Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors
Public Board

25th January 2017

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25th JANUARY 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	**Patient's Story** Director of Nursing and Midwifery	v
4	**Chairman's Business** Chairman	v
5	**Chief Executive's Report** Chief Executive	d
6. Quality and Safety		
6.1	**Report of the Quality and Safety Committee** Chair of Quality and Safety Committee	d
6.2	**Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Update Report** Director of Nursing and Midwifery	d
7. Performance and Improvement		
7.1	**Integrated Performance Report**	
	7.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	7.1.2 Month 9 Finance and Cost Improvement Programme Report Director of Finance	d
8. Governance		
8.1	**Report of the Finance, Business Performance and Assurance Committee** Chair of Finance, Business Performance and Assurance Committee	d

8.2	**Report of the Audit Committee** Chair of Audit Committee	d
8.3	**Report from Charitable Funds Committee** Chair of Charitable Funds Committee	d
8.4	**External Assurance** • **NHSI Month 9 NHSI Compliance Return** Director of Finance	d
8.5	**Board of Directors**	
	8.5.1 Minutes of the Previous Meeting • 30 November 2016	d
	8.5.2 Board Action Log Director of Corporate Affairs	d

9. Standing Items

9.1	**Items for BAF/Risk Register** Chairman	v
9.2	**Items to be considered by Assurance Committees** Chairman	v
9.3	**Any Other Business** Chairman	v
9.4	**Date and Time of Next Meeting** Wednesday 22nd February 2017	v

Agenda

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

I am pleased to confirm that Dr Susan Gilby commenced in post as the Trust's new Medical Director on the 3rd January 2017.

I am sure you will join me in wishing Chris Oliver, Director of Operations every success having accepted the position of Chief Operating Officer at Mid Cheshire Hospitals NHS Foundation Trust. Plans are being progressed to recruit to his replacement.

Regulatory

- **Care Quality Commission (CQC)**

The Trust met with the CQC on the 20th December 2016 as part of its regular engagement programme. The meeting enabled the Trust to update the CQC on its progress since the comprehensive inspection in September 2015; provide an overview of the current pressures being experienced as a result of winter pressures and provide an update on the ophthalmology external review following the recent Never Events.

The Trust also discussed the timing of its next inspection which is now likely to be delayed until later in the year because of the proposed changes to the regulatory regime which are currently out for consultation.

The Trust continues on its journey of improvement and monitors performance through the internal care quality inspections; ward accreditations and a series of "deep dive" sessions held with Divisional and Corporate Colleagues which focus on key areas for improvement.

External

- **Winter Pressures**

There has been significant reporting in the media about the national pressures facing the NHS this winter and in particular the pressures felt by acute Trusts during the beginning of January. Wirral has not been immune to these pressures, in fact the pressures seem to have been felt more significantly in the North West of England, especially in Cheshire and Merseyside, with a number of Trusts declaring the highest level of escalation.

During the first part of January the Trust has seen a 6% increase in attendances, 13% increase in ambulance arrivals and of most concern a 45% increase in those patients streamed to resus on arrival to the ED. At the same time the Trust had four wards impacted with norovirus, however due to containment actions, at the time of writing this report there are no wards affected by norovirus.

To meet the increased pressures the Trust has taken the following actions to ensure non elective flow is maintained:-

- Opened additional inpatient capacity above the planned acute inpatient contingency ward.
- Suspended elective orthopaedic elective activity to enable the elective orthopaedic ward to be used for emergency admissions.
- Cancelled non urgent elective activity to release capacity and staff to support emergency admissions
- Worked with the economy to obtain twenty additional Discharge to Assess beds, taking the economy total to 35 beds, plus spot purchased beds to mitigate the capacity issues within domiciliary care provision
- Instigated the full capacity policy on a number of days to help deal with surge within ED

As Chair of the A&E Delivery Board I have met with economy leads to continue to ensure that the pressures felt within the acute Trust are supported by economy wide support and this message has been echoed by the discussions with NHSE and NHSI.

Strategy

The Sustainability and Transformation Plan STP membership group met on the 18th January 2017 to consider its governance arrangements. The Trust along with other members of the STP will consider these proposals ahead of formal approval in March 2017.

Celebrating Success

The Trust has been shortlisted in five categories for the prestigious HSJ Value in Healthcare Award, where they have demonstrated outstanding practice as well as cutting-edge innovations.

Nomination	Category	Nomination Title
Stephen Blair and Emergency General Consultant Surgeons	Acute Services Redesign	7 day service provided by Emergency General Consultant Surgeons for patient's whole episode, improves care and saves money
Pharmacy	Pharmacy and Medicines Optimisation	Near Patient Chemotherapy Dispensing Model
Leadership and Development Team	Training and Development	Apprenticeships – Grow Your Own
HROD Team	Workforce Efficiency	Increasing Workforce Efficiency by Improving Employee Attendance
HROD Staff Engagement Team	Communication	Improving Staff Satisfaction and Engagement through communication and involvement

Entries are judged against the general criteria outlined below, as well as category-specific criteria, that are relevant to the individual entry:

- Working to a clear and focused strategy
- Delivering service improvements within the context of financial and resource constraints
- Delivering tangible improvements in efficiency
- Delivering quantifiable cost savings, improvements in health outcomes, or both
- Maintaining or improving the quality of services offered and ensuring services are patient-centred
- Ensuring the level of service provided meets local needs
- Adhering to relevant national guidelines and policies
- Adhering to current evidence on best practice
- Involving representatives of all stakeholder groups in planning, design and implementation of the initiative

David Allison
Chief Executive

January 2017

Board of Directors	
Agenda Item	6.1
Title of Report	Report of the Quality & Safety Committee – 11 January 2017
Date of Meeting	25 January 2017
Author	Cathy Maddaford, Chair of the Quality and Safety Committee
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery Dr Susan Gilby, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risks 1, 2, 3, 4, 12 and 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 11 January 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Quality and Safety Committee Terms of Reference

The Committee recommended, in principle, the approval of the revised Terms of Reference (ToR) as attached, which had been refreshed to support the Committee in discharging its responsibilities to the Trust Board.

The Committee agreed that a further review of the Terms of Reference would be undertaken by the newly appointed Medical Director and the outcome presented at the March 2017 meeting.

Quality and Safety Committee Workplan

The Committee received the 2017/18 Workplan which had been developed to support the Committee in discharging its responsibilities, as outlined within the revised terms of reference.

The Committee accepted the Workplan which would be subject to ongoing review as the role of the Committee develops.

Board Assurance Framework

The Committee reviewed the Board Assurance Framework (BAF) and gave consideration to the following key points:

- Reduction of the risk rating for Risk 1 (CQC Rating) to reflect the positive work undertaken in response to the findings of the Trust inspection of September 2015,
- The potential impact of:
    - Suspension of the HPV programme as a consequence of lack of ward availability due to winter pressures,
    - The inability to discharge patients to the Trust's lead provider of domiciliary care services within the community.
    - The potential outcomes of the Ophthalmology reviews and the work to be undertaken to address the issues identified.

The Committee requested that:

- Consideration was given to review of the risk descriptors to highlight those which pertain to patient safety, quality of care and clinical incomes,
- Future reports outline progress against mitigating actions,
- Future reports to include the overall Trust risk profile

The Committee received the 'Using the BAF' guidance and confirmed agreeance with the revised methodology and remit of the Committee and Executive Working Groups in undertaking review and management of BAF content.

Workforce & OD Dashboard and Report

The Committee received the Workforce and OD Dashboard Report which highlighted the following key points:

- Although an increase in sickness had been experienced over the winter period, the Trust continued to benchmark well against comparable organisations,
- A decrease in agency costs would be detailed in future reports due to the work carried out in high cost non-clinical areas.

The Committee was advised that the Trust continued to report low vacancy rates for both medical and nursing vacancies, however challenges had been experienced within the Medical and Acute Division. This situation was further exacerbated by the need to open additional capacity to meet winter pressures. The Committee requested that an action plan outlining the mitigating action to be taken to support recruitment in the Medical and Acute Division be presented at the March 2017 meeting.

The Committee noted the decrease in appraisal rates during the winter period and supported the proposal to develop an 'appraisal season' over the summer months, which would be underpinned by regular manager/staff meetings throughout the year, to ensure ongoing compliance with appraisal targets.

Further work is required to develop E-Learning across the Trust. A report is to be provided for the Committee.

The Committee was pleased to note the Trust's above average response rate of 46% for the NHS Staff Survey, the outcome of which was to be presented at the March 2017 meeting.

Quarterly Quality Account Report

The Committee noted the overall performance in respect of the Quality Account, in particular the achievements made in respect of pressure ulcers, which would be subject to further review at Clinical Governance Group and the CQC Safe Domain Deep Dive of January 2017.

The Committee requested that:

- regular reports are provided to the CGG on Medicines Management to monitor progress
- future reports include quantitative data in respect of performance against trajectory.

CQC Progress Report

The Committee reviewed the outcomes of the Care Quality Inspections (CQIs) conducted during the period and received confirmation of the commencement of the action planning process to address issues identified for those areas which were allocated a rating of 'Requires Improvement'. The Committee extended its congratulations to the staff of Ward M1 as the first ward to be allocated an 'Outstanding' rating during a CQI.

The Committee requested that:

- The report format be revised to triangulate the information obtained through the CQI and Ward Accreditation Programme, shared learning gained via examples of excellence and evidence of demonstrable improvement,
- Summary feedback reports from CQIs were disseminated to Governors for information,
- Future dates for CQI's are circulated to Governors Executive and Non-Executive Directors.

The Committee was pleased to note that a further CQC Deep Dive, which would focus on performance against the requirements of the 'Safe' domain, was to be carried out in January 2017.

Organ Donation Bi-Annual Report

The Committee noted that the Trust reported performance above the national average for organ donation during 2015/16.

The Committee extended its thanks to volunteer Paul Dixon for his continued commitment in encouraging the public to join the organ donation register.

Assurance Reporting

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

- Clinical Governance Group,
- Patient and Family Experience Group,
- Workforce and Communication Group.

Issues for escalation to the Board of Directors

There were no issues identified for escalation to the Board.

Cathy Maddaford
Chair of Quality and Safety Committee

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee

Terms of Reference

Authors Name & Title: Gaynor Westray, Director of Nursing and Midwifery Carole Self, Director of Corporate Affairs	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: N/A	
To be read in conjunction with the following documents: Board Assurance Framework Standing Financial Instructions	
Document for public display? Yes	

Unique Identifier:	**Review Date: January 2018**	
Issue Status: Draft	**Issue No: 4.0**	**Issue Date: January 2017**
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After this document is withdrawn from use it must be kept in an archive for 10 years		
Archive: Document Control	**Date added to Archive:**	
Officer responsible for archive: Document Control Administrator		

DRAFT

1 Constitution

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

2 Authority

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

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

3 Objectives

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

3.1 Risk

3.1.1 To assess, receive and monitor risks above 15 relating to quality and safety in accordance with the Risk Management Strategy.

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

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

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

3.2 Clinical Effectiveness and Safety

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

3.2.2 To seek assurance that clinical performance is of acceptable quality and improving through use of selected KPIs / quality dashboard, this will include

external benchmarking data and measures linked to continuous improvement in patient and staff experience as outlined within the Quality Improvement Strategy.

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

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

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

3.2.6 To receive assurance of actions arising from complaints, claims and incidents or Ombudsman's recommendations and consider trends, appropriateness of actions taken and impact of organisational learning as outlined within the Clinical Governance Group Chair's Report.

3.2.6 Receive and ratify the Clinical Audit Annual Report and Forward Plan, based on the Quality Improvement Strategy .

3.3 Patient Experience

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

3.3.2 To receive assurance via the Clinical Governance Group Chair's Report of review and monitoring of Divisional performance against delivery plans for patient experience as set out in the Quality Improvement strategy

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

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

3.4 Workforce

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

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

3.5 Staff Satisfaction and Engagement

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

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

3.5.3 To ensure investigation, learning and communication from concerns raised by staff and report upon concerns reported directly to CQC.

3.6 Governance

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

3.6.2 Receive and ratify the following annual reports and forward plans on an annual basis:

- Safeguarding Adults and Children,
- Accountable Officer Controlled Drugs,
- Emergency Planning and Business Continuity,
- Clinical Audit, annual report and forward plan.

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

3.6.4 To undertake annual review of Trust Compliance against the NHS Constitution.

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

3.6.6 Respond to actions from the Audit Committee and report items that could inform the Audit Committee's work.

3.6.7 To receive and recommend the Annual Quality Account.

3.6.8 To undertake 'deep dives' as appropriate.

4 Equality and Diversity

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

5 Integration

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

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

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

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

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

6 Membership

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

7 Attendance

- *Director of Corporate Affairs*
- *Divisional Representation*

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

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

8 Quorum and Frequency

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

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

9 Reporting

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

Chair's reports will be circulated to Board Members by email as soon as is practicable following the meeting.

The Committee will receive reports from the following:

- Clinical Governance Group (monthly) – Chair's report and annual review
- Patient & Family Experience Group (quarterly) – Chair's report and annual review
- Workforce and Communication (bi-monthly) – Chair's report and annual review

10 Conduct of Committee Meetings

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

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

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

- The agenda will include the following standing items:
  - Minutes of last meeting
  - Action Log
  - Risk
  - Enhanced Patient Experience
  - Workforce
  - No Avoidable Harm
  - Consistent and Reliable Care
  - Group Chair's Reports
  - Items for Escalation
  - Evaluation of Meeting and Papers
  - Date of next meeting

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

BOARD OF DIRECTORS	
Agenda Item	6.2
Title of Report	**Hard Truths Commitment:** Publishing of Staffing Data: 6 Monthly Update Report, including performance for November and December 2016
Date of Meeting	25 January 2017
Author	Clare Pratt, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head of Clinical Excellence & Organisational Development
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk Reference: 1, 2 and 3
Level of Assurance	**Positive** • Revised and triangulated systems and processes are in place to monitor safer staffing levels. • Workforce stability index of 91.37% (Above National Average) • Introduction of Specialty reporting of staffing fill rates and CHPPD allows for easier comparison of staffing data • Associate Director of Nursing Report to provide an auditable trail from Ward Sisters/Charge Nurses and Matrons on mitigating actions taken to address staffing shortfalls **Gaps** • MIAA - Nurse Staffing Levels Reporting • MIAA reported Limited Assurance and weaknesses in the design and/or operation of controls used to report Safe Staffing • There has been an increase in staff reported incidents relating to staffing levels
Purpose of the Paper	For discussion and approval
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 November and December 2016 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).

2. Background

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. The National Quality Board issued guidance in November 2013, 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This document informs this paper and is augmented with the June 2015 publication of the National Institute for Care and Healthcare Excellence (NICE) guidance.

The Government has made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' (2014) to make this information more publically available.

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the milestones set out in the guidance published.

The expectations of the Board of Directors have been presented previously and are represented with an update to demonstrate focus and progression of the nursing and midwifery staffing agenda.

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 • All matrons hold daily staffing meetings to determine whether or not planned staffing requirements are met and to take action where there may be a shortfall • Staffing plan with agreed potential moves is prepared for out of hours periods • Close workings with NHSP to ensure improvement in fill rates for temporary staffing is ongoing

Recommendation 3 Evidence based tools are used to inform nursing, midwifery and care staffing and capability	• Evidence based tools are utilised across the Trust • Representational attendance at a national CHPPD workshop hosted by the Centre for the Study of Policy and Practice in Health and Social Care University of West London has provided a direct link to contacts specialising in staffing models and audit methods who have access to other organisations data and are part of the Shelford group. As a result of attending this workshop a dependency audit has been shared that can be used within the Clatterbridge Rehabilitation Centre and assessment areas to assess safe staffing levels more accurately • Within the past 2 years all General Wards have been assessed using the Safer Nursing Care Tool (SNCT) recommended by the Selford Group • 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. The next review will take place in Quarter 1 2017 • 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. Once results are circulated a staffing review at WUTH will take place • 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 • A second phase of the Birthrate plus assessment, primarily focusing on antenatal care, has been completed and is currently being analysed • Scottish Children's Acuity Measurement in Paediatric Settings (SCAMPs) has been undertaken on the Paediatric Ward. A paper has been prepared to be discussed by Senior Nursing Team to reviewing suitability of tool for the paediatric assessment unit

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. Positive staff survey feedback indicates an improving engagement score • Two incidents of whistleblowing regarding safe staffing have been reported to the CQC in December 2016. Both investigated and assurance given regarding safe staffing levels • Staff Guardian contacts have increased
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 division and senior nursing team. Information on safe staffing is made available to the Board of Directors
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 comparison data of CHPPD across all wards and specialties as well as regional and national comparison data. This information demonstrates that WUTH staffing is consistently in line with peer organisations • An upward trend in incident reporting relation to safe staffing levels has been noted. This coincides with an improved reporting culture across the organisation. Analysis of reported incidents indicates that the majority of reports relate to staff moves and "red flag" events rather than patient safety issues. Nurse Sensitive Indicators do not demonstrate any increase in patient harms during the report time frame • Ward sisters have supervisory status. During the winter period it was reported that due to the requirement to safely staff additional wards, ward sisters and charge nurses had been required to work clinically to ensure minimum staffing levels were achieved. This position has since improved due to the positive impact of the recruitment strategy, improvement in staff attendance rates and the effective management of patient flow. In future, ward sisters ensure that this is recorded on eroster to allow for monitoring
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 • Work has commenced to include other non ward areas e/g/ OPD, theatres • 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 to fill vacancies in a timely manner. Nurse vacancy rate has remained below 5% compared to a National average of 10% • HEE has reported that WUTH has a very good workforce stability index of 91.37% when compared to National average. Comparison data has not yet been released but will be included in future reports • Rosters are currently being cleansed to ensure they are an accurate reflection of staffing on each ward • WUTH is working with local partners to secure future clinical workforce requirements met by taking part in physician associate and nurse associate pilots
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. Mersey Internal Audit Agency (MIAA)

The Trust recently received a draft report from MIAA following their review in February 2016. The review was requested by Deputy Director of Nursing who was not assured that systems and processes were being adhered to at ward level. Following the review (but prior to receiving the report) greater emphasis had been placed on Divisional accountability and assurance from Associate Directors of Nursing (ADN). This is now embedded across the organisation.

The report is one of "Limited Assurance" and the reviewers found that there were weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process but should not have a significant impact on the achievement of organisational objectives. The key issues were identified:

Key issue 1

The Trust has not formally detailed the key processes and controls for the collection of nurse staffing data. Roles and responsibilities were not found to be formally defined to support the process that is currently operating.

- Specific Risk – Inaccurate data collection and submission, lack of accountability to support the process and inconsistent working across the organisation

- Recommendation – It is recommended that the Trust produce a brief procedure document that defines the process for the collection, collation and submission of nurse staffing data internally and externally. Included within this process, clarity over individuals and staff groups roles and responsibilities should be clearly defined. Once finalised, the document should be appropriately disseminated and a process put in place to ensure ongoing monitoring of effective implementation
- Management Response – The current Standard Operating Procedure will be expanded to include monitoring & feedback systems to ensure compliance. Changes will be communicated across the organisation. Matrons and ADNs are now required to formally check and sign off staffing data prior to submission

Key issue 2

Inconsistencies in relation to the comparative testing between the central spreadsheet for recording nurse staff shortages, e-rostering reports and incident reporting data were identified.

- Specific Risk – Inability to assure the accuracy of data submitted. Inaccurate nurse staff data is reported
- Recommendation – The Trust needs to ensure that any triangulation of information relating to staff shortages provides rigor and not conflicting information. Additionally, clarity over the roles for staff requested to double check data should defined
- Management Response – The lack of integration between Eroster and NHSP necessitates a manual update of electronic rosters on a daily basis. This is time consuming and difficult to monitor and often leads to inconsistencies across the system

The E-roster has undergone a full cleanse since the MIAA audit to ensure that establishment data is correct and to review each areas “hours” in order to identify any “owed” hours within the system to ensure correct allocation of staff rotas. Work is still required in this areas and HROD are working on a full action plan to address this to ensure that all data within the system is correct.

The data within e-roster will be used to inform the National Model Hospital portal and therefore the Trust is committed to ensuring that this data is accurate.

4. Recruitment Strategy

A key priority at Wirral University Teaching Hospital 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 a stable nursing and midwifery workforce.

The total Trust vacancy rate for the registered nursing and midwifery workforce in December 2016 was reported as 4.45% which has remained significantly better than the national average of 10%.

When reviewing the vacancy rate for in-patient and Emergency Department Band 5 posts the Trust’s electronic staff records (ESR) data identified a vacancy rate of 5.94 % for December 2016, this equates to 40.06 WTE Band 5 posts.

Our recruitment strategy has ensured our vacancy rate remains low to ensure a sustainable nursing workforce additional elements will now be performance managed. With regards to retention of staff, nurse turnover at WUTH is low at 8.44%, with a stability index of 91.37%, however we must ensure that prior to exiting the Trust all registrants have a meeting with their manager to monitor and evaluate the reasons why employees leave their employment in order to identify trends and determine where action may be taken to try and reduce turnover rates. Embedding the Trusts exit policy will ensure that practical matters arising from an employee’s resignation are dealt with efficiently, and will give individuals an opportunity to provide feedback on their perceptions of the Trust as an employer, and allows the Trust to gather

valuable information which may be used constructively to enhance employment practices identify areas of good practice and areas for improvement

International Recruitment – The Trust is working with Placement Group and NHSP to identify the best solution to support international recruitment to ensure we have a supply of additional registrants for winter 2017.

Care support development programme – the Trust is working in collaboration with NHSP to recruit a cohort of 15-20 care support workers onto NHSP. The Trust will pilot this programme by allocating these staff to wards that have a high CSW bank demand and will provide a minimum of 30 hours per week on the agreed area throughout the 6 month programme.

Nursing Associate Pilot - The Trust, along with our local healthcare partners, is a test site to deliver a training programme for the new Nursing Associate role. This exciting opportunity will enable us to influence development of new roles that will build the future nursing workforce. We have recruited 6 trainee nursing associates who commence a 2 year work based learning programme February 2017.

Band 5 Vacancies Inpatient and Emergency Department Registered Nurses

	Feb 2016	March 2016	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016
Establishment	707.66	707.66	707.66	689.88	689.88	**691.22**	**692.40**	692.40	692.40	682.01	674.18
Actual Numbers	658.9	661.82	664.92	653.58	653.02	**656.05**	**648.2**	648.53	650.15	644.52	634.12
Vacancies	48.76	45.84	42.74	36.3	36.86	**35.17**	**44.2**	43.87	42.25	37.49	40.06
Vacancies %	6.89%	6.48%	6.04%	5.26%	5.34%	**5.09%**	**6.38%**	6.34%	6.10%	5.50%	5.94%

Current Band 5 vacancy position by division December 2016

Surgery, Women and Children's

- Vacancy rate is 2.38 % equating to 5.14 WTE Band 5 posts
- Vacancies within this division remains very low

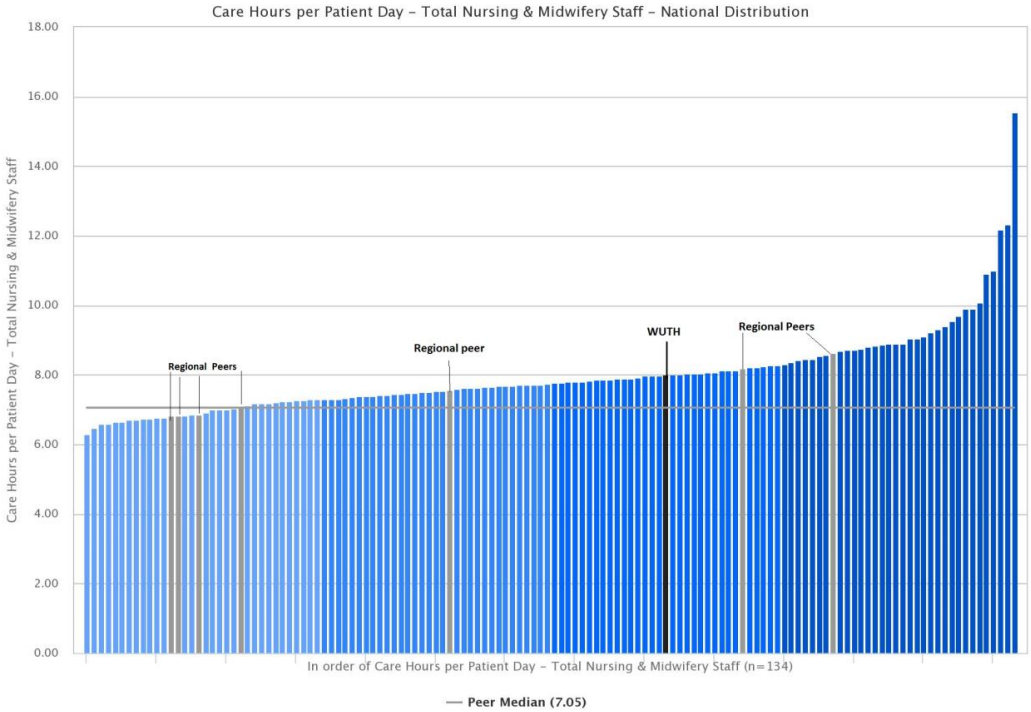
Medicine and Acute

- Vacancy rate is 7.62 % equating to 34.92 WTE Band 5 posts

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 provides further assurance for where staffing fill rates may have decreased, due to decreased activity, but CHPPD has remained static. 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.

The Department of Health (DoH) Efficiency Centre has developed a Model Hospital Portal to allow comparison of hospital data across the range of Carter recommendations. At the beginning of December new data was launched within the portal based on data collected up until September 2016. The chart below taken from the portal shows the overall CHPPD total for each Hospital organisation.



It must be acknowledged that this data is still in its infancy but provides a crude insight and general comparison until the data is more mature and can provide specialisms and direct hospital comparison, eg areas with Intensive care nursing will have higher CHPPD compared with general wards.

Measure	WUTH	Regional Peer	National average
Total Nursing and Midwifery staffing CHPPD	**8**	**7.05**	**7.76**
Registered Nurse CHPPD	**4.75**	**4.24**	**4.74**
Care Support Worker CHPPD	**3.25**	**2.95**	**2.91**

The Model Hospital Portal allows flexibility to change the peers however there must be a minimum of 7 within the set. The peers are currently set as:

- Countess of Chester NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospital
- Aintree University NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- St Helens & Knowsley NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Salford Royal NHS Foundation Trust

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

The Trust has been collecting CHPPD data for 8 months, this now enables some analysis to be undertaken on this initial data. The table below details the CHPPD for each ward from May to December 2016 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 within DME. Data has been reviewed to provide an "Average" for each individual ward and the range of CHPPD data for the 6 months with the addition of a CHPPD against a 100% fill rate against the funded establishment, to help inform if data is in line and provide some assurance where there are establishment changes, variances in fill rates and staffing pressures.

The Board of Directors requested that CHPPD based on funded establishment and average bed occupancy be calculated and included in future reports. This information is displayed directly below the Ward Number on the table below.

CHPPD

Orthopaedics	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
Ward 10	Average: **7**	CHPPD	7.3	6.2	8.8	6.8	6.5	6.9	6.6	6.6
7.6	Range 6.2 -8.8	Fill Rate	97%	96%	82%	87%	91%	92%	93%	92%
Ward 11	Average: **9**	CHPPD	9.9	9	10	8.9	8.4	7.6	8.9	6.8
9.6	Range 7.6 - 10	Fill Rate	94%	99%	83%	84%	77%	86%	103%	93%
Ward 12	Average: **10.3**	CHPPD	11.6	10.1	10.5	9.8	8.4	12.5	9.5	8.8
12.8	Range 8.4 - 12.5	Fill Rate	92%	94%	82%	83%	81%	65%	84%	73%
M1	Average: **11**	CHPPD	11.4	10.3	13.2	11.3	9.3	10.7	11.3	12.4
13.4	Range 9.3 - 13.2	Fill Rate	90%	82%	81%	70%	73%	75%	78%	70%

Surgical	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
Ward 17	Average: **6.2**	CHPPD	5.7	6.5	6.5	6.4	5.9	6	6.6	6.1
6	Range 5.7 - 6.5	Fill Rate	99%	120%	114%	101%	98%	99%	114%	108%
Ward 18	Average: **5.8**	CHPPD	5.7	5.8	6.2	5.8	5.9	5.7	5.8	6
5.9	Range 5.7 -6.2	Fill Rate	98%	97%	108%	99%	101%	100%	100%	95%
Ward 20	Average: **6**	CHPPD	5.8	6.2	5.9	6.7	5.8	5.8	5.8	6
6	Range 5.8 - 6.7	Fill Rate	99%	101%	95%	96%	96%	96%	98%	100%
ESAU	Average:**15.2**	CHPPD	17.3	15.9	15.5	14.8	15.2	13	14.6	14.9
14.5	Range 13 - 17.3	Fill Rate	100%	99%	99%	99%	98%	97%	99%	95%
M2	Average: **35.1**	CHPPD	23.8	32	30.3	35.4	23.7	43	57.5	27
42.9	Range 23.7 - 35.4	Fill Rate	100%	100%	100%	94%	96%	100%	89%	96%
Dermatology	Average: **12.1**	CHPPD	15.6	11.3	16	9.4	11.5	12.4	8.5	13.2
10.7	Range 9.4 - 16	Fill Rate	96%	100%	100%	100%	100%	100%	100%	100%

Women's & Childrens	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
Children's	Average: **10.8**	CHPPD	8.1	10.7	10.7	14.9	11.7	10.2	9.3	12.2
10.1	Range 8.1 - 14.9	Fill Rate	89%	112%	110%	94%	111%	112%	104%	98%
Maternity	Average: **6.1**	CHPPD	6.3	5.9	5.7	5.8	6	6.7	7.6	7.6
7	Range 5.7 - 6.7	Fill Rate	98%	98%	98%	94%	94%	99%	95%	102%
Delivery Suite	Average: **36.3**	CHPPD	31.6	37.9	45.5	32.3	30.8	37.3	39	39
36.6	Range 30.8 - 45.5	Fill Rate	97%	104%	98%	96%	95%	95%	108%	121%
Ward 54	Average: **7.7**	CHPPD	9.1	7.4	8.2	8.1	7.5	6.4	7.2	7.9
7.8	Range 6.4 - 9.1	Fill Rate	100%	100%	97%	85%	92%	76%	78%	84%
Neonatal	Average: **12.5**	CHPPD	12.7	12.3	11	12.6	12.6	14.2	12.1	10.9
12.5	Range 11 - 14.2	Fill Rate	92%	79%	97%	100%	107%	92%	99%	93%

Acute Care	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
MSSW	Average: **7.2**	CHPPD	8.8	8.5	5.9	7	6.3	6.4	7.2	6
8.2	Range 5.9 - 8.8	Fill Rate	95%	94%	86%	105%	84%	83%	89%	79%
AMU	Average: **11.6**	CHPPD	10.5	10.6	10.3	11.4	14.9	14.3	9.5	13.8
10.6	Range 10.3 -14.9	Fill Rate	99%	96%	92%	104%	97%	95%	91%	92%
EDRU	Average: **9.5**	CHPPD	8.7	9.5	7.8	10.7	10.3	9.1	10.6	10.5
9.6	Range 7.8 -10.7	Fill Rate	95%	101%	95%	101%	106%	103%	103%	99%
ITU	Average: **35.7**	CHPPD	39.5	32.6	36.3	41.6	36.3	35.6	29.2	26.8
35.8	Range 32.6 -41.6	Fill Rate	100%	91%	97%	96%	90%	88%	90%	94%
HDU	Average: **29**	CHPPD	24.3	35.1	24.6	36.3	25.1	26.9	30.9	25.2
27.6	Range 24.3 -36.3	Fill Rate	100%	98%	99%	96%	99%	93%	98%	96%

DME / Rehab	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
Ward 21	Average: **5.6**	CHPPD	5.8	5.3	5.1	6.4	5.8	6.1	6.5	5.8
6.3	Range 5.1 - 6.4	Fill Rate	95%	92%	94%	96%	92%	96%	105%	95%
Ward 22	Average: **6**	CHPPD	6.6	6	6.1	6.3	5.7	5.7	5.5	5.4
5.7	Range 5.7 - 6.6	Fill Rate	100%	107%	103%	99%	97%	99%	99%	96%
Ward 23	Average: **7.1**	CHPPD	6.7	7	7.3	7.2	7	6.8	7.8	6.9
7.3	Range 6.7 - 7.8	Fill Rate	100%	111%	111%	110%	98%	98%	97%	98%
Ward 27 (Ward 24)	Average: **6.7**	CHPPD	6.1	6.9	5.8	6	6.7	9.4	6.3	5.6
7.5	Range 5.8 - 9.4	Fill Rate	98%	111%	93%	96%	97%	98%	99%	97%
OPAU	Average: **8.2**	CHPPD	9.5	8.2	8.1	8.2	8.2	7.9	7.2	7.1
7.4	Range 7.2 - 9.5	Fill Rate	93%	94%	93%	96%	97%	105%	98%	99%
M2 Rehab	Average: **5.6**	CHPPD	6	5.9	6	5.8	5.4	4.9	5.5	5.7
5.5	Range 5.4 - 6	Fill Rate	100%	98%	98%	99%	96%	96%	98%	97%
CRC	Average: **6**	CHPPD	5.6	5.7	6.1	6.1	6	6.3	6.3	6.8
6	Range 5.6 - 6.3	Fill Rate	99%	100%	98%	97%	98%	106%	106%	107%

Medicine	CHPPD information	Indicators	May	June	July	August	Sept	October	November	December
Ward 26	Average: **6.1**	CHPPD	5.6	6.3	6.1	6	6.7	6.3	6	5.7
6.6	Range 5.6 - 6.7	Fill Rate	95%	107%	101%	97%	95%	96%	94%	94%
Ward 30	Average: **7.1**	CHPPD	7.3	6.6	7	6.9	7.5	7.2	7	7.4
8.1	Range 6.6 - 7.5	Fill Rate	100%	90%	90%	87%	91%	86%	90%	88%
Ward 32	Average: **7.6**	CHPPD	7.3	7.5	8.2	10.5	7.7	6.1	5.8	6
6.7	Range 6.1 - 10.5	Fill Rate	94%	96%	99%	98%	103%	91%	94%	91%
CCU	Average: **13.2**	CHPPD	12.6	12.3	12.4	12.2	16.3	14.4	12.1	13.2
14.9	Range 12.2 - 16.3	Fill Rate	100%	100%	100%	99%	100%	93%	93%	87%
Ward 33 Changed to winter November 2016	Average: **5.9**	CHPPD	5.8	6	5.8	6	5.9	6	5.9	5.9
	Range 5.8 - 6	Fill Rate	97%	98%	92%	90%	90%	86%	92%	90%
Ward 36	Average: **5.6**	CHPPD	5.6	5.6	5.6	6	5.5	5.5	5.6	5.5
6	Range 5.5 - 6	Fill Rate	99%	102%	107%	88%	87%	94%	94%	91%
Ward 37	Average: **7.1**	CHPPD	5.9	7.9	6.9	7.3	7.6	7.4	6.9	6.8
7.5	Range 5.9 - 7.9	Fill Rate	100%	100%	95%	99%	97%	101%	96%	91%
Ward 38	Average: **5.1**	CHPPD	5.7	3.4	5.5	5.9	6.4	3.2	5.6	5.7
5.7	Range 3.2 - 5.9	Fill Rate	99%	98%	94%	96%	106%	93%	98%	91%
Ward 25	Average: **9**	CHPPD		9.8	8	8.4	8.2	8	11.4	9
9.9	Range 8 - 11.4	Fill Rate		90%	109%	100%	100%	111%	119%	124%
		CHPPD								7.2
Ward 24 (IPC)		Fill Rate								100%

Although the CHPPD data is in its infancy the data provides a greater level of assurance in terms of consistency of delivery of care and planned hours to actual hours fill rates should be considered alongside CHPPD and Associate Directors of Nursing (ADN) mitigation when assessing if safe staffing levels are being met across the organisation.

An ADN report has been introduced to provide an auditable trail which provides details from Ward Sisters/Charge Nurses and Matrons on mitigating actions and an overall sign off from the ADN to provide assurance that safe staffing was in place. This assurance report will also help monitor trends for both over 100% fill rate areas and under 100% fill rates to help inform divisions regarding staffing establishments.

Ward 12, 54 and M1 have all been RAG rated as red for their overall staffing fill rate within either November or December 2016, however staffing levels were deemed safe and assurance provided within the ADN assurance report as outlined below.

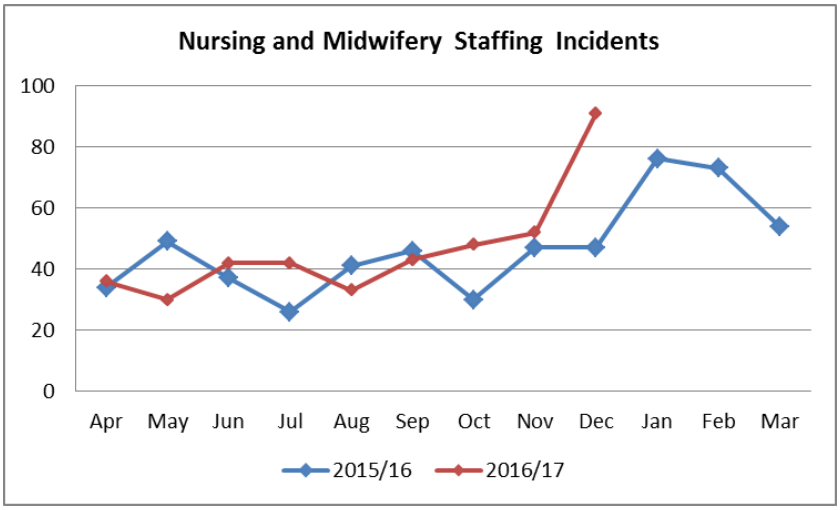
Ward 12: The Ward was safely staffed at all times according to the bed occupancy. The ward had minimum patients and correct staffing was in place to support the acuity of the patients, this is supported by high CHPPD.

Ward 54: Due to reduced elective activity CSW staff were reallocated to support areas of higher patient acuity and occupancy. Appropriate staffing was in place at all times and RN hours were at an acceptable level for ward.

Ward M1: Staffing was reduced to reflect the reduction in activity, where required the Ward Sister worked clinical shifts and appropriate staffing levels were in place at all times to support patient acuity, this is supported by high CHPPD.

6. Reported Staffing Incidents

There was an extraordinary spike of reported Nursing and Midwifery staffing incidents in December 2016 as displayed in the chart below. A total 102 staffing incidents were reported and 91 of these related to Nursing and Midwifery. As with each month a full review of staffing incidents is undertaken and reported to the Senior Nurse Management Team. During December there were three main areas who reported the highest number of staffing incidents, Acute Medical Unit (AMU) – 14 incidents, Ward 24 (IP&C Cohort Ward) – 12 incidents and Ward 25 (IP&C Isolation Ward) - 9 incidents.



AMU

A review of the incidents reported for AMU showed several were related to red flag incidents such as delays in completing patient focused rounding and skin checks. The full review of incidents confirmed that there were no patient harms. There is currently no other method of recording red flag incidents. CHPPD remained high with 9.5 in November and 13.8 in December and in addition to ward based staff the Hospital coordinator at night supports AMU by providing leadership and support with patient moves. The Matron and ADNs for the area are satisfied that, whilst the ward is very busy at present, patient safety has not been compromised by unsafe staffing levels.

Ward 24 (IP&C Cohort Ward)

The staffing incidents recorded for Ward 24 Isolation related to patient acuity rather than any reduction in staffing or staff moves. This is a new unit and in order to mitigate any inappropriate patients being placed in this unit moving forward the Ward Sister will be responsible for pre-screening admissions to the ward ensuring that they are patients who are CPE exposed, appropriate for the ward staffing model and that the acuity of patients on the cohort area is manageable.

Ward 25 (IP&C Isolation Ward)

Ward 25's CHPPD remains above that of the average medical ward with 11.4 in November and 9 for December. Corporate Nursing will conduct a snap shot acuity review of Ward 25's patients during January and will review other staffing indicators including sickness, vacancies, fill rates, CHPPD and incidents. It is acknowledged that this ward is a specialist Infection prevention control area with side room nursing however the professional judgment of the ADN for medicine and ADN for IPC confirm the ward staffing has remained safe.

It is also acknowledged that the Trust has increased the bed base during December 2016 with approximately 64 additional beds opened with additional staffing requirements and this has had a significant impact on staff morale as it has been necessary to move staff 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 strong focus on leadership and team working is in place.

Given the extent of the increase in incidents a full breakdown of each area is displayed below. A review of these incidents indicate that many are based on staff's perception of staff shortages and on investigation by senior nursing team, staffing levels were safe or mitigating actions had been put in place. Targeted work has commenced to understand if staff from key areas are reporting inability to take breaks as this has been raised as a concern via the staff side representatives. Initial investigation has demonstrated that this is not a significant issue.

7. Conclusion and Recommendations

Good progress has been made to meet the recommendations of 'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility and systems and process are now firmly embedded to provide assurance of safe staffing or to allow concerns to be appropriately escalated. Care Hours Per Patient Day (CHPPD) data collection has commenced and will continue to be reported through the bi-monthly safe staffing report. Benchmarking WUTH performance for Care Hours Per Patient Day (CHPPD) with other acute hospitals using model hospital portal allows us to provide further assurance that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low. This comparison work will be taken forward once real time reporting is available on the Portal. The Trust continues to ensure all mitigating actions are in place to ensure that there are safe and appropriate nurse staffing levels at WUTH. The Trust will continue with monthly Trust wide recruitment for registered nurses in conjunction with other initiatives outlined in this report. A small number of wards are reporting reduced staff fill rates whilst maintaining good levels of CHPPD and this may be indicative of over establishment. A full acuity review was due to be completed in January 2017, however this has had to be postponed until Quarter 1 2017 due to the increased activity across the organisation.

The Board of Directors are asked to receive this report and discuss the content.

Board of Directors	
Agenda Item	**7.1.1**
Title of Report	**Operational Performance**
Date of Meeting	**25th January 2017**
Author	**Chris Oliver, Director of Operations** **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**	**Risks, 9, 10, 11 ,12**
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 paper illustrates any key risks to delivery and provides an update on the work being undertaken. The Board is asked to note the performance to the end of December 2016.

2. Summary of Performance Issues

The Trust remains challenged with in delivery of the A & E four hour standard and the delivery of referral to treatment times within 18 weeks.

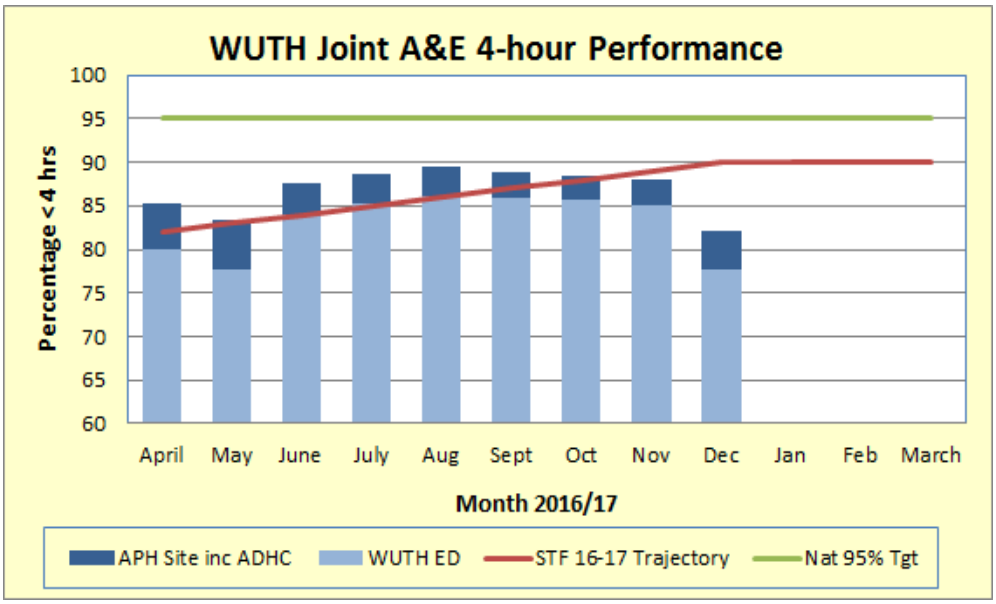
The Trust continues to deliver all cancer standards.

3. Detailed Explanation of Performance and Actions

a. Achievement of the A&E Target

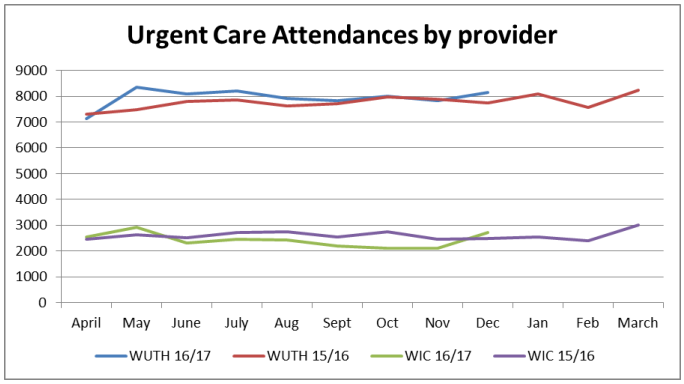
Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of December was 82.12% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 77.73%.

The performance in December for the emergency access standard did not achieve the regulatory compliance level of 95% or the Sustainability and Transformation Fun (STF) trajectory of 90.0%, as illustrated below. However in light of the overperformance in previous months the Q3 ED element of STF has been secured.



Performance has continued to be a challenge at the start of January with performance at 17th January for the Arrowe Park site at 79.54%.

The table below illustrates the increase in attendances both the ED and APH WiC have seen in December.



Although the majority of ED breaches can be assigned to patient flow and lack of egress out of the department, the site performance (to which NHSI use for reporting) has been impacted by a significant increase in WiC breaches, which has been attributed to a new computer system being introduced and staff taking a longer than anticipated period to get accustomed to the system. The concern has been raised with the Community Trust via the ED Delivery Board.

The Trust undertook the following actions to help mitigate the pressure on non-elective patient flow during December and early January:-

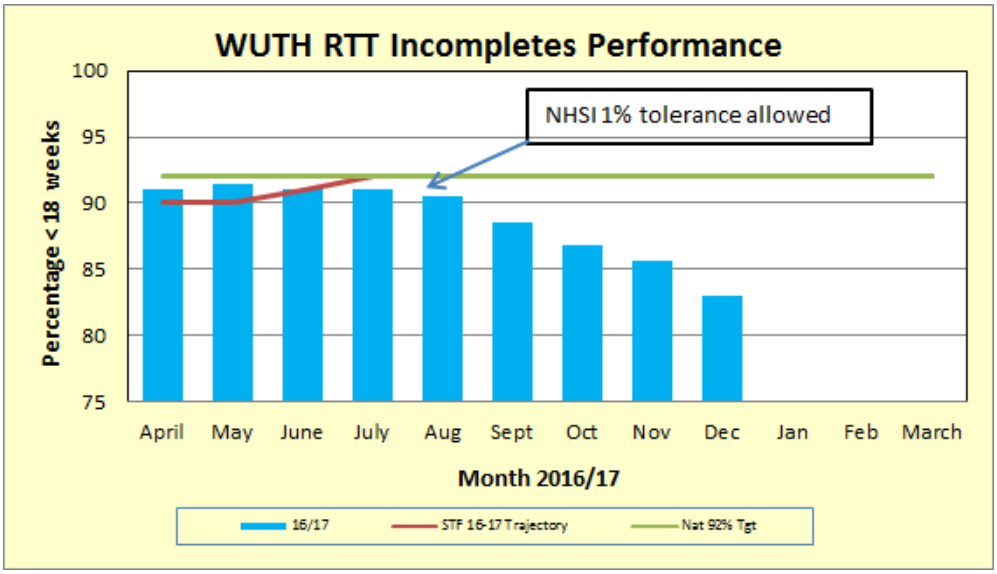
- Instigated the Full Capacity Policy in line with national OPEL (Operational Pressure Escalation Level) triggers
- Reviewed and cancelled a number of inpatient elective procedures. The Trust prioritised cancer and clinically urgent cases but this did require the cancellation of a number of routine inpatient procedures. The main areas impacted were orthopaedics and gynaecology. The orthopaedic ward was converted from elective care to provide care for non-elective surgical and orthopaedic patients as medical patients outlying into surgery increased. The gynaecology ward was closed due to norovirus.
- The Trust opened ward 19 to provide additional inpatient capacity. The use of this ward has resulted in a delay to the HPV programme.
- The Trust in conjunction with the A&E Delivery Board increased the discharge to assess bed capacity by 20 beds to 35, which is in addition to 12 spot purchased beds by social services to mitigate the impact of reduced package of care availability.

At the timing of writing this report the Trust has no beds closed due to norovirus and has started to de-escalate the elective orthopaedic was with a view to reintroduce elective inpatient orthopaedic operating from Monday 23rd January.

b. 18 Weeks RTT

The focus of RTT is now solely on the incomplete standard, with the threshold set at a minimum 92% of patients waiting to be at 18 weeks or less.

As expected the Trust did not achieve the national standard and STF trajectory at the end of December, with the final position being reported at 82.84%.



The Trust has an RTT improvement programme in place which has been shared with NHSI. The deterioration in RTT performance was expected having worked to cleanse PTLs and the suspension of WLI for non-cancer / clinically urgent procedures.

The Trust had previously asked the national intensive support team to come and review the action plan and make any further suggestions. The original request was declined by the IST, but NHSI have now confirmed that this additional external support will be made available to the Trust.

c. Infection Control

For C Difficile, there have been three cases in the month of December, however only one of these was considered avoidable. The year-to-date position is therefore 11 cases, and below the maximum plan trajectory of 21 cases for this period. In addition there was also a hospital acquired MRSA bactaeraemia case in December.

d. Cancer

For Cancer access targets, the 62-day standard continues to be the most difficult to achieve, and this is reflected in performance levels 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.

The current performance against the 62-day Cancer standard for the current quarter is detailed in the dashboard.

e. Advancing Quality (AQ) indicators

The two areas not achieving are Community Acquired Pneumonia and Acute Kidney Injury.

Community Acquired Pneumonia - the most recent data relates to October 2016 and shows an ACS of 74.7%. All measures were achieved for over 80% of the population audited, although ascertainment for those indicators that are time critical deteriorated including antibiotics and chest x-ray within 4 hours. There was an increase in the number of patients not abstracted in month (notes were not available within time) and AQ methodology assumes these are fails. The population also increased by 13% in October, indicating an increased activity in A&E. There are a number of actions in progress – in December, education was included within ED induction, and for doctors that will be repeated in junior doctors teaching sessions, training sessions have been held for associate practitioners and is included in the developmental programme for nursing staff. There has been increased visibility of the AQ nurses within the acute areas. In addition work has identified that Chest X-ray referrals from ACU are taking more than 4 hours and this is an area of focus. However, these changes are unlikely to lead to significant benefit until Q4 data. The Appropriate Care Score year to date is 60.3% against a target of 75.1%; no trust is hitting their target in year range (46.9% - 73.9%). Wirral has the largest pneumonia population in the region.

AKI – the most recent data relates to October 2016 and shows an ACS of 20.7%. The reduction in performance is due to nearly all patients failing the USS scan of the urinary tract within 24 hours of the first alert; this is a significant deterioration in performance against this indicator (2/19). This is because there has been significant delays in the procedure being carried out routinely (48-72hours) with urgent/complex scans being carried out immediately. This has been discussed within the renal meeting and escalated for further action. Preliminary information from the November data abstracted to date suggests this has improved but is still below 50%. There has been a 15% improvement in specialist review within the proposed time frame. The Appropriate Care Score year to date is 22% against a target of 50%; one trust is hitting their target in year (70.6%) with others between 0.6 – 42.8%.

4. Recommendation

The Board are asked to note the Trust's current performance to the end of December 2016.

WUTH Integrated Performance Dashboard - Report on December for January 2017 BoD

Area	Indicator / BAF	Oct	Nov	Dec	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	99%	99%	98%		*>=95%*	December 2016	GW
	Patient - F&F "Not Recommend" Rate	0%	0%	1%		*<=2%*	December 2016	GW
	Staff Satisfaction (engagement)	3.97	3.97	3.97		*>=3.69*	Q2 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	81.4%	81.3%	82.6%		*>= 85%*	July to Sept 2016	MC
	Demand Referral Rates	-6.1%	-5.5%	-6.8%		*>= 3% YoY variance*	Fin Yr-on-Yr to Dec 2016	MC
	Market Share Non-Wirral	9.0%	8.4%	7.9%		*>=8%*	July to Sept 2016	MC
	Strategic Objectives							
	Harm Free Care	98%	95%	95%		*>= 95%*	December 2016	GW
	HIMMs Level	5	5	5		*5*	December 2016	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	88.59%	87.94%	82.12%		*>=95%*	December 2016	CO
	RTT 18 Weeks Incomplete Position	86.80%	85.62%	83.00%		*>=92%*	December 2016	CO
	Cancer Waiting Time Standards	On track	On track	On track		*All met at Trust level*	Q3 to Dec 2016	CO
	Infection Control (cumulative)	0 MRSA; 9 C diff	0 MRSA; 10 C diff	1 MRSA; 11 C diff		*0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory*	December 2016	GW
	Productivity							
	Delayed Transfers of Care	33	27	43		*Metric definition redefined*	December 2016	CO
	Delayed Complex Care Packages	57	65	66		*<= 45*	December 2016	CO
	Bed Occupancy	90.7%	92.7%	93.7%		*<=85%*	December 2016	CO
	Bed Occupancy Medicine	90.3%	90.3%	92.7%		*<=85%*	December 2016	CO
	Theatre Utilisation	89.9%	90.0%	92.5%		*>=85%*	December 2016	CO
	Outpatient DNA Rate	7.8%	8.1%	8.5%		*<=6.5%*	December 2016	CO
	Outpatient Utilisation	82.9%	83.2%	81.8%		*>90%*	December 2016	CO
	Length of Stay - Non Elective Medicine	5.3	5.1	5.6		*<= 5.0*	December 2016	CO
	Length of Stay - Non-elective Trust	4.6	4.4	5.0		*<=4.2*	December 2016	CO
	Contract Performance (activity)	-3.9%	-3.9%	-4.0%		*0% or greater*	December 2016	CO
	Finance							
	Contract Performance (finance)	-0.5%	-0.8%	-0.9%		*On Plan or Above YTD*	December 2016	DJ
	Expenditure Performance	1.1%	-1.2%	-0.7%		*On Plan or Below YTD*	December 2016	DJ
	CIP Performance	10.8%	9.2%	0.0%		*On Plan or Above*	December 2016	DJ
	Capital Programme	63.6%	64.4%	24.6%		*On Plan*	December 2016	DJ
	Non-Core Spend	9.8%	9.6%	9.4%		*<5%*	December 2016	DJ
	Cash Position	-23%	101%	-30.0%		*On plan or above YTD*	December 2016	DJ
	Cash - liquidity days	-26.5	-26.7	-28.9		*> 0 days*	December 2016	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	0	2	0		*0 per month*	December 2016	SG
	Complaints	18	31	28		*<30 per month*	December 2016	GW
	Workforce							
	Attendance	95.7%	95.68%	95.61%		*>= 96%*	December 2016	JM
	Qualified Nurse Vacancies	2.5%	3.29%	4.45%		*<=6.5%*	December 2016	GW
	Mandatory Training	92.8%	97.76%	92.70%		*>= 95%*	December 2016	JM
	Appraisal	86.30%	84.88%	92.17%		*>= 85%*	December 2016	JM
	Turnover	10.16%	10.45%	10.60%		*<10%*	December 2016	JM
	Agency Spend	6.2%	8.70%	10.60%		*On plan*	December 2016	GW
	Agency Cap	118	105	85		*0*	December 2016	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	2	2		*All areas above target*	December 2016	SG
	Mortality: HSMR	88.46	86.96	88.92		*Lower CI < 0.90*	April to Sept 2016	SG
	Mortality: SHMI	0.983	0.983	0.983		*Lower CI < 90*	Jan to Dec 2015	SG
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	3	3	3		*1 or 2 (NHSI amended Oct 2016)*	December 2016	DJ
	CQC	Amber	Amber	Amber		*Overall CQC rating Requires Improvement*	December 2016	SG
	Local View							
	Commissioning - Contract KPIs	5	7	7		*<=2*	December 2016	CO

Quarter	3
Period	01/10/2016 - 31/12/2016

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 3 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	6	0	6	13	0	13	53.85%	53.85%
	Lung	3	0	3	11	1.5	12.5	72.73%	76.00%
	Other	0	0	0	0	1	1	N/A	100.00%
Med & Surg	Upper GI	3	0	3	5	1	6	40.00%	50.00%
Surgery	Breast	3	0	3	43.5	0	43.5	93.10%	93.10%
	Colorectal	5	0	5	21	7	28	76.19%	82.14%
	Head & Neck	2	0	2	7	2	9	71.43%	77.78%
	Skin	1	0	1	82	12	94	98.78%	98.94%
	Urology	12	1	13	53.5	6	59.5	77.57%	78.15%
Women's	Gynaecology	2	1	3	9.5	1	10.5	78.95%	71.43%
	Total	**37**	**2**	**39**	**245.5**	**31.5**	**277**	84.93%	85.92%

Quarter 3 - October

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	1	0	1	4	0	4	75.00%	75.00%
	Lung	0	0	0	4	0	4	100.00%	100.00%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	0	0	0	0	0	0	N/A	N/A
Surgery	Breast	0	0	0	11.5	0	11.5	100.00%	100.00%
	Colorectal	4	0	4	9.5	0	9.5	57.89%	57.89%
	Head & Neck	2	0	2	3.5	0	3.5	42.86%	42.86%
	Skin	1	0	1	30.5	0	30.5	96.72%	96.72%
	Urology	2	0	2	17.5	0	17.5	88.57%	88.57%
Women's	Gynaecology	2	0	2	4.5	0	4.5	55.56%	55.56%
	Total	**12**	**0**	**12**	**85**	**0**	**85**	85.88%	85.88%

Quarter 3 - November

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	2	0	2	4.5	0	4.5	55.56%	55.56%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	2	0	2	3.5	0	3.5	42.86%	42.86%
Surgery	Breast	1	0	1	14	0	14	92.86%	92.86%
	Colorectal	1	0	1	9.5	0	9.5	89.47%	89.47%
	Head & Neck	0	0	0	3	0	3	100.00%	100.00%
	Skin	0	0	0	36.5	0	36.5	100.00%	100.00%
	Urology	6	0	6	23	0	23	73.91%	73.91%
Women's	Gynaecology	0	0	0	2.5	0	2.5	100.00%	100.00%
	Total	**14**	**0**	**14**	**100.5**	**0**	**100.5**	86.07%	86.07%

Quarter 3 - December

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	3	0	3	5	0	5	40.00%	40.00%
	Lung	1	0	1	2.5	1.5	4	60.00%	75.00%
	Other	0	0	0	0	1	1	N/A	100.00%
Med & Surg	Upper GI	1	0	1	1.5	1	2.5	33.33%	60.00%
Surgery	Breast	2	0	2	18	0	18	88.89%	88.89%
	Colorectal	0	0	0	2	7	9	100.00%	100.00%
	Head & Neck	0	0	0	0.5	2	2.5	100.00%	100.00%
	Skin	0	0	0	15	12	27	100.00%	100.00%
	Urology	4	1	5	13	6	19	69.23%	73.68%
Women's	Gynaecology	0	1	1	2.5	1	3.5	100.00%	71.43%
	Total	**11**	**2**	**13**	**60**	**31.5**	**91.5**	81.67%	85.79%

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 9 Finance and Cost Improvement Programme Report
Date of Meeting	25th January 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)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the financial performance of the Trust at month 9 (31st December) of the 2016/17 financial year.

At the end of December (month 9) the Trust has reported a YTD deficit of £(6.1)m inclusive of £1.5m impairments, therefore the normalised deficit is £(4.6)m while this is an £(0.4)m adverse variance to the plan the Trust has delivered the operational control total in order to access the Sustainability and Transformation Fund (STF). The adverse variance is a result of the Trust failing to deliver the agreed RTT trajectory associated with the STF.

The Trust is currently forecasting to deliver a forecast deficit of £(10.5m). The deterioration from the plan is a result of the non achievement of the "Health Economy Challenge" of £5m, the YTD and subsequent loss of STF of £3m and operational pressures relating to reductions in care within the health economy via the Better Care Fund. The Trust has submitted the forecast Protocol to NHSI in line with National guidance and the Q3 submission. While the Trust is forecasting a £(10.5)m deficit the increased operational pressure as a result of winter will put at risk the delivery of the forecast. The Executive team is taking necessary action with external partners and Regulators to minimise the exposure to the Trust over the remaining financial year.

The Trust has delivered £8.6m of efficiencies as at the end of December against the target of £7.4m and is forecasting to deliver the 2016/17 target of £11.2m.

Cash balances at the end of December stood at £2.6m which is £1.1m below plan. The YTD cash position has been supported by lower than planned capital expenditure and an additional draw down of cash from the working capital facility but this has been offset by the non recurrent savings within the EBITDA performance and movements on working capital. Cash for the remainder of the financial year is forecast to be below plan with further additional cash support being required in line with previous forecasts shared with the Board.

The Trust has achieved an overall Use of Resources(UoR) rating of level 3, which is in line with the recalculated plan rating(due to this being the new risk rating within the Single Oversight Framework), with the exception of the "capital servicing capacity".

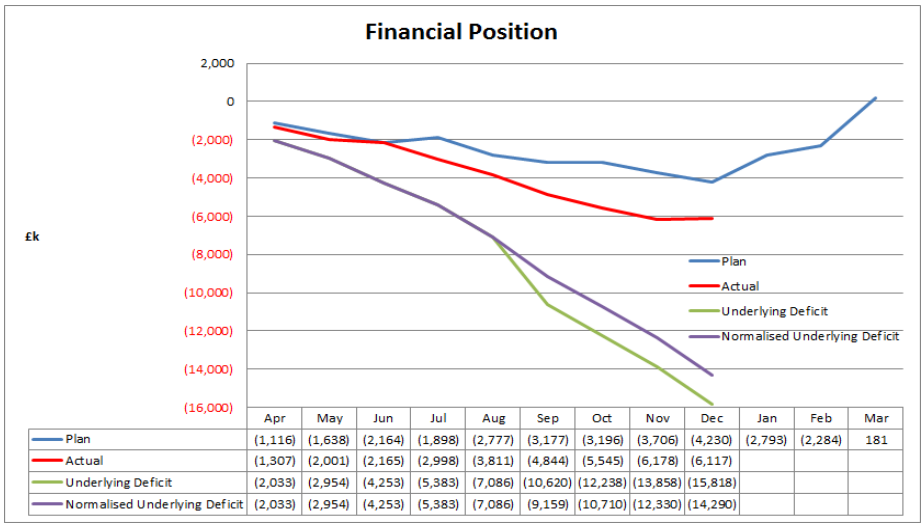
Income and Expenditure Performance

In March 2016 the Board of Directors agreed to the control total set by NHSI that enabled access to the STF. Table 1 below details the current performance against the submitted plan and Table 2 shows the underlying financial performance

Table 1: Summary Financial Statement

	PLAN	MONTH 9			YTD			Forecast		
	Full Year Plan £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHS Clinical Income	294.936	24.519	24.130	(0.389)	221.040	219.102	(1.938)	294.936	289.824	(5.112)
Other Income	29.987	2.493	2.590	0.098	22.313	24.163	1.850	29.987	31.696	1.709
Employee Expenses	(213.306)	(18.129)	(18.449)	(0.320)	(163.836)	(167.480)	(3.644)	(213.306)	(223.695)	(10.389)
All Other Operational Expenses	(97.763)	(8.249)	(7.224)	1.025	(73.564)	(71.668)	1.897	(97.763)	(96.478)	1.285
EBITDA	**13.854**	**0.634**	**1.048**	**0.414**	**5.952**	**4.116**	**(1.835)**	**13.854**	**1.347**	**(12.507)**
Post EBITDA Items	(13.673)	(1.158)	(0.987)	0.172	(10.183)	(10.234)	(0.051)	(13.673)	(13.347)	0.326
Net Surplus/(Deficit)	**0.181**	**(0.525)**	**0.061**	**0.586**	**(4.230)**	**(6.117)**	**(1.886)**	**0.181**	**(12.000)**	**(12.181)**
Adjusted Net Surplus/(Deficit)		**(0.525)**	**0.061**	**0.586**	**(4.230)**	**(4.589)**	**(0.359)**	**0.181**	**(10.472)**	**(10.653)**
EBITDA %	**4.3%**	**2.3%**	**3.9%**	**1.6%**	**2.4%**	**1.7%**	**(0.8%)**	**4.3%**	**0.4%**	**(3.8%)**

Table 2: Underlying Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	(1,116)	(1,638)	(2,164)	(1,898)	(2,777)	(3,177)	(3,196)	(3,706)	(4,230)	(2,793)	(2,284)	181
Actual	(1,307)	(2,001)	(2,165)	(2,998)	(3,811)	(4,844)	(5,545)	(6,178)	(6,117)			
Underlying Deficit	(2,033)	(2,954)	(4,253)	(5,383)	(7,086)	(10,620)	(12,238)	(13,858)	(15,818)			
Normalised Underlying Deficit	(2,033)	(2,954)	(4,253)	(5,383)	(7,086)	(9,159)	(10,710)	(12,330)	(14,290)			

The Trust underlying position is demonstrated within table 2 above. The normalised underlying deficit reflects the non recurrent savings and income gains that the Trust has delivered/received in year. The non recurrent nature of the savings has been reflected in the agreed Financial plan for 2017/18.

As previously reported to the Board of Directors agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. In the absence of the 'envelope' agreement the income position would have deteriorated by £4.4m. This can be analysed into two elements: non achievement of activity plan £4.3m and the re-profile of clinical income into 12ths £0.1m.

During December all points of delivery underperformed in terms of activity excluding A&E attendances.

Cumulatively all PODs are underperforming in terms of actual activity delivered against the plan, with the exception of Outpatient Diagnostics and A&E attendances. Penalties increased in month in relation to readmissions, NEL marginal rate and outpatients FUP caps. As a result of the financial envelope the penalties do not affect the financial position.

The Trust continues to develop the RTT recovery plan but as a result of not achieving the targets within the STF since July this yearthe STF allocation has been withheld from the Trust for the non achievement equating to c£(0.5)m. The Trust does not envisage RTT trajectories will be achieved for the remainder of the year and this has been reflected within the forecast. As a result of the cumulative A&E performance the Trust will receive the STF allocation for Q3 despite missing the target for November and December.

The financial "envelope" agreed with the CCG is inclusive of all CQUINs payments. Confirmation has been received from Commissioners that quarter 1 and quarter 2 have been achieved. Despite the financial security offered by the envelope it is vital that the Trust continues to implement the agreed CQUIN's to improve patient experience therefore the Trust will continue to shadow monitor all schemes as per previous years.

Operational expenditure is below plan for the month of December by £0.7m as a result of one off reductions in provisions and accruals.

Pay costs exceeded plan by (£0.3m) in month, and are showing a cumulative overspend of (£3.6m). The issues as previously reported to the Board of Directors driving the current cumulative adverse performance in pay are:

- A reduction in the provision of intermediate care beds within the health economy has resulted in an increased unplanned demand for non-elective beds within the Trust. As a result of this pressure escalation beds have remained open driving the adverse pay performance and further intermediate care (IMC) beds have been commissioned with Elderhome (c£0.9m ytd). The Trust is continuing to work with the health economy to try to reduce this pressure going forward and is currently reviewing the winter plan as a senior team.
- Other operational pressures in medical staffing costs have continued during the month. Within the Emergency Department, the medical staffing position has improved in month, but there remains a pressure of approximately (£0.5m) in the year to date position. There are further critical medical staffing gaps in other specialties, resulting in premium agency or locum staff being utilised to cover the gaps of (c£0.7m) ytd. WLIs have remained minimal in December as the focus is to utilise core capacity to deliver RTT targets, spend is now marginal in a couple of specialties for achieving RTT and cancer targets (c£0.4m ytd).
- Non–delivery of cost improvement plans in relation to pay work-streams of (£1.2m) comprises some of the pay overspend, this has been partially mitigated by vacancies within the Divisions.

Focus within the Trust will continue to remain on the use of non-core pay spend across all staff categories and continuing development of recruitment and retention strategies to address staffing gaps together with mitigating the slippage on the delivery of CIP schemes.

Agency spend, during December is lower than plan by £0.2m and is cumulatively below the NHSI target by £0.7m YTD. This improvement reflects the work the Trust is undertaking on managing agency costs across the organisation.

Non pay costs are below plan in December and cumulatively £1.9m lower than plan.

Cost Improvement Programme (CIP)

The CIP target for 2016/17 is £11.2m. The table below demonstrates CIP delivery in terms of the year to date, in-year and recurrent position, this is shown by both division and work stream.

Table 3 – CIP Performance by Workstream and Division

	YTD			In Year			Recurrent		
Workstream	NHSI Plan £m	Actual £m	Variance £m	NHSI Plan £m	Forecast £m	Variance £m	NHSI Plan £m	Forecast £m	Variance £m
Theatres/ Elective Pathway	0.9	0.9	0.0	1.5	1.4	(0.1)	1.5	1.4	(0.1)
Outpatients (Medical & Surgical)	0.5	0.2	(0.3)	0.7	0.2	(0.5)	0.7	0.3	(0.4)
Patient Flow - EL & NEL	0.5	0.0	(0.5)	0.8	0.0	(0.8)	0.8	0.0	(0.8)
Radiology	0.2	0.3	0.1	0.2	0.4	0.2	0.2	0.4	0.2
Pathology	0.3	0.1	(0.2)	0.4	0.1	(0.3)	0.4	0.2	(0.2)
Nurses & Therapies Staffing	0.4	0.4	0.0	0.6	0.7	0.1	0.6	0.3	(0.3)
A&C Review - Clinical/ Non Clinical/ Management	0.8	0.3	(0.5)	1.0	0.4	(0.6)	1.0	0.2	(0.8)
Medical Staffing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Central HR Initatives	0.5	0.6	0.1	0.7	0.9	0.2	0.7	0.8	0.1
COCH Collaboration	0.0	0.0	0.0	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Pharmacy Services & Medicines Management	0.3	0.7	0.4	0.4	0.9	0.5	0.4	0.5	0.1
Procurement & Inventory Management	0.9	0.5	(0.4)	1.3	0.8	(0.5)	1.3	0.5	(0.8)
IT Enabled	0.2	0.1	(0.1)	0.2	0.2	0.0	0.2	0.1	(0.1)
Special Purpose Vehicles/ Contract optimisation	0.0	0.0	0.0	0.5	0.0	(0.5)	0.5	0.0	(0.5)
Estates/ Site Review	0.3	0.1	(0.2)	0.6	0.2	(0.4)	0.6	0.2	(0.4)
Facilities	0.3	0.3	0.0	0.4	0.4	0.0	0.4	0.2	(0.2)
Coding	0.8	0.8	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Central Commercial Opportunities & Private Patients	0.1	0.1	0.0	0.3	0.2	(0.1)	0.3	0.2	(0.1)
Divisional & Departmental Schemes	0.3	0.5	0.2	0.4	0.7	0.3	0.4	0.6	0.2
Other	0.1	2.7	2.6	(0.1)	3.2	3.3	(0.1)	1.4	1.5
TOTAL PRE RISK ADJUSTMENT	**7.4**	**8.6**	**1.2**	**11.2**	**11.7**	**0.5**	**11.2**	**8.3**	**(2.9)**
Adjustment for risk			0.0		(0.5)	(0.5)			0.0
TOTAL	**7.4**	**8.6**	**1.2**	**11.2**	**11.2**	**0.0**	**11.2**	**8.3**	**(2.9)**
Medicine & Acute	2.2	1.1	(1.1)	3.1	1.5	(1.6)	3.1	1.1	(2.0)
Surgery, Women & Children	2.5	1.7	(0.8)	3.6	2.7	(0.9)	3.6	2.1	(1.5)
Clinical Support Services	1.2	0.8	(0.4)	1.7	1.0	(0.7)	1.7	0.9	(0.8)
Corporate	1.3	1.9	0.6	1.8	2.7	0.9	1.8	2.4	0.6
Central	0.2	3.1	2.9	1.0	3.8	2.8	1.0	1.8	0.8
TOTAL PRE RISK ADJUSTMENT	**7.4**	**8.6**	**1.2**	**11.2**	**11.7**	**0.5**	**11.2**	**8.3**	**(2.9)**
Adjustment for risk			0.0		(0.5)	(0.5)			0.0
TOTAL	**7.4**	**8.6**	**1.2**	**11.2**	**11.2**	**0.0**	**11.2**	**8.3**	**(2.9)**

The year to date position as at the end of December is £8.6m which is £1.2m ahead of the target of £7.4m.

The Trust is forecasting to deliver the planned CIP target of £11.2m in year although all this will not be recurrently. Included within the agreed Financial Plan for 2017/18 was the recurrent shortfall of £2.9m.

The above figures are exclusive of the £5m health economy challenge included in the submitted plans approved by the Board of Directors.

Cash position and Use of Resources (UoR) Rating

The December cash balance position was £2.6m, which is £1.1m below plan. Cash balances are lower than planned as a result of the technical non cash backed savings that have been delivered in year. The Trust has currently drawn down £11.8m from the working capital facility and forecasts that a further c£3.4m will be required before year end which is in line with the paper presented to previous Board meetings.

The Trust continues to submit monthly 13 week cash flows to NHSI in order to access further borrowing when required. The Trust is not forecasting to exceed 30 days of operational expenditure in year, therefore all cash support should be provided by the working capital facility with current rates of interest at 3.5%

Capital expenditure is £1.5m under plan as at the end of December as a result of delayed start to some capital spend; there are no major concerns on this timing difference.

The overall financial position returns a UoR of level 3, which is in line with plan as detailed overleaf.

Table 4 – Use of Resources (UoR)

	Metric	Description	Weighting %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	Liquidity (days)	Days of operating costs held in cash-equivalent forms	20%	-29.3	4	-28.9	4	-24.2	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	1.5	3	1.0	4	2.4	2
Financial efficiency	I&E margin (%)	Underlying performance: I&E deficit / total revenue	20%	-1.7%	4	-1.9%	4	0.1%	2
Financial controls	Distance from financial plan (%)	Shows quality of planning and financial control : YTD deficit against plan	20%	-0.5%	2	-0.2%	2	-0.5%	2
	Agency spend (%)	Distance of agency spend against cap	20%	-0.06%	1	-10.7%	1	-0.1%	1
	Overall NHSI UoR Rating				3		3		3

Conclusion

The Trust has delivered the financial plan for Q3 and as a result will receive the respective allocation of the STF. The Trust has revised the forecast outturn with NHSI in line with the national protocol and is now reporting through submitted templates a deficit of £(10.5)m after technical adjustments.

The Board are asked to note the non-recurrent support within the position and the additional pressure this will put on the underlying financial position of the Trust entering into Q4 and 2017/18 planning.

Cash is currently off plan and further drawdowns from the working capital facility will be required in Q4 in line with previous plans discussed at the Board.

While the current financial plan delivers a UoR of 3 which is line with plan, this has only been achieved as a result of the actions described above and the strong performance of the Trust against the agency target.

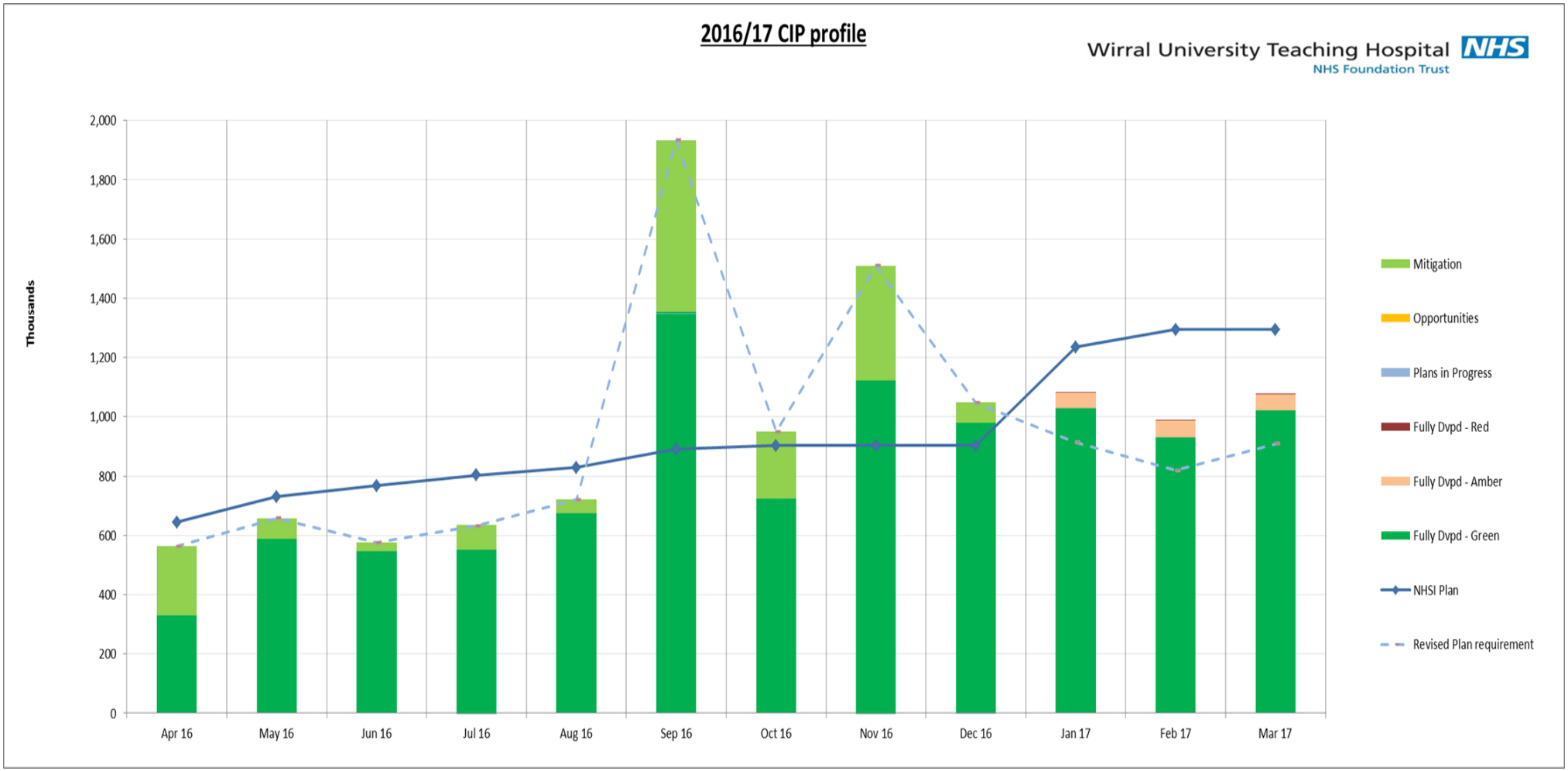
Recommendations

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

David Jago
Director of Finance
January 2017

Appendix 1: CIP Monthly Profile

The following chart highlights the CIP trajectory by Monitor Status and Risk Rating for the year, as at M9.



Board of Directors	
Agenda Item	8.1
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 16 December 2016
Date of Meeting	25 January 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**	Risks 5, 6, 7, 8, 9, 10, 11
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	N/A
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee which met on the 16 December 2016. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The Committee reviewed the updated Board Assurance Framework (BAF) and agreed that further review be undertaken in the areas of consideration recommended by the Audit Committee, specifically:

- Trust discharge of responsibilities regarding the Better Care Fund,
- Trust management of provider licence compliance in relation to Referral to Treatment Targets (RTT),

- Obtaining assurance in respect of compliance against all critical estates areas following the recent limited assurance report on water safety systems, and
- Oversight of the re-audit of IT business continuity systems following the recent limited assurance report.

The Committee received the 'Using the BAF' guidance and confirmed agreeance with the revised methodology and remit of the Committee and Executive Working Groups in undertaking review and management of BAF content.

M8 Financial Position

The Committee reviewed the cumulative normalized year to date position which was a cumulative net deficit of £4.6m against a trajectory of £3.7m. The £0.9m negative variance was materially accounted for by the loss of Sustainability and Transformation Fund (STF) monies(£515k) as a consequence of failure to achieve operation performance trajectories in RTT and the 4 hour A&E Standard.

The Use of Resources (UoR) rating was reported at level 3 in line with plan as all individual ratings remained in line with the plan with the exception of Capital Service Capacity.

The Committee noted the plans to minimize the risks to the performance outturn of £700k by the end of Q3 for 2016/17 and stated the importance of achieving an enhanced financial performance through improved operational efficiency as opposed to technical and non-recurrent solutions.

The risks and appropriate mitigations were outlined and debated by the Committee in relation to income, expenditure, CIP and cash. The Committee discussed escalation to Board on the risks around the year end outturn, residual expenditure gap and deteriorated forecast cash position.

Cost Improvement Programme at M8

The Committee received the Cost Improvement Programme (CIP) performance at M8 which confirmed an overall positive achievement of £7,515k cumulative savings, which was £1,042k above plan and contributed to an end of year forecast of £12,230k against a plan of £11,200k.

The Committee noted the ongoing development of a revised CIP reporting framework to support the two year transformation programme currently under development and due to commence in 2017/18. The Committee noted the challenging CIP target of £15m for 2017/18 for which £11m of schemes had been identified and stated the importance of identification of radical and truly transformational initiatives to realise the required savings.

The Committee was pleased to note the work undertaken by the Service Transformation Team which had led to the Trust having been approached to support other comparable organisations in the development of their CIP.

The Committee requested that a CIP Strategic Deep Dive be presented at the next meeting to be followed by an in-depth review of individual projects at future meetings.

Agency Cap Compliance Report including Revised Compliance Requirements

The Committee was advised of a decrease in agency spend over 2016/17 but was disappointed to note that non-core spend remained above plan for M8. The Committee was cited on the ongoing work to improve recruitment and retention to substantive positions, particularly in hard to recruit areas, to reduce agency spend. The Committee requested that future reports contain a more succinct summary of agency usage exceptions and mitigating actions in respect of non-core spend.

The Committee noted the changes to Agency Cap compliance requirements to promote improved transparency, robustness of data and stronger accountability by Boards, including a Board Self-certification checklist.

Performance Report for Period Ending 30 November 2016

The Committee noted that the Trust had reported a performance of 87.94% for the 4 Hour A&E Standard for November 2016 against a constitutional target of 95% and an STF trajectory of 89%. It was confirmed that the Trust held a strong position to make an STF appeal due to the external factors in domiciliary and intermediate care which had impacted on performance.

The Committee was disappointed to note that anticipated drop in Trust performance to approximately 80% by 2016/17 year end for RTT due to the data cleanse of the Primary Targeting Lists (PTLs) but agreed the appropriateness of the PTL review. The Committee requested that a breakdown of the RTT trajectory and 2017/18 recovery plan be presented at the next meeting.

The Committee noted an increase in the year-to-date number of avoidable cases of C Difficile to ten cases up until the end of November 2016. This remained below the cumulative plan trajectory for 2016/17. The Committee was assured of the ongoing risk assessment of the employment of deep clean methods in place of the Trust HPV Programme which had temporarily been postponed due to bed pressures.

The Committee was pleased to note the ongoing compliance with all cancer targets.

Changes to In-Year Financial Forecast

The Committee received the Changes to In-Year Financial Forecast which outlined the NHS Improvement (NHSI) protocol for adjusting the Trust's financial forecast position. The Committee reviewed the drivers which contributed to the Trust's financial deterioration, discussed the proposed recovery plan and confirmed that NHSI were cited on the proposed change to the Trust's financial forecast position in good time.

The Committee recommended to the Board of Directors, the completion of the Board Assurance Statement for adverse changes to forecast protocol.

Budget Setting/Planning Report

The Committee received the Income and Expenditure plans and Balance Sheet assumptions for 2017/18 and 2018/19, noting that although final tariffs were not anticipated until after the meeting, no changes were anticipated. During review the Committee gave consideration to the risks associated with:

- Compliance against RTT and 4 Hour A&E Standard,
- Management of agency spend within agreed financial parameters,
- Delivery of core activity,
- CIP preparedness,
- The proposed control total.

The Committee recommended that the Board of Directors approve the two year Financial Plan (2017-19) in the knowledge that the plan would not be in line with the control totals issued by NHSI.

Orthopaedic/Trauma Products – Contract Award Recommendation

The Committee reviewed the Orthopaedic and Trauma Products Contract Award Recommendation as Directed by the Board of Directors in November 2016. Following careful consideration of the shortlist of scenarios, qualitative assessment and analysis of cost the Committee recommend that the Board of Directors approve the contract award recommendation for orthopaedic and trauma products.

NHS Improvement – Monthly Return

The Committee noted the content of the NHSI Month 8 financial commentary which detailed the financial position at the end of November 2016 and cumulatively against the 2016/17 plan.

Assurance Reporting

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

- Finance, Strategy and Planning Group
- Informatics and Electronic Medical Devices Group
- Information, Information Governance and Coding Group

Andrea Hodgson
Chair of Finance, Business Performance and Assurance Committee

Board of Directors	
Agenda Item	8.2
Title of Report	Chair of Audit Committee Report
Date of Meeting	25 January 2017
Author	Cathy Bond, Chair of the Audit Committee
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
Reviewed by Assurance Committee	N/A
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

The Audit Committee met on 9 December 2016 and reports upon the following items to the Board of Directors:

Board Assurance Framework

The Committee received the updated Board Assurance Framework (BAF) and noted the input of the Finance, Business Performance and Assurance Committee and Quality and Safety Committee in respect of review of risk content and score.

The Committee considered the 'Using the BAF' guidance and confirmed agreement with the revised methodology and role of the Audit Committee in undertaking regular scrutiny of the effectiveness of BAF management processes. The Committee noted its support of the planned Divisional level training sessions, as proposed at the Operational Risk Management Team, to promote the embedding of internal processes for review, management and escalation of risks within the Trust.

The Chair of the Committee undertook to complete the 'Audit Committee Position' section of the individual BAF risk templates with other members of the Audit Committee, for review at the next Committee meeting.

The Committee also requested that the Finance, Business Performance and Assurance Committee give consideration to the discharge of Trust responsibilities with regards to the Better Care Fund in respect of Risk 9 – Sustainability.

Risk Management Processes

The Committee noted the limitations of the Trust's current Risk Management System and was provided with assurance on the working practices presently in place to ensure the preservation of effective risk management processes whilst a new system is procured.

The Committee was pleased to note the ongoing invitation to tender for the purposes of identification of a Risk Management System with enhanced functionality which would support the introduction of more efficient working processes and facilitate greater triangulation of data for improved patient safety and experience.

NHS Improvement Licence – Compliance Review

The Committee received the Provider Licence Quarterly Checklist which had been updated to reflect the actions being taken to address the breach in licence conditions outlined by NHS Improvement (NHSI) in August 2015.

The Committee noted the following key matters:

- The challenges experienced in meeting the Referral to Treatment Target (RTT) due to the current operational pressure faced by the Trust (C1(2))
- The support of the Trust's NHSI Engagement Partner in the application to remove section 111 (CoS31/FT4(7))

The Committee requested that the Finance, Business and Performance Committee give consideration to Trust management RTT compliance, throughout the winter pressures.

Legal Update

The Committee noted that the Single Oversight Framework (SOF) came into force on 1 October 2016 and assesses the Trust in respect of its performance within five key themes framework which are:

- Quality of Care
- Finance and Use of Resources
- Operational Performance
- Strategic Change
- Leadership and Improvement Capability

The Trust was allocated to segment three in shadow form based on the seriousness and complexity of the issues faced at the time of the implementation of the SOF.

The Committee supported the proposal to revise the Trust Standards of Business Conduct Policy with the caveat that any further amendments to national policy would be incorporated following receipt of the outcomes of the national consultation which commenced in September 2016.

Freedom to Speak Up Guardians Review

The Committee was pleased to note the overall positive performance in respect of the Staff Guardian Service with a strong increase in reporting and good staff response in the twelve month period following its introduction. The Committee noted that the initiative would be further enhanced following incorporation of the recommendations of the national Freedom to Speak Up Review and recently introduced National Whistleblowing Policy.

The Committee requested that metrics be developed to illustrate the positive performance of the Staff Guardian Service and feedback be given to staff governors on the uptake of the service.

Quarterly Financial Assurance Report

The Committee supported the resolution which had been reached with regards to One to One Midwives and noted that the Finance, Business Performance and Assurance Committee and Quality and Safety Committee would continue to monitor the performance of One to One Midwives and collaboratively develop revised patient pathways.

Internal Audit

The Committee reviewed the outcome/ratings of the audits undertaken during the reporting period as follows:

- IT Service Continuity – Limited Assurance
- Water Safety – Limited Assurance
- Quality Spot Checks (Phase 1) – Significant Assurance

The Committee was disappointed to note the receipt of Limited Assurance in the areas of IT Service Continuity and Water Safety and invited key colleagues to provide clarification regarding the basis for the assignment of Limited Assurance and the actions to be taken to address the recommendations.

The Committee requested that:

- Assurance be obtained in respect of compliance against all critical estates areas by the Finance, Business Performance and Assurance Committee,
- Follow up reports for both IT Service Continuity and Water Safety be undertaken ahead of March 2017 to obtain an update on levels of assurance ahead of the end of the 2016/17 financial year.

External Audit

The Committee was informed of the good progress in respect of interim audit fieldwork which was imminently due for completion with no items for escalation identified.

Clinical Audit Annual Update

The Committee noted the ongoing work in respect of Clinical Audit and the decision to - following analysis of the activity carried out in previous reporting periods - reduce the number of clinical audits undertaken during 2016/17 to ensure plan delivery.

The Committee requested that a review of the governance and reporting structure for Clinical Audit be undertaken.

Cathy Bond
Audit Committee Chair

BOARD OF DIRECTORS	
Agenda Item	8.3
Title of Report	Report of the Charitable Funds Committee – 21 September 2016 and 11 January 2017
Date of Meeting	25 January 2017
Author	Mr Michael Carr, Chair of the Charitable Funds Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 – Enabled by financial, commercial and operational excellence
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	N/A
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of work undertaken by the Charitable Funds Committee during its meetings of 21 September 2016 and 11 January 2017.

Charitable Funds Committee Terms of Reference

The Committee recommended the revised Terms of Reference as attached, which had been refreshed to support the Committee in discharging its responsibilities, to the Trust Board.

Annual Report and Accounts 2015/16

The Committee was pleased to receive and approve the Charity's Annual Report and Accounts for 2015/16 which would be publicised on the Trust's website.

Report from Independent Examiner

The Committee was pleased to note the draft Report from the Independent Examiner which confirmed that no matters had come to their attention during their examination of concern.

Communication and Consultation Proposal for Charity Re-Launch

The Committee approved the proposed communication and consultation programme to support the re-structure and re-launch of the Charity as agreed at the Board of Directors meeting of November 2016.

To further support the Charity re-launch, the Committee requested the development of information documents that provide greater clarity as to what is and what is not charitable funds for Trust staff to inform potential donors as to what and how to donate, in line with Charity Policy.

Recommendations

The Board formally approve the Terms of Reference.

Mr Michael Carr
Chair of the Charitable Funds Committee

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Charitable Funds Committee

Terms of Reference

Authors Name & Title: Director of Finance	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces:	
To be read in conjunction with the following documents: **Board Assurance Framework** **Board Assurance Framework Policy (from April 2013)** **Corporate Governance Manual (including Standing Financial Instructions)** **Charities Act 2011** **Trustee Act 2000** **Charity Treasury Management Policy** **Charities Act 1992 "Controlling of Fund-Raising"**	
Document for public display? Yes	

Unique Identifier:	**Review Date: 1st October 2016**	
Issue Status: Approved	**Issue No: 1.0**	**Issue Date: TBC**
Authorised by: Board of Directors	**Authorisation Date: TBC**	
After this document is withdrawn from use it must be kept in an archive for 10 years		
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Officer responsible for archive: Author		

1. Purpose

The Committee is established as a Committee of the Board of Directors of Wirral University Teaching Hospital NHS Foundation Trust in order to ensure that the Trust's duty as Corporate Trustee of its Charitable Funds has been discharged. Its purpose is to oversee management, investment and use of charitable funds within regulations provided by the Charity Commission and ensures compliance with charity law, including responsibility for the charity's fundraising activities. It does not remove from the Board the overall responsibility and legal obligation for this area, but provides a forum for a more detailed consideration of charitable matters.

The Charitable Funds Committee has delegated responsibility, from the Corporate Trustee, within the limits set out in these Terms of Reference, the charitable funds sections of the Scheme of Reservation and Delegations and Standing Financial Instructions for the efficient governance and running of the Wirral University Teaching Hospital (WUTH) Charity.

2. Authority

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

i) Maintain the Charity's governing document and registration with the Charity Commission.
ii) Review and advise on those aspects of Standing Orders and Standing Financial Instructions that appertain to the charity and its operation.
iii) Apply all charitable funds in accordance with the NHS Acts, Charities Act 2011 and good practice (including but not limited to WUTH Charity Expenditure Policy) and ensure that decisions on the use of investments of such funds are restricted to the explicit conditions or purpose of each donation, bequest or grant.
iv) Make decisions involving the use of charitable funds for investments subject to the powers laid down in the "Declaration of Trust" and with regard to the "Trustee Act 2000" and any subsequent legislation.
v) Consider the appointment of investment advisors and monitor the performance of the charitable fund portfolio and consider changes when deemed necessary.
vi) To oversee the Investment Policy of the Charitable Funds as required by the Trustee Investment Act 1961 and the NHS Acts.
vii) Act as the control mechanism for any approved fundraising appeals which may be initiated and to be aligned to the Charity Income and Fundraising Guidance Policy. Appointment and control of fundraisers will be in line with regulations and guidance contained in part 2 of the Charities Act 1992 "Controlling of Fundraising" and subsequent legislation.
viii) Oversee and monitor the functions with regards to the investment, accounting and reporting on the use of charitable funds.
ix) Receive Annual Accounts and Annual Reports of the Trust's charitable funds for consideration and recommendation for final approval to the Board of Directors.

x) To develop the strategy, policies and objectives for the Charity for consideration and approval by the Corporate Trustee.

3. Objectives

Act as the Committee that discharges the Boards responsibilities (as sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

3.1 Risk

3.1.1 To ensure that unacceptable risks and inadequate levels of assurance related to financial performance of the Charitable Fund or associated investments are reported to the Board for consideration.

3.2 Statutory duties

3.2.1 Ensure the approval and submission of statutory returns, annual accounts and Trustee's Report in accordance with the Charity Commissions Statement of Recommended Practice.
3.2.2 Review and update annually these Terms of Reference, recommending any changes to the Board of Directors.
3.2.3 Invest and apply the income, funds and property of the Charity in accordance with the governing document and complies with all legal relevant requirements including the Charity Act 2016 and agreed expenditure policy.
3.2.4 Maintain the solvency and continuing effectiveness of the Charity.
3.2.5 Safeguard permanent endowments.
3.2.6 Evaluate its own membership and performance on an annual basis and report findings to the Board of Directors.

3.3 Other Duties

3.3.1 Invest and review the investment funds not needed for immediate applications, in accordance with the Charity's investment objectives and the principles outlined in the Trust's Investment Policy.
3.3.2 Monitor the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.
3.3.3 Review and monitor the effectiveness derived from grants of money and property to the Trust.
3.3.4 Operate a visible and transparent decision making process for grants of money and property.

3.4 Governance

3.4.1 Ratify and review policies and procedures required for effective management of the Charity. This will incorporate oversight of associated compliance arrangements such as those required by the Charity Commission.
3.4.2 Ensure the Charity Treasury Management Policy is adhered to when considering related actions.
3.4.3 Give the Board assurance on an annual basis that the systems, policies and procedures they have put in place to deliver Charitable Funds plans are operating in compliance with appropriate standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.

3.4.4 Consider, interpret and disseminate guidance from relevant bodies including the Charity Commission and other regulatory/advisory bodies relating to the Charitable Funds agenda.
3.4.5 Approve the establishment, work plans, duration and effectiveness of sub-committees and working groups.
3.4.6 Respond to action plans referred by the Audit Committee.

4. Equality and Diversity

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

5. Membership

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Director of Finance
- Director of Workforce
- Deputy Director of Nursing

6. Attendance

In attendance:

Assistant Director of Finance (Financial Services)
Head of Financial Accounts
Director of Corporate Affairs

A nominated lay person, with appropriate experience, may attend upon invitation by the Chairman.

Other officers of the Trust will be invited to attend on an ad-hoc basis to present papers or to advise the committee. Professional advisors regarding investments may be invited to attend, when deemed necessary.

The Trust Chair and all Non-Executive Directors have a right to attend the Committee.

All members should aim to attend all scheduled meetings. Where they are unable to attend they should send their designated nominated deputy.

7. Quorum and Frequency

The quorum shall be three members, to include the Chair (or nominated deputy) and one Executive Lead/member of the Senior Management Team.

The Committee will meet at least four times a year. The Chairman can request additional meetings when he/she considers it appropriate.

8. Reporting

The Committee will report to the Board following each meeting via a Chair's report covering key decisions and risks and will present a comprehensive annual report to the Corporate Trustee.

Unapproved minutes will be circulated to Board Members by email as soon as is practicable following the meeting.

9. Conduct of Committee Meetings

The Terms of Reference shall be reviewed annually as part of the Annual Report to the Board of Directors as part of the Board Assurance Framework process. Any amendments will be approved by the Board of Directors.

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

Board of Directors	
Agenda Item	**8.4**
Title of Report	**Month 9 - NHSI Compliance Report**
Date of Meeting	**25th January 2017**
Author	**Shahida Mohammed - Assistant Director of Finance**
Accountable Executive	**David Jago, Executive 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**	**To note**
Review by Assurance Committee	**Not applicable**
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 9 2016/17 Financial Commentary for NHS Improvement

The following commentary details the Trust's financial position as at the end of December (Month 9) and cumulatively against the 2016/17 plan.

The Trust recorded an actual normalised surplus of c£0.1m during the month, against a planned deficit of (£0.5)m. This has improved the year to date position, which is showing a deficit of (£4.6m), against a plan of (£4.2m). The variance from plan relates to non achievement of RTT trajectories as a result of pressures within the Health Economy. While the Trust has successfully delivered the operational plan at the end of Q3 in line with forecasts it has been delivered utilising non recurrent and technical savings; the underlying pressures within the Trust's financial position are reviewed below.

Pay costs continue to overspend, reflecting operational pressures in supporting Non Elective and Social care shortfalls within the Health Economy. To protect patient safety the Trust increased escalation areas as a result of higher than planned demand for non elective patients within the system. The increased demand is due to a reduction in step down beds within the health economy as a result of savings within the Better Care Fund (BCF). As at December a total of 44 step down beds have been reduced within the health economy which has resulted in the requirement for escalation beds to be opened within the Trust. The Trust continues to work with the health economy and A&E Delivery Board to mitigate as best as possible the impact of these changes.

The Trusts cash balances position at the end of month 9 was £2.6m which is £1.1m below plan. The reduced cash balances are primarily as a result of negative working capital movements, the cumulative below plan performance in the EBITDA position and the non recurrent non cash savings within the YTD position. This has been mitigated somewhat by capital expenditure which is currently behind plan. It has to be noted the non cash backed savings in the YTD position and the deterioration in financial performance over the last quarter of the year will put cash balances under further strain. The effects of the pressure were reflected in the 13 week cash flow which was submitted to NHSI during November this identified that the Trust would be requiring further cash support in the final quarter of 2016/17.

The table below highlights the overall position in month and year to date after impairments.

	MONTH 9			YTD		
	Plan £m	**Actual £m**	**Variance £m**	**Plan £m**	**Actual £m**	**Variance £m**
NHS Clinical Income	24.519	17.218	(7.301)	221.040	212.189	(8.851)
Non NHS Clinical Income	0.152	0.161	0.009	1.368	1.277	(0.091)
Non Clinical Income	2.341	9.326	6.985	20.945	29.656	8.711
TOTAL INCOME	**27.012**	**26.705**	**(0.307)**	**243.353**	**243.122**	**(0.231)**
Employee Expenses	(18.129)	(18.449)	(0.320)	(163.830)	(167.481)	(3.651)
Other Operational Exp.	(8.249)	(7.224)	1.025	(73.569)	(71.669)	1.900
TOTAL EXPENSES	**(26.378)**	**(25.673)**	**(0.705)**	**(237.399)**	**(239.150)**	**(1.751)**
EBITDA	**0.634**	**1.031**	**0.397**	**5.954**	**3.972**	**(1.982)**
Post EBITDA Items	(1.158)	(0.969)	0.189	(10.183)	(10.095)	0.088
Net Surplus/(Deficit)	**(0.525)**	**0.062**	**0.587**	**(4.229)**	**(6.123)**	**(1.894)**
Normalised Surplus/(Deficit)	**(0.525)**	**0.062**	**0.587**	**(4.229)**	**(4.591)**	**(0.362)**
EBITDA Margin %	2.34%	3.86%	1.52%	2.45%	1.63%	(0.82%)

NHS Clinical Revenue

Cumulatively actual activity delivered is below the plan, with the exception of A&E, Non-Elective and Outpatient Diagnostics. This predominantly reflects the increase in emergency demand and patient acuity levels. The position also reflects a richer case mix which has impacted the financial position in non-elective activity. The year to date over recovery in Non PbR areas mainly reflects over performances in, neonatal, direct access pathology and rehabilitation activity.

The Trust continues to benefit from the envelope agreed with Wirral CCG at the start of the financial year by c£4.4m.

Non Clinical Income

Non clinical income continues to over perform against plan in December by £0.1m largely relating to higher research and development income and higher staff recharges offset partially by a retraction on education income for study leave.

Operating Expenditure

In December (Month 9) operating expenditure is below plan in month by £0.7m reducing the YTD variance to £(1.7m).

Pay costs exceeded plan by (£0.3m), and are showing a cumulative overspend of (£3.3m). The issues driving the current cumulative adverse performance in pay are:

- A reduction in the provision of intermediate care beds within the health economy has resulted in an increased unplanned demand for non-elective beds within the Trust. As a result of this pressure escalation beds have remained open through the year as well as additional staff required within A&E driving the adverse pay performance by c£1.7m ytd. The Trust is continuing to work with the health economy to try to reduce this pressure going forward and is continually reviewing the winter plan as a senior team.

- Other operational pressures in medical staffing costs have continued during the month. Within the Emergency Department, the medical staffing position has improved in month, but there remains a pressure of approximately (£0.5m) in the year to date position. There are further critical medical staffing gaps in other specialties, resulting in premium agency or locum staff being utilised to cover the gaps of (c£0.7m) ytd. WLIs have remained minimal in December as the focus is to utilise core capacity to deliver RTT targets, spend is now marginal in a couple of specialties for achieving RTT and cancer targets c(£0.4m) ytd.

- Non–delivery of cost improvement plans in relation to pay work-streams of (£1.2m) comprises some of the pay overspend, this has been partially mitigated by vacancies within the Divisions.

Focus within the Trust will continue to remain on the use of non-core pay spend across all staff categories and continuing development of recruitment and retention strategies to address staffing gaps together with mitigating the slippage on the delivery of CIP schemes.

Agency spend, during December is lower than plan by some £0.2m, cumulatively this is below the NHSI ceiling rate by £0.7m. This improvement reflects the work the Trust is undertaking on managing agency costs across the organization and further improvement on the agency trajectory is under review.

Non pay costs are £1m below plan in December and cumulatively £1.9m lower than plan and reflect a one-off reduction in provisions and accruals as well as the continued benefit of the renegotiation pf the Cerner contract.

EBITDA

EBITDA was below plan predominantly due to the adverse variances within expenditure with key drivers detailed above..

Post EBITDA Items

Cumulatively, there is a small variance from plan, as shown below.

Post EBITDA variances	£m
Donations and grants received	0.1
Depreciation lower than plan	1.2
Impairment due to revaluation	-1.5
Net gains/losses on asset disposals	-0.1
PDC dividend reforecast	0.3
Total variance of ITDA position to plan	**0.0**

Achievement of the 2016/17 Cost Improvement

The 2016/17 plan assumes the achievement of £8.6m of cost improvement programmes and £2.7m revenue generation schemes through the year, delivering a combined total of £11.2m.
Plans amounting to some £9.5m have been identified and were extracted according to the profile of the schemes, with the unidentified balance of £1.7m extracted in a flat profile (12 ths).
The CIP position at Month 9 (including non-recurrent schemes) can be summarised as follows:

Theme	YTD Plan (Mth 9) £m	YTD Actual £m	Variance (£m)
Productivity & Efficiency	2.4	1.5	(0.9)
Workforce	1.7	1.3	(0.4)
Cost Control & management	1.4	1.3	(0.1)
Estate Management	0.6	0.4	(0.2)
Income	0.9	0.8	(0.1)
Other schemes	0.4	3.3	2.9
TOTAL	**7.4**	**8.6**	**1.2**

The latest in year forecast is c£11.2m, underpinned by the depreciation review and Cerner contract savings. The challenge continues to be the conversion of ideas and opportunities into expenditure releasing recurrent schemes as the Trust progresses through the financial year. The Trust is closely monitoring the non recurrent schemes due to the impact on the underlying position.

The Trust continues to focus its attention on managing performance against schemes identified and milestones agreed through the Transformation Steering Group (TSG).

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 is working closely with the Divisions to secure the achievement of the 2016/17 CIP requirement and the formulating plans for 2017/18.

Statement of Financial Position for the period ending 31st December 2016

Total taxpayers' equity equals £114.4m. The main variances against plan are explained below.

a) Non-current assets

Capital assets are below plan by £16.3m at month 9. This variance is detailed in the table below.

Capital variances	£m
16/17 brought forward balances above plan (revaluation)	**4.2**
Capex underspend	**-1.4**
Depreciation below plan	**1.2**
Revaluation of built estate, not included in plan	**-20.1**
Derecognition correction for a finance lease (within disposals)	**-0.1**
Other disposals exceeding plan	**-0.1**
Total variance of capital assets to plan	**-16.3**

b) Current assets

Current assets are above plan by £2.1m. Current trade and other receivables are above plan by £3.1m, including accrued income for STF funding. Inventories are above plan by 0.1m. The remaining variance is due to cash balances being below plan by £1.1m. This cash variance is detailed in the table below.

Cashflow variances	£m
16/17 brought forward cash balance exceeded plan	1.2
EBITDA below plan	-2.0
Working capital movements	-6.9
Capital expenditure (cash basis) behind plan	2.8
Cash donations to purchase capital assets	0.1
Working capital facility extension	3.6
PDC drawn down, not within plan	0.1
PDC dividend paid above plan	-0.1
Total variance of cash to plan	**-1.1**

c) Current liabilities

Current liabilities are above plan by £1.8m. Trade and other payables are below plan by £2.4m, deferred income exceeds plan by £0.6m, and current borrowings are above plan by £3.6m, due to the extension to the existing working capital facility, drawn down in month 8.

d) Non-current liabilities

Non-current deferred income is below plan by £1.5m, due to technical adjustments to an IFRIC 12 asset which affected 2016/17 brought forward balances.

Use of Resource (UoR) Rating

The Trust has achieved an overall UoR Rating of 3, which is in line with the recalculated plan rating, with the exception of the "capital servicing capacity".

Detailed below is performance against each of the criteria.

	Planned Rating	Actual Rating
Liquidity	4	4
Capital service capacity	3	4
I&E margin	4	4
Distance from financial plan	2	2
Agency spend	1	1
Overall UoR Rating	**3**	**3**

Control Total and Sustainability and Transformation Fund (STF)

At the end of Mth 9 the Trust has achieved its planned control total position excluding STF target. The Trust as previously reported from month 6 narrative submission is not forecasting to deliver the quarter 4 control total as a result of the pressures mentioned above in conjunction with the stretch £5m challenge noted below.

The Trust has submitted the Board Assurance statement regarding the deterioration of the financial forecast.

Conclusion

The Trust delivered the Q3 position in line with the Board agreed recovery plan that was shared with NHSI during September albeit via one off non recurrent savings.
As reported during the health economy meeting during September the Trust is forecasting to deliver a deficit of c£10.5m. The deterioration is a result of the £5m health economy challenge not being concluded and operational pressures within the Trust which have arisen and are outside of the Trusts control resulting in the continuing need to provide escalation facilities within the Trust. This will subsequently result in the non-delivery of the Q4 position will also mean a further £2.5m reduction in the STF available to the Trust in the last quarter. The Trust has adjusted its financial forecast in line with the protocol issued by NHSI in October.

The Trusts cash position is currently behind plan as a result of the non recurrent cash savings utilised to deliver the Q3 position. The Trust will continue to submit 13 week cash flows in line with NHSI processes to support further draw down on the working capital facility.

The Trust continues to work 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
January 2017

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

30 NOVEMBER 2016

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
David Jago	Director of Finance
Mark Lipton	Interim Medical Director
Cathy Maddaford	Non-Executive Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Chris Oliver	Director of Operations
James Mawrey*	Director of Workforce
Clare Pratt	Deputy Director of Nursing
Gaynor Garner*	Ward 36 Manager
Sachin Ramdhay*	Ward 20 Manager
Jacqui Cooper*	Corporate Matron for Quality & Patient Experience
Jayne Kearley	Member of the Public

Apologies

Gaynor Westray	Director of Nursing and Midwifery
Janelle Holmes	Chief Operating Officer

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 16-17/197	**Apologies for Absence** Noted as above	
BM 16-17/198	**Declarations of Interest** None	
BM 16-17/199	**Patient's Story** The Deputy Director of Nursing provided the Board with some feedback from a family member whose mother had received care on the High Dependency Unit. The feedback included praise for the staff in terms of the respect and dignity shown to her mother and for looking after her father and the family on the whole.	
BM 16-17/200	**Ward Accreditation, Gold Award Presentations** The Chairman welcomed Ms Cooper; Ms Garner and Mr Ramdhay to the meeting.	

Reference	Minute	Action
	Ms Cooper provided the Board with an outline of the ward accreditation programme including the key focus areas and the ranking methodology. The specific achievements for both Ward 20 and Ward 36 were outlined which had resulted in both wards achieving the Gold standard. Ms Garner advised that IT was helping with record keeping and that the profile of sickness and vacancy rates had improved on her ward. Mr Ramdhay advised that the focus of attention for Ward 20 was on the MEWS assessment as the importance of this indicator was well recognised. The Board sought to understand how the staff were feeling about receiving this recognition and how this will be maintained in the future. Both wards were reported to be delighted with the recognition but there was acknowledgement that the key was maintaining this performance which would be achieved with the support of Ms Cooper in particular. The Board thanked and acknowledged both Ms Garner and Mr Ramdhay for their achievements and extended their thanks to their respective teams. The Board also thanked Ms Cooper for leading on this work.	
BM 16-17/201	**Chairman's Business** The Chairman updated the Board on the recent consultant appointment in community geriatrics – Dr Helen Kess. The Chairman advised that the Annual Members Meeting on the 23rd November 2016 was well received with a good level of questions from the public. He thanked the Board for their contributions and extended thanks to all those who took part in the Market Place by displaying their services.	
BM 16-17/202	**Chief Executive's Report** The Chief Executive focussed on the following areas from his report: **Cerner Phase 3 "Go Live" Update –** the Board was updated on the success of the "Go Live" the previous weekend and thanks was extended to all concerned for ensuring this happened. **NHS Improvement NHSI** – the Chief Executive confirmed that following the meeting he had now written to all partners outlining the expectations of NHSI in respect of the £5M system control total, although it was clear from the joint meeting with NHSI/NHSE and health economy partners this was not recognised by all. The Board was pleased to note the recommendation from the NHSI Regional Team to remove the section 111 with further details to follow on how this will be progressed. **Care Quality Commission CQC** – following the briefing from the last engagement meeting, the Chief Executive confirmed that he would update the Board on the inspection plans for 2017 when finalised with CQC **Winter Planning** – the Chief Executive advised that the emphasis of this year's planning was on whole system working and in particular ensuring the availability of social care and GPs. He did express concerns over the lack of resource made available to date over the Christmas and New Year period.	

Reference	Minute	Action
	Sustainability and Transformation Plan STP – following publication of the document the Chief Executive confirmed that a meeting had been attended with STP colleagues convened by Louise Shepherd the Chief Executive lead for the programme. He expressed concern over the estimation of additional resources deemed necessary to deliver the plan and the expectation of contributions from each organisation. **Joint engagement event with Primary Care Wirral and Trust Medical Leaders** – the Chief Executive confirmed that this event was well attended by both consultants and GPs. The evening was deemed to be positive with significant levels of commitment to progress the change required although he confirmed that it was vital that action now happened as a result of this. **Flu vaccination rates** – the achievement of the flu vaccination rate of 75% was noted by the Board and thanks extended to all involved **Library Quality Assurance Framework** – the Board noted the achievement of the library service having achieved 99% compliance which was one of the best rates in the country.	
BM16-17/203	**Bi-monthly Nurse Staffing Report** The Deputy Director of Nursing presented the Bi monthly nurse staffing report highlighting the latest nurse vacancy rates as at October of 2.5% although it was acknowledged that at Band 5 level this was 6.10% which equated to 42 staff for the same period. It was reported that these vacancies were predominantly in Medicine and were proving difficult to recruit to. The Board reviewed the care hours per patient day CHPPD levels records from May to October together with the fill rates for each ward/area. Particular attention was focussed on three areas that were rated as RED in the report during the month of October these being Ward 12, Ward 54 and M1. The Board was advised that Ward 12 was safely staffed at all times according to bed occupancy levels. The ward had minimum patients and the correct staffing ratio to support the acuity of these patients which was evidenced by the high CHPPD figure. Ward 54 again it was reported that the staffing was appropriate and safe. Due to reduced elective activity CSW staff had been reallocated to support areas of higher patient acuity and occupancy. It was reported that staff on M1 had been reduced to reflect the reduction in activity and where required the Ward Sister worked clinical shifts to ensure that safe staffing was in place at all times, again this was evidenced by the high CHPPD rates. The Deputy Director of Nursing advised that many of the staffing incidents were indicating that there were staff shortages however upon investigation it had been confirmed that this is perception as the staffing levels were found to be safe or mitigating actions had been put in place to ensure safety. The Board was advised that a programme of targeted work had commenced to ensure that staff understood safe staffing levels and to focus on another key area which was staff reporting an inability to take breaks which was of concern. The Board sought to understand how the average CHPPD had been determined which was confirmed as the average of the previous 6 months. The Deputy Director of Nursing advised that amongst the pilot sites the Trust	

Reference	Minute	Action
	was middle of the pack however specific benchmarking data was not currently available. The Trust requested that in the absence of comparative data, the Trust determine its own CHPPD levels for each ward. The Board sought clarity on the role of the Associate Nurse Practitioner and in particular whether this would attract new funding. It was reported that no funding would be available hence the work being undertaken in Divisions to determine the next steps which in the main would be focussed in Medicine and the Older Persons Assessment Team. The Deputy Director of Nursing advised that during the 2 year training period these roles would be included in the numbers for CSWs. The Board sought to understand the view of staffside to the movement of staff across wards. The Deputy Director of Nursing advised that it was largely supportive although there were some concerns with the feedback on staff not being able to take breaks although this was not being formally reported. The Board expressed concerns on the Trust's ability to maintain and improve on the CHPPD given the onset of winter and the level of demand being experienced in the hospital. The Deputy Director of Nursing shared these concerns although she confirmed that this was being managed through the use of Ward sisters where necessary on a one day per week clinical rota and through the use of bank and agency which was well controlled. The Board sought and received assurance that the staffing figures would include the step down facility once formally opened. The Chief Executive outlined the plans to ensure greater levels of flexible nurse staffing in the future recognising that the movement of staff was inevitable in all hospitals. He advised that a number of wards were beginning to work as a cohort to ensure that there was a greater level of control over the movement of staff which was helpful.	**CP**
BM16-17/204	**Appraisal and Revalidation Annual Report** The Interim Medical Director presented the Appraisal and Revalidation Report 2015/16. He provided the Board with an overview of this work since its inception in 2012 to aid with the review. The Board was updated on the numbers of appraisals undertaken during the reporting period; the number of revalidations and the number of deferrals. The Board sought to establish how long a deferral could be accepted before formal action was progressed, this was confirmed as 6 months. The Board sought and received assurance that there were no individuals approaching the 6 month target. The Board explored why appraisals did not take place as planned with some of this attributable to potential conflicts between the appraiser and appraisee. The Board was disappointed to note that the appraisal did not focus on clinical engagement; behaviour, and corporate responsibility and recommended that this be reviewed to encapsulate this in the future.	

Reference	Minute	Action
	The Interim Medical Director was asked how feedback from patients and colleagues was included in the appraisal. He confirmed that feedback from 10 patients and 10 colleagues was included every 3 years. The Board's focus was on whether the process was making a difference and agreed that this needed to be the key aim going forward. The Board was concerned to note that the Procedure for Handling Concerns about Conduct, Performance and Health of Medical and Dental Staff was reported as in need of review as it was out of date (2006). The Board sought to establish when this would be reviewed and the Interim Medical Director advised in the next financial year. In view of the level of concern raised regarding the outstanding procedure, subsequently the Director of Workforce sought to establish the status of this and confirmed as follows: 1. The above Procedure was approved at the JLNC on 13th November, 2014. This is evidenced within the minutes which are held and produced by the Medical Director's office. 2. The above Policy is next up for approval on 13th November, 2017. The note is included as a matter of public record.	
BM 16-17/205	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Director of Operations presented the Integrated Performance Report and highlighted the following areas: **A & E 4 hour compliance** – it was reported that the Trust achieved 88.59% as a combined Emergency Department and All Day Health Centre for the month of October. This was above the STF trajectory of 88%. The Board was advised of the increased pressure in the service as a result of concerns regarding capacity and quality in the care home market. The Board discussed the ongoing debate with regards to which data could be included in the national figures and sought to establish if any other organisations would be disadvantaged if the Trust were able to include the walk in centre figures. The Director of Operations advised that no other organisations would be disadvantaged hence the reason the recommendation for this to be included was being pursued. The Board noted that although perfectly reasonable to include the walk in centre figures, this would inevitably lead to a further unqualified opinion from the External Auditors as the Trust could not validate this external data. The Director of Finance confirmed that he was in dialogue with the External Auditors on this point in order to seek a resolution. The Board was advised of the risk of potential underachievement of the A & E trajectory for November as performance was 88% against the target of 88.5%. **RTT** – the position for October was reported at 86.80% against the target of 92%. The Board was advised as previously discussed that performance would continue to deteriorate to circa 80% by March 2017 before it improved as a result of the work of the improvement programme. The Director of	

Reference	Minute	Action
	Operations confirmed that the improvement programme focussed on the cleansing of patient lists; the training of staff to ensure correct procedures are followed when managing the 18 week pathway; the recruitment of a patient tracking team and the development of performance and data quality reports. The Board sought and received clarification that the loss of income associated with non-compliance of the STF trajectory was £103K per month however this had been factored into the financial plan. The Director of Finance advised the Board that the Trust had been encouraged to submit an appeal into NHSI for Q2 funding and would likely do the same in Q3. The Board sought and received clarification as to how the Trust was maintaining a level of safety as it undertook the improvement exercise. The Director of Operations confirmed that all urgent and cancer patients were treated as priority. All patients were risk assessed and trigger points were included in the waiting list to ensure that no patient waited more than 30 weeks. **C difficile** – it was reported that 9 avoidable cases had been recorded year to date against the trajectory of 29. **Cancer** – all targets confirmed as on track. The Board requested that further consideration be given to the reporting of cancer as concerns were raised with the number of RED areas being reported as a result of in-quarter reporting despite the expectation that compliance would be achieved. **Advancing Quality** – the Director of Operations advised the Board that a request to re-open the data set had been made in order that the Trust could input the additional information required in order to ensure performance is reported accurately. The current appropriate care score of 46% was attributed in part to information not being submitted due to sickness absence. The Board was disappointed to note the reliance on individuals for submissions; this view was acknowledged by the Director of Operations who confirmed that the manual entry exercise was being addressed through Phase 3 of Cerner and that it would be included as a mandatory field in the future. The Board was advised that compliance each month with the Acute Kidney Injury AKI appropriate care score was expected however the Trust could not achieve compliance for the whole year at this stage. The Board sought and received clarification that the lowest expected score for RTT before an improvement could be seen would be 80%. The Board debated the continuing demand and pressure on the hospital as a result of a lack of care in the community to avoid admission and to enable safe discharge. It was reported that the Trust currently had 4 wards full of medically optimised patients which was a picture mirrored nationally in many acute hospitals. • **M7 Finance and Cost Improvement Programme Report** The Director of Finance presented the M7 finance and cost improvement report and highlighted the following areas: The M7 variance against plan was reported at £697K. The variance in part was attributed to the failure of the RTT sustainability and transformational Funding trajectory which equated to £103K; lower than plan income from Wirral commissioners and from associate commissioners. The expenditure was reported to be in line with the plan and improved performance was noted on pay and in particular on agency spend. Payments for waiting list inititiatives was confirmed as £40K which was similar to September and	**CO**

Reference	Minute	Action
	much lower than previous expenditure of £190K per month. The adverse variance in pay was associated with the cost of escalation; emergency department medical cover and premium costs associated with waiting list initiatives. The Board was advised that the year to date deficit was £4M which was circa £800K away from plan. The £700K challenge to achieve Q3 performance was reported as unchanged although work was underway to address this. Capital programme – the Director of Finance reported no major concerns associated with the timing difference of some of the expenditure. Cash – the Board was advised of the delay in receiving the STF funding for November which was causing concern although receipt had been promised within the next hour. The Chief Executive confirmed that he was pleased that the expenditure actions had begun to take effect. He advised that the dip in activity in November was in part due to the impact of Cerner Phase 3 "go live". The Board acknowledged the challenges but was pleased to note the evidence of better financial control, which was largely attributed to the close working of operational and finance colleagues. • **Assurance on Agency Spend** The Director of Workforce presented the self-certification checklist following the introduction of further controls by NHSI. The Board reviewed the checklist and recommended the following amendments ahead of submission: **No. 4** – the Board sought to establish how it would actually know that the Trust was not engaging in any workarounds of the agency rules. The Director of Workforce outlined the processes; systems and checks and balances in place to prevent this happening which were fully supported by staff. The Board requested that this be included as part of the response. **No. 12** – the Board sought to establish whether it was actually possible for any Trust to fill vacancies in 21 days. The Director of Workforce advised that it was virtually impossible. The Board asked therefore that the response note that this was unrealistic. **No. 14** – the Board agreed that there was more work to do in this area in particular with medical and laboratory staff although recognised workforce planning was undertaken well in nursing. The Board requested that the workforce dashboard focus on this group of staff through its reporting to Quality and Safety Committee. The Board approved all the items in the checklist subject to the above changes and noted that in the absence of the Chief Executive, the Director of Finance would undertake approvals above £120.	**JM** **JM** **JM**
BM16-17/206	**Report of the Quality and Safety Committee** The Chair of the Quality and Safety Committee presented the report following the meeting that took place on 9th November 2016. The following areas were	

Reference	Minute	Action
	highlighted: It was reported that the Committee welcomed the methodology outlined by the Director of Corporate Affairs as to the remit of the Committee going forward. The Board was advised that the changes to the terms of reference and workplan for the Committee would be undertaken ahead of the January Committee meeting. The Board was notified that the average response rate to the NHS staff survey for the Trust was higher than the national average. The financial risks associated with the changes to the apprenticeship levy were noted acknowledging that this would be monitored by the Finance Business Performance and Assurance Committee. The Committee agreed to increase reporting against the OD strategy in future. The Board was advised that the Committee undertook the "deep dive" into the Health Education England findings following the visit in July 2016. The Committee agreed that although there were areas of concerns which form part of the improvement plan, there were also many positive areas. The Committee agreed to continue to monitor progress against the plan as part of its work programme. The Board was advised that the Committee recommended that the Director of Nursing and Midwifery review and reduce the CQC risk in relation to preparedness to reflect the work undertaken to date. The Board was advised that the Committee would continue to monitor the quality impact of the decision by the Commissioner to limit procedures of low clinical value. The Board was asked to formally note the following areas from the Health and Safety Report: • The commencement of the asbestos survey which was anticipated to reach completion at the end of December 16 • The positive response to the Health and Wellbeing LIA event held during October 2016 and the ongoing work • The work to be undertaken by the Water Safety Group to address the issues identified during the internal audit into water safety which received limited assurance. The Board was asked to note that the Chairs Reports from the Executive Working Groups had been improved in line with the Well led Governance Review recommendations and these were now providing the basis for additional assurance.	
BM16-17/207	**Charitable Funds Proposal** The Director of Finance presented the paper on the charitable funds proposal	

Reference	Minute	Action
	acknowledging the extensive discussions undertaken by the Board ahead of this final proposal. The Board was advised of the revisions made to the Mission statement to now include equipment; the decision to fund the additional post required in finance to support this proposal from Trust expenditure and the overall summary of costs. The Board agreed that the re-launch of the Charity would take place from 1st April 2017 and that benefits realisation had to be included in the job description for the Head of fundraising. The Board approved the proposal although it stressed the importance of consultation and communication with staff ahead of the re-launch. The Board asked the Trust to ensure that the Charitable Expenditure guidance and the Standards of Business Conducts on gifts and hospitality were aligned. The Board requested a further update on this work at the next Charitable Funds Committee.	**DJ**
BM16-17/208	**CQC Compliance and Action Plan Progress** The Deputy Director of Nursing presented the latest compliance and progress update report. This included the outcome of the care quality inspections which had seen significant improvements although the domain of "safe" still required some improvement particularly in relation to medicines management which was the subject of targeted improvement work. The Board was updated on the inspection preparedness including the latest CQC engagement meeting and the last "deep dive" Event which focussed on improvement in advancing quality, medicines management, infection prevention and control and nutrition and hydration. The Board acknowledged the work required in respect of standardising internal ward transfers as a result of findings from a previous serious incident. The Board noted the clear concise report and acknowledged the next steps being undertaken.	
BM16-17/209	**Board of Directors** The Minutes of the Board of Directors held on the 26th October 2016 were confirmed as an accurate record subject to the amendment to the role of Sue Wells in the clinical commissioning group, this should read Chair and not Medical Director. **Action Log** The Board accepted the action log as presented and noted the following additional updates: **Item 1 –** this was included in the paper to the Board in November – completed.	

Reference	Minute	Action
	Item 2 – the risks relating to contract sign off and RTT non-compliance had now been included in the BAF – completed **Item 6 –** it was reported that the Trust did not undertake this breakdown – completed **Item 7 –** the discrepancy noted in the nurse staffing table was attributed to the opening of an additional ward separately ward 37 and 38 out – completed **Item 8 –** the Director of Finance now accountable for this action **Item 14 –** this will not be available until April 17.	
BM16-17/210	**Items for the BAF/Risk Register** The Board requested that the changes to charitable funds be logged in the BAF	**CS**
BM 16-17/211	**Items to be considered by the Assurance Committees** **Quality and Safety Committee** – review consultant pinch point data **Audit Committee** – scheme of delegation in relation to the new agency spend limits	**JM** **DJ**
BM16-17/212	**Any Other Business** The Board sought assurance on whether the recent serious power outage was separate or related to the previous incident and as to the assurance of supply. The Director of Finance confirmed that the Trust had commissioned external due diligence in this area; the issues were unconnected with no need for wider review at this stage. The results of the report would be presented to the Operational Risk Management Team in December 2016. The Board requested that a summary report on backlog maintenance and the potential liability be provided to the Board under separate cover.	**DJ**
BM 16-17/213	**Date and Time of Next Meeting** Wednesday 25th January 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

ACTION LOG
Board of Directors
Updated – November 2016

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 30.11.16						
1	BM16-17/203	The Trust to determine its own CHPPD levels for each ward in the absence of benchmarking data	**CP/GW**		January 2017	
2	BM16-17/205	Consider future reporting of Cancer performance as in-quarter performance looks negative	**CO**		January 2017	
3	BM16-17/205	Agency Assurance self-certification: **Item 4** - Include work on processes, systems and checks in response **Item 12** – the response note should state this is unrealistic **Item 14** – Board requested further work on workforce planning in relation to medical and laboratory staff and report this through QSC	**JM** **JM** **JM**	**Completed** **Completed** **Completed**	January 2017	
4	BM16-17/207	Provide the Charitable Funds Committee with an update on the re-launch consultation at the next meeting	**DJ**	**Completed**	**January 2017**	
5	BM16-17/210	Log the changes to the charitable funds in the BAF	**CS**	**Completed**	January 2017	
6	BM16-17/211	**QSC** - Review consultant pinch point data **Audit** – review new agency spend limits as part of the review of the scheme of delegation	**JM** **DJ**		January 2017 February 2017	

7	BM16-17/211	Provide a summary report on backlog maintenance and the potential liability and circulate this separately to members	**DJ**	**Provided to Board members in January 17 - completed**	January 2017	
Date of Meeting 26.10.16						
8	BM16-17/175	Items to be considered by Assurance Committees: • FBPAC to focus on agency spend • QSC to focus on the actions being taken in response to Health Education England Report following the visit in July 16; any quality issues associated with RTT and the review of the work of clinical governance group in respect of advancing quality.	CS	**Completed**		
Date of Meeting 27.07.16						
9	BM16-17/102	The Board recommended that the Trust review its compliance against the boiler exhaust omissions.	DJ			
10	BM16-17/	Items to be considered by assurance committees: • FBPAC – an update on how the Divisions are progressing with the demand and capacity work • Consider the learning from this and how this might inform the finance report going forward	JH/DJ	**All capacity and demand work undertaken and subject to Executive Challenge by Director of Finance and Chief Operating Officer. This will also drive budget setting at speciality level.**	Sept 16	
Date of Meeting 29.06.16						

11	BM16-17/069	Review the corporate governance statements in relation to the CQC action plan; data quality and compliance with statutory access targets	CS	**Completed as part of the private Board session in December**	Dec 16	
12	BM16-17/071	Review the risk management process report for Audit Committee in view of the need for greater oversight of this going forward	EM/CB	**Completed at the December Audit Committee and December Private Board**	Sept 16	
Date of Meeting 25.05.16						
13	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	CS	**Agreed to defer this until later in the financial year in light of current position**	July 16	
14	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	JH	**This work will be undertaken as part of the action plan from the well led Governance review**		
15	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	GW		**April 17**	
16	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	EM	**Ongoing**	February 17	
Date of Meeting 30.03.16						
17	BM15-16/297	Present the Medical Engagement Strategy	EM/JM	**This work is underway and will be progressed further now the new Medical Director is in post**	May16	
18	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	CO		April 16	
19	BM15-16/300	Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process.	GW		April 16	
Date of Meeting 27.01.16						

20	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	**Trust above STF trajectories for Q1 and Q2 to date. Board of Directors to continue to receive updates as part of monthly Board of Directors Performance Report.**		
21	BM15-16/244	Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis	MB	**This work will be undertaken as part of the action plan from the well led Governance review**	March 2016	
Date of Meeting 28.10.15						
22	BM 15-16/163	Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	
23	BM 15-16/163	RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	
Date of Meeting 30.09.15						
24	BM 15-16/132	The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review.	MB	**This work will be undertaken as part of the action plan from the well led Governance review**	October 2015	