below 2% 2b – Deliver the Harm Free Care programme to ensure that our harm free care score is no lower than 95%	
				Linked Risks/ collaboration opportunities	Risk 1 Quality and Safety Countess of Chester – Vascular/Urology/Renal/haematology/Womens and Childrens/diagnostics	
Risk ID:	4	**Risk:**	**Improving Clinical Outcomes:** The Trust is unable to ensure consistent delivery of evidenced based practice 7 days per week as a result of failure to provide consultant review of all emergency admissions in 14 hours	**Board Lead:**	Medical Director	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	2 x 4 = 8
Residual Risk Score:	2 x 4 = 8
Tolerable Risk Score:	2 x 4 = 8
Direction of Travel:	↓



Controls: (How are we mitigating this risk?)

- Monthly Integrated Quality Dashboard
- Weekly safety summit
- Weekly serious incident review
- Weekly Safety Bites Bulletin – Trustwide
- Embedded clinical pathways and protocols
- Embedded clinical escalation policy

Assurances (How do we know if the things we are doing are having an impact?)

- HSMR April 16 – March 17 lower than expected based on peer group
- SHMI Jan 16 – Dec 16 latest data – as expected
- Safety Thermometer targets are compliant – July 17
- 3 out of the 5 standards for 7 day working are being met

Key Performance Indicators

See integrated quality governance dashboard

Gaps/rationale for current risk score/emerging risks

1. Number of RCAs with action plans overdue
2. 2 out of 5 standards for 7 day working not met
3. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year
4. Never Events – see risk 1
5. Mortality outlier for Sepsis – Dec 16

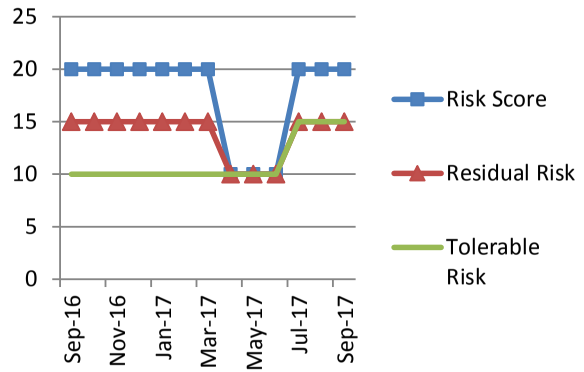
Mitigating actions: (What are we doing to mitigate this risk further?)

1. Action as part of quality governance review process
2. See integrated quality dashboard
3. Learning from Inquests paper along with recommendations to be presented to Q & S – Sept 17
4. The wider learning from the RCA review of Ophthalmology to be used Trustwide
5. Implementation of learning from deaths Policy – Q3 2017/18

Finance and Use of Resources

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating of level 3	
				Linked Risks/ collaboration opportunities	CoCH – collaboration on finance function and strategic estates work	
Risk ID:	5	**Risk:**	**Sustainability:** The Trust is unable to manage its capital and cash and risks being unable to cover its financial obligations	**Board Lead:**	Director of Finance	**Date last reviewed:** August 2017
				Audit Committee Position	The Committee requested that FBPAC review the Trust's responsibilities in relation to the Better Care Fund	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Divisional financial review meetings in place to monitor and where required identify potential risk mitigations to delivery of financial plan and CIP.
- TSG governance structure & process re identification & delivery of CIP work programme.
- Business as usual process initiated in areas where substantive recruitment has taken place thereby releasing interim support
- Contract negotiations concluded with main commissioners and control re cash payments of contractual performance
- Rolling 13 week cash flow forecasting
- Reviewing trade creditor payment terms and conditions

Assurances (How do we know if the things we are doing are having an impact?)

- Cash support agreed and drawn down with capital cash team in line with plan.
- Cash preservation initiatives deployed to protect year end cash balances.
- The Trust achieved an overall Use of Resources Rating of 3 in line with plan.
- The cash position at end of M4 was £6.5m, £4.5m more than plan with the variance primarily due to receipt of the GDE capital funding.

Key Performance Indicators

Liquidity

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
4	4	4	4	4

Gaps/rationale for current risk score/emerging risks

1. Overall deficit of £6.2 at end of M4. £1.8m above planned deficit of £4.3m reflecting loss of STF monies, escalation, non-delivery of CIP (and after deployment of £1.2m non recurrent initiatives and CQUIN risk reserve).
2. £1.3m adverse variance to the CIP plan having delivered £1.8m ytd compared to the planned £3.1m (with a full year challenge to delivery £15m savings plus £6.6m stretch initiatives).
3. Concerns with the Better Care Fund, additional innovation resource deployment and impact of trust escalation capacity
4. Potential trip of RWCF and move to uncommitted loan with terms and conditions to be set

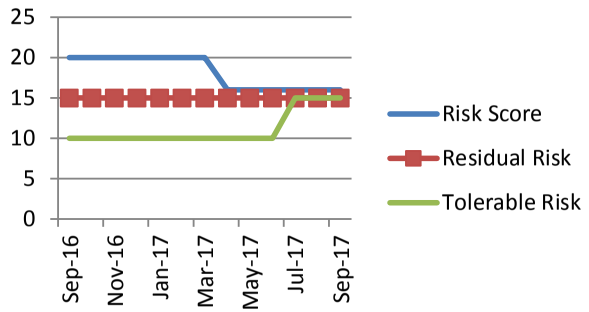
Mitigating actions: (What further mitigating action could we take?)

1. Financial recovery plan in development with actions to be agreed by FBPAC and then Board of Directors.
2. Non delivery of CIP mitigated (at month 3) by deployment of non-recurrent initiatives but not available going forwards.
3. Better visibility on BCF and initiatives to help support delivery of escalation facilities to financial plan funded levels
4. Working capital management to support cash balances and forecasting and cash preservation initiatives being progressed (ongoing)

Finance and Use of Resources

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8c – Implement relevant recommendations of Lord Carter's review of hospital performance and productivity to deliver an Adjusted Treatment Cost figure putting WUTH in top 10% of NHS Trusts in England	
				Linked Risks/ collaboration opportunities	CoCH as per risk 4	
Risk ID:	6	**Risk:**	**Efficiency:** The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	**Board Lead:**	Director of Finance	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Workforce and non-pay work streams governed through TSG
- Recovery plan governance structure and processes initiated and monitored on a weekly basis
- Monitoring of implementation of Carter recommendations
- Robust Pharmacy Hospital Transformation plan

Assurances (How do we know if the things we are doing are having an impact?)

- Delivery of efficiencies identified within improvement plan
- ATC currently at 0.91
- Performing well against pharmacy model hospital metrics
- Procurement efficiency work stream aligned to Carter report recommendations

Key Performance Indicators

Headline Metrics	As reported in dashboard
Cost per Weighted Activity Unit (WAU)	£3,289
Potential savings opportunity	7.0%
Surplus/ deficit as % of expenditure	-0.1%
Total pay cost per WAU	£2,213
Total non-pay cost per WAU	£1,076

Gaps/rationale for current risk score/emerging risks

1. Carter figures based on annual reference costs
2. Pay cost per WAU identified as outlier and opportunity for productivity improvement
3. Absence of plan to implement GS1

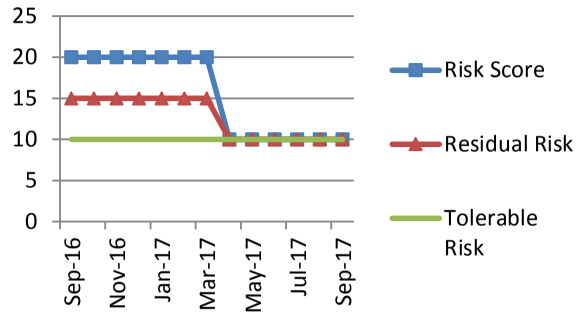
Mitigating actions: (What further mitigating action could we take?)

1. Workforce action plan to be produced to support 17/18-18/19 Operational Plan –Sept 17
2. STT to differentiate from data quality issues to absolute opportunity
3. Refreshed IT strategy to include GS1 implementation
4. Recovery action plan in development with specific focus on reducing pay run rate.

Finance and Use of Resources

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating at level 3		
				Linked Risks/ collaboration opportunities			
Risk ID:	7	**Risk:**	**Controls:** The Trust is unable to manage its agency spend and meet its agreed control total resulting in loss of STF funding and regulatory intervention	**Board Lead:**	Director of Finance	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	2 x 5 = 10
Residual Risk Score:	2 x 5 = 10
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Agency compliance report received and reviewed by EMT weekly
- Divisional authorisation controls in place
- Workforce & Communications Group governance

Assurances (How do we know if the things we are doing are having an impact?)

- Trust is currently below its month 4 agency trajectory expenditure plan(£2.7m) by £0.5m
- Continued reduction on 2016/17
- Continued low absence rates

Key Performance Indicators

As at month 4 agreed expenditure plan control total stood at £2.7m with actual expenditure at £2.2m.

Gaps/rationale for current risk score/emerging risks

1. Minimal retrospective authorisation
2. Breaches in respect of wage, price cap and framework
3. CIP behind plan
4. Increasing run rate on agency

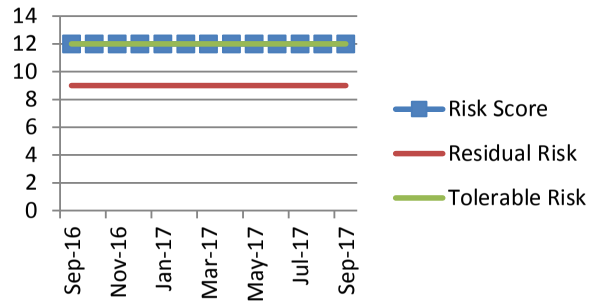
Mitigating actions: (What further mitigating action could we take?)

1. Ensure minimal retrospective authorisation (ongoing)
2. Review case of need for non-clinical agency and innovative recruitment and retention initiatives – Reviewed on weekly basis by EMT. EMT "deep dive" into the total number of vacancies and high areas of spend – August 17
3. Re-looking at the role of TSG/Finance & Performance & SSPG to ensure enables the Trust to focus on achievement of the plan at the right level
4. Recovery plan actions with focus on impact of agency moratorium and risk assessment

Finance and Use of Resources

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8d – We will deliver a Use of Resources rating of level 3		
				Linked Risks/ collaboration opportunities			
Risk ID:	8	**Risk:**	**Value for Money:** Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	**Board Lead:**	Director of Finance	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 4 = 12
Residual Risk Score:	3 x 3 = 9
Tolerable Risk Score:	3 x 4 = 12
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Transformational Team governance adhering to NHSI guidance delivering safe, sustainable cost improvement plans
- Budgetary Control
- Core Financial controls
- Service Line Reporting
- Divisional Performance review process
- Annual Plan

Assurances (How do we know if the things we are doing are having an impact?)

- MIAA Core financial systems
- External assessment against Well Led Framework
- Regulatory risk rating
- NHSI Review of Annual Plan
- ATC index
- External audit opinion
- Delivered CIP at £11.2m in 2016/17
- Reference Cost Index

Key Performance Indicators

Overall UoR detailed within Risk 5
New use of resources guidance

Gaps/rationale for current risk score/emerging risks

1. Service Transformation team not fully established
2. Improve adoption of SLR

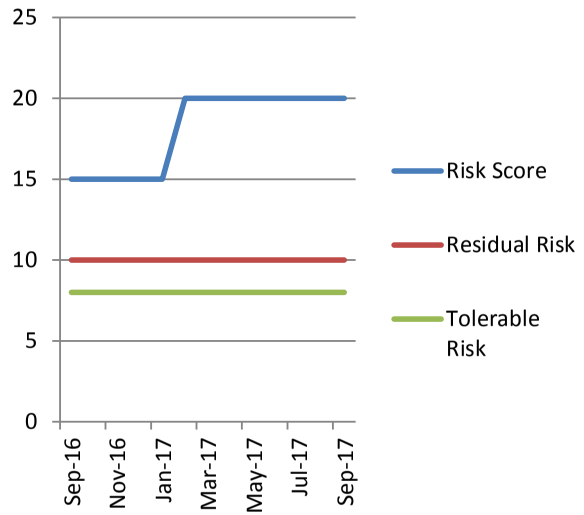
Mitigating actions: (What further mitigating action could we take?)

1. Service Transformation team to be fully established – STT currently holding 3 vacancies: portfolio manager, admin support and analyst currently.
2. Action plan to re-launch SLR (April 2017) with focus on three service lines

Operational Performance

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour emergency target in year and delivery of national cancer standards		
				Linked Risks/ collaboration opportunities			
Risk ID:	9	**Risk:**	**4 Hour A&E Standard:** Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patient experience, reduced clinical quality, regulatory action and loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	2 x 5 = 10
Tolerable Risk Score:	2 x 4 = 8
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Daily breach analysis and resulting actions
- Additional escalation capacity opened
- Capacity meeting – Director led
- Escalation policies & adherence monitoring
- Weekly Divisional director recovery meeting
- Internal roll out and monitoring of SAFER and red/green days, medically optimised
- Thrice weekly delayed Transfers of Care patient tracking to expedite discharge
- Performance review at Finance and Performance Group and reporting to FBPAC
- Weekly operational review
- CCG Contract Monitoring meeting
- A&E Delivery Board chaired by WUTH CEO
- Monitoring of DTOCs daily and performance
- Fortnightly Unscheduled Care Redesign Group in place
- OPEL escalation in place
- Full Capacity Protocol activation & Quality Reviews/Inputs when perf triggered

Assurances (How do we know if the things we are doing are having an impact?)

-

Key Performance Indicators

Feb 17	Feb 17	Feb 17	Feb 17	Feb 17	Mar 17	Jun 17	May 17
		77.61%	81.30%	82.21%	79.80%	81.14%	

Gaps/rationale for current risk score/emerging risks

- Health Economy Bed Modelling requires further work (Action 6)
- Internal bed modelling is complete however agreed site plan to be finalised (Action 16)
- Limited clinical/operational leadership in Emergency Department and Assessment Units following resignation of CD (Action 17)
- SAFER requires re-embedding (Action 18)
- Discharge to assess not yet in place

Mitigating actions: (What further mitigating action could we take?)

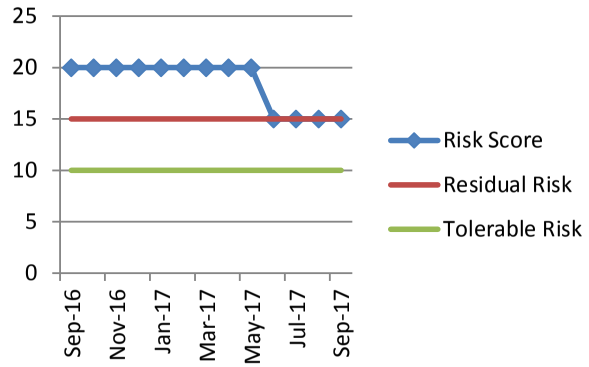
- Task & Finish Group refreshed as part of 'Patient Flow' work stream with STT to include full review of internal flows and best practice
- Better Care Fund to be reviewed at the A & E Delivery Board (Monthly)
- Health economy bed modelling piece of work agreed with partners (April 2017)
- Additional social care funding available to support medically optimised in place
- Establishment of executive led group to oversee BCF plans in place
- Primary Care screening service to be in place September 17
- Patient Flow - D2A, Trusted assessor,7 day discharge capability

• Internal bed plan confirms 50 beds deficit in Medicine and Acute	• Reduce DTOC - £1billion social care funding • Specialist Mental health - 24/7 50% by March 18 • NHS 111 - 30% of all calls by March probably looking at more like 50% with streaming to other clinicians. • GP access 50% access evenings & weekends by 2018, 100% by 2019 • Bolstering Care Home Support • Standardisation of WIC, UCC, MI Units - public are confused so go to ED. Will be outlining minimum standard at all to avoid confusion. • Ambulance response - see & treat / hear & treat in place by end of the year. • EY early diagnostic due end of August 2017 • Internal bed plan agreed July 2017 • Review of clinical leadership and external advert to support recruitment • Exemplar ward review of SAFER in place • GP Streaming in place from 4th September 2017

Operational Performance

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour emergency target in year and delivery of national cancer standards	
				Linked Risks/ collaboration opportunities		
Risk ID:	10	**Risk:**	**RTT** – Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patients experience and regulatory action	**Board Lead:**	Chief Operating Officer	**Date last reviewed:** August 2017
				Audit Committee Position	Audit committee requested that FBPAC review the impact on the Trust's provider licence as a result of the failure of RTT. The specific licence requirement is as follows "are clear systems in place for notifying individual patients about choice re "18 week" breaching when arranging alternative care	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 5 = 15
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- RTT Improvement Board in place
- Full Recovery Action Plan in place
- Weekly Access and Performance meeting established
- Development of data quality and patient tracking reports
- Compliance with Access Policy
- Reporting via Finance and Operational Group
- Full patient tracking in place with live PTL
- CCG Contract Monitoring meeting
- Data Quality monitoring in place
- Elective Intensive Support Team (IST) review of Trust action plan complete.

Assurances (How do we know if the things we are doing are having an impact?)

- Achieved STF trajectory in May 2017, June and July 17
- Demand and capacity completed
- Trajectories agreed for 2017/18 with no financial penalties

Key Performance Indicators

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17
82.51%	83.15%	83.93%	80.34%	82.05%	82.67%

Gaps/rationale for current risk score/emerging risks

1. Data quality – gaps in assurance (Actions 1 and 2)
2. Long waits in some specialties for first out-patient appointment (Actions 3 & 4)
3. Additional capacity to clear backload no robustly available

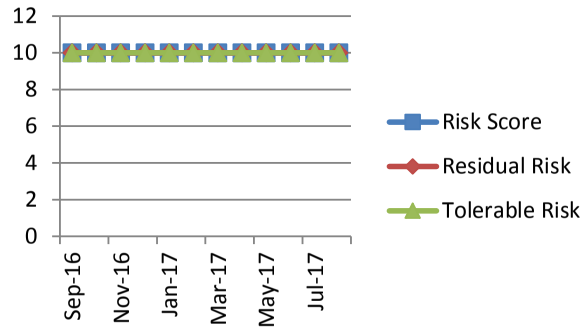
Mitigating actions: (What further mitigating action could we take?)

1. Clean up of PTL
2. Full roll out of 18 week training
3. Intensive Support Team supporting the improvement work
4. Full recovery action plan in place

Operational Performance

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour emergency target in year and delivery of national cancer standards	
				Linked Risks/ collaboration opportunities		
Risk ID:	11	**Risk:**	**Cancer:** Failure to deliver the National Cancer Standards for 2016/17 resulting in poor patient outcomes, regulatory action & loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	2 x 5 = 10
Residual Risk Score:	2 x 5 = 10
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Cancer tracking and monitoring weekly
- Escalation policies in place
- Full divisional overview
- Reporting via Operational Performance Team, Operational Management Team and Board of Directors
- Review via Finance Strategy & Performance Governance meeting
- CCG Contract Monitoring meeting

Assurances (How do we know if the things we are doing are having an impact?)

- Compliance with cancer standards regularly achieved with adherence to agreed pathways
- Capacity in line with current demand

Key Performance Indicators

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17
On track	On track	On track	Concern 1 Standard	Concern 1 Standard	Concern 1 Standard	

Gaps/rationale for current risk score/emerging risks

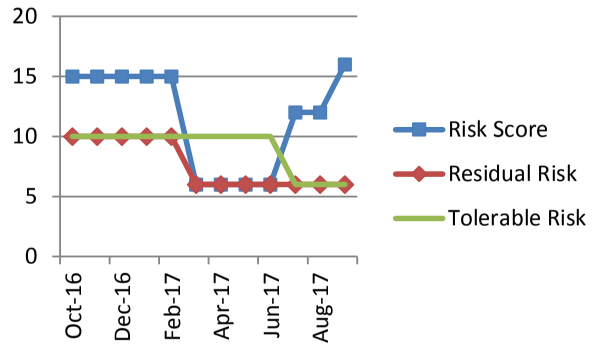
- National awareness campaigns drive demand and not always pre-warned which can increase demand & mismatch capacity (no mitigating actions applicable)
- Overall compliance reliant on good performance in dermatology

Mitigating actions: (What further mitigating action could we take?)

Operational Performance

Strategic Objective:			**To be**: the top NHS Trust in the North West for patient and satisfaction **Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8b – Deliver national infection and prevention control targets for C.diff	
				Linked Risks/ collaboration opportunities		
Risk ID:	12	**Risk:**	**C.diff:** There is a risk that the Trust fails to keep a grip on infection, prevention & control resulting in harm to patients, poor patient experience and potential regulatory action & loss of STF funding associated with exceeding the permitted cumulative number of C.diff cases for 17/18	**Board Lead:**		**Date last reviewed:** September 2017
				Audit Committee Position	Internal Audit – Water Safety – Limited assurance report received October 16 Internal Audit – infection prevention and control – significant assurance report received Sept 16	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Residual Risk Score:	2 x 3 = 6
Tolerable Risk Score:	2 x 3 = 6
Direction of Travel:	↑



Controls: (How are we currently managing this risk?)

- Rapid detection, effective isolation & doing the basics brilliantly
- HPV Programme and use of Ultra Violet Light Machines (UVLM) to be operationally delivered without interruption, together with effective environmental cleaning
- Isolate effectively; use Ward 25 and side rooms in the most effective way possible based on agreed protocols
- Doing the basics brilliantly; Daily & weekly MDT of patients with IPC concerns, Antimicrobial stewardship and prescribing audits
- Reconfiguration of beds within medicine and acute to support an extension to the isolation facilities on ward 24/25

Assurances (How do we know if the things we are doing are having an impact?)

- Full HPV and UVLM Programme in place
- Agreed protocols for isolation and step down
- Robust assurance on hand hygiene
- PIRs completed and lessons learned / actioned effectively

Key Performance Indicators

Mar 17	Apr 17	May 17	June 17	July 17
13 C.diff	0 MRSA 2 C.diff	1 MRSA 5 C.diff	1 MRSA 7C.diff	1 MRSA 8 C diff

Year to Date Cumulative

Gaps/rationale for current risk score/emerging risks

- Challenges associated with cohort nursing on Ward 25 (isolation unit)
- Limited capacity on Ward 25
- Absence of effective MDT / daily specialist nurse reviews and prompt action
- No follow up on discharged patients to reduce reoccurrence / readmissions
- Insufficient assurance on if we do basics brilliantly; hand hygiene, environmental cleaning, admin/data, monitoring alerts, step down from isolation
- Failure to follow up Post Infection Reviews to learn lessons
- Gaps in team and lack of ownership engagement across the trust beyond IPC

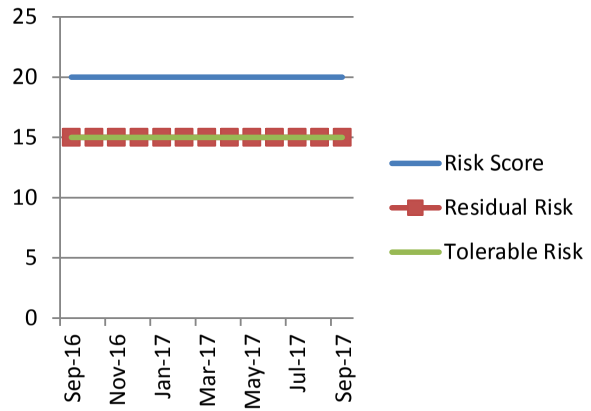
Mitigating actions: (What further mitigating action could we take?)

- Review the operational management of wards 24 and 25 to ensure high risk cohorts are maintained (positive C.diff and CPE) with appropriate staffing levels are in place
- Formalise the weekly MDT to include all patients with C.diff infection
- Workforce plan required following recent loss of ADN
- Refocus on doing basics brilliantly; hand hygiene, reduced admin burden, working smarter, divisional engagement, effective protocols, rapid detection and effective isolation, review governance framework to ensure fit for purpose and effective

Strategic Change

Strategic Objective:			**To build on:** joint working with partner agencies to deliver the maximum operational and financial benefits **To guarantee:** the sustainability of the Trust through transformation of service provision and system performance	**Key Measures:**	6a – Contribute to the development of the STP for the period 2021 across the Wirral, South Mersey and Cheshire and Mersey footprints and achieve all 2016/17 milestones		
				Linked Risks/ collaboration opportunities	As outlined below		
Risk ID:	13	**Risk:**	**STP C&M:** Failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Engagement in STP development / governance arrangements
- WUTH CEO, Strategy Director and Associate Director of Strategy are leading the LDSP workstream on Women and Children's high quality hospital care – including the future configuration of women's and children's services in Wirral and Cheshire as a solution for LDSP / STP to further consider
- Submission of position statement setting out preferred solution to STP workstream team
- Offer from NHSE to develop national model for partnering with alternative maternity providers as an ACO exemplar
- Engagement of CoCH clinicians and management team via more formal Wirral & West Cheshire Alliance structure

Assurances (How do we know if the things we are doing are having an impact?)

- Inclusion of WUTH preferred solution for Women and Children's services in STP
- Inclusion of WUTH preferred solution in LDSP workstream report on high quality hospital care

Key Performance Indicators

Gaps/rationale for current risk score/emerging risks

1. The STP's governance arrangements do not allow WUTH direct access to the 'top table' (Actions 1 & 2)
2. Acceptance of WUTH proposed solution for Women and Children's Services by CoCH is uncertain (Actions 3 & 4)
3. Recent result of the NWNODN options appraisal exercise (Action 5)
4. Offer for ACO/Prime provider national exemplar model from NHSE to be explored.(Action 6)

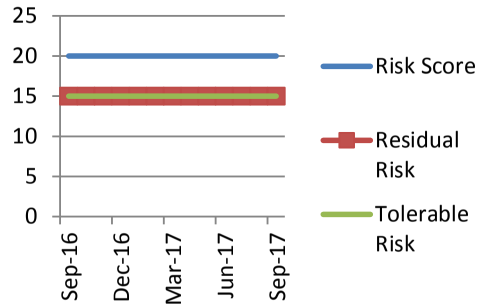
Mitigating actions: (What further mitigating action could we take?)

1. Direct engagement with STP women's and children's team
2. Emphasis on LDSP work streams taking precedence over STP work streams
3. Direct engagement of CoCH clinicians and management team
4. Submission to STP work stream of position statement for South Mersey
5. WUTH considering its position with regards to concerns over the process and how it communicates this internally
6. Engagement with NHSE

Strategic Change

Strategic Objective:			**To prioritise:** the development of new models of care in cooperation with our acute/secondary, primary, community and social care partners **To build on:** joint working with partner agencies to deliver the maximum operational and financial benefits **To guarantee:** the sustainability of the Trust through transformation of service provision and system performance	**Key Measures:**	3b – Work with acute/secondary, primary, community and social care partners on 'end to end' redesign of the unscheduled care system and services for older people 3c – Work with CoCH to deliver an agreed model for (i) future development of women's and children's services in South Mersey (ii) future development of ENT, maxillo-facial and ophthalmology services 4aiii – Progress the integration of back office and clinical support functions with CoCH 4b – Develop and implement a strategy to support a closer working relationship with primary care services 6a – Contribute to the development of the STP for the period 2021 across the Wirral, South Mersey and Cheshire and Mersey footprints and achieve all 2016/17 milestones	
				Linked Risks/ collaboration opportunities	As outlined below	
Risk ID:	14	**Risk:**	**LDSP C&W:** Failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality and sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	3 x 5 =15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Participation in LDSP Working group meetings to ensure connectivity with emergent plans
- Refocus on Wirral & West Cheshire Alliance, with formal structure and governance now established to take forward with renewed pace and rigour

Assurances (How do we know if the things we are doing are having an impact?)

- At this stage, no robust assurances can be given – WUTH does not have authority over key partners at any levels

Key Performance Indicators

Gaps/rationale for current risk score/emerging risks

1. Governance arrangements for joint working between WUTH, CoCH, MCH and ECT are ineffective (Action 1)
2. The strategies for the future development of East Cheshire Trust and Mid Cheshire Hospitals are unclear (Action 2)
3. Further progression depends on agreeing
    - the outcomes of the work on reconfiguration/ variation
    - More robust governance arrangements (Action 1)

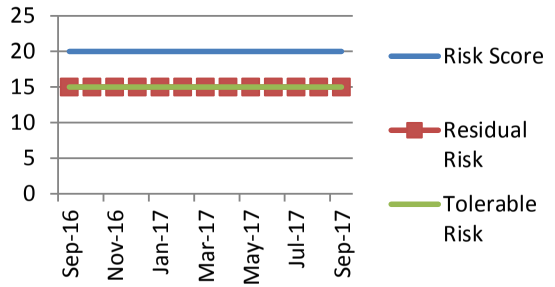
Mitigating actions: (What further mitigating action could we take?)

1. Development of agreed and managed work programme for the WWCA with CoCH as a priority to allow progress to be made with renewed pace & rigour
2. Confirmation of future LDSP footprint management arrangements via LDSP SRO

Strategic Change

Strategic Objective:			**To prioritise:** the development of new models of care in cooperation with our acute/secondary, primary, community and social care partners	**Key Measures:**	3a – Continue to support the roll out of the Healthy Wirral Programme to deliver (i) reduction in the level of unplanned hospitalisation for chronic ambulatory care sensitive conditions bringing Wirral nearer to the NHSE average (ii) Reduction in the level of emergency admission for acute conditions not usually requiring hospital admission bringing Wirral nearer to the NHSE average (iii) A year on year reduction in ED attendances (iv) A year on year reduction in non-elective admissions (v) A year on year reduction in avoidable readmissions (as a percentage of all admissions) (vi) A year on year reduction in admissions from nursing homes (vii) A reduction in ALOS bringing WUTH in line with best quarter performance	
				Linked Risks/ collaboration opportunities	As outlined below	
Risk ID:	15	**Risk:**	**Healthy Wirral:** Failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- There is an emerging formal set of governance arrangements supporting Healthy Wirral (HWPB, HWEDG, HW50+, GDE Board)

Assurances (How do we know if the things we are doing are having an impact?)

- At this stage, no robust assurances can be given – WUTH does not have authority over key partners at any levels

Key Performance Indicators

- Improved performance against KPIs (will form part of updated performance reports to the Trust board)

Gaps/rationale for current risk score/emerging risks

1. No clear route to ACO which is linked to financial sustainability and operational performance, system now considering Acute Care System as stepping stone – actions 1-3
2. We need to work proactively with CCG to influence joint commissioning prospectus (green paper) due Oct 2017.

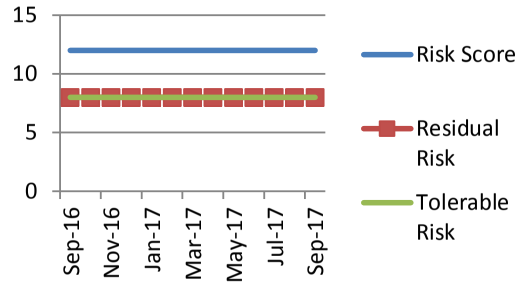
Mitigating actions: (What further mitigating action could we take?)

1. AQuA completed work with health and social care community to consider new model of accountable care, now to be taken forward as pilot of new care model for Over Fifty population (HW50+)
2. MSK Prime Provider contract let by CCG and secured by WUTH in partnership with WCT and Primary Care.
3. Deloittes and PWC have undertaken external review of future configuration of ACOs across C&W, without real conclusion at this stage. WUTH and WCT to hold exec to exec to determine Provider route to ACS in response to anticipated LA and CCG strategic commissioning prospectus green paper (Oct 2017)

Strategic Change

Strategic Objective:			**To maximise:** the benefits of innovation in clinical and organisational practice, enabling technologies and the role of the Trust as a teaching institution	**Key Measures:**	7a – Work towards full digitization of the Electronic Patient Record 7b – Work towards the achievement of HIMMS level 7 7d – Look to improve our digital maturity index score	
				Linked Risks/ collaboration opportunities		
Risk ID:	16	**Risk:**	**IT:** Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment	**Board Lead:**	Director of IT and Information	**Date last reviewed:** August 2017
				Audit Committee Position	Internal Audit Report – IT Service Continuity Review – Limited Assurance – Committee reviewed findings and proposed actions and requested that a re-audit was undertaken before the end of the financial year in view of the seriousness of the matter. A report was taken to Trust Board in January and progress will be reported on a quarterly basis. Remaining actions nearing completion and a new audit programme for 2017/18 is in progress	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 4 = 12
Residual Risk Score:	2 x 4 = 8
Tolerable Risk Score:	2 x 4 = 8
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- The Trust uses a standardised implementation methodology that is designed to engage and involve as many end users as possible in the system design and testing.
- All staff receive classroom based training prior to receiving a user name & password.
- Progress with the programme is managed through the Informatics governance structure and reported to the Digital Wirral Programme Board.
- All major go lives are signed off by the CEO and Medical Director, following a review of the risks and benefits expected

Assurances (How do we know if the things we are doing are having an impact?)

- Post implementation reviews completed at major milestones
- External review of GDE programme by representative of NHS Digital

Key Performance Indicators

A new benefits programme is being developed under Digital Wirral programme which will develop a set of metrics for the benefits of the programme published in September 2017

Gaps/rationale for current risk score/emerging risks

1. Training required for clinical staff (inc locum and bank staff) to ensure appropriate use of Cerner system following successful implementation of phase 3 (Action 1)
2. Limited Assurance received following the MIAA IT Service Continuity Review (Actions 2 and 3)
3. Delays in receiving GDE funding (Action 4) although funding now received
4. Additional work require to prepare for implementation of renewed General Data Protection Regulations (GDPR) (Action 5)

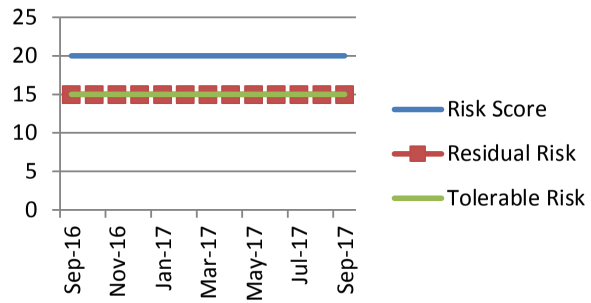
Mitigating actions: (What further mitigating action could we take?)

1. Undertaking review of training e.g. drugs administration refresher and will produce proposal for on-call training service for locums and bank staff (to include associated costs) (Date TBC)
2. Work underway to complete IT Service Continuity action plan to address limited assurance assigned by Internal Audit. A report was taken to Trust Board in January and progress will be reported on a quarterly basis
3. 'Snapshot' audit to confirm achievement of improved assurance in combination with cyber security and system resilience work – outcomes reported to Audit Committee in March 2017 and further audit in Q2
4. GDE benefits realisation plan for GDE using NHS digital approach now due end September 2017.(delayed as the start of the programme delayed by funding being delayed This will contribute to a refreshed business case. To be previewed by Trust Board once the financial details are settled
5. Information, IG & CG to oversee implementation of GDPR action plan through active engagement with the Clinical Divisions and Corporate Services – March 2018

Strategic Change

Strategic Objective:			**To build on:** joint working with partner agencies to deliver the maximum operational and financial benefits	**Key Measures:**	4a – Progress (i) the development of a VAT efficient Special Purpose Vehicle for service delivery (ii) A SEP with a third party	
				Linked Risks/ collaboration opportunities		
Risk ID:	17	**Risk:**	**Estates:** Failure to develop & implement a strategic estates strategy impacts on patient & staff experience and financial sustainability	**Board Lead:**	Director of Finance	**Date last reviewed:** August 2017
				Audit Committee Position	• limited assurance report on water safety – reviewed before March 17 confirming high level recommendations compelte • Full compliance review requested and undertaken in Estates against all the critical areas. This work should be aligned to the Health and Safety compliance and audit programme. • Internal Audit – Estates Maintenance Review – Significant assurance report received	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	3 x 5 = 20
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Experienced legal and financial partners have been contracted to ensure that the Trust follows the correct procurement process and avoid unnecessary legal challenges
- Ongoing monitoring of compliance with Water Safety measures undertaken by IPORT
- Glen Adams has been appointed chief engineer with specific duties concerning compliance.

Assurances (How do we know if the things we are doing are having an impact?)

- To be developed as the programme progresses
- Estates maintenance review – significant assurance report received
- High risk areas in limited assurance report satisfactorily dealt with and acknowledged by MIAA
- Initial Compliance assessment undertaken on all estates compliance and associated action plans produced.

Key Performance Indicators

To be determined

Gaps/rationale for current risk score/emerging risks

1. Inability to fully address backlog maintenance challenge
2. General capital investment demands vs capital resource and prioritisation requirement and residual risk
3. Authorised Person and Competent Person training needs to be undertaken
4. Procurement process for strategic estates partner as agreed at Board of Directors “paused “pending further legal advice

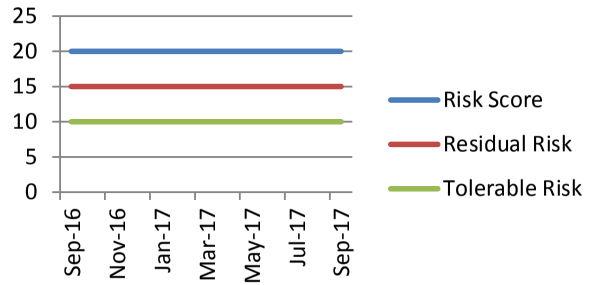
Mitigating actions: (What further mitigating action could we take?)

1. Prioritisation of maintenance issues in place
2. Strategic estates plans being developed
3. Authorised person and competent persons are undertaking the role, despite not having the written qualifications.
4. Next steps still to be determined

Leadership and Improvement

Strategic Objective:			**Enabled by:** financial, commercial and operational excellence	**Key Measures:**	8d – Deliver a Use of Resources (UoR) rating of level 3 8e – Work to improve our NHSI governance rating		
				Linked Risks/ collaboration opportunities	Risks 5,6,7,8,9,10		
Risk ID:	18	**Risk:**	**Enforcement Action** - Insufficient progress against agreed financial and access targets results in further regulatory action and enforcement of Section 111	**Board Lead:**	Chief Executive	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Residual Risk Score:	3 x 5 = 15
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- Progress review meetings with NHSI
- Monthly Board performance and financial reporting
- Operational Task and Finish Groups for RTT and A & E

Assurances (How do we know if the things we are doing are having an impact?)

- Removal of enforcement actions in relation to requirement for interim support
- Submitted application for the removal of section 111 – reviewed June 2017
- Positive Well led Governance Review
- Review of financial and governance undertakings to be undertaken by NHSI in August with a view to removing additional section 111 at the end of the financial year 17/18

Key Performance Indicators

- Overall UoR (see Risk 5)
- Liquidity (see Risk 5)
- 4Hour A&E Standard (see Risk 9)
- RTT (see Risk 10)
- Cancer (see Risk 11)
- C.diff (see Risk 12)

Gaps/rationale for current risk score/emerging risks

- Achievement of financial control total
- Non-compliance with A & E and RTT standards

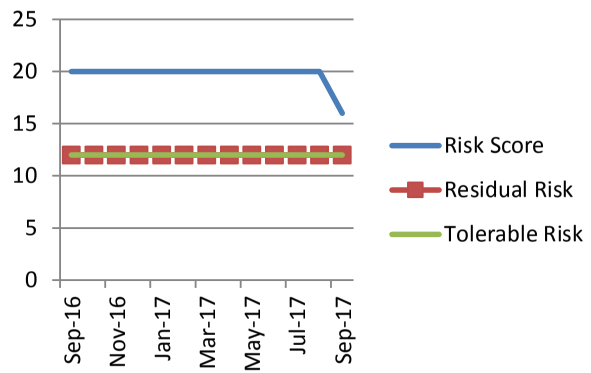
Mitigating actions: (What further mitigating action could we take?)

The actions being undertaken to mitigate the risks relating to RTT; A & E 4 hour standard and financial performance are outlined separately in the BAF as described under linked risks

Leadership and Improvement

Strategic Objective:			**To ensure:** our people are aligned to our vision and participate in the development and direction of policy	**Key Measures:**	5a – Continue the on-going delivery of the Workforce and OD Strategy in order to deliver (i) a healthy organisational culture (ii) a sustainable and capable workforce (iii) effective leaders and managers	
				Linked Risks/ collaboration opportunities	1,2,3 & 4	
Risk ID:	19	**Risk:**	**Medical Engagement:** failure to improve medical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity and increased costs	**Board Lead:**	Medical Director	**Date last reviewed:** August 2017
				Audit Committee Position		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Residual Risk Score:	3 x 4 = 12
Tolerable Risk Score:	3 x 4 = 12
Direction of Travel:	↓



Controls: (What are we currently doing about the risk?)

- Medical Engagement Strategy Development
- Medical Engagement Road Map – 3 Year Plan commenced April 17
- Change in Consultant Recruitment Process
- 2 week bespoke induction programme for new consultants
- 2 year consultant foundation programme
- Clinical leaders' development programme
- 'Later Years' Clinical Excellence Programme
- Informal drop-in sessions run by Medical Director and Chief Operating Officer
- Response to the medical engagement results

Assurances (How do we know if the things we are doing are having an impact?)

- Medical Engagement Survey (2-3 Yearly)
- Medical Board Meeting
- Medical Director 1:1 with Senior medical leaders
- Chief Operating Officer 1:1 with Divisional Medical Directors
- Senior Medical Leaders Meetings (Monthly)

Key Performance Indicators

- Monthly Integrated Quality Dashboard
- Attendance at weekly safety summit

Gaps/rationale for current risk score/emerging risks

- High level focus on quality and safety from senior clinical leaders to junior and trainee medical staff.

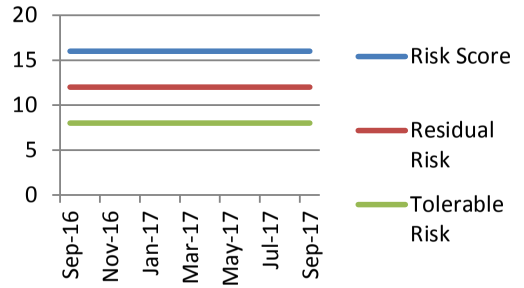
Mitigating actions: (What more should we do?)

- Developing new organisational structure to ensure services are clinically led.
- Re-design medical leadership Job Descriptions and Personal Specifications to support the new structure, and to focus on values, professional leadership and patient safety.

Leadership and Improvement

Strategic Objective:			**To maximise:** the benefits of innovation in clinical and organisational practice, enabling technologies and the role of the Trust as a teaching institution **Enabled by:** financial, commercial and operational excellence	**Key Measures:**	7a – Work towards the role of the Trust as a teaching institution 7b – Work towards the achievement of HIMMS level 6	
				Linked Risks/ collaboration opportunities		
Risk ID:	20	**Risk:**	**Data Quality:** failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	**Board Lead:**	Director of IT and Information	**Date last reviewed:** August 2017
				Audit Committee Position	May 2017 - Trust received qualified limited assurance on the Quality Accounts due to RTT data issues however all data quality errors had been identified in cases which had not been subject to the Trust's revised internal review processes and External Audit voiced support of the Trust approach to addressing RTT data quality. It was confirmed that no data discrepancies had been identified during the A&E data quality review.	

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Residual Risk Score:	3 x 4 = 12
Tolerable Risk Score:	2 x 4 = 8
Direction of Travel:	⟷



Controls: (How are we currently managing this risk?)

- All staff receive training on their use of the IT system prior to receiving their usernames and passwords
- There is significant validation built into the Trusts millennium system to ensure that only valid data can be collected
- The Data Quality Group reporting to the Finance and Performance Committee
- Where individual members of staff are found to be causing errors, this is escalated to line managers

Assurances (How do we know if the things we are doing are having an impact?)

- Generally speaking there is a series of local and national audits which cover these areas and show that WUTH performs strongly compared with their peers. Individual issues raised by the reports will be dealt with by the Data Quality Group or Audit committee

Key Performance Indicators

To be confirmed

Gaps/rationale for current risk score/emerging risks

1. Lack of awareness of the clinical coding agenda (Action 1)
2. It is not always clear the provenance of data used in performance reports (Action 2)
3. Quality Account external audit review highlighted concerns with data quality in relation to RTT and A & E (Action 3)

Mitigating actions: (What further mitigating action could we take?)

1. Raise the profile of the clinical coding agenda by ensuring a senior clinical coding presence at key governance meetings, including the CGG and divisional governance meetings – Delays experienced as a consequence of open vacancies and maternity leave. Priority has been assigned to delivery of coding & a coding action plan was developed March 2017 in the dept & in collaboration with Divisions & is not in progress including resolving staffing issues
2. Introduce data quality kite-marks for all reported KPIs, a draft was to be prepared for January 2017 however introduction of kite-marks is proving difficult to implement and further assistance with this issue has been sought from MIAA
3. Dedicated project led by operational team is improving the position on RTT and A&E 4 and 12 hour waiting data is now subject to routine audit for breaches and near misses

Board Assurance Framework – Summary

30.08.17

Risk Ref	SMT Lead	Theme	Potential Risk	Current Score L x C	Residual Score L x C	Tolerable Score L X C	Executive Committee	Assurance Committee
1	DoNM	Quality of Care	Quality and Safety – The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	4 x 3 = 12 ⟷	3 x 3 = 9 ⟷	1 x 3 = 3 ⟷	CGG	Board, QSC
2	DoNM	Quality of Care	Patient Experience – The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	3 x 3 = 9 ⟷	2 x 3 = 6 ⟷	2 x 2 = 4 ⟷	PFEG	QSC
3	DoW	Quality of Care	Staff Engagement – the challenging NHS environment impacts on staff engagement and results in a poor NHS staff survey	3 x 3 = 9 ⟷	2 x 4 = 8 ⟷	2 x 2 = 4 ⟷	WCG	Board, QSC
4	MD	Quality of Care	Improving Clinical Outcomes – The Trust is unable to ensure consistent delivery of evidenced based practice 7 days per weeks as a result of failure to provide consultant review of all emergency admissions in 14 hours	2 x 4 =8 ↓	2 x 4 = 8 ↓	2 x 4 = 8 ⟷	CGG	QSC
5	DoF	Finance & Use of Resources	Sustainability – The Trust is unable to manage its capital and cash and risks being unable to cover its financial obligations	4 x 5 = 20 ⟷	3 x 5 = 15 ⟷	3 x 5 = 15 ⟷	F & P	FBPAC
6	DoF	Finance & Use of Resources	Efficiency – The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	4 x 4 = 16 ⟷	3 x 5 = 15 ⟷	2 x 5 = 15 ⟷	F& P	FBPAC
7	DoF	Finance &Use of Resources	Controls – The Trust is unable to manage its agency spend and meet its agreed control total resulting in loss of STF funding and regulatory intervention	2 x 5 = 10 ⟷	2 x 5 = 10 ⟷	2 x 5 = 10 ⟷	F & P	FBPAC
8	DoF	Finance &Use of Resources	Value for Money – Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	3 x 4 = 12 ⟷	3 x 3 = 9 ⟷	4 x 3 = 12 ⟷	F & P	FBPAC
9	COO	Operational Performance	4-Hour A&E Standard – Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patient experience, regulatory action & loss of STF funding	4 x 5 = 20 ⟷	2 x 5 =10 ⟷	2 x 4 = 8 ⟷	F & P	Board, FBPAC
10	COO	Operational Performance	RTT – Failure to achieve the trajectory targets agreed with NHSI for 2016/18 resulting in poor patient experience and regulatory action	3 x 5 = 15 ⟷	3 x 5 =15 ⟷	2 x 5 = 10 ⟷	F & P	Board QSC FBPAC
11	COO	Operational Performance	Cancer – Failure to deliver the National Cancer Standards for 2017/18 resulting in poor patient outcomes, regulatory action & loss of STF funding	2 x 5 = 10 ⟷	2 x 5 =10 ⟷	2 x 5 = 10 ⟷	F & P	QSC
12	DoNM	Operational Performance	C.diff – Trust exceeds the permitted cumulative number of cases for 2017/18 resulting in poor patient experience, regulatory action & loss of STF funding	4 x 4 = 16 ↑	2 x 3 = 6 ⟷	2 x 3 = 6 ⟷	CGG	QSC
13	DoStrt	Strategic Change	STP C & M – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ⟷	3 x 5 =15 ⟷	3 x 5 =15 ⟷	SSPG	Board,
14	DoStrt	Strategic Change	LDSP W & C – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ⟷	3 x 5 =15 ⟷	3 x 5 =15 ⟷	SSPG	Board,
15	DoStrt	Strategic Change	Healthy Wirral – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ⟷	3 x 5 =15 ⟷	3 x 5 =15 ⟷	SSPG	Board,
16	DoI&I	Strategic Change	IT – Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment.	3 x 4 = 12 ⟷	2 x 4 = 8 ⟷	2 x 4 = 8 ⟷	DWPB	FBPAC
17	DoF	Strategic Change	Estates – failure to develop & implement a strategic estates strategy impacts on patient & staff experience and financial sustainability	4 x 5 = 20 ⟷	3 x 5 = 15 ⟷	3 x 5 = 15 ⟷	F & P	FBPAC
18	CEO	Leadership &Improvement	Enforcement Action – Insufficient progress against greed financial and access targets results in further regulatory action and enforcement of Section 111	4 x 5 = 20 ⟷	3 x 5 = 15 ⟷	2 x 5 = 10 ⟷	Board	Board
19	MD	Leadership & Improvement	Clinical Engagement – failure to improve clinical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity & increased costs	4 x 4 = 16 ↓	3 x 4 = 12 ⟷	3 x 4 = 12 ⟷	CGG	Board QSC
20	DoI&I	Leadership & Improvement	Data Quality – failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	4 x 4 = 16 ⟷	3 x 4 = 12 ⟷	2 x 4 = 8 ⟷	II&CG	FBPAC

Risk Appetite against strategic objectives for 2016-18

Risk Appetite	Theme(s)	Strategic Objective	Strategic Risks
Cautious The quality of our services, measured by clinical outcomes, patient safety and patient experience is paramount. The Trust does not want therefore to compromise quality and patient safety. For the avoidance of doubt this includes those risks associated with maintaining appropriate staffing levels	Quality of Care	To be: the top NHS Trust in the North West for patient and staff satisfaction To deliver: consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources To ensure: our people are aligned with our vision	1. Quality and Safety – The Trust does not undertake the necessary actions to achieve a 'Good' rating at its next inspection resulting in poor patient experience, loss of public confidence and regulatory action 2. Patient Experience – The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence 3. Staff Engagement – the challenging NHS environment impacts on staff engagement and results in a poor NHS staff survey 4. Clinical Outcomes – The Trust is unable to implement the 4 priorities by 2020 and risks regulatory action
Moderate The Trust is prepared to accept the possibility of increased financial risk where there is serious risk of harm to patients. The Trust's primary concern will always be the safety of its patients. The Trust will ensure that consistent financial rigour is applied to all the Trust's activities. The Trust is prepared to accept the possibility of increased operational risk where there is an evidenced based need to undertake transformational or internal reform for the medium to longer term. This is provided this is undertaken in conjunction with and accepted by Regulators.	Finance and Use of Resources Operational Performance Leadership and Improvement	To be: the top NHS Trust in the North West for patient and staff satisfaction To ensure: our people are aligned with our vision To maximise: the benefits of innovation in clinical and organisational practice, enabling technologies and the role of the Trust as a teaching institution Enabled by: financial, commercial and operational excellence	5. Sustainability – The Trust is unable to manage its capital and cash and risks being unable to cover its financial obligations 6. Efficiency – The Trust is unable to remove unwanted variation resulting in an inability to reduce costs 7. Controls – The Trust is unable to manage its agency spend and meet its agreed control total resulting in loss of STF funding and regulatory intervention 8. Value for Money – Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources 9. 4-Hour A&E Standard – Failure to achieve the trajectory targets agreed with NHSI for 2016/17 resulting in poor patient experience, regulatory action & loss of STF funding 10. RTT – Failure to achieve the trajectory targets agreed with NHSI for 2016/17 resulting in poor patient experience, regulatory action & loss of STF funding 11. Cancer – Failure to deliver the National Cancer Standards for 2016/17 resulting in poor patient outcomes, regulatory action & loss of STF funding 12. C.diff – Trust exceeds the permitted cumulative number of cases for 2016/17 resulting in poor patient experience, regulatory action & loss of STF funding 18. Enforcement Action – Insufficient progress against greed financial and access targets results in further regulatory action and enforcement of Section 111 19. Clinical Engagement – failure to improve clinical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity & increased costs 20. Data Quality – failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand

The Board is keen to return to regulatory compliance with NHS Improvement and recognises that its rating with CQC is a key indicator of quality and financial sustainability and the Trust will not take any risks that will compromise this.			
Open The Trust acknowledges that the context of the NHS is changing and in order to be sustainable in the future, it must undertake transformational change along with partners. The Board therefore accepts that this requires a high degree of tolerance for risk for which it is prepared to accept in order to achieve the very best for its population.	Strategic Change	To prioritise: development of new models of care in co-operation with our acute/secondary, primary, community and social care partners To build on: joint working with partner agencies to deliver the maximum operational and financial benefits To guarantee: the sustainability of the Trust through transformation of service provision and system performance To maximise: the benefits of innovation in clinical and organisational practice, enabling technologies and the role of the Trust as a teaching institution	13. STP C & M – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients 14. LDSP W & C – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients 15. Healthy Wirral – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients 16. IT – Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment. 17. Estates – failure to develop & implement a strategic estates strategy impacts on patient & staff experience and financial sustainability

Board of Directors	
Agenda Item	7.7
Title of Report	NHSI Quarterly Monitoring Report
Date of Meeting	27th September 2017
Author	Shahida Mohammed, Assistant Director of Finance
Accountable Executive	David Jago, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 5 2017/18 Financial Commentary for NHS Improvement

The following commentary details the Trust's financial performance during August (Month 5) and the cumulative outturn position for FY18 against plan.

The year to date performance excluding STF shows an actual deficit of (£10.9m) against a plan of (£7.5m). The Trust continues to experience an increase in demand for its Non Elective services with A&E activity significantly higher than the same period in 2016/17. This in turn has led to continued operational costs in delivering this increase in demand which has resulted in an adverse financial performance to plan. In month this has been compounded by a reduction in Clinical Income as a result of reduced Clinical availability in month and one off charges in relation to historic VAT recovery.

Despite this the Trust continues to forecast a planned deficit of c. £0.4m, particularly in relation to the A&E trajectory following the recent discussions held with NHSI colleagues and the planned economy wide interventions.

Pay costs exceed plan by c. (£4.9m) at the end of August, reflecting operational pressures in supporting Non Elective activity levels, non-delivery of CIP (in line with the original plan) and other operational pay pressures. In order to maintain patient safety the Trust has had to increase internal escalation areas as a result of higher than planned demand for non-elective services within the system. This is also in line with the direction issued by the NHS England TSAR of A&E, who visited the Trust during July. The Trust still has a high number of "medically optimised" patients within the bed base, reflecting a lack of alternative support within the health and social care system.

The Trust has utilised the 0.5% CQUIN risk reserve within the YTD position (c.£1.2m), this has yet to be paid over by the CCG, The Trust appreciates that there are wider discussions being undertaken between NHSE and NHSI, the failure for this core baseline resource to be paid to the Trust would result in a c.£1.2m deterioration within the YTD position. Included within the YTD position is £1.3m of non-recurrent support, this will affect the overall run-rate of the Trust going forward and the underlying position for 2018/19 all of which will be monitored through internal governance structures.

The Trust continues to perform well in terms of GP streaming in line with National timeframes and has plans in place to utilise the National Capital Funding that has been allocated to improve A&E flow and performance.

The cumulative cash position at the end of August is £3.9m, which is some £1.4m above plan. This primarily reflects the closing 16/17 cash position being higher than plan, the additional cash received to support the Global Digital Exemplar (GDE) programme, offset by movements in working capital and EBITDA performance.

As a result of the month 4 and subsequent month 5 financial positions the Trust has entered into an internal "recovery plan" to support the delivery of the full year plan. Discussions have taken place within the Health Economy around any potential support that could be provided to support the Trust; the Finance committee has received the first draft of the internal plan with a subsequent paper being presented at the September Board meeting.

The table overleaf details the year to date performance against the Trusts' control total.

SUMMARY FINANCIAL STATEMENT							
	PLAN	MONTH 5			YTD		
	Full Year	PLAN	ACTUAL	VARIANCE	PLAN	ACTUAL	VARIANCE
	£000	£000	£000	£000	£000	£000	£000
NHS Clinical Income	303,692	24,530	23,426	(1,105)	123,158	120,686	(2,473)
Other Income	35,854	3,037	2,632	(405)	14,741	13,765	(976)
Employee Expenses	(221,376)	(18,352)	(19,659)	(1,307)	(91,744)	(96,623)	(4,879)
All Other Operational Expenses	(106,045)	(8,868)	(9,116)	(248)	(46,032)	(43,125)	2,907
EBITDA	12,124	347	(2,717)	(3,064)	123	(5,297)	(5,420)
Post EBITDA Items	(12,693)	(1,052)	(904)	148	(5,195)	(4,476)	719
Net Surplus (Deficit) incl STF	(569)	(705)	(3,622)	(2,917)	(5,072)	(9,774)	(4,702)
Remove capital donations/grants I&E impa	142	12	13	1	59	7	(52)
Adjusted performance including STF	(427)	(693)	(3,608)	(2,916)	(5,013)	(9,766)	(4,754)
Less STF	(8,875)	(592)	0	592	(2,516)	(1,131)	1,385
Adjusted performance excluding STF	(9,302)	(1,285)	(3,608)	(2,324)	(7,529)	(10,897)	(3,369)
Control Total Excl STF	(9,302)	(1,285)	(3,608)	(2,324)	(7,529)	(10,897)	(3,369)
EBITDA %	3.6%	1.3%	(10.4%)	(11.7%)	0.1%	(3.9%)	(4.0%)

NHS Clinical Revenue

Cumulatively all PODs are over performing in terms of actual activity delivered against the initial plan, with the exception of EL excess bed days, NEL, OP First, Follow Up and OP diagnostic imaging. This has been partially mitigated due to higher patient complexity from an actual income generation perspective particularly in certain NEL areas, i.e. Geriatric Medicine £1.0m, Respiratory, £0.6m and Upper GI, £0.5m. Non PbR areas broadly delivered plan with the exception of neonatal bed days, rehab. and adult critical care. HCD income is below plan; this is offset by a reduction in drug expenditure.

Clinical income in month was below plan as a result of reduced Clinical availability in month. The Trust will be looking to recover the in month underperformance through the remainder of the year.

Performance against CCG contracts is broadly balanced with the exception of NHS England specialised commissioning reflecting the under recovery in drug “pass through” costs. The West Cheshire contract is currently below plan, possible reasoning for this could be the “fixed” price envelope they have agreed with their local Trust and also the closure collaborative work currently underway within the West Cheshire area,

Other Operating Income

In August (Month 5) other operating income is cumulatively (£0.4m) below plan, this reflects the non-delivery of the financial control total and the subsequent STF monies withheld. YTD the impact of the STF not achieved is a (£1.4m). During Q1 non-recurrent income of £0.3m has supported the financial position in other operating income.

Operating Expenditure

In August (Month 5) operating expenditure (excluding depreciation) is (£1.6m) above plan with a YTD overspend of (£2m).

Pay costs exceeded plan in August by (£1.3m), and are showing a cumulative overspend of (£4.9m). The issues driving the current cumulative adverse performance in pay are:

- Pressures relating to internal capacity continue in addition to the increased demand and associated costs within A&E to deal with higher levels of acuity and attendances. The Trust is working with external partners via the A&E Board and the System Wide Recovery group. The impact of these escalation costs beds are c (£0.7m). Continued medical staffing gaps in the Emergency department are resulting in a (£0.4m) pressure.

- Non–delivery of cost improvement plans in relation to pay work-streams of c.(£2.0m) ytd.

- Other operational pressures have impacted the position, further costs for medical staffing, high levels of qualified nurse vacancies and patient acuity; have resulted in the use of non-core spend of c(£4.8m) on bank staff and a further (£1.4m) on overtime to cover gaps and vacancies.

- Approximately £0.8m has been utilised in the use of WLIs to support delivery of the current income plan. The Trust continues to pursue opportunities to improve list and theatre utilisation in order to reduce the requirement for premium rate payments.

- Agency spend was £2.9m as at the end of August which remains c£0.4m lower than the agency cap. Although agency costs have been increasing of late, plans are in place for this to reduce in future periods.

Other operating Expenditure (exc. depreciation) is above plan by (£0.2m) in August and cumulatively below plan by £2.9m.

- Non-recurrent savings arising from accrual reviews have supported the financial position by £0.8m YTD. The underlying impact of this is being factored into plans for 2018/19.

- In month there has been a charge (£0.3m) charge in relation to historic VAT recovery that has deteriorated the financial position.

- High Cost pass through drugs is a further £2.5m underspent ytd and £0.6m in-month this is offset in NHS Clinical income.

- The CQUIN risk reserve has been fully utilised within the YTD position supporting the underlying position by £1.2m. If the funding is not received this will further deteriorate the YTD position away from plan.

Achievement of the 2017/18 Cost Improvement

The 2017/18 plan assumed the achievement of £14.0m of cost improvement programs and £1.0m revenue generation schemes through the year, delivering a combined total of £15.0m.
The Trust currently has c£9.0m of fully built up schemes with opportunities and plans continually explored and reviewed at the TSG monthly meeting to realise the remaining target.

The CIP position for 2017/18 (including non-recurrent schemes) can be summarised as follows:

Summary as at Month 5	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£4,233k		£15,000k		
Fully Developed TSG approved schemes	£2,823k		£8,996k		
Overperformance/ (Gap) v NHSi Plan	-£1,410k	-33.3%	-£6,004k	-40.0%	
Latest Forecast performance on TSG approved schemes	£2,597k		£8,976k		↑
Over/ (Under)performance compared to TSG approved schemes	-£226k	-8.0%	-£20k	-0.2%	
Latest Forecast including mitigation	£2,597k		£8,976k		↑
Performance Variance (Latest Forecast to NHSi Plan)	-£1,636k	-38.7%	-£6,024k	-40.2%	
Latest Forecast adjusted for risk	£2,597k		£6,674k		
Performance Variance (Latest Forecast to NHSi Plan)	-£1,636k	-38.7%	-£8,326k	-55.5%	

The in-year forecast on fully developed schemes is c£9.0m, £6.0m behind the NHSI requirement. Whilst this shortfall is of concern, considerable work has been undertaken with the divisional and programme leads to develop the plans in progress and opportunities schemes for approval at Transformational Steering Group (TSG) all schemes have been risk assessed with a small proportion rated as red. Work will continue to assess the remaining schemes within these categories, with a view to obtain approval at TSG and have a clear understanding of the unidentified gap in order to take the appropriate actions. It is recognised that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes. CIP performance has also been escalated to the weekly Executive Management Team meeting with particular focus on the delivery of the corporate directorate targets and again it is anticipated that there will be a significant advance within this area during September and October 2017.

It has to be noted that the lead time in terms of benefits realisation associated with many of the transformational and STP programmes will necessitate an increased focus on tactical in-year schemes

The Trust is mindful of the financially challenging environment and the need to maintain pace and focus in the identification of initiatives and subsequent delivery. The Service Transformation team continues to work closely with the Divisions to secure plans for 17/18 and provide support in the subsequent delivery.

Statement of Financial Position for the period ending 31st August 2017

Post EBITDA Items

For month 5, the year-to-date variance to plan for ITDA items totals £0.7m, due to depreciation savings based on the realignment of the Cerner contract.

Statement of Financial Position

Total taxpayers' equity equals £104.6m, the main variances on actual balances against plan are explained below.

a) Non-current assets

Total capital assets are above plan by £2.7m at month 5. This variance is detailed in the table below.

Capital variances	£m
17/18 brought forward balances above plan	1.7
Capex underspend, not including finance lease recognition	-0.8
Depreciation below plan	0.7
Donations above plan	0.1
Finance lease recognition / derecognition	0.9
Total variance of capital assets to plan	**2.7**

b) Current assets

Current assets are above plan by £1.3m. Current trade and other receivables are above plan by £0.3m, and inventories are below plan by a further 0.5m. The remaining variance is due to cash balances being above plan by £1.4m. The cash variance is detailed in the table below.

Cashflow variances	£m
17/18 brought forward cash balance exceeded plan	3.6
EBITDA below plan	-5.4
Working capital movements	-1.5
Capital expenditure (cash basis) behind plan	0.9
PDC received	3.9
Other minor variances	-0.1
Total variance of cash to plan	**1.4**

c) Current liabilities

Current liabilities are above plan by £1.8m. This is attributable to minor variances in the working capital cycle.

d) Non-current liabilities

Non-current liabilities exceed plan by £0.3m, primarily due to the recognition of a new finance lease liability within the Trust's borrowings balance.

Use of Resource (UoR) Rating

The Trust has achieved an overall UoR Rating of 3, which is in line with plan.

	Planned Rating	Actual Rating
Liquidity	4	4
Capital service capacity	4	4
I&E margin	4	4
Distance from financial plan	1	4
Agency spend	1	1
Overall UoR Rating	**3**	**3**

Control Total and Sustainability and Transformation Fund (STF)

The Trust has delivered £1.1m of the £2.5m available via the STF reflecting the achievement of the financial plan in quarter 1, and the GP streaming element of the A&E performance standards. During month 4 and 5 the Trust was unable to deliver the financial plan due to the continued pressures of escalation costs in emergency areas. The Trust continues to work with the Health Economy to improve this position and has also brought in external support to aid improvement.

Conclusion

The Trust continues to work towards achieving the control set and agreed for 2017/18. Work will continue over the quarter to recover the YTD performance and subsequent full year plan.

The Trust will continue to submit 13 week cash flows in line with NHSI processes to support the requirement of future cash draw downs in line with plan.

The Trust is working closely with all partners across the health economy to support the delivery of a sustainable health service within the Cheshire and Wirral LDSP.

David Jago
Director of Finance
September 2017

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

26 JULY 2017

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
John Coakley	Non-Executive Director
Susan Gilby	Medical Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
David Jago	Director of Finance
Sue Lorimer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Clare Pratt	Deputy Director of Nursing
Robert Howell	Lead Governor
Jayne Kearley	Member of the Public

Apologies

Gaynor Westray	Director of Nursing and Midwifery

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 17-18/090	**Apologies for Absence** Noted as above	
BM 17-18/091	**Declarations of Interest** None	
BM 17-18/092	**Chairman's Business** The Chairman advised the Board of the following recent consultant appointments: • Dr Helen Kalaher • Dr Hannah Cronin	
BM 17-18/093	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas: **Global Digital Exemplar Programme** - the Board was pleased to note that the Trust had now received the first tranche of funding for this programme of £3.9M. The Chief Executive advised that the split between capital and revenue posed a risk however the Trust would seek to ensure that it adheres to this alignment in order that it could meet the capital target. The Board was	

Reference	Minute	Action
	reminded of the need to re-profile the milestones in the programme because of the delay in receiving this funding. **NHSI – Protocol for Changes to an In-Year Financial Forecast** – the Board was updated on this guidance and reminded that this was not dis-similar to the previous year. The Board agreed with the importance of ensuring that clinical leaders were engaged in this work through the Divisional Triumvirates and the newly re-established Senior Management Team. **Accountable Care** – the Board was advised of the good progress made by PWC and colleagues in West Cheshire on this agenda hence the reason for engaging them to undertake work on the Wirral. The Chief Executive confirmed that 3 workshops had now taken place although work was required at scale and pace if partners were to address the urgent issues in the Health and Social Care Economy. The Board was advised of a further meeting with Healthy Wirral Partners which was due to take place on the following day to progress this. The Board was disappointed that PWC had not formally communicated their view on the risk with the current position of Partners, however it was hopeful that this would be addressed at the meeting the following day. **Sustainability and Transformation Plans STP** – the Board was advised that this had now moved from being a planning footprint to a delivery footprint. The new Chair of the STP was confirmed as Andrew Gibson who was due to meet with the Chair and Chief Executive in early August. The STP Lead Louise Shepherd was stepping down with applications for the new Senior Responsible Officer to be received by 28th July 2017. **Celebrating success** – the Board expressed their delight that the national lead for Gastroenterology as part of the Getting it Right First Time GIRFT work was Dr Beverley Oates.	
BM 17-18/094	**Patient Story/Learning** The Deputy Director of Nursing highlighted a patient story from NHS Choices. The story was associated with delays in the outpatient service. It included difficulties with car parking; delays in clinic times; limited time with professionals; delays with reporting information, all in all which took 5 hours for a routine review and fortunately the diagnostics were clear. The review was left anonymously however the Trust had requested that this patient contact the Trust so that it could ensure this did not happen again to another patient.	
BM 17-18/095	**Report of the Quality and Safety Committee** The Chair of the Quality and Safety Committee provided an update from the meeting which was held on 12th July 2017. This included a review of the Terms of Reference and recommendations for change associated with membership and quoracy in the main. The Board approved the changes noting that a further review would be undertaken as part of the Quality Governance Review.	

Reference	Minute	Action
	The key changes to the Board Assurance Framework BAF during the reporting period were highlighted which included a reduction in the risk score in relation to RTT to reflect the work undertaken to date and compliance with the STF trajectory; a review of the risk in relation to C difficile to take account of the recent upward trend in avoidable cases and the planned review of the 3 strategic risks by the new Director of Strategy and Sustainability. The Board also noted the decision by the Executive Teams of both the Trust and the Countess of Chester to share BAFs with a view to identifying where recruitment/collaboration would be suitable solutions to mitigating risk. The new risk above 15 in relation to potential non-compliance with the requirements of the NHS Cervical Screening Programme was received and reviewed with a view to determining whether all necessary mitigating action was being taken. The Committee reported that it was supportive of the measures being taken but agreed that the risk should remain at the current level until full assurance of the impact of these had been received. The Committee gave its support to the replacement of the Operational Risk Management Team with the Senior Management Team as this would ensure a wider representation from Divisions and Corporate Services and a greater emphasis on holding to account and risk management. The Workforce and OD dashboard although comprehensive had raised some concerns which required the Board's attention. These included increases in the nurse vacancy rates in Medicine and Acute which were now above 10% although there were plans in place to reduce this. Appraisal compliance had fallen so the Trust was in the process of reviewing compliance by area with a view to addressing this. The Board sought to clarify the effectiveness of appraisals particularly in light of feedback from the medical engagement survey in this regard. The Medical Director advised the Board that there were two aspects to appraisals, one associated with revalidation which was a national standard and the other was an appraisal for doctors as employees where career planning and performance could be managed. She did advise the Board that the Trust was in the minority of Trusts that undertook the separate appraisal although she felt it was worth undertaking. The Board was advised of the in-depth presentation the Committee received in respect of organisational development in the Trust, an overview of which was planned for the Board in its private session. The development of the Quality Dashboard was welcomed although the Committee was disappointed that a Never Event had been reported as advised at the Board in June 2017. The investigation was reported as underway and learning disseminated as part of the Safety Summit. The Board was advised of the work being undertaken to look at the recurrent and non-recurrent breaches in agency spend. The Committee reported that a deep dive into medicines management had been commissioned as the number of incidents continued to rise although the levels of harm had reduced.	

Reference	Minute	Action
	The Board was updated on the Outpatient Improvement Programme which focussed on 4 key areas these being space utilisation; outpatient workforce; IT enablers and Clinic utilisation. The Board was assured that this work would not have an adverse impact on patients and was supported by staff. The internal changes made to the mortality review process were highlighted to the Board together with how the process for dissemination of learning outcomes would be undertaken. The Board noted the changes nationally in this arena which would come into effect in quarter 3 of this year. The Board's attention was drawn to the publication by the National Quality Board "National Guidance on Learning from Deaths – a framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care". The Board supported the move to open reporting as a key requirement. The Board took assurance from the Quality and Safety Committee review of the Emergency Preparedness, Resilience and Response EPRR Annual Report which had been circulated separately by e-mail to Members. The Board formally approved this. The Board supported the planned changes to Clinical Audit going forward and noted the Annual Report for 2016/17. The Board took assurance from the Quality and Safety Committee review of the Safeguarding Annual Report noting the excellent work undertaken during the year. Compliance with mandatory training in this area still required further work acknowledging that the base figures had been reviewed to ensure that this training now encapsulated vulnerable people training. The Board approved the annual report. The Board noted the items escalated which were the requirements from Quarter 3 to report on mortality reviews which it supported; the work being undertaken to improve appraisal compliance and the increase in pace required to secure compliance with mandatory training for safeguarding.	
BM 17-18/096	**Nurse Staffing Report** The Deputy Director of Nursing presented the Nurse Staffing Report for May and June 2017 and highlighted the following: The Vacancy rates for registered nurses was increasing and in particular in the area of medicine and acute as previously discussed. Although the Board received details of the recruitment strategy to address this there was a concern that nationally this was an issue and therefore would be difficult to manage without further innovative thinking. The Chief Operating Officer updated the Board on the skill mix work being undertaken citing pharmacists undertaking medicine rounds as an example of the different ways of working being explored. The decrease in use of agency staffing by 15% and the corresponding increase in bank staff by 11% was welcomed as was the news that the Trust had the lowest agency fill rate of 4.4% against a national average of 20.8%.	

Reference	Minute	Action
	The Deputy Director of Nursing highlighted the slightly lower than regional/national average for care hours per patient day CHPPD. She confirmed that this was a result of an increase in rates for peers not a decrease by the Trust although still required close attention. The Chief Executive sought to establish why the Trust was not at the upper quartile for reporting in view of the investment in technology by the Trust. He was keen to determine what was taking nurses away from caring for patients. The Deputy Director of Nursing confirmed that the CHPPD was a crude measure and simply only measured the man hours with patients, not their acuity or how effective this was. The Board was advised that a full patient acuity audit was being undertaken which would be presented to the Board in September, this would provide the Board with much more meaningful data. The Board sought to establish the impact of the escalation wards on safe staffing. The Deputy Director of Nursing advised the Board that an increase in nurse staffing had been undertaken to allow for this. The Board was further advised that the Trust was looking to establish wards for step down that did not require registered nurses which were difficult to recruit. The Board reviewed the number of staffing incidents reported and noted the increase in June. The Board was advised that many of these were duplicates and levels of harm were low. The Board sought to establish whether the Trust had any information or benefits realisation that provided evidence on how the investment in technology had supported patient care. The Chief Executive confirmed that the Director of Information and Informatics was currently undertaking this evaluation. He took the opportunity to clarify that the number of nursing hours available in the Trust was as a direct result of the investment made by the Trust in nursing numbers which was supported by the Board. How those available hours now directly improved patient care though enhanced technology would be quantified. The Board sought to understand the incidents in ITU and the concern with staff being moved. The Deputy Director of Nursing confirmed that she and her team were working with these staff to ensure moves were safe but that flexibility had to be part of their role. The Board again sought assurance as to the safety of nurse staffing in light of the increased incidents; reducing CHPPD hours in comparison to peers and the increase in vacancy levels. The Deputy Director of Nursing confirmed that daily reviews were being undertaken to ensure the Trust was safe, she accepted the limitations with reporting against such a crude measure as CHPPD hence the move to provide a fuller report in September based on a patient acuity audit. The Director of Finance drew the Board's attention to the Board Model Hospital Portal which linked CHPPD to harm free care. The harm free care rate for the Trust was 96.2%. The Board agreed to await the patient acuity audit in September together with the review of the Board Model Hospital Portal and place reliance on the daily reviews of establishment levels, review of CHPPD, the high reporting of incidents which also instigate a specific review, if related to safe staffing as	**CP** **DJ**

Reference	Minute	Action
	reassurance of safe nurse staffing levels.	
BM 17-18/097	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated performance dashboard and advised the Board as follows: **A & E 4 Hour Access Standard** – performance for June was reported as 81.14% as a combined ED and All Day Health Centre and 76.08% for ED alone. The Board was advised that this performance level did not achieve the 95% standard or the STF trajectory. The Board noted that regulators had now determined that half of the STF monies would be attributable to the delivery of primary care screening and that this would take effect from Q1. The Board was advised that the Trust was confident in its ability to secure this part of the funding. The remaining half of the funding was linked to the delivery of 90% standard based on the A & E Delivery Board footprint, this would include walk in centres based in the community however even given that addition the % performance would only stand at 88%. The Board was advised that the Trust was in discussion with NHSI as to whether the original submitted STF would stand and if so how the delivery of May's standard would be treated, treatment of future STF funding was also the subject of ongoing discussions. The Chief Operating Officer advised the Board that she had expected to see a drop in attendance levels however this continued to grow at 7%. She confirmed that the focus was very much on GP streaming; patient flow in assessment areas and discharge. The additional beds at Clatterbridge for medically optimised patients would reduce the number of medical outliers on the Arrowe Park Hospital site. The Board sought to establish whether the additional beds at Clatterbridge could be staffed differently but safely and whether the funding would be available from the Better Care Fund. The Chief Executive advised that the staffing could be different and would be safe and that the funding was being supported by key colleagues however this was in no way guaranteed , the overall arrangement was safer for patients because it would improve patient flow. The Board was updated on the capital funding bid for ED which would support the single front door and primary care streaming. The Director of Finance confirmed that the monies secured were £0.99m which required matched funding to 50% which was currently being worked through. He also advised that the financial assumptions had been predicated on achievement of 90% against the A & E Standard by November however the new STF assumed compliance from the start of the year which wasnow the subject of an appeal, although there was recognition that the Trust needed to achieve its own trajectory in the first instance. The Chief Executive confirmed that the A & E Delivery Boards were now focused on the right metrics including volumes and expected timescales and that there was now better visibility amongst partners although he accepted there was still much more to do.	

Reference	Minute	Action
	18 Week Referral to Treatment Times RTT – the Chief Operating Officer confirmed that the final position for June was 82.67% which was a slight improvement on the previous month and above the STF trajectory although well below the national standard of 92% of patients waiting to be seen at 18 weeks or less. She advised that she was now confident that the Trust had the right systems and processes in place to achieve the standard and was currently working on clearing the backlog to ensure compliance by March 18 in line with the agreed trajectory. The Board was advised that there was still more work to be undertaken on the open pathways but all the necessary processes to enable this to happen were now in place. The Board sought and received assurance that the patient tracking list was live and cleansed. The Board acknowledged the difficulties with clearing the backlog within existing resources and the risk as to affordability by the commissioner. **Diagnostic Six Week Wait** – No issues with performance were reported **Cancer** – the Chief Operating Officer confirmed that performance remained strong although there was recognition that performance in dermatology and breast supported the rest of the organisation and could be a single point of failure should this position change. Further updates on this will be provided to the Board. **Infection Control** – 2 avoidable cases of C difficile were reported. The Board was advised that the Hospital Infection Control Team would meet again in August to review the high risk priorities and the control of MRSA. The Board sought to establish the status of the HPV programme and the use of Ultra Violet lights in the prevention of infection. The Chief Operating Officer confirmed that the HPV programme was now back on track following the closure of ward 19 and that the ultra violet lights supported this work rather than replaced it. **M3 Finance and Cost Improvement Programme Report** The Director of Finance presented the M3 finance and cost improvement report and highlighted the following areas: • The overall deficit at the end of M3 was reported at £3.9M against the plan of £3.7M. The underachievement was attributed to the non-delivery of A & E and the loss of STF. • The Board was reminded of the agreed control total of £0.426M deficit which included the requirement to deliver £15M of savings. • Use of Resources was reported at 3 in line with the plan • Cash was reported at £3.0M which was £1.1M above plan • The Cost Improvement Plan was reporting an adverse variance of £1.3M having delivered £0.2M in month and £0.75M for the year compared to the plan of £2.1M. The Board was reminded that agreement of the control total had protected the Trust from incurring penalties of £2.1M at the end of Quarter 1 although the underlying deficit was £23M which although not deteriorating was not improving either. The use of the £1.2M CQUIN reserve was acknowledged as a risk with discussions on this due to take place with commissioners at the	

Reference	Minute	Action
	end of the coming week, guidance was also due in this regard. The Director of Finance also confirmed that £1M of non-recurrent support had been used from provisions and accruals. He also confirmed that the contract extension with Cerner over 10 years had also been used to support the bottom line. The Board discussed the reasons for the slippage in the CIP trajectory which were attributed to additional capacity costs and specialising costs. The Director of Finance advised that he was looking to have the escalation costs offset by the BCF slippage in plans. The Board was advised of the fully developed plans in the Trust which equated to £9.9M which took the total up to £13M of identified plans. There was an acknowledgement that plans needed to be progressed at pace. The Board was advised that the overall activity plan was in line with the Payment By Results PBR plan although the Trust's cost base was high. Non elective activity was reported at £1.3M above plan and strong performance was reported in surgical activity. The Board was advised that the Trust was drawing down funds from the working capital facility in line with the plan and that the next tranche would be drawn down in September or possibly October. The Chair of the Finance Business Performance and Assurance Committee FBPAC concurred with the assessment and analysis of risk from the Director of Finance. The Board agreed that the savings schemes now required transformational change and was not surprised therefore that there was a delay in these coming to fruition. The quality of the schemes was commended by the Board following review at the Transformation Steering Group TSG. The Board debated the likely split of cost avoidance schemes versus cost reductions schemes acknowledging though that both would lead to quality improvements. The workforce scheme was likely to take 16-18 months to realise because of the changes required to terms and conditions so simply applying more pressure on pace here in particular might not yield the outcome required by the Trust. The Director of Finance confirmed that all the schemes were being revisited with Divisions and the Trust was looking at all discretionary spend and enacting changes to the oracle hierarchy to support more robust sign off in this area. The Board sought and received assurance that all schemes were still subject to a thorough quality impact assessment with full sign off by the Medical Director and/or the Director of Nursing and Midwifery. The Board was also reminded of the introduction of post project evaluation to ensure any unintended consequences on quality and safety or patient experience could be identified. The Board raised concerns that in the first quarter the Trust had used nearly all its reserves to meet the financial plan. Its creditors now totalled £38M so how well placed was the Trust to mitigate against any wider financial crisis of the kind that happened in 2007. The Director of Finance advised that the CIP risk reserve of £1.5M was only being released on a quarterly basis, so three quarters of this was still to be released. The inflation reserve had not been brought forward as yet although there was acknowledgement of the risk particularly in light of the use of CQUIN reserve.	

Reference	Minute	Action
	The Director of Finance confirmed that it was £34M of credit which had grown, a small stretch out of days would be a minimal risk although if everyone determined that they could not pay this undoubtedly would be a risk the Trust could not mitigate.	
BM 17-18/098	**NHS Improvement Quarterly Return** The Director of Finance presented the NHSI quarterly return for noting by the Board. The Board agreed that the narrative in this report should reflect the determination demonstrated in the verbal discussion to provide NHSI with greater confidence.	
BM17-18/099	**Report of Finance Business Performance and Assurance Committee** The Chair of the FBPAC provided the following update accepting that the financial position had been discussed in detail earlier in the meeting. Changes to the Board Assurance Framework during the reporting period were highlighted. These included the increase in risk 5 - sustainability to accurately reflect the anticipated challenges and risks associated with delivery of the financial plan; the increase in tolerable risk score number 6 - efficiency to illustrate a Trust willingness to explore innovative and pioneering initiatives to realise efficiency gains. The reduction in risk score 10 - RTT as discussed earlier in the meeting and the increase in risk score 12 - C difficile again discussed earlier in the meeting. Two new risks above 15 were presented, the first in relation to A & E performance at a Divisional level and the second relating to the potential limited access to transfusion data contained within the Triple G computer system, which was currently being worked through. The Committee requested that the risks associated with changes to the General Data Protection Regulation GDPR as discussed at the Board in June 2017 be reflected in the BAF. The Board was advised of the update on service line reporting and how this would be used going forward noting that this was a rich source of data. The Committee advised the Board that it had raised concerns over the capital plan and reviewed the unmet demand. The Committee agreed that periodic reviews in year of the plan would be undertaken in conjunction with quality discussions to ensure that risks were being prioritised appropriately. The Board was updated on the annual requirement to submit reference cost data. The Committee supported the proposal to delegate the final submission to the Chairman and the Director of Finance subject to this being on the basis of the methodology reviewed by the Committee. The Board supported this recommendation. The Committee reviewed the RAG rated 9 point plan for A & E and requested that future iterations of the report include a heat map to illustrate Trust performance against the projected trajectories. The “in depth” review of the CIP programme and the MSK project had been	

Reference	Minute	Action
	well received noting that engagement and sponsorship was key to its success. The non-core spend report highlighted that performance was on track acknowledging that there was no budget to spend. The rigour amongst the Executive Team was felt to be evident. The Committee reviewed the Orthopaedic Trauma contract as agreed 6 months ago by the Board. The Committee was pleased to report the benefits realised as a result of the positive performance against the contract. The Board was advised of the proposed changes to the Executive Working Groups that support FBPAC and the revised terms of reference which the Committee was reviewing.	
BM17-18/100	**Research Annual Report** The Medical Director presented the Research Annual Report. She requested that this be reviewed by Quality and Safety Committee in the future and the Board supported this. The Board was advised of the plans to have a "deep dive" into research activities across the Trust and the Countess of Chester which was particularly relevant given that the Trust did not have an innovation strategy. The Board was advised that the risks and benefits to the population would be addressed through projects in the future such as the genome project and although the Trust had a good level of resource for research there was currently no clinical lead or research job plan time. The job description for the clinical lead for research was being developed to support the future strategy and innovation. The Board noted the Research Annual Report.	
BM17-18/101	**Safeguarding Annual Report** In view of the in-depth review of the Safeguarding Annual Report and the earlier discussion, the Board noted and accepted the Annual Report.	
BM17-18/102	**Board of Directors** The Minutes of the Board of Directors held on the 28th June 2017 were confirmed as an accurate record. **Action Log** The Board accepted the action log as presented. The Director of Corporate Affairs advised of the following additional updates: **Action 2** – the Director of Finance confirmed that the £3M of savings discussed were savings in year with a full year effect of £4.2M **Action 3** – this action was marked as completed **Action 5** – this action was marked as completed	
BM17-	**Items for the BAF/Risk Register**	

Reference	Minute	Action
18/103	None	
BM 17-18/104	**Items to be considered by the Assurance Committees** The Board agreed the following focus areas for the assurance committees: **Quality and Safety Committee** – to review the research work in the Trust	**CS**
BM17-18/105	**Any Other Business** The Board agreed to bring an update on future Care Quality Inspections as a result of a query raised by the Lead Governor to the next meeting of the Council of Governors in September**.** The Board received clarification that it had had just the one Never Event during the financial year 2017/18 as the breast biopsy serious incident had not been classified as a Never Event. The Chairman referred to minute number BM17-18/066 in relation to fire compliance at Frontis and advised the Board that the Trust was still pursuing notification in writing from the owners that the cladding was compliant. The Board was advised that the Associate Director of Estates had since written to Merseyside Fire Service seeking assurance.	**SG**
BM 17-18/106	**Date and Time of Next Meeting** Wednesday 27th September 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors
Updated – September 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 26.07.17						
1	BM17-18/096	Receive the outcomes of the patient acuity audit	**CP**	**Included on the agenda – September 2017**	Sept 17	
2	BM217/18/096	Undertake a review of the Board Model Hospital portal	**DJ**	**To be undertaken with members as part of work programme in September**	Sept 17	
3	BM17-18/104	Quality and Safety Committee to review research work as part of their work plan	**SG**			
4	BM17*18/105	Provide an update on future Care Quality Inspections to the CoG in September	**SG**		September 17	
Date of Meeting 28.06.17						
5	BM17-18/068	Quality and Safety to receive assurance on CQC preparedness and overall compliance and provide regular reports on this to the Board	**SG**	**Ongoing**	July 2017	
Date of Meeting 24.05.17						
6	BM17-18/039	Provide regular reports on the A & E 9 point action plan – specifically those areas that relate to the Trust	**JH**	**Ongoing – last review June 17**	June 17	

7	BM17-18/049	Review the IT risk on the BAF in relation to cyber security	**PC**	Work is ongoing to implement further protections e.g. awaiting delivery of a new Internet circuit which is ordered but has a 90 day delivery time. Working with NHS Digital and GDE sites with Cerner to go through the Cyber Essentials plus framework funded by NHS Dgitial – dates being agreed. WUTH is leading work on Cyber for Cheshire and Mersey STP	July 17	
Date of Meeting 26.04.17						
8	BM17-18/006	Provide a trajectory to achieve "good" in the next CQC inspection	**SG**	The review will now be undertaken at Quality and Safety Committee – **action removed**	June 17	
9	BM17-18/013	Provide details of what "good" looks like under the Equality and Diversity indicator for inclusive leadership	**GW**	**Scheduled for update in September 17**	June 17	
10	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**		June 17	
Date of Meeting 25.01.17						
11	BM16-17/244	The Board agreed that the reporting of Advancing Quality Indicators needed to be strengthened	**SG**	The Board to receive an update on the work of the Quality Governance Review as part of a Development workshop in July 17 **- completed**	March 17	**Being reviewed as part of the Quality Governance Review**
Date of Meeting 25.05.16						
12	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	**SG**	**Updated as part of QSC agenda – action completed**	July 16	

13	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	**JH**	**The new Director of Operations and Performance is reviewing this and will provide an update in October 17**	Sept 17	
14	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**	**Director of IT and Information currently evaluating this work**	April 17	
Date of Meeting 30.03.16						
15	BM15-16/297	Present the Medical Engagement Strategy	**SG/JM**	Included as part of Board Development session in July **17 - completed**	May16	